OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

November 8, 2022

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

Re: Custodial Death on May 30, 2021
Death of Inmate Robert Martin
District Attorney Investigations Case # 21-001942
Orange County Sheriff's Department Case # 21-018120
Orange County Crime Laboratory Case # 21-46827

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 May 30, 2021, custodial death of 32-year-old inmate Robert Martin.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Robert Martin. 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 May 30, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Sheriff's Department Central Jail, where Robert Martin died while in custody after committing suicide by hanging. During the course of this investigation, the OCDASAU interviewed 21 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 policy, training, tactics, civil liability, or clinical conclusions by healthcare professionals.

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 / CHRONOLOGICAL HISTORY

On February 16, 2021, at approximately 4:30 a.m., Martin was arrested by the Santa Ana Police Department for discharging a firearm with gross negligence. He was later booked into the Orange County Jail Intake and Release Center. During the booking process, clinicians from the Orange County Health Care Agency (OCHCA) completed Martin's medical and mental health pre-screenings. During the receiving screening at approximately 9:58 a.m., Martin disclosed he had ideations of self-harm or killing himself the previous night and put a gun to his mouth. However, he stated at the time of the receiving screening he did not want to hurt or kill himself. Martin received a mental health triage referral due to his suicidal ideations.

At approximately 11:53 a.m., Martin received a mental health screening from another OCHCA clinician. Martin stated he was depressed but denied any suicidal ideations. He disclosed that he attempted suicide in the past and referenced putting a gun to his mouth the night prior. Additionally, he stated he had once overdosed. Martin also expressed he "was drinking a lot lately." When asked about how he felt regarding his current situation, he stated, "I am not suicidal anymore. I am sober." Following the evaluation, mental health personnel referred Martin for further mental health services and ordered he be placed on suicide watch in Module-L, which was the facility's mental health observation unit. Due to a lack of beds in Module-L, Martin was housed in an alternative area of the jail until a bed in Module-L became available.

At approximately 8:04 p.m., Martin received a psychiatric evaluation conducted by OCHCA personnel and he again denied any current suicidal ideations or plans. He consented to further

mental health treatment but refused medications. Following the evaluation, the clinician continued Martin's placement under psychiatric observation with a safety gown and daily follow-up visits.

On February 17, 2021, at approximately 8:48 a.m., Martin received another psychiatric evaluation by an OCHCA clinician. During this evaluation, Martin firmly denied any current suicidal ideations, plans, or intent, and he identified strong protective factors against suicide. He did, however, disclose a prior suicide attempt in which he overdosed on sleeping pills and did not tell anyone. Although he was depressed, the clinician noted Martin's thought process was appropriate and goal directed, and his psychiatric condition was generally improving. Martin's housing arrangement was continued and he was prescribed medication for his underlying depression and anxiety. Despite initially consenting to prescribed medication, Martin subsequently refused the medication on multiple occasions.

On February 18, 2021, at approximately 1:30 p.m., Martin received another psychiatric evaluation by an OCHCA clinician. He again denied any suicidal ideations or plans and agreed to notify jailhouse staff as soon as possible should suicidal ideations return or his mental health precipitously decline. Martin was then cleared for regular housing and scheduled for follow-up mental health visits.

On February 20, 2021, a mental health clinician met with Martin at approximately 9:03 a.m. in Module-L. Martin stated, "I'm doing alright, I just want to get out of here." His mood was depressed, but he denied any suicidal ideations and stated his previous suicide attempt was "due to being drunk." Martin also disclosed he was not taking his prescribed medication and stated, "I really don't believe in medication, but maybe if it helps my case I will start taking it."

On February 24, 2021, at approximately 10:13 a.m., a mental health clinician met with Martin outside his cell door. Martin expressed not wanting to take his medication until he spoke with a doctor, but reported his mood was stable. He denied any suicidal ideations and was informed about how to contact mental health or medical staff if he desired.

