*County of Orange*

# Independent Review of OCSD Custodial Death: William Wiley

April 2024

Office of Independent Review
601 N. Ross St., 2nd Floor
Santa Ana, CA 92701

Robert P. Faigin, J.D., MPA
Executive Director

# Table of Contents

# EXECUTIVE SUMMARY

The Board of Supervisors, through County ordinance, has established the Office of Independent Review (OIR) to review specific incidents occurring in the Orange County Sheriff's Department (OCSD) which may identify systemic issues with regard to the performance and operations of the OCSD, and to provide a resource to ensure that high risk and potential liability issues are identified and addressed through corrective actions.[1] The OIR is authorized to investigate and review deaths and uses of force resulting in, or reasonably likely to result in, death or serious bodily injury in custody.[2]

Pursuant to the above-described authority, the OIR has begun to review all custodial deaths commencing in the year 2022. This report, and the conclusion and recommendation that it contains, relies on the review of both publicly available and confidential information.

On March 15, 2022, William Wiley (Wiley) was arrested by the OCSD for homicide and brought to the Orange County Intake/Release Center (IRC) to be booked.[3] After being screened, it was determined that he needed to be medically cleared. Wiley was transported to the Orange County Global Medical Center (OCGMC) where he was medically cleared. Wiley was then returned to the IRC and completed the booking process at approximately 1:48 a.m. on March 16, 2022.

While in custody at the IRC, Wiley struggled with, and kicked, a deputy. Wiley was restrained resulting in minor skin tearing on his wrists and forearms that was treated with steri-strips and a band-aid. Due to Wiley's history of Alzheimer's disease and encephalopathy, a determination was made to admit Wiley to the Correctional Medical Services Unit (CMS) at the Anaheim Global Medical Center (AGMC). On March 17, 2022, at approximately 1:22 a.m., Wiley was transferred from the IRC to the CMS at AGMC, where he remained until his passing on June 22, 2022.

The District Attorney's Office investigated Wiley's death and issued a letter on October 24, 2023, finding that there was "no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of" Wiley. The DA's determination was based in part, on an autopsy conducted by an independent forensic pathologist who determined that the cause of Wiley's death was community acquired pneumonia along with other conditions, including Alzheimer's disease. The manner of death was identified as natural.

The OIR requested and received items related to Wiley's death from both the District Attorney and the OCSD. The OIR reviewed video, memoranda, records, and reports focusing primarily on the 24 hours that Wiley was at the IRC. During its review, the OIR looked specifically to see if any OCSD personnel, actions, policies, procedures, training, or tactics contributed to Wiley's death.

After a thorough review, the OIR concurred with the District Attorney that no OCSD personnel nor any individual under the supervision of the OCSD failed to perform a legal duty causing Wiley's death.

---

[1] Section 1-2-225(b) and (c) of Codified Ordinances of Orange County.
[2] Section 1-2-226(e)(3) of Codified Ordinances of Orange County.
[3] Factual information contained in this report comes from verified information contained within the publicly available District Attorney letter ("D.A. letter") regarding Wiley's death, as well as other publicly available information.

Additionally, the OIR did not identify any OCSD personnel, actions, policies, procedures, training, or tactics that contributed to Wiley's death.

Ultimately, within 24 hours of arrival at the IRC, staff identified that the CMS unit at AGMC was the most appropriate placement for Wiley. As a result, Wiley was transferred, and remained, at CMS for over three months under the care of medical professionals until his passing.

## DECEDENT INFORMATION

The decedent, Wiley, was an 87-year-old incarcerated male, arrested on March 15, 2022. Wiley was being held on one count of homicide and had a history of Alzheimer's disease and encephalopathy.[4]

## FACTUAL BACKGROUND

On March 15, 2022, Wiley was arrested and brought to the IRC to be booked. After being screened, it was determined that Wiley needed to be medically cleared. Wiley was then transported to the OCGMC, where he was examined and medically cleared. Wiley was returned to the IRC and booked on March 16, 2022, at approximately 1:48 a.m.

