OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

December 4, 2023

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

Re: Custodial Death on July 1, 2021
Death of Inmate Fredrick Douglas Chism
District Attorney Investigations Case # 21-002444
Orange County Sheriff's Department Case # 21-021028
Orange County Crime Laboratory Case # 21-48455

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 July 1, 2021, custodial death of 39-year-old inmate Fredrick Douglas Chism.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Chism. 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 July 1, 2021, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the OCSD Intake/Release Center (IRC), where Chism died while in custody. During the course of their investigation of Chism's death, the OCDASAU interviewed two 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 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.

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. Thus, when the OCDASAU Investigator has concluded the investigation, the file is turned over to an experienced deputy district attorney for legal review. If necessary, the reviewing prosecutor will send the case back for further investigation.

Throughout the review process, the assigned prosecutor will consult with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting memos. It is also common for the case to be reviewed by several experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews and approves all officer involved shootings and custodial death letters.

FACTS

On June 20, 2021, at approximately 9:15 p.m., OCSD deputies were dispatched to an apartment on River Bank Dr. in Yorba Linda in reference to an assault and battery. The reporting party (RP) advised that a family member, later identified as Fredrick Douglas Chism, had barged into her bedroom and hit her in the face with a closed fist approximately eight times. In fear that Chism would continue to assault her, RP grabbed her eight-year-old son and exited the residence through a patio door. RP left the residence and then called the police.

Upon police arrival, RP complained of pain to her head and exhibited a laceration under her left eye approximately one-half inch in length, but refused medical attention. Deputies then approached the residence and knocked on the front door, in an attempt to contact Chism. Chism complied with requests to exit the residence and speak to responding officers. Upon exiting, Chism was handcuffed and spoke to deputies. He admitted to shaking RP violently.

After entering the residence, deputies observed a broken glass table inside, a hole in the wall, and obscenities written in blue crayon inside RP's bedroom. Deputies also observed food thrown against the kitchen walls and floor, and a broken television.

Upon waiving his Miranda rights, Chism admitted to causing all of the damage inside of the home. Chism was subsequently arrested at approximately 10:40 p.m. for the following violations: CPC 273a(b) – Cruelty to a Child; CPC 240 – Assault; CPC 242 – Battery; CPC 594(b)(1) - Vandalism $400 or More; and two counts of CPC 594(a) – Vandalism.

At approximately 10:55 p.m., Chism was transported to and booked into Orange County Jail in Santa Ana. At approximately 11:51 p.m. and during the booking process, an Orange County Health Care Agency (OCHCA) Comprehensive Care Nurse (CCN) completed a receiving screen of Chism. Chism was oriented, communicated effectively, and did not appear unsteady, confused,

or lethargic. Chism denied any pre-existing medical conditions or history of drug or alcohol abuse. Chism denied having any current homicidal or suicidal ideations, but did disclose a previous 2009 suicide attempt by hanging. Based on his mental health history, Chism was referred to Mental Health for further evaluation. At 11:56 p.m., OCSD booking number 3202720 was issued for Chism.

At 1:47 a.m., Chism was booked at the OCSD intake release center. He was held there until he cleared the classification process at 04:12 a.m. One hour later, at approximately 5:36 a.m., an OCHCA Mental Health Clinician evaluated Chism. Chism was oriented, cooperative, and exhibited an appropriate thought process. Chism appeared to be disheveled and demonstrated a depressed and anxious mood. Chism disclosed mental health problems dating back approximately ten years, including a mood disorder diagnosis and a previous commitment to the Metropolitan State Hospital in Norwalk. Chism also revealed that he had previously attempted suicide "two or three times" by cutting his wrists, overdosing on pills, and attempting to hang himself. While incarcerated in the Orange County Jail in 2014, Chism was prescribed Zyprexa and Zoloft. Chism stated that he no longer took the prescribed mood medications, and that he abused methamphetamine and marijuana on a daily basis. No blood or urine analysis was done to confirm this; a urine analysis is only done if there is a concern regarding drug interactions if medication is prescribed. Based on the aforementioned, the evaluating Mental Health Clinician scheduled follow-up mental health evaluations and cleared Chism for regular housing.

Later that day, at approximately 12:03 p.m., Chism was transferred to Theo Lacy Facility in Orange, California and was assigned as the only inmate in a cell in Module R, Sector 58 (a medical isolation unit). During this time, in the month of June 2021, the Theo Lacy Facility had COVID-19 protocols in place to limit the spread of COVID-19. As part of this protocol, any newly booked inmates started their custody housing time in a medical isolation unit for two weeks, until they cleared a two week quarantine timeframe as determined by the medical staff. Chism was to complete a two-week quarantine in that cell pursuant to COVID-19 protocols. That sector had two stationary video surveillance cameras which recorded activity occurring within the sector.

An OCHCA Mental Health Clinician performed a further evaluation of Chism at 3:45 p.m. During that evaluation, Chism stated he was "doing okay," and denied wanting to harm himself. The clinician noted that Chism had "presented groomed, appropriate, and friendly in mood and affect." The clinician determined that, based on Chism's mood and disposition, Chism was housed "appropriately."

On June 24, 2021, between 10:03 a.m. and 10:06 a.m., OCSD deputies conducted a head count and safety check of all inmates housed in the various sectors of Module R, and reported no incidents. At 10:30 a.m., the security camera captured Chism getting off of the bottom bunk, walking over to the cell door, and staring out the window toward the Dayroom and the Guard Station. At 10:39 a.m., inmate workers began delivering sack lunches to the Sector 58 inmates. Chism accepted his lunch and spent the next four plus minutes walking around the cell, periodically stopping at the cell door to look out to the Dayroom. At approximately 10:43 a.m., the inmate workers left the sector. Within seconds, Chism walked up to the cell door, looked around the Dayroom, turned to his right, and walked toward the foot of the bunk out of the camera view.

At approximately 11:09 a.m., Deputy Addison Colangelo conducted another safety check and witnessed Chism kneeling with his back to the cell door and his forehead on the wall next to the foot of the cell's bunk. Chism appeared to have a torn bedsheet wrapped around his neck and

affixed to the top bunk in his cell. Deputy Colangelo made a radio broadcast requesting medical personnel to respond to Module R. Deputy Colangelo then entered Chism's cell, lifted him up, and released the bedsheet from around his neck. He then removed Chism from the cell and laid him on the adjacent walkway.

At approximately 11:10 a.m., Deputy Rami Murillo and an OCHCA Nurse Practitioner (NP) arrived. The NP noted Chism was unconscious, unresponsive, and without a pulse, bearing ligature marks on the front of his neck. Chism also had dilated pupils. At 11:12 a.m., an OCHCA doctor arrived and saw Chism supine on the walkway outside of Cell 10. Chism was unconscious and unresponsive. Deputies and medical personnel performed chest compressions and supplied oxygen via an air-bag-valve mask. An AED was attached and readings were monitored. Two unsuccessful attempts were made to start an intravenous line (IV) in Chism's left arm. Epinephrine was administered intramuscularly, and four (4) doses of Narcan were administered intranasally. Chism did not respond to medications, and CPR was continued.

At approximately 11:28 a.m., Paramedics from the Orange and Anaheim Fire Departments arrived. Paramedics established an IV and attached a heart monitor. They administered 250 ml of normal saline. The heart monitor showed Chism was in sinus rhythm/bradycardia. Chism had a return of spontaneous circulation. He was then placed in an ambulance for transportation to the University of California, Irvine Medical Center (UCIMC) in Orange.

When Chism arrived at UCIMC, his condition had worsened. He was in cardiac arrest, with agonal breathing and no pulse. A computerized tomography ("CT") scan of Chism's head, demonstrated that Chism had sustained an anoxic brain injury. Chism was admitted to the Cardiovascular Intensive Care Unit. He received 72 hours of targeted temperature management in an effort to preserve brain function. Although brain swelling had been reduced, there was no discernable brain stem reaction.

