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October 30, 2012

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

Re: Custodial Death on July 3, 2011
Death of Inmate Charlotte Jean Engle
District Attorney Investigations Case # 11-012
Santa Ana DR # 11-012 / FR # 11-48962

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 July 3, 2011, custodial death of inmate Charlotte Jean Engle.

## OVERVIEW

This letter contains a description of the scope and legal conclusions resulting from the OCDA's investigation of the July 3, 2011, custodial-related death of inmate Engle at Western Medical Center in Santa Ana. 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 personnel from the Newport Beach Police Department (NBPD) or Orange County Sheriff's Department (OCSD).

On July 4, 2011, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center after Engle died while in custody and was declared brain dead. 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 Newport Beach Fire Department (NBFD) personnel, NBPD officer, OCSD personnel, or Santa Ana Fire Department personnel. The OCDA will not be addressing policy, training, tactics, or civil liability.

During the course of this investigation, OCDA Investigators interviewed 14 witnesses. Additionally, we obtained and reviewed NBFD reports, NBPD reports, OCSD reports, laboratory and identification reports, hospital records, and other relevant reports and materials.

The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and legal standards available.

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

An important part of investigating incidents such as this is seeking to obtain a statement from people who had contact with the deceased in the hours leading up to her death. All involved NBPD and OCSD personnel voluntarily spoke to OCDA investigators.

## FACTS

On July 1, 2011, at approximately 3:30 p.m., Engle approached NBFD Captain Cameron Hutzler, firefighter engineer Jimmy Strack, and firefighter Cory Freeman in the parking lot near Wells Fargo Bank located at 2750 West Coast Highway in Newport Beach. She stated that she had just been in a car accident in the parking lot, and that the man in the other car had become hostile. At this point, both parties to the accident had contacted Newport Beach Police, but the police had not responded to the scene because the accident was on private property.

Captain Hutzler smelled a faint odor of alcohol on Engle's breath and noted that she was anxious, but said that her level of anxiety seemed appropriate given the situation. Captain Hutzler and his crew went to the scene of the accident to see how they could help. The damage to the vehicles was minimal. It was evident that Engle had hit the other party's car while she was trying to park her vehicle.

While Captain Hutzler attempted to ask questions of both parties regarding the incident, Engle became interruptive and hostile. Firefighter engineer Strack pulled Engle aside to medically evaluate her. Engle complained of anxiety, but not of any kind of injury, pain, dizziness, blurred vision, or ringing in the ears. She had no difficulty answering any orientation questions. All of her vitals were appropriate. While she was being evaluated by firefighter engineer Strack, Captain Hutzler called NBPD to inform them of a possible driving under the influence (DUI) incident.

NBPD Officer David Darling was the first to respond to the scene and began conducting a field sobriety test, beginning with a horizontal gaze nystagmus test. Engle had difficulties complying with the instructions for the nystagmus test, but the test did ultimately indicate that she was impaired. She showed no evidence of a head injury. Her eyes appeared to be watery, but not bloodshot. When Engle made inconsistent statements regarding how the accident had happened, Officer Darling asked paramedics to test for diabetic shock, but they found no evidence of shock.

Engle admitted to police that she had a glass of wine at 5:30 a.m. and took a Klonapine at 11:30 a.m. During the remainder of the field sobriety test, Engle was unable to remain focused. NBPD Reserve Officer Jonathan Sunshine arrived while Officer Darling was conducting the field sobriety test. The rest of the field sobriety test confirmed that Engle was impaired – she had poor balance and failed the alphabet test and had mildly slurred speech. In addition, when Officer Sunshine used a portable breath-testing device to measure Engle's breath alcohol, it showed a blood alcohol content (BAC) of approximately 0.13%. Neither Officers Darling nor Sunshine noticed anything about Engle that would indicate that she was in need of any medical assistance. Officer Darling informed Engle that she was being arrested for DUI.

Officer Sunshine drove Engle to the Newport Beach Police station in a department transportation van. She was the only passenger in the van and made no complaints of pain, illness, or injury. Once she arrived at the NBPD station, Engle was searched by a female officer and underwent a medical evaluation by Custody Officer Bob Yamada. During her intake process, Engle disclosed that she was under a doctor's care for high blood pressure and psychological problems and that she was taking Atenolol for high blood pressure, Prilosec for acid reflux, and Klonapine for anxiety. She also reported that she had a knee replacement. She did not report any other health issues upon intake. A contracted agency drew blood to test for blood alcohol levels, which later tested at 0.12% BAC. Officer Yamada did not observe anything abnormal about Engle during the time she was detained at the station.

When Newport Beach Police Reserve Officer Dennis Hoo handcuffed Engle in order to transport her to the OCSD Intake and Release Center (IRC), she became upset and expressed concerns for her dogs. Officer Hoo allowed Engle to make two phone calls to make arrangements for someone to care for her dogs. There were three male detainees in the van along with Engle, but they were separated from her by a partition. All four detainees reached the IRC without incident.

Officer Hoo escorted the four directly to the IRC's triage bench. Officer Hoo reported that Engle was walking around aimlessly in the triage area until she was asked to sit down. Engle never complained of or showed any kinds of medical distress while in Officer Hoo's custody. When Officer Hoo left the IRC, Engle was still sitting on the triage bench.

Engle reported to IRC medical staff that she suffered from high blood pressure and psychological problems and that she drank regularly. She indicated that she was receiving treatment for menopausal depression. She was deemed acceptable for booking, but that she needed to be treated with medication for her high blood pressure; she was given Atenolol prior to being placed in a holding cell. She was also referred to mental health. She otherwise complained of no health problems and none were observed.

On July 2, 2011, at approximately 12:20 a.m., Engle was placed in a holding cell and was given a cup to collect a urine sample. One other inmate, Lindsey H., was in the cell with Engle. According to OCSD Deputy Sherri Mullen, Lindsey H. was crying and seemed oblivious to her surroundings. Lindsey H. stated that she saw Engle walk toward the rear of the cell toward the toilet, behind the privacy wall, and sit down to collect a urine sample.

Lindsey H. stated that, when Engle sat down on the toilet, Deputy Mullen called for Engle by name, and Engle said that she could not get up from the toilet. Lindsey H. stated that Deputy Mullen again told Engle to get up, after which Engle attempted to stand up, but fell. Deputy Mullen stated that, when she opened the door to the holding cell and called Engle's name, no one answered. She then closed the cell door and looked over at the medical triage bench to check for Engle. When she did not see Engle there, she went into the holding cell and discovered Engle lying on the floor, halfway behind the privacy wall. Deputy Mullen estimated that Engle was in the cell for a total of about 10 minutes before she was found. Deputy Mullen asked Engle what had happened, and Engle replied that her arm hurt, and didn't respond when Deputy Mullen further asked her if she had fallen. Deputy Mullen told Engle not to move and indicated to a passing medical staff member that help was needed.

At approximately 12:35 a.m., two correctional health services nurses responded. Deputy Mullen removed inmate Lindsey H. from the holding cell. The nurses felt Engle's head and arms for an initial assessment, determining that there were no signs of neurological or spinal injuries. While they moved her to a wheelchair, they noticed that Engle had decreased

movement on her left side and was unable to lift herself into the chair. One of the nurses checked for facial movement symmetry because he suspected a stroke. He also conducted a "hand drop test," and her left hand dropped. The nurse recognized all of these as signs of a stroke and immediately requested paramedics. The nurses then transferred Engle onto a gurney and relocated her to the triage area to have more space to treat her. They began a saline intravenous line and oxygen via a face mask. Her pulse and blood pressure, while waiting for paramedics, was appropriate given her medical history and nervousness.

When SAFD paramedics arrived at the IRC at 12:44 a.m., the nurse notified them that Engle was a stroke patient and that she had complained of left-sided weakness and a headache and displayed slurred speech. Engle vomited in the mask, so paramedics turned her on her side to keep her airway clear. Paramedics also determined that Engle was unable to move the left side of her body. Per OCSD policy, a deputy must accompany any inmate who is taken to the hospital. In order to leave the facility, the deputy assigned as an escort had to change into a patrol uniform. At 1:05 a.m. paramedics decided to leave without an escort because they felt the delay was too long.

On the way to Western Medical Center, Engle was given 8 mg of Zofran to reduce her vomiting, and oxygen was administered through a "blow-by" technique in case she vomited again. Engle's condition deteriorated while she was in transport. Paramedics suspected that she had suffered a stroke, but it was difficult to determine whether the vomit in her mouth had caused her slurred speech as well. They arrived at Western Medical Center at 1:11 a.m., and Engle was relinquished to the care of emergency room (ER) staff. After OCSD Deputy Julian Saenz, who was assigned as the escort, arrived at the hospital, he observed that Engle was unconscious and that ER staff were intubating her. Within one hour of his arrival, a CAT scan was done, and a few hours later, Engle was transported to the Critical Care Unit. Deputy Saenz observed no signs of trauma and indicated that hospital staff appeared to be treating Engle appropriately.

Upon arrival at the CCU at 4:45 a.m., Engle was displaying symptoms that were indicative of brain death. Engle's condition was monitored and given medication to help stabilize her blood pressure. Neurosurgeons conducted tests and determined that blood was no longer flowing to Engle's brain. Dr. Yancey Beamer declared Engle brain dead on July 3, 2011, at 6:35 p.m.

## AUTOPSY

On July 9, 2011, at approximately 10:00 a.m., United Forensic Services, P.C., Forensic Pathologist Dr. Joseph Cohen performed the post-mortem examination of Engle at the Orange County Sheriff-Coroner's Department Coroner's Division Facility. After completing the examination, Dr. Cohen concluded that the cause of death was a stroke due to hypertension, with chronic alcoholism as a contributing factor.

## EVIDENCE ANALYSIS

## TOXICOLOGY

OCCL analyzed Engle's blood sample for BAC. The following results were obtained:

| ANALYSIS DATE | INST # | RESULTS |
|---|---|---|
| 07/05/2011A | 22-29 | 0.132 +/- 0.004 |
| 07/05/2011A | 11-29 | 0.126 +/- 0.004 |

Engle's post-mortem and antemortem blood samples were analyzed for prescription drugs and common drugs of abuse; none were detected.

## 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 elements 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 deliberately acted with conscious disregard for human life.

A person can also commit murder by his 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.

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 NBFD personnel, NBPD officer, OCSD personnel, or SAFD personnel. Thus, the only possible type of homicide to analyze in this situation is murder or involuntary manslaughter under the theory of failure to perform a legal duty.

As Engle's jailers, the NBPD and OCSD owed Engle a duty of care. However, the evidence does not support a finding that the duty was breached – neither intentionally (as required for murder) nor through criminal negligence (as required for involuntary manslaughter). Newport Beach Police followed appropriate procedures and protocol, including assuring that Engle did not need medical attention before being taken into custody and post-arrest medical screening. During the time she was in their custody, she made no complaints of pain or illness, nor did any officers observe any signs of medical distress.

Similarly, OCSD personnel followed appropriate procedures, including medical screening upon intake. Upon intake, Engle was appropriately treated with her prescription medication for high blood pressure and initially showed no signs of medical distress. Once Engle showed signs of medical distress, OCSD personnel responded appropriately to assess and address

her medical needs. While there was a short delay while waiting for an escort to the emergency room, this delay does not rise to the level of criminal negligence. Further, there was no indication of injury or trauma from any person that Engle came into contact with.

**CONCLUSION**

Based on all evidence provided and reviewed by the OCDA and pursuant to applicable legal principles, it is my legal opinion that that evidence does not support a finding of criminal culpability on the part of any NBPD personnel or OCSD personnel. It is my conclusion that Engle died as a result of stroke due to hypertension, with chronic alcoholism as a contributing factor.

Respectfully,

Sonia Balleste
Senior Deputy District Attorney
Homicide Unit

Read and Approved,

Dan Wagner
Assistant District Attorney
Head of Homicide Unit