Later that morning, at approximately 7:06 a.m., a deputy came to Wiley's cell to escort him to an examination. Wiley failed to follow instructions to turn around and be handcuffed and instead pushed himself out of his cell. A short struggle ensued, and Wiley kicked the deputy in the shin. Deputies were able to use control holds and body weight to hold Wiley against a wall as they handcuffed him. As a result of the struggle, Wiley sustained minor abrasion-breaking of the skin to both of his forearms. Following the incident, Wiley was medically treated by a registered nurse and evaluated by a mental health nurse.

Due to Wiley's medical history, on March 17, 2022, at approximately 1:22 a.m., the Orange County Health Care Agency (OCHCA) transferred Wiley from the IRC to the CMS at AGMC, where he remained until his passing.

On, or around, June 14, 2022, Wiley developed abdominal pain, nausea, and vomiting. A computerized tomography scan showed extensive areas of pneumoperitoneum, a condition in which gas is present within the peritoneal cavity.

On June 16, 2022, doctors noted a bowel perforation and obstruction. Wiley's daughter, who was designated as someone who could make medical decisions for him, transitioned Wiley to comfort care after doctors informed her that Wiley was suffering from acute renal failure.

On June 22, 2022, at approximately 2:20 p.m., a nurse who was checking on Wiley noticed his respirations were fast. The nurse checked on Wiley again a couple of minutes later and noticed he was not breathing. Multiple nurses attempted to locate vital signs on Wiley to no avail. Wiley was pronounced deceased at approximately 2:40 p.m.

[4] According to an OCSD news release dated March 16, 2022, "Family members indicated Wiley was previously diagnosed with dementia."

## ANAHEIM GLOBAL MEDICAL CENTER

The OCHCA contracts with AGMC for inpatient and specialty care for adult incarcerated persons. Inpatient services are provided in a secure correctional medical services (CMS) unit located at AGMC. AGMC is fully licensed by the State of California and the Center for Medicare and Medicaid Services as an acute care hospital. The hospital is accredited by The Joint Commission and is governed by a managing board of local business professionals, physicians, and active community members.[5]

The CMS unit has five rooms with 11 inpatient beds and is staffed by AGMC medical staff. Medical decisions at the CMS unit are made by AGMC medical staff as opposed to Orange County's Correctional Health Services (CHS) who provide medical, dental, nursing, infections control, health education and pharmaceutical services to all adult incarcerated persons in the County's jails.

A staff member from the OIR toured the CMS unit and observed it to be a hospital medical unit staffed by AGMC medical staff and secured by OCSD sworn staff.

## CUSTODIAL DEATH REVIEW

On June 22, 2022, the OCDA Special Assignments Unit (OCDASAU) Investigators responded to the CMS at the AGMC, where Wiley died in his medical bed while in custody. During their investigation of Wiley's death, the OCDASAU interviewed witnesses. They also gathered reports, incident scene photographs, and other relevant materials.

The OIR requested copies of the investigative material gathered and produced by OCDASAU Investigators. The DA's office provided redacted copies of reports, photographs, and audio files. The OIR also requested records, reports, and videos from the OCSD. That information was also provided.

### OCDA Custodial Death Investigation Report

On October 24, 2023, the Orange County District Attorney issued a public letter summarizing its review of the custodial death of Wiley. While the letter's focus was on the legal analysis regarding whether OCSD members failed to perform a legal duty, it provided valuable insight into the overall investigation of this custodial death.

The D.A.'s letter summarized its findings of facts beginning with Wiley's booking at the IRC on March 16, 2022, following his arrest for homicide related to the suspicious death of his wife. Less than 24 hours later, on March 17, 2022, Wiley was transferred to AGMC where he remained for the remainder of his incarceration.

