OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

September 19, 2022

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

Re: Custodial Death on March 14, 2021
Death of Inmate Eric Paul Ivanoff
District Attorney Investigations Case # SA 21-000847
Orange County Sheriff's Department Case # 21-008667
Orange County Crime Laboratory Case # 21-43153

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 March 14, 2021, custodial death, of 41-year-old inmate Eric Paul Ivanoff.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Eric Paul Ivanoff. 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 March 14, 2021, Orange County District Attorney Special Assignment Unit (OCDASAU) Investigators responded to the OCSD's Intake/Release Center (IRC) in the city of Santa Ana, where Ivanoff died while in custody, having been discovered in his cell, hanging from his bedsheet. During the course of this investigation, the OCDASAU interviewed more than twenty witnesses, including the thirteen (13) inmates housed in Invanoff's module at the time of his death, obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), scene photographs, identification reports, videos from the jail, audio recordings, digital images 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 read and 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 August 7, 2020, Ivanoff was involved in dispute with Suzanne Moriarty, his stepmother at their home in Cypress. During the dispute, Ivanoff grabbed Ms. Moriarty by the neck and stabbed her with a kitchen knife. Paul Ivanoff, his father, grabbed Ivanoff and tried to protect Ms. Moriarty. Ivanoff began stabbing himself in the neck and abdomen. Cypress Police Department (CPD) Officers arrived and detained Ivanoff. They provided lifesaving treatment to Ms. Moriarty at the scene and transported her to UCI Medical Center. CPD officers administered lifesaving care to Ivanoff and transported him to Long Beach Memorial Hospital. Ms. Moriarty and Ivanoff survived their injuries. Ivanoff was hospitalized until August 18, 2020.

On August 18, 2020, when Ivanoff was discharged from Long Beach Memorial Hospital, he was placed under arrest by the Cypress Police Department for attempted murder, assault with a deadly weapon, assault with a caustic chemical, and attempted mayhem. At approximately 8:16 p.m., Ivanoff was transported and booked into the OCSD IRC.

At approximately 8:43 p.m., Nurse J.S., an Orange County Health Care Agency (HCA) Comprehensive Care Registered Nurse, completed the medical screening of Ivanoff. Ivanoff was

oriented to person, place, and time, and was able to communicate effectively. Ivanoff told Sepulveda he was transgender, HIV positive, and Bipolar. J.S. scheduled Ivanoff to receive daily wound care due to his stab wounds to his neck and abdomen. J.S. referred Ivanoff to Mental Health Triage.

At approximately 9:01 p.m., HCA Nurse F.S. completed the Mental Health screening of Ivanoff. Ivanoff was calm and cooperative and disclosed that he had been previously diagnosed with Bipolar Depression and had previously been prescribed Seroquel, Inderal, Remeron, and Adderall. Due to the severity of Ivanoff's injuries and the seriousness of his charges, Nurse F.S. believed Ivanoff was at a high risk for suicide. Ivanoff was placed in a safety gown and held in IRC receiving and observation until a cell in the Acute Mental Health Unit, Module L became available.

At approximately 10:05 p.m., Psychiatrist J.H. directed that Ivanoff be placed on a daily medication protocol of Topamax, Vistaril, and Inderal, and that Ivanoff be seen daily by HCA mental health providers. The next day at approximately, 4:43 p.m., Psychiatrist E.J. added Seroquel and Risperidone to Ivanoff's daily medication regiment.

On August 20, 2020, at approximately 12:03 p.m., Ivanoff was transferred from IRC receiving and observation unit to Module L, Sector 17, Cell 4. On September 7, 2020, at approximately 12:03 p.m., Ivanoff was transferred from Module L to Module K and housed in Sector 9, cell 5.

On September 12, 2020, at approximately 8:09 p.m., Nurse M.A. was advised by an OCSD deputy that a noose made out of blankets and 12 Seroquel tablets, 5 Propranolol tablets and 5 Remeron tablets, had been found in Ivanoff's cell. Ivanoff denied any knowledge of the existence of these items and denied suicidal ideations. At approximately 10:25 p.m., Nurse K.B. recommended that Ivanoff be moved to Mod L, Sector 18, Cell 10 and placed into lockdown and scheduled him to be seen by a psychiatrist the following day.

