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May 30, 2013

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

Re: Custodial Death on November 26, 2011
Death of Inmate Gordon Thomas Lewis
District Attorney Case # S.A. 11-025
District Attorney Investigations Case # S.A. 11-025
Orange County Sheriff's Department DR # 11-213255
Orange County Crime Laboratory Case # 11-55791

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. 26, 2011, custodial death of inmate Gordon Lewis.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Lewis. 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 deputy of the Orange County Sheriff's Department (OCSD) or any other person under the supervision of the OCSD.

On Nov. 26, 2011, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center-Anaheim (WMCA) after Lewis died while being treated at the hospital after being taken into custody. The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD deputies or personnel. The OCDA will not be addressing 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 and evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the Orange County Crime Laboratory 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. Prosecutors assigned to the Special Prosecutions Unit review the non-fatal officer-involved shooting cases for possible criminal filings. Throughout the review process, the assigned prosecutor will be in consultation with his or her supervisor, and this Assistant District Attorney 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 May 23, 2011, Lewis was arrested by the Santa Ana Police Department for assault with a deadly weapon. Subsequently, the California Department of Corrections and Rehabilitation placed a parole revocation hold on Lewis. Lewis was then booked at the OCSD Intake/Release Center and later housed at the Theo Lacy Jail facility.

On Nov. 2, 2011, Lewis was transported by OCSD deputies to WMCA because of concerns of medical staff in the jail about Lewis' health. Lewis had several chronic conditions, including cirrhosis of the liver, for which he received medical care while he was a patient at WMCA. Lewis was released from WMCA and returned to OCJ on Nov. 7, 2011.

On Nov. 15, 2011, at 10:30 p.m., Lewis complained to a jail nurse of abdominal size abnormality and discomfort. After assessment by a nurse practitioner, Lewis was transported via ambulance to WMCA, where he was admitted at approximately midnight. Lewis was diagnosed with end-stage liver disease, which was causing fluid to build up in his abdomen. Lewis was kept and treated at WMCA until his death on Nov. 26, 2011.

On Nov. 25, 2011, Lewis began to experience multiple organ failure with a gastrointestinal bleed and was therefore transferred to the hospital's intensive care unit (ICU), where he received appropriate treatment. On Nov. 26, 2011, Lewis' heart rate dropped into the 40s (typically, a healthy heart rate is between 60 and 100 beats per minute). A "Code Blue" was called and, due to his condition, advance life savings (ALS) measures were initiated. ALS measures included cardiopulmonary resuscitation and providing the following medications: atropine, levophed, epinephrine, and calcium gluconate. At 4:22 p.m., because Lewis was non-responsive to ALS measures, the lack of heart activity and no pulse, the treating physician pronounced him deceased.

AUTOPSY

On Wednesday, Nov. 30, 2011, at approximately 1:00 p.m., the post-mortem examination of Lewis was conducted at the Orange County Sheriff-Coroner Forensic Science Center by Dr. Joseph Cohen, the former chief pathologist for Riverside County who is now employed by United Forensic Services, a company with whom Orange County contracts for services in OCSD custodial death cases. Dr. Cohen concluded that the cause of death was acute gastrointestinal hemorrhage, which was due to bleeding esophageal varices, which were due to cirrhosis of the liver, which were caused by chronic alcoholism.

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, it must be proven:

a. The person committed an act that caused the death of another person;
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 acted he 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;
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 *Girardo v. California Department of Corrections and Rehabilitation* (2008) 168 Cal.App.4th231,251, the court establishes that there is a "special relationship" between custodian and inmate:

> "The most important consideration in establishing duty is foreseeability. It is manifestly foreseeable that 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 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.

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

Dr. Cohen found that the cause of death was acute gastrointestinal hemorrhage due to bleeding esophageal varices, due to cirrhosis of the liver, due to chronic alcoholism. Thus, Lewis died of natural causes. There is no evidence of foul play, and thus no evidence of express or implied malice on the part of any OCSD deputy, any inmates or other individuals under the

supervision of OCSD, or WMCA staff. 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 OCSD owed inmate Lewis a duty of care, the evidence does not support a finding that this duty was breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). There is no evidence that OCSD or WMCA staff failed any duty of care in giving medical treatment Lewis. To the contrary, when Lewis's health deteriorated, OCSD and WMCA staff took action to address the situation. However, despite appropriate treatment for his condition, and ALS measures when his heart rate and blood pressure dropped, Lewis died of natural causes. All of the available evidence indicates that OCSD and WMCA staff properly fulfilled their duty of care in giving medical treatment to Lewis.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA and pursuant to the applicable legal principles, there is no evidence to support a finding of criminal culpability on the part of any OCSD or WMCA personnel or any individual under the supervision of OCSD. The evidence shows that Lewis died as a result of his deteriorating health, rather than due to the actions or inaction of others. Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully Submitted,

Jason Baez
Deputy District Attorney
Gang Unit

Read and Approved,

Dan Wagner
Assistant District Attorney
Homicide Unit