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August 1, 2017

Chief Thomas C. Kisela
Orange Police Department
1107 North Batavia Street
Orange, CA 92867

Re: Custodial Death on July 22, 2016
Death of Inmate Justin Gregory Brown Harris
District Attorney Investigations Case # S.A. 16-025
Orange Police Department Case # 16-07-0459
Orange County Crime Laboratory Case # FR 16-49560
Orange County Sheriff's Coroner Case # 16-03266-MR

Dear Chief Kisela,

Please accept this letter detailing the investigation and legal conclusion by the Orange County District Attorney's Office (OCDA) in connection with the above-listed incident involving the July 22, 2016, custodial death of 34-year-old inmate Justin Gregory Brown Harris.

OVERVIEW

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

On July 15, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to St. Joseph's Hospital, where Harris died 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 the OPD 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 OPD personnel or any other person under the supervision of the OPD. 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 Thursday, July 14, 2016, at approximately 11:40 p.m., OPD Sgt. Rafael Ward observed Harris walking through a shopping center parking lot and asked Harris whether or not he was on probation or parole. Harris affirmed that he was a probationer and consented to a pat-down search of his person. During this contact, Sgt. Ward noticed that Harris was sweating heavily, his pupils were dilated, and his speech was rapid. Sgt. Ward believed Harris was displaying symptoms consistent with being under the influence of a central nervous system (CNS) stimulant. As a result, OPD Officers Evan Smith and Jordan Uemura responded to the scene to further evaluate Harris. Upon their arrival, Officer Smith observed the same symptoms and noted, among other things, that Harris had elevated pulse rates of 140 and 132 beats per minute at 11:49 p.m. and 11:51 p.m., respectively. Following his investigation, Officer Smith placed Harris under arrest for violating Health and Safety Code section 11550, being under the influence of a controlled substance, as well as for having an outstanding out-of-county warrant. At approximately 11:52 p.m., Harris was transported to the OPD by Officers Smith and Uemura for further investigation and booking into Orange County Jail (OCJ).

On July 15, 2016, at approximately 12:17 a.m., Officers Uemura and Smith arrived at the OPD with Harris and parked in a secured jail sally port. Two video cameras were recording the sally port at the time of their arrival. On video, both officers are observed exiting the police vehicle while Harris remained confined in the rear seat of the vehicle. Both officers conducted periodic visual checks on Harris over the next several minutes. At 12:22 a.m., OPD Watch Commander Sgt. Sean O'Toole entered the sally port area in order to update the Mobile Digital Computer in the vehicle containing Harris, who was still seated in the rear seat of the vehicle. Harris asked Sgt. O'Toole about what was going to happen to him, and Sgt. O'Toole directed Harris to ask his question to the transporting officers. Officer Uemura subsequently told Harris he had a warrant and needed to be booked into jail. According to Sergeant O'Toole, Harris appeared coherent, was not slurring his words, and the conversation was not unusual in any way. Sgt. O'Toole left the sally port area at approximately 12:24 a.m.

At approximately 12:39 a.m., 22 minutes after their arrival in the sally port, Officers Smith and Uemura removed Harris from the rear seat of the police vehicle and escorted him to a chair located within the sally port. Officer Smith then completed an additional, more thorough, examination of Harris and determined he was still displaying signs consistent with being under the influence of a CNS stimulant. At approximately 1:07 a.m., a technician from California Forensic Phlebotomy Inc. conducted a blood draw from Harris to be analyzed for the presence of controlled substances. Officer Smith witnessed the blood draw and no abnormalities were observed or noted. Additionally, approximately one minute later, Sgt. O'Toole returned to the sally port area and did not observe anything to suggest Harris required any medical attention. Sgt. O'Toole left the sally port area at approximately 1:09 a.m.

At approximately 1:18 a.m., Officers Smith and Uemura placed Harris back in the police vehicle. Harris remained there, without complaint, until approximately 1:45 a.m. when he was removed from the vehicle, un-handcuffed, and requested to sign booking paperwork. Harris ultimately refused to sign the documents. However, Harris was re-handcuffed and returned to the police vehicle, without incident, at approximately 1:48 a.m.

At approximately 1:56 a.m., Officers Smith and Uemura re-entered their vehicle and transported Harris to the Orange County Sheriff's Department (OCSD) Men's Central Jail. They arrived at approximately 2:09 a.m. and Harris appeared calm and compliant as he was escorted from the vehicle. Harris was directed by the officers to sit on a cement bench located in the processing area while his paperwork was delivered to the processing booth, located several feet away. While seated on the bench, and without warning, Harris became increasingly agitated; his body movements became erratic. Harris began bending forward and backwards at his waist and then side to side. Harris also began moving his legs and feet back and forth and became increasingly difficult to control. Harris' speech was slurred and rambling. At one point, Harris unexpectedly stood up and walked away from the bench without permission. Thereafter, approximately six OCSD deputies were needed to assist Officers Uemura and Smith in regaining control of Harris as he actively resisted.

Efforts to control Harris were recorded using a handheld video recorder. With the assistance of OCSD deputies, Officers Uemura and Smith rolled Harris onto his stomach and gained physical control of his arms and legs. Harris continuously resisted the officers despite the fact that handcuffs restrained his arms behind his back, and leg chains restrained the movement of his legs and feet.

At approximately 2:18 a.m., Harris was placed into a wheelchair and moved to a medical screening area. While Harris was being transported in the wheelchair, he continuously kicked his feet, stiffened his body, and forcefully attempted to stand up. Harris also placed his feet onto the ground several times in an attempt to stop the movement of the wheelchair. Harris continued making unintelligible and irrational statements throughout this time period. Additionally, a paper mesh "spit mask" was placed over Harris' head and face to prevent Harris from trying to spit blood on the officers. Due to his agitated state, medical personnel inside the medical screening area rejected Harris for booking and preparations began to transport Harris to a local hospital for medical clearance.

At approximately 2:23 a.m., Officers Smith, Uemura, and several OCSD deputies escorted Harris via wheelchair out of the medical screening area and returned him to the OPD vehicle in the parking lot. Harris was still agitated and combative. In the following minutes, OPD officers and OCSD deputies placed Harris on the ground on his back, removed the existing leg restraints, and replaced them with a hobble restraint. The hobble was affixed around Harris' ankles and attached to the handcuffs behind his back. Slack was observed in the hobble strap between the handcuffs and ankles which allowed Harris to fully extend his legs outward.

At approximately 2:26 a.m., Harris was successfully placed on his stomach across the back seat of the police vehicle. Officer Smith tried to position Harris onto his left side, so that Harris would remain on the seat of the vehicle. However, Officer Smith was unsuccessful and Harris' momentum rolled him back onto his stomach, and down towards the floor of the vehicle. Harris ultimately came to rest lying face-down across the rear floor area of the vehicle. During this time, in-car audio recording equipment recorded sounds of Harris breathing heavily, groaning, and speaking unintelligible words.

At approximately 2:31 a.m., Officers Smith and Uemura entered the front portion of the vehicle and began their transport of Harris to St. Joseph Hospital in the city of Orange. The officers requested, via their police radio, that two officers and a supervisor meet them at the hospital to provide additional assistance. Soon after, Officer Smith attempted to ask Harris how he was doing; there was no response. Officer Uemura shined a flashlight into the rear seat of the vehicle and could not obtain a clear view of Harris due to his position on the floor of the vehicle. However, Officer Uemura observed that Harris was moving his hands. As a result, the Officers promptly stopped and exited their vehicle to check on Harris. During this time, Harris was unresponsive and appeared to be sleeping as Officer Smith observed that Harris was snoring. Consequently, both officers re-entered the vehicle and continued to transport Harris to the hospital.

At approximately 2:42 a.m., Officers Smith and Uemura arrived with Harris at St. Joseph Hospital in Orange. When the officers contacted Harris to remove him from the rear seat of the police vehicle they discovered him unresponsive, not breathing, and without a pulse. The officers immediately alerted the hospital staff of Harris' condition. Medical intervention and care for Harris was turned over to the emergency room hospital staff who provided advanced-life saving measures, including Cardio Pulmonary Resuscitation (CPR). While in the emergency room, the attending physician intubated Harris, continued CPR, and administered epinephrine and other medications to him. The medical staff was able to get Harris'

heart started again, but Harris did not regain consciousness. As a result, Harris was admitted into the Intensive Care Unit (ICU) and placed into a medically-induced coma. At approximately 10:45 a.m., OCDA Investigator Pete Montez and OPD Detective Leslie Franco responded to St. Joseph Hospital. According to DA Investigator Montez, Harris was lying on a hospital gurney in the ICU with various pieces of medical monitoring equipment attached to his body. Harris was on an intravenous drip and was undergoing induced hypothermia therapy. Harris had cooling pads on his torso and legs, was unconscious, and appeared to be experiencing seizures.

At approximately 2:39 p.m., St. Joseph Hospital staff advised OPD personnel that Harris was not showing signs of brain activity and his prognosis for recovery was poor. Harris continued to receive medical treatment over the next few days. On July 22, 2016, Harris' medical condition had deteriorated even further. At approximately 4:10 p.m., all lifesaving medical intervention was stopped and Harris was pronounced deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- One pair of Adidas shoes and tan shorts from Harris.
- One black and white striped shirt (cut) from Harris.
- One nylon "RIPP" Hobble Restraint.

INTERVIEWS

During the course of the investigation, a total of 15 interviews were conducted, which included members of OPD, OCSD, medical personnel, family members, and others.

AUTOPSY

On July 26, 2016, Forensic Pathologist Dr. Yong-son Kim from the Orange County Coroner's Office conducted an autopsy on the body of Harris. Dr. Kim noted multiple minor abrasions, minor contusions, and old scars. However, Dr. Kim found no significant injuries or trauma. An anatomic summary of Harris revealed the following:

- Dilated cardiomyopathy.
- Evidence of old trauma of skin: abrasions of bilateral wrists, right chest contusion.
- Evidence of anoxic brain injury: base of right occipitotempotal lobe, base of left parietal lobe of brain.
- No evidence of acute trauma or hemorrhages.
- Focal mild coronary artery disease: 20% stenosis, left coronary artery.
- Focal acute bronchitis.
- Focal acute gastritis.

Following the autopsy, Dr. Kim concluded that the manner of death was an accident, and that the cause of death was acute poly-drug intoxication due to the combined effects of methamphetamine and amphetamine.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Harris's antemortem and postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Methamphetamine	Antemortem Blood	5.60 ± 0.37 mg/L
Amphetamine	Antemortem Blood	Detected
Methamphetamine	Postmortem Blood	0.846 ± 0.056 mg/L
Amphetamine	Postmortem Blood	0.375 ± 0.024 mg/L
Morphine (Free)	Postmortem Blood	0.362 ± 0.037 mg/L

The OCCL toxicology results revealed a potentially lethal level of Methamphetamine in Harris' antemortem blood sample.

BACKGROUND INFORMATION

Harris was transient and living in his vehicle at the time of his arrest. Additionally, Harris was on probation and had active arrest warrants from Inyo County, California and from the State of New Mexico. Harris' California Driver's License had been suspended/revoked. Harris had a State of California Criminal History record that revealed arrests and/or convictions for the following violations:

- Battery
- Being under the influence of a controlled substance
- Preventing or dissuading a witness
- Criminal threats
- Parole violation
- Forgery / False Checks
- Burglary
- Resisting, evading, or obstructing an officer
- Petty theft

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 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 they act 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 OPD personnel or other individuals under the supervision of the OPD. 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 OPD owed Harris a duty of care, the evidence does not support a finding that this duty was in any way breached by OPD, either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

Harris was increasingly under the combined effects of both methamphetamine and amphetamine throughout the course of his arrest. Initially, Harris was calm and cooperative. However, over time, he became increasingly agitated and combative, requiring the use force to restrain him and to keep him from harming himself, or others. After Harris was medically rejected for booking at OCJ, the procedures requiring Harris to be taken to a local hospital for medical clearance were followed without delay. Throughout the entire course of the incident, Officers Uemura and Smith conducted frequent checks on Harris to evaluate his well-being. Transportation of Harris to the hospital took only eleven minutes and the officers did not observe any indication that Harris required more immediate emergency medical attention until after their arrival at the hospital. Further, Officers Smith and Uemura called for hospital medical personnel to attend to Harris as soon as they became aware his condition had deteriorated. Consequently, there are no facts to support any inference that the OPD intentionally breached their duty of care to Harris.

There is also no evidence to support criminal negligence on the part of anybody connected with the OPD. Criminal negligence is established when a person 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. There is no evidence that any OPD personnel or anyone under their supervision acted in a reckless manner. Officers Smith and Uemura continuously monitored Harris after he was taken into custody. There was no indication from Harris, or otherwise, that Harris would soon need emergency life-saving care. The manner and rate at which Harris' medical condition deteriorated was unexpected, rapid, and a direct result of his ingestion of both methamphetamine and amphetamine. OPD personnel did not do anything,

intentionally or negligently, to exacerbate Harris' condition and were already in the process of transporting Harris to the hospital when his condition became critical. Officers Smith and Uemura notified hospital staff of Harris' condition without delay. Thus, there is no evidence to support a finding that any OPD personnel or any individual under the supervision of the OPD was criminally negligent or failed to perform a legal duty owed to Harris.

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 OPD personnel or any individual under the supervision of the OPD. The evidence shows that Harris died from acute poly-drug intoxication due to the combined effects of methamphetamine and amphetamine.

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

Respectfully submitted,

JEFFREY KIRK
Deputy District Attorney
Special Prosecutions Unit

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