OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TONY RACKAUCKAS, DISTRICT ATTORNEY

JIM TANIZAKI
SENIOR ASSISTANT D.A.
VERTICAL PROSECUTIONS/
VIOLENT CRIMES

WILLIAM FECCIA
SENIOR ASSISTANT D.A.
SPECIAL PROJECTS

MARY ANNE MCCAULEY
SENIOR ASSISTANT D.A.
BRANCH COURT OPERATIONS

JOSEPH D'AGOSTINO
SENIOR ASSISTANT D.A.
GENERAL FELONIES/
ECONOMIC CRIMES

JEFF MCLAUGHLIN
ACTING CHIEF
BUREAU OF INVESTIGATION

LISA BOHAN - JOHNSTON
DIRECTOR
ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER
CHIEF OF STAFF

February 7, 2011

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

Custodial Death of Gregorio Aguilar Torres
Orange County Sheriff's Department Booking #2579273
S.A. # 10-018 / FR # 10-48907

Dear Sheriff Hutchens,

On Thursday, July 22, 2010, the Orange County District Attorney's Office Special Assignments Unit (OCDASAU) was called upon by the Orange County Sheriff's Department (OCSD) to conduct an investigation into the custodial death of Gregorio Aguilar Torres, an inmate of the Orange County Jail. The purpose of this letter is to provide your department with a summary of this investigation, its findings, and the legal conclusions drawn from it by the Orange County District Attorney's Office (OCDA). In particular, the following content describes the investigative methodology employed by the OCDA in this matter, evidence examined, witnesses interviewed, facts discovered and the applicable legal principles analyzed for the OCDA to determine whether criminal culpability exists on the part of any OCSD personnel, any individuals under the supervision of OCSD, or any other persons involved in the treatment and care of Torres during his period in custody.

OVERVIEW

On July 22, 2010, at approximately 6:30 p.m., the OCDASAU was contacted by the OCSD regarding the custodial death of Torres at the Western Medical Center Anaheim. OCDASAU investigators subsequently responded to the medical center and began an investigation into the circumstances surrounding Torres' death. During the course of this investigation, OCDASAU investigators interviewed multiple witnesses, reviewed the documented statements of additional witnesses, examined the reports of the OCSD and Orange County Health Care Agency (OCHCA), the medical records of Western Medical Center Anaheim and Mission Hospital Laguna Beach,

attended the autopsy and coroner's review regarding Torres, and reviewed various laboratory, identification, and autopsy reports, as well as investigative photographs and other relevant materials.

Through this process and subsequent analysis, the OCDA conducted an independent and thorough investigation of the facts and circumstances of Torres' death and impartially reviewed all available evidence and applicable principles of law. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred in the death of Torres on the part of any OCSD personnel, any individuals under the supervision of OCSD, or any other persons involved in the treatment and care of Torres during his period of custody.

INVESTIGATIVE METHODOLOGY

The OCDASAU is responsible for the investigation of custodial deaths within Orange County, including those which occur while an individual is in the custody of the OCSD. The investigative protocol for custodial deaths involves the assignment of a lead investigator from the OCDASAU, who is then supported by additional investigators from both the OCDASAU and other OCDA investigative units, as well as by other staff. The OCDASAU consists of six-full time investigators and one supervising investigator. There are also an additional 25 investigators within other OCDA units who are trained to assist in custodial death investigations when needed. The OCDASAU is also assisted by the OCSD Crime Laboratory which processes physical evidence that is recovered in the course of the investigation.

At the conclusion of the OCDASAU's investigation, an investigative file is prepared containing all the relevant reports, documents and records, audio-recordings, photographs, and related material. The investigative file is then assigned to an experienced deputy district attorney for his or her legal review and for a determination of whether criminal charges are warranted. In the case of fatal, officer-involved shootings and custodial deaths, a deputy district attorney in the OCDA's Homicide or Gang Unit conducts the review. In the case of non-fatal officer-involved shootings, an experienced deputy district attorney in the Special Prosecutions Unit conducts the review. Ultimately, one deputy district attorney prepares a memorandum outlining his or her factual and legal analyses of the case and his or her legal conclusions.

Throughout the legal review process, the assigned prosecutor may consult with his or her supervising assistant district attorney who will also review the prosecutor's memorandum and legal conclusions. The matter may also be reviewed by a senior assistant district attorney, the Chief of Staff, and the District Attorney. If necessary, the assigned prosecutor may request further investigation before he or she renders a conclusion.

FACTS

On July 22, 2010, at approximately 6:00 p.m., 43 year-old Torres was pronounced deceased at Western Medical Center Anaheim while in the custody of OCSD. The relevant circumstances which led up to his custodial death and which were revealed through the subsequent investigation are as follows:

Torres had a history of chronic alcohol abuse and a series of medical complications arising, at least

in part, from his alcoholism. On June 21, 2010, Torres, living as a transient in the city of Dana Point, was treated at Mission Hospital Laguna Beach Emergency Room for complaints of leg swelling and ear infection. His documented medical history from this visit indicated that he had been "homeless for many years" and "had alcoholism for 10 years." Torres reported to hospital staff that he would drink "approximately 12 beers a day." A doctor evaluated Torres and diagnosed him with alcoholism and malnutrition, mild alcohol hepatitis, inflammation of the ears, and swelling of the feet due to possible alcoholic cardiomyopathy. Torres was then discharged from the hospital at his own request.

On June 24, 2010, Torres was arrested by OCSD (DR#10-114477) on an outstanding arrest warrant in Orange County Superior Court case 10SF0395. The arresting officer, Deputy J. Good (3903) indicated that Torres may require medical treatment and submitted him for "medical booking" to the OCSD Intake Release Center (Booking No. 2579273). During the intake screening and triage, Torres admitted being an alcoholic but denied any other medical problems. After a medical assessment, he was noted as being fit for medical booking.

On June 25, 2010, Torres was assigned to a medical housing unit within the jail where he was under the care of Correctional Medical Services (CMS). The records of the OCHCA revealed that Torres received regular daily medical assessment and treatment multiple times a day by CMS from the date of his booking through July 4, 2010.

On July 4, 2010, at approximately 8:19 a.m., CMS Doctor Pushpa Chandwani requested that Torres be transferred from a medical ward of the Central Men's Jail to the hospital for treatment. At the time, Torres was displaying a fever and cellulitis. Torres was then transported to Western Medical Center Anaheim for further treatment, where he remained in the custody of OCSD until his death on July 22, 2010.

During an initial assessment at Western Medical Center Anaheim, a medical doctor diagnosed Torres as suffering from ethyl alcohol withdrawal, fever, hyponatremia, possibly lower extremity cellulitis and liver disease. Torres continued to receive regular medical care pursuant to his diagnoses. On July 13, 2010, further medical examinations revealed that Torres had an enlarged heart and a loss of lung volume.

On July 17, 2010, Torres' medical condition deteriorated and he was transferred to the Intensive Care Unit (ICU) exhibiting hypotension and tachycardia. On July 21, 2010, Torres was intubated by hospital staff due to respiratory distress.

On July 22, 2010, at 6:22 a.m., further medical examination of Torres revealed that his heart remained enlarged with persistent underlying pulmonary vascular congestion and congestive heart failure. After 5:00 p.m., a registered nurse (RN), who had been monitoring Torres, noticed his blood pressure and heart rate dropping. The RN then activated a "code blue" to alert other medical staff in the ICU to respond and attend to Torres' condition. The RN also checked Torres for a carotid pulse but none was detected.

At 5:45 p.m., Torres experienced full cardiopulmonary arrest, his heart rhythm indicated asystole, and cardiopulmonary resuscitation (CPR) was provided. Medical staff performed advanced life saving (ALS) measures but failed to produced results. Throughout the ALS measures, Torres remained pulseless and asystole despite several rounds of medications and CPR. At 6:00 p.m., based upon an examination by another medical doctor, Torres was then pronounced deceased.

AUTOPSY

On July 23, 2010, at approximately 9:16 a.m., Riverside County Chief Forensic Pathologist Doctor Richard Cohen conducted the post-mortem examination of Torres at the Coroner facility of the Orange County Sheriff-Coroner's Forensic Science Center. Dr. Cohen concluded that the manner of death was natural and that the cause of death was due to cirrhosis of the liver, attributable to chronic alcohol abuse, liver failure, heart failure and multiple organ failure. Dr. Cohen noted no non-medical external trauma on Torres' body. A toxicological examination detected the presence of multiple substances of prescription medication at therapeutic levels. Those substances are noted below.

EVIDENCE ANALYSIS

TOXICOLOGY

A subsequent toxicological examination was performed by the OCSD Crime Laboratory on Torres' post-mortem blood sample. The results were as follows and all substances were found to be at therapeutic, below fatal levels:

DRUG	MATRIX	RESULT
Diazepam / Nordiazepam	Post-mortem Blood	Detected
Lidocaine	Post-mortem Blood	Detected
Midazolam	Post-mortem Blood	Detected
Lorazepam	Post-mortem Blood	Detected
Temazepam	Post-mortem Blood	Detected
Oxazepam	Post-mortem Blood	Detected
Trimethorprim	Post-mortem Blood	Detected
Lidocaine Metabolite	Post-mortem Blood	Detected
Quetiapine Metabolite	Post-mortem Blood	Detected

THE LAW

Homicide is the killing of one human being by another. Murder, manslaughter, and involuntary manslaughter are types of homicide.

To prove that a person is guilty of murder, the following elements must be proven:

1. The person committed an act that caused the death of another person;
2. When the person acted he had a state of mind called malice aforethought; and
3. He 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 acted he knew his act was dangerous to human life, and he deliberately acted with conscious disregard for human life.

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.

A person can commit murder by his failure to perform a legal duty. A legal duty must be owed to the decedent by the person for the decedent's help or care. The person must then have failed to perform that duty. The failure to act is the same as doing a negligent or injurious act.

A killing that would otherwise be murder is reduced to voluntary manslaughter if the person killed someone because of a sudden quarrel or in the heat of passion. CALCRIM 570 defines "sudden quarrel or heat of passion." A killing that would otherwise be murder is also reduced to voluntary manslaughter if the defendant killed a person because he acted in imperfect self defense. For a definition of imperfect self defense, see CALCRIM 571. When a person commits an unlawful killing but does not intend to kill and does not act with conscious disregard for human life, then the crime is involuntary manslaughter. The difference between other homicide offenses and involuntary manslaughter depends on whether the person was aware of the risk to life that his actions created and consciously disregarded that risk. An unlawful killing caused by a willful act done with full knowledge and awareness that the person is endangering the life of another, and done in conscious disregard of that risk, is voluntary manslaughter or murder. An unlawful killing resulting from a willful act committed without intent to kill and without conscious disregard of the risk to human life is involuntary manslaughter.

In custodial death situations, the most likely application of the law would be a review of involuntary manslaughter based on a failure to perform a legal duty. To prove that a person is guilty of this crime, the following elements must be proven:

1. The person had a legal duty to the decedent;
2. The person failed to perform that legal duty;
3. The person's failure was criminally negligent; and
4. The person's failure caused the death of the decedent.

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he 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 acts is so different from how an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act. For an explanation of causation, see CALCRIM 582. The language is the same found above for causation under murder.

LEGAL ANALYSIS

A finding of criminal culpability in the death of Torres would necessitate evidence of malice or criminal negligence on the part of an individual whose act or qualifying omission proximately caused Torres' death. There is no such evidence in this case. There is a complete absence of evidence that any member of the OCSD, any individuals under the supervision of OCSD, or any other persons involved in the treatment and care of Torres during his period of custody acted with malice or criminal negligence in his death. There is similarly an absence of evidence that any act or qualifying omission on the part of any such individual had any causal connection to Torres' death. Torres' manner of death was natural, caused by cirrhosis of the liver, attributable to chronic alcohol abuse, and multiple organ failure. The evidence demonstrates that OCSD personnel and those responsible for the treatment of Torres exercised reasonable care in assessing and rendering him appropriate medical attention. At the outset, OCSD personnel identified Torres as necessitating medical assessment and treatment, provided him constant and regular medical care, and obtained advanced medical assistance at Western Medical Center Anaheim early. Similarly, the evidence indicated that Torres was provided regular and appropriate care at Western Medical Center and that all necessary life-saving measures were employed, but to no avail. Simply put, the evidence does not support a finding of criminal culpability in Torres' death.

CONCLUSION

On the basis of the evidence gathered and provided to the OCDA, all of the surrounding factual circumstances and applicable principles of law, it is my legal opinion that the evidence does not support a finding of criminal culpability in the death of Torres on the part of any OCSD personnel, any individuals under the supervision of OCSD, or any other persons involved in the treatment and care of Torres during his period of custody. It is my conclusion that the manner of Torres' death was natural, caused by cirrhosis of the liver, attributable to chronic alcohol abuse, and multiple organ failure.

Respectfully,

Keith Bogardus
Deputy District Attorney
Homicide Unit

Read and Approved by Jim Tanizaki
Senior Assistant District Attorney