OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

July 9, 2020

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

Re: Custodial Death on July 30, 2019
Death of Baby Doe
District Attorney Investigations Case # SA 19-016
Orange County Sheriff's Department Case # 19-028595
Orange County Crime Laboratory Case # 19-50000

Dear Sheriff Barnes,

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 July 30, 2019 custodial death of Baby Doe.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Baby Doe. 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 July 30, 2019, OCDA Special Assignment Unit (OCDASAU) Investigators responded to University of California, Irvine – Medical Center (UCIMC) where Baby Doe was delivered stillborn by inmate Jane Doe. During the course of this investigation, the OCDASAU interviewed four witnesses, as well as obtained and reviewed reports from the OCSD, Orange Police Department (OPD), Orange County Fire Authority (OCFA), Orange County Coroner (OCC) 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 an experienced deputy district attorney for legal review. Deputy district attorneys from the Homicide, 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 several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On July 21, 2019, 30-year-old transient Jane Doe was arrested by OPD for two outstanding warrants. The arrest occurred at St. Joseph Hospital, located at 1100 W. Stewart Drive, in the City of Orange. Earlier that morning, Doe had been transported by ambulance to that location following her call to Santa Ana Police Department (SAPD) Dispatch from the front steps of the station. She reported she was pregnant and wanted to have her baby checked. Doe had been to St. Joseph Hospital on several prior occasions and was known to the medical staff. After Doe was examined and medically cleared, she was provided new clothing and discharged. However, Doe refused to dress or leave the hospital, telling the responding OPD officer she was either going to stay at the hospital or go to jail. A records check revealed Doe had two outstanding bench warrants, and she was placed under arrest at approximately 12:33 hours and transported to the Orange County Intake-Release Center (IRC) without incident.

Jane Doe was booked into custody at approximately 13:49 hours on July 21, 2019 at the IRC, indicating during the pre-booking procedure that she was pregnant. Additionally, Doe stated she suffered from psychosis, schizophrenia and post-traumatic stress disorder, and used methamphetamine occasionally, as recently as three days prior (July 18, 2019). Due to her pregnancy, Doe was considered a medical booking and prescribed prenatal vitamins.

On July 22, 2019, Jane Doe was examined by Orange County Health Care Agency (OCHCA) medical personnel. After determining Baby Doe's baseline fetal heartrate, Doe was placed on sick call and scheduled for evaluation by the obstetrician at the next possible date. However, Doe did not attend her initial obstetrics examination scheduled for later that day because she refused to leave her cell. The following day, July 23, 2019, Doe appeared in court, and therefore was not taken to her initial obstetrics examination. At that court appearance, she was placed on a court-ordered 72-hour mental health treatment evaluation per Penal Code Section 4011.6 and Welfare and Institutions

Code Section 5150. It was also determined that due to her current mental condition, Doe was too unstable to safely be escorted to her obstetrician appointment at that time. Based on IRC staff recollection, Doe had no physical altercations with any other inmates while housed at the IRC.

On July 26, 2019 at approximately 09:06 hours, Doe refused a visit from the OCHCA Mental Health staff, stating she did not want to get up. Later that day, at approximately 18:00 hours, Doe requested to see Correction Health Services, reporting she had not heard her baby's heartbeat since the previous morning, nor had she felt movement since that morning. Additionally, Doe reported experiencing cramping all that day, and spotting the day prior. At approximately 21:00 hours, Doe was examined by OCHCA medical staff, who were unable to locate the baby's heartbeat, noting Doe had difficulty tolerating and allowing the examination. The following day, July 27, 2019 at approximately 10:00 hours, Doe was again examined by Correctional Health Services medical staff, who were unable to detect fetal heart tones and ordered Doe to be transported to OC Global Medical Center (OCGMC) in the City of Anaheim for further evaluation and ultrasound. At approximately 13:15 hours, Doe was transported to OCGMC by ambulance where she was admitted and examined by on-duty medical staff, which included an abdominal ultrasound. At approximately 15:07 hours, the attending physician informed Doe that the ultrasound revealed no fetal heartbeat and subsequently declared the fetus deceased.

Doe refused to accept the death of her fetus and requested to be transferred to UCI Medical Center (UCIMC) for additional medical assessment of her fetus. Following a conference between doctors at OCGMC and UCIMC, Doe was transported to UCIMC via ambulance at 18:41 hours, where she was immediately admitted to the Labor and Delivery Unit. After additional testing and ultrasound examination, the attending physician determined the fetus presented no signs of life and confirmed the diagnosis of intrauterine fetal demise.

