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May 31, 2013

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

Re: Custodial Death on October 12, 2011
Death of Inmate Steven Douglas Mott
District Attorney Investigations Case # S.A. 11-019
Orange Country Sherriff's Department Case # 11-185943
Orange County Crime Laboratory Case # FR 11-53793

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 Oct. 12, 2011, custodial death of inmate Steven Douglas Mott.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of inmate Mott. 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) deputy or any other person under the supervision of the OCSD.

On Oct. 12, 2011, Investigators from the OCDA Special Assignment Unit (OCDASAU) responded to Western Medical Center – Anaheim (WMCA) after inmate Mott died while in custody and while being treated at the hospital. 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 supported by additional 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 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 from 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 also 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

Mott was a 55-year-old male who had a history of drug and alcohol abuse that spanned many years. On Oct. 11, 2011, Mott was arrested by the Costa Mesa Police Department (CMPD) for a no-bail burglary warrant. Thereafter, Mott was transported to CMPD and booked for the warrant. Due to a leg and wrist injury, which Mott sustained during a prior traffic accident, he was transported to the Orange County Men's Jail Intake/Release Center (IRC) located at 550 North Flower Street in Santa Ana.

Upon arrival at the IRC, Mott was released to OCSD personnel. During the triage process at the IRC, Mott was evaluated by a Correctional Medical Services (CMS) registered nurse (RN). The RN indicated that Mott had physical injuries due to the prior traffic accident and that Mott was an alcoholic who may need detoxification. The RN then referred Mott to a CMS nurse practitioner (NP) for further evaluation.

The NP concluded that Mott had not consumed alcoholic beverages for five days, nor did he show signs of alcohol withdrawal symptoms. Based on her evaluation, the NP determined that Mott did not require the alcohol detoxification protocol. Since Mott had a history of alcoholism, however, the NP prescribed Thiamine and a multi-vitamin with folic acid. Due to Mott's physical injuries, he was assigned to the jail's medical ward, Ward D.

On Oct. 11, 2011, at approximately 11:30 p.m., another CMS RN observed an order for crutches for Mott. This RN contacted Mott and found he already had a walker. As the RN walked away from Mott's bunk, another inmate told the RN that he believed Mott had an alcohol problem and needed Serax (Oxazepam). The RN then asked Mott about his alcohol consumption, to which Mott replied that he drinks "a lot" of alcohol during the day.

The RN reviewed Mott's chart and observed an entry for the protocol for alcohol-related problems; however, it had been crossed out. The RN reviewed the notes, which were taken upon Mott's triage upon arrival to the facility, and observed that Mott stated he drinks six to seven "40s" a day. Although the RN did not observe Mott display any symptoms of alcohol withdraw, he believed Mott should be placed on the alcohol withdraw protocol due to his stated alcohol use on the triage notes. Mott was then placed on the alcohol withdraw protocol by a second NP, which included receiving a dose of Serax.

At approximately 11:35 p.m., the second RN brought Serax capsules and water to Mott and observed Mott ingest the medication. That RN later left the facility and did not have any further contact with Mott.

On Oct. 12, 2011, at approximately 2:30 a.m., Mott was experiencing Delirium Tremens (DTs) from alcohol withdraw. Mott was then evaluated by a third RN, who contacted a CMS medical doctor (MD) regarding Mott's condition. The MD recommended Mott be transported to WMCA for treatment.

At approximately 3:24 a.m. that same day, Mott was transported by ambulance to WMCA. Mott was referred to the emergency Room (ER) for evaluation at approximately 4:00 a.m.

A WMCA MD was assigned to treat Mott, and during the initial assessment, Mott claimed that he had been involved in a prior accident and sustained a knee injury. An X-ray computed tomography (CT) scan of Mott's head was negative for injuries and an x-ray of his knee did not reveal any fractures. At times, Mott appeared to be confused, distracted and hallucinating. The MD treated Mott and admitted him to the hospital due to DTs, dropping blood pressure, and dehydration. The MD explained that complications of DTs sometimes result in renal failure.

Due to Mott's condition, he was admitted into the Intensive Care Unit (ICU). During his transfer to the ICU, Mott's condition deteriorated further and he had to be intubated.

At approximately 8:10 p.m., the MD was called to the ICU at a request for assistance with Mott. When he arrived at the ICU, he observed Mott was pulseless and had no respirations. Advanced Life Support Protocol (ALS) was initiated and performed; however, Mott did not respond to these measures.

At approximately 8:36 p.m., the MD pronounced Mott deceased. This pronouncement was based on Mott being pulseless, a "flat line" reading on the heart monitor, no spontaneous respirations, and being unresponsive to all ALS measures.

AUTOPSY

On Oct. 16, 2011, at approximately 10:20 a.m., the post-mortem examination of Mott was conducted at the Orange County Sheriff-Coroner Forensic Science Center. The autopsy was conducted by Dr. Joseph Cohen, former chief pathologist for Riverside County. The autopsy revealed evidence of a fatty liver, enlarged spleen, esophagitis, and a bruised heart, which was consistent with receiving cardiopulmonary resuscitation. There were no signs of trauma or fractures.

Following the autopsy, Dr. Cohen concluded that the cause of death was due to complications of chronic alcoholism.

EVIDENCE ANALYSIS

Toxicological Examination:

DRUG	MATRIX	RESULT
Lidocaine, metabolite	Postmortem Blood	Detected
Methadone, metabolite	Postmortem Blood	Detected
Midazolam	Postmortem Blood	Detected
Lorazepam	Postmortem Blood	Detected
Oxazepam	Postmortem Blood	Detected

BACKGROUND INFORMATION

Mott's California criminal history was reviewed and considered.

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.

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 or she 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 death.

LEGAL ANALYSIS

Although the OCSD owed inmate Mott 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). Therefore, there is no evidence of express or implied malice on the part of any OCSD deputy 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.

Inmate Mott suffered from chronic alcoholism at the time he was placed in OCSD custody. Additionally, Inmate Mott went through medical screening at the time he was booked through the OC Men's Jail IRC on Oct. 11, 2011. Approximately 10 hours later, when it became apparent he needed medical attention, he was promptly transported by ambulance to WMCA, where he received further medical treatment. On Oct. 12, 2011, he was admitted into the ICU, where his condition deteriorated further and the doctor intubated him. Finally, later that day when the doctor was called into the ICU after a request for assistance with Mott, he observed that Mott was pulseless and had no respirations. Proper measures were then taken to resuscitate him, including ALS, however, Mott did not respond to these measures. There was no evidence of foul play on the part of any person who came into contact with Mott prior to his death.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA and pursuant to applicable legal principles, 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 OCSD. Evidence shows that inmate Mott died as a result of complications due to chronic alcoholism.

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

Respectfully Submitted,

Beth Costello
Senior Deputy District Attorney
Gang Unit

Read and Approved,

Dan Wagner
Assistant District Attorney
Head of Homicide Unit