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October 31, 2012

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

Re: Custodial Death on November 7, 2011
Death of Inmate Paul Michael Dewey
District Attorney Investigations Case # S.A. 11-020
Orange County Sheriff's Department DR #11-197770
Orange County Crime Laboratory Case FR#11-54524

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 Nov. 7, 2011, custodial death of inmate Paul Michael Dewey.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Dewey. 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 Department (OCSD) deputy or any other person under the supervision of OCSD.

On Oct. 30, 2010, OCDA Special Assignment Unit (OCDASAU) Investigators began the investigation into the apparent suicide attempt of inmate Dewey, who ultimately died on Nov. 7, 2011, at the Western Medical Center in Santa Ana. The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event, including conducting 49 separate interviews from inmate witnesses, OCSD Deputies and Jail Staff, Anaheim Police Department Officers, as well as medical personnel from the Western Medical Center and Orange County Coroner's Office, to document the facts and circumstances of this event. The OCDA impartially reviewed all evidence and legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD officer or personnel. 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 and 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. Prosecutors assigned to the Special Prosecutions Unit review the non-fatal officer-involved shooting cases for possible criminal filings. Throughout the review process, the assigned prosecutor will be in consultation with his or her supervisor, and this Assistant District Attorney will eventually review and approve any legal conclusions and resulting memos. 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.

An important aspect of the investigation of incidents such as this is to seek a statement from people who had contact with the deceased in the hours leading up to his death. All OCSD personnel involved in this incident voluntarily spoke to OCDA investigators soon after the incident.

FACTS

Dewey was a 54-year-old male who had a significant criminal history, including a long history of intravenous drug and methamphetamine use. Dewey had spent a significant amount of his life in custody up to and including the time of his death. He died as a result of suicide, although the particular cause of death (head injuries) was not the method he intended.

On Oct. 26, 2011, Dewey was arrested by Anaheim Police Officer Kyle Poffenberger for several narcotics violations, including possession for sale of methamphetamine, and for an active Felony Parolee At Large Warrant. During the booking process, Dewey admitted that he had a long history of drug use including daily injections of methamphetamine; however, he had not injected himself on the day of his arrest. He told staff that he not tried to harm himself in the past.

On Oct. 27, 2011, Dewey was transported with other inmates to the OSCD Inmate Reception Center without incident. He completed the medical screening and booking process without incident and was booked into the Orange County Jail (OCJ). Dewey answered "No" to all questions related to any attempts in the past to take or harm his life and again answered "No," that he did not have any current considerations to take or harm his life as well as any questions relating to his mental conditions. Dewey was sent to Disciplinary Isolation, Cell #14, which is customarily used to ease overcrowding.

On Oct. 30, 2011, at approximately 2:10 p.m., Dewey was escorted by Deputy Robert Hack to Module M, Sector 24, for his extended period of dayroom privileges. Dewey was dressed in his jail-issued 2-piece smock and pants and was carrying his towel and shower slippers. Deputy Hack left Dewey alone and returned to resume his normal duties. Dewey was alone; all other inmates were secured in their cells. Dewey had access to the open area on the first floor and the stairs that led to the second floor, where the shower was located. During this period in the dayroom, Dewey was observed by another inmate making a phone call and then walking up the stairs and into the shower fully clothed. Several inmates stated that he looked distraught after hanging up the phone. Several minutes later, at about 3:25 p.m., Dewey was observed by inmates exiting the shower wearing only his boxer shorts and with a braided bed sheet tied around his neck. Dewey then tied the other end of the rope to the safety rail on the second level. Several inmates saw what Dewey was doing and, believing that he was about to hang himself, started yelling, "Don't do it, don't do it," and began activating their in-cell emergency buttons.

Correctional Services Assistant Karen Huggins and Deputy Jimmy Pena heard the commotion and then saw Dewey facing them while straddling the safety rail on the second floor in front of cell #2 and #4. Deputy Pena saw the braided bed sheet around Dewey's neck and ran out of the guard tower to try and stop Dewey while Deputy Huggins called for more assistance. Before Deputy Pena could get to him, Dewey jumped off of the second floor. The braided bed sheet stretched

– but rather than suspending Dewey, the sheet ripped, causing Dewey to fall down to the first floor, where he landed hard on his head on the concrete floor.

Almost immediately after landing, Deputy Pena contacted Dewey, who was lying face-down with a small amount of blood coming from his mouth and nose and still breathing. A small portion of the bed sheet was still tied around his neck. Medical staff arrived approximately 30 seconds later, cut the bed sheet from around Dewey's neck, rolled him on his back, wiped blood from his mouth, and removed his dentures. Attempts to place an IV were unsuccessful due to scarring on Dewey's arms from his prior intravenous drug use. Dewey was then placed in a cervical collar and given oxygen. Dewey's vital signs were stable but he was nonresponsive. Paramedics arrived at approximately 3:35 p.m., placed Dewey on a backboard and then transported him to Western Medical Center in Santa Ana at approximately 3:47 p.m. Dewey was still nonresponsive and began showing irregular blood pressure -- common in people who have sustained head injuries.

Dewey arrived at the hospital at approximately 3:54 p.m. where he was then taken to Trauma Bay T-1 for evaluation by the trauma team. At that time, Dewey was comatose, nonresponsive and making involuntary muscle movements. A computed tomography scan revealed multiple skull and facial fractures with an intracranial hemorrhage. Dewey was then admitted to the Intensive Care Unit for further treatment. An intracranial pressure monitor was administered that monitored the oxygenation, blood flow and pressure in Dewey's brain. A subsequent magnetic resonance imaging revealed structural evidence of a significant and life threatening brain injury.

On Nov. 4, 2011, after meeting with medical staff, Dewey's daughter signed a Do-Not-Resuscitate order, where only pain medication would be administered.

On Nov. 7, 2011, at 2:40 p.m., Dewey succumbed to these injuries and was pronounced dead at 2:40 p.m.

AUTOPSY

On Nov. 10, 2011, an autopsy was performed by Napa and Marin County Coroner Chief Forensic Pathologist Dr. Richard Cohen, who concluded that the cause of death was blunt force craniocerebal trauma as a result of Dewey landing on his head after falling from the second floor.

EVIDENCE ANALYSIS

Dewey's post-mortem blood samples were analyzed for prescription and common drugs of abuse and both amphetamine and methamphetamine were detected.

BACKGROUND INFORMATION

Dewey's lengthy criminal history was reviewed and considered.

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, it 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;
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.

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 Deputy, jail staff 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 OCSD owed inmate Dewey a duty of care, the evidence does not support a finding that this duty was breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

Dewey's actions caused the injuries that subsequently claimed his life. There was no indication or evidence from prior contacts with Dewey or statements made to law enforcement from the time of his arrest until his attempted suicide that Dewey posed a threat to himself. Moreover, OCSD staff did everything possible to prevent Dewey's suicide attempt, and then to save and preserve his life. Specifically, from the moment he was first observed by Deputy Pena before he jumped off the rail, Deputy Pena tried to prevent Dewey from jumping. Deputy Pena then began administering first aid to Dewey after he fell. Approximately 30 seconds later, Dewey began receiving additional medical attention from OCSD jail staff, which stabilized Dewey for paramedics, who then transported him to the hospital. The OCSD staff acted with great speed and took every necessary step to prevent, preserve and save Dewey's life. There was no indication or reason to suspect that Dewey posed a threat to harm or kill himself that would have alerted OCSD staff to take any precautionary measures. As such, the OCSD did not cause Dewey's death as a result of criminal negligence and did everything possible to prevent, save and preserve his life.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA and pursuant to applicable legal principles, 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 OCSD. Evidence shows that Dewey died as a result of suicide.

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

Respectfully Submitted,

David Porter
Senior Deputy District Attorney
Gang Unit

Read and Approved,

Dan Wagner
Assistant District Attorney
Head of Homicide Unit