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November 27, 2017

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

Re: Custodial Death on April 1, 2017
Death of Inmate Brian Delbert Finnan
District Attorney Investigations Case # 17-009
Orange County Sheriff's Department Case # 17-012672
Orange County Crime Laboratory Case # 17-45792
Orange County Sheriff-Coroner Case # 17-01651-CO

Dear Sheriff Hutchens,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the above-listed incident involving the April 1, 2017, custodial death of 46-year-old inmate Brian Delbert Finnan.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Finnan. 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 April 1, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Anaheim Global Medical Center (AGMC) where Finnan died while in custody after receiving medical treatment. During the course of this investigation, the OCDASAU interviewed one witness, as well as obtained and reviewed reports from AGMC, OCSD, the Orange County Crime Laboratory (OCCL), Orange County Sheriff-Coroner (OCSC), 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 any OCSD personnel or any other person under the supervision of 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 Nov. 27, 2016, Finnan was arrested by the Anaheim Police Department (APD) for narcotics crimes. Finnan was booked into the Orange County Jail (OCJ) on Nov. 28, 2016. Finnan was 46 years old and had a history of methamphetamine abuse, Chronic Obstructive Pulmonary Disease (COPD), and asthma. OCJ took an x-ray of Finnan's chest as part of their medical screening. No abnormalities were observed.

On Nov. 29, 2016, Finnan was seen by Correctional Medical Services (CMS) and given an inhaler for his asthma. Finnan did not contact jail medical staff again until Jan. 18, 2017, when he submitted an "Inmate Health Message Slip" to CMS for a loose tooth. Finnan was seen and refused treatment, but did receive medication.

On Feb. 20, 2017, Finnan submitted another "Inmate Health Message Slip" to CMS regarding back and neck pain. On Feb. 22, 2017, Finnan's back was adjusted and he was given pain medication. CMS recommended Finnan be transferred to a medical ward. Two days later, Finnan was transferred to the Theo Lacy Facility (TLF) Medical Ward. Finnan complained of bowel issues and was treated.

On March 6, 2017, Finnan submitted an "Inmate Health Message Slip" to CMS complaining of constant back pain and numbness in his left leg. He said the pain started ten days prior when he was doing pushups. Finnan was given medication and instructed to use a wheelchair.

Between March 9, 2017 and March 20, 2017, Finnan was seen by CMS numerous times for back pain. Finnan's doctor noted that Finnan's pain continued, rendering him unable to care for himself or move without the wheelchair. The doctor also noted that Finnan was losing weight and appeared dehydrated, due to diminished food and water intake. Multiple attempts were made to admit Finnan to AGMC, but no beds were available.

On March 21, 2017, Finnan was transferred to the medical ward at OCJ's Main Jail. On March 22, 2017, Finnan was transported to the Orange County Global Medical Center, Santa Ana (OCGMC), where an MRI scan was taken of his back. The MRI showed spinal bone movement and a bulging disc. Finnan was treated for back pain, general weakness, and weight loss, but his condition continued to decline.

On March 29, 2017, Finnan went to the OCGMC for an abdominal ultrasound, which showed an enlarged liver.

On March 30, 2017, an inmate reported that Finnan was vomiting blood. That morning, Finnan was transferred to the AGMC by ambulance, where he also presented with shortness of breath, chest pain, low blood pressure, and low glucose levels.

On March 31, 2017, Finnan's health continued to deteriorate and he was transferred to the ICU, where a CT scan was taken of Finnan's chest. The CT scan showed nodules in Finnan's trachea, left lower lung, liver, and spleen.

On April 1, 2017, Finnan continued to experience shortness of breath. He was unable to cough and became increasingly agitated. Both Finnan's respiratory and heart rates were elevated. A pulmonary doctor intubated Finnan and tried to biopsy his trachea and lung, but the nodules were outside of the trachea and the doctor did not have the necessary equipment. The doctor recommended Finnan's transfer to the University of California - Irvine, Medical Center (UCIMC), but UCIMC declined the transfer request.

Finnan's pulmonary doctor opined the nodules located throughout Finnan's body were indicative of Lymphoma or small cell carcinoma, and that Finnan was terminal and his death was imminent. Finnan's family was notified of his condition and arrived at the hospital. Finnan began to show signs of sepsis and was given additional medication. Finnan's family signed a "Do Not Resuscitate Order" that afternoon and directed the AGMC staff to withdraw life support. Life support was terminated on April 1, 2017, and Finnan died within an hour, in the presence of his family.

AUTOPSY

On April 5, 2017, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on Finnan's body and concluded that Finnan died of natural causes due to Lymphoma.

BACKGROUND INFORMATION

Finnan's State of California Criminal History consists of arrests for the following crimes:

- First Degree Robbery
- False Imprisonment
- Possession of a Controlled Substance for Sales
- Possession of a Controlled Substance
- Possession of Controlled Substance Paraphernalia
- Possession of Marijuana for Sales
- Petty Theft
- Misappropriating Lost Property
- Destroy / Conceal Evidence
- False Personation
- Petty Theft with Prior Conviction
- Provide False Information to Peace Officer
- Failure to Appear at Work Release

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 beyond a reasonable doubt:

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 there is a "special relationship" between jailer and prisoner:

> "The 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 provides 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/she 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

In this case, there is no evidence of express or implied malice on the part of any OCSD personnel 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 Finnan 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). A duty of care owed to Finnan was carried out by the OCSD through numerous attempts to treat Finnan for each medical issue he reported while in custody.

The day after being booked, Finnan received an OCJ medical screening and an x-ray, in which no abnormalities were observed. Between Nov. 29, 2016, and March 20, 2017, Finnan submitted multiple "Inmate Health Message Slips" to CMS, and jail medical personnel responded to each request promptly and administered medical care responsive to his complaints.

When Finnan's health began to deteriorate, he was transferred to the medical ward, then to the OCGMC for testing. When Finnan began to vomit blood on March 30, 2017, he was immediately transported to the AGMC for treatment. Additional tests were conducted and hospital medical staff continued to treat Finnan.

On April 1, 2017, Finnan's treating physician determined he had terminal cancer and his death was imminent. Finnan's family was immediately notified and arrived at the hospital. The family signed a "Do No Resuscitate Order," and, with their permission,

the hospital withdrew all life support. Finnan died shortly thereafter. Lastly, the forensic pathologist determined Finnan's death was consistent with natural causes.

Based on all the available evidence, it is clear 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 owed to Finnan.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion 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.

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

Respectfully submitted,

ERIN ROWE
Deputy District Attorney
Special Prosecutions Unit

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