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

JIM TANIZAKI
CHIEF ASSISTANT D.A.

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

SCOTT ZIDBECK
SENIOR ASSISTANT D.A.
VERTICAL PROSECUTIONS/
VIOLENT CRIMES

PAUL M. WALTERS
CHIEF
BUREAU OF INVESTIGATION

JENNY QIAN
DIRECTOR
ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER
CHIEF OF STAFF

November 29, 2017

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

Re: Custodial Death on May 23, 2017
Death of Inmate Orville Thomas Kangas
District Attorney Investigations Case # SA 17-015
Orange County Sheriff's Department Case # 17-019704
Orange County Crime Laboratory Case # 17-49050 and 17-49425

Dear Sheriff Hutchens,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the above-listed incident involving the May 23, 2017, custodial death of 69-year-old inmate Orville Thomas Kangas.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Kangas. 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 in connection with the death of Kangas.

On May 23, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC), where Kangas died shortly after being released from OCSD custody with credit for time served. During the course of this investigation, the OCDASAU interviewed four witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs and videos, 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 did not address 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, TARGET/Gangs, and Special Prosecutions Units review fatal, as well as non-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 the Assistant District Attorney supervising the Special Prosecutions Unit, who 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

Kangas was a 69-year-old male with a prior medical history of alcoholic liver cirrhosis, esophageal varices with a prior gastrointestinal bleed, and hypertension.

On May 13, 2017, Garden Grove Police Department (GGPD) officers arrested Kangas at his home for vandalism. Kangas was taken to GGPD where he was medically screened. Kangas stated he had back and joint problems, but that he did not require medical care at the time. At approximately 10:52 p.m., Kangas was booked into Orange County Jail (OCJ) where he was medically screened and placed on a detox protocol for alcoholism.

On May 14, 2017, Kangas was sent to the OCGMC for abdominal discomfort that, according to him, started before his arrest. Kangas reported to the emergency room personnel that he had been binge drinking for the last four days, and he was treated for gastrointestinal bleeding. On May 16, 2017, at approximately 8:40 p.m., Kangas returned to OCJ.

On May 17, 2016, at approximately 10:00 a.m., Kangas pled guilty to the vandalism charge in Department CJ-1 of the Superior Court, and he was sentenced to 20 days in OCJ and three years informal probation. At the time of his plea, Kangas had credits for 10 days jail, and had approximately five additional days of actual jail time to serve. Upon his return to the jail, Kangas was re-housed in the infirmary for symptoms of alcohol withdrawal.

On May 21, 2017, at approximately 1:30 p.m., Kangas informed the attending Registered Nurse (RN) he had a "splitting headache." The RN gave Kangas Tylenol. Approximately two minutes later, Kangas vomited and the RN gave Kangas Zofran to help the vomiting as well as more Tylenol since Kangas threw up the first dose. A second RN responded to assist in treating Kangas. Shortly after vomiting, Kangas became very lethargic and stopped responding verbally. Each time an RN asked Kangas how he felt, Kangas responded with a thumbs-up sign. Kangas had difficulty using the bathroom on his own. Soon his eyes remained closed, he appeared to be in a deep sleep, and it sounded like he was snoring. The RN reported that Kangas' vital signs were unstable—his blood pressure and pulse were high—and his legs were stiff. Kangas' blood sugar was also elevated, so the RN gave him Gatorade to prevent dehydration. One of the attending RN called the Nurse Practitioner for assistance, and then placed Kangas in a wheelchair, escorted him to the dispensary area of the Medical Housing Unit (MHU), and took his vital signs again, which were now very elevated. Kangas was placed on a gurney and an attending RN started an intravenous line. Kangas' condition remained the same, and Paramedics were dispatched to the scene at approximately 2:08 p.m.

The attending RN reported he never observed Kangas fall or sustain an injury and did not receive any information indicating that he had. In addition, the RN did not receive any information indicating Kangas had been involved in a physical fight or confrontation with any inmates or jail staff. The RN examined Kangas and did not observe any external injuries or trauma to any portion of his body, head, or face. According to the RN, Kangas got along well with inmates and jail staff. While his medical

chart indicated his gait was unsteady, Kangas told medical staff he did not need a walker. Prior to this incident, the RN observed that Kangas was "walking slow, but he was walking good."

While the RN was not aware of any incident where Kangas fell, jail video footage shows Kangas falling on two occasions. Both falls appear to be minor and do not involve Kangas hitting his head. On May 21, 2017, at approximately 1:19 p.m., Kangas slipped and fell to the ground on his buttocks while attempting to sit on his bed in the infirmary. Two inmates then helped Kangas back up. At approximately 1:33 p.m. on that same date, Kangas stumbled to the ground as two inmates escorted him to the bathroom. Kangas landed on his right side, breaking the fall with his arm and by bending his knee. Both inmates immediately helped Kangas up, and then the RN arrived and placed Kangas in a wheelchair.

On May 21, 2017, paramedics arrived at approximately 2:14 p.m. Kangas was in the same non-responsive condition observed by the RN. One paramedic examined Kangas and did not observe any injuries or trauma to his body or head. Paramedics observed Kangas was showing signs of neuro-deficits and suspected he was suffering from a neuro-hemorrhage. The Paramedics transported Kangas to the OCGMC, arriving at approximately 2:43 p.m.

