OFFICE OF THE
# DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

August 17, 2022

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

Re: Custodial Death on July 31, 2021
Death of Inmate Omar Jose Valle
District Attorney Investigations Case # 21-002837
Orange County Sheriff's Department Case # 21-025654
Orange County Crime Laboratory Case # FR 21-49927

Dear Sheriff Barnes,

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 31, 2021 custodial death of 29-year-old inmate Omar Jose Valle.

## OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Omar Jose Valle. 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 August 1, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Jail in reference to an inmate who died while in custody. Upon arrival, Investigators learned that inmate Omar Valle died while in custody on July 31, 2021. During the course of this investigation, the OCDASAU interviewed eight (8) witnesses and obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL). Investigators also reviewed 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 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, TARGET/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 Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

## FACTS

On Wednesday July 28, 2021, Omar Valle appeared at the North Justice Center, Department N8, to be arraigned on a violation of the terms of his probation (Court Case #19WM06380). At the conclusion of the arraignment, a formal probation violation hearing was set for August 16, 2021 and Valle was remanded to the custody of the Orange County Sheriff's Department (OCSD). Following the arraignment, Valle was transported to the Orange County Jail (OCJ) Intake Release Center (IRC) for booking.

At approximately 18:10 hours, Valle was booked into OCJ IRC. During the booking process, Valle was screened by an Orange County Health Care (OCHC) Comprehensive Care Registered Nurse (RN). The RN reported that Valle communicated efficiently and was oriented as to his person, place, and time. Valle did not appear unsteady, confused, or lethargic. Valle denied any medical problems, but disclosed prior mental health issues. Valle explained that in July 2020, he spent one (1) week in a psychiatric unit, but he was unable to explain why he was placed in the psychiatric care facility. Valle denied prior suicide attempts and denied having any current suicidal ideations. Valle was referred to Mental Health Triage and placed into booking loop Cell PM 1.

At approximately 20:00 hours, Deputies responded to Cell PM 1 in regards to an inmate striking himself in the face. Deputies arrived and found Valle repeatedly hitting himself in the face with a closed fist. Valle was handcuffed and escorted to Mental Health for evaluation. At Mental Health, Valle was again evaluated by a Registered Nurse.

During the evaluation, Valle's mood was observed to be aggressive, depressed, and agitated, but he was oriented as to his person, place, and time. Valle disclosed a prior diagnosis of anxiety and depression. He indicated that he had attempted suicide once in 2018 or 2019 by driving his car into parked cars, but denied any suicide attempts within the last three months. The nurse indicated a need for suicide watch and designated Valle for mental health housing in Mod-L. The nurse also gave Valle a mental health referral for a Mod-L psych evaluation. Due to unavailable housing in module L, Valle was placed into Receiving and Observation (RO) cell 5 with a safety gown and a mattress as a mental health expedite.

On Thursday, July 29, 2021, at approximately 21:28 hours, a cell became available in Mod-L and Valle was transferred from RO Cell 5 to Mod-L, Sector 18, Cell 12.

On Saturday, July 31, 2021, at approximately 09:25 hours, a Nurse Practitioner conducted a second psychiatric evaluation with Valle. During that evaluation, Valle stated that he had made the previous suicidal statements because he got frustrated about the court decision to make him stay in jail longer. Valle denied feeling depressed or anxious. He denied any suicidal plans, ideations, or intentions. Following this evaluation, the Nurse Practitioner determined Valle was not a threat to himself and cleared Valle for regular inmate housing.

Pursuant to COVID-19 protocols, Valle was assigned to complete a two-week COVID-19 quarantine in Mod N, Sector 30, Cell 8 (N-30-8). Valle was transferred to Mod-N, Sector 30, Cell 8, at approximately 09:50 hours.

