OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

December 27, 2023

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

Re: Custodial Death on September 23, 2022
Death of Inmate Nelson Gam
District Attorney Investigations Case # 22-002950
Orange County Sheriff's Department Case # 22-031641
Orange County Crime Laboratory Case # 22-50150

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 September 23, 2022, custodial death of 65-year-old inmate Nelson Gam.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Mr. Gam. 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 September 20, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to Theo Lacy Facility Jail (TLF). Gam had attempted to hang himself while in custody and was being treated at the University of California, Irvine Medical Center. During the course of this investigation, the OCDASAU interviewed seven witnesses, as well as obtained and reviewed reports, incident scene photographs, and other relevant materials from the OCSD and Orange County Crime Laboratory (OCCL).

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. If necessary, the reviewing prosecutor will send the case back for further investigation.

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 review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews and approves all officer involved shooting and custodial death letters.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage at http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On Friday, September 9, 2022, at approximately 1:00 a.m., Gam was arrested by OCSD Deputies for unlawful possession of methamphetamine for purposes of sales in violation of Health and Safety Code Section 11378. He was subsequently transported for booking at the Orange County Jail - Intake / Release Center (IRC), Santa Ana. At approximately 3:34 a.m., an Orange County Health Care Agency (OCHCA) staff member completed a medical screening of Gam. He was oriented to person, place, and time, communicated effectively, and did not appear unsteady, confused, or lethargic. Gam reported sciatica pain and previous diagnoses of hypertension, high cholesterol, and diabetes. He said he received a weekly injection of Ozempic for his diabetic condition.

Gam disclosed that in February of 2022, he had attempted suicide by cutting his wrist. He denied any current suicidal or homicidal ideations. Gam was referred to Mental Health for "depression" and given a "Prescriber Referral" for hypertension, high cholesterol, and diabetes. Gam was cleared for regular housing and scheduled for a September 16, 2022, follow-up medical appointment. At approximately 6:27 a.m., Gam was booked into the IRC.

At 10:57 p.m., Gam was transferred from the IRC to the TLF. Pursuant to COVID-19 Quarantine Protocols, he was housed by himself.

On Saturday, September 10, 2022, an OCHCA staff member ordered Gam to have his blood glucose checked twice a day for 2 days, and his blood pressure checked once a day for 3 days. Gam was placed on the following daily medication regimen to address his hypertension, high cholesterol, and diabetes: Metformin HCl 800mg twice a day; Lisinopril 10mg once a day; and Atorvastatin 40mg once a day.

At 12:48 p.m., an OCHCA Behavioral Health Clinician (BHC) completed a Mental Health Screening of Gam. Once again, he was oriented to person, place, and time. He communicated effectively and did not appear unsteady or confused. The BHC described Gam's mood as "depressed."

During the mental health screening, Gam again disclosed that in February 2022, he had attempted suicide and had been diagnosed with "severe depression." Gam reported previously attending court ordered therapy, which he believed was beneficial. Gam told the BHC he felt bad about his current incarceration, but denied being depressed. He believed he had a good support group outside of jail and was looking forward to celebrating his daughter's upcoming birthday. Gam declined psychotropic medication and rejected further psychological evaluation. He did agree to contact the mental health department within the jail if he needed help.

On Sunday, September 11, 2022, at approximately 12:15 a.m., an OCHCA Senior Registered Nurse (RN) conducted a follow-up mental health evaluation of Gam. He refused to go to the treatment room, so the evaluation was completed in his cell. During the evaluation, Gam told the RN, "I need mental health now.... I don't need a nurse.... I'm at a breaking point.... I don't know what I'll do.... Just have me talk to mental health."

The RN noted Gam was a danger to himself and others. The RN recommended that Gam wear a safety gown, be placed on two hour visual checks, and return to the IRC for a mental health evaluation.

At 2:33 a.m., Gam was transported back to the IRC, where a Mental Health Nurse (MHN) completed an evaluation. According to the evaluation report, Gam was calm, cooperative, alert, and oriented. He made eye contact and demonstrated a linear thought process. Gam admitted being depressed but firmly and repeatedly denied suicidal ideations. He attributed his earlier outburst to not being allowed to make a phone call. Gam told the MHN,

> "All I want is a phone call to my daughter so she can get in touch with my brother to bail me out. I became desperate and lost my cool. I am not suicidal. I did that before, and I am not going to do it again. I just want to bail out. I don't hear voices. I am depressed, but I don't want to see a psychiatrist here. I have my own therapist. Can you call my daughter, please?"