On June 30, 2021, the UCIMC Medical Treatment Team and Ethics committee convened to evaluate Chism's case. During that meeting, the Neuro Critical Care Attending Physician opined that Chism would not be able to make any meaningful neurological recovery from his injuries, would never wake up or be removed from a ventilator, and may have already been brain dead. It was determined that Chism would remain on life support pending the arrival of his next of kin.

On July 1, 2021, at approximately 2:00 p.m., members of the UCIMC Palliative Team met with Chism's next of kin. Upon consulting with the hospital staff, Chism's next of kin authorized for Chism to be removed from life support and for him to be placed in comfort care. Chism's life support was discontinued and Chism was administered medication, including fentanyl, for pain management.

At approximately 10:35 p.m., Chism's heart stopped. He was pronounced deceased at 10:40 p.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- One apparent ligature from Chism's cell
- Bloodstain standard from Chism

AUTOPSY

On July 13, 2021, Forensic Pathologist Dr. Scott A. Luzi, M.D., of the Orange County Coroner's Office conducted an autopsy on the body of Chism. Chism's neck displayed an external circumferential, discontinuous ligature furrow measuring 35 centimeters. Upon an internal examination, Dr. Luzi noted that Chism's neck demonstrated no injuries underlying soft tissues or hemorrhage into the strap muscles, and that the hyoid bone, thyroid cartilage, and major neck vessels were all intact. Chism's tongue was free of bite marks, hemorrhage, or other injuries. Furthermore, an examination of Chism's brain was unremarkable, and no hemorrhages, aneurysms, or lesions were noted.

Dr. Luzi also examined a white linen cloth ligature that was presented separately from the body, noting that the 0.5 centimeter diameter was consistent with the width of Chism's furrow which ranged from 0.2 to 0.6 centimeters. Dr. Luzi stated the death was consistent with hanging ligature strangulation. Dr. Luzi's final autopsy diagnoses included opinions of hanging and a cerebral edema with changes consistent with hypoxic encephalopathy. Upon receiving toxicology results (detailed below), Dr. Luzi determined Chism's cause of death to be hypoxic encephalopathy due to hanging and the manner to be suicide.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Carboxy-THC	Antemortem Blood	Detected
7-Aminoclonazepam	Postmortem Blood	Detected
Fentanyl	Postmortem Blood	0.0194 ± 0.0018 mg/L
Levetiracetam	Postmortem Blood	Detected
Midazolam	Postmortem Blood	0.77 ± 0.11 mg/L

BACKGROUND INFORMATION

Chism had a State of California Criminal History record with prior arrests for the following violations:

- Driving or taking of Vehicle without Consent
- Possession of a Controlled Substance
- Domestic Violence, Battery
- Battery on a Peace Officer or Medical Personnel
- Being Under the Influence of a Controlled Substance
- Battery on a Person
- Assault with a Deadly Weapon
- Grand Theft of Money/Labor/Property
- Resisting Arrest
- Trespass
- Receiving Stolen Property
- Vandalism
- Possession of Marijuana for Sale
- Petty Theft

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 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 Chism 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).

On the day of Chism's hanging, OCSD deputies consistently performed hourly safety checks on housed inmates. Upon discovering Chism in his cell, deputies immediately removed Chism's body from the ligature, called for medical assistance, and began rendering medical aid including chest compressions. While waiting for paramedics, medical personnel in the jail administered epinephrine to stimulate consciousness and Narcan to counteract a potential drug overdose. Chism failed to respond to either medication. Chest compressions were continued until paramedics arrived.

Chism was subject to numerous comprehensive mental health evaluations throughout his time in custody, the first commencing upon his initial booking. In each evaluation, Chism was cooperative and openly disclosed his mental health history, including previous suicide attempts and self-harm methodology. The OCHCA Mental Health Clinician who conducted Chism's second evaluation noted that Chism was receptive to future psychiatric treatment, agreed to regular housing, and was provided with information how to contact mental health services as needed. A third evaluation conducted by another OCHSCA Mental Health Clinician concluded that per Chism's mood and disposition, his placement in regular housing was appropriate.

Thus, 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.

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 Fredrick Chism.

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

Respectfully submitted,

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Senior 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**