Mod-N is equipped with a closed-circuit television (CCTV) video surveillance system with no audio that captures the mod from a 180-degree view. The entrance and front left-hand side of cell 8 can be seen from the video footage. A review of the video surveillance of the cell revealed the following:

Valle was housed alone in his cell. Between the time that Valle entered his cell at 12:30 hours until 21:48 when Deputies discovered Valle, no one entered Valle's cell. During this period, Valle's cell was locked, except for two medication distributions and one meal delivery. The cell was unlocked at approximately 13:53 hours for Valle's medication distribution, at 15:15 hours for his meal delivery, and again at 19:22 hours for another medication distribution. On each occasion, the cell door was closed and locked immediately after the medication and meal deliveries were completed. At approximately 21:09 hours, Valle was released from his cell to obtain a clean shirt and towel and immediately returned to his cell.

Throughout the day, Deputies completed safety checks, without incident, every forty-five (45) minutes as required. They performed additional informal safety checks during medication and meal distributions and while completing inmate book counts.

At approximately 20:22 hours, Deputy Tran and Deputy Olive conducted a head count of Mod N. Valle had not received his ID bracelet yet, so Deputy Tran verified his identity by asking for Valle's name and matching it with his photo. Deputy Tran described Valle as "quiet" and "not really talkative." Deputy Tran also reported that Valle was cognitive and able to answer questions. He also indicated that Valle did not appear angry, depressed, or anything else out of the ordinary.

After this, Valle is seen on the surveillance footage periodically pacing in and out of camera view within his cell for approximately twenty-five (25) minutes. At approximately 20:49 hours, Valle can be seen standing at his cell window, looking out over the day room, twisting what appears to be a white towel in his hands. Valle placed the white towel around the back of his neck in a U shape holding

the ends down in front of his torso. Valle then turned and walked toward the back of the cell out of camera view. This is the last time he is seen moving on the surveillance footage.

At approximately 20:56 hours, Deputy Tran and Deputy Olive conducted a safety check of Sector 30 without issue. At approximately 21:17 hours, another inmate walked past Valle's cell to use the payphone. During his interview, this inmate made no mention of seeing anything unusual in Valle's cell during this time.

At approximately 21:48, Deputy Tran and Deputy Olive conducted their routine safety walk. Deputy Tran looked through the window of Valle's cell and noticed him kneeling with a sheet around his neck in a "praying position." Deputy Tran kicked the door, but Valle did not respond. Deputy Tran immediately yelled to Deputy Olive. Deputy Tran then broadcasted via his hand-held radio, "914 Alpha [attempt suicide] Mod November, Sector 30, Cell 8, additional prowlers [code for jail deputies assigned to respond to emergency calls]."

At approximately 21:48:37 hours, Deputy Tran used his key to open Valle's cell door, and he and Deputy Olive entered the cell. Valle was hanging from two bedsheets tied together. One was across the top bunk and the second was around his neck. Deputy Olive immediately lifted Valle up to release the tension around his neck while Deputy Tran cut the sheet from the bunk and placed Valle on the floor.

Valle's skin was still warm, his eyes were open, and there was snot coming out of his nose. Deputy Olive assessed Valle and determined he had no pulse and no respirations. Deputy Olive immediately initiated chest compressions and completed approximately three (3) rounds of CPR before medical personnel arrived at 21:50 hours. Deputy Olive continued to perform chest compressions while medical personnel provided oxygen via an air-bag-valve mask. Automated external defibrillator (AED) pads were placed on Valle. CPR was paused three (3) or four (4) times to allow the AED to evaluate Valle. Each time the AED advised no shock, continue CPR.

This was continued until Orange County Fire Authority (OCFA) Paramedics arrived at approximately 22:03 hours. When OCFA Paramedics arrived, Valle was unresponsive and his skin was pale and cyanotic, his pupils were fixed and dilated, and he had no pulse and no respirations. Paramedics noticed there was visible trauma to his neck consistent with hanging. At approximately 22:05 hours, the OCFA heart monitor showed Valle was in pulseless electrical activity (PEA). Valle was intubated and an advanced airway was placed. CPR was continued and an intraosseous infusion (IO) was introduced into the right anteromedial aspect. Advanced Life Support (ALS) medications, including Epinephrine, Sodium Bicarbonate and Normal Saline were administered.