The MHN called Gam's daughter at the phone number Gam provided, but did not receive an answer. At Gam's request, the MHN left a voice message. Gam agreed to return to regular housing and at 11:15 a.m., he was transferred back to TLF. Pursuant to COVID-19 Quarantine Protocols, Gam was housed by himself.

A review of the Thursday, September 15, 2022, TLF video surveillance system showed that OCSD deputies completed safety checks without incident every 45 minutes as required and performed additional informal safety checks while completing inmate book counts and medication distributions. Throughout the day, Gam was seen moving around inside his cell. He had no

contact with other inmates. Gam came out of his cell once, for less than a minute, to throw trash away.

At 7:44 p.m., during a medication distribution, Gam handed an OCHCA Licensed Vocational Nurse (LVN) an "Inmate Health Message Slip." The slip indicated that Gam was depressed and anxious. In the comments portion of the slip, Gam wrote, "I NEED HELP PLEASE!!" "ASAP!!" The LVN date stamped the message slip, September 15, 2022, and was processed in a routine manner. This was because Gam had placed check marks in the boxes marked "Depressed" and "Anxious," but left the "Suicidal" box unchecked. The Mental Health slip was recorded on Gam's "Sick Calls" log as "MH (mental health) 24-hour follow-up," meaning Gam was in the queue to be seen by Mental Health staff within the next 24 hours.

California Code of Regulations (CCR) Title 15 § 1052 requires local detention facilities to have written policies and procedures for inmates who may be in a "behavioral crisis" (formerly psychiatric crisis). OCSD Policy 6000 is written to comply with that regulation and establishes the procedures for handling inmate health message slips. It states in relevant part that the slips will be collected at least three times per day. It mandates that clinical staff picking up the slips screen them for emergent conditions. Any emergent condition is immediately referred to CHS clinical staff for further evaluation. "Emergent Conditions" are defined as:

> "A health condition manifesting to itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." Examples include, but are not limited to:
>
> (a) Chest pain
> (b) Shortness of breath or difficulty breathing
> (c) Suicidal/homicidal ideations, psychiatric crisis
> (d) Active bleeding
> (e) Fall/injury which prohibits the patient from getting to the Dispensary."

CCR Title 15 § 1052 states that an inmate is in behavioral/psychiatric crisis if "they appear to be a danger to themselves or others or appear gravely disabled." It further states that in the event an inmate is identified as being in crisis, "An evaluation from medical or mental health staff shall be secured within 24 hours of identification or at the next daily sick call, whichever is earliest."

At 11:29 p.m., OCSD Deputy Mendoza walked past and looked into Gam's cell while conducting a 45-minute safety check. At the time, Gam stood facing the deputy through the glass door. Deputy Mendoza noted in the log at 11:30 p.m. that there were no problems to report.

At 11:42 p.m., the dayroom lights were dimmed, and the cell lights were turned off. Within one minute of the lights going off, Gam pushed the in-cell intercom button and asked Sheriff's Special Officer (SSO) Guerrero Oajaca for dayroom privileges. SSO Oajaca explained to Gam that dayroom privileges ended at 11:30 p.m. Gam was assured that he would be given dayroom privileges first thing in the morning.

Based on a review of surveillance video, Gam became visibly agitated after being denied dayroom access and spent the next five minutes standing at the cell door, repeatedly hitting and kicking the door and bottom bunk.

At 11:48 p.m., Gam walked back to the bunks, removed a bedsheet from the bottom bunk, and began to twist the sheet several times before draping it over his shoulders. Gam walked to the cell door and looked out towards the dayroom as he appeared to tie a knot in the bedsheet. At 11:50 p.m., Gam walked out of camera view toward the foot of the bunk, where he remained for approximately two minutes. At 11:52 p.m., he briefly moved back into camera view; with his back toward the door. The sheet appeared to be draped over his shoulders and/or around his neck. At 11:52:10 p.m., Gam walked out of view of the camera and toward the foot of the bunk. The security camera recordings captured no further movement.

