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October 11, 2016

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

Re: Custodial Death on Jan. 23, 2016
Death of Inmate Timothy Willard Reece
District Attorney Case #SA 16-003
Orange County Sheriff's Department Case #16-017635
Orange County Crime Laboratory Case #16-41213

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 Jan. 23, 2016, custodial death of 49-year-old inmate Timothy Willard Reece.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Reece. 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 Jan. 23, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Jail where Reece died while in custody at the medical unit in the jail where he was receiving medical treatment. During the course of this investigation, the OCDASAU interviewed seventeen 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 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

On Jan. 21, 2016, at 10:40 p.m., Orange Police Department (OPD) police officers observed Reece lying down outside of a store drinking an alcoholic beverage from a brown paper bag. Reece identified himself and stated that there was a warrant for his arrest. Reece had two outstanding warrants for his arrest, and he was arrested and transported to the OPD for booking.

On Jan. 22, 2016, at 1:29 a.m., OPD officers transported Reece to the Orange County Jail (OCJ.) At the OCJ Intake Release Center, Reece underwent a medical assessment. His blood pressure reading was 152/107 and his pulse rate was 60 beats per minute. He stated that he drank vodka and beer daily, had a seizure disorder with his last seizure occurring two weeks prior and had been previously given a prescription for phenobarbital but last took the medication eight months prior. Reece further stated that he had been shot in the head 18 years ago and had been suffering from scabies for the last three months. Reece's urine drug screen was positive for THC and barbiturates. At approximately 1:47 a.m., Reece was cleared for regular housing with a request that he be assigned to a low bunk by the medical staff and placed on withdrawal orders for alcohol. Reece was cleared for standard booking and housing procedure at OCJ.

At approximately 6:00 a.m., an OCSD deputy observed Reece in an identification cell and he appeared to be okay. Reece received medication at approximately 12:30 p.m. At that time, several inmates that were housed with Reece were complaining that he was acting bizarre and weird and they did not want Reece housed with them. At 2:36 p.m., Reece was moved to a separate identification cell by himself for his safety. At approximately 2:58 p.m., Reece was escorted to his housing location by an OCSD deputy. Reece was having difficulty walking and the deputy held the back of Reece's shirt to prevent him from falling. It was determined that Reece could not be housed in the regular housing unit due to his condition.

At approximately 3:09 p.m., Reece was escorted to the second floor medical triage area of the main jail where deputies took control of Reece. Deputies informed a registered nurse that Reece needed to be seen because he could not be housed in a regular housing unit. At approximately 3:22 p.m., the nurse performed an assessment on Reece. She noted that Reece, who was sitting in a wheel chair, appeared groggy and sleepy. Reece's lower legs had signs of edema, his pulse rate was 100 beats per minute, and his blood pressure was "borderline" which the nurse stated was not unusual for an individual abusing alcohol. Reece's speech was slurred, but he was able to answer questions correctly. Reece was not showing signs of body tremors, being agitated, or suffering from hallucinations. Reece continuously fell asleep and had to be woken up. The nurse gave Reece water so he could hydrate himself, but he was unable to tilt his head back to drink the water due to his condition. The nurse stated that Reece possibly drank a cup of water while he was being assessed. The nurse determined that Reece was not fit for regular housing. The nurse contacted the medical doctor on duty who requested that Reece be assigned to the Medical Observation Unit (MOU) so that he could be seen by a doctor the next morning. The MOU is a 24-hour observation unit for inmates with medical conditions including seizure disorders and alcohol withdrawal. There is a nurse and a deputy station with windows that have a clear view of the inmates.

At approximately 3:58 p.m., Reece was moved to the dispensary exam room to be assessed for admission in the MOU. At 4:09 p.m., deputies moved Reece to the MOU for treatment and observation. In the MOU, Reece was placed on alcohol protocol which required that he be assigned to a low bunk and prescribed Serax medication. Reece received 30 milligrams of Serax medication three times that day and his vital signs were checked two to three times that day. At approximately 7:55 p.m., a nurse in the MOU gave Reece his medication and took his vital signs. Reece's vital signs were in the normal range; he was alert, oriented, and able to sit up and follow directions. At approximately 10:00 p.m., a nurse practitioner advised the nurse to continue monitoring Reece and to encourage him to take fluids.

While in the MOU, the nurse checked Reece's body position visually from inside the nursing station. Every 35 to 45 minutes, the nurse physically checked on Reece. Occasionally, Reece would slide down in his bed and the nurse would reposition Reece so that he was sleeping on his back or his side. Several inmates housed in the MOU stated that they could hear Reece snoring throughout the night and that they saw the nurse and the deputies check on him several times. When the nurse could not hear Reece snoring, she would call out his name to which he always responded.

