



OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TONY RACKAUCKAS, DISTRICT ATTORNEY

JIM TANIZAKI
SENIOR ASSISTANT D.A.
VERTICAL PROSECUTIONS/
VIOLENT CRIMES

JOSEPH D'AGOSTINO
SENIOR ASSISTANT D.A.
GENERAL FELONIES/
ECONOMIC CRIMES

MICHAEL LUBINSKI
SENIOR ASSISTANT D.A.
SPECIAL PROJECTS

JAIME COULTER
SENIOR ASSISTANT D.A.
BRANCH COURT OPERATIONS

CRAIG HUNTER
CHIEF
BUREAU OF INVESTIGATION

LISA BOHAN - JOHNSTON
DIRECTOR
ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER
CHIEF OF STAFF

July 31, 2015

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

Re: Custodial Death on Oct. 7, 2013
Death of Inmate Timothy Erect Griffith
District Attorney Investigations Case # S.A.13-026
Orange County Sheriff's Department Case # 13-197733
Orange County Crime Laboratory Case # FR 13-54101

Dear Sheriff Hutchens,

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 Oct. 7, 2013, custodial death of 52-year-old inmate Timothy Erect Griffith.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Griffith. In this letter, the OCDA describes the investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to determine whether criminal culpability exists on the part of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD.

On Oct. 7, 2013, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center Anaheim (WMCA), where Griffith died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, 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 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 Investigator has concluded the investigation, the file is turned over to a veteran deputy district attorney for legal review. Deputy district attorneys from the Homicide or Gang Units review 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 his or her supervisor, and this Assistant District Attorney eventually will review and approve any legal conclusions and resulting memoranda. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

Timothy Erect Griffith, a 52-year-old male was arrested on June 10, 2012 for CPC section 664(a)-187(a) Attempted Murder and CPC section 273.5(a)/(e)(1) Domestic Battery. During the intake screening at the Orange County Jail – Santa Ana, Griffith made no complaint of pain or medical distress and denied any ongoing medical issues. From his admittance to Orange County Jail until his transfer to Western Medical Center – Anaheim (WMCA) on August 5, 2013 Griffith made periodic requests for medical attention for minor ailments such as back pain, toothache, and eye glasses. After each request Griffith was evaluated by medical personal and given treatment where applicable.

On Aug. 4, 2013, Griffith complained to deputies of severe pain in his left calf. On Aug. 5, 2013 at approximately 3:30 a.m., Griffith was seen by the Correctional Registered Nurse (CRN) and after an evaluation, the CRN recommended Griffith be transported to the WMCA for further evaluation.

On Aug. 5, 2013 at approximately 5:30 a.m., Griffith was transported by Care Ambulance to WMCA for acute swelling and pain in his left leg. Once there, a limited ultrasound of Griffith's leg revealed extensive deep vein thrombosis with an underlying hypercoagulable disorder. Doctor 1 performed a computed tomography (CT) scan which revealed an "ascending colon mass with multiple liver lesions as well as bilateral pulmonary lesion consistent with metastatic malignancy." Due to the size of the detected mass, Griffith underwent a diverting ostomy which revealed "intraperitoneal metastatic disease," and was started on a systemic anticoagulation therapy program which consisted of 10mg Vitamin K, and 1.5mg Warfarin daily. After being diagnosed with colon cancer with hepatic and pulmonary metastatic disease, Griffith was admitted to WMCA with plans to start on outpatient chemotherapy and was housed in the hospital jail ward.

On Sept. 17, 2013, Griffith was brought to the WMCA Emergency Department and was found to be in acute renal failure with hyperkalemia and acute blood loss anemia. After treatment in the Emergency Room, Griffith was admitted to the Intensive Care Unit and was seen again by Doctor 1. Doctor 1 conducted a physical examination of Griffith and found him to be awake, alert, oriented, and in no acute distress but reported that Griffith suffered from temporal wasting.

Given Griffith's underlying malignancy, deep vein thrombosis, and pulmonary embolism, on Sept. 17, 2013, Doctor 2 was requested to provide a hematology – oncology consultation. Doctor 2 observed Griffith to be "cachectic and with bilateral extremity swelling," and to be very weak and unable to care for himself. Doctor 2 listed Griffith's prognosis for survival of his stage IV cancer as "exceedingly poor" and estimated Griffith's life expectancy as "extremely limited." Doctor 2 suggested hospice care and noted that Griffith was not a candidate for chemotherapy because it "may harm him and may cause toxicity with no appreciable benefit."

On Sept. 29, 2013, Griffith was seen by Doctor 3 for acute renal failure and hyperkalemia and observed that Griffith's cancer was "significantly worsening." Doctor 3 discovered significant kidney dehydration and started a hydration IV regimen.

On Oct. 7, 2013 at approximately 2:00 p.m., Doctor 4 responded to a "Code Blue" emergency response alert when Griffith went into cardiac arrest and stopped breathing. Doctor 4 was aware that Griffith was under "comfort care/ hospice" due to an incurable malignancy. Doctor 4 and nursing personnel administered lifesaving procedures to stabilize Griffith and intubated him to assist his breathing. On Oct. 7, 2013 at approximately 3:20 p.m., Doctor 4 responded to a second "Code Blue" alert when Griffith went into full cardiac arrest again. No lifesaving measures were attempted and at 3:24 p.m. Doctor 4 pronounced Griffith deceased.

An OCSD Deputy was stationed outside Griffith's hospital room door to prevent unauthorized access and preserve evidence within the scene until approximately 5:45 p.m. when the OC Sheriff Coroner and Crime Lab personnel arrived to begin their investigation. The investigation noted that Griffith was supine on a hospital bed with various medical apparatuses around the bed and there were no signs of "suspicious trauma" on the body. At approximately 6:12 p.m., the Traditional Funeral Services Attendant arrived and prepared the body for transportation to the Orange County Coroner's Office.

AUTOPSY

On Oct. 9, 2013 at 12:43 p.m., Doctor Joseph Cohen conducted the autopsy. The autopsy revealed evidence of colon and liver cancer. An old gunshot wound was discovered on the left thigh and two bullet fragments were collected from the wound. There were no other obvious signs of trauma or fractures to the body. Following the examination, Doctor Cohen concluded that the preliminary cause of death was due to cancer, specifically complications of metastatic adenocarcinoma of the colon.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Griffith's postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethanol/Volatiles	Postmortem Blood	None Detected
Benzodiazepines	Postmortem Blood	Negative
Cocaine and/or Metabolite	Postmortem Blood	Negative
Phenethylamines	Postmortem Blood	Negative
Opiates	Postmortem Blood	Presumptive Positive
Cannabinoids	Postmortem Blood	Negative
Alkaline Drugs	Postmortem Blood	None Detected
Strong Acid/Neutral Drugs	Postmortem Blood	None Detected
Weak Acid/Neutral Drugs	Postmortem Blood	None Detected

BACKGROUND INFORMATION

Griffith had a State of California Criminal History record that was considered in this review process.

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:

- The person committed an act that caused the death of another person;
- When the person acted he/she had a state of mind called malice aforethought; and
- 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 that 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 whatsoever of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Griffith a duty of care, the evidence 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). Griffith received prompt and thorough medical treatment and was determined to have died of natural causes.

Thus, there is no evidence whatsoever to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that Griffith died as a result of cancer, specifically complications of metastatic adenocarcinoma of the colon.

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

Respectfully submitted,



ANNA MCINTIRE

Deputy District Attorney
Gangs Unit



Read and Approved by **EBRAHIM BAYTIEH**

Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit