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August 16, 2017

Police Chief Todd Eligin
Garden Grove Police Department
11222 Acacia Parkway
Garden Grove, CA 92840

Re: Custodial Death on November 7, 2016
Death of Mark James Lighthipe
District Attorney Investigations Case # SA 16-032
Garden Grove Police Department Case # DR 16-060079
Orange County Crime Laboratory Case # FR 16-57728
Orange County Coroner's Office # 16-04721-MG

Dear Chief Eligin,

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 Nov. 7, 2016 custodial death of 43-year-old Mark James Lighthipe.

OVERVIEW

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

On Nov. 7, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Garden Grove Hospital Medical Center (GGHMC), where Lighthipe died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU conducted 10 interviews. Eight additional witnesses were contacted during supplemental canvass interviews. OCDASAU also obtained and reviewed: GGPD reports; Orange County Crime Laboratory (OCCL) reports; laboratory and identification reports; incident scene photographs; videos 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 GGPD personnel or any other person under the supervision of the GGPD. 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, and 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. 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.

An important part of the investigation of an incident such as this is attempting to obtain statements from the involved or witnessing officers. The following GGPD officers were present during Lighthipe's initial arrest: Michael Gerdin, Christopher Shelgren, Jeremy Morse, Chris Wasinger, Gary Stahl, Jerome Cheatham, John Raney, and Kory Ferrin. Each of these GGPD Officers was represented by legal counsel, and through their attorneys, regretfully each of these officers declined to provide a voluntary statement to investigators from OCDA.

FACTS

On Friday, Nov. 4, 2016, at approximately 3:00AM, Jane Doe 1, an employee of Walmart, located at 1822 Gilbert Street in the city of Garden Grove, was sitting outside on her break when she first observed Lighthipe quickly walking through the Walmart parking lot while clenching a plastic bottle of water. Lighthipe then ran quickly through the parking lot near 24 Hour Fitness, located nearby at 9561 Chapman Avenue, and walked directly into the glass door of the 24 Hour Fitness. Lighthipe bounced off the glass door, and was yelling for help before entering the 24 Hour Fitness. Jane Doe 1 had never seen Lighthipe before.

At approximately 3:13 a.m., Lighthipe can be seen on surveillance footage entering the 24 Hour Fitness. A witness from inside the gym, Jane Doe 2, stated that Lighthipe stumbled in and was stumbling/running around the lobby area, yelling for help. Jane Doe 2 stated that she knew something was wrong and believed Lighthipe was on drugs because he did not look injured or bloody, and his "eyes were huge." Jane Doe 2 called 911 to report the incident. Jane Doe 2 stated that she had never seen Lighthipe at the 24 Hour Fitness before, but that one of the janitors had seen Lighthipe sleeping outside the gym in the weeks prior. Another witness from inside the 24 Hour Fitness, John Doe 1, was walking out of the gym after working out when Lighthipe approached him and was incoherently attempting to speak with him. John Doe 1 believed Lighthipe appeared to be "high on something." John Doe 1 indicated that Lighthipe was sweating, he appeared very hyper, and was looking around in a paranoid manner.

Lighthipe exited through the 24 Hour Fitness front doors and ran through the parking lot, where Jane Doe 1 and John Doe 1 could see Lighthipe pounding on cars with his hands. At that point, Jane Doe 1 told another person to call the police. The only coherent thing Jane Doe 1 could hear Lighthipe yelling was "help me." After Jane Doe 1 saw a police car arrive, she went back inside Walmart. Lighthipe proceeded to run and scream through the parking lot, heading towards the nearby Hometown Buffet and Bank of America. At one point, Lighthipe removed the T-shirt he was wearing. Soon after, John Doe 1 called 911 and waited for the police to arrive.

At 3:21 a.m., GGPD officers Cheatham and Shelgren arrived on scene and made contact with Lighthipe, who was lying on his back in the parking lot, holding his arms to his chest. Lighthipe was screaming incomprehensibly and flailing on the ground. Officer Cheatham attempted to speak to Lighthipe, who did not respond. Based upon his training and experience, Officer Cheatham believed Lighthipe to be under the influence of a controlled substance. Officers Morse, Stahl, Gerdin, and Corporal Wasinger arrived to assist. At approximately 3:25 a.m., Officer Shelgren requested Garden Grove Fire department (GGFD) respond to assess Lighthipe's medical condition.

Lighthipe continued to exhibit violent behavior as he attempted to get up from the ground. Officers Shelgren, Gary Staal, Cheatham, and Corporal Wasinger held Lighthipe on the ground and placed him in handcuffs. Lighthipe continued to scream and violently flail his body by kicking and bringing his knees to his chest. Lighthipe screamed profanities at the officers and was spitting at them as the officers were holding Lighthipe down. Officer Cheatham attempted to calm Lighthipe and asked Lighthipe which drugs he had taken; Lighthipe did not respond.

