OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

May 30, 2019

Chief Jorge Cisneros
Anaheim Police Department
425 S. Harbor Boulevard
Anaheim, CA 92805

Re: Custodial Death on June 23, 2018
Death of Inmate Ian Elliot Tompko
District Attorney Investigations Case # SA 18-020
Anaheim Police Department Case # 18-96423
Orange County Crime Laboratory Case # FR 18-48799

Dear Chief Cisneros,

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 June 23, 2018, death of 46-year-old arrestee Ian Elliot Tompko.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Ian Tompko. 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 Anaheim Police Department (APD) personnel or any other person under the supervision of the APD.

On June 23, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Anaheim Regional Medical Center, where Tompko was pronounced dead while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed fifteen witnesses, as well as obtained and reviewed reports from APD 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 APD personnel or any other person under the supervision of the APD. 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 or while being detained by law enforcement. 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 and 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 Senior Assistant District Attorney supervising the Operations IV Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors and their supervisors. The District Attorney reviews all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. Relevant video/audio evidence is available on the OCDA webpage http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On June 23, 2018, approximately 5:39 p.m., Tompko walked into the middle traffic lanes and oncoming traffic on West Lincoln Avenue in the City of Anaheim near several businesses. Footage from security cameras obtained from nearby businesses as well as a witness' cell phone show Tompko was wearing a red shirt and khaki shorts. Tompko can be seen running directly toward oncoming vehicles and repeatedly bending forward at the waist in apparent distress while he was in the roadway. Several witnesses called 911, and APD received multiple reports that a male, wearing a red shirt and khaki shorts was walking into oncoming traffic in an attempt to be struck by vehicles. Witnesses described the male as doing a "crazy dance," possibly having a heart attack, "hallucinating", or that he was "high on something."

Several minutes later, a witness called APD and reported that Tompko was crawling and rolling around on the floor inside the First Stop Liquor store, which was captured by the store's surveillance camera. At approximately 5:42 p.m., APD Officers Jason Carney and Kenneth Gulley responded to the liquor store and activated their AXON Body Worn Cameras (BWC).

When Officers Carney and Gulley arrived at the liquor store they observed Tompko walking quickly toward a white iron fence that separated the liquor store's parking lot from the outdoor dining area of a neighboring restaurant. There were families and other individuals dining at the establishment. Officer Carney immediately noticed that Tompko "had foam, saliva coming out of his mouth, he was sweating profusely, [and] he was breathing very heavily." Based on the speed and direction that he was heading, Officers Carney and Gulley feared Tompko might run into traffic again. Officer Gulley ordered Tompko to stop and sit on the ground. Tompko initially complied with Officer Gulley's command, as he "kind of flopped on the ground" into a seated position. Officer Gulley stated that after Tompko momentarily complied with his order to stop and sit on the ground, Tompko began "kicking his feet around", "waving his arms around," and appeared to "slam himself" as he rolled around on the ground. In an effort to gain control of Tompko and to ensure that Tompko would not run away, Officer Gulley then ordered Tompko to lay down on his stomach. Tompko laid back onto his right side.

Based on both officers training and experience, they believed Tompko to be under the influence of a central nervous system stimulant. Officers Carney and Gulley rolled Tompko onto his stomach, and attempted to place him in handcuffs. Tompko then began to resist and attempted to jerk his arms away from the officers. Officer Gulley placed his knee on Tompko's upper back and momentarily used his body weight to pin Tompko to the ground. Officer Gulley was then able to reach Tompko's left arm and place a handcuff on Tompko's left wrist. Officer Gulley then moved to a position where he was straddling Tompko's waist. Tompko still continued to be non-compliant. Several seconds later, Officer Carney placed his knee on Tompko's upper back in order to gain control of Tompko's right arm. Tompko continued to be non-compliant, but Officer Carney was able to gain control of Tompko's right arm and handcuffed him.

As Officers Carney and Gulley handcuffed him, Tompko yelled for help and repeatedly stated that he was going to die as he continued to be non-compliant. Both officers reassured Tompko, and told him that they were there to help him. Officers Carney and Gulley asked Tompko to relax and stop struggling. Officer Gulley also retrieved a hobble to attempt to control Tompko's legs. Officer Gulley proceeded to move from Tompko's waist to a kneeling position to the left of him, and placed Tompko's legs against his buttocks in a "Figure 4 Leg Lock" to prevent Tompko from kicking the officers. As additional officers arrived and Officer Gulley prepared to apply the nylon hobble device, Officer Carney noticed that Tompko was unconscious, unresponsive and was no longer breathing.

At approximately 5:44 p.m., officers requested paramedic assistance and immediately began performing life saving measures. Officer Carney rolled Tompko onto his back and retrieved Narcan nasal spray from his nearby patrol vehicle. Officer Pedersen checked Tompko and noticed that he had a very slow pulse. Approximately one minute later, Officer Carney administered the first dose of Narcan nasal spray to Tompko, but it had no effect. Officer Carney then began performing Cardio Pulmonary Resuscitation (CPR) on Tompko while Officer Pedersen used an Artificial Manual Breathing Unit (AMBU) to ventilate him. Approximately one minute later, Officer Carney administered the second dose of Narcan to Tompko, but it still had no effect. Approximately three minutes later, Officers Pedersen and McGlade applied an Automated External Defibrillator (AED) to Tompko's chest area. The AED analyzed Tompko's cardiac rhythm and determined no shock was advised.