On July 28, 2019, the UCIMC Ethics Committee was consulted and determined that Jane Doe was unrepresented and lacked the capacity to make medical decisions due to her psychosis and severe paranoia. The Committee concluded that Doe could become more cooperative through an antipsychotic medication regimen, and that induction of labor was the preferred method of treatment. On July 29, 2019, Doe's psychosis was stabilized through medication and she consented to having her labor induced.

On July 30, 2019, Doe went into medically-induced labor and had a spontaneous delivery of stillborn Baby Doe at 11:34 hours. Baby Doe, who was delivered at 28 & 3/7 weeks, was examined and immediately declared deceased by the attending physician.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- White blanket with pink and blue stripes
- Disposable diaper
- Pre-admittance blood
- Placenta
- 23 digital color photographs of the hospital scene and body

AUTOPSY

On August 8, 2019, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Baby Doe. Dr. Luzi determined the manner of death to be natural, with the cause of death being intra-uterine fetal demise of undetermined etiology.

EVIDENCE ANALYSIS

Toxicological Examination

An analysis of Baby Doe's postmortem liver and peripheral blood samples could not be performed due to insufficient volume. A sample of Jane Doe's ante-mortem blood was obtained on July 28, 2019 at 00:00 hours. When analyzed for the presence of ethanol, a level of 0.000 ± 0.005 w/v was obtained. When analyzed for the presence of drugs, it was determined the sample may have contained haloperidol, but additional examination did not confirm its presence. No additional findings were made in the examination of the sample for the presence of drugs.

BACKGROUND INFORMATION

At the time of the declaration of Baby Doe's death, Jane Doe had three pending cases which included the following violations of law:

- Resisting and Deterring an Executive Officer
- Interference with a Business
- Possession of Controlled Substance Paraphernalia
- False Report of an Emergency

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/fetus;
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 whatsoever 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. 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 Baby Doe and Jane Doe a duty of care, the evidence does not support a finding that this duty was in any way breached -- either intentionally or through criminal negligence. Prior to being booked at the IRC, Jane Doe was discharged and medically cleared following an examination of both herself and her fetus, Baby Doe. After being booked at IRC, Jane Doe was evaluated by OCHCA medical personnel and provided with prenatal vitamins. At that time, Doe indicated to medical staff that she occasionally used methamphetamine and smoked during the pregnancy. Additionally, Doe told investigators she recalled suffering at least one prior miscarriage, most recently the year prior. The following day, after Doe was again examined and Baby Doe's fetal heartbeat detected, Jane Doe was twice scheduled for an obstetrician appointment, but missed them first due to safety concerns related to her instability and unpredictability, and then a court appearance that resulted in a court-ordered 72-hour psychiatric treatment evaluation. When Doe alerted jail staff

that she had experienced symptoms of possible pregnancy complications three days after her court appearance, it was not immediately after the symptoms began, but rather the following day. Jane Doe was examined by OCHCA medical staff the same day, though they reported Doe had difficulty allowing the examination for fetal heart tones. When Orange County Health Care Agency medical personnel were able to complete their examination of Doe the following day, and were unable to locate fetal heart tones, they immediately arranged to transport her via ambulance to OCGMC for further medical evaluation and treatment. Once there, medical staff similarly concluded that no fetal heart tones could be detected and determined Baby Doe was deceased, as did the medical staff at UCIMC, where Baby Doe was ultimately induced and delivered stillborn on July 30, 2019.

There is no indication that Jane Doe was involved in any type of physical altercation with any other inmates while housed in OCSD custody at the IRC that could have contributed to the death of Baby Doe. The only physical altercation reported by Doe during her interview with investigators was with a female at a homeless shelter at un undetermined date earlier in her pregnancy prior to her arrest. Additionally, there is no evidence to suggest that the actions taken by OCSD were negligent, unreasonable, or contributed in any way to the death of Baby Doe

Thus, there is no evidence to prove beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Baby Doe.

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 beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Baby Doe. The evidence shows that Baby Doe's cause of death was intra-uterine fetal demise of undetermined etiology and that the manner of death was a natural one.

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

Respectfully submitted,

Cliff Bodley

CLIFF BODLEY
Deputy District Attorney
Gangs Unit

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

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