The D.A.'s letter concluded that based on all the evidence provided and reviewed, there was no evidence to support a finding that any OCSD members failed to perform a legal duty causing the death of Wiley.

### Records

The OIR reviewed Wiley's jail records and confirmed that he was brought to the IRC for booking on March 15, 2022. At approximately 6:48 p.m., Wiley was seen by a nurse at receiving screening who went

[5] https://www.anaheimglobalmedicalcenter.com/about/

through preliminary questions with him that included his mental health state, physical disabilities, medical history, and any special accommodations that he might need.

Wiley's booking was refused at approximately 10:30 p.m., and he was taken to OCGMC for medical clearance to determine whether he was suitable to be booked into the jail. Wiley arrived at OCGMC at approximately 11 p.m. and was cleared for booking two hours later on March 16, 2022, at 1:00 a.m. Wiley was then returned to the jail, and completed a second receiving screening process at approximately 1:40 a.m. During this screening, Wiley was given a mental health triage referral. During both of Wiley's receiving screening processes, he was identified as having hearing issues. Upon Wiley's return to the IRC form OCGMC, Correctional Health Services (CHS) staff issued him a vest with the letters "DEAF/HH" on it to alert staff that he was hard of hearing.

Wiley was also seen by CHS staff several times on March 16, 2022. At approximately 7:38 a.m., Wiley received care for an injury he sustained on his arms following a minor use of force incident with deputies. A short while later, a different registered nurse conducted a mental health acuity exam on Wiley at approximately 7:51 a.m. That same nurse also completed a mental health screening on Wiley at 9:06 a.m. and indicated that medical staff were evaluating whether Wiley needed to be transferred to a hospital due to the level of care that he required. A nurse practitioner also appears to have visited Wiley at his cell door at approximately 2:07 p.m. Finally, a standard nursing assessment of Wiley was completed at 4:58 p.m.

During Wiley's evaluations, CHS staff assessed Wiley's accessibility needs, medical needs, mental health acuity level, and housing recommendations. Ultimately, CHS staff determined that Wiley needed to be housed alone in a particular module under observation. However, due to unavailable housing in that particular module, Wiley was placed in a different observation cell in the IRC booking loop without further incident.

At 6:56 pm., a decision was made to send Wiley to AGMC. Around 1:00 a.m. on March 17, 2022, Wiley was transferred to the CMS unit at AGMC, where AGMC medical staff took over caring for him.

Wiley remained at AGMC and received care from AGMC medical staff until he passed on June 22, 2022.

On June 22, 2022, a deputy prepared a brief report documenting the circumstances surrounding nursing staff discovering Wiley unresponsive in his hospital bed at AGMC. The deputy noted that at approximately 2:30 p.m., Wiley, who was alone in his room at AGMC, was found unresponsive. Medical staff pronounced Wiley deceased at 2:40 p.m., and a crime scene was established, which is standard practice for all custodial deaths. Members from the OCSD Homicide team, Orange County District Attorney's Office, Orange County Coroner's Office (OCCO) and Orange County Crime Lab (OCCL) were notified.

The reports reviewed by the OIR confirmed that the OCDASAU responded to the AGMC on June 22, 2022. The reports provided a description of the hospital scene where Wiley was located at the time that he passed and established that OCDASAU Investigators examined the scene as well as interviewed Wiley's daughter and AGMC medical staff.

Redacted reports from the OCCL and OCCO were also reviewed, which confirmed that relevant evidence was gathered and that an autopsy was conducted.

On June 28, 2022, Dr. Scott Luzi[6], conducted a post-mortem examination of Wiley. Dr. Luzi noted there were no major or minor injuries on Wiley.

On August 1, 2022, Dr. Luzi conducted a neuropathology examination on Wiley's brain. Dr. Luzi noted the examination confirmed the presence of severe neurodegenerative brain disease, with frequent senile plaques and neurofibrillary tangles in widespread brain structures, consistent with Alzheimer's disease. Dr. Luzi noted there was no evidence of recent or remote traumatic brain injury.