A hobble restraint was used on Lighthipe's legs to restrain him from kicking the police officers. Officer Cheatham searched Lighthipe, removed a syringe from Lighthipe's front right shorts pocket, then placed it on the ground. Officer Staal picked up the syringe and placed it on the hood of his police vehicle. Officer Shelgren asked Lighthipe, "How high are you?" to which Lighthipe responded, "I'm fine, anxiety attack." Lighthipe then stated, "Honest to God, I don't know how high I was, I'm exhausted." Officer Shelgren asks Lighthipe what his name is, to which Lighthipe responds, "My name is Mark." Lighthipe then admits to using a "dime" saying that he injected it.

From 30-40 yards away, John Doe 1 observed the officers make contact with Lighthipe and struggle for a couple of minutes to gain control of Lighthipe and take him into custody. John Doe 1 could not hear specific words, or see any police officer's weapons; he could only hear Lighthipe yelling. Eventually other officers arrived and Lighthipe was taken into custody; Lighthipe remained on the ground until the ambulance arrived. At approximately 3:31 a.m., GGFD arrived on scene. Upon arrival, GGFD personnel observed three to four GGPD officers holding Lighthipe face down on the ground. Lighthipe was yelling, combative, and appeared very aggressive, like he was trying to get away. Due to Lighthipe's excessive movement and combative nature including kicking and spitting, vital signs were unable to be accurately taken through normal medical procedures. Lighthipe appeared sweaty and clammy, but also presented with an apparent high body temperature as he visibly emitted steam. GGFD believed Lighthipe to be suffering from agitated delirium caused by an overdose of some type of stimulant drug.

At approximately 3:36 a.m., GGFD administered five milligrams intranasal of a sedative called Versed, commonly used to relax and/or calm a person. Lighthipe was then placed on his back on a gurney, and restrained with handcuffs and soft restraints on his legs. When Lighthipe was being loaded into the ambulance at approximately 3:43 a.m., Lighthipe began again to spit at paramedics and officers. A paper pillowcase was placed over Lighthipe's head as a spit mask.

At 3:45 a.m., paramedics departed in the ambulance with Lighthipe, headed to Garden Grove Hospital Medical Center (GGHMC). No GGPD officers were inside the ambulance during Lighthipe's transportation, but they were following closely behind in a marked police vehicle. Inside the ambulance, Lighthipe continued to thrash his body around and hit the sides of the gurney, remaining "super combative". Before pulling into GGHMC, Lighthipe all of a sudden became motionless. A Paramedic immediately removed the spit mask. The attending paramedics determined that Lighthipe had gone into cardiac arrest and they checked for a pulse. Not being able to find a pulse, the paramedics initiated CPR chest compressions while administering oxygen. CPR was continued for 30-60 seconds until they arrived at GGHMC emergency room.

At approximately 3:55 a.m., Lighthipe arrived at GGHMC's Emergency Room and Lighthipe's care was turned over by GGFD to emergency room personnel. Immediately upon Lighthipe's arrival, medical staff placed a breathing tube in Lighthipe and continued chest compressions. Lighthipe was also given epinephrine in an attempt to start his heart. Just after 4:00 a.m., Lighthipe regained a pulse and subsequently underwent chest X-rays, lab tests, and CAT scans. Nursing staff attempted to place a catheter in Lighthipe, and discovered that Lighthipe's penis had a string tied around it. The catheter was unsuccessful because a large amount of blood was present in Lighthipe's urine, and staff was unable to obtain a urine sample at that time. Around 6:30 a.m., Lighthipe was admitted to the Intensive Care Unit (ICU), where he remained unresponsive. Lighthipe was hooked up to a ventilator to help him breathe, and he was covered under a hypothermia treatment blanket to assist in preventing possible brain damage. At 9:30 a.m., Lighthipe's assigned ICU

doctor advised Officer Wardle that Lighthipe was in critical condition. An urologist responded to administer a suprapubic catheter to obtain a urine sample from Lighthipe; the procedure was successful. Lighthipe's condition did not improve. On Nov. 7, 2016 at 9:38 a.m., Lighthipe was pronounced dead.

In a follow-up interview with a person who knew Lighthipe, Jane Doe 3 told the Investigators that she had last seen Lighthipe in the City of Orange a few days prior to the incident, and that Lighthipe had just received $1,700 cash, a portion of Lighthipe's share of his recently deceased mother's estate. Jane Doe 3 further stated that Lighthipe was supposed to be living in a sober living house in Santa Ana, but he kept getting kicked out and had gone through several sober living homes because he kept using drugs. According to Jane Doe 3, Lighthipe was "homeless" and a "meth addict" who had used drugs for "20-25 years." She indicated that Lighthipe would sometimes "go on benders," and according to Jane Doe 3, Lighthipe had gone through "about $20,000 since January." Another person who knew Lighthipe, John Doe 2, also told the Investigators that Lighthipe had been using illegal narcotics for years, and that Lighthipe had been battling drug addiction for a long time, mainly with crystal meth.

