

January 30, 2014

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

Chief Daniel S. Llorens
Fountain Valley Police Department
10200 Slater Ave
Fountain Valley, CA 92708

RE: Custodial Death on April 5, 2012

Death of Inmate Chad E. Smith

District Attorney Investigations Case # 12-010

Fountain Valley Police Department DR# 11- 3195

Orange County Sheriff's Department DR# 11-113145

Orange County Crime Laboratory Case#12-01421-RL

Dear Sheriff Hutchens and Chief Daniel S Llorens,

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 April 5, 2012, custodial death of inmate Chad E. Smith.

## **OVERVIEW**

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Smith. 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) deputy or Fountain Valley Police Department (FVPD) any other person under the supervision of the OCSD or FVPD.

On April 5, 2012, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center-Santa Ana (WMCSA) after Smith died while being treated at the hospital after being taken into custody. The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD deputies or personnel. The OCDA will not be addressing policy, training, tactics, or civil liability.

JIM TANIZAKI
SENIOR ASSISTANT D.A.
VERTICAL PROSECUTIONS

**VIOLENT CRIMES** 

MARY ANNE MCCAULEY SENIOR ASSISTANT D.A.

BRANCH COURT OPERATIONS

JOSEPH D'AGOSTINO
SENIOR ASSISTANT D.A.

MICHAEL LUBINSKI SENIOR ASSISTANT D.A. SPECIAL PROJECTS

GENERAL FELONIES/ ECONOMIC CRIMES

JEFF MCLAUGHLIN CHIEF BUREAU OF INVESTIGATION

LISA BOHAN - JOHNSTON DIRECTOR ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER

## **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, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

#### **FACTS**

Jane Doe was in a dating relationship with Chad Smith. During a phone conversation, Smith threatened to have Jane Doe deported if she left him. Jane Doe responded that she would then tell authorities about his illegal firearms and steroid distribution. After the apparent break up over the phone, Smith arrived at their apartment driven by an individual named "Carlos." Jane Doe entered the car with the two believing that "Carlos" would help her out of the situation. During their ride, Smith stated that he was going to kill himself and showed a gun to "Carlos." The three drove to Smith's former residence to retrieve some of his property. "Carlos" then drove away, leaving Jane Doe and Smith.

Smith entered a white BMW, drove around the street and then pulled alongside Jane Doe, pointed a gun at her, and demanded she enter the car. While Smith pointed his gun at Jane Doe, he repeatedly spoke of killing himself. During the ride, Jane Doe called 911. Smith eventually pulled into a parking lot at Euclid Street and Condor Avenue and told Jane Doe that, if the police showed up, he was going to kill himself.

At approximately 2:26 p.m., Fountain Valley Police Department (FVPD) Officer Jarred Frahm arrived and observed Smith in the driver's seat and Jane Doe in the passenger seat of Smith's white BMW. As Officer Frahm approached on foot, he observed the windows to be closed and Smith and Jane Doe appeared to be talking with one another.

Officer Frahm tried getting their attention and told Smith and Jane Doe to come over to his location; however, they did not respond.

Once Smith noticed the police car pull up, and he told Jane Doe, "I'm sorry. This is not your fault, but you ruined my life." Smith immediately pointed a handgun at his head and shot himself. Officer Frahm heard a single gunshot, and then observed Jane Doe frantically exit the passenger seat and run toward him. Officer Frahm did not observe the source of the gunshot.

Fountain Valley Fire Department Paramedics rendered aide and Smith was transported to University of California, Irvine Medical-Center, where he was treated for his self-inflicted gunshot wound. During their interview with Jane Doe, FVPD learned that this incident started in south Orange County. FVPD then contacted OCSD, who took over the investigation. After being treated at UCI, Smith was transported to Western Medical Center Santa Ana. Smith was booked into Orange County Jail as a "hospital booking" meaning that although he was in the hospital, he

remained in custody.

Smith was arrested in his hospital bed for kidnapping Jane Doe. Over approximately the next two months, Smith failed to make scheduled court appearances due to his medical condition, as he remained hospitalized and in custody.

On April 5, 2012, Smith's mother submitted a letter to Orange County Superior Court Judge Craig E. Robinson requesting a compassionate release of Smith based on his grave medical condition. The court granted Smith's release from custody.

Smith died at approximately 7:50 p.m. while in his hospital bed at WMCSA.

# **AUTOPSY**

On April 9, 2012, at approximately 9:18 a.m., an autopsy was conducted by Chief Forensic Pathologist, Doctor Joseph Cohen, performing a post-mortem examination of Smith at the Orange County Sheriff-Coroner Forensic Science Center. Dr. Cohen conducted a thorough examination of Smith's body and determined that Smith had suffered a "through and through" gunshot wound to the right side of his head. The bullet had entered the right temporal area and exited the right frontal area of Smith's head. Dr. Cohen also noted that Smith's lungs were heavy, discolored and engorged with fluid, an indication of bronchial pneumonia.

Dr. Cohen later concluded that the cause of death was due to complications of a penetrating gunshot wound to the head.

## **BACKGROUND INFORMATION**

Smith's 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.

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 Cai.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.

#### LEGAL ANALYSIS

There is no evidence of express or implied malice on the part of any OCSD deputy, FVPD officer, or any inmates or other individuals under the supervision of the OCSD or FVPD. 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 OCSD and FVPD owed inmate Smith 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 involuntary manslaughter).

OCSD and FVPD personnel complied with applicable procedures and protocol, including medical screenings and daily chart reviews. Smith remained under medical observation and was administered medication upon doctors' orders.

In order to rule out negligence, there is one relevant area of inquiry:

1) Compliance with proper observation procedures.

Close review of the records reveals no deficiency in compliance with observation requirements by hospital staff.

There is no evidence of any breach in the duty of care owed to Smith. Without a breach of failure to perform a duty there can be no negligence, much less criminal negligence.

Furthermore, there was no evidence of foul play on the part of any person who came into contact with Smith prior to his death. Smith's death was due to his own decision to end his life.

# 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 or FVPD personnel or any individual under the supervision of OCSD or FVPD. The evidence shows that Smith died as a result of complications of a self-inflicted penetrating gunshot wound to the head.

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

Respectfully Submitted,

DANIEL FELDMAN

SENIOR DEPUTY DISTRICT ATTORNEY

Gang Unit

Read and Approved,

MARC ROZENBERG

ASSISTANT DISTRICT ATTORNEY

Gang Unit