OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

March 1, 2022

Sheriff Don Barnes
Orange County Sheriff's Department
550 N. Flower Street
Santa Ana, CA 92703

Re: Custodial Death on September 1, 2020
Death of Inmate Paul Alexander Gill
District Attorney Investigations Case # SA 20-022
Orange County Sheriff's Department Case # 20-028753
Orange County Sheriff's Department Case # 20-028838
Orange County Crime Laboratory Case # 20-50012
Orange County Coroner's Office Case # 20-04548-KI

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the September 1, 2020 custodial death of 26-year-old inmate Paul Alexander Gill.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Mr. Gill. In this letter, the OCDA describes the criminal investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD in connection with this custodial death incident.

On September 1, 2020, OCDA Special Assignment Unit (OCDASAU) Investigators responded to University of California, Irvine-Medical Center (UCIMC), where Gill died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 6 witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, videos and other relevant materials.

The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and applicable legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of any OCSD personnel or any other person under the supervision of the OCSD. The OCDA will not be addressing policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating custodial deaths within Orange County when an individual dies while in custody. An OCDASAU Investigator is assigned as a case agent and is supported by other OCDASAU Investigators, as well as Investigators from other OCDA units.

Six Investigators are assigned to the OCDASAU on a full-time basis. There are additional OCDA Investigators assigned to other units in the Office trained to assist when needed. On average, eight Investigators respond to an incident within an hour of being called. The Investigators assigned to respond to an incident perform a variety of investigative functions that include witness interviews, scene processing, evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the OCCL processes all physical evidence related to the investigation.

When the OCDASAU Investigators have concluded their investigation, the file is turned over to an experienced deputy district attorney for legal review. Deputy district attorneys from the Homicide, TARGET/Gangs, and Special Prosecutions Units review fatal and non-fatal officer-involved shootings and custodial death cases, and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage: http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On August 14, 2020, Gill was in custody at the Los Angeles County Jail. Gill had four outstanding warrants issued in Orange County. On August 14, 2020, the OCSD took custody of Gill and transported him to Orange County. Gill was booked into the Orange County Jail (OCJ). At approximately 8:55 a.m., an Orange County Health Care Agency (OCHCA) staff member completed a medical screening of Gill. Gill indicated that he was diagnosed with

schizophrenia and that he had attempted to harm himself in the past. Gill indicated that, "it's been a while" since the last time he thought of hurting or killing himself. The OCHCA staff referred Gill to Mental Health for further evaluation.

At approximately 12:59 p.m., an OCHCA staff member completed a Mental Health Screening of Gill. Gill indicated that he had been diagnosed with schizophrenia and experienced auditory hallucinations. Gill denied any history of attempted suicide, but his chart indicated that he admitted to attempting suicide by overdose in 2017 or 2018. Gill reported that his brother committed suicide a year ago. Gill stated that he was not depressed and not thinking of hurting or killing himself at this time. Gill was not placed on suicide watch and was cleared for housing in general population. Gill was initially housed in the main jail and then transferred to the Theo Lacy Facility (TLF) on August 18, 2020. Jail staff placed Gill in COVID-19 quarantine.

On August 18, 2020, an OCHCA staff member visited Gill. Gill reported a history of hearing voices due to illicit street drug usage but stated that it had decreased as the drugs had "worn off." A staff member determined that a mental health follow-up in three weeks would be appropriate. On August 19, 2020, an OCHCA Nurse Practitioner visited Gill. Gill was evaluated for the prescription of Subulex. Gill admitted to prior use of heroin and methamphetamine one year prior. Gill denied having any cravings or using any illegal drugs while in the facility. The Nurse Practitioner prescribed him the following medication:

DRUG	STRENGTH	AMOUNT
Diphenhydramine	25 MG	Once a day at bedtime

On August 21, 2020, an OCHCA Mental Health Clinician (MHC) visited Gill's cell. The MHC found that Gill was coping well. Gill did not express any medical concerns at the time. On August 26, 2020, an OCHCA Doctor (MD) prescribed Gill the following medication:

DRUG	STRENGTH	AMOUNT
Diphenhydramine	25 MG	Once a day at bedtime

On August 27, 2020, the MD changed the frequency of the medication to the amount reflected below:

DRUG	STRENGTH	AMOUNT
Diphenhydramine	25 MG	Three times a day

On August 27, 2020, an MHC visited Gill. The MHC found that Gill was coping well and did not express any medical concerns. Gill denied having any suicidal or homicidal ideations. Gill also denied having any auditory or visual hallucinations.