On March 2, 2021, at approximately 4:14 p.m., Martin was again seen by a mental health clinician. Martin expressed he was not comfortable taking the prescribed medication, but reported a decrease in depression and stated he felt better. He also acknowledged the benefit of implementing coping skills to further improve his mental health.

On March 3, 2021, at approximately 2:55 p.m., Martin expressed symptoms of anxiety while being seen by a mental health clinician. The clinician discussed coping and provided Martin with literature on coping skills for anxiety. They further discussed resources and programs that Martin could pursue if he desired to continue receiving mental health services upon his release from custody.

On March 8, 2021, at approximately 10:53 a.m., Martin received a mental health check at his cell door due to quarantine housing that had gone into effect. He reported to the clinician that he was "doing okay."

On March 10, 2021, Martin resolved his criminal case stemming from his February 16, 2021, arrest. As part of the resolution, he was placed on one year of informal probation and given credit for time served for the days he spent in custody. He was subsequently released from the Orange County Jail.

On May 20, 2021, at approximately 10:39 p.m., Martin was arrested by the Costa Mesa Police Department for attempted murder, corporal injury of a spouse, cruelty to a child, and false

imprisonment. In addition, he had an active supplemental misdemeanor probation hold from his prior case.

On May 21, 2021, at approximately 3:08 a.m., Martin was booked into the Orange County Jail Intake and Release Center. During the booking process, an OCHCA Comprehensive Care Nurse (CCN) completed Martin's medical and mental health pre-screenings. During the mental health pre-screening, Martin denied ever having any suicidal ideations or attempts of self-harm or killing himself. At the conclusion of this screening, Martin was referred to mental health services based on his disclosure of a prior diagnosis of anxiety, depression, and bipolar disorder.

At approximately 9:09 a.m., Martin received another mental health screening by OCHCA personnel. Martin disclosed a prior suicide attempt in February 2021 where he put a gun to his mouth. However, he indicated that he did not feel depressed and was not currently thinking of hurting or killing himself. Martin was observed to be oriented as to person, place, and situation. His behavior was described as appropriate and cooperative. He was cleared for regular housing and scheduled for a mental health follow-up visit.

At approximately 9:54 a.m., Martin received a psychiatric evaluation conducted by a doctor from OCHCA. Martin denied suicidal ideations, but stated, "I feel fine. I'm just over life. I'm not having any fun at all." Martin also adamantly refused medications and stated they were harmful. Following the evaluation, mental health personnel again ordered Martin housed in Module-L, the mental health observation unit.

On May 22, 2021, at approximately 8:36 a.m., Martin was moved from Receiving and Observation (RO) to Module-L, Sector 19, Cell 6. At approximately 10:01 a.m., Martin received another psychiatric evaluation, which was again conducted by a clinician from OCHCA. Martin reported he was doing better, but was "just overwhelmed." He also reported feeling depressed about his situation and anxious about his upcoming court date, but he denied any suicidal ideations, plans, or intentions. The evaluating clinician noted that Martin's psychiatric condition was generally improving and continued Martin's mental health housing arrangement in Module-L.

On May 23, 2021, at approximately 3:37 p.m., a mental health clinician observed Martin through his cell door in Module-L. Martin remarked he was "fine" regarding his general condition and gestured with his thumbs up. When asked if he had any suicidal ideations, Martin shook his head "no." At approximately 4:25 p.m., a CCN from OCHCA contacted Martin after receiving a deputy referral that Martin was not feeling well. After an examination, it was determined that Martin was dehydrated and needed to increase his fluid intake. He was treated and provided with fluid replacement instructions.

On May 24, 2021, at approximately 3:09 p.m., Martin received another follow-up psychiatric evaluation conducted by a doctor from OCHCA. Martin again denied any suicidal plans, ideations, or intentions. He expressed a desire to be moved out of Module-L and into regular housing. The doctor noted Martin's psychiatric condition to be generally improving, but continued the mental health housing arrangement due to Martin's poor insight and tendency to minimize his mental health issues. Martin agreed to inform staff in the event he began to have suicidal ideations or other mental health issues arise.

