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June 24, 2015

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

Re: Custodial Death on Oct. 5, 2014
Death of Inmate Donald Roy Shipley
District Attorney Investigations Case # S.A. 14-015
Orange County Sheriff's Department Case # 14-192593
Orange County Crime Laboratory Case # 14-53201

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 Oct. 5, 2014, custodial death of 73-year-old male inmate, Donald Roy Shipley.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Shipley. 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 Oct. 6, 2014, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center Anaheim (WMCA), where Shipley died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed four 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

Shipley was arrested by the Fountain Valley Police Department (FVPD) on July 18, 2012, for a warrant under Orange County Superior Court case number 12WF1737. The charges on the warrant were:

- 288(a) PC – Lewd or lascivious act with a minor
- 288(b)(1) PC – Forcible lewd act upon a child
- 269(a)(1) PC – Aggravated sexual assault of a child
- 311.11(a) PC – Possession/control of child pornography

Shipley was booked into the Orange County Sheriff's Department, Intake Release Center jail, and his bail was set at $1 million.

Shipley's medical records indicate that while Shipley had been in the custody of the OCSD, he had been receiving treatment for:

- Generalized weakness
- Advanced dementia with depressive mood
- History of cerebral vascular accident (CVA), resulting in left-side paralysis
- Hypertension
- Peripheral neuropathy, chronic kidney disease stage 3

Due to the above medical conditions, Shipley was unable to take care of his own daily activities, and therefore was deemed not suitable for placement in any of the Orange County jail facilities. Shipley remained in the custody of OCSD, while he remained at WMCA. During his custody time at WMCA, Shipley received evaluations from medical professionals for neurology, psychiatry, and physical therapy.

On Oct. 26, 2012, Judge John S. Adams of the Orange County Superior Court (OCSC) ordered that criminal proceedings be suspended and ordered that Shipley be examined by mental health experts to determine his mental competency to stand trial on his charges. Shipley was examined by several court appointed mental health experts and several hearings were conducted to update the court on the status of his mental competency.

On March 8, 2013, OCSC Commissioner Christopher Evans ordered that Shipley be committed to the Napa State Hospital, for a maximum term commitment of three years. Shipley remained at WMCA for an extended period of time while arrangements were made to attempt to transfer him to Napa State Hospital. Due to the population of individuals at Napa State Hospital being at max capacity, there was not a bed available for Shipley to be transferred there. Shipley was placed on a waiting list for transfer to Napa State Hospital once a bed became available.

Shipley had a "Do Not Resuscitate (DNR)/Resuscitation Order," on file in his medical records. The most recent form was signed and dated July 9, 2014. The order indicated that no resuscitative measures, including cardiac compressions, medications,

defibrillation or assisted ventilations were to be administered in the event that Shipley went into cardiac arrest. The order was signed by one of the attending doctors at WMCA.

On Oct. 5, 2014, at 7:00 p.m., Registered Nurse (RN) Jane Doe started her regular shift at WMCA. As the nurse from the prior shift was briefing Jane Doe about Shipley's condition on the prior shift, she noticed a respiratory technician was providing Shipley with a breathing treatment. This was not unusual, as Shipley frequently suffered from shortness of breath in the evening. RN Jane Doe was very familiar with Shipley, as she had been his nurse for the past several years, and she was aware that Shipley suffered from a history of pneumonia, advancing dementia, and left-side paralysis. At approximately 7:30 p.m., Shipley was still short of breath, wheezing, and coughing. RN Jane Doe provided oxygen and positioned Shipley on his side to aid in his breathing. Between 8:15 and 8:30 p.m., Shipley's attending physician made rounds and examined Shipley. The attending physician noted Shipley's difficulty in breathing and ordered a chest X-ray for the morning. The doctor administered Shipley his routine medications, which included:

- Lipitor
- Colace
- Pepcid
- Flonase
- Megace
- Primidone
- Seroquel
- Benadryl

At approximately 9:30 to 9:45 p.m., RN Jane Doe was attending to Shipley and helping him clean himself. At that time, she noticed that Shipley was still coughing and suffering from respiratory distress. At approximately 10:25 p.m., after RN Jane Doe had admitted a new patient, she again checked on Shipley and found that he was unresponsive, had no pulse, and was not breathing. RN Jane Doe called for another on-duty nurse to assist her, as well as calling for an emergency room doctor and the on-call doctor on duty at the time. At approximately 10:51 p.m., the on-call physician responsible for Shipley's care examined Shipley's body and stated that Shipley was unresponsive and had no vital signs. He informed the medical staff on scene that Shipley had a DNR form on file in his medical chart and requested that the emergency room doctor on duty at that time respond to the jail ward to pronounce Shipley deceased.

At approximately 11:59 p.m., the emergency room doctor responded to the jail ward and examined Shipley, and determined that Shipley was still unresponsive, not breathing, and did not have a pulse. Shipley had no signs of life, and was pronounced deceased at that time.

AUTOPSY

On Oct. 12, 2014, at approximately 1:45 p.m., Forensic Pathologist Dr. Scott Luzi of Anatomic, Clinical & Forensic Pathology Services conducted an autopsy of Shipley's body, with an OCDA Investigator present, to attempt to determine the cause of Shipley's death. At the conclusion of the autopsy, Dr. Luzi advised that the autopsy results were inconclusive and required further toxicological analysis.

After reviewing the results of the toxicological analysis, Dr. Luzi ultimately classified Shipley's death as natural, and found the cause of death to be hypertensive and atherosclerotic cardiovascular disease.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Shipley's postmortem blood was analyzed by the OCCL. The findings were:

- Codeine (Free)
- Diphenhydramine

- Donepezil
- Fluoxetine
- Promethazine
- Quetiapine
- Quetiapine metabolite

The levels of Diphenhydramine, Promethazine, and Quetiapine were within the therapeutic range.

BACKGROUND INFORMATION

According to his California Criminal History Record, Shipley had no criminal history prior to his above described July 18, 2012, 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 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/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 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 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

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. 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 Shipley 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). Shipley had been deemed not suitable for placement at one of the Orange County jail facilities due to his several ongoing medical conditions requiring medical treatment. As such, Shipley remained in custody in the hospital jail ward at WMCA, where he would be able to receive ongoing medical treatment and regular checkups from his attending physicians and other medical staff. Shipley's medical records indicate that Shipley's medical condition was monitored almost constantly by medical staff, and that he continued to undergo further medical checkups by his attending physicians to continually monitor his condition.

On the night Shipley died, his attending physician had noted Shipley's difficulty breathing and ordered a chest X-ray for the next morning, and administered his routine medications. The RN who was on duty the night Shipley died was personally familiar with him as a patient because she had been his nurse for several years at that point. The RN had checked on Shipley approximately 45 minutes prior to finding him unresponsive. While Shipley's RN noticed that Shipley was coughing and suffering from respiratory distress, she knew this was not out of the ordinary for Shipley. Shipley's RN provided him oxygen and positioned Shipley on his side to aide in his breathing. When the nurse returned from admitting a new patient, she found Shipley unresponsive and alerted additional hospital staff and emergency room doctors. There was no criminal negligence whatsoever in the way the medical staff dealt with Shipley.

As mentioned above, Shipley had a "DNR/Resuscitation Order," on file in his medical records. The most recent form was signed and dated July 9, 2014. The order indicated that no resuscitative measures, including cardiac compressions, medications, defibrillation or assisted ventilations were to be administered in the event that Shipley went into cardiac arrest. The order was signed by one of Shipley's attending physicians at WMCA.

All of the available evidence supports the conclusion that Shipley received satisfactory and reasonably acceptable medical treatment while he was in custody at WMCA. The doctor who conducted Shipley's autopsy concluded that Shipley died as a result of natural causes, and hospital staff acted according to procedure when they did not attempt to revive Shipley after he had been found unresponsive due to his DNR status.

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.

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 Shipley died as a result of natural causes; specifically hypertensive and atherosclerotic cardiovascular disease.

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

Respectfully submitted,

STEPHEN J. MCGREEVY
Senior Deputy District Attorney
Homicide Unit

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