On August 28, 2020, an RN visited Gill for COVID-19 clearance. Gill denied having any medical concerns and was cleared for release from COVID-19 quarantine.

On August 29, 2020, at approximately 7:42 p.m., Gill contacted two OCSD deputies while in line to get his Diphenhydramine medication. Deputies removed Gill from Barracks F and had him sit on the ground next to the door. Gill told the deputies that he believed another inmate in Barracks F wanted to kill him for sleeping with his wife when he had been out of custody. Gill requested to be placed in protective custody. The deputies further questioned Gill and Gill

stated that he was not sure if another inmate wanted to kill him or if it was the voices he was hearing in his head. Gill told the deputies that he was schizophrenic. The deputies decided to escort Gill to the booking loop where he could be evaluated by medical staff and transported back to the Intake Release Center (IRC) for reclassification.

At approximately 7:56 p.m., while being escorted by the deputies, Gill, with a frantic look on his face shouted, "You guys are going to kill me!" He then began running towards Barracks F. Gill ran a short distance before an OCSD deputy ordered him to get on the ground. Gill complied and laid face down on the ground. Two deputies then handcuffed Gill without incident. Three deputies then transported Gill to the booking loop where they placed him alone in cell 11. At approximately 8:12 p.m., an RN spoke with Gill in cell 11. Gill stated the following:

> "I have had kidney failure since 2016, but I don't want dialysis. I pee every 15 minutes after I have my coffee in the morning until 2, that's why I need to go to medical mod. I have kidney problems, disease, and failure. I have kidney pain. Why are you asking me that? Yes, I hear voices, but why do you need to know that for my kidney problems? They are telling me not to go back to the barracks. I'm being threatened by a guy with the same name as mine, the same date of birth, his name is my name."

At approximately 9:24 p.m., an OCSD Sergeant interviewed Gill in cell 11 with regard to him running from the deputies. Gill stated that he was not injured and that the deputies did not use any force against him. No injuries were observed on Gill's body.

Cell 11 had a sink/drinking fountain located in the rear right corner and a toilet in the rear left corner. The toilet was concealed behind a short block wall. There was a concrete bench along the left wall of the cell extending from the short block wall to the glass front windows of the cell. Jail surveillance shows Gill's movements within cell 11 from approximately 7:58 p.m., when he was placed in the cell, until 10:50 p.m., when deputies entered the cell to transport him to the IRC. During this two hour and fifty-two-minute period, Gill walked around the cell nearly constantly and went to the sink/drinking fountain approximately 64 times. The angle of the surveillance camera did not provide a full field of view to show what Gill was doing at the sink/drinking fountain, but only revealed Gill's lower legs as he stood in front of it. At approximately 9:35 p.m., Gill vomited in the middle of the cell. He then removed his pants and used them to mop the vomit toward the toilet. When Gill put his pants back on, they appeared to be soaking wet. Gill went to the sink/drinking fountain approximately 53 times after vomiting.

During the above period of time, it was the standard practice of deputies to conduct regular "safety checks" on inmates temporarily housed on the Theo Lacy booking loop. The checks occur approximately every 60 minutes or sooner. The purpose of safety checks is to confirm that the inmate is alive, is not in immediate distress, and is not violating any jail rules. It is very common for inmates to vomit while on the booking loop, as they are detoxing. Absent other information, an inmate vomiting would not necessarily constitute a significant event warranting immediate attention and would not normally be addressed until after the inmate had been removed from the cell. In this case, Gill also cleaned up immediately after he vomited, which was between safety checks.

At approximately 10:50 p.m., two deputies handcuffed Gill for transport to the IRC. The deputies noticed that Gill's pants were wet and issued him a clean, dry pair and requested that he put them on. Gill replied that he was thirsty and then went to the sink/drinking fountain to get a drink of water. While in the process of changing his clothes, Gill went to the sink/drinking fountain again and drank water. When the two deputies requested that Gill exit the cell to be handcuffed, he replied that he was thirsty and went to drink water for an extended period. The deputies believed that Gill was attempting to stall the handcuffing process, so they entered the cell. The deputies faced similar circumstances in the past where an inmate purposely put water on the ground to make it slippery to subject them to a greater risk of injury if the inmate tried to attack them.

The deputies ordered Gill to face the wall and place his hands on the wall above his head. Gill complied with the orders. As one deputy began to place waist chains on Gill, Gill began biting his own left wrist. The deputies struggled to control Gill and prevent him from harming himself. The wet floor made it difficult for the deputies to maintain their balance. Gill broke free, exited the cell, and ran toward cells 14 and 15. While he was running, he stumbled and fell to the ground. The deputies regained control of Gill by holding him to the ground. Gill began biting his own left wrist again. It took several deputies to secure Gill's left arm. Deputies then placed waist chains on Gill and secured both arms. The deputies placed Gill in a recovery position on his right side while waiting for medical staff to arrive.

At approximately 11:00 p.m., an RN examined Gill and determined he needed to be transported to the hospital for treatment of the injury to his left wrist. At approximately 11:10 p.m., staff moved Gill by wheelchair to cell 1 to await transport to the hospital by paramedics. At approximately 11:20 p.m., an OCSD Sergeant interviewed Gill regarding the incident in cell 11. The interview was recorded. As the interview began, Gill vomited a large volume of clear liquid. During the interview, Gill stated the deputies did not injure him. When Gill was asked if he bit himself, he said he had not. When Gill was asked how he got the bite marks on his left wrist, Gill said the voices in his head told him people were trying to abduct him. During this interview Gill repeatedly asked for a drink of water.

When an Orange Fire Department (OFD) paramedic arrived at cell 1, the paramedic saw Gill standing at the sink/drinking fountain consuming a large amount of water. Deputies ordered Gill to sit but he refused. Gill remained at the sink/drinking fountain and continued to drink water. Gill eventually sat down, and the paramedic examined him. The paramedic found that Gill's vitals were normal, and he answered all of the paramedic's questions coherently. The only injury that the paramedic discovered was a quarter sized avulsion on his left wrist. During the paramedic examination, Gill vomited water again. At approximately 11:38 p.m., OFD paramedics transported Gill to UCI Medical Center. Gill vomited water several more times while en route to the hospital. Paramedics believed that Gill was vomiting water due to the fact that he may have consumed the water too quickly. Gill told paramedics that he was fine and not feeling nauseated.

At approximately 11:49 p.m., Gill was transferred into the care of UCI Medical Center Emergency Room (ER) personnel. As Gill was being transferred from the gurney to a hospital bed, he suddenly became agitated and began screaming. ER staff administered Haldol and Ativan in an effort to calm Gill. While in the ER, Gill's oxygen levels began to decline. He was intubated and placed on a respirator. Laboratory reports and blood work indicated that Gill was

suffering from hyponatremia. Hyponatremia is a condition where sodium levels in the blood are lower than normal. The condition is often caused by having too much water in the body.

On August 30, 2020, at approximately 1:00 a.m., UCIMC medical staff determined that Gill's pupils were fixed and dilated, a condition that could indicate loss of brain function. Gill was given a computerized axial tomography (CAT) scan, which showed swelling and herniation of the brain. Gill's medical condition continued to decline.

At 1:25 a.m. a urine sample was collected from Gill. A hospital drug screen of the urine revealed Gill tested positive for fentanyl. Urine is considered a historical sample and if the individual is not urinating, drugs are known to collect in the urine, and the urine sample does not necessarily reflect what is occurring in the body. It should be noted that Gill had a blood draw at 12:09 a.m., which was subsequently tested by the OCCL and no fentanyl was detected in the blood sample. The absence of fentanyl in the ante-mortem blood, collected nearly 1 ½ hours before the urine test, shows that Gill had not recently ingested fentanyl and that fentanyl consumption was not a medical factor in his death.

