OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

June 10, 2024

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

Re: Custodial Death on July 11, 2023
Death of Inmate Jason Williams
District Attorney Investigations Case # 23-001985
Orange County Sheriff's Department Case # 23-025786
Orange County Crime Laboratory Case # FR 23-45958
Orange County Coroner's Office Case # 23-04002-FM

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 July 11, 2023, custodial death of 50-year-old inmate Jason Williams.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Williams. 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 July 11, 2023, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), located at 1001 North Tustin Avenue, Santa Ana, where Williams died while in custody. During the course of their investigation of Williams' death, the OCDASAU interviewed four witnesses and obtained reports, incident scene photographs, jail surveillance footage, medical records, and other relevant materials from the OCSD, the Orange County Fire Authority (OCFA), 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 July 5, 2023, at approximately 2:55 p.m., Williams was arrested by Huntington Beach Police Department (HBPD) Officer Humberto Valdez on an outstanding Orange County Superior Court warrant for violating Penal Code (PC) section 417 (a)(1) – Brandishing of a Deadly Weapon and PC section 245(a)(4) – Assault by Means Likely to Produce Great Bodily Injury.

Officer Valdez transported Williams to the HBPD Jail and completed an HBPD-Jail Medical Screening Questionnaire on Williams and noted that Williams appeared to be under the influence of drugs. Officer Valdez also noted that Williams had a small abscess on his right hip. No other medical problems were reported.

At approximately 3:55 p.m., HBPD Officer Lance Everett completed a Statement of Booking Officer on Williams. Officer Everett noted in the Statement of Booking that Williams appeared in good health and was not a danger to himself or others.

On July 6, 2023, at approximately 11:20 a.m., Williams was transported to the Orange County Jail (OCJ) and booked into the Intake/Release Center (IRC). Williams was given a rapid COVID-19 test that was negative.

An Orange County Health Care Agency (OCHCA) Comprehensive Care Nurse (CCN) completed a Receiving Screening on Williams. Williams told the CCN that he suffered from thyroid disease and was currently prescribed Levothyroxine. Williams stated he smoked daily and used street narcotics such as marijuana and amphetamines. Williams appeared unkempt and agitated and admitted to having mental health problems. Williams had previous incarceration records within

the OCSD Jail system, dating back to May 5, 2020, and the records showed that he had been previously documented with mental health problems. Williams denied being suicidal and was deemed not to be a danger to himself or others. Williams was again documented as having an abscess on his right groin/thigh but was cleared for regular housing. Williams was given a Mental Health Triage Referral and scheduled for a recheck on July 13, 2023.

Williams had additional medical tests completed and an OCHCA physician noted that he appeared to be in good physical health.

At approximately 7:32 p.m., Williams was moved to Module (Mod) F, Tank 32, Cell 4, Bed 8. Williams was housed with seven other inmates in Cell 4. OCSD Men's Jail Mod F, Tank 32, is equipped with surveillance video.

On July 07, 2023, an OCHCA Nurse Practitioner (NP) ordered the following medications for Williams:

- Sulfamethoxazole-Trimethoprim Oral – 800-160 MG, two times a day
- Levothyroxine Sodium Oral – 50 MCG, once a day

On July 08, 2023, at approximately 2:23 p.m., an OCHCA Medical Staff Member (MSM) completed a progress note on Williams. The MSM noted that she provided medical attention for Williams' abscess. Williams reported his pain was mild, but his appetite was good. Williams was calm and cooperative, with a steady gait, no acute respiratory issues, and normal skin color. Follow-up medical care was to include wound care, clean dressings, and hygiene.

On July 09, 2023, at approximately 10:00 a.m., an OCHCA Clinical Care Nurse (CLCN) completed a Correctional Health Services Registration form on Williams. The CLCN documented that Williams had been housed prior to receiving a mental health screening. The CLCN completed a Columbia-Suicide Severity Rating Scale form on Williams and indicated that Williams stated he was not suicidal.

It should be noted that on this date, Williams completed an Inmate Message Slip requesting to see a nurse for an unknown medical concern. The message slip did not include a time.

At approximately 3:09 p.m., the CLCN completed the mental health screening on Williams. During the screening, Williams admitted to receiving prior mental health treatment for mood disorder, psychosis, and drug use. Williams stated he was currently prescribed medications, but denied being prescribed Zyprexa and Vistaril during previous incarcerations within the Orange County Jail. At the time of this screening, Williams stated he felt depressed and later indicated being targeted, being followed, and not being allowed to get better. Williams would not indicate who was following him or targeting him. The CLCN noted that Williams was orientated to place and time, but his appearance was bizarre and disheveled.

The CLCN further indicated that Williams' insight and judgment were impaired. Williams was described as irritable, delusional, and paranoid. Williams' discharge needs included medication management, psychiatric hospitalization, housing, drug/alcohol treatment, and outpatient mental health management. Williams remained in the Booking Loop and was returned to regular housing. The CLCN later completed a Mental Health Evaluation for the court indicating Williams was "Gravely Disabled."

