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June 25, 2015

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

Re: Custodial Death on Nov. 28, 2013
Death of Inmate Itzcoatl Ocampo
District Attorney Investigations Case # SA 13-028
Orange County Sheriff's Department Case # 13-231669
Orange County Crime Laboratory Case # FR 13-56549

Dear Sheriff Hutchens,

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 Nov. 28, 2013, custodial death of inmate Itzcoatl Ocampo, 25.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Ocampo. 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 Nov. 28, 2013, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Orange County Central Men's Jail (OCCMJ). During the course of this investigation, 21 interviews were conducted, along with 19 canvass interviews. In addition, OCDASAU Investigators 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 or Gang Units review 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 his or her supervisor, and this Assistant District Attorney eventually will review and approve any legal conclusions and resulting memoranda. 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

On Jan. 13, 2012, at approximately 10:30 p.m., APD officers arrested Itzcoatl Ocampo in connection with four murders, stemming from a series of stabbing murders that occurred over an approximate 3-week period in the cities of Anaheim and Yorba Linda. On Jan. 14, 2012, at approximately 9:39 p.m., Ocampo was booked into the OCCMJ and held without bail. During the booking phase, an initial intake screening and triage was conducted by a Registered Nurse (RN) from OCCMJ Correctional Mental Health Services (CMHS). During her interview with Ocampo, the RN noted that Ocampo had attempted suicide by suffocation in 2010. At approximately 10:00 p.m., Ocampo was interviewed by a second CMHS RN. This second RN noted that Ocampo did not take any medications, but he complained of feeling hopeless and depressed, and he admitted to a prior suicide attempt in 2010.

As a result of the two evaluations by the RNs, Ocampo was classified as a "total separation/protective custody" inmate; therefore, Ocampo was placed in Module L, a housing location containing six sectors, numbered 15 through 20. Each sector contained 16, one-man cells. Sectors 18 and 19 housed inmates that were under observation for "suicide watch;" these inmates were issued safety gowns made of a heavy, canvass-type material designed to prevent tearing and usage as a ligature. Ocampo was transferred between sectors 18 and 19 frequently during his first year in the OCCMJ.

In late January 2012, Ocampo was transferred to Module J, an observation unit similar to Module L, but with less supervision. Module J is reserved for inmates with medical conditions and psychological disorders. Ocampo continued to be seen and evaluated frequently by medical and psychiatric staff. Several incidents were noted in Ocampo's OCCMJ medical records.

On Feb. 16, 2012, medical staff was summoned because deputies had found Ocampo unresponsive on the floor of his cell. Medical staff attempted to awaken him with external rub and ammonia ampules. After several attempts, Ocampo woke up and claimed that he had "felt dizzy" and "passed out." Medical staff determined that Ocampo was holding his breath and faking unconsciousness. CMHS staff questioned Ocampo's claimed syncopal episode because he would not have remembered passing out if he had actually fainted.

On March 3, 2012, Ocampo was standing in his cell with a large contusion on the left side of his head, but he denied experiencing dizziness or nausea. When examined, he claimed that he had intentionally hit his head several times on a wall. Despite his assurances that he would not do it again, Ocampo was deemed suicidal and he was transferred back to Module L, sector 18.

On April 4, 2012, Ocampo claimed that he was suffering from tremors and that he had a prior diagnosis of Wilson's disease, which results in elevated levels of copper in the body. Ocampo claimed that he was diagnosed with the disease upon returning from active duty with the Marine Corps. Upon further examination, medical staff was skeptical of his claim; however, they sought Ocampo's consent to obtain and review his medical records from the Veterans Administration (VA). Over the next

several weeks, multiple attempts were made to obtain written consent from Ocampo, but he refused, and the records were never obtained.

CMHS psychiatric staff prescribed multiple medications to Ocampo while he was in custody. Ocampo was prescribed the following: Zoloft – used in the treatment of depression, social anxiety disorder, panic disorder and post-traumatic stress disorder; Zydis (Zyprexa) – used in the treatment of psychotic conditions such as schizophrenia and bipolar disorder; Celexa – used to treat depression; Remeron – used to treat major depressive disorder; Inderal, used to treat tremors, chest pains, hypertension, and heart rhythm disorders; and Paxil – used to treat depression, obsessive compulsive disorder, anxiety disorders and post-traumatic stress disorder.

Between March 2012 and July 2013, Ocampo refused to take his prescribed medications on 16 occasions. Each occurrence was documented on a form by the respective medical staff personnel that provided the dose to him. Some of the forms were signed by Ocampo and others were not, frequently due to security concerns.

