OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

September 27, 2023

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

Re: Custodial Death on May 11, 2022
Death of Inmate Jade Sasha Castellanos
District Attorney Investigations Case 22-001419
Orange County Sheriff's Department Case 22-015532
Orange County Crime Laboratory Case 22-45462

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 11, 2022, custodial death of 44-year-old inmate Jade Sasha Castellanos.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Castellanos. 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 11, 2022, at approximately 12:00 a.m., and while conducting a routine safety check, OCSD Deputy Kristen Woodward discovered Castellanos unconscious and unresponsive in her cell at the Men's Central Jail, Intake Release Center (IRC). This Mod is located in the Men's Central Jail and is designated for female inmates with mental health needs. Immediately thereafter, Deputy Woodward radioed for assistance and began providing emergency medical treatment to Castellanos. Several additional deputies and Orange County Health Care Agency (OCHCA) medical personnel responded to provide further aid, pending arrival of Orange County Fire Authority (OCFA) paramedics. This included the use of an automated external defibrillator (AED), insertion of an oral airway, and cardiopulmonary resuscitation (CPR).

Upon their arrival, paramedics noted Castellanos was unresponsive, cold to the touch, and had no pulse or respirations. Despite their subsequent efforts to revive Castellanos, paramedics were unsuccessful and Castellanos was pronounced dead at approximately 12:34 a.m.

Shortly thereafter, OCDA Special Assignments Unit (OCDASAU) Investigators responded to IRC to investigate the matter. OCDASAU interviewed numerous 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, 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 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. 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 correspondence. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer involved shootings and custodial death letters.

FACTS

On Sunday, May 8, 2022, at approximately 1:54 p.m., the Huntington Beach Police Department (HBPD) arrested Castellanos on an outstanding warrant.

On Monday, May 9, 2022, HBPD officers transported Castellanos to the Orange County Jail Intake/Release Center (IRC). Castellanos did not display any symptoms of being under the influence of a controlled substance, and there was no indication that Castellanos was concealing contraband. As a result and in accordance with OCSD protocol, Castellanos was not subject to a body cavity search.

At approximately 1:03 p.m., an Orange County Health Care Agency's (OCHCA) Comprehensive Care Nurse (CCN) completed the "Receiving Screening" of Castellanos. Castellanos appeared unkempt, but was oriented to person, place, and time. Castellanos communicated effectively, but appeared to be "paranoid and seeing objects." Castellanos denied any preexisting medical conditions or a history of alcohol abuse. She admitted prior amphetamine use and said she had

a thyroid disease. Castellanos answered "yes" when asked if she had ever been diagnosed with mental health problems and if she had ever received counseling, prescribed medications, or had been hospitalized for mental health issues. Castellanos denied any prior suicide attempts or having ideations of suicide or self-harm. Castellanos was given a Mental Health Triage Referral and scheduled for a re-check on May 23, 2022. Castellanos was then booked into the IRC.

Later on May 9, 2022, at approximately 4:22 p.m., an OCHCA Registered Nurse (RN) completed a mental health screening of Castellanos. During the screening, Castellanos denied receiving prior mental health treatment, but admitted prior alcohol and drug abuse. Castellanos also admitted hearing "spirits" but denied visual hallucinations. The RN noted that Castellanos' insight and judgment were impaired and Castellanos was anxious, delusional, and paranoid. Castellanos' mental health acuity level was described as "Severe," and Castellanos was classified as "Gravely Disabled." The RN recommended Castellanos be placed under mental health observation and housed in Mod K, the mental health ward of IRC.

On May 10, 2022, at approximately 12:35 p.m., Castellanos was moved to Mod K, Sector 10, where she was housed alone in Cell 10. This cell had been cleaned out and sterilized by a female inmate at 12:07 p.m.

At approximately 1:52 p.m., an OCHCA RN completed a standard nursing assessment of Castellanos. The RN described Castellanos as calm and cooperative, and oriented to person, place, and time. Castellanos walked with a steady gait during the assessment. Castellanos reported feeling anxious and requested medication to help relieve the anxiety. The RN noted that Castellanos was to remain on daily observation, but the mental health referral was no longer required.