On September 13, 2020 at approximately 1:23 p.m., Ivanoff was seen by Psychiatrist E.L. Again, Ivanoff denied making the noose or hoarding the pills. Ivanoff continued to deny suicidal ideations. Psychiatrist E.L. directed HCA to crush all of Ivanoff's medications and dissolve them in water prior to giving them to Ivanoff.

On September 23, 2020, Psychiatrist S.J., in consultation with staff who were familiar with Ivanoff's psychiatric history, concluded that Ivanoff could be moved from Mod L in the Acute Mental Health Unit to Mod K the Chronic Mental Health Unit.

On September 26, 2020, at approximately 4:11 p.m., Ivanoff was transferred from Mod L to Mod K and housed in Sector 9, Cell 5. Ivanoff remained in Mod K, Sector 9, Cell 5 until November 4, 2020, at which point he was transferred to Mod J, Sector 8, Cell 8. Cell 8 is a two-person cell, but Ivanoff was never assigned a cellmate. In this module, odd numbered cells are on the first floor and even numbered cells are located on the upper floor. Ivanoff's cell was number 8 so he was on the upper floor.

On November 10, 2020, Mental Health Specialist K.G. met with Ivanoff for routine case management and potential discharge from the mental health program. K.G. described Ivanoff as stable. Ivanoff again denied having suicidal ideations. Ivanoff additionally denied homicidal ideations.

On March 14, 2021, at approximately 6:02 p.m., Deputy Carlos Palomares-Velasco completed a safety check of the upper level cells in Mod J, Sector 8, Ivanoff's cell location. Video surveillance from the module shows Deputy Palomares-Velasco walk by Cell 8. As Deputy Palomares-Velasco walks by Sector 8, Cell 8, Ivanoff is seen standing by the door looking out towards Deputy Palomares-Velasco. The video shows Ivanoff calmly looking out of the window. There was nothing unusual or remarkable about Ivanoff's behavior. After conducting his safety check of the sector, the video shows Deputy Palomares-Velasco leave the sector.

At approximately 6:59 p.m., video surveillance shows Deputy Daniel Neumann and HCA License Vocational Nurse (LVN) S.D. entered Sector 8 to begin to distribute medication to the inmates. Deputy Neumann and Nurse S.D. begin to distribute medication to the odd numbered cells on the ground level, before walking up the stairs to the even numbered cells on the upper level.

At approximately 7:01 p.m., Deputy Neumann walks by Ivanoff's cell and knocks on the cell window, which is his habit and practice of alerting inmates that their medicine has arrived. Deputy Neumann noticed Ivanoff did not respond, which was highly unusual, and was not moving. Deputy Neumann immediately entered Ivanoff's cell and saw that Ivanoff had something wrapped around his neck. Deputy Neumann used his hand-held radio and broadcasted, "Man down, Mod J, Sector 8." Deputy Neumann used safety cutters to cut the bed sheet which was around Ivanoff's neck and tied to the top bunk of Ivanoff's bed. Deputy Neumann laid Ivanoff on the floor and LVN S.D. entered the cell to assess Ivanoff's condition. LVN S.D. determined that Ivanoff had no pulse, no respirations and was cyanotic. Deputy Neumann engaged in chest compressions while Nurse S.D. stepped out of the cell to flag down the medical personnel.

At approximately 7:02 p.m., HCA personnel arrived with a "man down bag." Deputy Neumann continued to perform chest compressions on Ivanoff until Deputy Sean Huddleston relieved him. Both deputies continued to perform chest compressions while medical personnel provided oxygen via an air bag valve mask. An intravenous line was placed and CPR was performed on Ivanoff until paramedics arrived.

At approximately 7:12 p.m., Orange County Fire Authority (OCFA) personnel arrived and were told of the observations made by Deputy Neumann and Nurse S.D. OCFA personnel examined Ivanoff and observed he was unresponsive, his skin was cool, dry and pale, and his pupils were fixed and dilated. The heart monitor attached to Ivanoff confirmed he was in asystole. OCFA personnel observed that the only trauma Ivanoff exhibited was redness around his neck. OCFA pronounced Ivanoff deceased at 7:15 p.m. Ivanoff's body was covered with a sheet and the OCDA, OCSD, and Orange County Coroner's Office (OCCO) began an investigation into his death.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Swabs of Ivanoff's face, hands, and neck
- Ivanoff's clothing
    - Pants
    - Socks (2)
    - Boxers
    - T-shirt (2)

- 2 pieces of apparent ligature
- 19 videos from the jail
- 26 jail calls made by Ivanoff
- OCSD Packet including Certified Inmate File, TRED records, HCA J112 forms, Initial Packet and Activity Logs, and Death Packet
- 210 OCCL photos of scene, post embalming, and autopsy
- 41 OCCO photos of scene

AUTOPSY

On March 19, 2021, Forensic Pathologist Dr. Scott Luzi of OCCO conducted an autopsy on the body of Ivanoff. Dr. Luzi observed a 43 cm circumferential, brown, discontinuous ligature furrow on the skin of the neck. Dr. Luzi's preliminary finding was that the death was consistent with suicide by ligature strangulation, and ultimately concluded that the cause of death was hanging and the manner of death was suicide.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Ivanoff's postmortem blood was examined for the presence of drugs and alcohol. No alcohol or illicit drugs were detected. There was caffeine and Lamotrigine, his prescription medication, detected in his system at the time of his death.

BACKGROUND INFORMATION

Ivanoff had a State of California Criminal History record that revealed arrests for the following violations:

- Driving Under the Influence, Causing Bodily Injury
- Driving with a Blood Alcohol Level over .08%, Causing Bodily Injury
- Hit & Run, Causing Injury or Death
- Obstruct/ Resist Executive Officer
- Resist Peace Officer
- Arson: Inhabited Structure
- Battery upon a Peace Officer
- Attempted Murder
- Assault with a Deadly Weapon, Likely to Commit Injury
- Assault with a Caustic Chemical

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 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 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, other inmates, or other individuals under the supervision of the OCSD. Video surveillance confirms that Ivanoff was the only person in the cell when he died. Photographs of Ivanoff, his autopsy, and the statements of the OCSD and medical personnel about their observations, confirm that Ivanoff died from strangulation of a ligature that he used against himself. 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 Ivanoff 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). Ivanoff was provided appropriate care by the medical staff within the jail leading up to the date he died, OCSD deputies performed the appropriate safety checks on Ivanoff before and after his death, and the treatment of Ivanoff once his body was discovered was reasonable and appropriate.

First, Ivanoff was psychiatrically evaluated several times and Ivanoff's mental state was monitored closely and regularly. Each time Ivanoff was questioned regarding suicidal ideation, Ivanoff denied suicidal ideations. Ivanoff appeared to be stable and was calm and cooperative when spoken to by OCSD personnel.

On September 12, 2021, when a noose made out of blanket and several medications were found in Ivanoff's cell, Ivanoff was immediately moved to a different cell and placed into lockdown. The following day, Ivanoff was seen by psychiatrist E.L., and HCA personnel were instructed to crush Ivanoff's medications and dissolve them in water prior to giving them to Ivanoff. Over the next few days, HCA personnel routinely checked in on Ivanoff's mental health. Ivanoff was only removed from Module L and placed into Module K after a determination by medical personnel that he did not pose a danger to himself. There were no incidents of Ivanoff having suicidal ideations or making any attempts to hurt himself before March 14, 2021. In sum, there was nothing to suggest that OCSD medical staff was in any way negligent in their evaluation, assessment, or treatment of Ivanoff.

Second, OCSD deputies followed their training and policies by conducting regular safety checks on Ivanoff every hour. Video surveillance from the jail shows Deputy Palomares-Velasco walking into Module J, Sector 8 at approximately 6:02 p.m. on March 14, 2021. The video shows Deputy Palomares-Velasco walk by Ivanoff's cell. In the video, Ivanoff is seen standing in the window of

his cell looking out towards Deputy Palomares-Velasco. There is nothing unusual or remarkable about Ivanoff's behavior.