Approximately 19 minutes later, on Friday, September 16, 2022, at approximately 12:11 a.m., Deputies Pham and Mendoza entered Gam's jail sector to conduct a safety check. As Mendoza walked past Gam, he looked inside and saw Gam at the foot of the top bunk, hanging by a white bedsheet. Deputy Mendoza yelled for Deputy Pham, keyed the cell door open, and entered the cell. Once inside the cell, Deputy Mendoza pushed the intercom button and notified SSO Oajaca and Deputy Ramirez of the emergency. Deputy Mendoza determined Gam was unconscious, unresponsive, and not breathing. He grabbed Gam around the waist and lifted him up to relieve the pressure from his neck. Deputy Pham unsuccessfully tried to cut the sheet with a pair of safety cutters. When Deputy Ramirez arrived, he lifted Gam's legs up, which allowed Deputy Pham to untie the bedsheet and remove it from around his neck.

At 12:13 a.m., surveillance video showed that deputies carried Gam out of the cell and placed him on the dayroom floor to render aid. Deputy Ramirez immediately initiated chest compressions and continued doing so until additional deputies arrived and relieved him. Deputies performed chest compressions while OCHCA medical personnel provided oxygen via an air-bag-valve mask and placed automated external defibrillator (AED) pads on Gam. Cardiopulmonary resuscitation (CPR) was paused several times to allow the AED to evaluate his condition; each time, the AED advised no shock and to continue CPR.

At 12:26 a.m., Orange Fire Department, Rescue 6 personnel arrived. Despite the efforts of OCSSD and OCHCA personnel, Gam was unconscious, unresponsive, and had no pulse. According to one of the paramedics who treated him, Gam had ligature marks, consistent with hanging, on his neck. A cardiac monitor was attached, and an intraosseous access line was established in his right leg. Normal saline was administered. Gam regained sinus rhythm and a return of spontaneous circulation. He was transported by ambulance to The University of California, Irvine Medical Center (UCIMC) Emergency Room.

At approximately 12:45 a.m., Gam arrived at UCIMC, where his care was relinquished to the care of an emergency room physician. The doctor noted Gam had erythema (signs of redness) on his neck, consistent with hanging, and a deformity to his chest, consistent with CPR. Gam was intubated and placed on mechanical ventilation for acute hypoxic respiratory failure. He was placed under targeted temperature management to protect his brain and transferred to the Intensive Care Unit.

On September 17, 2022, a UCIMC doctor met with Gam's family. They were told Gam had suffered a cardiac arrest resulting in an anoxic brain injury, his prognosis was very poor, and that he was not expected to survive. Gam's family signed a do-not-resuscitate order and consented for OneLegacy to procure organs and tissue. Gam remained on life-support while OneLegacy coordinated with the Orange County Coroner's Office (OCCO) to determine which organs could be procured without jeopardizing the custodial death investigation.

On September 20, 2022, OCCO Forensic Pathologist Doctor Etoi Davenport reviewed Gam's medical records and approved the procurement of "organs and tissues below the neck."

On September 23, 2022, at 10:38 p.m., OneLegacy, notified the OCCO that Gam had been removed from life support, pronounced deceased, and organs and tissues procured. Gam's body was transported to the OCCO where an autopsy was performed by Forensic Pathologist Dr. Scott Luzi.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- 2 OCSD TLF Surveillance video recordings
- 6 Jail Phone Call recordings
- 21 OCCL Jail Scene photographs
- 53 OCCL Hospital Scene photographs
- 54 OCCL Autopsy photographs
- 1 Muscle Standard
- 1 Knotted Sheet
- Antemortem blood sample
- Postmortem blood sample

AUTOPSY

On September 26, 2022, Dr. Luzi, conducted an autopsy on Gam's body. Dr. Luzi found no external or internal injuries to Gam's neck. He found anterior rib fractures consistent with CPR. Dr. Luzi listed the cause of death as pending investigation and the manner of death as pending. On May 31, 2023, Dr. Luzi amended the cause of death as anoxic encephalopathy due to hanging and the manner of death as suicide. Dr. Luzi's report noted the following Final Autopsy Diagnoses:

1. Hanging
2. Other injuries: none
3. Natural disease and pre-existing conditions
    a. Cerebral edema
    b. Pontine infarct
    c. Emphysematous changes
    d. Cardiomegaly
    e. Mild coronary atherosclerosis
    f. Mild to moderate peripheral atherosclerosis
    g. Cirrhosis
    h. Prostatic hypertrophy