At approximately 1:56 p.m., an OCHCA CCN completed a medical health visit with Castellanos. Castellanos' vitals were normal, and she was described as pleasant, polite, and in good spirits. Castellanos' only complaint was difficulty sleeping. The RN associated the difficulty sleeping with Benzodiazepine withdrawal and recommended Castellanos be reassessed within 12 hours.

At approximately 10:49 p.m., surveillance video captured Castellanos moving within her single person cell.

At approximately 11:31 p.m., Deputy Woodward conducted a routine safety check of Sector 10 and looked inside Castellanos' cell. Nothing unusual was observed. Castellanos was seen lying on her back on the lower bunk under a blanket.

At approximately 12:00 a.m. on May 11, 2022, Deputy Woodward conducted another safety check. Castellanos was again observed lying on her back on the lower bunk under a blanket. However, this time Castellanos' feet were protruding from under the blanket and they appeared discolored. Concerned, Deputy Woodward banged on the cell door and yelled to get Castellanos' attention. Castellanos did not respond. Deputy Woodward then used her key to enter the cell.

At approximately 12:01 a.m., Deputy Woodward tapped Castellanos' foot but received no response. When Deputy Woodward removed the blanket covering Castellanos, Castellanos did not respond. Deputy Woodward noticed Castellanos' eyes were partially open, and her skin was grey and pale. Deputy Woodward noticed no signs of life from Castellanos. Deputy Woodward exited the cell to radio for paramedics and medical assistance, and then re-entered the cell to begin chest compressions on Castellanos.

Several deputies and OCHCA medical personnel arrived within minutes and began to render further medical aid to Castellanos. OCSD Deputy Michael Claeson checked Castellanos for a pulse, but could not find one.

At 12:03 a.m., Castellanos was moved out of the cell to provide more space for the deputies and medical personnel rendering medical aid. An OCHCA RN observed Castellanos' eyes were fixed and dilated, and she was not breathing. An oral airway was used to provide oxygen to Castellanos, which was administered via an Ambu bag. CPR was continued while an AED was attached to Castellanos. The AED went through four cycles, and advised "no shock" each time. CPR was continued until OCFA paramedics arrived.

At approximately 12:13 a.m., OCFA paramedics arrived and took over from OCSD deputies and OCHCA medical personnel. Castellanos still had no breathing or pulse when the paramedics arrived. The paramedics noted Castellanos was unresponsive, cold to the touch, and had no pulse or respirations. They also observed no signs of trauma on Castellanos' body.

In addition to CPR, an intraosseous (IO) line was placed on Castellanos' left tibia to administer medication. Three 0.1 mg doses of Epinephrine and one 2 mg dose of Narcan were administered. All resuscitation efforts were unsuccessful. At approximately 12:34 a.m., Castellanos was pronounced deceased.

Castellanos was subsequently transported to the coroner's office where a post-mortem examination of Castellanos was later conducted.

No evidence of controlled substances, paraphernalia, or packaging was noted in Castellanos' cell.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Swabs of Castellanos's hands and face
- Safety gown and underwear worn by Castellanos
- White sheet from top bunk

AUTOPSY

On May 18, 2022, Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Castellanos. Dr. Luzi noted Castellanos had no major injuries, but did have several minor injuries. These minor injuries consisted of contusions. Dr. Luzi also found that Castellanos possessed the following natural disease and pre-existing conditions: pulmonary congestion and edema, cardiomegaly, hepatic steatosis, status post cholecystectomy, nephrosclerosis, and status post partial gastrectomy. Dr. Luzi conducted an external and internal examination of Castellanos. The cause of death was determined to be acute methamphetamine intoxication, and the manner of death was determined to be accidental.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Acetone	Post-mortem Blood	7.7 ± 0.7 mg/dL
Amphetamine	Post-mortem Blood	0.0682 ± 0.0051 mg/L
Caffeine	Post-mortem Blood	Detected

Methamphetamine	Post-mortem Blood	0.106 ± 0.008 mg/L
Naloxone	Post-mortem Blood	Detected
Norchlorcyclizine	Post-mortem Blood	Detected
Norquetiapine	Post-mortem Blood	Detected
Ondansetron	Post-mortem Blood	Detected

BACKGROUND INFORMATION

Castellanos had a State of California Criminal History record dating back to 1997 that revealed arrests for the following violations:

Driving Under the Influence
Grand Theft
Burglary
Domestic Violence
Child Cruelty

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 Castellanos 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). OCSD deputies and OCHCA medical personnel followed protocol and provided the required level of diligence and care to Castellanos during her time in the IRC.