On October 27, 2022, Dr. Luzi issued a final report identifying the cause of Wiley's death as community acquired pneumonia along with other conditions, including Alzheimer's disease. The manner of death was identified as natural.

Wiley's Toxicological Examination Report was negative for abused drugs. Morphine was the only drug detected in his blood.

## Photographs

Redacted copies of photos from the OCCL and OCCO were also reviewed by the OIR. The photos were taken at the AGMC and the OCCO.

## Audio Files

Redacted copies of audio interviews of witnesses, conducted by OCDASAU Investigators, were also reviewed by the OIR. The audio files indicated that recorded interviews were conducted with Wiley's daughter, a registered nurse, and a charge nurse. A doctor was also interviewed; however, the investigator was unable to record the interview because it took place over the telephone while the investigator was at the hospital.

The OIR's review of witness interviews confirmed that Wiley suffered from Alzheimer's disease, and that at approximately 2:32 p.m. on June 22, a nurse checked on Wiley and noticed that he was not breathing. Multiple nurses attempted to locate vital signs on Wiley, but none were found. A doctor examined Wiley and found no signs of life. The doctor pronounced Wiley deceased at 2:40 p.m.

## Analysis

The materials reviewed by the OIR indicate that Wiley was already suffering from Alzheimer's disease and encephalopathy by the time he was booked into the IRC on March 16, 2022, at approximately 1:48 a.m. The OIR's review also confirmed that both CHS and OCSD staff recognized early on that Wiley needed to be medically cleared before being booked into the IRC. As a result, Wiley was seen, evaluated, and cleared for booking by medical personnel at the OCGMC.

During his short stay in the IRC, Wiley was mentally assessed during the booking process and placed under observation. He was also identified as having hearing difficulties. CHS staff followed protocols and ensured that OCSD staff were aware of his potential ADA issues.

A short time after Wiley was booked into the IRC, it was determined that he would need a higher level of medical care due to his age and overall health. As a result, within 24 hours from the time of his booking, CHS staff transferred Wiley to AGMC, where he remained until his passing.

[6] Dr. Scott Luzi is an independent Forensic Pathologist retained by the Orange County District Attorney's Office to perform post-mortem examinations of custodial deaths occurring in Orange County.

Deputy reports and the D.A. letter both indicate that Wiley was under the care of medical staff during his hospitalization and was closely monitored. When Wiley began to experience renal failure, his daughter requested that no surgical interventions be made, and requested for her father to be placed on comfort care. From June 14, 2022, through June 22, 2022, Wiley's condition continued to deteriorate, and ultimately, he was pronounced deceased on June 22, 2022.

Based on the above, the OIR did not identify any OCSD personnel, actions, policies, procedures, training, or tactics that contributed to Wiley's death.

## USE OF FORCE REVIEW

During this custodial death review, the OIR learned that a minor use of force occurred involving Wiley during the approximately 24 hours that he was at the IRC. The OIR requested records, reports, audio, and video related to the use of force incident. The OCSD provided the requested information.

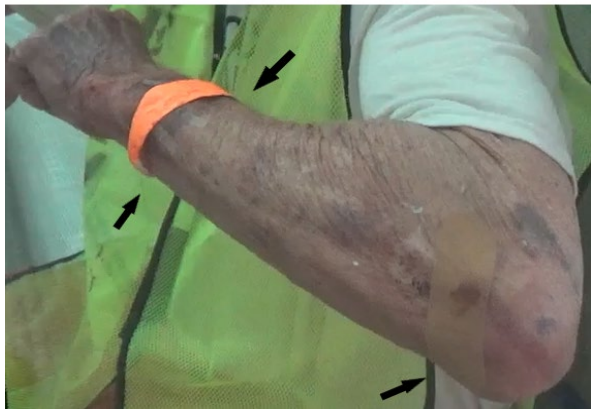
### Reports

According to deputy reports, on March 16, 2022, at approximately 7:06 a.m., a deputy went to Wiley's cell to escort him to see mental health staff for a psychological evaluation. The deputy told Wiley that he was going to bring him out to be seen by mental health staff. Wiley agreed and stood at the door. However, when the deputy opened the cell door, Wiley refused to turn away from the deputy and put his hands behind his back. Wiley eventually exited his cell, and the deputy was able to regain Wiley's compliance. Wiley turned away from the deputy and put his hands behind his back as instructed.

As the Deputy began to put handcuffs on Wiley's left wrist, Wiley suddenly turned toward the deputy and pulled his right hand away. The deputy gave Wiley commands, which he failed to follow. Wiley then grabbed the deputy's left hand. As the deputy grabbed Wiley's wrists, Wiley kicked the deputy on the left shin. An additional deputy responded and assisted by using body weight on the right side of Wiley's body to hold Wiley against a glass wall while he was placed in handcuffs. Wiley was then placed in a wheelchair and taken to be seen by medical staff.

### Records

After the use of force incident, Wiley was seen by a registered nurse who treated him by cleansing his wrist wound and applying steri-strips and a band-aid.



## Video

The OIR reviewed multiple fixed overhead jail videos that captured the use of force incident on March 16, 2022, at approximately 7:06 a.m. The OIR also reviewed handheld videos taken later in the morning after Wiley was returned to his cell. While there is no audio in the overhead camera videos, they do capture multiple angles of the incident. There is audio on in the handheld videos provided by the OCSD.

### Fixed Overhead Cameras

In the fixed overhead videos a deputy approached the door of Wiley's cell, opened it a few inches, and began to speak with Wiley while he was standing at the door on the other side. Wiley then attempted to push his way out of the cell. The Deputy continued speaking with Wiley, while simultaneously preventing the door from fully opening by holding his foot against the bottom of the door. Wiley then turned away from the deputy, and using his back, attempted to push himself out of the cell through the partially opened door. The deputy did not make any attempts to physically push Wiley back into the cell or close the door. Instead, the deputy took his hand off the door and allowed it to open. The deputy then took hold of Wiley's right arm while Wiley was inching his way out of the cell. As Wiley exited the cell, the deputy took control of Wiley's right hand. Once Wiley exited the cell, he closed the cell door from outside with his left hand.

After Wiley exited the cell, and was facing the deputy, he tried to push away from the deputy while the deputy still had a hold of his forearm. The deputy and Wiley continued to speak to each other and eventually Wiley turned around and put his hands behind his back.

As soon as the deputy attempted to place handcuffs on Wiley, he turned around to face the deputy. Wiley then pushed the deputy's hands away and proceeded to kick the deputy's left leg. Another deputy arrived and the two deputies were able to gain control of Wiley by placing him against a wall and holding him there while handcuffing his hands behind his back. At no point did the deputies strike Wiley nor did they take him down to the ground.

A wheelchair was then brought over and Wiley was escorted to the medical observation corridor where he was examined by medical staff. Wiley remained in the wheelchair during the examination. After the examination, Wiley was wheeled to a different cell. At the entrance to the cell, Wiley stood up, with the assistance of deputies, and walked into the cell. Deputies then removed Wiley's handcuffs without incident while he was standing just inside the cell door. Once the handcuffs were removed, the cell door was closed, and Wiley could be seen standing on his own and looking around the cell.

### Handheld Camera Video

The OCSD also provided copies of two handheld camera videos taken after the use of force incident. These videos contained audio and were taken approximately four hours after the use of force incident.