On September 1, 2020, Gill was given a nuclear brain scan, which showed he had no evidence of brain function. A neurological critical care team and a medical team conducted brain death examinations on Gill. The results of these examinations indicated that Gill was brain dead. The medical team did not find any trauma to Gill's head that would have contributed to the swelling of his brain. At approximately 5:00 p.m., Mr. Gill was pronounced clinically deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- 51 OCCL hospital scene photographs
- 58 OCCL autopsy photographs
- 10 OCCO coroner photographs
- 16 OCCO embalming photographs
- Deep muscle standard

AUTOPSY

On September 9, 2020, independent Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Gill. Dr. Luzi determined that Gill's cause of death was hypoxic encephalopathy due to hyponatremia due to primary polydipsia. Dr. Luzi reported that Gill had cerebral edema and suffered from schizophrenia and pneumonia. Dr. Luzi found no significant signs of trauma. The manner of death was found to be undetermined.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Gill's antemortem blood yielded the following results:

DRUG	ANTEMORTEM BLOOD
Caffeine	Detected
Diphenhydramine	0.155 ± 0.015 mg/L

BACKGROUND INFORMATION

Gill had a State of California Criminal History record that revealed arrest for the following violations:

- Possession of a controlled substance without a prescription
- Assault with a deadly weapon – not a firearm
- Personate to make another liable
- Assault
- Battery
- Trespass – refuse to leave property
- Shoplifting
- Disorderly conduct – under the influence of drugs
- Carry concealed dirk or dagger
- Exhibit deadly weapon – not a firearm
- Pedestrian failure to yield out of sidewalk
- Petty theft
- Threaten crime with intent to terrorize
- Possession of a controlled substance
- Under the influence of a controlled substance

THE LAW

Homicide is the killing of one human being by another. Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. To prove that a person is guilty of murder, the following must be proven:

a. The person committed an act that caused the death of another person;
b. When the person acted he/she had a state of mind called malice aforethought; and
c. He/she killed without lawful excuse or justification.

There are two kinds of malice aforethought, express malice and implied malice. Express malice is when the person unlawfully intended to kill. Implied malice requires that a person intentionally committed an act, the natural and probable consequences of the act were dangerous to human life, at the time he acted he knew his act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

A person can also commit murder by his/her failure to perform a legal duty, if the following conditions exist:

a. The killing is unlawful (*i.e.*, without lawful excuse or justification);
b. The death is caused by an intentional failure to act in a situation where a person is under a duty to act;
c. The failure to act is dangerous to human life; and
d. The failure to act is deliberately performed with knowledge of the danger to, and with conscious disregard for, human life.

A person can also commit involuntary manslaughter by failing to perform a legal duty, if the following conditions exist:

a. The person had a legal duty to the decedent;
b. The person failed to perform that legal duty;
c. The person's failure was criminally negligent; and

d. The person's failure caused the death of the decedent.

In *Giraldo v. California Dept. of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 250-251, the court held that there is a "special relationship" between jailer and prisoner:

> "[T]he most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable than an inmate may be at risk of harm.... Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

> "[A] public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he acts is so different from how an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

There is no evidence of express or implied malice on the part of any OCSD deputies, other personnel or other individuals under the supervision of the OCSD. There is also no evidence of any other inmate being involved in these events. The only possible type of homicide to analyze in this matter is murder or manslaughter under the theory of failure to perform a legal duty. Like all inmates, the OCSD and its personnel owed Gill a duty of care. The evidence in this matter does not support a finding that this duty was in any way breached -- either intentionally (as required for murder), or through criminal negligence (as required for involuntary manslaughter).

When OCSD first took custody of Gill, they provided him with a medical screening. During this time, Gill indicated that he had been diagnosed with schizophrenia and in the past had tried to harm himself. Out of concern for his health and well-being, Gill was referred to Mental Health for further examination. At the Mental Health screening Gill indicated again that he had been diagnosed with schizophrenia and experienced auditory hallucinations. While his chart indicated that he admitted to attempting suicide by overdose in 2017 or 2018, Gill stated that he was not depressed and not thinking of hurting or killing himself at the time. However, due to his past history, the staff flagged Gill for a mental health follow-up out of precaution but allowed him to be housed in general population.