On May 25, 2021, at approximately 10:34 a.m., a mental health clinician attempted a follow-up visit with Martin in his cell to assess him for safety and coping. Martin was observed in the cell bed, under the covers, breathing normally, and did not appear to be in any distress. However, Martin did not engage with the clinician despite several verbal attempts and knocks on the cell door.

On May 26, 2021, the same doctor who evaluated Martin on May 24, 2021, conducted a psychiatric follow-up with Martin at his cell. Martin denied any suicidal thoughts, impulses, intentions, or plans. Regarding his mood, Martin denied being depressed or anxious and denied any ongoing depressive features when asked about the prior two to four weeks. The doctor noted Martin was future oriented and was requesting to be moved to regular housing. When asked about ending his life, Martin stated it was just initially when he was arrested and he no longer wished to die.

Martin's psychiatric condition was marked as generally improving and the doctor cleared Martin for regular housing at approximately 7:48 a.m. The doctor also recommended a mental health clinician follow up with Martin to assess how he was coping with the housing transition. It was noted during the evaluation that Martin continued to decline psychotropic medications, but he agreed to a safety plan to inform jailhouse staff immediately if suicidal ideations, impulses, or planning began to appear. At approximately 10:11 a.m., Martin was moved to Module-N, Sector 29, Cell 8, where he was the lone inmate in a two-person cell pursuant to COVID-19 protocols. On May 28, 2021, Martin was moved to Module-N, Sector 30, Cell 16 and was again alone in the cell.

On May 30, 2021, at approximately 3:45 p.m., a mental health clinician conducted a follow-up visit with Martin. Martin was seen lying in bed and came to the cell door upon request. During the assessment the clinician utilized active listening and motivational interviewing techniques. Martin was informed how to contact mental health services if needed. Martin stated, "I'm fine" and denied having any concerns or distress. He firmly denied any suicidal ideations, intent, or plans, and reported he was sleeping and eating fine.

In the hours prior to Martin's death on May 30, 2021, OCSD deputies conducted routine safety checks in Module-N. Each safety check was initiated within at least 60 minutes of the prior check, which was consistent with existing OCSD protocol. The protocol was modified on June 28, 2021 via an OCSD Jail Compliance & Training Team briefing item, which directed that all 60 minutes safety checks be conducted 45 minutes from the beginning of the prior safety check.

On May 30, 2021, at approximately 3:29 p.m., Deputy Ramsey completed a safety check of Sector 30, which was logged with the notation, "ALL SECURE." Martin was seen on video surveillance standing at the entry door window of his cell facing outward as Deputy Ramsey walked past at approximately 5:27 p.m. The video surveillance system continued to capture Martin standing at the entry door window of his cell until approximately 5:34 p.m. when he turned and walked toward the rear of the cell out of view.

At approximately 6:05 p.m., Deputy Ferguson completed a safety check of Sector 30, which was logged with the notation, "ALL SECURE." The video surveillance system captured Deputy Ferguson looking into Martin's cell as he walked past it at approximately 6:04 p.m. When later interviewed, Deputy Ferguson recalled it was a typical walkthrough and he did not note anything out of the ordinary.

At approximately 7:01 p.m., Deputy Olive and a Licensed Vocational Nurse (LVN) began a safety check that included medical distributions to inmates housed in Module-N. At approximately 7:13 p.m., they arrived at Martin's cell and observed him unresponsive, lying on his stomach with his feet against the door, and his chin and upper body elevated facing towards the bottom bunk. A bedsheet was tied around his neck with the other end tied to the top bunk bed frame.

The LVN (LVN 1) and Deputy Olive immediately began attending to Martin and removed him from the bedsheet. Deputy Olive used his handheld radio to broadcast "914 Mod November, additional prowlers," which is code for a suicide attempt and a request for additional deputies, medical staff, and paramedics. LVN 1 could not find a pulse for Martin and noted Martin felt cool to the touch. Deputy Olive and LVN 1 began cardiopulmonary resuscitation (CPR) on Martin, and Deputy Olive noticed red marks on the upper front portion of Martin neck below his chin.

