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November 28, 2017

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

Re: Custodial Death on April 16, 2017
Death of Inmate Rajan Magarati
District Attorney Investigations Case # S.A. 17-012
Orange County Sheriff's Department Case # 17-014593
Orange County Crime Laboratory Case # 17-46621
Orange County Sheriff-Coroner's Office Case # 17-01874-EK

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 April 16, 2017, custodial death of 42-year-old inmate Rajan Magarati.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Magarati. 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 April 16, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the OCSD Theo Lacy Facility (TLF), where Magarati died while in custody. During the course of this investigation, the OCDASAU interviewed eight witnesses, as well as obtained and reviewed reports from the OCSD, Orange County Sheriff-Coroner's Office (OCCO), and Orange County Crime Laboratory (OCCL), medical records, 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, 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

Magarati was a 42-year-old male. Beginning in 1996, Magarati experienced seizures, fainting spells, and severe headaches. After an MRI examination, Magarati was diagnosed with a brain tumor in 2005, which was deemed inoperable. The tumor was not biopsied, but Magarati did receive radiation therapy. In 2009, Magarati travelled to New York and obtained another MRI examination. It was confirmed Magarati's brain tumor was inoperable, and he was given anti-seizure medication. In 2012, Magarati moved to California and he continued to take his medication, but did not follow up with treatment for his tumor.

On July 25, 2016, Magarati was struck by a car while crossing the street. Magarati was transported to the hospital and was diagnosed with two bone fractures. One of the fractures required surgery. Magarati underwent another MRI examination, which showed the continued presence of a brain tumor. Medical records indicated the tumor was progressing.

On Nov. 2, 2016, Magarati was admitted to the hospital for a rapid heart rate and pulmonary infection. A physician at the hospital discussed treatment of Magarati's tumor and noted a biopsy and treatment were needed immediately. Magarati declined a biopsy in the hospital, but said he was in contact with his New York doctors regarding his treatment and would obtain a biopsy at a later time. Magarati was discharged on Nov. 18, 2016, and he was prescribed blood thinner medication. Magarati was transported to a skilled nursing facility, but the location and duration of his stay are unknown.

On January 4, 2017, Magarati was arrested by the Anaheim Police Department for domestic violence. He was transported to the Orange County Jail (OCJ) and initially housed at the OCJ Central Men's Jail Complex. On Feb. 7, 2017, Magarati was transferred to the OCJ's Theo Lacy Facility. On March 21, 2017, Magarati was transferred to a four-man cell in Module O, a 24-hour observation medical unit. Magarati had been prescribed an anti-seizure medication called Levetiracetam (Keppra), which he continued to receive in jail.

On March 29, 2017, an Orange County Healthcare Agency (HCA) doctor examined Magarati and prescribed blood thinner medication for his pulmonary issues. Due to potential complications from the blood thinners, the doctor recommended Magarati be placed in a single-man cell. Magarati was moved to a single-man cell in the same Module.

On April 15, 2017, the day before his death, at approximately 7:00 p.m., Magarati came out of his cell to take his medication. During a routine inspection later that evening, deputies did not note anything unusual in Magarati's cell.

On April 16, 2016, at 12:30 a.m., an OCSD deputy confirmed Magarati was in his cell. During a routine check at approximately 3:00 a.m., a deputy knocked on Magarati's cell door. Magarati woke and sat up, and the deputy did not notice anything unusual in Magarati's cell. At approximately 4:00 a.m., breakfast was served and the doors to the cells in Module O were remotely unlocked. Magarati was contacted via the intercom system in his cell and he advised that he did not want breakfast. Magarati did not come out of his cell. Deputies did a visual check of Magarati's cell at 5:15 a.m. and 6:15 a.m., respectively, and did not notice anything unusual.

