OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

October 25, 2023

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

Re: Custodial Death on October 14, 2022
Death of Inmate Jose Dorellana Ruiz
District Attorney Investigations Case # SA 22-003191
Orange County Sheriff's Department Case # 22-035138
Orange County Crime Laboratory Case # FR 22-50783
Orange County Coroner's Office Case # 22-06033-AA

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 October 14, 2022, custodial death of 52-year-old inmate Jose Dorellana Ruiz.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Jose Dorellana Ruiz (Ruiz). 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 Orange County Sheriff's Department (OCSD) personnel involved with this custodial death incident as well as any other individuals working under the supervision of the OCSD.

On October 14, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to Anaheim Global Medical Center (AGMC), where Ruiz had died. At the time of Ruiz's death, he had been incarcerated in the Orange County Jail and was in the custody of the OCSD. Accordingly, investigation of the matter falls within the purview of OCSDSAU.

During the course of this investigation, the OCDASAU interviewed four witnesses. OCDASAU also obtained and reviewed reports from the OCSD, Orange County Crime Laboratory (OCCL), Orange County Coroner's Office (OCCO), Orange County Fire Authority (OCFA), as well as incident scene photographs, medical records, 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 does not address any issues relating to policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating the deaths of individuals occurring in Orange County 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.

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 consult with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will review any legal conclusions and resulting memos. 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

On June 19, 2022, at approximately 1:20 a.m., Ruiz was arrested by OCSD deputies on an outstanding arrest warrant for lewd and lascivious acts with a child under 14. Ruiz was transported to the Orange County Jail – Intake/Release Center (IRC) for booking.

During the booking process, a Comprehensive Care Nurse (CCN) from the Orange County Health Care Agency (OCHCA) completed a medical screening of Ruiz and cleared him for regular booking. Ruiz denied any preexisting medical conditions.

On June 30, 2022, at approximately 5:38 p.m., while waiting to be transferred to a housing unit, Ruiz appeared to lose his balance and fell. Ruiz was assisted into a wheelchair and medical personnel was requested. At approximately 5:51 p.m., Ruiz was medically evaluated by OCHCA registered nurses, and he was cleared for regular housing.

On July 1, 2022, at approximately 10:40 p.m., Deputy Tae Kim of OCSD noticed inmates trying to wake Ruiz, who was unresponsive. Deputy Kim went over to Ruiz's bunk and called out to Ruiz multiple times before Ruiz awoke. Once awoken, Ruiz required assistance to exit his bunk, and once out of his bunk, Ruiz could not stand or walk. Ruiz was taken to the medical dispensary where he was examined by medical personnel. It was determined Ruiz had low blood pressure

and was dehydrated. Ruiz was given fluids and cleared for regular housing with a low bunk. Ruiz returned to his housing without further incident.

That same day, at approximately 8:10 p.m., inmates were ordered to stand in their full jail-issued clothing for "count." Ruiz, who was awake, failed to obey repeated orders to stand up. As the deputies stood by, Ruiz eventually stood up and presented his identification card. Ruiz did not appear to be in distress or in need of medical attention. A Jail Incident Report was later completed, alleging that Ruiz had failed to obey a directive and disrupted a count.

On July 9, 2022, at approximately 7:48 p.m., inmates pushed the emergency button and reported that Ruiz had fallen in the shower. OCSD deputies responded and found Ruiz awake and on the shower floor. Ruiz was taken to the medical dispensary where he was examined by a CCN. Ruiz was given fluids and band aids for a scratch on his knee. A doctor's appointment was scheduled for the following morning. Ruiz was cleared to return to his housing location and walked on his own back to his cell.

Later that night, at approximately 9:35 p.m., inmates pushed the emergency button and reported that Ruiz had fallen again, this time in the dayroom. OCSD deputies responded and found Ruiz conscious and on the dayroom floor. Ruiz was taken back to the medical dispensary where it was determined he should be taken to the hospital. At approximately 10:04 p.m., Ruiz was transported via Care Ambulance to Orange County Global Medical Center (OCGMC).

At approximately 10:19 p.m., Ruiz arrived at the OCGMC emergency room. A computerized cranial tomography (CT) scan was ordered. The CT scan revealed a 4 centimeter calcified suprasellar hypothalamic mass on the right side of Ruiz's brain. Doctors determined Ruiz had a mass in the back of the brain that was giving off extra fluid, which was creating pressure and causing some of Ruiz's symptoms.

On July 13, 2022, Ruiz underwent neurosurgery. A ventriculoperitoneal shunt was placed in Ruiz's head to relieve the pressure, but doctors were not able to surgically remove the mass. Ruiz remained under observation at OCGMC and received physical, occupational, and speech therapy.

Ruiz continued his therapy and over the next couple months, Ruiz could verbally respond, follow simple commands, move his limbs, and feed himself with some assistance. However, beginning on September 12, 2022, Ruiz's condition began to deteriorate, where he was unable to take medications and he only responded to noxious stimuli. A CT scan revealed the mass had grown in size.