Under California Government Code 845.6, OCSD deputies and OCHCA medical personnel would be liable if they knew or had reason to know that Castellanos needed immediate medical care and failed to take reasonable action to summon such medical care. Following her arrival at IRC, OCHCA medical personnel screened Castellanos multiple times and determined she should be moved into Mod K and observed due to her potential mental health problems.

Following protocol, Deputy Woodward conducted a safety check at approximately 11:31 p.m. on May 10, and nothing unusual was observed. Castellanos was observed under a blanket on her bunk. Thirty minutes later, a second check was conducted, at which time Deputy Woodward noticed Castellanos was still on her bunk under a blanket, but her feet were now exposed and discolored. Concerned, Deputy Woodward attempted to get Castellanos' attention by banging on the cell door and yelling. When Castellanos failed to respond, Deputy Woodward entered her cell. Once she was discovered to be unresponsive, Castellanos was immediately provided medical aid. This included assistance from Deputy Woodward, additional deputies, and OCHCA medical personnel. OCFA paramedics were promptly notified, and upon arrival assumed responsibility for Castellanos' treatment.

Furthermore, at no point during her incarceration was there any indication that Castellanos possessed or had taken methamphetamine. Consequently, there was no procedural justification for OCSD to conduct a search of Castellanos' body to determine if she was secreting contraband. Moreover, there is no evidence that if a search had been conducted, it would have recovered any controlled substances. The source of the methamphetamine that ultimately caused Castellanos' death is unknown. There is no evidence that this lack of knowledge was the product of a failure to follow protocol or other inaction by OCSD personnel that could constitute a breach of OCSD's duty of care to Castellanos.

Collectively, there is no evidence that observation of and safety checks on Castellanos were inadequate. Similarly, there is no evidence that the medical treatment provided was improper, insufficient, or untimely.

For the OCSD deputies and OCHCA medical personnel to be guilty of criminal negligence, their actions or inactions would have to constitute more than ordinary carelessness, inattention, or mistake in judgment. Their actions would have to be reckless and create a high risk of death or great bodily injury to Castellanos. In this case, OCSD deputies and OCHCA medical personnel certainly did not act in a reckless manner. Rather, OCSD deputies and OCHCA medical personnel acted in a way an ordinarily careful person would have acted in the same situation.

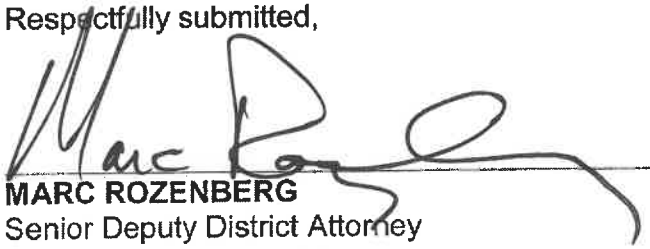
Thus, there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty.

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 that caused the death of Castellanos. The evidence demonstrates that Castellanos died as a result of acute methamphetamine intoxication and that the manner of death was an accident.

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

Respectfully submitted,



MARC ROZENBERG
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Read and Reviewed by **BRETT BRIAN**
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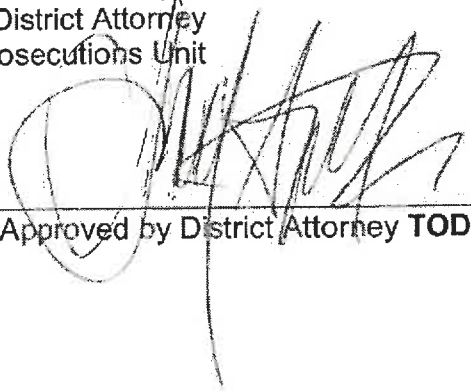

Read and Approved by District Attorney **TODD SPITZER**