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May 20, 2014

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

Re: Custodial Death on September 1, 2012
Death of Inmate Byron Ray Baker
District Attorney Investigations Case # 12-021
Orange County Sheriff's Department Case # 12-154970
Orange County Crime Laboratory Case # FR 12-53145
Orange County Sheriff's Coroner Case # 12-03402-MT
Orange County Fire Department Incident # 12-8199

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 September 1, 2012, custodial death of inmate Byron Ray Baker.

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 Byron Ray Baker ("Baker"). 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 Deputy ("OCSD") or any other person under the supervision of the OCSD.

On September 1, 2012, OCDA Special Assignment Unit ("OCDASAU") Investigators responded to the University of California, Irvine Medical Center ("UCIMC") after inmate Baker died in custody after receiving medical treatment 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. During the course of this investigation, OCDASAU interviewed 38 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 scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of the Orange County Sheriff's Department deputy 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 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. 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 and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

Baker was arrested on August 21, 2012. On September 1, 2012, Baker was housed in cell number 14, sector 19 of Module "L" at the Theo Lacy Jail Facility. Module "L has a total of six sectors; sectors 19, 20, 21, 22, 23 and 24 with 16 cells per sector. Sector 19 has a total of 16 two person cells. Baker was house with cellmate, Marco Ortiz ("Ortiz"). At approximately 1:40 a.m., OCSD Deputy Joseph Pawlikowski was working inside the Module "L" guard station when the emergency button from Baker's cell was activated. Using the intercom system, Deputy Pawlikowski spoke to inmate Ortiz who stated Baker was having a seizure and needed medical assistance. For safety reasons, Deputy Pawlikowski immediately called for a back up Deputy to assist entering sector 19. OCSD Deputy Peter Kim immediately responded and both deputies entered Baker's cell. Deputy Pawlikowski found Baker lying on the cell floor, partially under the fixed table and bench seat.

Deputy Pawlikowski immediately performed a visual inspection of inmate Ortiz and did not observe any blood, visible injury, or any evidence of Ortiz being involved in an assault. Deputy Pawlikowski also conducted a visual inspection of Baker's cell but did not find any evidence of a struggle or assault. Deputy Pawlikowski attempted to get Baker's attention by shouting his name and by shaking him but Baker was unresponsive. Baker's arms were pulled up close, stiff into his chest, with his fists clenched, as if in a state of rigor mortis. Deputy Kim used his flashlight to check Baker's pupil's for any reaction to light but found none. During the investigation, Deputy Pawlikowski found Baker to have a pulse but was not breathing. Deputy Pawlikowskil then requested the jail medical staff respond to assist Baker.

Deputy Kim stayed with Baker to await the arrival of the jail medical staff. Deputy Pawlikowski obtained a bag-valve mask ("BVM") and began giving Baker rescue breathes. Deputy Pawlikowski also called main control and requested assistance from the local fire department. Deputy Kim and Pawlikowski continued to monitor Baker's pulse and provide rescue breathes until jail medical and the fire fighters arrived. At approximately 1:44 a.m., Orange Fire Department ("OFD") was dispatched to Theo Lacy Jail to assist Baker. The OFD arrived at Theo Lacy at approximately 1:52 a.m. and were tending to Baker at approximately 2:02 a.m.

OFD Harley Shields observed Bakers eyes, nose, mouth and neck covered in what appeared to be emesis and vomiting. Shields intubated Baker and suctioned a heavy amount of apparent emesis from the endotracheal tube in an attempt to maintain an open airway. No medications were administered to Baker at this time except for a slow drip of less than 50 cc's of saline for purposes of preventing a blood clot. Two "fast pads" were positioned on Baker's torso area for preventative measures. At approximately 2:28 a.m. hours, OFD Rescue 5 transported Baker to UCIMC Emergency Room. During the transportation there was no significant change in Bakers vital signs. OFD rescue 5 arrived at UCIMC at 2:30 a.m. hours and relinquished care of Baker to UCIMC Emergency Room personnel. Baker was unresponsive upon his arrival at UCIMC. He "coded" twice, once before the Computed Tomogrpahy ("CT") scan and once after. While in the emergency room, a neurosurgeon inserted an external ventricular device ("EVD") into Baker's brain to drain the hematoma. Baker was unresponsive to any commands. He was given Levophed and Dopamine in order to keep his blood pressure and heart rate up. Baker was on life support with one hundred percent oxygen through a pressure control ventilator. Baker's blood pressure was stabilized, his heart rate was regular with occasional irregularity, and his body temperature was extremely

cold. Baker was put through the process of warming the patient in order to further determine neurological status of the patient. After the process, Baker was found to have no gag reflex, no response to painful stimuli and no cornea reflex. It was determined that no sign of life existed. Several more tests were conducted which showed that Baker had minimal lower brain stem reflexes. Dr. Johnny Delashaw, head of UCIMC's Neurosurgery department, concluded that Baker's prognosis was poor and surgery was not an option. Baker's family was advised of his poor condition and decided on a "no code" to withdraw life support. At 6:45 p.m. Baker was pronounced deceased. An extensive visual examination of Bakers body was later conducted, upon which no indication of traumatic injury was found. The tentative cause of death was consistent with a ruptured cerebral artery aneurism at the base of the brain.