On September 15, 2022, neurosurgeons from OCGMC and the University of California-Irvine Medical Center (UCIMC) evaluated Ruiz and determined there would be a significant risk to his health if they tried to surgically reduce the size of the mass. Additionally, doctors further determined application of radiation therapy would be ineffective without first reducing the size of the mass. Given his condition, and the absence of treatment options, he was determined to have a poor prognosis for survival and was transitioned to end-of-life care.

On September 30, 2022, Ruiz was transferred to AGMC. On October 2, 2022, Ruiz's mother, was contacted to discuss his care. Based on Ruiz's condition, Ruiz's mother elected to place a do-not-resuscitate (DNR) order on file. Ruiz was transitioned to comfort care.

On October 14, 2022, at approximately 5:30 a.m., Ruiz went into cardiac arrest. Per the DNR order, no medical intervention was performed. At approximately 7:15 a.m., the emergency room doctor pronounced Ruiz deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Forty-eight (48) OCCL scene photographs
- Forty-six (46) OCCL autopsy photographs
- Twenty-six (26) OCCO scene photographs
- Bloodstain Standard (Ruiz)
- Muscle Standard (Ruiz)

AUTOPSY

On October 27, 2022, Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Ruiz. There were no signs of trauma to the body, nor any evidence of major or minor injuries. In his report, Dr. Luzi also listed a number of natural diseases and pre-existing conditions, including pulmonary congestion and edema, cardiomegaly, mild coronary atherosclerosis, mild to moderate peripheral atherosclerosis, and nephrosclerosis. The manner of death was determined to be natural and the cause of death was a tumor, adamantinomatous craniopharyngioma.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Ruiz's postmortem blood tested negative for the presence of drugs and alcohol.

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

In this present case, 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. Rather, the only issue is whether there was a murder or involuntary manslaughter for failure to perform a legal duty that caused Ruiz's death. Due to Ruiz's incarceration, OCSD owed him a duty of care.

After review, the evidence does not support the conclusion that this duty was breached in either an intentional (as required for murder) or criminally negligent (as required for involuntary

manslaughter) manner. A review of OCSD medical aid reports and all other relevant evidence reveals that OCSD personnel exercised reasonable care to Ruiz. When OCSD initially took custody of Ruiz, they provided him with a medical screening, after which Ruiz was cleared for regular housing. None of Ruiz's preexisting medical conditions or prior medical interventions were made known to OCSD staff at the time of Ruiz's booking.

Furthermore, Ruiz's death was not foreseeable. Over the course of several weeks following Ruiz's booking, Ruiz suffered seemingly minor medical episodes in which he would either appear to fall or would be unresponsive. In each of these episodes, OCSD promptly summoned medical personnel to examine Ruiz. Ruiz was checked out and given fluids before he was medically cleared to return to his regular housing. These incidents were not of a grave or critical nature that would have alerted OCSD personnel to the life-threatening brain mass that was growing inside of Ruiz's head.

On July 9, 2022, at approximately 7:48 p.m., Ruiz was taken to the medical dispensary after inmates reported Ruiz had fallen in the shower, which marked the third time Ruiz had to be medically evaluated in the past 10 days. Ruiz was cleared to return to his housing and a doctor's appointment was scheduled for the following morning. However, later that evening, inmates reported Ruiz falling once again. At that time, OCSD medical personnel determined Ruiz was to be taken to the hospital immediately. At approximately 10:04 p.m., Ruiz was transported to the emergency room at OCGMC. OCSD personnel swiftly acted and arranged for Ruiz to receive emergency medical attention once staff became aware of his concerning condition.

At OCGMC, a CT scan was ordered and showed that Ruiz had a mass growing on the right side of his brain. The mass was giving off extra fluid, creating pressure and causing some of Ruiz's symptoms. Ruiz underwent surgery, after which, Ruiz received physical, occupational, and speech therapy over the next several months. Unfortunately, the mass in Ruiz's head continued to grow and after consultation with OCGMC and UCIMC doctors, the doctors determined further surgery or medical interventions were not medically viable and transitioned Ruiz to end-of-life care.

Based on the evidence discussed above, there is insufficient evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty. Since causation must be established beyond a reasonable doubt for any form of homicide to be prosecuted, it is significant to note that there is nothing in Dr. Luzi's autopsy report to suggest that receiving hospital services hours or days or weeks earlier could have saved Ruiz's life. Ruiz's hospital treatment at AGMC and OCGMC under the care of neurosurgeons and oncology doctors spanned several months, where ultimately, doctors concluded Ruiz's brain mass reached a point where it was deemed medically inoperable.

Accordingly, there is insufficient evidence to prove beyond a reasonable doubt that any OCSD personnel committed a crime resulting in Ruiz's death.

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 Ruiz. The evidence shows that Ruiz died as a result of a brain tumor and that the resulting death was from natural causes.

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

TOM PHAN
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**