On Jan. 23, 2016, at 3:55 a.m., the nurse checked Reece and repositioned him on the bed. At approximately 4:20 a.m., the nurse observed that Reece's chest was not rising and falling. The nurse alerted the deputies and at approximately 4:26 a.m., the deputies and the nurse physically checked on Reece, who was unresponsive and did not react to a sternum rub. The nurse started administering cardiopulmonary resuscitation (CPR) and requested 911 be called. Two additional nurses arrived to assist with administering medical aid. As the CPR continued, the nurses placed an Ambu Bag, attached to oxygen, over Reece's mouth. The nurse could not detect a pulse or respirations. The nurses attached an Automated External Defibrillator (AED) to Reece and turned it on. The AED analyzed Reece's heart rhythm and delivered a total of two shocks.

The paramedics arrived at approximately 4:42 a.m. At that time, Reece was receiving CPR from the jail medical staff. Reece appeared obviously deceased to one of the paramedics because he was unresponsive, stiff, modeled, had fixed pupils, absent lung sounds, and was not breathing. The paramedics attached a heart monitor which showed that Reece lacked a heartbeat. The paramedics did not render additional medical aid and Reece was pronounced dead at 4:47 p.m.

Surveillance cameras recorded Reece's movements throughout the jail facility. A surveillance camera in the MOU recorded the jail staff's attempts to administer CPR and other lifesaving measures.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Two white bed sheets
- One inmate orange smock and trousers
- Two black socks
- Two orange sandals
- Two white towels

AUTOPSY

On Jan. 31, 2016, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Reece. Dr. Luzi conducted an extensive examination of the body and found no significant injuries or trauma. Dr. Luzi noted that Reece had an enlarged heart consistent with hypertension and a history of alcoholism detoxification. Additionally, Reece had evidence of having pneumonia. Dr. Luzi determined that the cause of death was consistent with natural causes.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Benzodiazepines	Postmortem blood	0.225 ± 0.013 mg/L

BACKGROUND INFORMATION

Reece had a State of California Criminal History record of arrests for possession of cocaine base and cocaine base for sale, domestic battery and indecent exposure.

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 section 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/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

There is no evidence whatsoever in this case 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 Reece 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). There is no evidence that OCSD intentionally breached any duty of care to Reece from the time he was booked into custody until the time that he died. The evidence shows that from the point that Reece came into the custody of the OCSD, the deputies and medical staff took repeated steps to ensure that Reece's medical condition was evaluated, treated and monitored. The evidence shows that when Reece was taken into the custody of the OCSD, he was suffering from alcohol intoxication, had a history of daily alcohol use, edema in his lower legs, scabies and a seizure disorder. After Reece's initial evaluation at OCJ, OCSD personnel determined that Reece would be placed on withdrawal orders for alcohol and assigned to a lower bunk in regular housing. Reece was placed in an identification cell and appeared to be okay. Several hours later when inmates complained of Reece's bizarre behavior, OCSD personnel moved Reece to his own cell for his own safety. Then when an OCSD deputy who was escorting Reece to his regular housing approximately 30 minutes later noticed that Reece had difficulty walking, he informed medical staff. Reece was evaluated by a nurse approximately 13 minutes later, and the determination was made that Reece should be housed in the MOU rather than regular housing due to his medical condition. The nurse contacted the on-duty physician and requested that Reece be assigned to the MOU so that he could be seen by a doctor the next morning.

While Reece was housed in the MOU for treatment and observation, medical staff continuously monitored him visually, physically evaluated him every 35 to 45 minutes, repositioned his body if necessary, and gave him medication per schedule. The nurse monitoring Reece immediately notified deputies that Reece needed to be checked when she observed that Reece's chest wasn't rising and falling at 4:20 a.m. Two deputies responded to the MOU within approximately six minutes and escorted the nurse to Reece where she started administering cardiopulmonary resuscitation. Two additional nurses arrived to assist with administering medical aid and continued to render medical aid until paramedics arrived. The evidence further supports the finding that OCSD personnel and the medical staff were reasonably responsive to observations and changes in Reece's medical condition.

The totality of all the circumstances clearly supports the conclusion that there is a lack of evidence to conclude that OCSD or anybody under the supervision of OCSD failed to carry out the legal duty owed to Reece as an inmate in the custody of OCSD. Reece's death was not the result of any criminal conduct by OCSD or anybody under the supervision of the OCSD.

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 Reece died as a result of complications consistent with natural causes. Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,

DENISE HERNANDEZ
Deputy District Attorney
Special Prosecutions Unit

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