OCSD Deputy Daniel Castillo was assigned to Module F and he was familiar with Ocampo. According to Deputy Castillo, Ocampo did not have much interaction with staff or other inmates in the Module initially, but as time passed, he became more social. According to Deputy Castillo, Ocampo generally was calm and cooperative, and he did not have "any issues" with other inmates. Ocampo smiled and laughed more over time, and Deputy Castillo never heard Ocampo mention that he wanted to hurt himself. Ocampo interacted most with inmates John Doe 1, John Doe 2, and John Doe 3 who were housed in nearby cells. John Doe 1 described Ocampo as "quiet" and not always "mentally stable." John Doe 2 recalled that Ocampo never complained of any medical issues.

Inmate John Doe 3 had known Ocampo for approximately five to six months prior to Ocampo's death. Approximately in the middle of November 2013, Ocampo told John Doe 3 that if he were to receive a sentence of life without the possibility of parole, he would "take a big shot of heroin and kill himself." John Doe 3 thought Ocampo was "joking." John Doe 3 spoke with Ocampo for the last time on the evening of Tuesday, Nov. 26, 2013, and he did not notice any change in Ocampo's behavior.

An inmate in a sector assigned by a deputy to clean the walkways in front of the cells is referred to as the "porter." The assigned porter is allowed out of his cell by a deputy, who then provides the porter with the cleaning solutions and equipment to perform his duties. When the porter completes his tasks, the deputy removes the supplies and equipment from the sector. Since inmates are responsible for the cleanliness of the interior of their individual cells, it is common for inmates to ask the porter for a small amount of cleaning solution or cleanser, so that the requesting inmate can clean the interior of his cell. The porter typically gives an inmate a small amount of cleanser in a milk carton saved from a prior meal.

At the time of Ocampo's death, John Doe 3 was the porter for sector 29. Prior to John Doe 3, the longtime porter was inmate John Doe 4. John Doe 4 stated that Ocampo never requested cleanser or any other cleaning substance from him while he was the porter.

John Doe 3 served as the porter for approximately three weeks prior to Ocampo's death. Ocampo had never asked John Doe 3 for cleanser until Nov. 25, 2013. John Doe 3 recalled providing Ocampo with a small amount of cleanser in a sandwich bag or cereal bowl that Ocampo provided. OCSD deputies interviewed in the course of this investigation stated that it was not uncommon to find a small quantity of cleanser in inmates' cells during searches. On Nov. 25, 2013, inmates began to notice that Ocampo's behavior began to change. Ocampo stopped conversing with John Doe 1 and John Doe 2, and he just lay in bed. The inmates stated that on Wednesday, Nov. 27, 2013, Ocampo seemed disappointed that he did not receive any mail, but he did not make any statements regarding an intent to harm himself.

At approximately 5:10 p.m. on November. 27, 2013, John Doe 4 passed by Ocampo's cell and noticed that Ocampo appeared sick. John Doe 4 offered to help Ocampo, but Ocampo declined. John Doe 4 heard John Doe 1 and John Doe 2 tell Deputy Castillo that Ocampo may have food poisoning. Ocampo proceeded to vomit but continued to decline any help from John Doe

4 or the deputies. At approximately 6:00 p.m., Deputy Castillo observed that Ocampo was drinking excessive amounts of water and vomiting. Deputy Castillo saw Ocampo drink water from a milk carton approximately 10 times, vomit, and then continue drinking water. John Doe 1 and John Doe 2 told Deputy Castillo that Ocampo had been vomiting for the past hour, and they believed that he may have been suffering from food poisoning.

At approximately 6:13 p.m., Deputies Castillo and Bradley Ray entered sector 29 and approached Ocampo's cell, in order to check on his welfare. Deputy Castillo saw Ocampo sitting partially on his toilet and defecating into a brown paper bag. Deputy Castillo asked Ocampo if he was "okay" and he responded, "Yes." Deputy Castillo asked Ocampo if he needed medical attention and he replied, "No." Deputy Castillo then offered to take Ocampo to the second floor dispensary and Ocampo accepted. Deputy Castillo noted that Ocampo was wearing a jail-issued towel around his head as a blindfold, although it was not unusual to see Ocampo wearing a blindfold. Deputy Castillo asked Ocampo if he had poisoned himself and Ocampo did not respond. Ocampo's body started shaking as though he was having a seizure. For security reasons, Deputies Castillo and Ray did not enter the cell until additional personnel arrived.

