OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

September 4, 2019

Chief Jorge Cisneros
Anaheim Police Department
425 South Harbor
Anaheim, CA 92805

Re: Custodial Death on March 15, 2019
Death of Inmate Alejandro Alvarez
District Attorney Investigations Case # S.A. 19-005
Anaheim Police Department Case # 19-036115 / 19-036246
Orange County Crime Laboratory Case # 19-43463 / 19-43848

Dear Chief Cisneros,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the above-listed incident involving the March 15, 2019, custodial death of 45-year-old inmate Alejandro Alvarez.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Alvarez. 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 Anaheim Police Department (APD) personnel or any other person under the supervision of APD.

On March 14, 2019, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Anaheim Detention Facility, where the custodial-related incident occurred. On March 15, 2019, OCDASAU Investigators responded to Anaheim Global Medical Center (AGMC), where Alvarez died after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed eight witnesses, as well as obtained and reviewed reports from APD and Orange County Crime Laboratory (OCCL), incident scene photographs, video recordings, 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 APD personnel or any other person under the supervision of APD. 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 Operations IV 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 and their supervisors. The District Attorney reviews all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

At approximately 6:30 p.m. on March 14, 2019, APD Officer Michael Padilla arrested Alvarez for fleeing the scene of a collision and suspicion of DUI, and he transported Alvarez to the Anaheim Detention Facility (Jail). Once at the Jail, Alvarez was searched by APD Corrections Officer Ernesto Cendejas, and corrections officers indicate that Alvarez was agitated and argumentative until he was allowed to use the restroom. After using the restroom, Alvarez's demeanor calmed, and he underwent the standard intake process, which included medical screening questions. APD Corrections Sergeant Abigail Vazquez supervised the questioning while Officer Cendejas translated to Alvarez because Alvarez was a monolingual Spanish-speaker. During the questioning, Alvarez indicated that he had no history of mental health issues, had never tried to harm himself, and was not thinking about harming himself at that time.

Alvarez did not consent to voluntary breath or blood samples as a part of the DUI investigation, and he was placed into cell H-5, a single-person holding cell, while officers obtained a warrant for a blood sample. H-5 is a narrow, concrete-block cell with a door made of woven metal bars; the cell contains only a light, a concrete-block bench at the rear of the cell, and a payphone mounted on the wall immediately to the left upon entering. The payphone has a braided metal cable, approximately twelve inches in length, connecting the handset to the body of the phone. A fixed surveillance camera outside of the cell captured the cell door and part of the interior of cell H-5, including the area where the payphone is mounted.

The surveillance footage shows that, at approximately 8:46 p.m., Sergeant Vazquez enters the holding cell area to place another inmate, Jane Doe, into a neighboring holding cell. Sergeant Vazquez can be seen talking with Alvarez briefly at the front of his cell. At approximately 8:54 p.m., Alvarez approached the pay phone mounted in his cell, removed the handset from the receiver,

placed the braided metal cable around his neck, and returned the handset to the receiver, effectively creating a noose around his neck. Alvarez then dropped to his knees with the cable around his neck, causing the phone cable to place pressure on his neck by virtue of his body weight.

At approximately 9:02 p.m., surveillance footage shows that APD Corrections Officer Jessica Maciel exited an adjacent room, walked past cell H-5, looked towards the cell, but did not appear to notice Alvarez's situation, and continued walking. Officer Maciel stated in her voluntary statement to OCDA that when she walked past the cell containing Alvarez, she was not conducting routine hourly cell checks, but that she was walking by as a matter of course in conducting fingerprint scanning of other inmates. At approximately 9:05 p.m., Officer Maciel can be seen on the same surveillance camera entering the adjacent room used for fingerprint scanning while escorting another inmate.

At approximately 9:12 p.m., Officer Cendejas retrieved inmate Jane Doe from a neighboring holding cell and directed her into the nearby room used for fingerprint scanning. As he walked past cell H-5, Officer Cendejas noticed Alvarez positioned on his knees in front of the payphone. Alvarez's fingers were sticking out of the cell door, and they appeared blue to Officer Cendejas. Officer Cendejas tapped Alvarez's hands, but Alvarez did not respond. Officer Cendejas then immediately directed Jane Doe back into a holding cell and called for support from other officers.

Sergeant Vazquez and Officer Maciel responded, and Officer Cendejas unlocked the door to H-5. Officer Cendejas and Sergeant Vazquez entered the cell, removed the phone handset from the receiver, and Alvarez fell to the floor. Officer Cendejas and Sergeant Vazquez moved Alvarez out of the cell and began administering cardiopulmonary resuscitation (CPR). At approximately 9:14 p.m., Sergeant Vazquez directed APD Cadet Jillian Hernandez to notify dispatch that they were in need of paramedics.

Sergeant Vazquez and Officer Cendejas continued administering CPR until Anaheim Fire & Rescue (AF&R) personnel arrived at the Jail at approximately 9:18 p.m. When one of the AF&R Paramedic arrived, he assessed Alvarez and found him to be unconscious, unresponsive, and in full cardiac arrest. Alvarez had no heart rate, no blood pressure, and was not breathing. The Paramedic administered CPR, inserted an oropharyngeal airway (OPA) and used a valve mask to perform ventilations on Alvarez. The Paramedic also started a cardiac monitor, inserted an intravenous line (IV), and initiated an endotracheal intubation on Alvarez.