At approximately 5:50 p.m., paramedics from the Anaheim Fire Department arrived and took over medical care of Tompko. The paramedics confirmed via electrocardiogram (EKG) that Tompko had no respirations or pulse. The paramedics continued CPR, and determined that Tompko was experiencing Pulseless Electrical Activity (PEA). They then administered a total of three doses of epinephrine and transported Tompko to the Anaheim Regional Medical Center at approximately 6:05

p.m. At approximately 6:12 p.m., Tompko arrived at the hospital and Advanced Cardiac Life Support protocols were continued by on-duty emergency room staff. The hospital staff was unable to revive Tompko and he was pronounced dead at 6:23 p.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- One Black Nylon Hobble Restraining Device
- One Red Shirt
- Two Pairs Of Eye Glasses
- One Phillips Heartstart Automated External Defibrillator

AUTOPSY

On June 26, 2018, Forensic Pathologist Dr. Aruna Singhania of the Orange County Coroner's Office conducted an autopsy on the body of Tompko. Dr. Singhania noted that there were superficial abrasions on Tompko's head, knees, and wrists, and that there were no signs of significant trauma. Dr. Singhania determined Tompko's manner of death to be accidental and the cause of death to be acute methamphetamine and amphetamine intoxication with cardiomegaly listed as an additional condition.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Methamphetamine	1.40 ± 0.10 mg/L	4.87 ± 0.35 mg/kg
Amphetamine		<0 0.067 mg/kg
Buprenorphine(Free)	0.0019 ± 0.0003 mg/L	
Norbuprenorphine (Free)	0.0017 ± 0.0003 mg/L	

BACKGROUND INFORMATION

Tompko had an extensive State of California Criminal History record dating back to 2010 that revealed arrests for the following violations:

- Possession of a Hypodermic Needle and Syringe
- Selling Hypodermic Needle and Syringe Without a Permit
- Trespass to Injure Property
- Domestic Battery to Spouse or Cohabitant
- Petty Theft
- Second Degree Commercial Burglary
- Possession of a Controlled Substance
- Possession of Paraphernalia
- Malicious Mischief to a Vehicle
- Post-Release Community Supervision Violation
- Exhibiting a Dangerous Weapon: Not a Firearm
- Under the Influence of a Controlled Substance

- Possession of a Laundry/Shopping Cart and Disorderly Conduct - Begging
- Manufacture Leaded Cane, Blackjack
- Trespass or Loitering on Posted Property
- Appropriation of Lost Property

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.' 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/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 present case, there is no evidence whatsoever of express or implied malice on the part of any APD personnel or any inmates or other individuals under the supervision of the APD. 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 APD owed Tompko a duty of care, the evidence clearly does not support a finding that this duty was breached in any way, either intentionally as required for murder, or through criminal negligence as required for involuntary manslaughter.

APD's contact with Tompko from initial observation through resuscitation efforts lasted approximately 20 minutes. When Officers Carney and Gulley arrived, they observed a male matching the description multiple callers had identified as acting erratically and running into oncoming traffic. The officers noticed Tompko was foaming at the mouth and sweating profusely. They ordered Tompko to stop and sit down and he responded by slamming himself to the ground and proceeded to kick and flail his arms. It was abundantly clear to the officers, based on his appearance and behavior that Tompko was under the influence of a controlled substance, which was subsequently confirmed by toxicological results. When Officers Gulley and Carney detained Tompko to address his condition, Tompko continued to yell, flail, kick and resist the officers' repeated attempts to calm him down. The officers were concerned that Tompko may attempt to run into oncoming traffic again and therefore be a danger to himself and others. Because Tompko would not comply with the officer's commands, they determined Tompko needed to be handcuffed. They accomplished this by a controlled take-down of Tompko from a seated position to lying on the ground on his stomach. This conduct by Officers Carney and Gulley was completely reasonable under the circumstances.

Witnesses stated that Tompko was not complying with the officers' commands and continued to resist their attempts to detain and calm him down. Despite Tompko's shouting and struggling, the officers repeatedly told Tompko to relax using calm voices, and told him that they were there to help

him. When Tompko became unresponsive, the officers promptly checked for a pulse and respiration and upon finding none, immediately began life-saving measures including administering Narcan. The paramedics arrived approximately six minutes later and took over Tompko's medical care. Tompko was then transported to the hospital where the life-saving efforts were continued until Tompko was pronounced dead. The coroner determined that Tompko's death was the result of complications due to acute methamphetamine and amphetamine intoxication with cardiomegaly being an additional condition. The coroner determined that Tompko's death was accidental.

Thus, there is no evidence whatsoever to support a finding that any APD personnel or any individual under the supervision of the APD failed to perform a legal duty. To the contrary, the evidence clearly show that the APD officers acted reasonably, treated Tompko with compassion and respect, and handled his medical emergency reasonably and with efficiency.

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 APD personnel or any individual under the supervision of the APD. The evidence demonstrates that Tompko died as a result of complications of substance abuse.

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

Respectfully submitted,

Cliff Bodley

CLIFF BODLEY
Deputy District Attorney
TARGET/Gangs Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney - Operations IV