OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

February 10, 2020

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

Re: Custodial Death on May 12, 2019
Death of Baby Doe
District Attorney Investigations Case # SA 19-008
Orange County Sheriff's Department Case # 19-018053
Orange County Crime Laboratory Case # 19-46112

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 May 21, 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 May 21, 2019, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center ("OCGMC") where Baby Doe died while in custody. 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 an experienced 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 several experienced 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

On April 29, 2019, 32-year-old female Jane Doe, was arrested by the Cypress Police Department ("CPD") for an outstanding warrant. The CPD Officer searched Jane Doe and found that she was in possession of drug paraphernalia, then she was transported to CPD. While at CPD, Jane Doe completed the Inmate Medical Screening during which she admitted to using methamphetamine but denied being pregnant.

After completing the Inmate Medical Screening, Jane Doe was transported to the Orange County Jail ("OCJ") for booking and housing. Once booked into the Women's Central Jail ("WCJ"), Jane Doe provided a urine sample which indicated a positive reaction to methamphetamines / amphetamines, and pregnancy.

On April 30, 2019, at approximately 10:33 a.m., Jane Doe was seen at WCJ for her first obstetrics ("OB") visit. Jane Doe stated that she had been using methamphetamines since she was fourteen years old, and that she had last used methamphetamine on the day she was arrested, April 29, 2019. Jane Doe stated that she did not plan on keeping the baby, and was planning on placing the baby up for adoption. OCJ medical staff diagnosed Jane Doe with high blood pressure and confirmed that she was pregnant. OCJ medical staff transported Jane Doe to the Anaheim Global Medical Center ("AGMC") for further examination. Jane Doe spent two days at AGMC before being transported back to WCJ. AGMC medical staff estimated Jane Doe was 28 weeks pregnant.

On May 7, 2019, Jane Doe was transported to OCGMC for an OB follow up appointment. OCGMC medical staff diagnosed Jane Doe with high blood pressure and she was kept under observation for two days. On May 9, 2019, Jane Doe was discharged and transported back to WCJ. On May 11, 2019, around approximately 9 or 10 p.m., Jane Doe began to experience stomach pains. She did not tell anyone about her stomach pain and merely drank some water and went back to sleep.

On May 12, 2019, at approximately 4:27 a.m., Jane Doe pressed the emergency intercom button in her call stating, “I’m pregnant and I’m bleeding.” The on-duty OCSD Deputy (“Deputy”) responded to Jane Doe’s cell immediately. The Deputy escorted Jane Doe to the First Floor Medical Dispensary where a Registered Nurse (“RN”) visually examined Jane Doe for vaginal bleeding. The RN examined Jane Doe and determined that her blood pressure was elevated and she was having contractions. There were no signs of trauma on Jane Doe’s body, and she did not report any incidents of falling or being assaulted. The RN recommended Jane Doe be sent to OCGMC for further evaluation.

At approximately 5:08 a.m., Orange County Fire Authority (“OCFA”) arrived and transported Jane Doe to OCGMC by ambulance. She arrived at OCGMC at approximately 5:20 a.m., and was placed in Labor and Delivery (“L&D”) Room #211. Medical staff conducted various medical examinations on Jane Doe and attempted to locate a heartbeat for Baby Doe. They completed an ultrasound but were unable to locate a heartbeat. Medical staff noticed that Jane Doe had abdominal bleeding and she was complaining of abdominal pain and dehydration.

At approximately 7:32 a.m., medical staff prepared Jane Doe for an emergency cesarean section. The RN informed the on-scene officer that Baby Doe died and did not have a fetal heartbeat. At approximately 7:56 a.m., medical staff moved Jane Doe into the operating room. At approximately 8:22 a.m., the attending physician conducted the cesarean section and delivered Baby Doe. Baby Doe did not have a heartbeat and was not breathing. The physician pronounced Baby Doe deceased upon delivery.

The physician stated that Jane Doe had suffered a placenta abruption, which caused the placenta to separate from the uterus. The abruption was due to high blood pressure which is a symptom of preeclampsia pregnancy. The abruption resulted in the death of Baby Doe.

EVIDENCE COLLECTED

The following items of evidence were collected and examined: Blood Standard.

AUTOPSY

On May 14, 2019, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Baby Doe. Baby Doe was determined to have reached approximately thirty weeks of gestation. Dr. Luzi observed that there was an umbilical clamp on Baby Doe, and that there were no signs of injuries on her. Dr. Luzi concluded that Baby Doe died from natural causes as a result of intra-uterine demise.

EVIDENCE ANALYSIS

A sample of Baby Doe’s postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethanol/Volatiles	Postmortem Blood	Not Detected
Barbiturates	Postmortem Blood	Negative
Methamphetamine and Related	Postmortem Blood	Negative
Cannabinoids	Postmortem Blood	Negative

BACKGROUND INFORMATION

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

- Possession of Controlled Substance Paraphernalia
- Probation violation
- Under the Influence of a Controlled Substance
- Petty Theft
- Loitering
- Possession of Controlled Substance

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

In the present case, there is no evidence whatsoever 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 (as required for murder) or through criminal negligence (as required for involuntary manslaughter). Jane Doe was a chronic methamphetamine user and was using methamphetamine during her pregnancy, up until the day of her arrest, April 29, 2019. Jane Doe was monitored throughout her incarceration in WCJ, and had access to proper care for her medical needs.

While housed in WCJ, Jane Doe was taken to AGMC twice and held under observation at the hospital for her high blood pressure. When Jane Doe began to experience vaginal bleeding, the on-duty OCSD Deputy immediately responded to her cell and transported her to the WCJ medical wing to be evaluated. The RN stationed there quickly determined that she needed further observation and assistance and called an ambulance to transport Jane Doe to AGMC as soon as possible. Once at the hospital, medical staff conducted various examinations to determine Baby Doe's condition and they discovered there was no fetal heartbeat. Medical staff performed an emergency caesarean on Jane Doe, but Baby Doe was born not breathing and without a heartbeat.

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 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 died from as a result of a placenta abruption which caused Jane Doe's vaginal bleeding and resulted in the death of Baby Doe.

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

Respectfully submitted,

WHITNEY BOKOSKY
Senior Deputy District Attorney
Homicide Unit

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