OFFICE OF THE
# DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TONY RACKAUCKAS



August 16, 2017

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

Re: Custodial Death on June 5, 2016
Death of Brian Joseph Carter
District Attorney Investigations Case # SA 16-021
Orange County Sheriff's Department Case # 16-134206
Orange County Crime Laboratory Case # FR 16-49560
Orange County Coroner's Office # 16-02591-KI

Dear Sheriff Hutchens,

Please accept this letter detailing the Orange County District Attorney's Office (OCDA) investigation and legal conclusion in connection with the above-listed incident involving the June 5, 2016, custodial death of 53-year-old inmate Brian Joseph Carter.

## OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Carter. 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 June 5, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC), where Carter died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU conducted three interviews. OCDASAU also obtained and reviewed: OCSD reports; Orange County Crime Laboratory (OCCL) reports; laboratory and identification reports; autopsy reports; medical reports; incident scene photographs and videos; 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, TARGET/Gangs, and Special Prosecutions Units review fatal, as well as non-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 the Assistant District Attorney supervising the Special Prosecutions Unit, who will eventually review and approve any legal conclusions and resulting memos. 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

On Sunday, April 24, 2016, at approximately 8:22 p.m., Carter was arrested by Westminster Police Department (WPD) for three active misdemeanor warrants. The arrest was documented under WPD Case #16-03165. At approximately 11:22 p.m., Carter was booked into the Orange County Jail – Inmate Release Center. On April 27, 2016, Carter was transferred to the Theo Lacy Facility in Orange.

On May 29, 2016, Carter submitted an Inmate Health Message Slip, indicating that, "Voices won't stop. Want to hurt everyone and all of them. They can't hear me. I can hear all of them." That same day Carter was transferred to the Men's Main Jail – Module L (Medical Module) for a mental health evaluation. Carter was evaluated as a potential danger to others with complaints of anxiety, depression, and difficulty coping.

On Thursday, June 2, 2016, at approximately 8:15 a.m., Carter was approved for regular housing and transferred to the Men's Main Jail – Module A, Tank 6. At approximately 11:33 p.m., one of Carter's cellmates at the time, John Doe 1, can be seen on the Module A, Tank 6, Dorm East security video waving his arm through the bars while the lights were off. Approximately one minute later, at 11:34 p.m., the lights in the module were illuminated and deputies arrived to assist Carter who appeared to be suffering from an unknown medical episode.

John Doe 1 was interviewed on June 7, 2016. According to John Doe 1, the incident occurred on June 2, 2016, sometime after the lights were turned off for the night. Carter was lying on his back on the lower bunk of the cell and John Doe 1 was on his side on the adjacent upper bunk of the cell. The two inmates were talking with a third and fourth inmate; other inmates were also present in the cell. John Doe 1 was in custody with Carter for approximately three days, and he stated that Carter was a heroin user, but he hadn't seen Carter do any drugs during their time in custody together. John Doe 1 portrayed Carter as a quiet inmate who didn't have any problems with inmates, deputies, or jail staff. According to John Doe 1, while the group of inmates were talking, Carter suddenly began breathing heavily. John Doe 1 felt Carter's skin with the back of his hand, and Carter's forearm felt clammy. Carter's breathing then became erratic and he started to make noises, as if he was having trouble breathing. At one point, Carter's eyes rolled into the back of his head.

John Doe 1 thought Carter may have been having a stroke or heart attack and told the other inmates to call the deputies and tell them Carter was "down" and not responding. One of the other inmates put a wet rag on Carter's face, attempting to wake him up, but Carter began making choking noises again. John Doe 1 grabbed Carter's tongue to prevent him from swallowing and choking on it, and then turned Carter's head to the side to prevent Carter from swallowing his own vomit. John Doe 1 stated that he had been CPR certified through the military and while working for Edison Company. John Doe 1 aided Carter until OCSD deputies arrived to take over.

At approximately 11:40 p.m. OCSD Deputy Smith responded to Module A with other deputies and medical staff, and he found Carter unresponsive and breathing heavily. Medical staff immediately evaluated Carter and determined that he required additional treatment and evaluation at a hospital. Orange County Fire Authority (OCFA) was called to assist.

At approximately 11:47 p.m., OCFA Engine 75 arrived on scene and the responding OCFA Paramedics evaluated Carter. Carter was unresponsive with an altered state of consciousness, and presented with a rigid body and pinpoint pupils. At approximately 11:58 p.m., Carter was placed on a gurney and transported to OCGMC. Upon transport, Carter's blood pressure steadily increased from 140/90 to 210/108.

