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December 9, 2013

Chief Paul Workman
Laguna Beach Police Department
505 Forest Avenue
Laguna Beach, CA 92651

Re: Custodial Death on April 9, 2013
Death of Inmate Stephen Gregory Gage
District Attorney Case # S.A. 13–007
Orange County Crime Laboratory Case # FR 13–45069
Laguna Beach Police Department Case # 13–01133
Orange County Coroner's Case # 13–01621–OS

Dear Chief Workman,

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 April 9, 2013 custodial death of Stephen Gregory Gage, 43.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Gage. 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 Laguna Beach Police Department (LBPD) officer or any other person under the supervision of the LBPD.

On April 9, 2013, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Mission Hospital – Mission Viejo (MH–MV) after Gage died while in custody and while being treated at the hospital. 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. During the course of this investigation, OCDASAU Investigators conducted witness interviews and reviewed LBPD reports, laboratory and identification reports, autopsy reports, digital images of the incident scene, and other relevant materials.

The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of any LBPD officer or personnel. The OCDA will not be addressing policy, training, tactics, or potential 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 OCDA 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 Orange County Crime Lab 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. Deputy district attorneys 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.

FACTS

Gage was a 43-year-old homeless male with a documented history of drug and alcohol abuse. On April 8, 2013, at approximately 7:00 a.m., LBPD officers were dispatched to a residence on Ocean Way in Laguna Beach after a homeowner reported that Gage was digging through residential trashcans. According to LBPD Officer Greg Hiler, Gage was leaning into a trashcan and removing items. Officer Hiler recognized Gage from three prior contacts. Officer Hiler observed that Gage was visibly intoxicated. Further, Gage exhibited additional signs of impairment, including walking with an unsteady gait, slurring his speech and making unintelligible statements, clear mucus running from his nose, and bulging eyes. Officer Hiler and LBPD Officer Rock Wagner assisted Gage with walking to prevent him from falling. Officer Hiler concluded that Gage was unable to care for himself and arrested him for public intoxication and possession of 0.01 grams of methamphetamine.

Officer Hiler transported Gage to LBPD jail for booking. During the booking process, Gage complained of swollen legs and pain in his feet and groin area. However, Gage did not exhibit any obvious signs of a medical emergency. At approximately 9:35 a.m., Officer Hiler transported Gage to Mission Hospital – Laguna Beach (MH–LB) to obtain a medical clearance for booking. Gage was evaluated by an MH–LB doctor, who observed that Gage was experiencing multi-system organ failure, multifocal pneumonia, venous thrombosis, hypothermia, sepsis, acute renal failure, and anasarca (general swelling). The MH–LB doctor admitted Gage to MH–LB for medical treatment. Due to Gage's condition, Officer Hiler released him from custody, and Gage remained at the hospital for medical treatment.

At approximately 3:48 p.m., a doctor evaluated Gage and observed that he was conscious, breathing on his own, and talking. According to the doctor, he observed no signs of visible injuries on Gage's body, and Gage made no statements regarding his interaction with the police. The doctor diagnosed Gage as "critically ill" because Gage was suffering from septic shock, systemic inflammatory response syndrome, metabolic acidosis, kidney failure, lactic acidosis, rhabdomyolysis (break down of muscle fiber), shock liver with hepatitis, hemoptysis, and multifocal pneumonia. Additionally, Gage – who had a history of tuberculosis, anemia, and alcohol abuse – tested positive for amphetamines.

Gage was admitted into the Cardiac Intensive Care Unit due to his critical condition and was placed on a "sepsis order set," which included administering antibiotics, intravenous fluids, blood tests, and isolation for possible tuberculosis. A short time later, the attending physician was notified by medical personnel that Gage's condition had deteriorated. Gage had gone into cardiopulmonary arrest. The physician responded, intubated Gage to assist with breathing, and initiated cardiopulmonary resuscitation (CPR). Gage received the following medications intravenously: epinephrine, atropine, sodium bicarbonate, and rocuronium. After approximately 20 minutes of medical intervention, Gage regained a blood pressure and pulse. Gage remained unconscious and on a ventilator. The attending doctor inserted a catheter into Gage's chest, an arterial line into his wrist to monitor blood pressure, and a dialysis catheter into his groin. The doctor also placed a flexible camera down Gage's breathing tube and drained fluid from the inside of his lungs.

