OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

February 7, 2024

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

Re: Custodial Death on November 4, 2022
Death of Inmate Joseph Wayne King
District Attorney Investigations Case# 22-003392
Orange County Sheriff's Department Case # 22-037872
Orange County *Crime* Laboratory Case # FR 22-51562
Orange County Coroner's Office Case # 22-06447-AY

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the November 4, 2022, custodial death of 59-year-old inmate Joseph Wayne King.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Joseph King. 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 all Orange County Sheriff's Department (OCSD) personnel as well as those under the supervision of the OCSD involved *in* this custodial death *incident.*

On November 4, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Anaheim Global Medical Center (AGMC), located at 1025 South Anaheim Boulevard, Anaheim, where King died while in custody. During the course of their investigation of King's death, the OCDASAU interviewed seven witnesses, and obtained reports, incident scene photographs, jail surveillance footage, medical records and other relevant materials from the OCSD and the 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 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 shooting and custodial death letters.

FACTS

On October 29, 2021, at approximately 10:45 p.m., the Anaheim Police Department (APD) arrested King for allegedly committing lewd acts with a minor. King was transported to the Orange County Jail (OCJ) - Intake Release Center (IRC) for processing.

Following his arrival at IRC, King was medically screened. According to OCSD records, he was denied clearance for booking into IRC on October 30, 2021, at approximately 12:57 a.m., due to the following medical findings:

- Elevated blood pressure
- Pacemaker for bradycardia since 2016
- Last took his prescription medication on the morning of October 29, 2021

APD officers transported King to Anaheim Global Medical Center (AGMC), where he was medically examined and released for transportation back to IRC. Upon his return to IRC and based on the results of the AGMC examination, OCSD booked King into IRC on October 30, 2021, at 7:13 a.m.

Orange County Health Care Agency (OCHCA) medical records indicated King was initially given five milligrams of Amlodipine on October 30, and then placed on a daily dosage regimen of ten milligrams thereafter.[1] His vitals were to be taken twice a day until November 3, 2021.

On Sunday, October 31, 2021, King submitted an Inmate Health Message Slip (IHMS) to medical personnel requesting contact solution and a refill of his prescription for Amlodipine.

On November 1, 2021; King was transferred to OCJ-Men's Central Jail, Module A, Tank 05, Cell DO (housing area), Bunk 68.

On November 1, 2021, at approximately 4:30 a.m., King was seen by jail medical *staff.* His blood pressure was checked, and his scheduled medication was given early due to an elevated blood pressure of 200 / 96. An OCHCA physician ordered continued monitoring of King's blood pressure. King's blood pressure was checked twice more on November 1, and found to be 158/100 and 160/102. Despite being somewhat elevated, King continued to state that he felt fine. Staff noted that the high readings could be a result of the stress from being incarcerated as well as his being noncompliant with his blood pressure medication. OCHCA staff continued to monitor his blood pressure throughout his time in custody. Staff noted that King became compliant with his medication and his blood pressure readings improved to a normal level.

On November 3, 2021, King submitted an IHMS requesting a low-sodium diet due to chronic hypertension and a heart condition. On November 5, 2021, an OCHCA Nurse Practitioner (NP) noted that King requested a low-sodium diet, and his request would be reevaluated during his sick call visit.

On December 9, 2021, King submitted an IHMS requesting to schedule an appointment with a cardiologist regarding his pacemaker. King's IHMS indicated he was experiencing chest pains and shortness of breath.

On December 10, 2021, King was seen by medical staff, and a Registered Nurse **(RN)** recorded that he had no complaints of shortness of breath at that time. The RN noted King 's lungs sounded clear bilaterally on auscultation. King was offered pain medication, but declined, stating, "I'm okay." King's medical chart indicated that OCHCA had not yet received his Kaiser medical records.

On December 18, 2021, King submitted an IHMS indicating he had extreme lower back pain and a sore throat. In response, King was seen the following day by medical personnel for lower back pain. King was given six 200 milligram Ibuprofen tablets to keep on his person and was instructed to take two tablets daily.

On March 30, 2022, King submitted an IHMS indicating he needed treatment for a painful infection on his right second toe. On April 2, 2022, King was seen by medical staff, and it was noted that he needed no intervention at the time and was advised to keep his toe clean and submit an IHMS should his condition worsen.

[1] Amlodipine is a calcium channel blocker used to treat hypertension.

On June 29, 2022, King was advised of an upcoming medical appointment and was told he needed to fast.

On June 30, 2022, King received a Specialty Clinic Appointment Notification (SCAN) regarding an upcoming echocardiogram, Lexiscan stress test, and a pacemaker check. King initialed the form, indicating he would not attend his medical appointment. King noted, "This is (sic) procedure is not what I require for my pacemaker. Fasting is never required."

On July 1, 2022, at approximately 3:40 a.m., King signed a Refusal to Accept Treatment and Release of Liability form. King provided the following reason for his refusal, "I don't want to go. I'll see the doctor outside once I'm released. I have not eaten yet, but I don't want to go." At approximately 3:54 a.m., an OCHCA RN recorded that King refused to attend his medical appointment scheduled for later that day.

On July 5, 2022, at approximately 2:19 p.m., an OCHCA doctor noted that King had refused to attend his July 1, 2022, medical appointment and declined to reschedule the procedure.

On August 4, 2022, King submitted an IHMS requesting to speak with mental health staff. King checked the boxes indicating he was "Depressed" and "Anxious." King noted, "I would like to speak with Kimberly. I have been in custody for 9 months and my pre-trial was extended again (5th time) for another 7 wks. She is familiar with my issues."

