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October 31, 2014

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

Re: Custodial Death on September 9, 2013
Death of Inmate Matthew Shawn Gordon
District Attorney Investigations Case # S.A. 13-026
Orange County Sheriff's Department Case # 13-178205
Orange County Crime Laboratory Case # 13-52688

Dear Sheriff Hutchens,

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 Sept. 9, 2013, custodial death of 32-year-old inmate Matthew Shawn Gordon.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Gordon. In this letter, the OCDA describes the investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to determine whether criminal culpability exists on the part of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD.

On Sept.10, 2013, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center – Santa Ana (WMC-SA), where Gordon died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 15 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 any possible issues relating to 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 a veteran deputy district attorney for legal review. Deputy district attorneys from the Homicide or Gang Units review fatal, officer-involved shootings and custodial death cases and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with his or her supervisor, and this Assistant District Attorney eventually will review and approve any legal conclusions and resulting memoranda. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

Gordon was a 32-year-old male who had a history of long-term [redacted].

On Sept. 8, 2013, at approximately 12:19 a.m., Gordon was arrested by the Placentia Police Department (PPD) for possession of narcotics for sale, possession of paraphernalia and transportation/sales of narcotics. Gordon was transported to the Placentia City Jail (PCJ) to begin the booking process. At approximately 6:00 p.m., Gordon was transported to the Intake/Release Center (IRC) of the Orange County Jail (OCJ) in Santa Ana for booking. During the intake screening, a Correctional Medical Services Registered Nurse documented that Gordon used [redacted]. Pursuant to [redacted] Gordon was prescribed and administered [redacted] to help alleviate the [redacted] symptoms.

On Sept. 9, 2013, at approximately 8:26 a.m., Gordon was cleared for regular housing and placed in the Orange County Jail (OCJ), Modular C, Tank 11, Bunk 48. Upon arrival to Modular C, Tank 11, Gordon told fellow inmate John Doe 1 that he was "kicking" heroin, a term used to describe the process of trying to stop using heroin and/or going through the symptoms of withdrawal from heroin. John Doe 1 said Gordon was "lucid, responsive, communicated well and didn't look bad."

At 10:30 a.m., Gordon told another inmate, John Doe 2, that he was feeling "dope sick." Gordon then skipped lunch, took a shower, laid on his bunk, and went to sleep. At approximately 6:00 p.m., an inmate count was conducted. John Doe 2 stated that he saw Gordon standing for the count and talking on the telephone a short time later.

At approximately 8:30 p.m., Gordon stood in line with other inmates to receive medications. Inmate John Doe 3 described Gordon as "antsy" and resembled someone who was "kicking heroin." According to John Doe 3, Gordon immediately returned to his bunk after receiving his medication.

At around 10:45 p.m., inmate John Doe 4 heard inmate John Doe 5 yell, "Dude's not breathing." At this point, John Doe 2 heard John Doe 5 ask, "Hey man does this guy look all right?" and John Doe 2 went to investigate. According to John Doe 2, when he arrived at Gordon's bunk he found Gordon with one eye open, and with bluish-purple skin color that was cold to the touch. John Doe 2 attempted to wake Gordon by splashing water on his face and pushing on his chest but received no response. John Doe 2 checked for a pulse on the left side of Gordon's neck but could not locate a pulse. At that point John Doe 2 went to the cell bars and called out, "man down!"

At approximately 10:45 p.m., OCSD Deputies responded and radioed for medical assistance. According to the deputies, Gordon appeared "very stiff," his skin was blue, his mouth and eyes were open, and he was unresponsive to stimuli and commands. OCSD deputies carried Gordon out of the Tank.

At approximately 10:47 p.m., a licensed vocational nurse (LVN) and a registered nurse (RN) responded to a call for assistance. They found Gordon unresponsive, pale and cool to the touch, with his eyes open. The nurses began administering CPR and

did not notice any injuries that would be consistent with an assault on Gordon. The nurses were unable to administer intravenous fluids to Gordon due to the heavy scarring on Gordon's arms.

At this point, the medical supervisor registered nurse (SRN) arrived at Tank 11 and he did not see any trauma consistent with an assault on Gordon. The SRN inserted an oropharyngeal tube in Gordon's airway, in an effort to keep the airway open. He also attempted to establish an IV on Gordon but was unsuccessful as a result of an absence of vascular assets seen or felt on Gordon.

At approximately 10:48 p.m., Orange County Fire Authority (OCFA) Engine 75 was dispatched to OCJ. Engine 75 arrived on scene at approximately 10:53 p.m. At the scene, OCFA Paramedics observed Gordon lying supine on the ground, unconscious, and in full cardiac arrest. OCJ nursing personnel and deputies performed CPR on Gordon. An AED was connected to Gordon, but the device was indicating that no shock was advised. Paramedics examined Gordon and were unable to detect a pulse, blood pressure, or respirations. Paramedics defibrillated Gordon, continued CPR, and applied a Bag Valve Mask. They administered 5 rounds of Epinephrine, 1 round of sodium bicarbonate, dextrose, saline, and 2 milligrams of naloxone. Gordon was subsequently transferred out of the jail and to the hospital. Gordon never made any statements or regained consciousness while being treated in the jail.

At approximately 11:20 p.m., Gordon was transported by Care Ambulance Service to Western Medical Center – Santa Ana (WMC-SA). Upon arrival to the hospital, the attending physician observed fire paramedics administering CPR and ventilating Gordon with an Ambu Bag. The attending physician also observed that Gordon was intubated, unresponsive, not breathing, his pupils were dilated and non-reactive to light, he had no pulse, and his heart rhythm was a-systole. Gordon had no signs of trauma to his body. The attending physician administered CPR and three rounds of Epinephrine. At approximately 11:35 P.M., the attending physician pronounced Gordon deceased.

AUTOPSY

On Sept. 13, 2013, at approximately 1:00 p.m., a post-mortem examination of Gordon was conducted by Dr. Joseph Cohen, a board certified forensic pathologist on contract with Orange County, but independent of OCSD. Prior to the examination, Dr. Cohen reviewed X-rays of Gordon's body and observed that Gordon's left lung appeared "hazy" in the X-ray and noted the possibility of pneumonia present in the lung.

Dr. Cohen conducted an extensive visual examination of Gordon's body and noted that there were no external injuries. The autopsy revealed that Gordon had four fractured ribs on his left side and 2 fractured ribs on his right side, and Dr. Cohen noted that such injuries were consistent with a patient who had received CPR. Dr. Cohen also noted that Gordon had an unusually large heart and his lungs were "enlarged and very wet."

Following the autopsy, Dr. Cohen determined that Gordon's death was the result of acute cardiorespiratory arrest due to chronic substance abuse with hypertrophy and dilation of the heart. Dr. Cohen also concluded that Gordon also exhibited signs of opioid (heroin) toxicity.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethanol / Volatiles	Postmortem Blood	None Detected
Benzodiazepines	Postmortem Blood	Negative
Cocaine and/or Metabolite	Postmortem Blood	Negative
Phenethylamines	Postmortem Blood	Negative

[redacted]	Postmortem Blood	0.058 mg/L
Cannabinoids	Postmortem Blood	Negative
Alkaline Drugs	Postmortem Blood	None Detected
Strong Acid / Neutral Drugs	Postmortem Blood	None Detected
Weak Acid / Neutral Drugs	Postmortem Blood	None Detected

BACKGROUND INFORMATION

Gordon had a State of California Criminal History record that revealed arrests for the following violations:

[redacted]

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 human being;
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 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 to perform the legal duty was criminally negligent; and
d. The person's failure to perform the legal duty caused the death of the decedent.

In *Girardo v. California Department of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 251, the court held that there is a "special relationship" between custodian and inmate:

> "The most important consideration in establishing duty is foreseeability. 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 section 845.6 codifies the legal notion 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 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 whatsoever of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. According to the inmate witnesses, after Gordon stood at the last inmate count, he used the telephone, and received medication before returning to his bunk to sleep. Gordon never made any statements regarding being injured or assaulted while incarcerated in the OCJ. No inmates ever stated that Gordon was assaulted. Additionally, none of the treating jail staff or medical professionals noticed any indication that Gordon was assaulted. 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 Gordon 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). Upon Gordon's arrival to OCJ, medical personnel documented his history of long term narcotic abuse. Gordon was placed on "opiate protocol" which consisted of medication to help alleviate the opiate withdrawal symptoms. Gordon stood for an inmate count and there was no indication of a medical emergency. Once the OCSD deputies heard the call of "man down," they responded immediately. The deputies gave Gordon CPR until jailhouse nurses and OCFD paramedics arrived at the scene and attempted to revive Gordon. Thus, there is no evidence whatsoever 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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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 of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that Gordon died as a result of complications from chronic substance abuse with hypertrophy and dilation of the heart.

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

Respectfully submitted,

Daniel Feldman
Senior Deputy District Attorney
TARGET Unit

Read and Approved by **Ebrahim Baytieh**
Acting Assistant District Attorney
Head of Court – Special Prosecutions Unit