The following day, April 9, 2013, at approximately 1:15 a.m., Gage's doctor transferred him from MH-LB to MH-MV in order to

receive Continuous Renal Replacement Therapy, a treatment that replaces the lost function of a patient's kidneys. Upon arrival at MH-MV, Gage was already intubated and attached to a ventilator to assist with breathing. Roughly eight hours later, Gage's condition deteriorated as he became bradycardic (his resting heart rate slowed to an unsafe level). A doctor responded to assist with advanced lifesaving measures and administered to Gage two rounds of epinephrine and one of sodium bicarbonate. Gage's condition stabilized within a few minutes, but approximately half an hour later, his condition once again deteriorated, with his blood pressure and heart rate dropping to the point that he was not producing a pulse. Again, CPR was administered, and Gage intravenously received dopamine, norepinephrine, neosynephrine, vasopressin, and eight rounds of epinephrine.

Approximately an hour later, the attending physician concluded that Gage did not have a "sustained response to CPR" due to his multi-system organ failure. Gage was pronounced deceased at approximately 11:19 a.m. on April 9, 2013.

Autopsy

On April 11, 2013, at approximately 9:00 a.m., Orange County Coroner Chief Forensic Pathologist Dr. Anthony Juguilon performed an autopsy on Gage's body. According to Dr. Juguilon, the autopsy revealed evidence of excessive fluid in Gage's abdomen and body cavity, an enlarged heart, and severe pneumonia. There were no obvious signs of trauma or fractures to the body. Following the autopsy, Dr. Juguilon concluded that the cause of Gage's death was due to severe pneumonia and multiple organ failure. Methamphetamine and amphetamine were found to be present in Gage's system. Gage's manner of death was determined to be natural.

Evidence Analysis

Samples of Gage's ante-mortem and post-mortem blood were removed for testing. The following results were obtained:

DRUG	MATRIX	RESULT
Amphetamine	Postmortem Blood	0.027 mg/L
Methamphetamine	Postmortem Blood	0.76 mg/L
Amphetamine	Antemortem Blood	0.015 mg/L
Methamphetamine	Antemortem Blood	0.47 mg/L
Amphetamine	Brain	Detected
Methamphetamine	Brain	2.1 mg/kg
Lorazepam	Postmortem Blood	Detected
Lorazepam	Antemortem Blood	Detected

Gage's Prior Criminal History

Gage's California 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 that:

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

There are two kinds of malice aforethought, express malice and implied malice. Express malice is present when the person

unlawfully intended to kill. Implied malice requires that a person intentionally committed an act, the natural and probable consequences of which were dangerous to human life, at the time he acted he knew his act was dangerous to human life, and he deliberately acted with conscious disregard for human life.

A person can also commit murder by his 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 *Girardo v. California Department of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 251, the court held that there is a "special relationship" between custodian and inmate:

> "The most important consideration in establishing duty is foreseeability. 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

No LBPD officers committed any acts that caused the death of Gage. They did not commit any acts at all, besides taking Gage into custody before releasing him for hospitalization and treatment. Further, there is no evidence of express or implied

malice on the part of any LBPD officer or any other individuals under the supervision of the LBPD. 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 LBPD owed inmate Gage a duty of care, the evidence does not support a finding that this duty was breached, either intentionally (as required for murder) or in a criminally negligent manner (as required for involuntary manslaughter). On the contrary, all of the available evidence reasonably shows that LBPD fulfilled its duty of care to Gage. Shortly after arresting Gage, LBPD took Gage to the hospital to obtain a medical clearance for booking. When it was determined that Gage was in need of medical care, LBPD released him from custody so that he could receive treatment at the hospital. Gage was then appropriately treated by doctors, monitored, and attended to every time his condition deteriorated up until his time of death.

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 LBPD personnel or any individual under the supervision of LBPD. The evidence shows that Gage died as a result of severe pneumonia and multiple organ failure. There is no evidence of foul play or neglect; Gage's manner of death was determined to be natural.

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

Respectfully submitted,

Ebrahim Baytieh
Senior Deputy District Attorney
Assistant Head of Homicide Unit

Read and Approved by **Dan Wagner**
Assistant District Attorney
Head of Homicide Unit