



OFFICE OF THE

DISTRICT ATTORNEY

ORANGE COUNTY, CALIFORNIA

TONY RACKAUCKAS, DISTRICT ATTORNEY

JIM TANIZAKI
CHIEF ASSISTANT D.A.

JOSEPH D'AGOSTINO
SENIOR ASSISTANT D.A.
GENERAL FELONIES/
ECONOMIC CRIMES

MICHAEL LUBINSKI
SENIOR ASSISTANT D.A.
SPECIAL PROJECTS

JAIME COULTER
SENIOR ASSISTANT D.A.
BRANCH COURT OPERATIONS

SCOTT ZIDBECK
SENIOR ASSISTANT D.A.
VERTICAL PROSECUTIONS/
VIOLENT CRIMES

CRAIG HUNTER
CHIEF
BUREAU OF INVESTIGATION

JENNY QIAN
DIRECTOR
ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER
CHIEF OF STAFF

April 17, 2017

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

Re: Custodial Death on March 25, 2016
Death of Inmate Joseph Edward Alvarado
District Attorney Investigations Case #SA16-014
Orange County Sheriff's Department Case #16-071836
Orange County Crime Laboratory Case #16-44977

Dear Sheriff Hutchens,

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 March 25, 2016, custodial death of 46-year-old male Inmate Joseph Edward Alvarado.

OVERVIEW

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

On March 25, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to University of California, Irvine Medical Center (UCIMC) after inmate Alvarado died in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed three 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 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, as well as 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, 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

Background

Alvarado had a history of [REDACTED] including [REDACTED] and [REDACTED]. Alvarado also had multiple medical issues including [REDACTED] (diagnosed in 2007), [REDACTED]
[REDACTED]

From October to December 2015, Alvarado was placed in home hospice for his [REDACTED] but he subsequently removed himself from hospice. On Jan. 20, 2016, Alvarado was treated at St. Joseph's Hospital emergency room for [REDACTED]. He was released the same day upon his request with prescriptions. Later that day, however, he was admitted and treated in the Intensive Care Unit (ICU) of Orange County Global Medical Center (OCGMC) for the same symptoms. Alvarado was discharged on Jan. 26, 2016 after his condition stabilized, but he remained noncompliant with his medications since his release from the hospital on Jan. 26, 2016. On Jan. 30, 2016, Alvarado returned to OCGMC's emergency room and was treated for his [REDACTED].

Summary of Events

On Feb. 3, 2016, at approximately 3:00 p.m., officers from the Santa Ana Police Department arrested Alvarado for the following violations:

- California Vehicle Code section 10851(a) – vehicle theft
- California Penal Code section 215 (a) – carjacking
- California Penal Code section 211 – robbery
- California Penal Code section 245(a)(1) – assault with a deadly weapon

SAPD transported Alvarado to Orange County Jail for booking but Alvarado was refused due to preexisting medical issues. On Feb. 3, 2016, Alvarado was transported and admitted to OCGMC in Santa Ana. He was treated for his [REDACTED] but he constantly refused care while in the hospital. Alvarado expressed that he was not keen on continuing his treatment regimen while being hospitalized. On Feb. 9, 2016, Alvarado was discharged once he was clinically stable, and was given a recommendation to follow up with the physician at the facility and an outpatient HIV specialist.

On the same day, at approximately 3:41 p.m., Alvarado was booked into OCSD, Intake and Release Center (IRC), and his bail was set at \$250,000. On Feb. 10, 2016, Alvarado was transferred to the OCSD's Theo Lacy Facility (TLF) and was housed in the Medical Ward, Module "O". On Feb. 11, 2016, Alvarado was examined by the Orange County Health Care Agency (OCHCA) doctor John Doe 1 who discovered [REDACTED]. Alvarado was then transported to OCGMC on the same day at approximately 8:57 p.m.

On Feb. 12, 2016, approximately at 7:29 p.m., Alvarado was discharged from OCGMC and transferred back to the TLF Module "O". Alvarado was housed in the Men's Observation Unit, Ward C, bed 6. At approximately 10:00 p.m., Alvarado was examined by the OCHA RN Jane Doe 1 and doctor John Doe 2, and was found to be incoherent and unable to communicate. Upon doctor John Doe 2's order, Alvarado was transferred back to OCGMC via ambulance by Orange County Fire Authority (OCFA), Engine 75 paramedics at approximately 11:10 p.m. Alvarado was treated at the OCGMC for his altered mental status, and as he became more awake and alert, he became noncompliant and not cooperative with his treatment. When his condition stabilized, Alvarado was discharged from OCGMC back to TLF on Feb. 17, 2016. Alvarado was rehoused in Module O, cell 41-5.

On Feb. 19, 2016, approximately at 2:44 a.m., Alvarado was found unresponsive on his cell floor. After being evaluated by OCHCA RN Jane Doe 2, paramedics were requested. At approximately 3:16 a.m., Orange County Fire Department (OCFD), Station 6, Rescue 5 transported Alvarado by ambulance to UCIMC. Alvarado was treated at UCIMC until Feb. 24, 2016. On Feb. 24, 2016, Alvarado was transferred to TLF and rehoused in Module "O".

On March 2, 2016, at approximately 5:45 p.m., Alvarado was seen by OCHCA doctor John Doe #3 for medical treatment. Doctor John Doe #3 believed Alvarado's [REDACTED] and requested that Alvarado be transported to UCIMC for further evaluation and treatment. On the same day at approximately 8:00 p.m., Alvarado was admitted to UCIMC ICU and received treatments for [REDACTED].

On March 22, 2016, upon doctors' consultation with Alvarado's wife and mother regarding Alvarado's terminal condition, Alvarado was placed on "Do Not Resuscitate/Do Not Intubate Order" Status. Alvarado was moved from ICU to the Telemetry Unit and placed on "comfort care".

On March 25, 2016, at approximately 7:09 a.m., medical staff noted that Alvarado had stopped breathing and had no pulse. At 8:44 a.m., Alvarado was pronounced deceased by the attending physician.

AUTOPSY

On March 25, 2016, independent Forensic Pathologist Dr. Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Alvarado. Following the autopsy, Dr. Luzi concluded that the cause of death was due to natural causes resulting from [REDACTED].

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
[REDACTED]	Postmortem Blood	0.137 ± 0.006 mg/L
[REDACTED]	Postmortem Blood	0.779 ± 0.078 mg/L
[REDACTED]	Postmortem Blood	Detected

Alvarado's Criminal History

Alvarado's criminal history dates back to 1986 and continued through 2016. During that time frame, Alvarado had an extensive State of California Criminal History record including, but not limited to, [REDACTED]

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 beyond a reasonable doubt:

- 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 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/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 whatsoever in this case of express or implied malice on the part of any OCSD personnel, 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 Alvarado 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). Alvarado had multiple medical issues including [REDACTED] at the time he was placed in custody with OCSD. The OCSD jail and medical staff responded quickly each time Alvarado's health problem was observed, and facilitated his transportation to the appropriate medical facilities (OCGMC, UCIMC) for a total of four times.

The facts and evidence in this case are consistent with the pathologist's conclusion that Alvarado died from [REDACTED]. Thus, there is no evidence whatsoever 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 Alvarado died from natural causes as a result of cirrhosis of the liver.

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

Respectfully submitted,



Lori Smith
Deputy District Attorney
TARGET/Gangs Unit



Read and Approved by **Ebrahim Baytieh**
Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit