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

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

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

MICHAEL LUBINSKI
SENIOR ASSISTANT D.A.
SPECIAL PROJECTS

JAIME COULTER
SENIOR ASSISTANT D.A.
BRANCH COURT OPERATIONS

CRAIG HUNTER
CHIEF
BUREAU OF INVESTIGATION

LISA BOHAN - JOHNSTON
DIRECTOR
ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER
CHIEF OF STAFF

May 4, 2015

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

Re: Custodial Death on July 30, 2014
Death of Inmate Brekka Renee Lancaster
District Attorney Investigations Case # SA 14-012
Orange County Sheriff's Department Case # 14-139129
Orange County Crime Laboratory Case # FR 14-50159

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 July 30, 2014, custodial death of inmate Brekka Renee Lancaster, 25.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Lancaster. 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 29, 2014, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center Santa Ana (WMCSA), where on July 30, 2014, Lancaster died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed twelve witnesses, as well as obtained and reviewed reports from the OCSD 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 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 or Gang Units review 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 his or her supervisor, and this Assistant District Attorney eventually will review and approve any legal conclusions and resulting memoranda. 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

Background

Lancaster was a 25-year-old female who battled depression and suffered from mental health problems. Her family denied witnessing any suicidal behavior, but Lancaster's friends observed suicidal ideations. According to Jane Doe, one of Lancaster's friends, Lancaster made the following remark a few weeks before her death: "I think everyone would be better if I wasn't here." Jane Doe believed that Lancaster was tired of the "cycles" of feeling better for a short period of time, followed by severe depression.

Synopsis

On July 22, 2014, at approximately 8:30 a.m., OCSD Investigators David Purser and Mark Baltodano responded to a residence in Norco to arrest Lancaster for an outstanding warrant. Assisting the investigators with the arrest were two uniformed Riverside County Sheriff's Department (RCSD) deputies. Investigators Purser and Baltodano stood near the side of the residence while the RCSD deputies knocked on the front door. Lancaster's grandmother answered the door and spoke to the deputies. After approximately two minutes, Lancaster appeared at the front door. The deputies arrested Lancaster and handcuffed her wrists behind her back. Lancaster was cooperative and did not appear to be sick or injured. Investigator Purser placed Lancaster in the back seat of his patrol vehicle. Lancaster did not mention any illness, injury, or suicidal ideation. Investigator Purser spoke to Lancaster's grandmother briefly at the residence and she did not mention anything about Lancaster being sick, injured, or having suicidal ideations. At approximately 8:42 a.m., Investigator Purser transported Lancaster approximately 15 miles to the Yorba Linda Sheriff's station. Lancaster did not display any unusual behavior en route to the station. They arrived at the station at approximately 9:14 a.m. and Lancaster was escorted to an interview room. Investigators Purser and Baltodano interviewed Lancaster for approximately 25 minutes regarding an open grand theft case. During the interview, Lancaster was alert and cooperative, and she did not complain about any medical or psychiatric issues. At the conclusion of the interview, Lancaster requested and received a cup of water. A few minutes after Lancaster drank the water, she spit it out of her mouth as if she had choked. Investigator Purser asked Lancaster if she was "okay," and Lancaster responded that police officers made her nervous, but she was fine. Investigator Purser asked Lancaster if she needed medical attention and she declined.

Lancaster asked to use the restroom, and OCSD Community Services Officer Kara Boyd escorted her to the restroom. Officer Boyd stood by while Lancaster went to the restroom and then escorted her back to the interview room. At approximately 10:00 a.m., OCSD Deputy Scott Ferraro transported Lancaster to the Orange County Central Jail (OCCJ) in Santa Ana where she was booked for the outstanding warrant. At approximately 11:16 a.m., Deputy Ferraro and Lancaster arrived at the OCCJ Inmate Reception Center. Jail surveillance footage captured Lancaster walking without difficulty, and she appeared alert and cognizant of the booking deputy's instructions.

At approximately 11:25 a.m., Orange County Health Care Agency Nurse Helen Badri asked Lancaster a series of health screening questions. Lancaster claimed she was hypoglycemic and that her family had a history of diabetes. Lancaster

denied being sick, injured, or having any other medical issues. Lancaster also denied consuming alcohol, ingesting any controlled substances, or taking any prescription medications. Although Lancaster denied having suicidal thoughts, she admitted to being under the care of a psychiatrist for problems with anxiety. Nurse Badri referred Lancaster to the Correctional Mental Health (CMH) nurse and requested that Lancaster be housed in the triage area of Women's Reception. At approximately 11:44 a.m., Lancaster was fingerprinted and officially booked into the OCCJ by OCSD Deputy Ashley Reyes. Lancaster was placed in the Triage Loop area of the Women's Inmate Reception Center awaiting further evaluation by CMH psychiatric staff.

At approximately 4:30 p.m., CMH Nurse Mary Ann Tan conducted a mental health evaluation of Lancaster. During this evaluation, Lancaster stated that she had been treated by a psychiatrist for depression approximately four years ago and was prescribed psychiatric medications. When Nurse Tan asked Lancaster follow-up questions regarding her mental health, Lancaster responded by talking about how much she hated her dead grandfather. Lancaster had disorganized thoughts and displayed bizarre behavior. Nurse Tan recommended that Lancaster be placed in the Female Observation Unit (FOU) of the OCCJ with orders to be monitored by nursing staff. Nurse Tan also restricted Lancaster from having visits, going to church, attending education classes, and having dayroom time. At approximately 5:23 p.m., Lancaster was evaluated by Nurse Roberto Loqinario who noted the following:

- Blood pressure: 150/101
- Pulse: 110 beats per minutes
- Body temperature: 98.9 degrees
- Oxygen saturation: 97
- Respirations: 20 breathes per minute

Nurse Lydia Iorga was assigned to the FOU to observe inmates and provide medical assistance as needed. At approximately 7:15 p.m., Nurse Iorga made her rounds to distribute medicine. As Nurse Iorga walked past Lancaster's cell, she saw Lancaster sitting on the floor at the foot of her bunk. Lancaster's chin was resting on her chest and she was making a "clucking" noise. Nurse Iorga did not believe there was anything wrong with Lancaster, so she moved on to the next cell to deliver medication. Lancaster was not prescribed any pills, so Nurse Iorga determined that there was no reason to disturb her. Nurse Iorga conducted her cell checks on inmates in the FOU every half-hour from approximately 7:15 p.m. to 9:00 p.m. and did not observe any problems with the inmates. Nurse Iorga specifically remembered looking in Lancaster's cell during this time period and noticed she was still sitting on the floor and appeared to be breathing. Nurse Iorga assumed Lancaster preferred to sit on the floor instead of on her bunk.

OCSD deputies assigned to the OCCJ Women's Facility are responsible for conducting safety checks in the FOU every half-hour. This requires deputies to conduct a walk-through of the FOU and look into each of the cells every half-hour to check on the well-being of inmates. As deputies enter the FOU, they are required to log in and out of the unit. Deputies are also required to note if there were any problems in the FOU. According to the inmate safety check log dated July 22, 2014, there were no discrepancies or large gaps in time between safety checks from the time Lancaster was first placed in FOU #5 and 9:26 p.m. In fact, the safety checks occurred more frequently than the required thirty minute intervals. On this day, deputies conducted safety checks on inmates in the FOU approximately every 15 minutes.

At approximately 9:30 p.m., OCSD Deputy Amber Garcia was assigned as the Female Prowler Deputy at the OCCJ Women's Facility and conducted safety checks in the FOU. Deputy Garcia heard heavy breathing as she approached Lancaster's cell. Deputy Garcia looked through the window of the cell door and saw Lancaster seated on the floor in an upright position. Lancaster's chin was resting on her chest. OCSD Deputy Nicole Freeman arrived on the scene and tried to speak with Lancaster through the cell door, but she was unresponsive. Deputies Garcia and Freeman opened Lancaster's cell door and attempted to place her in a supine position inside her cell, but they had a difficult time moving her because of her large stature.

At approximately 9:35 p.m., Nurse Iorga heard Deputies Garcia and Freeman open Lancaster's cell door and attempt to communicate with her, so Nurse Iorga responded to the cell for assistance. As they repositioned Lancaster in a supine position, Lancaster's breathing became labored. Nurse Iorga used an electronic monitor to measure Lancaster's blood pressure, but she could not hear anything due to the loud noise Lancaster made as she breathed. Nurse Iorga attempted to use a manual blood pressure cuff to measure Lancaster's blood pressure, but she was unsuccessful because Lancaster continued to make loud "snoring noises" as she breathed. Nurse Iorga attempted to talk to Lancaster, but she was unresponsive, so Nurse Iorga instructed the deputies to call for paramedics. Nurse Iorga delivered oxygen to Lancaster and monitored her breathing while waiting for paramedics to arrive.

At approximately 9:39 p.m., Orange County Fire Authority (OCFA) Station #75 personnel were dispatched to a call of a "woman down" in her jail cell at the OCCJ Women's Facility. Approximately five minutes later, OCFA firefighters and paramedics arrived at the OCCJ and were escorted to the Women's Medical Ward. OCFA Fire Captain Robert Richardson saw Lancaster lying on the floor of her cell in a supine position, and noticed that Lancaster had urinated in her pants, was breathing heavily, and was unresponsive to his questions. OCFA Paramedic Netzer Muro conducted a full-body assessment of Lancaster and did not notice any signs of injury or trauma. Paramedic Muro measured Lancaster's vital signs and noted that her blood pressure was 160/120 and her pulse was 150 beats per minutes. Accordingly, Paramedic Muro established a twenty-gauge intravenous line on Lancaster's left arm and delivered 10 cc's of saline using a lock valve adaptor. OCFA fire personnel treated Lancaster for approximately 20 minutes before Care Ambulance arrived at the scene.

At approximately 10:25 p.m., Care Ambulance Unit #284 arrived and transported Lancaster to WMCSA "Code 3", using its lights and siren. Fire Captain Richardson and Paramedic Muro rode in the back of the ambulance with Lancaster and monitored her vitals. OCSD Deputy Samantha Seigel also rode in the back of the ambulance for security reasons. While in transport to the hospital, Lancaster appeared to be in an altered state of consciousness and had an inconsistent breathing pattern. Fire Captain Richardson called the WMCSA Emergency Room (ER) and told medical staff that they were transporting a possible "neuro-stroke" patient. Lancaster did not receive any medical treatment or additional medications while in transport to the hospital.

At approximately 10:30 p.m., Lancaster arrived at WMCSA and her care was transferred to ER staff. Lancaster was transferred immediately to Trauma Room #2 and placed on a heart and oxygen monitor. The attending physician assessed Lancaster's condition and noted that she had abnormally high blood pressure of 205/105, an elevated pulse of 140 beats per minute, and rapid coarse respirations of 28 breaths per minute. The attending physician also noted that Lancaster was not alert and in moderate distress, but he did not observe any physical trauma or peripheral edema. An intravenous line was established and a saline solution was delivered. Lancaster was placed on a non-breather mask and given oxygen. Lancaster was given 300 milligrams of Etomidate, followed by 100 milligrams of Succinylcholine. In addition, Lancaster was sedated with Propofol, and the attending physician used a MAC 3 blade to perform a direct laryngoscopy, and an endotracheal tube was then passed through Lancaster's vocal cords. A chest x-ray was performed, which confirmed that the endotracheal tube was in the correct position. The attending physician ordered an immediate I-Stat chemistry blood test on Lancaster, which revealed that she was hyperkalemic. An EKG test showed that Lancaster had peak T-waves, confirming her hyperkalemia. Lancaster was then given one amp of calcium chloride, one amp of bicarbonate, five units of regular insulin, and one ampule of D5. After the medication was delivered, Lancaster's heart rate gradually decreased.

The attending physician attempted to establish a central line on the right femoral vein, internal jugular, and left subclavian, but was unsuccessful due to Lancaster's body habitus. Another physician at WMCSA established a central line on Lancaster's upper right chest using an 18-gauge needle to access the right subclavian vein. A chest x-ray confirmed that the central line was established in the correct position. The attending physician performed approximately 45 minutes of critical care on Lancaster in the ER and gave the following clinical impression of Lancaster at the conclusion of his assessment:

- Altered level of consciousness
- Acute respiratory failure requiring intubation

- Sepsis
- Severe hyperkalemia

WMCSA attending Intensive Care Unit (ICU) physician examined Lancaster in the ER and concluded that Lancaster was in critical condition and recommended that she be transferred to the ICU. On July 23, 2014, at approximately 1:45 a.m., Lancaster was transferred to Room #9 in the ICU and placed on a respirator. Given Lancaster's condition, the ICU attending physician suspected that Lancaster may have ingested a toxic substance adversely affecting her organs and requested toxicological tests specifically for methanol, ethylene glycol, and isopropyl alcohol. At approximately 1:38 p.m., a WMCSA specialist conducted a renal consultation on Lancaster and he concluded that Lancaster had acute renal failure, severe metabolic acidosis, sepsis, and hyperkalemia. Therefore, the specialist placed Lancaster on hemodialysis with potassium, bicarbonate, and calcium bath drip. At approximately 8:11 p.m., a WMCSA neurologist conducted a neuro examination of Lancaster. The neurologist measured Lancaster's brain activity using an electroencephalography test. The test results were severely abnormal, showing very little brain activity. The neurologist also conducted a physical examination of Lancaster and noted the following:

- Unresponsive to noxious stimuli
- Comatose
- Slight corneal reflex
- No facial movement

At the conclusion of the examination, it was the neurologist's opinion that Lancaster had suffered from acute toxic encephalopathy, most likely due to ingestion of an unknown substance such as toluene, methanol, or ethylene glycol. The neurologist also believed the ingestion of the unknown substance had also caused severe metabolic acidosis and acute renal failure.