The video surveillance from the jail shows Deputy Neumann and Nurse S.D. enter Module J, Sector 8 at 6:59 p.m. The video shows Deputy Neumann and Nurse S.D. approach Ivanoff's cell. Deputy Neumann immediately enters the cell. Nurse S.D. quickly enters and exits and begins to flag down medical personnel. In sum, OCSD personnel conducted the appropriate safety checks and did not exercise negligence based on their conduct surrounding Ivanoff's death.

Finally, OCSD personnel were not negligent during their treatment of Ivanoff after discovering his body. When Deputy Neumann knocked on Ivanoff's door and received no answer, Deputy Neumann immediately unlocked and entered Ivanoff's cell. Deputy Neumann radioed "Man down Sector 8" to alert medical personnel that there was an emergency. He used safety cutters to remove the bed sheet which was around Ivanoff's neck and laid Ivanoff down so that he could perform chest compressions on Ivanoff. Deputy Neumann began chest compressions immediately and continually until Deputy Huddleston relieved him. HCA personnel soon arrived and provided oxygen via an air bag valve mask, while deputies continued compressions. An intravenous line was placed and CPR was performed until OCFA arrived and took over treating Invanoff. OCFA arrived they observed that Ivanoff was unresponsive and was in asystole. After making these observations, consistent with their medical training and expertise, they pronounced Ivanoff deceased.

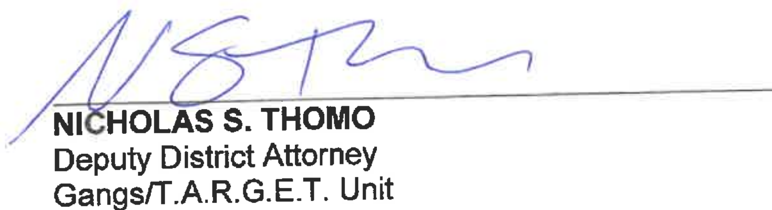
Thus, there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty. OCSD staff acted immediately and appropriately upon discovering Ivanoff lifeless in his cell to provide medical assistance. Deputy Neumann called for medical assistance within moments, and cut the ligature around Ivanoff's neck and performed chest compressions until Deputy Neumann was relieved by fellow deputies and medical staff who responded to assist. Ivanoff was provided with emergency medical care until OCFA arrived. When the medical care that was provided prior to the arrival of OCFA did not improve Ivanoff's condition, OCFA administered additional emergency care to no effect and Ivanoff was pronounced dead.

CONCLUSION

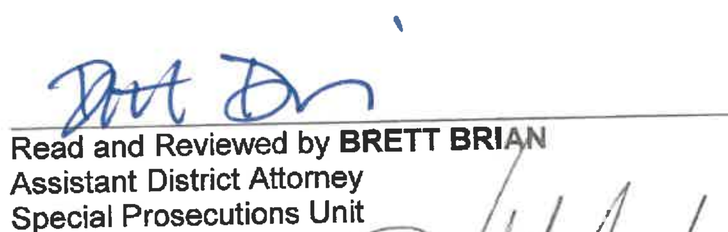
Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Ivanoff. The evidence shows that Ivanoff's death was consistent with suicide by hanging.

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

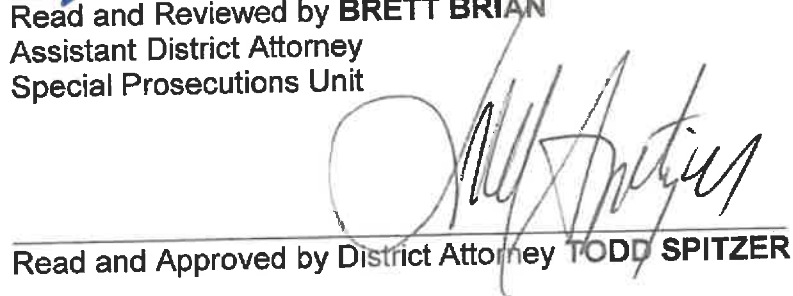
Respectfully submitted,



NICHOLAS S. THOMO
Deputy District Attorney
Gangs/T.A.R.G.E.T. Unit



Read and Reviewed by **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit



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