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June 18, 2012

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

Re: Custodial Death on November 30, 2010
Death of Inmate Keith Eric Files
District Attorney Investigations Case # 10-022
Orange County Sherriff's Department DR # 10-221574
Orange County Crime Laboratory Case #10-54960
Coroner Case #10-06201-RE

Dear Sheriff Hutchens,

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 Nov. 30, 2010, custodial death of inmate Keith Eric Files.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Files. 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 any other person under the supervision of the OCSD.

On Nov. 30, 2010, the OCDA Special Assignment Unit (OCDASAU) Investigators responded to the OCSD Intake/Release Center after inmate Files died while in 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.

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 Orange County Crime Laboratory (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 and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On Nov. 29, 2010, at approximately 12:15 p.m., Probation Officer Laura McMahon arrested inmate Files for probation violations. At approximately 1:14 p.m., McMahon booked Files into the Orange County Jail Intake/Release Center. As part of the booking process, McMahon completed the top-portion of the "Intake screening and triage" form, which asks, "Does the arrestee appear to be under the influence of drugs or alcohol, disoriented, confused or have impaired level of consciousness or injured in any way?" McMahon checked the "No" box and signed and dated the form.

During the medical screening portion of the booking process, a staff nurse noted that Files had a history of depression for which he had been prescribed the medication "Paxil." At approximately 4:00 p.m., Files was cleared by jail medical staff to be housed in Module L due to his medical/psychiatric history.

At approximately 4:40 p.m., Files' vital signs were checked. At that time, Files denied any medical problems, pain, or discomfort. Files was dressed in a safety gown and housed in cell 5, a single person cell within Module L, Sector 19.

Between approximately 9:00 p.m. and 10:00 p.m., Deputy Jaime Cuadras briefly conversed with Files through the cell door and observed that Files seemed "jovial." From approximately 10:00 p.m., the last time anybody had one-on-one contact with Files, to the following morning at approximately 7:30 a.m. when Files was discovered, deputies conducted hourly visual checks of the inmates within Module L, Sector 19. Also during that period of time, Orange County medical health employees working within Module L conducted semi-hourly visual checks of the inmates. Nothing was noted regarding Files during the visual checks by either the deputies or the medical health employees.

On Nov. 30, 2010, Deputy Randolph Torres, who was assigned to work in the OCSD Intake/Release Center, was conducting a scheduled inmate safety check within Sector 19 of Module L. At approximately 7:36 a.m., Deputy Torres looked in cell 5 and noted Files' feet were colorless. Deputy Torres banged on the door but received no response from the inmate. Deputy Torres entered the cell and found Files to be unresponsive. Torres, other deputies, and jail medical staff began to administer cardiopulmonary resuscitation (CPR).

At approximately 7:37 a.m., Santa Ana Fire Department (SAFD) paramedics were dispatched to the Orange County Jail. Jail personnel applied Automated External Defibrillator (AED) pads to Files' body; no shock was advised and CPR continued. This pattern continued until approximately 7:54 a.m., when SAFD paramedics arrived in Module L and assumed care of Files. Paramedics applied their own AED pads and their electrocardiogram indicated Files heart was not beating. Their rescue efforts included the intravenous administration of Epinephrine and Atropine; however, Files remained without a heartbeat. At approximately 8:05 a.m., SAFD paramedics pronounced Files deceased.

A background investigation revealed the following: Files was a 28-year-old male who had a history of substance abuse dating back to 1996. The history of substance abuse is based upon interviews with his father, sister, Probation Officer McMahon, and from a social history questionnaire completed at the "Roque Center" and signed by Files on Oct. 4, 2010.

On Oct. 4, 2010, Files enrolled in a substance abuse treatment program at the "Roque Center," a sober living home

and in-patient substance abuse recovery program in Garden Grove.

On Nov. 16, 2010, his probation officer, McMahon, received a telephone call from the "Roque Center" and learned that Files had been discharged from the program because he left the previous night and did not return.

On Nov. 24, 2010, Files telephoned McMahon, who told Files that he needed to report to her office to be arrested for violating his probation by leaving his substance abuse program at the "Roque Center." McMahon directed Files to report to her office on Monday, Nov. 29, 2010, at 12:00 p.m.

On Nov. 28, 2010, Files returned to the "Roque Recovery Center" to retrieve his belongings, at which time he spoke with an acquaintance and former fellow-patient. Files told the patient that he ingested 25 methadone pills and indicated to the patient that he planned to smuggle more methadone into jail with him.

On Nov. 29, 2010, at approximately 12:00 p.m., Files reported to McMahon's office. During this office visit, McMahon asked Files if he was under the influence of "anything" and Files said he was not. McMahon did not observe any signs of Files being under the influence of drugs or alcohol.

McMahon subsequently arrested Files and booked him into the Orange County Jail Intake/Release Center.

AUTOPSY

On Dec. 2, 2010, at approximately 8:00 a.m., Forensic Pathologist Joseph Cohen conducted the post-mortem examination of Files at the Orange County Sheriff-Coroner Forensic Science Center located at 1071 Santa Ana Boulevard, Santa Ana. After completing the post-mortem examination, Dr. Cohen concluded that the cause of death was acute methadone toxicity. The autopsy findings were documented under Coroner Case # 10-06201-RE.

EVIDENCE ANALYSIS: TOXICOLOGY

The OCCL analyzed Files' post-mortem blood samples for prescription drugs and commonly abused drugs. The following drugs and concentrations were detected:

DRUG	MATRIX	RESULT
Methadone	Postmortem Blood	0.54 mg/L
Methadone	Peripheral Blood	1.5 mg/L
Methadone	Liver	7.5 mg/L
Methadone	Stomach Contents	0.36 mg
Hydrocodone	Postmortem Blood	Detected
Methadone metabolite, Atropine	Postmortem Blood	Detected

The level of methadone found in Files' blood is within a range that researchers have been observed to be fatal in other cases.

BACKGROUND INFORMATION

A review of Files' prior criminal record, which included alcohol and theft-related convictions, was taken into consideration.

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.

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 acted he knew his 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;
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 Cal.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. 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 of express or implied malice on the part of any OCSD deputy 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 OCSD owed inmate Files 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 deputies and medical staff under the supervision of OCSD conducted a medical screening as well as routine welfare checks on the inmates housed in Module L. There is no evidence that the deputies assigned to monitor that section of the jail, nor the medical staff assigned to screen and monitor the inmates, had any reason to believe that Files posed a danger to himself or that he was under the influence of any substances – let alone that he had ingested a potentially fatal dose of narcotics. Files turned himself in to his probation officer, completed the booking process at the jail, cooperatively answered medical questions, and engaged in conversations with OCSD deputies. There is no evidence of foul play on the part of any person who came into contact with Files prior to his death, and even his probation officer was unable to detect any problematic behavior or condition at the time she booked him into the OCSD Jail Intake/Release Center.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA and pursuant to applicable legal principles, there is no evidence to support a finding of criminal culpability on the part of any OCSD deputy or any individual under the supervision of OCSD. Evidence shows that Files died as a result of a Methadone overdose caused solely by his decision to ingest a large amount of the substance.

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

Respectfully Submitted,

SUSAN A. PRICE
Senior Deputy District Attorney, Homicide Unit

Read and Approved,

DAN WAGNER
Assistant District Attorney
Head of Homicide Unit