On July 26, 2014, at approximately 10:20 a.m., Lancaster's toxicology lab results were returned and showed a critically-high ethylene glycol level of 441 HH <10.0 mcg/mL. Ethylene glycol is a chemical commonly found in automobile anti-freeze.

Over the next several days, Lancaster remained in the ICU in a comatose state. She had frequent seizures and was continually sedated. WMCSA medical staff continued to treat Lancaster for metabolic acidosis, respiratory failure, sepsis syndrome, lactic acidosis, acute renal failure, and critical hyperkalemia. Lancaster's overall prognosis was extremely poor.

On July 29, 2014, at approximately 3:00 p.m., WMCSA medical staff consulted with Lancaster's family regarding continued medical care. Lancaster's mother signed a Do-Not-Resuscitate (DNR) order and, the following day, Lancaster's family decided to withdraw Lancaster's medical care.

On July 30, 2014, at approximately 7:30 p.m., Lancaster went asystole (no heart rhythm), in the ICU. WMCSA medical staff called for the ER doctor to pronounce her death per hospital protocol. At approximately 9:40 p.m., The ER attending physician responded to the ICU and evaluated Lancaster. He noticed that Lancaster had no pulse, was asystole, and was not breathing. After reading her medical chart and noticing that she had gone asystole at 7:30 p.m., he pronounced her death at that time.

Lancaster's sister was interviewed and she indicated that there were two plastic jugs of automobile anti-freeze in the garage of the residence where Lancaster was arrested. The two plastic jugs of anti-freeze were collected from the garage of the residence where Lancaster was arrested.

AUTOPSY

On Aug. 10, 2014, at approximately 9:00 a.m., a postmortem examination of Lancaster was conducted by Dr. Scott Luzi, a United Forensic Pathologist. During the examination, Dr. Luzi observed foaming in Lancaster's mouth, nose, and trachea. Dr.

Luzi also noted an enlarged brain and enlarged swollen lungs, which he concluded were consistent with someone who had overdosed with an opiate.

Dr. Luzi also concluded that if Lancaster ingested an unknown substance such as ethylene glycol, which is found in automobile anti-freeze, it could take up to 24 hours before actual physical symptoms took effect on her body. Dr. Luzi stated that vomiting and severe illness would occur, eventually leading to possible organ failure.

Following the autopsy, Dr. Luzi was unable to determine the preliminary cause of death and the results of his postmortem examination were inconclusive. The result of the toxicological examination listed below confirmed that Lancaster died as a result of ingesting ethylene glycol, a substance found in automobile anti-freeze.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Lancaster's ante-mortem blood was collected on July 23, 2014, and specifically tested for ethylene glycol. The following results and interpretations were documented:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethylene Glycol	Ante-mortem Blood	441.0 HH <10.0 mcg/mL

DNA Testing

A DNA examination of the two plastic jugs of anti-freeze collected from the garage of the residence where Lancaster was arrested revealed the presence of Lancaster's DNA on the rim of one of the jugs.

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

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 Lancaster 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). During Investigator Purser's entire contact with Lancaster, she never mentioned having any medical or psychiatric issues. Lancaster denied taking any prescription drugs or illegal narcotics, and she did not appear sick or injured in any way during their encounter. Lancaster was monitored frequently while incarcerated at the OCCJ, and staff responded to her in a timely fashion when she exhibited signs of distress. Finally, Lancaster's sister mentioned that there were two plastic jugs of automobile anti-freeze in the garage of the residence where Lancaster was arrested, and Lancaster's toxicology lab results showed a critically-high level of ethylene glycol, a chemical commonly found in automobile anti-freeze.

Thus, there is no evidence whatsoever to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty casing the death of Lancaster. In addition, there is no evidence whatsoever to show that Lancaster had access to ethylene glycol, a chemical commonly found in automobile anti-freeze, while she was in custody. Furthermore, and since it could take up to 24 hours after ingesting ethylene glycol for actual physical symptoms to appear, the evidence clearly supports the conclusion that Lancaster ingested the ethylene glycol before she was arrested by OCSD. This conclusion is made even stronger by the presence of Lancaster's DNA on the rim of one of the jugs of anti-freeze collected from the garage where Lancaster was arrested.

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 Lancaster most likely committed suicide and died as a result of voluntarily ingesting a toxic substance.

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

Respectfully submitted,

ROBERT GOODKIN
Deputy District Attorney
TARGET/Gang Unit

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