At approximately 9:32 p.m., Care Ambulance transported Alvarez to AGMC. While in transit, the Paramedics continued to monitor Alvarez's vital signs and administered CPR. Paramedics continued ventilation on Alvarez and administered two doses of epinephrine. At approximately 9:35 p.m., Alvarez arrived at AGMC where the Paramedics provided information regarding Alvarez's condition to emergency room staff before they released Alvarez to AGMC.

When Alvarez arrived at AGMC, he was in a state of asystole, and the emergency room staff performed CPR and intubated him. At approximately 9:49 p.m., Alvarez regained a pulse and went into atrial fibrillation. On March 15, 2019, at approximately 7:36 a.m, Alvarez was transferred to the intensive care unit at AGMC, and he remained in unstable condition. At approximately 2:30 p.m., hospital staff found Alvarez with no blood pressure and in a state of asystole. At the direction of Alvarez's wife, no further life saving measures were taken. At 3:36 p.m., the attending physician pronounced Alvarez dead.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Blood Standard

AUTOPSY

On March 18, 2019, Forensic Pathologist Dr. Aruna Singhana of the Orange County Coroner's Office conducted an autopsy on the body of Alvarez. During the autopsy, Dr. Singhana made the following observations:

- Approximate one inch abrasion on left jaw line
- Ligature mark around the neck with vertical line pattern
- A fatty liver
- A slightly enlarged heart
- A tear in the left thyroid cartilage

Dr. Singhana's findings indicate that the only sign of trauma was the ligature mark around Alvarez's neck and that the cause of death was ligature strangulation.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Alvarez's antemortem and postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethanol	Antemortem blood	0.093 ± 0.004 % (w/v)

BACKGROUND INFORMATION

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

- Domestic Violence Battery
- Hit and Run
- DUI Drugs/Alcohol
- Unlicensed Driver

THE LAW

Homicide is the killing of one human being by another. *CALCRIM No. 500* (2018 edition). Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. *Ibid*. 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.

Pen. Code, § 187; *Ibid*.

There are two kinds of malice aforethought, express malice and implied malice. *Pen. Code,* §188. Express malice is when the person unlawfully intended to kill. *Ibid.* 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. *Ibid.*

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.

Pen. Code, § 192(b).

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.

Ibid.

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. *Pen. Code*, § 192(b); *CALCRIM* No. 580 (2018 Edition). 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. *Pen. Code*, § 192(b); *CALCRIM* No. 580 (2018 Edition). A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes. *Ibid.*

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. *CAL CRIM* Nos. 580, 581 & 582. 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. *Ibid.*

LEGAL ANALYSIS

There is no evidence whatsoever in this case of express or implied malice on the part of any APD personnel or any inmates or other individuals under the supervision of APD. 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 APD owed Alvarez 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). Review of surveillance video, and all other relevant evidence, shows that APD personnel responded to the scene effectively and appropriately upon discovery of Alvarez's situation.

Upon arrival at the Jail, Alvarez was placed in a holding cell, following standard APD procedures, while officers waited for a warrant for a blood sample as part of the DUI investigation pending against Alvarez. Following standard intake procedures, Alvarez indicated that he had no history of mental illness nor any history or present intention of harming himself. As such, APD personnel had no reason to believe that Alvarez posed a danger to his own life.

Additionally, APD custodial protocol was followed during the time surrounding the incident. Voluntary statements from APD personnel indicate that cell checks of the entire jail occur hourly. As the evidence shows, between the times Sergeant Vazquez can be seen talking with Alvarez until Officer Cendejas discovered Alvarez unresponsive, approximately twenty-six minutes elapsed. As custom would allow inmates to go unchecked for periods up to one hour, and Alvarez was checked on twice within twenty-six minutes, APD personnel did not fail to perform their legal duty to ensure the safety of inmates.

Further, although Officer Maciel appeared not to notice that Alvarez was strangulating when she walked by to conduct fingerprinting of other inmates, this failure to notice Alvarez does not amount to criminal negligence. As noted above, criminal negligence does not include ordinary carelessness, inattention, or mistake in judgment, but rather criminal negligence requires reckless action creating a high risk of death or great bodily injury. By walking past Alvarez's cell as part of a separate duty, Officer Maciel did not act in a reckless manner, and did not create any additional risk of death or great bodily injury to Alvarez. As such, Officer Maciel's failure to notice Alvarez's situation does not amount to criminal negligence.

Finally, as soon as Officer Cendejas discovered Alvarez unresponsive, APD personnel responded immediately and appropriately. Officer Cendejas and Sergeant Vazquez removed Alvarez from his cell and administered emergency medical aid without hesitation or delay. Upon the instruction of Sergeant Vazquez, Cadet Hernandez called into dispatch to request paramedics, and AF&R personnel arrived promptly. Despite the prompt and appropriate emergency response by APD personnel, Alvarez's self-inflicted ligature strangulation ultimately resulted in his death.

Thus, there is no evidence whatsoever to support a finding that any APD personnel or any individual under the supervision of APD 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 APD personnel or any individual under the supervision of APD. The evidence shows that Alvarez died as a result of a self-inflicted ligature strangulation using the phone cable in his cell.

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

Respectfully submitted,

FRANK ACOSTA
Deputy District Attorney
Special Prosecutions Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney