OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

November 3, 2022

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

Re: Custodial Death on May 09, 2021
Death of Inmate Jeffrey Stephen Burdolski
District Attorney Investigations Case # 21-001575
Orange County Sheriff's Department Case # 21-015441
Orange County Crime Laboratory Case # 21-45780
Orange County Coroner's Office # 21-02979-TM

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 May 9, 2021, custodial death of 50-year-old inmate Jeffrey Stephen Burdolski.

OVERVIEW

This letter contains a description of the scope and legal conclusions resulting from the OCDA's investigation of the custodial death of Jeffrey Stephen Burdolski. 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 May 9, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC), where Jeffrey Stephen Burdolski died while in custody after being admitted on April 30, 2021. Due to Burdolski's condition upon arrival at the Hospital and pre-existing health conditions, hospital staff admitted and placed him in the intensive care unit. Over several days at the hospital, Burdolski's health continued to rapidly decline and on May 9, 2021 Burdolski went into code blue four times before being pronounced deceased at 11:54 a.m. by a doctor at OCGMC. During the course of this investigation, the OCDASAU interviewed and spoke to OCSD personnel, Orange County Coroner's Office (OCCO) Personnel, a Registered Nurse from OCGMC, an Orange County Fire Authority (OCFA) firefighter/paramedic who treated Burdolski, Dr.

Scott Luzi who performed his autopsy, as well as Burdolski's father. They also obtained and reviewed reports from the OCSD, OCGMC, Garden Grove PD, Orange County Crime Laboratory (OCCL), photographs, medical records, surveillance footage, 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 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 read and 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 all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation as was done in this case.

FACTS

On April 29, 2021 at about 06:06 a.m., Jeffrey Burdolski was arrested by the Garden Grove Police Department for Health and Safety Code 11377(a) Possession of a Controlled Substance. During the officer's record check, an out-of-State Warrant from Colorado was discovered and Burdolski was arrested. After being arrested, he was transported to the Orange County Jail in Santa Ana to be booked.

At 12:23 p.m., as part of his booking process he received a screening by Orange County Heath Care Agency (OCHCA). In the screening, he mentioned having hypertension and indicated he was taking Metoprolol, Lisinopril and Gabapentin. Burdolski noted he was using alcohol, having drank 12 hours ago, and was a methamphetamine user. An X-ray was conducted showing no abnormal results. His vitals were all normal, and a Detox screen was conducted by the medical staff in which Burdolski admitted to drinking five days a week. He was administered Lisinopril and Metoprolol at 9:09 p.m., and was placed on a daily plan to receive his medication. His BinaxNow Covid-19 test came back negative at 12:10 p.m.

On April 30, 2021, Burdolski was processed through the Intake Release Center (IRC) and was placed in cell PM-16. At around 03:52 a.m., Burdolski contacted a Deputy and reported he had a nose bleed. At approximately 03:55 a.m., OCSD Deputy Pelayo took Burdolski by wheelchair to be examined by OCHCA registered nurses for his nose bleed. During the evaluation, it was noted that Burdolski's feet were swollen, which he explained was due to being an alcoholic. Medical staff noted he had a round, distended abdomen that was tender to the touch with multiple bruises around the abdomen. When asked, Burdolski denied knowing what caused the bruising and denied any recent trauma, altercation, or falls. The on-call doctor was consulted by the medical staff at the Jail. The On-Call doctor determined that Burdolski would need to go to the hospital for further evaluation. Burdolski was placed in cell H-4 (Pelayo wrote H-1 and other deputies state H-4) for medical observation and to await transportation to the hospital. Regardless, he was near the nurse's station and jail staff at all times.

It is noted that around 04:15 a.m., the staff requested a Basic Life Support (BLS) transport to the hospital for Burdolski to comply with the consulting doctor's advice: "Consulted with on call provider, Dr. ..., per provider send to ER for further eval via BLS within 1-2 Hrs – placed in H1 for med obs until picked up by BLS advised to lean forward and apply pressure with gauze until bleeding subsides." A note at 05:26:51 a.m. PDT notes that, "BLS arrived at 0515 to pick up pt for transport, per uncuff deputy, no security staff available for transport, deputy states will delay transport for -40 minutes."

IRC security cameras show that around 06:04 a.m., on April 30, 2021, Burdolski leans to his left and falls from the bench and lands on his face. Between 06:04 a.m. and 06:15-06:16 a.m., deputies look into the holding cell and see Burdolski lying on the ground still moving his head, legs and arms. It should be noted it is common to have individuals who are under the influence of drugs or alcohol or both decide to lie on the ground while in the holding cells. At around 06:15 a.m., Officer Lacroix noticed Burdolski in the observation cell in a fetal position and saw Burdolski had blood on the side of his face. After observing this, Officer Lacroix notified the nurse at the medical triage station. Shortly after notification, medical staff checked on Burdolski and applied a C-collar and noted he had a 4 cm laceration on his forehead. Once medical staff made contact with Burdolski, Orange County Fire Authority (OCFA) were called for assistance and transport. Within 12 minutes of the call, OCFA was on scene treating Burdolski and preparing for transport.

Investigators interviewed the OCFA firefighter/paramedic who was part of the responding team called to check on Burdolski. He has been a firefighter for six and a half years and a paramedic for two years, and at the time, all of his licenses and certifications were current. He explained that on April 30, 2021 at 06:25 a.m. he and two others assigned to the engine were dispatched to the Orange County Jail Intake & Release Center (IRC) in reference to an ill person. While he could not recall this specific call, he was able to refer to the report narrative. He explained that Burdolski had a one-inch laceration on the forehead which was not bleeding when they checked on him. They conducted an electrocardiogram (EKG) on Burdolski which showed he was suffering from sinus tachycardia. There were no other injuries noted and contact was made with the hospital base station. About twenty minutes later, Burdolski was transported by CARE Ambulance to Orange County Global Medical Center (OCGMC) for further examination and treatment. His recollection was that they did not provide medication or treatment while en route to the hospital other than an IV and continued observation up and until Burdolski was transferred to the Emergency Room Staff.

OCGMC admitted Burdolski into the hospital for further examination. He was found to have liver cirrhosis and sepsis. On May 01, 2021, Burdolski was found to have blood in his rectum and his labs

showed he had macrocytic anemia, thrombocytopenia, and coagulopathy. On a report from May 4, 2021, the physician indicated Burdolski's health was complicated by upper GI bleed s/p esophageal varices banding, toxic encephalopathy, acute renal failure, and decompensated alcoholic liver cirrhosis.

On May 8, 2021, the daily assessment at OCGMC diagnosed Burdolski with severe sepsis. The report from the attending physician noted Burdolski's health continued to deteriorate and showed evidence of multi-organ failure, rising creatinine, rising bilirubin, and rising white blood cell count. At this point in time, Burdolski had received multiple services: trauma service, infectious disease, gastroenterology and nephrology. Burdolski was transferred to the ICU due to hypertension and he was intubated.

Investigators interviewed a registered nurse assigned to the ICU that provided care for Burdolski. She had been employed at OCGMC since becoming a nurse (RN) in 2019. She explained that prior to his admission Burdolski had the following pre-existing health conditions: pancreatitis, acute kidney failure, end stage liver disease, cirrhosis, ascites, was a past IV drug abuser, had a past history of alcoholism, and tricuspid valve infection that led to endocarditis.

She reported that on May 9, 2021, at 07:20 a.m., Burdolski's heart rate began to slow down to the point of not being registered on the monitor but he continued to have a palpable pulse. Emergency doctors responded to the code blue and ordered two amps of Bicarb and a dose of Atropine, which increased Burdolski's heart rate. At 10:55 a.m., Burdolski went asystole [meaning no movement in the heart/no pumping and or flat line] and had no pulse. A second code blue was called and cardiopulmonary resuscitation (CPR) was administered. CPR was continued until Burdolski moved into a slow regular heart beat (sinus bradycardia).

Again at around 11:15 a.m., Burdolski went asystole and had no pulse. A third code blue was called and CPR was initiated. CPR was administered until Burdolski went into slow regular heartbeat. At 11:23 a.m., Burdolski had returned to a pulse of 100.

Deputy J. Wilson, assigned to Hospital watch, noted that around 11:47a.m., Burdolski's heart rate slowed down to a stop, setting off an alarm. Medical staff responded and began CPR. As his condition did not improve, the doctor applied further life-saving measures, but they were not successful. The doctor directed medical staff to cease CPR and pronounced Burdolski dead at 11:54 a.m. In total, Mr. Burdolski suffered four (4) CODE BLUES during his hospital stay due to a litany of issues. He had severe alcoholic liver cirrhosis associated with liver insufficiency. He underwent a paracentesis procedure multiple times at the hospital along with esophagogastroduodenoscopy (EGD) that revealed esophageal varices that caused gastrointestinal (GI) bleed. Mr. Burdolski had severe sepsis that likely resulted from tricuspid endocarditis, and he was treated by multiple specialists who attempted to treat him. However, his condition deteriorated because of hepatic encephalopathy, acute kidney failure secondary to acute tubular necrosis (ATN), and multiple organ failure that resulted in his death.

On May 17, 2021, Burdolski's father mentioned to OCDA investigators that his son (J. Burdolski) had previously been hospitalized earlier in April before he was arrested and that he had Covid with no symptoms. His father further mentioned Burdolski had a drinking problem which led him to have several medical issues, and he believed Burdolski had cirrhosis of the liver. He also explained Burdolski mentioned to him in some texts messages that he had been having medical procedures that required some liquid to be drained weekly from his body. He stated Burdolski was taking

medication for his illness but was having difficulty getting the prescriptions filled at his pharmacy of choice and possibly wasn't getting the prescriptions he needed.

During review of the evidence in this case which included the logs, medical records, interviews, coroner reports, and investigative reports, it appeared there was a possible delay in the transportation of Burdolski from OCSD to OCGMC. Based on that information additional investigation was requested. As a result, OCDASAU Investigator Brian Sheldon interviewed Dr. Scott Luzi who performed the autopsy and also reviewed medical records to determine the cause of death. He was asked whether a delay in transporting Budrolski to the hospital on April 30, 2021 contributed to his death and the Doctor's response was no.

EVIDENCE COLLECTED/REVIEWED

The following items of evidence were collected and examined:

- Bloodstain Standard and report
- OCCL took Forty-Six (46) Photographs and created a report
- Forty-Four (44) color digital photographs during the autopsy
- Thirteen (13) post-embalming photos and report
- Medical Records / Patient Care Report
  - Daily Hospital Activity Log
  - HCA logs
- Coroner Report and Death Certificate
- OCSD reports – supplemental, jail incident, medical aid report, inmate packet, surveillance video.
- GGPD initial arrest report
- OCDA Bureau of Investigation reports
- Audio Recording of Interview of Burdolski's father and report
- Audio Recording of Interview of registered nurse employed by OCGMC and report
- Audio Recording of Interview of Paramedic employed by OCFA and report
- Interview of Dr. Scott Luzi on 6-3-2022 supplemental report

AUTOPSY

On May 21, 2021, Forensic Pathologist Dr. Scott A. Luzi of the Orange County Sheriff Coroner's Office conducted an autopsy on the body of Jeffrey Stephen Burdolski. The cause of death after the autopsy was Pending Investigation, and the manner of death was pending. An amendment was issued on 10/18/21 and the cause of death was determined to be sepsis due to infectious endocarditis, pneumonia, and pyelonephritis. Other conditions present were liver failure due to cirrhosis from chronic alcohol abuse. It was also determined that his manner of death was natural.

Other relevant autopsy findings are as follows:

- Major injuries:
  - None
- Minor Injuries:
  - Contusions, left chest
  - Contusion, right hip
  - Contusion, right forearm
  - Contusion, right leg
  - Contusion, left leg
  - Contusion, left foot
- Natural disease and pre-existing conditions:
  - Dermatitis, not further specified, face, neck, chest, and both forearms

- Skin erosions; forehead and face
- Healing abrasion: forehead
- Decubitus ulcer, buttocks
- Skin erosions, forearms
- Pleural and pericardial effusions
- Ascites
- Cerebral edema
- Pulmonary congestion and edema
- Nodule, right lung (refer to microscopic examination report-21-02979-TM
- Cardiomegaly
- Cirrhosis
- Esophageal erosions

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Jeffrey Stephen Burdolski postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Chlordiazaepoxide	Postmortem Blood	0.239 ± 0.024 mg/l
Demoxepam	Postmortem Blood	Detected
Methamphetamine	Antemortem Blood	Detected
Ethanol/Volatiles	Postmortem Blood	Not Detected
Amphetamine and Related	Postmortem Blood	Negative
Barbiturates	Postmortem Blood	Negative
Methamphetamine and Related	Postmortem Blood	Negative
Cannabinoids	Postmortem Blood	Negative
QTOF Drug Identification (Positive Mode)	Postmortem Blood	See Results/Interpretations
Benzodiazepines/Sedative	Postmortem Blood	See Results/Interpretations
Ethanol/ Volatiles	Antemortem Blood	Not Detected
Amphetamine and Related	Antemortem Blood	Negative
Barbiturates	Antemortem Blood	Negative
Methamphetamine and Related	Antemortem Blood	Presumptive Positive
Cannabinoids	Antemortem Blood	Negative
QTOF Drug Identification (Positive Mode)	Antemortem Blood	See Results/Interpretations

Phenethylamines	Antemortem Blood	See Results/Interpretations

BACKGROUND INFORMATION

Jeffrey Stephen Burdolski had a State of Colorado, Hawaii, Missouri, and Kansas Criminal History record that revealed arrests for the following violations since 1998:

- 21-3701 KS Theft
- 21-3701 b2 KS Theft value $25,000 to alt: $100,000
- 22-3716 KS Probation Violation
- 22-3716 KS Probation Violation
- 22-2713 KS Uniform Criminal Extradition Act; Arrest prior to requisition
- 08-1567 KS Driving Under the Influence of alcohol or drugs
- 570.030 MO Theft-500/More-Less $25000
- 709-0906 Abuse Family
- 710-1077 Crim Contmp CRT
- 291E-0061 OP VEH INF INTX
- 286-0102 DWOL-Licensing
- 1551.1 PC- Fugitive From Justice Arrest W/O Warrant

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 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

Based on the evidence that was reviewed and available, there is no evidence of express or implied malice on the part of any OCSD personnel, inmates, or any other individuals under the supervision of the OCSD. Therefore, 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 Jeffrey Stephen Burdolski 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). Review of the evidence shows that OCSD consistently provided medical care during Burdolski's incidents and exercised reasonable care in treating and handling Burdolski. It could be argued there was a slight delay in transporting Mr. Burdolski from his cell to the Hospital. However, when Dr. Luzi was consulted, his opinion was that slight delay did not contribute to Burdolski's death.

During Burdolski's booking, he underwent a medical evaluation showing his vitals were stable and, his x-ray showed no abnormal results. During his evaluation he stated he had hypertension, was taking Lisinopril and Metoprolol, had a history of using alcohol, and was a methamphetamine user.

He was given his medication and was then placed on a daily plan to receive his medication.

When Burdolski was taken for medical observation for his bloody nose, the OCHCA medical staff noted he had swollen feet and bruising in his abdomen that Burdolski could not explain. They consulted with a doctor on staff, who declared Burdolski would need to go to the hospital for further examination, and they placed him in cell H-4 to await transportation to the hospital. As Burdolski waited for the transport, he fell from the cell bench resulting in the injury to his forehead. Once the OCSD officer noted Burdolski's injury, it appears the officer immediately notified OCHCA medical staff who checked on Burdolski and placed him in a C-collar. Once OCHCA made contact with him, they then called OCFA for further care of Burdolski, and he was subsequently taken to OCGMC for assessment and treatment.

At OGMC, Burdolski was admitted into the hospital where a CT of his head did not show any acute findings. The physician examination showed he had lower extremity edema with cellulitis, urinary tract infection, had coagulopathy, and acute blood loss anemia secondary to cirrhosis. During his treatment, doctors found Burdolski had sepsis. As his time in the hospital continued, Burdolski had a poor/grave prognosis of health. His condition worsened due to acute kidney failure, and doctors stated he was expected to pass due to the multiple organ failure. Tragically, Mr. Burdolski died after his fourth code blue while in the ICU when it was determined by a Doctor that no further life saving measures would be successful.

Unfortunately, Burdolski came to OCGMC with pre-existing health conditions: end stage liver disease, pancreatitis, acute kidney failure, cirrhosis, ascites, it appeared he was an IV drug user, suffered from alcoholism, and had a tricuspid valve infection. His father also stated that before Burdolski was arrested, he had been in the hospital just a few weeks earlier and was having liquid drained weekly, and that he was prescribed medication to deal with his health issues. The information provided by his father alluded to his son having serious pre-existing health conditions well before coming into the custody of OCSD. When Burdolski entered into the custody of OCSD, Burdolski did not make them aware of all his pre-existing conditions. Burdolski only told them about the medication he was taking, which OCSD administered to him, as well as his hypertension diagnosis and alcohol abuse issues. Unfortunately, it is unclear whether Mr. Burdolski even knew how dire his situation actually was prior to coming to the jail. Based on that information, the staff checked his vitals and cleared him based on his status at the time. Later, when he reported the nose bleed, they checked him again and after consulting with an M.D. they determined more care was needed due to the swelling in his feet and other observations. Based on that, they had him in an observation room waiting to be transported to the hospital.

While Burdolski was waiting in one of the observation rooms for transport, a BLS unit did arrive at 05:15 a.m., but no security staff was available for transport and the transport was delayed for 40 minutes. At 06:04 a.m., Burdolski fell to the ground and when the staff realized he wasn't just lying down and or sleeping, they provided care and called OCFA for immediate assistance and transport. During his time in the custody of OCSD, they provided Burdolski with health care and consulted with a Doctor to confirm the appropriate course of action. Although there was a delay in transport due to staffing, he was taken to the hospital to be further examined and cared for until his unfortunate death 9 days later. Under the circumstances, OCSD did all that was reasonable to provide him care when he fell and reported his nose bleed. Based on the medical records provided, Burdolski's time in the hospital continued due to a myriad of issues including multiple pre-existing conditions, sepsis, and end stage liver disease, but not his head injury.

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

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 that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Jeffrey Stephen Burdolski. The evidence shows that Jeffrey Stephen Burdolski died as a result of sepsis due to an infectious endocarditis, pneumonia, and pyelonephritis, and that the death was a natural one based on his pre-existing conditions.

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

BRIAN C. ORUE
Deputy District Attorney
Homicide Unit

READ AND REVIEWED BY **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

READ AND APPROVED BY DISTRICT ATTORNEY **TODD SPITZER**