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December 13, 2018

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

Re: Custodial Death on February 28, 2018
Death of Inmate Jesus Deleon
District Attorney Sheriff's Department Case # SA 18-008
Orange County Sheriff's Department Case #18-008680
Orange County Crime Laboratory Case #18-43263

Dear Sheriff Hutchens,

This letter details the Orange County District Attorney's Office's (OCDA) investigation and legal conclusions in connection with the above-listed incident involving the Feb. 28, 2018, custodial death of 38-year-old inmate Jesus Deleon.

OVERVIEW

This letter contains a description of the scope of, and the legal conclusions resulting from the OCDA's investigation of the custodial death of Deleon. In this letter, the OCDA describes the investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and legal principles applied by the OCDA to determine whether any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD is criminally culpable for Deleon's death.

On Feb. 28, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to UCI Medical Center (UCIMC) where Deleon died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed fifteen witnesses. Additionally the OCDASAU 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 any possible issues relating to 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 a veteran 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 Senior Assistant District Attorney supervising the Felony Operations II Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On April 16, 2017, at approximately 12:45 a.m., an officer from the Fullerton Police Department (FPD) responded to a request by St. Jude Medical Center (SJMC) to investigate the circumstances of a shooting incident. Upon arrival, the officer contacted Deleon and conducted a records check. Deleon reported he had accidentally shot himself in the hand while cleaning a gun at approximately 12:10 a.m. earlier that night, and his wife had driven him to SJMC for treatment. The records check showed Deleon was on Post Release Community Supervision and was prohibited from possessing a firearm. Subsequently, the OCDA filed a felony complaint against Deleon alleging a violation of Penal Code section 29800(a)(1), possession of a firearm by a felon. On Jan. 5, 2018, Deleon was sentenced to 180 days in Orange County Jail for being a felon in possession of a firearm.

During the booking process, Deleon did not inform the medical staff he had any pre-existing medical conditions or was taking any medications. The St. Jude Fullerton Emergency Department Report detailed Deleon had a history of hypertension, but was not medicated for it. Deleon was cleared for booking and eventually assigned to F-Barracks at the Theo Lacy Jail Facility at 501 The City Drive South in Orange.

Based upon a review of all the available evidence, the OCDA concluded that on Feb. 20, 2018, at approximately 6:28 p.m., Deleon began working out with several other inmates in the F-Barracks common area, doing decline and regular pushups for nearly 30 minutes. After working out, Deleon gathered his belongings for a shower and walked up the stairs to the shower area on the second floor of F-Barracks. Deleon stumbled around the area and leaned against the wall on the right side of the shower area. Deleon did not shower and exited the shower area about four minutes after entering. Deleon briefly stopped at a drinking fountain and then continued walking toward the sleeping area located on the same floor. He appeared to speak with two other inmates while leaning against the top bunk of a nearby bunkbed. Deleon also appeared to communicate with an inmate who was at the bottom of the stairs.

Inmates gathered around Deleon and called the deputies for help. Jail medical staff arrived within six minutes of the deputies entering F-Barracks and reported that Deleon was diaphoretic with an elevated heart rate and high blood pressure. Deleon exhibited symptoms of a stroke- slurred speech, left side weakness, and no gaze preference. The medical staff gave Deleon an IV and oxygen until the Orange County Fire Department paramedics arrived approximately 10 minutes later. Deleon was transferred via ambulance to UCIMC.

Upon arrival at UCIMC, the team of medical staff activated a stroke code for Deleon. Initially, Deleon was able to participate in the initial stroke examination conducted by the medical staff. Deleon's condition, however, rapidly declined as he vomited and became comatose. The treating registered nurse reported Deleon "looked expired" and his body seemed cold to the touch when she took his vitals upon arrival. The medical team continued to treat him and Deleon's treating physician reported there was no sign of traumatic injury to his head upon initial assessment. A CT scan revealed a large right pontine hemorrhage, which is highly correlated with hypertension. A urine drug screen was also conducted and showed no drugs were present in Deleon's system at the time. The medical staff concluded the hemorrhage was due to uncontrolled high blood pressure. Deleon was admitted to the Critical Care Unit and remained comatose for the remainder of his duration at UCIMC.

The medical staff spoke with Deleon's girlfriend and mother and told them Deleon would remain in a vegetative state for the rest of his life. Deleon's girlfriend and mother did not sign a Do Not Resuscitate (DNR) order at first and wanted to proceed with surgery for Deleon. After surgery, Deleon remained comatose and unresponsive. On Feb. 23, 2018, Deleon was placed on a DNR order by his mother. His health and condition continued to deteriorate and he developed cardiac problems.

On Feb. 28, 2018, at approximately 5:15 p.m., the medical staff removed all tubes from Deleon's body and started comfort care measures for him. Deleon was declared deceased at 7:32 p.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Bloodstain standard
- Muscle standard

AUTOPSY

On March 2, 2018, Forensic Pathologist Dr. Scott Luzi of Anatomic, Clinical and Forensic Pathology Services conducted an autopsy on the body of Deleon. Dr. Luzi examined Deleon's body and found no significant minor or major injuries or trauma. Dr. Luzi's final autopsy diagnosis includes the following natural and pre-existing conditions: healed skin erosions on the left lower extremity, pontine hemorrhage, pulmonary congestion and edema, cardiomegaly, moderate coronary atherosclerosis, mild to moderate peripheral atherosclerosis, nephrosclerosis, and status post appendectomy. The autopsy of Deleon revealed he had an enlarged heart and a large bleed in his brain. Dr. Luzi determined the cause of death to be acute pontine hemorrhage as a result of hypertensive heart disease, and the manner of Deleon's death to be natural.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Deleon postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
[redacted]	Postmortem Blood	0.302 ± 0.013 mg/L
[redacted]	Postmortem Blood	0.0279 ± 0.0030 mg/L
[redacted]	Postmortem Blood	0.0114 ± 0.0012 mg/L

BACKGROUND INFORMATION

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

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 human being;

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/she acted he/she knew his/her 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:

> "The 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/she 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/she acts is so different from how an ordinarily careful person would act in the same situation that his/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 in this case of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Additionally, although the OCSD owed Deleon a duty of care, the evidence does not support a finding this duty was breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

During Deleon's booking process, Deleon did not report to medical staff at the Intake Release Center that he had any pre-existing medical conditions nor that he was taking any medications. On Jan. 5, 2018, the medical staff conducted a routine exam of Deleon and noted no abnormal signs of serious health problems. Deleon was cleared for booking and eventually transferred to Theo Lacy Jail Facility. On Feb. 20, 2018, Deleon displayed abnormal behavior after engaging in physical exercise with other inmates. When deputies were notified of Deleon's abnormal condition, they promptly responded to him and administered medical care to Deleon until paramedics arrived approximately 10 minutes later. Deleon was transported to UCIMC without incident.

Upon arrival at UCIMC, a stroke code was activated and Deleon was continually monitored by hospital staff. When staff noticed Deleon's health quickly deteriorated after his initial assessment, they acted diligently and responded to his comatose state. Deleon's subsequent death was the result of complications due to hypertensive heart disease and an acute pontine hemorrhage.

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 of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that Deleon died of natural causes as a result of complications of hypertension and pontine hemorrhage.

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

Respectfully submitted,

SETON HUNT
Deputy District Attorney
Homicide Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney
Felony Operations II