At OCGMC, a computed tomography (CT) scan of Kangas' brain revealed a large, left side, subdural-hematoma and mid-line shift. The attending physician examined Kangas and noted his pupils were unequal in size and non-responsive to stimulus. Kangas also did not respond to pain stimulus. The attending physician looked for exterior injuries to Kangas' head, including the area of the subdural-hematoma, but did not find any. The attending physician also did not observe any exterior injuries or trauma to Kangas' body. Due to Kangas' poor health and fragile condition, it was determined Kangas was a poor candidate for any neurological surgery and his prognosis for recovery was poor. The attending physician reported Kangas' platelets were low and his coagulation profile was deranged. A second CT scan revealed that Kangas' hemorrhage was still present and the mid-line shift had actually worsened. Consequently, the attending physician and other surgeons determined that Kangas' best option was supportive care.

On May 22, 2017, at approximately 1:44 a.m., Kangas was released from OCSD's custody with credit for time served, although he was still hospitalized and on life-support. On May 23, 2017, members of Kangas' family signed a "do not resuscitate" document and requested further medical care for Kangas be withdrawn. At approximately 10:16 a.m., Kangas was given morphine, extubated, and medical care was stopped. The attending physician pronounced Kangas deceased at approximately 11:17 a.m. on May 23, 2017.

AUTOPSY

On March 1, 2017, independent Forensic Pathologist Dr. Scott A. Luzi of Clinical and Forensic Pathology Services conducted an autopsy on the body of Kangas. Dr. Luzi found no external injuries to the head or face, and no skull, face, or jaw fractures. Dr. Luzi did observe minor bruises to the right and left shins. According to Dr. Luzi, there were injuries around and to the brain consistent with a fall. However, according to Dr. Luzi none of these injuries were consistent with a physical confrontation. The autopsy revealed Kangas had cirrhosis of the liver and a diminished ability to clot blood. Dr. Luzi determined that the cause of Kangas' death was due to bleeding of the brain from accidental blunt force injuries to the head.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Kangas' postmortem blood collected during the autopsy yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Carboxy-THC	Postmortem Blood	0.0114 + 0.0014 mg/L
Citalopram	Postmortem Blood	0.379 + 0.068 mg/L
Levetiracetam	Postmortem Blood	Detected

Morphine (Free)	Postmortem Blood	0.279 + 0.034 mg/L
Norcitalopram	Postmortem Blood	Detected
THC	Postmortem Blood	0.0103 + 0.0013 mg/L

BACKGROUND INFORMATION

Kangas had no criminal history prior to his arrest and conviction for the above listed vandalism.

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 there is a "special relationship" between jailer and prisoner:

> "The most important consideration 'in establishing duty is foreseeability.' 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 provides 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

In the present case, 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 Kangas 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). At the time Kangas was placed in custody with OCSD, he had several pre-existing and life-threatening medical conditions, including alcoholic liver cirrhosis, esophageal varices with a prior gastrointestinal bleed, and hypertension. Kangas was medically screened and treated according to established medical protocol. Less than 24 hours after being placed in custody, Kangas was transported to the hospital for a pre-existing medical condition and treated for gastrointestinal bleeding. Shortly after returning to the jail, he was placed in the infirmary where he could easily access and be monitored by medical staff.

OCJ staff did not observe or receive any information indicating that Kangas had sustained an injury or was involved in a physical altercation while at the jail. The jailhouse footage shows Kangas falling twice while in the infirmary. However, the falls were very minor and do not involve Kangas hitting his head. When Kangas complained of a headache on May 21, 2017, he was treated by OCJ medical personnel. When Kangas became unresponsive to questioning and appeared to be in an altered mental state, he was promptly transported in an ambulance to a local hospital. The treating physicians determined that Kangas suffered a subdural-hematoma and mid-line shift. Because surgeons determined Kangas was a poor candidate for any neurological surgery and his prognosis for recovery was poor, he received supportive care. Kangas' family then signed a "do not resuscitate" form and requested medical care be withdrawn. Medical care was subsequently stopped and Kangas was pronounced deceased shortly thereafter.

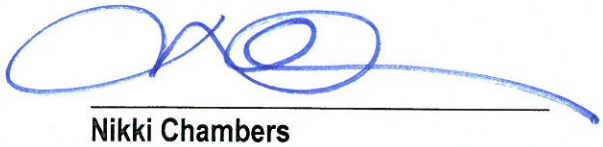
Kangas had no visible signs of trauma or injury consistent with an attack or any type of foul play. There was no evidence of any altercations between Kangas and other inmates or jail staff. The facts are consistent with the forensic pathologist's conclusion that Kangas died from bleeding of the brain. All available records support the conclusion that the OCSD met its legal duty with the appropriate standard of care. Thus, there is no evidence whatsoever to support a finding that any OCSD personnel or any individual under OCSD supervision failed to perform a legal duty.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion 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.

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

Respectfully submitted,



Nikki Chambers
Deputy District Attorney
Special Prosecutions Unit

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