Gill was initially housed in the main jail, but then transferred to TLF. Due to the ongoing COVID-19 pandemic, Gill was placed in COVID-19 quarantine. On August 18, 2020, an MHC visited Gill and determined that a mental health follow-up would be appropriate. On August 21, 27, and 28, 2020 medical staff visited Gill and found that he was coping well and did not express any medical concerns at those times. Up until that point in time, the staff constantly monitored Gill and checked up with him and did not have any reason to suspect that he was suffering from any medical conditions or using drugs.

On August 29, 2020, at approximately 7:42 p.m., Gill told deputies that he believed that another inmate wanted to kill him. He was not sure if another inmate wanted to kill him or if it was the voices in his head. Because of this, the deputies decided to escort him to the booking loop where he could be evaluated by medical staff. At approximately 7:56 p.m., Gill tried to run away from the deputies, but he was subdued. At approximately 8:12 p.m., an RN spoke with Gill and Gill made various statements to the nurse. Subsequently, an OCSD deputy interviewed Gill and he was able to communicate to him that he was not injured when the deputies got control of him and there was no reason at that time to suspect that Gill needed medical attention.

Jail surveillance video showed that Gill went to the sink/fountain numerous amounts of times prior to being transported to IRC. However, the video surveillance only showed Gill's lower legs and nothing else. At approximately 9:35 p.m., Gill vomited in the middle of the cell and then cleaned up the liquid with his pants. Seeing that Gill could still move and function, there was no immediate cause for concern.

Subsequently, when two OCSD deputies went to handcuff Gill to transport him to the IRC, they noticed that his clothes were wet and that there was water on the cell floor. During that time Gill went to the sink/fountain and began drinking water again. Due to Gill's clothing and cell floor being wet, the deputies believed that Gill was trying to stall the handcuffing process or possibly plan an attack on the deputies. The deputies faced similar circumstances in the past where an inmate purposely put water on the ground to make it slippery to subject them to a greater risk of injury if the inmate tried to attack them.

After this happened, Gill tried to run away again, and a struggle ensued. The deputies were able to control Gill, but Gill bit down hard on his own left wrist. The bite caused bleeding and the medical staff determined Gill needed to be transported to the hospital. While waiting for transport to the hospital, another OCSD deputy interviewed Gill about the struggle and he was able to respond. Gill kept drinking at the sink/fountain and an OFD paramedic examined Gill and then transported him to the hospital. While in transport, the paramedic believed that Gill was throwing up due to in taking water too quickly and did not suspect that anything else was

wrong with Gill. At the time, Gill's vitals were normal and he appeared calm. Once at the hospital, the medical staff conducted more tests and addressed his declining medical condition.

Mr. Gill died due to hyponatremia. The OCSD deputies and staff acted reasonably and with appropriate care. When Gill bit himself, the deputies did have reason to seek medical help, which they did and in a timely manner. The OCSD deputies did not breach their duty of care at any point while Gill was in custody. Breach of a duty is based upon foreseeability—which in this case, regarding Gill's water consumption, did not exist. At the time, it was not reasonably foreseeable to the deputies that Gill's water consumption could lead to his death. Instead, what was foreseeable, was the risk of being setup for a possible attack against the deputies. This belief was reasonable due to their prior experiences with other inmates. Therefore, there is insufficient evidence to show that a duty of care was breached under the circumstances.

CONCLUSION

Based on all the evidence gathered, provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is insufficient evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Gill. The evidence shows that Gill died as a result of hypoxic encephalopathy due to hyponatremia due to primary polydipsia. The manner of death remains undetermined.

Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,

MARK BIRNEY
Senior Deputy District Attorney
Homicide Unit

Read and Reviewed by **BARBARA KIM**
Assistant District Attorney
Special Prosecutions Unit

Read and Approved by District Attorney **TODD SPITZER**