At approximately 3:17 p.m., the CLCN completed a Mental Health Acuity Level form on Williams and rated his mental health acuity level as "Severe."

On July 10, 2023, at approximately 5:02 p.m., an OCHCA MSM completed a progress note on Williams. The MSM indicated she had contacted Williams for wound care, but at the time of her visit, Williams was agitated and raising his voice. Williams reported the abscess he had was not normal and requested that his blood be evaluated.

Because of Williams' agitated state, and for her safety, an OCSD deputy was called to assist the MSM in her duties. The MSM's interaction with Williams was limited due to his agitated state.

On July 10, 2023, surveillance video captured OCSD deputies conducting numerous safety checks within the module. Williams was observed climbing in and out of his top bunk without hesitation. Williams was seen walking, eating, and talking with other inmates within the cell. Williams showed no signs of distress.

At approximately 7:38 p.m., surveillance video captured a deputy escorting jail medical staff to cell 4 for medication distribution. Williams received his medication (Sulfamethoxazole-Trimethoprim) and appeared to ingest his medication orally without incident. All prescribed medications were documented as being given without disruption.

On July 11, 2023, at approximately 3:28 a.m., OCSD Deputy Carlos Nunez escorted jail medical staff to Williams' cell to distribute medication. Deputy Nunez and the MSM did not enter the cell. Surveillance video captured Williams on his top bunk, being asked to step down to receive his medication. Williams is captured sitting up at the edge of his bunk, then shortly after, lying back down.

Deputy Nunez documented that Williams was communicating with him and jail medical staff but was unable to get up from his bunk, felt weak, and did not know why he was feeling ill. Williams again was reported as being agitated. Nunez and the jail medical staff left the cell area. Williams did not receive medical attention or medication at this time.

At approximately 3:36 a.m., Deputy Nunez returned to the cell with OCSD Deputy Jonathan Silva to monitor Williams, asking him to come down from his bunk for evaluation at the medical dispensary. Williams remained agitated, stating he could not get up. Deputy Nunez asked Williams if he would allow his fellow inmates to assist him off his bunk. Deputy Nunez requested assistance from Williams' cellmates to help him down from the bunk. One of Williams' cellmates contacted Williams and reported that Williams felt sweaty.

Deputies Nunez and Silva left the cell to contact medical staff and obtain a wheelchair.

At approximately 3:39 a.m., a surveillance camera captured fellow inmates of Williams, removing him from his bunk and onto the floor.

At approximately 3:42 a.m., Deputy Tony Finlen arrived at the cell and ordered the inmates away from Williams. Deputy Finlen remained adjacent to Williams. Williams was lying down but was moving his leg.

At approximately 3:46 a.m., Deputy Nunez returned to the cell with a wheelchair. Deputies Nunez and Finlen entered the cell and attempted to place Williams in the wheelchair, but were

unsuccessful. Several OCSD deputies then pulled Williams out of his cell and onto the front landing.

At approximately 3:50 a.m., OCSD deputies moved Williams away from the landing and down toward a secured area below the module.

At approximately 3:53 a.m., an OCJ MSM contacted Williams and began to evaluate his condition. Additional medical staff began to respond and continued to monitor and treat Williams.

At approximately 3:55 a.m., OCFA paramedics were dispatched to the scene.

At approximately 4:02 a.m., OCFA paramedics arrived on the scene. An OCFA Paramedic observed OCHCA medical personnel and OCSD deputies adjacent to Williams, who was supine on the ground. The paramedic noted that Williams had an altered level of consciousness and was lethargic. His speech was sluggish and he could not answer questions. Williams only stated his name, "Jason," and said he needed help. The paramedic observed no apparent signs of trauma on Williams' body.

The OCFA paramedic began to examine Williams and found he was experiencing low blood pressure. He attached an electrocardiogram to Williams and found no indications of a heart attack. An intravenous line was established and Williams was administered 250 milligrams of saline.

At approximately 4:32 a.m., Williams was loaded onto a gurney and transported to OCGMC.

At approximately 4:38 a.m. Williams arrived at OCGMC where care was transferred to Emergency Room (ER) personnel. An OCGMC Registered Nurse (RN) noted that Williams was experiencing hypertension and was only responsive to the calling of his name. An OCGMC physician was present in the ER when Williams arrived at the hospital. The physician saw Williams was not moving his left arm and left leg, which he believed to be consistent with having a stroke. Williams was stabilized in the ER, and a computed axial tomography ("CAT") scan of his brain was ordered. This scan, however, returned negative for a stroke.

At approximately 6:46 a.m., the OCGMC physician requested a drug screening be completed on Williams. His drug screening (urine) returned positive for Tetrahydrocannabinol (THC) but otherwise negative.

At approximately 9:30 a.m., Williams was transferred out of the ER into room 401. Williams was scheduled for an MRI, but at the time, he was confused and uncooperative. Williams was provided the following medications at the listed times:

- 11:56 a.m., Geodon 10 mg
- 12:38 p.m., Ativan 1 mg
- 7:40 p.m., Geodon 10 mg

At approximately 8:00 p.m., OCGMC medical staff contacted Williams for a vitals check. Williams was talking and restless, but overall, his medical conditions were deemed to be improving.