On June 3, 2016, at approximately 12:17 a.m., Carter was admitted to OCGMC and immediately placed on life support. Although Carter presented with no apparent external injuries or signs of external trauma, a subsequent CT scan of his brain revealed "severe intraventricular hemorrhage," a worsening "extensive subarachnoid bleed," and an increasing "intraparenchymal midline hemorrhage" into Carter's frontal lobe. It was determined that Carter had undergone a massive stroke. A ventriculosotmy catheter was inserted into Carter's head in an attempt to drain some of the blood and combat the problems being caused by blood clots.

On June 5, 2016, Carter's primary attending physician determined Carter was comatose, on a ventilator, and had a poor prognosis for recovery. The CT scan had revealed a large amount of blood in Carter's brain and that his brain had shifted positions. Carter's attending neurological surgeon stated that Carter's brain injury was "non-reversible" and that there was no further treatment that could be provided. It was determined that Carter had suffered an "acute hemorrhagic stroke" with a "ventricle bleed and hydrocephalus" related to "hypertension."

On June 5, 2016, at approximately 1:00 p.m., OCGMC medical staff, including Carter's attending physician and nurse, met with Carter's immediate family to discuss Carter's condition. Because Carter's prognosis for any recovery was extremely poor, and no additional medical intervention options were available, Carter's family decided to withdraw all medical care. At approximately 6:15 p.m., Carter's respiratory ventilator was disconnected and his breathing tube removed. Carter continued to receive Morphine as a comfort measure. At 6:33 p.m., Carter was pronounced deceased.

## EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- 46 Inmate/Hospital Room Photographs
- 54 Autopsy Photographs
- 20 Post-Embalming Photographs
- Bloodstain Standard from Carter
- Muscle Standard and Heart sample from Carter

## AUTOPSY

On June 11, 2016, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Carter. Dr. Luzi concluded that Carter's cause of death was bleeding in the brain consistent with high blood pressure and an enlarged heart.

## EVIDENCE ANALYSIS

### Toxicological Examination

Samples of Carter's postmortem blood yielded the following results:

| DRUG | MATRIX | RESULTS & INTERPRETATIONS |
|---|---|---|
| Morphine (Free) | Postmortem Blood | 1.98 ± 0.20 mg/L |
| Lidocaine | Postmortem Blood | Detected |

## BACKGROUND INFORMATION

Carter had a State of California Criminal History record that revealed arrests dating back to 1982 for the following violations:

- Assault With a Deadly Weapon with Great Bodily Injury Likely
- Threats to Terrorize

- Spousal Battery
- Burglary
- Receiving Stolen Property
- Possession of a Switchblade Knife
- Possession of Drug Paraphernalia
- Possession of a Controlled Substance
- Under the Influence of a Controlled Substance
- Indecent Exposure
- Contempt of Court for Violation of a Court Order
- Failure to Appear
- Probation Violation

**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/she acted he/she knew his/her 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:

> "The most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable that 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/she 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/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 whatsoever in this case of express or implied malice on the part of any OCSD personnel or any 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 Carter 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). As soon as OCSD personnel became aware that Carter was undergoing medical difficulties, OCSD Deputies responded to Carter's location, immediately began aiding Carter, and called for assistance in transporting Carter to the local hospital upon determining that Carter's situation needed further medical treatment. Less than 40 minutes elapsed between the time that OCSD Deputies initially responded to Carter's location inside the cell, and the time at which Carter was admitted to OCGMC, including the time needed for initial stabilization and transportation. Upon arrival at OCGMC, Carter exhibited no external injuries, and there was no evidence that he had suffered any external trauma. Carter was immediately placed on life support, due to his unresponsiveness upon arrival at the hospital. It would later be determined by Carter's attending physician, and supported by the evidence, that Carter suffered a stroke, resulting from high blood pressure and an enlarged heart that caused a massive bleeding into Carter's brain. There is no evidence whatsoever in this case to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty.

## CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that Carter died as a result of bleeding in the brain consistent with high blood pressure and an enlarged heart.

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

Respectfully submitted,

**PATRICK MOSS**
Deputy District Attorney
TARGET/Gangs Unit

Read and Approved by **EBRAHIM BAYTIEH**
Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit