OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

February 16, 2023

Chief of Police David Valentin
Santa Ana Police Department
20 Civic Center Plaza
Santa Ana, CA 92701

Re: Custodial Death on 11/04/2020
Death of Inmate: Jason Ray Jones
District Attorney Investigations Case # 20-027
Santa Ana Police Department Case # 20-23197
Orange County Crime Laboratory Case # 20-53528

Chief Valentin,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusions concerning the November 4, 2020, custodial death of 47-year-old inmate Jason Ray Jones. In sum, the investigation revealed evidence that the Santa Ana Police Department (SAPD) breached its duty of care to Jones, however the OCDA cannot prove that the breach caused Jones' death. Consequently, there is an insufficient basis upon which to find criminal culpability for Jones' death on the part of any SAPD personnel or those under the supervision of the SAPD.

OVERVIEW

This letter contains a description of the scope of OCDA's investigation of the custodial death of Jason Ray Jones, a summary of the subsequent legal analysis, and the resulting legal conclusions concerning any potential criminal liability. 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 all SAPD personnel involved with this custodial death incident as well as any other individuals under the supervision of the SAPD.

On November 4, 2020, OCDA Special Assignments Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC) where Jones died after receiving medical aid. Jones had been in custody at the Santa Ana Police Department Detention Facility and was found in his cell suspended above the floor by a ligature around his neck. The ligature had been formed with a bed sheet. During the course of this investigation, the OCDASAU interviewed 19 witnesses, and obtained and reviewed reports from SAPD and the Orange County Crime Laboratory (OCCL), as well as 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 applied all relevant legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of SAPD personnel or any others acting under the supervision of the SAPD. The OCDA will not be addressing any possible issues related to policy, training,

tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating the deaths of individuals that occur while an individual is in custody within Orange County. 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.

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. Thus, when the OCDASAU Investigator has concluded the investigation, the file is turned over to an experienced deputy district attorney for legal review. If necessary, the reviewing prosecutor will send the case back for further investigation.

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 documents. It is also common for the case to be reviewed by several experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews and approves all officer involved shooting and custodial death letters.

FACTS

Jason Ray Jones was booked into the Santa Ana Police Department Detention Facility on July 3, 2020. From that time and until his death, Jones was moved to several different cells because of disciplinary issues. Jones was on Floor 3, Module D, Cell 24 when he died in custody.

During his incarceration, Jones experienced the death of his mother and brother; he suffered from substance abuse; and was in an unstable relationship with his girlfriend. Jones received both medical and mental health care while in custody and was prescribed medication for anxiety, hypertension, and addiction cessation. There was no known history of suicide attempts.

On November 3, 2020, at approximately 9:01 a.m., Jones was administered Acetaminophen (500 mg tablet), Lisinopril (2.5 mg tablet), and Hydroxyzine Pamoate (25 mg tablet) by a Licensed Vocational Nurse (LVN). Later at approximately 6:41 p.m., Jones spoke with his girlfriend over the phone and the two discussed a variety of topics including their finances, their relationship, their future living arrangements, and their substance abuse problems. That night at approximately 7:42 p.m., Jones was again administered Acetaminophen (500mg tablet), Trazodone HCL (100 mg tablet), and Hydroxyzine Pamoate (25 mg tablet) by an LVN.

On November 3, 2020, at approximately 9:30 p.m., SAPD Correctional Officer Celeste Fernandez (C.O. Fernandez) was assigned to oversee Floor 3, Modules C and D until her shift ended at 6:30 a.m. the next morning. As part of her job duties, C.O. Fernandez was required to conduct two welfare checks every hour on all inmates in her assigned area. At approximately 9:50 p.m., 10:28 p.m., 10:57 p.m., and 11:47 p.m., C.O. Fernandez logged welfare checks of Floor 3 Modules C and D using a department computer and reported no issues with any of the inmates. At approximately 11:45 p.m., SAPD Detention Facility video surveillance recorded C.O. Fernandez conducting a welfare check of Jones' cell. Video surveillance then showed SAPD C.O. Mary Valenzuela (C.O. Valenzuela) arriving at 11:59 p.m. to relieve C.O. Fernandez for her break.

On November 4, 2020, at 1:04 a.m., C.O. Valenzuela logged a welfare check of Floor 3 Modules C and D via computer and reported no issues with any of the inmates. SAPD Detention Facility video surveillance system recordings showed, however, that C.O. Valenzuela remained at the module's officer podium for the entire period of time she covered for C.O. Fernandez, which lasted until 1:14 a.m. C.O. Valenzuela subsequently declined to give a statement to investigators to explain the discrepancy between her computer log entry and the surveillance video recording.

At approximately 1:04 a.m., C.O. Fernandez returned from her lunch break and can be seen on surveillance conversing with C.O. Valenzuela for a few minutes before C.O. Valenzuela left. At 1:10 a.m., 1:15 a.m. and 1:16 a.m., video surveillance recorded Jones moving freely near the front entrance door of his cell. Due to the angle and distance of the surveillance camera, it cannot be determined what Jones was specifically doing inside his cell.

At approximately 1:30 a.m., C.O. Fernandez began her first set of welfare checks after returning from her break. At approximately 1:35 a.m., surveillance shows C.O. Fernandez approach Jones' cell, immediately reach for her handheld radio, request emergency assistance, and attempt to enter the cell. When interviewed by investigators, C.O. Fernandez stated that it was at this time that she saw Jones unresponsive and hanging by a bedsheet from the top bunk inside his cell. Specifically, she stated that Jones was in a seated position between the bunk and toilet with bedding wrapped around his neck, and his head was slumped downward and his arms were hanging at his sides.

Immediately upon entering the cell, C.O. Fernandez tried to free Jones' neck from the bedding. Her initial efforts were unsuccessful, and she yelled for responding personnel to bring scissors. Within seconds, Correctional Officer James Elizondo (C.O. Elizondo) and an LVN arrived to assist. C.O. Fernandez and the LVN were able to lift Jones' body while C.O. Elizondo loosened all three knots in the bedding. Together, they were able to free Jones.

At approximately 1:36 a.m., a Registered Nurse (RN) arrived on scene to also provide aid. In a subsequent interview with investigators, the RN stated that immediately upon her arrival, Jones was unresponsive to verbal and tactile stimuli; his face and hands were mild-moderately cyanotic; and his skin was warm and dry, but pallid in color. At approximately 1:37 a.m., personnel moved Jones to a common area outside his cell where medical staff determined Jones had no pulse or respirations. A pulse oximeter reading indicated Jones had a blood oxygen level of 48%, consistent with a deceased person.

Medical staff began cardiopulmonary resuscitation (CPR), and a bag-valve mask was utilized to provide oxygen to Jones. At approximately 1:44 a.m., an LVN administered one dose of Narcan to Jones. At approximately 1:46 a.m., personnel removed Jones' shirt, and an Automatic External Defibrillator (AED) was attached to his upper torso. After analyzing his condition, the AED audibly stated, "No treatment advised." CPR and oxygen delivery continued, although medical staff still did not detect any pulse, any measurable blood pressure, or any pupillary response.

At approximately 1:47 a.m., a second pulse oximeter reading indicated Jones had a blood oxygen level of 50%. At approximately 1:48 a.m., Orange County Fire Authority (OCFA) personnel from Engine #71 arrived and took over patient care. They examined Jones and confirmed that he had no pulse, was not breathing, and had no blood pressure. Jones' Glasgow Coma Scale score was measured as a three, the lowest score possible and also consistent with a deceased person.

At 1:50 a.m., Jones was intubated, an intraosseous infusion line was established in his lower right leg, and a Lucas Chest Compression System was attached to his chest. At 1:58 a.m., Jones was administered 1 mg of epinephrine. At approximately 1:59 a.m., Jones was transported Code-3 (lights and siren) via ambulance to OCGMC. During his transportation to the hospital, Jones received another dose of epinephrine. The ambulance arrived at the hospital at approximately 2:09 a.m., and OCFA relinquished responsibility of Jones' care to OCGMC Emergency Room staff.

Following arrival at the emergency room, Jones' was observed to have an asystolic heart rhythm (having no electrical cardiac activity), his skin was cyanotic, and his pupils were fixed and dilated. Emergency room staff continued advanced life-saving measures, including administering medications and providing mechanical ventilation. These efforts did not

revive Jones. At approximately 2:14 a.m., Jones was observed to have a pulseless electrical activity heart rhythm followed by asystole, while his pupils remained fixed and dilated. At 2:15 a.m., Jones was pronounced dead by an OCGMC attending emergency room physician.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- One white t-shirt cut open with apparent blood stains
- One pair of tan jail pants
- One pair of white boxers
- Possible ligature blanket with sheet tied in knots (west end of jail cell bed)
- Tied sheet with apparent blood (east end of jail cell bed)
- Plastic baggie containing a white/brown substance
- Brown paper bag, removed from the right hand
- Brown paper bag, removed from the left hand
- Deep tissue standard
- Heart blood standard

AUTOPSY

On November 6, 2020, Forensic Pathologist Dr. Etoi Davenport of Orange County Coroner's Office conducted an autopsy on Jones at the Orange County Sheriff-Coroner Forensic Science Center. Dr. Davenport found no significant trauma to the body. Jones had an enlarged heart, but no coronary heart disease. Dr. Davenport found no ligature marks and determined that Jones had no neck fractures. Dr. Davenport determined cause of death to be ligature hanging in the manner of suicide.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Jason Ray Jones' postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Amphetamine	Postmortem Blood	0.0632 ± 0.0047 mg/L
Methamphetamine	Postmortem Blood	1.08 ± 0.08 mg/L
Hydroxyzine	Postmortem Blood	0.152 ± 0.019 mg/L
Morphine (free)	Postmortem Blood	0.122 ± 0.013 mg/L
Acetaminophen (free)	Postmortem Blood	1.85 ± 0.18 mg/L
1-(4-chlorobenzhydryl)-piperazine	Postmortem Blood	Detected
Cetrizine	Postmortem Blood	Detected
Noscapine	Postmortem Blood	Detected
Papaverine	Postmortem Blood	Detected
Trazodone	Postmortem Blood	Detected
Caffeine	Postmortem Blood	Detected

BACKGROUND INFORMATION

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

- Domestic Battery
- Willful Cruelty to a Child
- Violation of Protective Order
- Violation of Probation
- Under the Influence of a Controlled Substance

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 SAPD personnel, inmates, or other individuals under the supervision of the SAPD. Therefore, the only possible type of homicide in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Without question, the SAPD and its custodial personnel owed Jones a duty of care to protect him from foreseeable harm. This included any harm he intended to bring upon himself. Based on this investigation, there is no evidence that C.O. Fernandez, C.O. Elizondo, or SAPD medical personnel breached this duty of care. By contrast, there is evidence that C.O. Valenzuela failed to follow SAPD protocols and in so doing breached her duty of care. However, there is insufficient evidence of a causal connection between C.O. Valenzuela's breach and Jones' death to establish criminal liability.

The two SAPD Correctional Officers assigned to monitor Jones' cell leading up to the time of his death were C.O. Fernandez and C.O. Valenzuela. These correctional officers were responsible for conducting welfare checks twice per hour on inmates housed on Floor 3, Modules C and D, which included Jones.

On November 3, 2020, at 9:30 p.m., C.O. Fernandez began her shift and performed three welfare checks at approximately 10:28 p.m., 10:57 p.m., and 11:47 p.m. before going on her lunch break at 11:59 p.m. SAPD Detention Facility video surveillance confirmed that C.O. Fernandez conducted her last welfare check of Jones' cell at approximately 11:45 p.m., approximately 14 minutes before her lunch break. According to computer entries made by C.O. Fernandez, there were no issues with any of the inmates at this time. Thereafter at 11:59 p.m., surveillance showed C.O. Valenzuela arriving at the module's officer podium to assume shift duties for C.O. Fernandez.

On November 4, 2020, at 1:04 a.m. (approximately 1 hour and 5 minutes into C.O. Valenzuela's shift duties), C.O. Valenzuela made a computer entry indicating that she had conducted a welfare check on Floor 3 Modules C and D and reported no issues with any of the inmates. Contrary to this record, however, SAPD Detention Facility video surveillance showed that C.O. Valenzuela never left the module's officer podium until her shift ended at 1:14 a.m. No other evidence was provided to account for this inconsistency, and C.O. Valenzuela declined to provide any statement to investigators. Based on this contradiction, it is fair to conclude that C.O. Valenzuela did not actually perform a welfare check on Jones' cell during the approximate 1 hour and 15 minutes she was on duty, and that two welfare checks were missed between the hours of 12:00 a.m. and 1:00 a.m. on November 4, 2020.

Despite the two missed welfare checks leading up to the final hour of Jones' death, SAPD Detention Facility video surveillance recorded Jones moving about near the entrance door of his cell at 1:10 a.m., 1:15 a.m. and 1:16 a.m. As a result, Mr. Jones must have committed suicide between 1:16 a.m. and 1:35 a.m.

After returning from her break, C.O. Fernandez performed a welfare check on Jones' cell and discovered him at

approximately 1:35 a.m. unresponsive and hanging from a bedsheet tied around his neck and attached to the top bunk of his cell. At this moment, C.O. Fernandez was under the legal duty to render immediate medical care to Jones, which she did.

C.O. Fernandez acted in accordance with her legal responsibilities by immediately requesting emergency medical aid and attempting to free Jones from the ligature wrapped around his neck. SAPD medical staff arrived within seconds and assisted C.O. Fernandez in freeing Jones. They then began to render emergency medical services to him, including performing CPR, artificially inducing breathing through an oxygen bag-valve mask, and using an AED device to try and revive his heart. Despite these efforts, SAPD personnel were unable to revive Jones.

Based on the evidence collected and statements made by responding medical personnel, it appears likely that Jones had died prior to C.O. Fernandez discovering him unconscious hanging inside his cell. In support of this conclusion, one of the first nurses to respond to Jones' cell at 1:36 a.m. described to investigators that Jones was unresponsive to verbal and tactile stimuli, his face and hands were mild-moderately cyanotic, his skin was pale in color and was warm and dry to the touch. Next at 1:37 a.m., additional SAPD medical staff arrived on scene and determined that Jones had no pulse or respirations and had a blood oxygen level of 48%. At 1:48 a.m., OCFA paramedics arrived and confirmed that Jones was not breathing, and had no pulse or blood pressure. Thereafter, Jones was transported to the OCGMC emergency room and continued to receive medical treatment. Such treatment was unsuccessful, and Jones was officially pronounced dead at 2:15 a.m.

Based on the foregoing, it is clear that C.O. Fernandez acted within the scope of her legal duties under the circumstances. C.O. Fernandez conducted her last welfare check in accordance with set policy based on the information she knew to be true at that time. Upon finding Jones' unresponsive in his cell, she promptly called for assistance and immediately began to render emergency aid to him. Therefore, C.O. Fernandez is not legally culpable for Jones' death.

With respect to C.O. Valenzuela, while there is evidence that she breached her legal duty of care to Jones, there is insufficient evidence that this breach contributed to his death. To establish criminal liability under a theory of murder or manslaughter, evidence must show beyond a reasonable doubt that C.O. Valenzuela's failure to act "caused" the death of Jones.

C.O. Valenzuela apparently failed to conduct welfare checks between 12:00 a.m. and 1:14 a.m. in accordance with SAPD protocol. Had Jones attempted suicide during this timeframe, criminal responsibility would potentially lie with her. However based on the surveillance video recordings and Jones' observed movements thereon, it is clear that Jones committed suicide after C.O. Fernandez relieved C.O. Valenzuela and sometime between 1:16 a.m. and 1:35 a.m.

It is possible that welfare checks conducted prior to 1:14 a.m. would have revealed evidence that Jones was preparing to commit suicide. It is equally possible that Jones' made no preparations until after he was observed on surveillance video at 1:16 a.m. Ultimately, both theories are speculative, and lack evidentiary support.

Consequently, evidence of a causal connection between the absence of earlier welfare checks and Jones' suicide sufficient to prove criminal responsibility beyond a reasonable doubt is lacking. This determination is not a referendum on potential civil or administrative liability. Again, such evaluations are beyond the scope of this investigation. Rather solely for criminal liability purposes, there is insufficient evidence to establish that had C.O. Valenzuela conducted welfare checks in accordance with protocol, it would have prevented Jones' suicide.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, the evidence shows that Jason Ray Jones died by suicide as a result of a ligature hanging. Pursuant to applicable legal principles, it is our conclusion that there is

insufficient evidence to support a finding of criminal culpability for Jones' death on the part of any SAPD personnel or any individual under the supervision of the SAPD.

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

STEVEN SCHRIVER
Senior Deputy District Attorney
Special Prosecutions Unit

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

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