OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

April 2, 2020

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

Re: Custodial Death on December 1, 2018.
Fetal Demise of J. Doe
District Attorney Investigations Case S.A. #18-037
Orange County Sheriff's Department Case #18-047864

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 December 1, 2018, custodial fetal demise 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 December 1, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Central Women's Jail, after it was determined that Baby Doe did not have a heartbeat at the Anaheim Global Medical Center. During the course of this investigation, the OCDASAU interviewed three witnesses, as well as obtained and reviewed reports from the OCSD, medical records, 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 November 14, 2018, inmate Jane Doe was booked into OCSD Central Women's Jail. During the booking process, Jane Doe informed the jail medical staff she was pregnant and she estimated she was approximately nine weeks into the pregnancy. The medical staff conducted an ultrasound, however it was too early into the pregnancy to detect a heartbeat. Jane Doe had not been treated by a medical professional for the pregnancy prior to entering the jail. On November 29, 2018, Jane Doe informed the jail staff she noticed a small amount of vaginal bleeding. The Medical staff evaluated her and advised her to remain in her bunk and alert them if symptoms worsen.

On November 30, 2018, at approximately 0330 hours, Jane Doe informed jail staff that she was just assaulted by a fellow inmate and received a single punch in the side of the head. There were no visible injuries to Jane Doe from this incident. The inmate Jane Doe alleged to have hit her was interviewed by the jail staff. The inmate disputed the version of events articulated by Jane Doe and stated that it was Jane Doe who had hit her in the face. Jane Doe declined prosecution. The case was not forwarded to the OCDA's office for legal review.

On December 1, 2018, Jane Doe complained of spotting blood and was seen by the medical staff. Jane Doe was then transported to the Anaheim Global Medical Center (AGMC) due to a possible miscarriage. The ultrasound at AGMC revealed that there was no fetal heartbeat, indicating a probable fetal demise/miscarriage. It is unclear as to how far along Jane Doe was into the pregnancy. However, the ultrasound indicated that Baby Doe had gotten to 6 weeks and 1 day in size. Upon being notified that there was no heartbeat, Jane Doe declined a dilation and curettage (D and C) procedure and chose to abort Baby Doe naturally on her own. Jane Doe was returned to Central Women's Jail the same day, and was placed under medical observation. Jane Doe was released from jail on December 23, 2018, without any record that she passed the fetus. Therefore, no remains of Baby Doe were ever recovered.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Medical Records
- OCSD Reports
- Interviews

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 person or 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

In evaluating whether a homicide has been committed, there must be an act or failure to act that caused the death of a person. However, there is no evidence that Baby Doe ever had a heartbeat or at what point the demise of Baby Doe was imminent. The evidence only shows that at the time of the diagnosis of a fetal demise, Baby Doe had grown to the equivalent of 6 weeks and 1 day in age. There is no evidence Baby Doe had a heartbeat or at what point that heartbeat stopped. Further, there is no evidence for purposes of criminal liability as to what or who caused the miscarriage.

There is also 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. Even if we were able to determine that there was a death and the cause of that death, then the only possible type of homicide to analyze in this situation is under the theory of failure to perform a legal duty.

Although the OCSD owed Jane Doe and Baby 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. The medical staff at Central Women's Jail treated Jane Doe for her pregnancy and conducted medical evaluations immediately when she notified them of any potential concerns regarding her pregnancy while under the care of the OCSD. On December 1, 2018 the medical staff sent Jane Doe to AGMC when notified of possible complications related to the pregnancy. While at AGMC, tests were run and it was determined that Jane Doe had already lost her baby. Jane Doe does not claim she was mistreated or denied medical attention. She also stated she was treated well by OCSD deputies. There is no evidence presented to suggest that the actions taken by the OCSD were unreasonable, or that the actions could be characterized as negligent. There is no evidence the miscarriage was caused by any action by the OCSD.

Additionally, there is no evidence the miscarriage was caused by an inmate at OCSD. There was an altercation between Jane Doe and another inmate in the evening prior to the diagnosis of a fetal demise by the medical staff. There is a dispute as to who started the altercation and if any violence or force was used by that inmate. However, even assuming that the inmate did use violence in the manner describe by Jane Doe, there is no evidence to suggest this impacted the pregnancy in any way that would create legal causation as required by law. Jane Doe had symptoms of the miscarriage prior to the altercation and there is nothing alleged by Jane Doe or any of the medical staff that such

force had an impact on the pregnancy causing miscarriage. Thus, there is no current 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 demise of baby Doe.

CONCLUSION

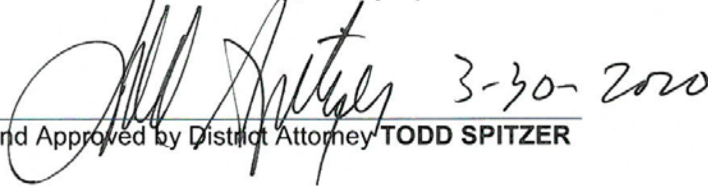
Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is lack of sufficient evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Baby Doe. The evidence shows that the fetal demise was a natural one.

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

Respectfully submitted,

BRADLEY SCHOENLEBEN
Senior 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**