At approximately 6:18 p.m., OCSD Deputies Jason Lanier, Carlos Palomares-Velasco, and Michael Sakamoto arrived and entered Ocampo's cell. Deputy Sakamoto drew his department-issued Taser and pointed it at Ocampo, in the event that Ocampo was faking the incident and planned to attack staff. Once inside the cell, Deputy Sakamoto realized that Ocampo was actually in distress, so he holstered his Taser. Deputy Lanier lifted Ocampo's left arm and shoulder area, Deputy Palomares-Velasco lifted Ocampo's legs, and Deputy Sakamoto lifted Ocampo's right arm and shoulder area, so they could move Ocampo from the toilet to the walkway in front of his cell. The towel was removed from Ocampo's eyes, and a towel or blanket was placed under Ocampo's head as he was laid on his back.

Deputies Lanier and Sakamoto searched the inside of Ocampo's cell for anything that he may have swallowed, and they observed a small milk carton on the table that contained what appeared to be the white powdered cleaning substance used in the OCCMJ. Deputy Lanier also saw two additional milk cartons wrapped in plastic underneath Ocampo's bed. Approximately 30 seconds after Ocampo was removed from his cell, two RNs with the Orange County Correctional Medical Services (OCCMS) arrived at the scene. Upon arrival, one of the RNs noted that Ocampo was foaming from the mouth, indicating a potential seizure, so she immediately instructed deputies to request paramedics. Ocampo was breathing, but unresponsive. Ocampo's blood pressure was 180 over 100, with a pulse rate of 100-102, and blood sugar of approximately 160. Ocampo's pupils were reactive. After checking Ocampo's vitals, the RN administered oxygen and established an intravenous (IV) line in Ocampo's right arm. The RN did not note any signs of trauma on Ocampo during her treatment.

At approximately 6:27 p.m., Orange County Fire Authority (OCFA) Engine 75 arrived on the scene. OCFA Captain Paul Carlton was directed to Ocampo, who was non-responsive. Ocampo had a respiratory rate of 8, a pulse rate of 70, and blood pressure of 140 over 100, but his heart rate showed normal sinus rhythm. Captain Carlton was told by OCCMS staff that Ocampo was found unconscious in his cell with a towel around his eyes and was seen drinking an excessive amount of water. OCCMS staff believed that Ocampo had ingested some type of cleanser, and they showed Captain Carlton a torn, half cup containing an unknown white powder.

Captain Carlton continued the administration of oxygen and use of an IV in Ocampo's arm. No physical trauma was observed on Ocampo's body, but due to the unknown circumstances surrounding Ocampo's condition, Captain Carlton treated Ocampo as a "trauma patient."

At approximately 6:49 p.m., Ocampo was transported via Care Ambulance to Western Medical Center Santa Ana (WMCSA). During the transportation, no additional treatment was provided, and Ocampo did not regain consciousness. Deputies Austin Kaesman and Jordan Lado accompanied Ocampo in the ambulance. At approximately 6:59 p.m., Ocampo arrived at WMCSA, and Captain Carlton relinquished care of Ocampo to hospital personnel. The attending trauma surgeon at WMCSA was briefed by paramedics regarding Ocampo's condition. Paramedics advised the attending surgeon that Ocampo was found unresponsive in his cell and was suspected of having ingested some type of cleaning agent or suffering from possible water

intoxication. The attending surgeon intubated Ocampo to ensure an open airway, and he had a nasogastric tube inserted into Ocampo's stomach. Ocampo was given a dose of activated charcoal to absorb any toxins from the substance he had ingested. Blood test results indicated that Ocampo had extreme electrolyte abnormalities, which consisted of low sodium levels in his blood stream, and the acid base level in his body was very high and acidic. These results were consistent with the presence of a toxin in the body.

Ocampo received an X-ray to ensure proper placement of the intubation tube and a Computerized Tomography (CT) scan to check for possible injuries or trauma. The CT scan indicated that Ocampo was suffering from cerebral edema, or brain swelling. Ocampo was treated with saline through an IV drip in both arms in an effort to stabilize the sodium level in his blood. Ocampo's pupils were initially sluggish but reactive; however, within an hour of arrival at the hospital, his pupils had become dilated and non-reactive which lead the treating surgeon to conclude that these symptoms were caused by Ocampo's brain continuing to swell. The treating surgeon ordered a central IV line, which was inserted through the subclavian vein, to administer a greater concentration of saline solution. Ocampo also was given Mannitol to improve blood flow to his brain and increase his urine output. These ongoing efforts to balance Ocampo's electrolyte level and stem his brain swelling were unsuccessful. The attending surgeon consulted with a neurosurgeon who opined that Ocampo had possibly suffered a catastrophic neurological event. At the neurosurgeon's direction, the treating surgeon performed a CT scan and forwarded the images to the neurosurgeon for review. The neurosurgeon's review of the CT scan revealed that Ocampo had suffered from massive brain swelling that could be fatal. Accordingly, Ocampo was moved to the Intensive Care Unit (ICU) and was provided supportive treatment until the neurosurgeon could see Ocampo the following morning.