On August 5, 2022, a mental health clinician (MHC) recorded that King's pre-trial had been moved, and that he had been worrying about his pacemaker. King told the MHC he usually gets his pacemaker checked yearly to see if adjustments are needed, and that he had not had his pacemaker checked while in custody. The MHC noted King could remain in his current housing and that he was aware of how to contact mental health if needed.

On September 1, 2022, an OCHCA doctor assessed King and determined that his hypertension needed tighter control. The doctor attempted to adjust King's medication, but he refused, stating, "I was anxious after a fight in our mod earlier." King also refused a stress test stating, "I am doing well with chest pain, my cardiologist couple of years ago said I don't need it." King also said that he would be leaving in a few days and would follow up with his primary care provider and cardiologist. King was informed about the ramifications of uncontrolled hypertension, and reminded of the cardiology recommendations for him.

On November 3, 2022, at approximately 8:16 p.m., King received a SCAN form regarding an upcoming appointment to check his Biotronik pacemaker. King initialed the form acknowledging that he would attend his appointment. The following day, at approximately 8:30 a.m., King attended his pacemaker appointment in the Correctional Medical Services (CMS) Unit located at AGMC. A Biotronik representative saw King and determined that the battery life remaining on his device was at 55%, which equated to 5 years and three months. The representative further noted that the device was stable and functioning, and no changes were made.

After the appointment, King was placed in CMS holding cell 3 to await transportation to the Women's Central Jail. King was scheduled to be placed in quarantine.

At approximately 11:00 a.m., an OCHCA LVN saw King eating lunch and he appeared to be fine at that time.

At approximately 12:35 p.m., OCSD Deputy Grant Finlay conducted a safety check of cell 3 with no problems noted.

At approximately 12:52 p.m., Deputy Finlay was asked to remove King from holding cell 3 in preparation for transportation. In a voluntary interview with OCDA investigators, Deputy Finlay indicated that when he entered the holding cell, he found King unresponsive and supine on the cell's floor. Deputy Finlay checked for a pulse but found none. He then exited the cell and yelled for an RN. Deputy Finlay returned to King and began cardiopulmonary resuscitation (CPR) chest compressions. The RN announced a code blue over the telephone intercom throughout the hospital.

Several RNs responded to cell 3 to assist Deputy Finlay with CPR. Additional medical staff arrived within 60-90 seconds and initiated advanced cardiac life support treatment. After approximately 30 minutes of unsuccessful treatment, an OCHCA physician declared King deceased at 1:29 p.m.

Although CMS was equipped with surveillance cameras that allowed for the monitoring of CMS in real time, they did not preserve or record any video.

While in OCSD custody, King was prescribed and given the following medications:

- Amlodipine Besylate Oral 5 mg (Once on October 30, 2021)
- Amlodipine Besylate Oral 10 mg (Once daily between October 31, 2021, and December 25, 2022)
- Lisinopril Oral 5 mg (Once daily between March 10, 2022, and December 25, 2022)
- Ibuprofen Oral 200 mg (Two pills were given three times daily between December 19, 2021, and December 21, 2021)
- Ibuprofen Oral 200 mg (Two pills were given three times daily between September 22, 2022, and September 24, 2022)

EVIDENCE COLLECTED

An OCCL Forensic Specialist took 53 digital color photographs of the hospital scene and King's body.

AUTOPSY

On Tuesday, November 15, 2022, at approximately 8:10 a.m., Forensic Pathologist Doctor Chanikarn Lopez conducted a post-mortem examination of King at the Orange County Sheriff-Coroner Forensic Science Center. An OCCL Forensic Specialist took 50 color digital photographs documenting the autopsy. An OCCL Forensic Scientist collected deep muscle tissue.

After the autopsy, Dr. Lopez listed King's tentative cause of death to be the result of an enlarged heart and cardiovascular disease. Dr. Lopez indicated the final determination would be determined following toxicology results and the microscopic examination of slides. On May 31, 2023, Dr. Lopez issued a final report identifying the cause and manner of King's death. The cause of death was determined to be "Atherosclerotic with hypertensive cardiovascular disease." The manner of death was identified as "natural."

EVIDENCE ANALYSIS

Toxicological Examination

Samples of King's postmortem blood were collected and examined for the presence of drugs and alcohol.

The following results and interpretations were documented:

DRUG/ALCOHOL	POSTMORTEM BLOOD
EthanolNolatiles	Not Detected
Barbiturates	Negative
Cannabinoids	Negative

BACKGROUND INFORMATION

King had no criminal history before his October 29, 2021 arrest.

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 King 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). King was evaluated by OCHCA personnel upon admittance to the IRC on October 29, 2021. Due to his medical status, he was transferred to AGMC for further evaluation, and was not booked into IRC until he had been medically cleared. Once cleared, OCHCA professionals prescribed him medication to address his conditions.

Throughout his time in custody, OCHCA personnel monitored his various conditions and provided appropriate medical care, when needed. Part of the follow-up care was conducted at the CMS, where his pacemaker was checked. That examination, conducted by the pacemaker company's representative, showed that the pacemaker was functioning properly, and there was no cause for concern.

After the check-up, King was placed in a holding cell where a safety check was conducted at approximately 12:35 p.m. King appeared to be fine.

Less than 20 minutes later, when OCSD personnel went to prepare King for transportation, he was found unresponsive. Immediately, OCSD personnel followed medical protocol and began providing care to King.

AGMC medical staff arrived in less than two minutes and provided advanced cardiac life support treatment for approximately 30 minutes. Unfortunately, King could not be revived.

His cause of death was ultimately determined to be the natural result of atherosclerosis and hypertensive cardiovascular disease. There is nothing to indicate that King's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

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 Joseph King.

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

Respectfully submitted,

MARC ROZENBERG
Deputy District Attorney
Special Prosecutions Unit

Read and Reviewed by **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

Read and Approved by District Attorney **TODD SPITZER**