OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

April 28, 2021

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

Re: Custodial Death on July 16, 2020
Custodial Death of Inmate Charlie Choi
Orange County District Attorney Investigations Case #20-0170
Orange County Sheriff's Department Case #20-022588
Orange County Crime Laboratory Case #FR 20-47024- Jail, #FR 20-47284- Hospital
Orange County Coroner's Office Case #20-03571-MT

Dear Sheriff Barnes,

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 July 16, 2020 custodial death of 50-year-old inmate Charlie Choi.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Choi. In this letter, the OCDA describes the criminal investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD in connection with this custodial death incident.

On July 16, 2020, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC), where Choi died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed two 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 an experienced deputy district attorney for legal review. Deputy district attorneys from the Homicide, Gangs, and Special Prosecutions Units review fatal and 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 Senior Assistant District Attorney supervising the Operations IV Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer involved shootings and custodial death cases and letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On June 19, 2017, Choi was arrested by the Irvine Police Department (IPD) for Penal Code section 209(b)(1) - Kidnapping to commit robbery or rape, Penal Code section 459 - Burglary, and Penal Code section 245(a)(1) - Assault with a deadly weapon. On August 31, 2018, the court found Choi to be a mentally incompetent person under Penal Code section 1367(a) (Superior Court Case No. 17HF02405). The court ordered the OCSD to deliver Choi to the Department of Mental Health, specifically, Patton State Hospital for restoration of mental competency per Penal Code section 1370. On February 21, 2019, Choi was returned to the custody of the OCSD for court hearings regarding his mental health competency. On October 4, 2019, the court found that Choi's mental health competency had not been restored and he was remanded to Patton State Hospital. Choi remained in the custody of the OCSD until he was able to be readmitted to Patton State Hospital.

On June 24, 2020, Choi ate a bar of soap while being housed in Sector 18, Module L at the Intake Release Center in the City of Santa Ana. Choi was subsequently transported to the hospital for medical observation and then returned to the Intake Release Center where he was housed alone in Module L, Cell 1.

On July 13, 2020, the assigned RN, “Jane Doe #1” conducted her sector check of Module L at 6:15 a.m. where she observed Choi lying with his back on the bunk and his head slightly elevated. She saw Choi chewing or moving his right hand and proceeded to log her check and exit the sector. At 6:33 a.m. Deputy Robert Hanley, who was assigned as the Behavioral Health Deputy in Module L, conducted a sector check. During his check, he saw Choi lying with his back on the bunk and his legs hanging over the end of the bunk. Deputy Hanley believed Choi was not

breathing as his chest was not rising or falling. Upon his observation, Deputy Hanley called for Deputy Snow to assist him in going inside Cell 1 to check on Choi.

Upon entering Cell 1, Deputies Hanley and Snow checked for breathing and a pulse. Choi was not breathing and appeared to have bread in his mouth. Choi did not have a pulse. Deputy Hanley immediately began cardiopulmonary resuscitation (CPR) on Choi while Deputy Snow requested medical help on his radio. While Deputy Hanley performed CPR, RN “Jane Doe #1” began to remove the bread out of Choi's mouth and moved him to the floor of the cell. While Deputy Hanley continued CPR, additional medical staff arrived including RN “John Doe” and LVN “Jane Doe #2.” RN “Jane Doe #1” set up an Automated External Defibrillator (AED) and attached it to Choi's chest. The AED analyzed Choi and advised, "Do not touch the patient," followed by, "Shock not advised." Deputy Hanley then continued CPR as RN “Jane Doe #1” continued to clear Choi's airway. After several rounds of CPR, Deputy Hanley was relieved by RN “John Doe” who began chest compressions. Deputy Hanley then relieved RN “John Doe” after several more rounds of CPR and a bag- valve mask was placed on Choi. The staff then moved Choi to the outside of the cell to allow for more room to provide care.

Once Choi was moved to the outside of the cell, RN “Jane Doe #2” began chest compressions until being relieved by RN “John Doe.” At 6:41 a.m. Orange County Fire Authority (OCFA) Engine #75 arrived on the scene while Choi was receiving medical assistance from the OCSD staff. OCFA personnel, which included “Firefighter/Paramedic,” “Captain/Paramedic,” and “Engineer/ Paramedic,” took over patient care. Choi still had no pulse and was not breathing (asystole) when they arrived. At 6:58 a.m., “Firefighter/Paramedic” examined Choi and determined he was in cardiac arrest. OCFA Paramedics placed a CPR machine onto Choi since he did not have a shockable rhythm and started an IV. “Engineer/Paramedic” observed the scene and noted partially eaten pieces of sandwich on the floor. “Engineer/Paramedic” checked Choi's airway and saw food stuck in his throat that was consistent with the food that was observed on the floor of his cell. OCFA Paramedics used Magill Forceps to dislodge the food from Choi's throat. After the food was dislodged from his throat, Choi remained in asystole. An airway tube was then inserted into Choi's throat which provided oxygen as chest compressions continued. Through his IV, Choi was given a total of six epinephrine. A low heart rhythm was detected for a very brief moment, but quickly returned to no rhythm. Choi was then placed on a gurney and as the chest compressor continued CPR. OCFA rolled Choi out to the ambulance and was escorted by Deputy Labella. The Care ambulance departed the Intake Release Center at 7:04 a.m. At 7:10 a.m. Choi had a return of idioventricular cardiac rhythm in the ambulance. The Ambulance arrived at OC Global Hospital at 7:13 a.m.

Upon arrival to the hospital, Choi was back in asystole and ER staff continued with life-saving measures. At 7:49 a.m., Choi had a return of spontaneous circulation and the ER staff immediately started a hypothermia protocol for possible organ donation. Choi underwent multiple tests which included an x-ray and a CT scan. Choi was moved to the Critical Care Unit and ER staff noted no visible physical trauma on his body. On July 14, 2020, after continuing Choi's care and running multiple tests, he continued to show no signs of brain activity. On July 15, 2020, Choi's condition continued to decline and tests were done for brain death confirmation. On July 16, 2020 at 8:50 a.m., Choi was pronounced deceased by “Neurologist,” and Internal Medicine “Physician.” One Legacy, an organ donation non-profit, had been contacted because Choi was listed as a donor, however, they notified that they would not have any involvement in organizing for Choi's organs to be donated. At 2:35 p.m. Choi's body was removed from the hospital and transported to the OCSD Coroner's office for a postmortem examination.

EVIDENCE COLLECTED

The following items of evidence were collected and submitted to the OCCL's Evidence Control Unit:

- Bloodstain standard
- Possible pill fragments from stomach lining

AUTOPSY

On July 23, 2020, independent Forensic Pathologist Scott Luzi conducted an autopsy on the body of Choi. After the autopsy, Dr. Luzi concluded that there were no major or minor injuries to the body. The oral cavity contained blood and mucus. The heart showed signs of enlargement. Dr. Luzi also found evidence of choking and asphyxiation. Choi was also found to have an enlarged liver. Dr. Luzi concluded that Choi's cause of death was anoxic encephalopathy due to choking, and noted a history of psychosis and aspiration pneumonia. Dr. Luzi also concluded that the manner of death was an accident.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Fluoxetine	Postmortem Blood	Detected
Meperidine	Postmortem Blood	0.369 ± 0.037 mg/L
Norfluoxetine	Postmortem Blood	Detected
Normeperidine	Postmortem Blood	0.397 ± 0.037 mg/L
Olanzapine	Postmortem Blood	0.245 ± 0.032 mg/L

BACKGROUND INFORMATION

Choi had a State of California Criminal History record that revealed arrest for the following violations:

- Indecent Exposure
- Kidnapping to Commit a Sex Offense
- Assault with a Deadly Weapon

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 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

In this case, there is no evidence 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 Choi a duty of care, the evidence does not support a finding that this duty was in any way breached, either intentionally or through criminal negligence. Review of the relevant evidence shows that OCSD personnel responded to the scene in an appropriate and effective manner upon discovering that Choi required medical assistance.

The OCSD and Intake Release Center requires a safety check every fifteen minutes. A safety check can be described as a direct, visual observation to provide for the health and welfare of inmates that is completed every fifteen minutes at a minimum. More frequent safety checks are encouraged. Every safety check is logged by the person conducting the check. On July 13, 2020, the day of Choi's death, the safety checks of module L, sector 18 were conducted every fifteen minutes per the safety check protocol.

At 6:15 a.m., RN “Jane Doe #1” conducted a sector check and observed Choi lying with his back on the bunk and his head slightly elevated. RN “Jane Doe #1” observed Choi either chewing food or moving his right hand. After conducting the safety check, she logged it in and exited the sector. At 6:30 a.m., Deputy Hanley began his safety check. At 6:33 a.m., Deputy Hanley observed Choi lying with his back on the bunk and his legs hanging over the bed. His chest did not appear to be rising or following, at which point, Deputy Hanley called for assistance from Deputy Snow to enter into Choi's cell to check on him. Immediately upon discovering Choi's condition, deputies initiated a "man-down" call, started CPR, called for medical assistance, and requested OCFA paramedics. Within minutes, the medical team began to remove the food from Choi's mouth, set up an AED to Choi's chest, and continued CPR. When OCFA paramedics arrived on scene, they took over patient care and transported him to the hospital. Upon arrival to the hospital, life-saving attempts were exhausted until Choi was pronounced deceased on July 16, 2020 by medical personnel.

Thus, the totality of the evidence do not support a conclusion that OCSD personnel or any individual under the supervision of OCSD failed to perform a legal duty causing the death of Choi.

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 beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Choi.

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

Respectfully submitted,

WHITNEY BOKOSKY
Senior Deputy District Attorney
Homicide Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney Felony Operations IV

Read and Approved by District Attorney **TODD SPITZER**