At approximately 7:20 a.m., a Licensed Vocational Nurse (LVN), escorted by Deputy Frank Liu, dispensed medication throughout Module O. At approximately 7:33 a.m., the LVN called Magarati by name from outside his cell. Magarati did not

answer. Deputy Liu entered Magarati's cell and shook his shoulder. Magarati was unresponsive. Deputy Liu saw that Magarati was not breathing and was unable to detect a pulse. Deputy Liu alerted the LVN, who was outside the cell, and the LVN activated the emergency medical response system.

At approximately 7:35 a.m., the LVN performed cardio pulmonary resuscitation (CPR) chest compressions. Another LVN arrived and set up the automated external defibrillator (AED), but the AED did not advise a shock to be administered. Deputy Liu initiated CPR respirations with an Ambu bag. Emergency resuscitation efforts continued until relieved by Orange Fire Department (OFD) personnel at approximately 7:39 a.m. An OFD Paramedic administered medication, but noted that Magarati had no blood pressure, heart rate, or respirations, and appeared to have been deceased. The Paramedic contacted the UCI Medical Center and relayed Magarati's vital signs and the medical treatment performed. The attending physician instructed them to continue CPR. After approximately one hour of unsuccessful CPR and no signs of life, the physician declared Magarati deceased at 8:05 a.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Bloodstain standard
- Muscle standard

AUTOPSY

On April 19, 2017, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Magarati. The pathologist found no evidence of major injuries or trauma. The autopsy revealed a mass in the left frontal lobe, with associated cerebral edema and Duret hemorrhages. Dr. Luzi concluded that Magarati died from natural causes as a result of his brain tumor.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Magarati's postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Acetaminophen (Free)	Postmortem Cardiac Blood	Detected
Levetiracetam (Keppra)	Postmortem Cardiac Blood	14 mcg/mL

BACKGROUND INFORMATION

Magarati had a State of California Criminal History record that revealed arrests for the following violations:

- Willful cruelty to a child
- Infliction of corporal injury to spouse
- False Imprisonment
- Disorderly Conduct

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 provides 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 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 in this case of express or implied malice on the part of any OCSD personnel 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 Magarati 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).

Magarati had suffered from neurological difficulties since 1996, and was diagnosed with an inoperable brain tumor in 2005. Prior to Magarati's arrest on January 4, 2017, he had been treated in Nepal and New York for his brain tumor, which was deemed inoperable. Magarati received radiation and was given anti-seizure medication. An MRI taken months before Magarati's incarceration indicated that the tumor was progressing. During his stay at the hospital in November 2016, Magarati was advised to undergo a biopsy and get immediate treatment. Magarati declined a biopsy or surgical intervention.

Magarati had been prescribed an anti-seizure medication called Levetiracetam (Keppra), which he continued to receive in jail. Medical records show that Magarati received ongoing medical care while in custody, which included continuous monitoring of his medication and his transfer to a 24-hour observation medical unit. A single-man cell was later recommended to maintain his safety because Magarati was prescribed blood thinner medication. There is no evidence to suggest Magarati stopped receiving or taking his medication. Similarly, there is no evidence to suggest a failure in providing Magarati his medication as required.

OCSD personnel within Module O conducted regular checks on all inmates, including Magarati, to ensure their safety and wellbeing. Magarati behaved appropriately and did not complain of medical issues the day before his death. On the morning of his death, Magarati awoke at 3:00 a.m. during the deputies' routine check. Magarati also verbalized he did not want breakfast at 4:00 a.m. Deputies did additional visual checks at 5:15 a.m. and 6:15 a.m. and did not notice anything unusual.

At approximately 7:30 a.m., during the routine dispensation of medication, Magarati was found lying on his bunk, not breathing and without a pulse. Nurses, deputies and paramedics attempted to revive Magarati with CPR and assisted breathing for approximately one hour, but were unsuccessful. A forensic pathologist deemed the cause of death to be a result of Magarati's brain tumor. 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, or caused the death of Magarati.

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 Magarati died as a result of an inoperable, pre-existing brain tumor.

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

Respectfully submitted,

ERIN ROWE
Deputy District Attorney
Special Prosecutions Unit

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