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April 2, 2018

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

Re: Post-Custodial Death on August 18, 2017
Death of Inmate Rick Lee Rose
District Attorney Investigations Case # 17-023
Orange County Sheriff's Department Case # 17-032582
Orange County Crime Laboratory Case # 17-54739

Dear Sheriff Hutchens,

Please accept this letter detailing the investigation and legal conclusion of the Orange County District Attorney's Office (OCDA) in connection with the above-listed incident involving the Aug. 18, 2017, post-custodial death of 61-year-old inmate Rick Lee Rose.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the post-custodial death of Rick Lee Rose. 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 Aug. 18, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to an apartment on the 2100 block of Orange Avenue in Costa Mesa where recently released inmate Rick Lee Rose died soon after being released from custody. During the course of this investigation, the OCDASAU interviewed two 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 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 post-custodial deaths within Orange County when an individual dies within 24 hours of release from 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

On June 22, 2017, Rose was arrested by the OCSD for violations of Vehicle Code § 23152(b), driving under the influence of alcohol, and Vehicle Code §14601.2(a), driving with a suspended license. Rose was booked into the Orange County Jail (OCJ) without incident. While in custody, Rose was housed in a single-person cell and had no documented fights, conflicts, or altercations with any other inmates or OCJ staff.

On Aug. 17, 2017, at approximately 7:24 p.m., Rose was released from custody from OCJ. At approximately 9:00 p.m., Rose's girlfriend picked up Rose and an acquaintance from a nearby bus stop. They transported the acquaintance from Santa Ana to Fountain Valley and then drove to a McDonald's restaurant for dinner. After consuming their meals, they continued to their apartment on Orange Avenue in Costa Mesa. They arrived at the apartment approximately 30 minutes later. Upon their arrival, Rose told his girlfriend that he was having intestinal problems, did not feel well, and was very tired. Rose excused himself to the restroom, took a Xanax pill that was prescribed to him, then laid down in the bedroom and fell asleep. Rose's girlfriend did not observe Rose use any illicit drugs.

On Aug. 18, 2017, at approximately 2:00 a.m., Rose's girlfriend attempted to awaken Rose in order to move him across the bed. However, she was unable to do so. To her, it appeared as if Rose "was in a coma." She could not wake him up and was unable to obtain responses to her questions. However, since she observed that Rose was still breathing, she took no further action and went to sleep. At approximately 12:00 p.m., Rose's girlfriend awakened and observed that Rose was still lying in the same position on the bed. His eyes were closed and he still appeared to be sleeping. However, she noticed that he was now making gurgling sounds as he breathed. Upon closer examination, she noticed that Rose had fallen asleep with his dentures in place. She adjusted the dentures in an attempt to improve his breathing but her efforts had no effect; the gurgling sounds continued. Shortly thereafter, Rose's girlfriend left the bedroom to take a phone call from a friend. At around 12:30 p.m., Rose's girlfriend returned to the bedroom where Rose was sleeping and observed that Rose was not breathing. His eyes were open and he felt cold to the touch. Rose's girlfriend attempted to perform Cardio Pulmonary Resuscitation (CPR) before calling 911, but her attempts were unsuccessful. Rose remained unresponsive.

At approximately 1:48 p.m., Costa Mesa Fire Department (CMFD) paramedics arrived and assumed medical care of Rose. They observed that Rose had no pulse, was not breathing, and had rigor mortis in his jaw. They also noted that Rose's pupils were fixed and dilated. A Costa Mesa Police Department officer applied electrocardiogram monitoring strips to Rose, and attempted to use an Automatic External Defibrillator (AED). However, due to Rose's condition, the instrument did not advise to administer a shock. Additionally, it was apparent to the responding paramedics that Rose had been deceased past the point where lifesaving efforts would have been effective. As a result, no further lifesaving efforts were performed. Rose was pronounced deceased at approximately 1:49 p.m.

CMFD paramedics and responding officers noted that Rose had skin ulcers and obvious signs of previous intravenous and intra-muscular injections in his arms, legs, and feet consistent with intravenous drug use. Prescription bottles bearing Rose's name for Gabapentin, Verapamil ER, Cyclobenzaprine, and Amitriptyline HCL, were also observed near Rose on the

bedroom's nightstand. Additionally, officers located plastic packaging material, with brown heroin residue, in a trashcan near Rose's body.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Apparent plastic with brown residue

AUTOPSY

On Aug. 22, 2017, independent Forensic Pathologist Dr. Scott A. Luzi conducted an autopsy on the body of Rose. The preliminary examination of Rose revealed that Rose suffered from myosclerosis, hypertension, and an enlarged heart. Dr. Luzi found no signs of major or minor injuries to Rose's body that would otherwise indicate the application of force. Instead, Dr. Luzi noted that Rose had a history of drug abuse, which included the use of heroin, and other associated pre-existing conditions such as cardiomegaly, cerebral edema, hepatitis C, HIV 1, moderate coronary atherosclerosis, moderate peripheral atherosclerosis, nephrosclerosis, and pulmonary congestion and edema. Following the autopsy, Dr. Luzi concluded the manner of death was an accident, and that the cause of death was acute intoxication resulting from heroin use.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Rose's postmortem blood was collected for testing. The blood was examined by the OCCL for the presence of drugs and alcohol. The following results and interpretations were documented:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Norverapamil	Postmortem blood	Detected
Verapamil	Postmortem blood	Detected
6-Monoacetylmorphine	Vitreous Humor	Detected
Codeine (Free)	Brain	Detected
Morphine (Free)	Postmortem blood	0.0472 ± 0.0057 mg/L
	Brain	0.147 ± 0.018 mg/kg
	Vitreous Humor	Detected

BACKGROUND INFORMATION

Rose had a State of California Criminal History record that revealed arrests and/or convictions dating back to 1974 for the following violations:

- Attempted murder
- Exhibiting a firearm in the presence of a peace officer
- Assault with a deadly weapon on a peace officer
- Felon in possession of a firearm
- Escape from jail
- Inciting a riot
- Robbery and Burglary
- Petty theft and Receiving stolen property
- Driving under the influence and being under the influence of a controlled substance
- False identification to a peace officer
- Forgery
- Carrying a concealed dirk or dagger

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.' 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 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

In this 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 Rose 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).

Rose suffered from numerous pre-existing medical conditions at the time he was placed in custody. However, Rose's death occurred after his release from custody and apparently resulted from drugs he ingested post-release. During the booking process, Rose underwent, and successfully completed, a medical screening interview where medical service personnel reviewed his medical history and interviewed Rose to determine if he had any immediate medical concerns that required treatment. From the time Rose was booked, to the time he was released, Rose did not complain of any immediate health issues to OCSD personnel. Rose did not request, nor was he denied, any medical care while he was incarcerated. Additionally, there was no indication to OCSD personnel that, once released from custody, Rose planned to ingest a lethal quantity of heroin immediately upon his arrival at his apartment.

There is also no evidence whatsoever to support a finding that any OCSD personnel or any individual under the supervision of the OCSD were criminally negligent. Criminal negligence is established when a person acts in a reckless manner that creates a high risk of death or great bodily injury, and a reasonable person would have known that acting in that manner would create such a risk. Here, there is no evidence that any OCSD personnel or anyone under their supervision acted in a reckless manner. The OCSD took active steps to ensure that any of Rose's potential medical needs were met while he was in custody. OCSD personnel did not do anything, intentionally or negligently, to exacerbate any of Rose's pre-existing conditions at any time.

The facts of this case are consistent with the pathologist's conclusion that Rose's death was the result of an accidental drug overdose from substances ingested after Rose's release from custody. All available records support the conclusion that the OCSD met its legal duty to Rose, with the appropriate standard of care, during the time their duty of care was owed. Therefore, there is no evidence to support a finding that any OCSD personnel, or any individuals under the supervision of the OCSD, were criminally negligent or failed to perform a legal duty owed to Rose.

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 that Rose died as a result of an accidental drug overdose after he was released from custody. Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,

JEFFREY KIRK
Deputy District Attorney
Special Prosecutions Unit

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