



TONY RACKAUCKAS
ORANGE COUNTY DISTRICT ATTORNEY

ORANGE COUNTY DISTRICT ATTORNEY'S OFFICE
401 CIVIC CENTER DRIVE WEST • SANTA ANA, CA 92701 (714) 834-3636

August 17, 2018

VIA ELECTRONIC & U.S. MAIL

THE HON. CHARLES MARGINES, Presiding Judge
Orange County Superior Court
Central Justice Center
700 Civic Center Drive West
Santa Ana, CA 92701

Re: Response to 2017-18 Orange County Grand Jury Report, "*Preventable Deaths in Orange County Jails*"

Dear Judge Margines:

Please find enclosed a copy of the Orange County District Attorney's response to Findings F10 and F11, and Recommendations R13-R14 of the Orange County Grand Jury Report, "*Preventable Deaths in Orange County Jails.*"

Sincerely,

A handwritten signature in blue ink that reads "Tony Rackauckas".

Tony Rackauckas
District Attorney-Public Administrator

TR:vlb
Enclosure

PREVENTABLE DEATHS IN ORANGE COUNTY JAILS

SUMMARY RESPONSE STATEMENT

On June 25, 2018, the Orange County Grand Jury (OCGJ) released the report, “Preventable Deaths in Orange County Jails” (hereinafter referred to as “report”). The report directed a response from the Orange County District Attorney’s Office (OCDA) on certain findings and recommendations which are detailed below.

During the 2017-2018 Grand Jury term, the OCGJ requested information and material from the OCDA in connection with this report. The OCGJ also asked to interview members of the OCDA. The OCDA fully and completely cooperated with the OCGJ, and always promptly provided the OCGJ with all the requested material and information. Throughout the entire framework of the OCDA’s interaction with the OCGJ and response herein, it should be clear the OCDA is committed to the rule of law and the pursuit of justice in every case.

On page 23 of the OCGJ report, the OCDA is directed to provide a response to Findings 10 and 11, as well as to Recommendation 14.

FINDINGS AND RESPONSES

Finding F10

“The Orange County District Attorney does not require its forensic pathologists to comply with national standards, limiting potentially valuable information on cause and manner of death.”

Response to Finding F10: Disagree with the Finding.

At the request of the Orange County Sheriff’s Department - Coroner (OCSD), and pursuant to an established protocol, the OCDA conducts a **criminal investigation and a legal review** whenever an individual dies while in the custody of the OCSD, including when the death occurs in the Orange County Jail. At the conclusion of the criminal investigation and the legal review, the OCDA issues a public report describing 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 OCSD personnel or any other person under the supervision of the OCSD. All reports are published on the OCDA’s website after issuing news releases announcing the findings.

The OCDA conducts an independent and thorough investigation of the facts and circumstances of each custodial death and impartially reviews all evidence and applicable legal standards. The scope and findings of the criminal investigation and legal review conducted by the OCDA 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. As specifically stated in each and every report the OCDA issues in connection with custodial death investigations, the OCDA

does not address “any possible issues relating to policy, training, tactics, or civil liability.” The sole purpose of the OCDA’s involvement in investigating and reviewing custodial death cases is to determine if any crime was committed in connection with the custodial death.

Investigations of custodial deaths by the OCDA are conducted by the OCDA Special Assignment Unit (OCDASAU). Six experienced 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, five Investigators respond to a custodial death incident within an hour of being called. The Investigators assigned to respond to an incident perform a variety of investigative functions including witness interviews, scene processing, evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the Orange County Crime Lab processes all physical evidence related to the investigation.

When the criminal investigation is concluded by the OCDASAU, the file is turned over to a veteran deputy district attorney for legal review. The assigned deputy district attorney completes the legal review and determines whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the appropriate Senior Assistant District Attorney 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.

In conducting criminal investigations into custodial death incidents from the Orange County Jail, the OCDA retains the services of an independent Board Certified Forensic Pathologist to conduct the autopsy on the decedent. The OCDA retains the services of this independent pathologist to eliminate even an appearance of a conflict of interest of a pathologist who is working for the OCSD, since the OCSD also operates the Orange County Jail. The background and qualifications of the independent pathologist retained by the OCDA are as follows:

- Over twenty years of experience in Anatomic, Clinical, and Forensic Pathology;
- Specialties in Anatomic and Clinical Pathology (American Board of Pathology 2002), and Forensic Pathology (American Board of Pathology 2005);
- Member in the National Association of Medical Examiners (NAME), and College of American Pathologists;
- In addition to conducting autopsies for the OCDA, he currently conducts autopsies for the San Bernardino County Sheriff-Coroner, the Los Angeles County Department of the Coroner, and the Riverside County Sheriff-Coroner.

On page 16, the OCGJ report states, “In accordance with NAME, Los Angeles and Riverside Counties expect the forensic pathologist to write a report that includes the cause of death, the manner of death, and their opinion regarding both. In contrast, the Orange County District Attorney's office does not require forensic pathologists to comment on the toxicology report or to render an opinion on the cause or manner of death. Without the toxicology report, autopsy findings alone may be insufficient to determine the cause of death.” In reality, the toxicology report relating to each custodial death incident is forwarded to the independent pathologist for his review and consideration as part of his determination of the cause of death.

As listed above, the independent forensic pathologist retained by the OCDA is a member of NAME, and he conducts the autopsies for custodial death cases consistent with the national standard. Furthermore, the final autopsy reports signed by the independent forensic pathologist expressly provide both the cause and the manner of death.

Finding F11

“Timely receipt of autopsy and toxicology reports provides important information that could assist Correctional Health Services in implementing needed changes.”

Response to Finding F11: Agree with the finding.

The OCDA agrees it may be beneficial for Correctional Health Services (CHS) to receive the autopsy and toxicology reports in a timely manner so CHS may implement needed changes. The OCDA however is entrusted with safeguarding the evidentiary integrity of the criminal investigation and legal review in order to reach the appropriate legal conclusions based on the facts and the law. The OCDA always aims to complete the investigations and legal reviews of custodial death incidents in a timely manner. As soon as this investigative and legal process is completed, the OCDA makes the autopsy and toxicology reports available to OCSD and therefore to CHS.

RECOMMENDATIONS AND RESPONSES

Recommendation R13

“By October 1, 2018, the Orange County District Attorney's office should require the forensic pathologist's report to follow the standards of the National Association of Medical Examiners (NAME) for custodial death autopsies.”

Response to Recommendation R13: Implemented.

This recommendation is not assigned by the OCGJ as a recommendation requiring a response by the OCDA, rather, it is assigned as a recommendation requiring a response by Correctional Health Services (OCGJ report, page 24.) However, and based on the language used in this recommendation, it appears this may be a clerical mistake by the OCGJ, and the OCDA is providing the response listed below in the event this recommendation requires a response by the OCDA.

As previously discussed in the response to Finding 10 above, the independent forensic pathologist is a member of NAME and his reports follow the standards of NAME.

Recommendation R14

“By October 1, 2018, Correctional Health Services should review the autopsy, toxicology, and pathologist's reports, as soon as they are available, for ways to improve healthcare processes.”

Response to Recommendation R14: Implemented as legally permitted.

As soon as the criminal investigation and legal review of a custodial death incident is completed by the OCDA, the corresponding autopsy and toxicology reports are provided by the OCDA to the OCSD, and therefore to CHS.