The first video was taken at approximately, 11:08 a.m., and began with Wiley standing inside his cell. Wiley was outfitted in jail issued clothing and wearing an "HOH" (hard of hearing) vest which read "DEAF/HH." The deputy asked Wiley to sit down, but he continued to stand near the door. The deputy read Wiley his Miranda rights through the closed door, but Wiley appeared to not understand what he was being asked. The deputy then asked Wiley if he wanted to talk about what happened. Wiley began to talk, but his voice could not be clearly heard in the video. The deputy asked Wiley if he knew where he was and Wiley responded and gestured, but his answer could not be clearly heard on the video. The deputy asked Wiley if he had anything to say about what happened and Wiley continued to talk. The

deputy then walked away, and the video ended. The entire interaction lasted one minute and twenty-two seconds. Even though Wiley was ambulatory and standing near the door facing the deputy, his responses could not be clearly heard in the video and did not appear to be related to the questions asked.

The second video began at approximately 11:10 a.m. on March 16, 2022. This time, a Sergeant attempted to conduct an administrative interview with Wiley as part of a use of force investigation following the incident earlier in the morning. The video began with Wiley seated on the mattress in his cell, still wearing the same attire from the earlier video.

The Sergeant slightly opened the cell door and told Wiley to stay where he was. Wiley appeared to acknowledge that he was to stay put by nodding and putting his hand up. The Sergeant identified herself and told Wiley that she was there to check on him. Wiley can be seen nodding his head, and heard saying "o.k." The Sergeant asked Wiley several times to tell her his name and whether his name was William Wiley.

The distance between the Sergeant and Wiley was approximately three and a half to four feet. Wiley's response was unable to be clearly heard on the video. Wiley eventually stood up and moved closer to the door. The Sergeant told Wiley to "stay there" and Wiley sat back down.

In a louder tone, the Sergeant asked again if Wiley's name was "William Wiley." Wiley then responded "Oh, yes, yes." The Sergeant next asked Wiley what his date of birth was, and Wiley correctly provided his date of birth. Next, the Sergeant asked Wiley if he was injured. Wiley's response could not be clearly heard on the video. The Sergeant then asked again and pointed to her arm. Wiley held his arms out in front of him and made comments that could not be clearly heard on the video. The Sergeant asked Wiley if he could tell her "how it happened," and Wiley looked at his right hand and said, "this is what comes off of the plant out in the field." The Sergeant asked specifically about Wiley's band aids and if he saw "a doctor or nurse today," and both of Wiley's responses were not clear on the video. The Sergeant then stated to the camera that Wiley was unable to articulate an answer to her questions.

The Sergeant instructed Wiley to hold his arms out so that the video could capture a closeup of his arms and he complied. Wiley was wearing small band aids on his right and left arms near his elbows. The Sergeant then asked Wiley whether he knew that he was in jail, and Wiley stated he did not until now.

The interview with the Sergeant lasted approximately six minutes. Wiley was able follow simple directions to stay seated, sit down, and show his arms. However, most of the time, Wiley's answers did not appear to fit the questions asked by the Sergeant.

## Analysis

### Use of Force on Wiley

At the time force was used on Wiley he was classified as a pretrial detainee.

In 2015, the U.S. Supreme Court held "that the appropriate standard for a pretrial detainee's excessive force claim is solely an objective one."[7] According to the Court, the standard cannot be applied mechanically, and it cited to the case of *Graham v. Connor* for the proposition that "objective

[7] Kingsley v. Hendrickson, 576 U.S. 389 (2015)

reasonableness turns on the 'facts and circumstances of each particular case.'"[8] The Court stated that the determination must be made "from the perspective of a reasonable officer on the scene, including what the officer knew at the time, not with the 20/20 vision of hindsight. … A court must also account for the "legitimate interests that stem from [the government's] need to manage the facility in which the individual is detained," appropriately deferring to "policies and practices that in th[e] judgment" of jail officials "are needed to preserve internal order and discipline and to maintain institutional security."[9]

The court went on to state that "[c]onsiderations such as the following may bear on the reasonableness or unreasonableness of the force used: the relationship between the need for the use of force and the amount of force used; the extent of the plaintiff's injury; any effort made by the officer to temper or to limit the amount of force; the severity of the security problem at issue; the threat reasonably perceived by the officer; and whether the plaintiff was actively resisting."[10]