On the morning of Thursday, Nov. 28, 2013, the medical team completed a brain death examination on Ocampo, which revealed no brain stem reflexes, indicating that Ocampo was brain dead. The attending surgeon did not observe any internal or external trauma on Ocampo during his treatment, and Ocampo never obtained a level of consciousness enabling him to speak. At approximately 7:30 a.m. on Nov. 28, 2013, the neurosurgeon arrived at WM-SA and performed several examinations on Ocampo. A visual examination revealed no obvious signs of physical trauma. The neurosurgeon also performed a neurological examination, testing Ocampo's brain stem response, his response to pain stimuli, and his gag and cough reflexes. In addition, the neurosurgeon performed an apnea challenge to check for any spontaneous breathing, and he performed a blood gas analysis. Upon concluding his examinations, the neurosurgeon's findings were consistent with brain death. At approximately 11:00 a.m., Ocampo's treating surgeon consulted with a second neurosurgeon regarding Ocampo's condition. During this second neurosurgeon's assessment, Ocampo was not under the influence of any medication that would interfere with the brain function tests being performed. This second neurosurgeon described Ocampo as being comatose, unresponsive to stimuli, having widely-dilated pupils that were unresponsive to light, no gag or cough reflex, and flaccid limbs. The second neurosurgeon also described Ocampo as having a lack of oculocephalic reflex, also known as "doll's eyes." This reflex is tested by moving a patient's head side to side. If a brain stem injury is present, the patient's eyes will move side to side with the movement of the head, as opposed to remaining fixed on a point.

To determine if there was any blood flow to the brain, the second neurosurgeon ordered a cerebral blood flow test, which produced negative results. Therefore, the second neurosurgeon determined that Ocampo showed no brain stem reflexes, no respiratory efforts to breathe, and he was totally unresponsive. As a result, the second neurosurgeon also concluded that Ocampo was "brain dead."

In compliance with California State law, both neurosurgeons completed separate "brain death" notes. Ocampo was kept on a ventilator and administered Vasopressin, as needed, pending his family's decision to donate his organs. After consulting with an organ donation organization, Ocampo's family declined to donate Ocampo's organs. At approximately 7:19 p.m. on Nov. 28, 2013, Ocampo was extubated and removed from the ventilator. At approximately 7:38 p.m. on Nov. 28, 2013, Ocampo's heart stopped and he was pronounced deceased.

AUTOPSY

On Dec. 2, 2013, at approximately 8:50 a.m., a postmortem examination of Ocampo was conducted by Dr. Joseph Cohen, a Board Certified Pathologist with United Forensic Pathologist. During the examination, Dr. Cohen noted the absence of trauma to Ocampo's body. Following the autopsy, Dr. Cohen stated that the results were inconclusive pending the results of toxicological testing.

On Dec. 18, 2014, and after reviewing the results of the toxicological tests, Dr. Cohen determined that Ocampo's death was a suicide due to acute cerebral edema, severe metabolic derangements and pulmonary edema, and acute ingestion of uncertain toxic substances.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Ocampo's postmortem blood, stomach contents, urine, and liver was collected and examined for the presence of drugs and alcohol. The examination did not detect the presence of any drugs or alcohol.

BACKGROUND INFORMATION

According to California criminal history records, Ocampo's only arrest was for the murder charges for which he was in custody.

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 acted he knew his 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:

> "[T]he 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 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 acts is so different from how an ordinarily careful person would act in the same situation that his or 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 this 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 Ocampo 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). Given Ocampo's known history of suicidal ideations, he was monitored frequently while incarcerated at the OCCMJ. Ocampo's positive behavior while in custody allowed him to be housed in a non-suicide-watch module in which he was permitted access to small amounts of cleaning solution for use in his cell. Unbeknownst to fellow inmates or staff, Ocampo accumulated and ingested a lethal amount of powdered cleanser. Despite rapid respond when Ocampo exhibited signs of distress, medical personnel were unable to prevent his death. It would be unreasonable under the totality of the circumstances to conclude that anybody acted in a criminally negligent manner when Ocampo was allowed to receive the small quantities of cleaning solution, just like all the other inmates in the area where he was housed.

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 owed to Ocampo.

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 Ocampo committed suicide and died as a result of acute cerebral edema, severe metabolic derangements and pulmonary edema, and acute ingestion of uncertain toxic substances.

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

Respectfully submitted,

Scott A. Simons

SCOTT SIMMONS
Senior Deputy District Attorney
Homicide Unit

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