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August 16, 2017

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

Re: Custodial Death on July 5, 2016
Death of Inmate Jack London Evans
District Attorney Investigations Case # SA 16-024
Orange County Sheriff's Department Case # 16-166400
Orange County Crime Laboratory Case # 16-51095

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 July 5, 2016, custodial death of 68-year-old inmate Jack Evans.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Jack Evans. 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 July 5, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center, where Evans died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed witnesses, as well as obtained and reviewed reports from the La Palma Police Department, OCSD and Orange County Crime Laboratory (OCCL), medical records, and other relevant reports and 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 May 14, 2016, at approximately 3:15 a.m., Evans was contacted by Officer John Lopino with the La Palma Police Department (LPPD). Evans was seated against a wall in front of the Coffee Bean and Tea Leaf at 5510 La Palma Avenue in the city of La Palma. While Evans was being approached by Officer Lopino, he was asked how he was doing, and Evans responded by asking Officer Lopino for a ride back to his residence. Officer Lopino asked for Evans' name and date of birth, and after receiving the correct information, ran a records check on Evans. The records check revealed that Evans had an outstanding no bail warrant for a probation violation in Orange County Superior Court case number 15WF2754. At this time, Evans was placed under arrest and transported to LPPD for booking purposes. After being booked at LPPD, Evans was transported to the Intake/Release Center (IRC) at Orange County Jail (OCJ).

Evans had a prior medical history which included dilated cardiomyopathy, systolic congestive heart failure, chronic obstructive pulmonary disease, and alcohol and drug abuse. Evans had an aortic valve replacement in 1987, as well as having been treated for pneumonia as recently as March 2016. Additionally, Evans had a history of refusing medication and medical assistance. Due to his medical history and poor health, Evans was housed in Module "O" at the Central Men's Jail (CMJ). Module "O" is a medical unit within the jail which is monitored by medical staff 24 hours a day.

When Evans was being booked, he acknowledged his alcohol abuse, said he had been drinking almost daily before his arrest, and complained of headaches relating to his drinking. Due to Evans' recent abuse of alcohol, he was put on "Alcohol Withdrawal Orders" to help him safely detox. Evans was prescribed Thiamine, a multivitamin with folate, as well as four tablets of Maalox daily, and was placed on a seven day Serax taper, to help with symptoms of withdrawal. In addition to the medication, Evans was directed to stay in a lower bunk in Module "O".

As part of the intake procedures, Evans was given an electrocardiogram (EKG) where he was found to have a moderately large left pleural effusion. Evans was given medication and continually monitored as a result of this discovery. On May 22, 2016, after having an argument with another inmate, Evans complained to the medical staff that he was experiencing shortness of breath. After telling staff about his shortness of breath, Evans was seen by a doctor assigned to the jail facility, who observed Evans to have an altered level of consciousness and determined that Evans should be sent to a hospital. At approximately 2:30 p.m., Evans was transported to Orange County Global Medical Center (OCGMC) in Santa Ana by CARE ambulance, where he was evaluated by additional doctors. During his stay at OCGMC, Evans was diagnosed as experiencing heart failure as well as pneumonia. After monitoring him, doctors decided to discharge Evans, feeling that his symptoms had improved and he was in stable condition. Doctors also noted that there were no changes between the EKG given when Evans was brought to OCJ on May 14, 2017, and the EKG preformed during this stay at OCGMC. Evans was advised to have a follow up appointment with a cardiologist within two days of the discharge, and to take his regularly prescribed medication. Before his discharge, Evans was advised of the risks, signs, and symptoms of heart failure.

After being discharged from OCGMC on May 22, 2017, and returned to CMJ, Evans refused to take medication prescribed for his various heart problems. Each time Evans refused, he was advised of the risks of not taking the medication by the nursing staff at CMJ. Evans also refused to be transported to a scheduled EKG appointment on May 31, 2016. On June 2,

2016, while still housed in Module "O" at CMJ, Evans complained of chest pain at approximately 9:40 a.m. while being taken to the dispensary for his medication. Evans was evaluated by a doctor assigned to the jail facility. The doctor observed Evans had an altered level of consciousness. Evans was given an EKG, and the doctor determined that Evans had a possible myocardial infraction and needed to be transported to OCGMC to be further assisted. At approximately 10:14 a.m., Evans was transported to OCGMC by an Orange County Fire Authority Ambulance. Upon his arrival at OCGMC, Evans complained of chest pain and being short of breath, as well as having a cough that continued to worsen. Upon being admitted, Evans was placed in the telemetry unit, which treats patients experiencing cardiac problems.

During Evans' initial observation on June 2, 2016, at OCGMC, he was given an EKG, which showed the same small left plural effusion that was seen during his first EKG at OCJ on May 14, 2016. Doctors determined Evans was experiencing chronic congestive heart failure, coupled with systolic dysfunction, pneumonia, and dilated cardio myopathy. Further testing showed that Evans was suffering from acute renal failure; however doctors felt the renal failure was secondary to the cardiac problems Evans was experiencing. Evans was given respiratory treatment to try and relieve the chest pain related to the congestion shown on the EKG, as well as medication to stabilize his blood pressure. In the days following his arrival at OCGMC, doctors noticed that the aortic valve Evans had replaced was showing signs of thickening. Evans' cough and congestion continued to worsen after his admission, and he also started to experience fever and chills. Doctors placed Evans on oxygen supplementation, cardiac monitoring, and IV antibiotics to help with the pneumonia. As treatment continued, Evans' cough and congestion gradually improved.

On July 4, 2016, nurses in the telemetry unit noticed that Evans' blood pressure was starting to drop. In an attempt to stabilize his blood pressure, Evans was given 500 cc of saline IV treatment, along with 250 cc of Albumin. Albumin is a blood volume enhancer, which is intended to help raise a patient's blood pressure. Despite the medication given, Evans' blood pressure continued to drop, and it was determined that Evans should be moved to the Critical Care Unit (CCU) at OCGMC. Upon his arrival at the CCU, Evans was assigned to bed 8, at approximately 12:15 a.m. on July 5, 2016.

While Evans was in the CCU, he was given additional medications in an attempt to improve and stabilize his blood pressure. An ejection fraction test was also performed on Evans, which is intended to see the amount and how efficiently Evans' heart was pumping blood. The test indicated that Evans' heart was pumping at approximately 20 percent, where the normal range is 50 percent or greater. Evans' treatment was continued in the CCU until approximately 5:36 a.m., when Evans went into cardiopulmonary arrest. When Evans went into cardiopulmonary arrest, a code blue was broadcast, which indicated that an Advanced Cardiac Life Support (ACLS) team was needed at Evans' bedside. The ACLS team was comprised of a doctor, a Registered Nurse, additional nurses, a pharmacist, and a respiratory therapist. The ACLS team started treatment, and observed that Evans' heart showed pulseless electrical activity. Pulseless electrical activity indicates that there is electrical activity in the heart, however Evans' heart was not beating, nor did he have a pulse.

In an attempt to revive Evans, the doctor administered 1 mg of epinephrine while CPR was being performed at approximately 5:37 a.m. The ACLS team reassessed Evans' condition at 5:40 a.m., 5:43 a.m., 5:46 a.m., and 5:48 a.m. Each time Evans was reassessed, he was given an additional 1 mg dose of epinephrine. During this entire time, Evans was experiencing pulseless electrical activity. CPR was continuously administered to Evans until 5:48 a.m., when it was determined that Evans' heart was in asystole, meaning there was a lack of electrical activity or contractions. After observing the asystole, CPR was administered for an additional three minutes, until approximately 5:51 a.m., at which time Evans was evaluated. It was determined that Evans was non-responsive to the treatment being performed. The doctor pronounced Evans deceased at 5:51 a.m., due to his heart remaining in asystole.

EVIDENCE COLLECTED

AUTOPSY

On July 9, 2016, an independent Forensic Pathologist from Clinical and Forensic Pathology conducted an autopsy on the body of Evans and concluded that Evans died as a as a result of an enlarged heart and complications relating to his previous cardiovascular problems

EVIDENCE ANALYSIS

Toxicological Examination
A sample of Evans' postmortem blood returned with negative results for any contraband.

BACKGROUND INFORMATION
Jack Evans had a State of California Criminal History record that revealed a long list of arrests for a wide variety of criminal offenses.

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 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 specific case, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel, 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 Evans a duty of care, the evidence does not support a finding that this duty was breached, either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). From the moment Evans was booked into the OCJ, Evans was housed in Module "O", which has continuous monitoring of inmates with medical conditions by trained medical staff. Additionally, an EKG was performed on Evans the day he was brought into OCJ, which allowed staff to better understand his cardiac problems, and a medication regiment was started. In addition to the constant monitoring, Evans was transported to OCGMC on May 22, 2016, where he was given instructions to have a follow up EKG preformed, as well as being instructed to continue on his medication requirement. After his return to CMJ from OCGMC on May 22, 2016, Evans continually refused his medication, and refused to attend his follow up EKG. On both May 22 and June 2, 2016, Evans was promptly evaluated by medical staff at CMJ, who determined he should be sent by ambulance to OCGMC. From June 2 until his death on July 5, 2016, Evans was housed at OCGMC, where his condition deteriorated while he was receiving all appropriate medical care.

Thus, it is very clear that 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 causing the death of Evans.

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 Jack Evans died as a result of an enlarged heart and complications relating to his previous cardiovascular problems.

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

Respectfully submitted,

Amy Swanson
Deputy District Attorney
TARGET/Gangs Unit

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