EVIDENCE COLLECTED

The following items of evidence were collected and examined by OCCO:

- One pair boxer shorts [belonged to Lighthipe]
- One pair grey boxer shorts [belonged to Lighthipe]
- One pair black denim shorts with pink lip balm container in right front pocket
- Thirty-three color digital photographs of the scene
- One hospital gown [worn by Lighthipe]
- Twenty-two photographs of Lighthipe postmortem
- One muscle standard [Lighthipe]
- Sixty-six photographs taken during Lighthipe's autopsy
- Eighteen post-embalming photographs of Lighthipe
- Samples of Lighthipe's postmortem and antemortem blood [examined for drugs]
- Note: The paper pillowcase used as a spit mask on Lighthipe was discarded inside a bio-hazard GGHMC dumpster prior to the investigation.

AUTOPSY

On Nov. 9, 2016, Forensic Pathologist Dr. Aruna Singhania of the Orange County Coroner's Office conducted an autopsy on the body of Lighthipe. Dr. Singhania concluded that Lighthipe's cause of death was the result of acute amphetamine and methamphetamine intoxication.

EVIDENCE ANALYSIS

Toxicological Examination

Samples of Lighthipe's postmortem and antemortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Amphetamine	Postmortem Blood	Blood 0.278 ± 0.018 mg/L Brain 0.508 ± 0.033 mg/kg
Amphetamine	Antemortem Blood	Blood 0.104 ± 0.007 mg/L
Methamphetamine	Postmortem Blood	Blood 1.16 ± 0.08 mg/L Brain 4.22 ± 0.28 mg/kg
Methamphetamine	Antemortem Blood	Blood 3.22 ± 0.21 mg/L

BACKGROUND INFORMATION

Lighthipe had a State of California Criminal History record that revealed arrests dating back to 1996 for the following violations:

- Petty Theft
- Grand Theft

- Receiving Stolen Property
- Under the Influence of a Controlled Substance
- Possession of Paraphernalia
- Possession of a Controlled Substance
- Burglary
- Assault With a Deadly Weapon
- Criminal Threats
- Driving Under the Influence
- Driving With a Suspended Driver's License
- No Proof of Insurance
- Giving False Name to a Police Officer

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 the present case, there is no evidence whatsoever of express or implied malice on the part of any GGPD personnel or any other individuals under the supervision of the GGPD. 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 GGPD owed Lighthipe 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). Based on the available evidence, it appears that the involved GGPD officers conducted themselves appropriately in dealing with Lighthipe, a highly combative arrestee under the influence of a controlled substance who posed a threat to those around him.

As captured on surveillance footage and witnessed by several citizens and police officers, it was apparent that Lighthipe was under the influence and violent to the point that he required physical restraints. As several personnel continued to attempt to aid Lighthipe in determining the exact state of his current physical/medical condition, Lighthipe began to spit on those around him. Even though he was spitting, medical personnel still needed to be able to administer medical treatment to Lighthipe, although not at the expense of their own physical health and safety. As a result, police officers placed the paper pillowcase spit mask over Lighthipe's head for their own and medical personnel's protection.

Even with the newly placed spit mask, Lighthipe remained violent and combative—continuing to thrash his body around after being loaded into the ambulance. It was not until Lighthipe instantaneously went limp, inside the ambulance and almost at the emergency room entrance of GGHMC, that the GGFD paramedics removed the spit mask and had the first indication that Lighthipe was beginning to suffer cardiac arrest. GGPD officers were not in the ambulance at any time during the transportation, but were following closely behind in a marked GGPD vehicle.

Upon realizing that Lighthipe had gone into cardiac arrest only seconds away from the GGHMC emergency room entrance, the GGFD paramedics and the paramedics immediately began administering CPR to Lighthipe while continuing his transportation. Lighthipe's care was shortly thereafter transferred to the GGHMC emergency medical staff. Therefore, there is no evidence whatsoever to support a finding that any GGPD personnel or any individual under the supervision of the GGPD failed to perform a legal duty.

Certainly, it would have been preferable if the OCDA were able to obtain voluntary statements from the involved and present GGPD officers regarding their observations and state of mind at the time of their interactions with Lighthipe. However, the decisions of the GGPD Officers to decline to give the OCDA voluntary statements, while regrettable and unfortunate, such decisions may not legally and ethically be used to draw negative evidentiary inferences regarding the conduct or the state of mind of any of the GGPD Officers.

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 a lack of sufficient evidence to support a finding of criminal culpability on the part of any GGPD personnel or any individual under the supervision of the GGPD. The evidence shows that Lighthipe died as a result of acute amphetamine and methamphetamine intoxication.

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

Respectfully submitted,

MICHAEL PEVNEY
Deputy District Attorney
Special Prosecutions Unit

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