At approximately 22:25 hours, all advanced lifesaving efforts were ceased and Dr. Imran Imam pronounced Valle dead.

## EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Swabs of Valle's face, hands, and fingers
- One (1) light green jail shirt
- One (1) light green jail pants
- One (1) pair of white boxers
- One (1) white t-shirt
- One (1) pair of black socks
- One (1) piece of white fabric from floor

- Two (2) pieces of sheet from bed
- Bloodstain standard
- Eighty-eight (88) digital photographs of the scene and body
- Fifty-six (56) digital photographs during the autopsy
- Twenty-two (22) post embalming photographs

**AUTOPSY**

On August 18, 2021, Forensic Pathologist Dr. Scott A. Luzi of the Orange County Coroner's Office conducted an autopsy on the body of Omar Valle. Dr. Luzi observed a 37-centimeter discontinuous ligature furrow on the skin of Valle's neck. Dr. Luzi's preliminary finding was that Valle's death was consistent with ligature hanging. Dr .Luiz concluded that the cause of death was a hanging and that the manner of death was a suicide.

Other relevant autopsy findings are as follows:

I. Hanging
II. Other injuries
    a. Contusion, abdomen
    b. Contusion, left hip
    c. Contusion, right knee
    d. Contusion, left knee
III. Natural disease and preexisting conditions
    a. Cluster of skin erosions, chest
    b. Healing skin erosions, left hand and right ankle
    c. Cerebral edema
    d. Pulmonary congestion and edema
    e. Left ventricular hypertrophy
    f. Mild peripheral atherosclerosis

**EVIDENCE ANALYSIS**

**Toxicological Examination**

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

| DRUG | MATRIX | RESULTS & INTERPRETATIONS |
|---|---|---|
| THC | Postmortem Blood | 0.0038 ± 0.0006 mg/L |
| Carboxy-THC | Postmortem Blood | 0.0070 ± 0.0010 mg/L |
| Ethanol/Volatiles | Postmortem Blood | Not Detected |
| Amphetamine and Related | Postmortem Blood | Negative |
| Barbiturates | Postmortem Blood | Negative |
| Methamphetamine and Related | Postmortem Blood | Negative |
| Cannabinoids | Postmortem Blood | Presumptive Positive |

## BACKGROUND INFORMATION

Omar Valle had a State of California Criminal History record that revealed arrests dating back to 2009 for the following violations:

1. PC 496(A) - Receiving Stolen Property
2. PC 148(A)(1) - Obstructing a Police Officer
3. PC 602(K) – Trespass
4. PC 602(M) – Trespass
5. VC 10851 - Taking Vehicle Without Owner's Consent
6. PC 496D(A) – Possessing a Stolen Vehicle
7. PC 21810 - Possessing Metal Knuckles
8. PC 487(A) - Grand Theft
9. PC 69 - Obstructing a Police Officer
10. PC 647(F) - Disorderly Conduct, Under the Influence of Drugs
11. VC 23152(A) - Driving Under the Influence of Alcohol
12. VC 23152(B) - Driving Under the Influence of Alcohol / 0.08 Percent
13. HS 11364(A) - Possession of Unlawful Paraphernalia
14. VC 12500(A) - Driving on Suspended License
15. PC 1203.2 - Violation of Parole

## 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 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; 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:

> "[T]he most important consideration 'in establishing duty is foreseeability.' [citation] 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 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 Valle a duty of care, the evidence does not support a finding that this duty was in any way breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). There is no evidence that Deputies and/or jail staff failed to take reasonable action to summon medical or mental health care upon notice it was needed. During booking, Valle disclosed prior mental health issues, but denied prior suicide attempts or having any current suicidal ideations. Valle was referred to Mental Health Triage and placed into booking loop Cell PM 1. Approximately one hour later (20:00 hours), Deputies responded to Valle's cell upon reports he was hitting himself in the face. Valle was immediately handcuffed and escorted to Mental Health for evaluation. During the evaluation, Valle was aggressive, depressed, and agitated, but he was oriented as to his person, place, and time. Valle disclosed one prior suicide

attempt from a few years ago. Valle also disclosed a depression and anxiety diagnosis. The nurse thereafter designated Valle for suicide watch, mental health housing in Mod-L, and a Mod-L psych evaluation. Due to unavailable housing in Mod L, Valle was transferred to RO cell 5 with a safety gown and a mattress as a mental health expedite. The next day on July 29, 2021, Valle was transferred to Mod L. On July 31, 2021, after remaining in Mental Health housing for approximately two days, Valle received a psych evaluation where he indicated that his previous suicidal statements were due to frustration about the court requiring him to remain in jail. Valle denied feeling anxious, depressed, or suicidal. Only after this evaluation, Valle was then cleared for regular housing.

There is no evidence to indicate that the deputies were careless or were inattentive towards Valle once he was transferred to Mod N, Sector 30, Cell 8. Valle was housed alone in a cell per OCSD's jail quarantine protocol. The deputies checked on and observed Valle during his two medical distributions and one meal distribution. Other than being described as "quiet" and "not really talkative," there was nothing in his behavior that alarmed Deputy Tran to a possible safety risk. He did not appear angry, depressed, or anything out of the ordinary. Valle can be seen moving around his cell throughout the day.

There is no evidence to indicate that Deputy Tran or Deputy Olive acted in a way that was so different from how an ordinary person would act in the same situation, as criminal negligence requires. Rather, Deputy Tran and Deputy Olive acted in accordance with OCSD policy. Deputies conducted routine safety walks and head counts every forty-five minutes as required. Valle is last seen moving throughout his cell in the CCTV footage at 20:47 hours. Approximately 14 minutes later (20:01 hours), Deputies conducted a routine safety walk and noticed nothing out of the ordinary occurring in Valle's cell. The fact that another inmate walked past Valle's cell approximately 16 minutes after the safety check (21:17 hours) and did not notice anything unusual further indicates that Deputy Tran did not act inattentively during the 20:01 hour safety check.

There is no evidence to indicate that deputies knew an inmate needed medical care and failed to take reasonable effort to summon that care. At approximately 21:48, Deputy Tran conducted a routine safety walk and noticed Valle kneeling in a "praying position" with a sheet around his neck. Deputy Tran kicked the door. When Valle did not respond, Deputy Tran immediately yelled for help from Deputy Olive. Deputy Tran also promptly broadcasted "914 Alpha...additional prowlers" to request emergency assistance for an attempted suicide. Within a minute, Deputy Tran and Deputy Olive lifted Valle up, cut the sheet from the bunk, placed Valle on the floor, and initiated chest compressions. Within minutes, medical staff arrived. CPR was paused three to four times to allow the AED to evaluate Valle, but each time the AED advised no shock. CPR continued. OCFA Paramedics arrived shortly thereafter and administered ALS medications including Epinephrine, Sodium Bicarbonate and Normal Saline. Valle's condition remained unchanged. Despite performing these measures for almost an hour (21:48 to 22:55), the resuscitative efforts were unsuccessful and Valle was pronounced dead at 22:55 hours.

Thus, there is 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.

**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 that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Valle. The evidence shows that Valle died as a result of suicide by hanging.

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

**Harris Siddiq**
Deputy District Attorney
Gang Unit

READ AND REVIEWED BY **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

READ AND APPROVED BY DISTRICT ATTORNEY **TODD SPITZER**