INTERVIEWS

A total of 38 witnesses were interviewed in this case. Among those interviewed was inmate Jose Medrano ("Medrano"). Medrano had attended bible study earlier on September 1, 2012 with Baker. Medrano stated he spoke to Baker during bible study but was unaware of any issues Baker had with any other inmates or staff. Inmate Arturo Gonzalez ("Gonzalez") indicated he had several conversations with Baker but Baker never disclosed any medical issues or any other problems with any inmates. Inmate Ryan LeFevre ("LeFevre") indicated Baker had mentioned to him that Baker was not getting along with his cellmate and they were "butting heads." However, inmate Jason Leibl ("Leibl"), an inmate in the neighboring cell to Baker, spoke with Baker hours prior to the incident and stated that Baker was "upbeat" and did not mention any problems with his cellmate or any medical issues. Leibl was lying in is bunk when he heard Ortiz yelling, "Byron, Byron," and heard Ortiz push the emergency button and call for medical assistance. Leibl also heard Ortiz tell the jail staff that Baker was having a seizure. Leibl never mentioned ever hearing any verbal or physical altercation between Ortiz and Baker. Inmate Ortiz indicated he had been Baker's cellmate for approximately two weeks. On September 1, 2012, Ortiz went to bed between 10:30 p.m. and 11:00 p.m. Ortiz awoke and found Baker lying on the floor having an apparent seizure. Ortiz stated he immediately pushed the emergency button to call the jail deputies to render medical assistance.

AUTOPSY

On September 5, 2012, at approximately 9:27 a.m., the post-mortem examination of Mr. Baker 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 there were no signs or indications of any traumatic injury on the interior or exterior of the body. There were no skull fractures, epidural or subdural hemorrhage. Dr. Cohen did note fibrosis of the liver and a fine line fracture of the fourth rib on the left side, possibly from cardiopulmonary resuscitation. The right frontal ventriculostomy tube was a therapeutic procedure performed by a medical doctor for purposes of draining fluid or minimizing pressure to the brain. Dr. Cohen noted the brain was swollen and the distribution of blood in the brain was consistent with a ruptured aneurism.

Following the autopsy, Dr. Cohen concluded that the cause of death was a ruptured cerebral artery aneurism at the base of the brain.

EVIDENCE ANALYSIS:

Toxicological Examination:

DRUG	MATRIX	RESULTS
Morphine	Postmortem blood	0.030 mg/L
Fentanyl	Postmortem blood	0.007 mg/L
Hydroxyzine/Buclizine metabolite	Postmortem blood	Detected
Lorazepam	Postmortem blood	Detected
Phenytoin	Postmortem blood	Detected

BACKGROUND INFORMATION

Baker'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.

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

There is no evidence 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 case is murder or manslaughter under the theory of failure to perform a legal duty. Although the OCSD owed inmate Baker 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 voluntary manslaughter). Therefore, there is no evidence of express or implied malice on the part of any OCSD deputy or any 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.

Baker suffered a ruptured cerebral artery aneurism at the base of the brain. Baker's cellmate called for emergency medical assistance upon discovering Baker having a seizure. OCSD Jail staff responded quickly and immediately requested additional medical support from OFD. OFD provided medical treatment and immediately transported Baker to UCIMC, where he was then treated in the neurosurgery unit. Baker showed no internal or external signs of injury or trauma consistent with an attack, assault or any type of foul play. There was no evidence of any type of assault inside of Baker's cell or any type of injury or trauma on Baker's cellmate. In fact, Baker's cellmate was the person who alerted and called the jail staff for assistance. The facts and evidence are consistent with the coroner's conclusion that Baker died from a ruptured cerebral artery aneurism at the base of the brain. Thus, 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.

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 personnel or any individual under the supervision of OCSD. The evidence shows that Baker died as a result of a ruptured cerebral artery aneurism at the base of the brain.

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

Respectfully Submitted,

RAHUL GUPTA
DEPUTY DISTRICT ATTORNEY,
GANG UNIT

Read and Approved,

MARC ROZENBERG
Assistant District Attorney,
GANG UNIT