*Relationship between the need for the use of force and the amount of force used*

As indicated above, Wiley was in custody for homicide. He was also 86 years old and suffering from Alzheimer's disease and encephalopathy. When the deputy went to escort Wiley to see mental health staff, he began by trying to get Wiley to comply using conversation and verbal commands. Wiley then pushed his way out of the cell. The deputy then resorted to hand control by holding onto Wiley's left arm and continued to converse and give commands to Wiley to get him to comply. Wiley then turned on the deputy, grabbed the deputy's hands, and kicked him in the left shin. The deputy appeared to remain calm and continued holding onto Wiley's hands while another deputy responded and used his body weight to hold Wiley upright against the wall while Wiley struggled and the first deputy applied the handcuffs.

OIR's review of the reports and multiple video angles showed that, based on Wiley's actions against the deputy, some force was necessary to get Wiley handcuffed so that he could be escorted to see mental health staff. Further, the minimal amount of force used, which consisted of handholds and body weight, did not exceed the force necessary to gain control of Wiley.

*Extent of Wiley's injury*

OCSD reports and Wiley's appearance in videos, taken approximately four hours after the incident, showed that the extent of his injuries were minimal. The injuries consisted of minor abrasions and skin tears that were treated with band aides and steri-strips.

*Effort made by the deputies to temper or to limit the amount of force*

The original deputy interacting with Wiley began by conversing and using verbal commands. When Wiley escalated his behavior, the deputy applied a minimal amount of force by holding onto Wiley's left arm. When Wiley kicked the deputy, the deputy maintained his calm demeanor and tempered the amount of force that he used by simply holding onto Wiley's hands until a second deputy arrived. The second deputy also used a minimal amount of force by simply using his hands to guide Wiley to a clear wall and then using his body weight to hold Wiley while the first deputy placed handcuffs on him. This

[8] Id. at 397.
[9] Id.
[10] Id.

deputy also identified Wiley's frail state, age, confusion and bruising on both arms as a reason that he used a control hold to assist the deputy in placing handcuffs on Wiley.

Additionally, numerous deputies responded to the incident, however, only three deputies ever touched Wiley. The first two deputies, as described above, and a third deputy who relieved the second deputy who was holding Wiley against the wall. None of the deputies used strikes, blows, or impact weapons to gain control of Wiley, nor was he taken to the ground. Additionally, once Wiley was handcuffed, no additional force was used.

#### *Severity of the security problem at issue*

Wiley's resistance wasn't a hypothetical security problem. The point at which Wiley became physically aggressive with the deputy was after Wiley had already exited his cell, into an actively used hallway, and closed the door. When Wiley began to struggle with the deputy, a second deputy arrived four cells away with an uncuffed incarcerated person. That deputy had to divert his attention away from his incarcerated person to focus on the incident unfolding nearby. Eventually then second deputy called for help, left his incarcerated person, and ran to assist the deputy struggling with Wiley.

Incidents occurring in view of other incarcerated persons often provoke them to similarly act out, or to take advantage of the distraction to engage in nefarious conduct. It would have been reasonable for both deputies to be concerned about the situation escalating if swift action were not taken.

#### *Threat reasonably perceived by the deputies*

Both deputies clearly perceived a threat of violence based upon Wiley's conduct. The deputy who was attempting to take Wiley to see mental health staff articulated in his report the actual threat, as he perceived it, which included Wiley kicking and struggling with him, as well as Wiley's continued ongoing resistance. The second deputy, who observed the deputy being kicked and struggling with Wiley, also articulated the actual threat that he saw.

#### *Whether Wiley was actively resisting*

While Wiley may not have understood the nature of what was happening, the videos and reports reviewed by the OIR leave no doubt that Wiley was actively resisting the deputy who came to escort him.