At approximately 8:44 p.m., an OCGMC RN was at her desk adjacent to Williams' room when she heard Williams gasping for air. She responded to the room to check his condition and saw that Williams was not breathing. Williams was cold, cyanotic, and his right pupil was non-reactive.

The RN immediately initiated a "CODE," requesting additional medical staff for emergency life-saving efforts.

An ER physician responded to the room and found Williams was blue in appearance, unresponsive, and pulseless. The physician found that both of Williams' eyes were dilated and fixed, showing signs of possible brain damage due to the lack of oxygen. Medical staff initiated cardiopulmonary resuscitation (CPR) and intubated Williams.

At approximately 8:59 p.m., a cardiac ultrasound was conducted and found Williams with minimal heart activity. CPR continued, but Williams did not respond to life-saving methods.

At approximately 9:01 p.m., the OCGMC ER physician pronounced Williams deceased.

AUTOPSY

On July 27, 2023, at approximately 8:00 a.m., Forensic Pathologist Scott Luzi conducted a postmortem examination of Williams at the Orange County Sheriff-Coroner Forensic Science Center.

An OCCO Forensic Specialist took 54 digital color photographs, and an OCCL Forensic Scientist collected muscle and bloodstain standards.

After the autopsy, Dr. Luzi noted that Williams had a swollen brain, an enlarged heart, and signs of a ruptured aorta. Dr. Luzi stated the cause and manner of death were pending review of medical records, toxicology results, and examination of microbiological slides.

On January 18, 2024, Dr. Luzi issued an amendment to the initial autopsy report. Dr. Luzi documented the cause of death as hemopericardium due to aortic dissection and hypertensive cardiovascular disease. Dr. Luzi classified the manner of death as natural.

EVIDENCE COLLECTED

An OCCL Forensic Specialist took 91 digital color photographs of the hospital scene and body, located at OCGMC. No evidence was collected

EVIDENCE ANALYSIS

Toxicological Examination

Samples of Williams' antemortem and postmortem blood were collected and examined for the presence of drugs and alcohol.

The following results and interpretations were documented:

Drug	Postmortem Blood	Antemortem Blood
Acetaminophen	Detected	Not Detected
Cannabidiol	0.0024 ± 0.0003 mg/L	Not Detected
delta-8-Carboxy-THC	Detected	Detected
delta-8-THC	Detected	Detected
delta-9-Carboxy-THC	Detected	Detected
delta-9-THC	Detected	Detected
Lorazepam	0.0164 ± 0.0015 mg/L	Not Detected

Trimethoprim	Detected	Detected
Ziprasidone	0.073 ± 0.013 mg/L	Not Detected

BACKGROUND INFORMATION

Williams had a State of California criminal history record dating back to 1992 that revealed prior arrests for the following violations:

- Assault and Battery
- False Imprisonment
- Domestic Violence
- Witness/Victim Intimidation
- Possession of a Controlled Substance
- Kidnapping
- Under the Influence of a Controlled Substance
- Unlicensed Driver
- Open Container/Alcohol in a Vehicle
- Carry Concealed Dirk/Dagger
- Vandalism
- Burglary
- Assault with a Deadly Weapon
- Exhibit a Deadly Weapon
- Robbery
- Driving with a Suspended License
- 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 Williams 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). Williams was evaluated by medical personnel upon admittance to the IRC on July 6, 2023. It was noted that he appeared unkempt and agitated, and admitted to having mental health problems. Records from prior incarcerations at the OCJ confirmed Williams' mental health issues and he was referred for a Mental Health Screening. Additionally, an abscess was observed on his right leg/groin for which he received treatment on July 7, 2023. There were no other signs of Williams having physical problems. On July 8, 2023, Williams was again evaluated for health issues and reported mild pain due to the abscess, but otherwise appeared and reported to be well.

On July 10, 2023, when Williams complained about the abscess, an MSM attempted to care for his wound but was limited due to Williams' agitated state. Throughout the day, however, Williams was interacted normally and took his medication as prescribed. Williams showed no signs of distress during numerous contacts.

On July 11, 2023, when Williams was contacted by OCSD Deputy Nunez, he was agitated and unable to get out of his bunk to receive his medication. Due to his agitated state, the medication was not given and the deputy did not enter the cell. Deputy Nunez left the cell area but returned shortly thereafter to observe Williams. When other inmates were reporting that Williams was sweaty, Nunez immediately went to contact medical staff to assist Williams. Medical staff arrived and monitored Williams within minutes. OCFA paramedics were called two minutes after MSM members contacted Williams.

Once OCFA paramedics arrived, they noted an altered mental state and low blood pressure. There were no indications of trauma or a heart attack. He was, however, promptly transported to the OCMGC ER where he was treated for a suspected stroke.

Ultimately, it was a sudden medical incident, namely an aortic dissection that caused Williams' death. There is nothing to indicate that Williams' death was the result of inaction or improper action by 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 Jason Williams.

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**