EVIDENCE ANALYSIS

Toxicological Examination

Samples of Mr. Gam's blood yielded the following results:

DRUG	ANTEMORTEM BLOOD	POSTMORTEM BLOOD
Fentanyl	Negative	0.0098 ± 0.0010 mg/L
Norfentanyl	Negative	Detected

Midazolam	Negative	0.363 ± 0.049 mg/L
Metformin	Detected	Negative

BACKGROUND INFORMATION

Gam had a State of California Criminal History record that revealed arrests dating back to 2021 for the following violations:

- Possession of Controlled Substance for Sale
- Assault with a Deadly Weapon (Not a Firearm) on a Police Officer
- Obstruct/Resist Executive Officer
- Possession of Drug Paraphernalia

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 Gam 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).

When Gam was booked into the IRC on September 9, 2022, he was screened by medical staff to determine if he had any mental health issues or was a risk of harming himself. He indicated a suicide attempt approximately seven months prior, but denied currently experiencing any suicidal ideation.

He was transferred to the TLF on September 10, 2022, and was given a second mental health screening upon his arrival at that facility. During that evaluation he repeated that he had attempted suicide seven months earlier while diagnosed with severe depression, but had since attended court-ordered therapy and was doing better. He admitted feeling badly about being incarcerated, but explicitly denied being depressed or suicidal and stated that he was looking forward to his daughter's birthday. Gam also declined psychotropic medications and rejected a further psychological evaluation.

OCSD took measures to address his physical health conditions, ordering that his blood pressure be checked twice a day for two days, then once a day for three days. He was placed onto a

prescription drug regimen to address the chronic health conditions he reported upon his entrance to the facility.

Shortly after midnight on September 11, 2022, the OCHCA medical staff re-evaluated Gam's mental health. In that evaluation he stated that he was at his breaking point and needed "mental health." The OCHCA nurse immediately recommended that he be sent back to the IRC for an additional evaluation and that he be placed on two-hour safety checks. The OCSD transferred Gam back to the IRC and he was reevaluated within two and a half hours.

During that evaluation Gam repeatedly and firmly told the MHN that he was not suicidal and that all he wanted was to call his daughter and to try and bail out. After the MHN assisted him in trying to call his daughter, Gam agreed to return to the TLF.

Over the first two days of his incarceration, OCHCA and OCSD staff responded immediately to every indication that Gam might have been depressed or suicidal, and at every intervention, Gam denied that he was contemplating suicide.

On the September 15, 2022, Inmate Health Message Slip, Gam wrote that he needed help "ASAP" and checked the depression and anxiety boxes. He did not check the suicidal box, display symptoms that his mental state had worsened in the last four days, or state that he was now contemplating suicide.

Following OCSD Policy 6000, the LVN processed the message slip and Gam was placed into the queue for a follow-up appointment within 24 hours of his request. There was no indication from his statement on the slip or his behavior at the time that he was a danger to himself or others, or that he was gravely disabled such that he should have been referred to OCHCA staff for immediate evaluation.[1]

At 11:29 p.m., OCSD deputies performed their safety checks within the required time frame. An OCSD deputy walked past and looked directly at Gam through the glass cell door. Gam made no other statements, and did not make any request for help.

About 12 minutes later after the lights were turned off in the dayroom for the night, Gam called the guardhouse over the intercom to ask for dayroom privileges. He was told he could not go to the dayroom, but would have access first thing in the morning. Again, he did not indicate that he was contemplating suicide, needed help, or show any signs of physical or mental distress.

Deputies Pham and Mendoza performed their required safety check at 12:11 a.m. on September 16, 2022. When they observed Gam hanging in his cell, they immediately administered aid by performing CPR along with other OCSD deputies and OCHCA personnel and following the directions of the AED until the emergency medical services arrived thirteen minutes later.

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.

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[1] Even if Gam had been identified as being in a psychiatric crisis, scheduling him for follow-up evaluation within 24 hours would have met the legal standard of care in California. (See Cal. Code. Reg. Tit. 15, § 1052.)

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 Gam. The evidence shows that Nelson Gam died as a result of hanging and that the death was a suicide.

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

Respectfully submitted,

NATHANIEL BARRETT
Deputy District Attorney
Gang/TARGET Unit

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

READ AND APPROVED BY **TODD SPITZER**
District Attorney