Based on the above, the level and amount of force used by both deputies was reasonably necessary to gain control of Wiley.

## OBSERVATIONS

During this review, the OIR reviewed redacted interviews of the witnesses. One of the witnesses appeared to have some questions regarding the care of her father. The OIR sought, and received, information in an attempt to obtain an answer to one of the questions raised by the witness.

### Why was Wiley restrained while he was at the AGMC?

In order to determine why Wiley was restrained while he was at the AGMC, the OIR began by identifying who makes the determination that an incarcerated person be restrained while in a hospital bed at the AGMC.

According to the OCSD Custody and Court Operations Manual (CCOM), it is the primary responsibility of the deputies assigned to AGMC to maintain "custody of persons in the hospital who are charged with a crime and have been committed to the custody of the Orange County Sheriff."[11]

The CCOM goes on to state how a determination is made by stating that "[t]he utilization of security restraint devices to include leg restraints and/or handcuffs, will be based on an individual assessment of the inmate by the deputy on duty. Classification status, staff safety, physical security of the facility where the inmate is receiving treatment, and input from medical staff regarding the medical/mental condition of the inmate will be taken into consideration prior to the application of security restraint(s), if any, or continuous application of a security restraint."[12]

According to the OCSD, Wiley was restrained due to his classification status and safety concerns.

## CONCLUSION

No actions of OCSD staff or policies of the OCSD were found to have a nexus to the natural death of Wiley. As for the use of force incident that occurred on the morning of March 16, 2022, OIR's review substantiated that it had nothing to do with Wiley's death, which occurred over three months later.

Following the use of force incident, OCSD staff properly took Wiley to be evaluated by medical staff. Wiley's minor abrasions/breaking of the skin were appropriately treated with band aides and steri-strips.

[11] CCOM §7032.3(a).
[12] CCOM §7032.7(b).

ORANGE COUNTY
SHERIFF'S DEPARTMENT

SHERIFF-CORONER DON BARNES

OFFICE OF THE SHERIFF

April 29, 2024

*Via Email and U.S. Mail*

Robert Faigin
Executive Director
Office of Independent Review
601 N. Ross St., 2nd Floor
Santa Ana, CA 92701
Robert.Faigin@ocgov.com

Re: In-Custody Death Review – William Wiley (Booking # 3230956)

Dear Mr. Faigin:

We received the report prepared by the Office of Independent Review ("OIR") titled, Independent Review of OCSD Custodial Death: William Wiley ("Report"). The Orange County Sheriff's Department ("OCSD") is proud of our conscientious efforts and those of the Orange County Health Care Agency's Correctional Health Services ("CHS") to protect the medical rights of those housed in an OC Jail.

OIR's Report confirmed OCSD's actions in housing Mr. Wiley after his arrest and booking for California Penal Code § 187, murder, was lawful with no additional observations regarding areas for improvement. Similarly, after a thorough review of OCSD policies, OIR determined that there were no recommended changes to OCSD's policies or procedures. Ultimately, the OIR's review determined that OCSD staff, and those contracted to work with OCSD, acted lawfully and did not perform any acts that contributed to the natural death of Mr. Wiley. Our priority is to comply with the law and provide all incarcerated persons with a safe and healthy environment. I am encouraged to have this report which provides an independent validation of our existing practices.

The Report also reflects the consistent cooperation and transparency between OIR, OCSD and CHS. OCSD cooperated with all OIR requests and promptly provided substantive records, such as Department Reports, policies, video, CHS medical records, forms, and other jail records. OCSD also facilitated your tour of Anaheim Global Medical Center's Jail Ward, providing direct access to OCSD staff as well as hospital leadership.

As always, I remain committed to continued cooperation with OIR as it provides the Board of Supervisors and my Department with an independent perspective to ensure those housed in an Orange County Jail Facility receive the best possible care.

Sincerely,

Donald D. Barnes
Sheriff-Coroner