Based on video surveillance, numerous OCSD deputies reached Martin's cell in Module-N and began to assist with rescue efforts within 60 seconds of Deputy Olive's broadcast. This included Deputy Robinson, who retrieved a handheld video camera from the Module-N guard station and began documentation procedures within approximately 90 seconds. After approximately 128 seconds, additional OCHCA personnel began to arrive and attend to Martin. Among the responding staff were two registered nurses (RN), a CCN, and an additional LVN (LVN 2). An RN (RN 1) reported seeing OCSD deputies and LVN 1 already performing CPR on Martin when they arrived at his location and began to render aid. Additionally, RN 1 reported that Martin appeared ashy with a blue tinge and blue fingertips, which felt cold to the touch as she applied a pulse oximeter. After an oral airway was inserted, a responding deputy was given an Ambu bag (bag valve mask) to provide rescue breaths to Martin. The team continued rescue efforts on Martin, including chest compressions, providing oxygen, administering saline via an intravenous line (IV), and utilizing an automated external defibrillator (AED).

Orange County Fire Authority (OCFA) and ambulance personnel were called and arrived to Martin's cell at approximately 7:24 p.m. As OCFA personnel took over patient care of Martin, a certified OCFA paramedic began his initial assessment and confirmed Martin was in cardiac arrest with no pulse and no respirations. Asystole was confirmed by utilizing a heart monitor. Upon further examination, the paramedic found Martin to be exhibiting obvious signs of death that included cool and dry skin, no lung sounds, and pupils that were dilated and fixed. The paramedic also observed Martin to have trauma marks on the front and rear portion of his neck, but noted no other visible injuries

OCFA personnel next established a second IV for Martin, an Intraosseous (IO) line in his left tibia, inserted an airway, and supplied Martin with oxygen via a bag valve mask. Automatic chest compressions were established and Martin was given four doses of epinephrine intravenously. Despite these efforts, no change in Martin's condition was produced. Martin was pronounced dead at 7:45 p.m. A suicide note written by Martin was recovered from his cell during the subsequent investigation. In the note, Martin does not reference or mention the jail or jail staff in any way.

Seven inmates housed with Martin in Module-N were interviewed as part of the investigation into Martin's death. None of them reported seeing anything unusual regarding Martin prior to his suicide. One inmate (Inmate 1) reported seeing Martin in his cell from the "Day Room" the previous Friday (May 28, 2021) and did not interact with him. Inmate 1 was able to see Martin in his cell watching television and laughing. Martin did not appear to be distressed in any way. Another inmate (Inmate 2) stated he saw Martin the previous day (May 29, 2021) and did not interact with him, but did not notice any unusual behavior. A third inmate (Inmate 3) who also had no interaction with Martin recalled seeing him earlier in the morning. According to Inmate 3, Martin looked "sad for being here."

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Swabs from Martin's face, neck, and hands
- One (1) mask with blood from Martin
- One (1) bloodstain standard

- One (1) t-shirt
- One (1) pair of pants
- One (1) pair of boxers
- Two (2) singular socks
- One (1) bedsheet ligature
- One (1) suicide note
- One hundred forty-one (141) photos of the scene / decedent
- Sixty-nine (69) autopsy photographs
- Nineteen (19) post embalming photographs

AUTOPSY

On June 8, 2021, independent Forensic Pathologist Dr. Scott Luzi of the Orange County Coroner's Office conducted an autopsy on the body of Martin. Dr. Luzi observed a 25 cm incomplete, red-brown ligature furrow on Martin's neck and a 3.5 cm by 1cm discontinuous contusion on Martin's forehead. Dr. Luzi also diagnosed the following natural disease and pre-existing conditions: cerebral edema, pulmonary congestion and edema, left ventricular hypertrophy, mild coronary atherosclerosis, and mild peripheral atherosclerosis. At the conclusion of the Coroner's investigation, Dr. Luzi determined the cause of death to be hanging and the manner of death to be suicide.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
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	Negative
QTOF Drug Identification	Postmortem Blood	Not Detected

BACKGROUND INFORMATION

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

- PC 246.3(a) – Willful Discharge of a Firearm with Gross Negligence
- PC 664(a)/PC 187(a) – Attempted Murder
- PC 245(a)(4) – Assault Likely to Produce Great Bodily Injury
- PC 273.5(a) – Corporal Injury of Spouse
- PC 273a(b) – Child Abuse and Endangerment
- PC 236/237(a) – False Imprisonment
- PC 1203.2 – Rearrest/Revocation of Probation

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 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 Martin 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 OCSD deputies and/or jail staff failed to take reasonable action to summon medical or mental health care at any point upon noticing it was needed. Martin received multiple mental health evaluations and treatment subsequent to his original booking into the Orange County Jail on February 16, 2021. Upon his booking on May 21, 2021, Martin received a mental health screening. Due to his disclosure of a prior diagnosis of anxiety, depression, and bipolar disorder, Martin received a mental health referral. During the mental health screening that followed, Martin disclosed a prior suicide attempt but indicated that he did not feel depressed and was not thinking of hurting or killing himself. Shortly after, Martin received another psychiatric evaluation in which he denied any suicidal ideations but made vague suicidal statements. Mental health clinicians ordered Martin housed in Module-L, a mental health observation unit. Martin remained in mental health housing from May 22, 2021, until he was cleared for regular housing by a doctor from OCHCA on May 26, 2021. During this period, Martin received medical care that included numerous mental health visits and evaluations.

There is no evidence to indicate that OCSD deputies or staff were careless or were inattentive towards Martin once he was transferred to Module-N, where he was housed alone pursuant to COVID-19 protocols. On May 30, 2021, less than four hours before Martin was found unresponsive in his cell, a mental health clinician conducted a follow-up visit with Martin where he was informed on how to contact mental health if needed. Moreover, during the visit Martin stated he was "fine" and denied having any concerns, distress, or suicidal ideations, intent, or plans.

There is no evidence to indicate that any OCSD personnel acted in a way that was so different from how an ordinary careful person would act in the same situation, as criminal negligence requires. Deputies Ramsey, Ferguson, and Olive carried out routine safety checks in Module-N and no deputies documented anything unusual prior to finding Martin unresponsive. At approximately 5:29 p.m., Deputy Ramsey completed a safety check during which Martin is seen standing at the entry door of the cell. Again, at approximately 6:05 p.m. Deputy Ferguson completed a safety check, and video surveillance captured Deputy Ferguson looking into Martin's cell as he walked past. When later interviewed, Deputy Ferguson recalled it was a typical walkthrough and he did not note anything out of the ordinary. 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 7:13 p.m., when Deputy Olive and LVN 1 observed Martin lying on his stomach with a bed sheet tied around his neck and the other end tied to the bed frame, Deputy Olive immediately used his handheld radio to broadcast "914 Mod November, additional prowlers" – code for attempted suicide requesting additional deputies, medical staff, and paramedics. Deputy Olive and the LVN also immediately began to render emergency aid to Martin. Other deputies and medical staff promptly responded where they inserted an airway and supplied oxygen, gave fluids via an IV line, continued CPR, utilized an AED, and provided rescue breaths to Martin with a bag valve mask until paramedics arrived. When paramedics arrived, they confirmed Martin was in cardiac arrest with no pulse and no respirations. Paramedics also established an IV line, an IO line, and gave normal saline and four doses of epinephrine intravenously. In addition, they established automatic chest compressions. However, Martin's condition remained unchanged and he was pronounced dead at 7:45 p.m.

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 Martin.

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

ADAM ZAMORA
Deputy District Attorney
Gangs/Target Unit

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

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