



OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

October 28, 2022

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

Re: Custodial Death on August 20, 2021
Death of Inmate Juventino Gregorio Ahuatlcabrera
District Attorney Investigations Case # 21-003129
Orange County Sheriff's Department Case # 21-028120
Orange County Crime Laboratory Case # 21-04976-AZ

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 August 20, 2021, custodial death of 26-year-old inmate Juventino Gregorio Ahuatlcabrera.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Ahuatlcabrera. 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 20, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Theo Lacy Facility jail, where Ahuatlcabrera died while in custody after receiving medical treatment at the jail and hospital. During the course of this investigation, the OCDASAU Investigators interviewed 22 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

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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.

DISCLOSURE OF CUSTODIAL DEATH INCIDENT VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage:

<http://orangecountyda.org/reports/videoandaudio/default.asp>.

FACTS

On July 26, 2019, Ahuatlcabrera was placed on felony formal probation after he was convicted of violating Vehicle Code Sections 23153(a) [driving under the influence (DUI) causing bodily injury] and 20001(a) [hit-and-run with injury], under court case number 18CF3419.

On May 30, 2021, Ahuatlcabrera was re-arrested for new DUI and hit-and-run offenses. On June 2, 2021, Ahuatlcabrera was arrested by Orange County Probation for violating his probation on case 18CF3419, and the court revoked probation. On August 6, 2021, Ahuatlcabrera admitted to his felony probation violation in 18CF3419 and was sentenced to 16 months state prison.

At the time of the incident in August 2021, Ahuatlcabrera was housed in F-Barracks, which was a large open dormitory-type setting that was divided into two sides, West Wing and East Wing. Each wing was divided to an upper tier and lower tier, in which multiple cubicles with bunk beds were located, with a centralized common day-room that had two stairwells between upper and lower tiers. The cubicles were open to the dayroom and the inmates could freely move about the barracks. OCSD deputies were required to complete one Safety Check every 45 minutes and two Head Counts in every 12-hour shift. During Safety Check, deputies would not wake inmates up or contact them unless something looks out of place or inmates are in apparent distress.

F-Barracks were equipped with a closed-circuit television (CCTV) security camera system. At the time of the incident, Ahuatlcabrera was assigned to Barracks-F, West Side, Cube-D, Bunk-11. There were 102 inmates housed in West Side at F-Barracks.

On August 20, 2021, at approximately 1:21 a.m., CCTV security cameras captured Ahuatlcabrera walking out of his cubicle with a large opaque plastic bag with a reddish tint, which appeared to be an inmate-made alcoholic drink. This drink is commonly known as pruno and is made from fermented fruit and sugar amongst other ingredients.

At 1:21 a.m., CCTV security cameras captured Ahuatlcabrera walking to the bathroom sink, filling the pruno bag with water, and returning to Cube-E, Bunk-3. Ahuatlcabrera and another inmate spent the next hour drinking pruno together in the cubicle. At 1:57 a.m., OCSD deputies conducted Safety Check without incident. At approximately 2:25 a.m., Ahuatlcabrera left for the bathroom again, filled the pruno bag with water, and returned to Cube E, Bunk-3. At 2:40 a.m., OCSD deputies conducted Safety Check without incident.

At approximately 2:42 a.m., CCTV security cameras captured an inmate and Ahuatlcabrera standing in Cube-G at the foot of Bunks-5 & 6. A short time later, Ahuatlcabrera and the inmate snorted Subutex, which is also known as Buprenorphine, a narcotic that can treat pain as well as addiction to narcotic pain relievers. Subutex can also cause respiratory distress and possibly death, when taken in high doses or when combined with other substances, especially alcohol.

After snorting Subutex, Ahuatlcabrera and the inmate returned to Cube-E. Ahuatlcabrera told the inmate that he did not feel any effects of Subutex and wanted more. At approximately 3:05 a.m., Ahuatlcabrera and the inmate left Cube-E and returned to Cube-G. They spoke with another inmate briefly, and they each snorted additional amount of Subutex.

At approximately 3:08 a.m., CCTV security cameras captured Ahuatlcabrera appearing to be intoxicated and unsteady on his feet. At approximately 3:23 a.m., OCSD deputies conducted a Random/Head Count without incident. At approximately 3:36 a.m., Ahuatlcabrera went to his assigned bunk, Cube-D, Bunk 11, and remained there until deputies completed the Head Count.

At approximately 3:37 a.m., CCTV security cameras showed Ahuatlcabrera getting in line for breakfast while appearing to be intoxicated, swaying back and forth on his feet. At approximately 3:43 a.m., CCTV security cameras captured Ahuatlcabrera getting into a bunk bed in F-Barracks, West Side, E-Cube, Bunk-3. Between 4:03 a.m. and 9:25 a.m., OCSD deputies completed nine Safety Checks, approximately one in every 45-minutes, without incident. Ahuatlcabrera never left the bunk and nobody went near him.

At approximately 6:05 a.m., CCTV security cameras captured an inmate repositioning Ahuatlcabrera. This inmate reported that he was awakened by Ahuatlcabrera's loud snoring. CCTV security cameras captured the inmate rolling Ahuatlcabrera onto his side and propping his head up. The inmate reported that he had done this to allow Ahuatlcabrera to breathe easier and believed that Ahuatlcabrera had sleep apnea. The inmate reported that Ahuatlcabrera's snoring was not unusual or uncommon, and he did not think there was anything unusual with Ahuatlcabrera at this time.

At approximately 10:05 a.m., several inmates tried to awaken Ahuatlcabrera, but he appeared to be unresponsive and have no pulse. At approximately 10:05 a.m., the inmates yelled "Man Down" and called for OCSD deputies. At approximately 10:05 a.m., two deputies responded and saw that Ahuatlcabrera appeared to be pale, unconscious, and unresponsive. The deputies found a small amount of blood between Ahuatlcabrera's nostrils and upper lip but saw no signs of trauma. One deputy checked for a pulse and respirations but found none.

At approximately 10:06 a.m., Deputy Williams radio called for the paramedics. Shortly thereafter, Deputies Adham and Williams grabbed the mattress Ahuatlcabrera was lying on and moved it to the ground. Then Deputy Adham initiated chest compressions and continued compressions until additional deputies arrived on scene and relieved him.

At approximately 10:10 a.m., HCA medical staff arrived with a Man-Down-Bag and began to administer oxygen through the Ambu-bag-air valve mask, during which chest compressions were still being administered. HCA medical staff also administered 4 doses of Narcan where 2 doses were administered into the right nostril and 2 were administered into the left nostril. The 4 doses of Narcan had little to no effect on Ahuatlcabrera.

At approximately 10:19 a.m., Orange City Fire Department (OFD) paramedics arrived. HCA medical staff and deputies were still conducting lifesaving CPR. The paramedics administered emergency medical treatment to Ahuatlcabrera. They assessed that he was pulseless, apneic, in asystole (flat lined), and observed that he had scant dry blood in mouth and on both nostrils with no bruises or signs of trauma on scalp, neck, chest, abdomen, or legs. The paramedics connected Ahuatlcabrera to an automated CPR device that provided chest compressions and administered four 1 mg doses of epinephrine. The 4 doses of epinephrine had little to no effect on Ahuatlcabrera, who remained unconscious and unresponsive.

At approximately 10:45 a.m., OFD paramedics transported Ahuatlcabrera to the UCI Medical Center (UCIMC) located at 101 The City Drive South, Orange, CA, 92868. At approximately 10:48 a.m., Ahuatlcabrera arrived at the UCIMC emergency room in cardiac arrest. Ahuatlcabrera had no pulse, no signs of life, and no visible trauma. Ahuatlcabrera was treated but could not be revived despite being given several rounds CPR and Advanced Cardiac Life Support medications. At approximately 11:10 a.m., Ahuatlcabrera was pronounced deceased.

While processing the cubicles in jail, the following items were located and booked into evidence: a white T-shirt with apparent blood; white crystalline substance; and a large clear plastic bag with approximately 2 gallons of red-colored liquid, which was suspected pruno and placed into Pruno Kit #483; and rolled playing cards.

During the investigation, an inmate reported that Ahuatlcabrera had been drinking pruno on the night of August 19, 2021. Another inmate reported that Ahuatlcabrera had asked for Subutex and wanted to snort it. The inmate reported that he warned Ahuatlcabrera that it might make him sick

because he had never taken it before. Ahuatlcabrera said he still wanted to try it and agreed that he would use a small amount. The inmate obtained Subutex from another inmate in Cube-G and gave it to Ahuatlcabrera.

At approximately 2:42 a.m., CCTV security cameras captured the inmate and Ahuatlcabrera walking over to the foot of Bunks-5 & 6 in Cube-G. They rolled up a red playing card like a straw, snorted Subutex, and walked back to Cube-E. At approximately 3:05 a.m., Ahuatlcabrera and the inmate returned to Cube-G, Bunks 5 & 6, and they snorted more Subutex. At no time was Ahuatlcabrera ever assaulted or attacked by another inmate or deputy.

Aside from CCTV security cameras and statements by the inmates, the jail medical records revealed that on June 2, 2021, Orange County Health Care Agency (HCA) Comprehensive Care Nurse (CCN) completed the Receiving Screening of Ahuatlcabrera and noted the following observations: Ahuatlcabrera was oriented to person, place, and time; he communicated effectively; he did not appear unsteady, confused, or lethargic; denied any preexisting medical conditions and denied any history of drug or alcohol abuse. The HCA doctor also noted the following: no acute pneumonia; no evidence of pleural effusion; no pneumothorax; normal cardiac silhouette noted; no active TB; and no acute cardiopulmonary disease.

The jail medical records from June 2, 2021, to August 20, 2021, indicated that Ahuatlcabrera did not complain of any pain or discomfort related to his health. The jail records also indicated that the HCA medical personnel had never prescribed or provided Ahuatlcabrera with Subutex.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Unknown light color crystalline substance with a net weight of 283 ± 4 milligrams
- Buprenorphine (Subutex) with a net weight of 453 ± 4 milligrams
- Pruno, Ethanol Result (% V/V) was > 0.500 Acetaldehyde (Ethanol).
- Rolled playing card from Cube-G in the cubby attached to Bunk # 5/6.

AUTOPSY

On September 2, 2021, a forensic pathologist of Orange County Sheriff Coroner Forensic Science Center conducted an autopsy on the body of Ahuatlcabrera. The forensic pathologist stated that the preliminary cause of death was pending toxicological results and microscopic examination.

On April 21, 2022, the forensic pathologist reported that the cause of death to be community acquired pneumonia along with acute exacerbation of chronic alcohol abuse. The manner of death was natural.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Ahuatlcabrera's postmortem and antemortem blood was collected and examined for the presence of drugs and alcohol. The following results and interpretations were noted:

DRUG	Postmortem Blood	Brain	RESULTS & INTERPRETATIONS
Ethanol	0.088 ± 0.004 % (w/v)		Antemortem Blood: 0.104 ± 0.004 % (w/v)
Acetaldehyde	Detected		
Buprenorphine	Detected	0.0056 ± 0.0010 mg/kg	
Naloxone	Detected		
Caffeine	Detected		

A sample of the suspected Subutex and pruno were examined and the following results and interpretations were documented:

- The white powder substance had a net weight of 453 ± 4 mg and contained Buprenorphine (Subutex).
- Pruno Kit #483 was tested and > 0.500 % (w/v) acetaldehyde (ethanol) was detected.

BACKGROUND INFORMATION

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

- Drive Under the Influence of Alcohol/ Drugs, Cause Bodily Injury
- Drive Under the Influence of Alcohol, Cause Bodily Injury
- Hit & Run, Death or Injury
- Probation Violation
- Vandalism

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

Here, the evidence does not rise to the level of beyond a reasonable doubt of express or implied malice on the part of any OCSD personnel 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 Ahuatlcabrera 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).

On June 2, 2021, within three days after he was placed under arrest for a new DUI and booked into custody at Theo Lacy Jail Facility, Ahuatlcabrera was medically screened and examined by the HCA personnel, including a doctor. At that time, Ahuatlcabrera was oriented to person, place, and time; he communicated effectively; he did not appear unsteady, confused, or lethargic. Ahuatlcabrera denied any preexisting medical conditions and denied any history of drug or alcohol abuse. The HCA doctor noted the following for Ahuatlcabrera: no acute pneumonia; no evidence of pleural effusion; no pneumothorax; normal cardiac silhouette noted; no active TB; and no acute cardiopulmonary disease. The jail medical records from June 2, 2021, and August 19, 2021, indicated that Ahuatlcabrera had never complained of any pain or discomfort relating to his health. The jail medical records also indicated that HCA medical personnel had never prescribed or provided Ahuatlcabrera with Subutex.

The events that transpired from the night of August 19, 2021, to the early morning hours of August 20, 2021, show that Ahuatlcabrera wanted to be intoxicated without being detected by OCSD deputies. Ahuatlcabrera achieved this end by consuming pruno and seeking out Subutex from another inmate and snorting two rounds of it when OCSD deputies were not nearby.

Both items were collected as evidence and tested by OCCL. Testing determined that the reddish liquid that resembled pruno contained 0.500% Acetaldehyde or ethanol (alcohol), and the white substance that resembled Subutex contained Buprenorphine.

After snorting Subutex the first time, Ahuatlcabrera told the inmate that he was not feeling any effects of Subutex and asked for more. Within 30 minutes, Ahuatlcabrera snorted more Subutex. Furthermore, to avoid detection or suspicion by OCSD deputies, Ahuatlcabrera went to his assigned bunk at approximately 3:36 a.m. and remained there until deputies completed the Head Count of all inmates.

From when he first snorted Subutex at 2:42 a.m. to when he went to bed at 3:43 a.m., Ahuatlcabrera did not alert anyone, including the inmates and OCSD deputies, that he had any trouble or difficulty breathing or that he needed immediate medical care. From 3:43 a.m. to 10:05 a.m., the actions and behaviors of Ahuatlcabrera as seen by OCSD deputies appeared to be typical of an inmate sleeping in a bunk. Consequently, there was no reason to believe that Ahuatlcabrera needed medical treatment.

In short, there is no evidence to prove that OCSD deputies knew or should have known that Ahuatlcabrera was in medical distress or in need of immediate medical care. Similarly, there is no evidence that they intentionally or negligently failed to summon medical care prior to being alerted by inmates that Ahuatlcabrera was unresponsive.

Once the inmates called for help, the nearby OCSD deputies came over to Ahuatlcabrera and immediately summoned HCA personnel for assistance and began performing CPR. HCA personnel arrived within minutes and gave Ahuatlcabrera life-saving medications and continued performing CPR; they also called the OFD paramedics for assistance.

Less than ten minutes later, OFD paramedics arrived and gave Ahuatlcabrera several rounds of CPR and advanced life support medications. OFD paramedics transported Ahuatlcabrera to UCIMC where he received additional life support medications and medical care but could not be revived.

OCCL conducted toxicology test of Ahuatlcabrera's blood for the blood alcohol content (BAC) and brain for the presence of Buprenorphine. His blood test showed that Ahuatlcabrera's antemortem BAC was 0.104% and postmortem BAC was 0.088%. This means that his BAC was a lot higher than 0.104% at around 3:00 a.m., approximately 7 hours before he was found unconscious.

In Ahuatlcabrera's brain, the presence of Subutex or Buprenorphine was detected, consistent with the inmates' statement that Ahuatlcabrera had ingested Subutex, corroborated by CCTV security cameras. The only reasonable finding supported by all the evidence collected is that Ahuatlcabrera died in his sleep due to respiratory distress caused by the effects of Buprenorphine mixed with alcohol.

All the evidence collected is corroborated by the forensic pathologist's finding that the cause of death was due to community acquired pneumonia along with acute exacerbation of chronic alcohol abuse. The forensic pathologist also reported that the manner of death was natural.

Based on the totality of circumstances known to OCSD deputies, they acted rationally and reasonably; they summoned medical care immediately upon learning of Ahuatlcabrera's unresponsive condition. 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 Ahuatlcabrera. The evidence shows that Ahuatlcabrera died because of community acquired pneumonia along with acute exacerbation of chronic alcohol abuse, and that the death was a natural one.

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

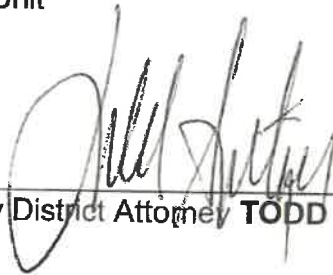
Respectfully submitted,



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



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