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May 4, 2018

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

Re: Custodial Death on November 18, 2017
Death of Inmate Nelson Ward
District Attorney Investigations Case # 17-031
Orange County Sheriff's Department Case # 17-045733
Orange County Crime Laboratory Case # 17-59549
Orange County Coroner Case # 17-05085-RA

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 Nov. 18, 2018, custodial death of 62-year-old inmate Nelson Ward.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Ward. 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 Nov. 18, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Anaheim Global Medical Center (AGMC), where Ward 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 OCSD, Orange County Crime Lab (OCCL), and Orange County Coroner's Office (OCCO), photographs of the deceased taken by Orange County Crime Lab (OCCL) Forensic Specialists, 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, 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 Felony Operations II 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, 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 Saturday Sept. 12, 2015, Ward was arrested by the Buena Park Police Department (BPPD) for murder, attempted murder, and assault with a deadly weapon. On Sept. 13, 2015, Ward was booked into the Orange County Jail (OCJ). Ward was 60 years old and had a history of diabetes mellitus, hypertension, asthma, peripheral neuropathy, depression, anxiety, and back pain.

On Sept. 13, 2015, upon Ward's medical screening while entering OCJ, Ward indicated he needed assistance with his mobility and was subsequently issued a cane. Over the following two years, Ward was housed at the Theo Lacy Jail Facility, Module "O," where he received care for his pre-existing medical conditions. Ward often utilized the "Inmate Health Message Slip" to notify the jail staff of medical issues and concerns, which were promptly addressed.

On Oct. 19, 2015, Ward was seen by the Retina Associates of Orange County. It was determined he had diabetes II ocular complications. Ward was advised of the importance of maintaining adequate blood sugar control to prevent ocular complications. His ocular complications were reported to the physicians maintaining his diabetes care at OCJ, and he was continuously provided with follow-up care and appointments, some of which Ward refused to attend.

On Feb. 9, 2017, Ward received dental treatment and it was determined he had severe tooth decay. Ward refused further treatment of the tooth and stated he understood the risk and benefits of refusing the recommended procedure on his tooth.

Ward reported on an "Inmate Health Message Slip" to Correctional Medical Services (CMS) that he had pain on the right side of his stomach. Subsequently, on Aug. 29, 2017 ultrasound images were obtained of Ward's right upper quadrant. These images demonstrated that there were multiple echogenic and hypoechoic masses throughout Ward's liver.

On Sept. 14, 2017, a CAT scan was performed on Ward to obtain images of Ward's abdomen and pelvis. The results of these images determined that the lower right lobe of the liver had mixed areas of attenuation as well as varying shapes that were suspicious for underlying masses such as metastases. The images also revealed that there were low density lesions in the left kidney and that the bowel wall had thickening.

On Oct. 24, 2017, one of the healthcare providers in OCJ noted that Ward had multiple liver masses that was consistent with metastatic disease, a form of liver cancer. Throughout the two years that Ward was in OCJ he consistently refused his insulin and other diabetic testing and medications multiple times a month. From January 2017 to November 2017, Ward refused his medications approximately 59 times, specifically refusing his diabetes check and insulin 42 out of the 59 times it was offered to him. Ward was counseled as to the risks and benefits of the medication each time he refused. Nevertheless, despite indicating he understood the dangers, Ward continued with his frequent refusals of medication. Additionally, Ward refused to go to his scheduled medical appointments on at least 10 different occasions within the same time frame.

On Nov. 1, 2017 Ward refused to go to an interventional radiology appointment. Furthermore, on November 2, 2017 Ward was advised to be admitted to the hospital for therapeutic paracentesis but Ward refused.

On the evening of Monday, Nov. 6, 2017, Ward was taken by ambulance to Anaheim Global Medical Center (AGMC) for his failing health as a result of his ascites becoming worse, not responding to oral diuretics and becoming more short of breath with exertion. Ward was subsequently admitted to the Medical Surgical Unit.

On Thursday, Nov. 16, 2017, Ward's treating physician advised him that he needed to be placed on Dialysis immediately for his failing liver and kidneys. Ward declined to be placed on Dialysis and told the medical staff "Just let me die." At that time, Ward signed a "Do-Not-Resuscitate" medical directive. Ward was then placed on a comfort-care protocol.

On Nov. 17, 2017, at approximately 7:00 p.m. a visual examination was conducted by an AGMC medical nurse and there were no signs of trauma or injuries in any portion of his body. Later that evening, at approximately 11:30 p.m., Ward was given Morphine as part of his comfort-care-protocol.

On Saturday, Nov. 18, 2017, at approximately 6:44 a.m., AGMC medical staff entered Ward's hospital room to check his vital signs and noted that he was not breathing, had no pulse, and was absent heart activity. On Nov. 18, 2017 at 7:28 a.m., Ward was pronounced deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- A sample of Ward's antemortem and post-mortem blood
- Muscle standard

AUTOPSY

On Nov. 21, 2017, independent Forensic Pathologist Dr. Scott Luzi of Anatomic, Clinical and Forensic Pathology Services conducted an autopsy on the body of Nelson Ward. Dr. Luzi examined Ward's body and found no significant minor or major injuries or trauma. Dr. Luzi's final autopsy diagnosis includes the following natural and pre-existing conditions: Ascites, pulmonary congestion and edema, pulmonary consolidation, cardiomegaly, mild coronary atherosclerosis, cirrhosis, metastatic tumor (liver), nephrosclerosis, pancreatic mass, and hilar adenopathy. The autopsy of Ward revealed several "masses" consistent with cancer in his pancreas, liver, and lungs. Dr. Luzi determined the cause of death to be complications of carcinoma, favor pancreatic origin, and that the manner of Ward's death to be natural.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	Postmortem Blood	RESULTS & INTERPRETATIONS
Ethanol/Volatiles	Postmortem Blood	Not Detected
Benzodiazepines	Postmortem Blood	Negative
Cocaine and/or Metabolite	Postmortem Blood	Negative
Phenethylamines	Postmortem Blood	Presumptive Positive
Opiates	Postmortem Blood	Negative

BACKGROUND INFORMATION

Nelson Ward had a State of California Criminal History record that revealed arrests for the following violations:

- Murder
- Attempt murder
- Assault with a deadly weapon
- Drunk in public/Disorderly conduct
- Possession of controlled substance
- Violation of Parole
- Domestic violence/Corporal injury of spouse
- Violation of probation
- Assault on transporting official
- Resisting arrest
- Possession of controlled substance without prescription
- Possession of hypodermic syringe
- Possession of switchblade knife
- Possession of drug paraphernalia
- FTA Warrant
- Possession of marijuana
- Violation of court order

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 case, 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 Ward 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). Upon entrance to Theo Lacy Jail on Sept. 13, 2015, and throughout the two years Ward was housed at Theo Lacy Jail he received appropriate care and assistance for his preexisting medical conditions, in the medical section of the jail, in Module "O."

Between Sept. 13, 2015, and Nov. 7, 2017, Ward submitted numerous "Inmate Health Message Slips" to CMS and jail medical staff respondent promptly to each request and administered medical care responsive to his complaints. Further, Ward repeatedly refused medication and verbalized his understanding of the benefits and risks of not taking his medication.

On Aug. 29, 2017, an ultrasound of Wards upper right quadrant was obtained. Then on Sept. 12, 2017, a CAT scan was performed. These scans revealed that Ward had several "masses" in his liver. OCJ Medical recommended to Ward medical treatments for his chronic illnesses, including interventional radiology as well as hospitalization to obtain treatment for his medical conditions. Ward repeatedly refused these treatments.

On Nov. 2, 2017 OCJ medical staff advised Ward to be admitted to the hospital but he refused. When Ward's health began to further deteriorate, he was immediately transferred by ambulance to AGMC on Nov. 6, 2017.

On Thursday, Nov. 16, 2017, Ward was advised to be placed on Dialysis immediately for his failing liver and kidney. Ward was advised that refusing dialysis would be fatal. Ward declined this treatment and told medical staff "just let me die." At that time Ward signed a "Do-Not-Resuscitate" order and was placed on comfort-care protocol. Ward was pronounced deceased on Nov. 18, 2017, and the forensic pathologist determined that he died of natural causes from complications of carcinoma, favor pancreatic origin.

Based on all of the available evidence, 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 owed to Ward.

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 Ward died naturally from complications of cancer following his signed "Do-Not-Resuscitate" directive.

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

Respectfully submitted,

ANGELA HONG
DEPUTY DISTRICT ATTORNEY
SPECIAL PROSEOCUTIONS UNIT

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney
Felony Operations II