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May 22, 2017

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

Re: Custodial Death on April 15, 2016
Death of Inmate Mario Rafael Chacon
District Attorney Investigations Case # S.A. 16-015
Orange County Sheriff's Department Case # 16-090570
Orange County Crime Laboratory Case # FR 16-46816

Dear Sheriff Hutchens,

Please accept this letter detailing the investigation and legal conclusion by the Orange County District Attorney's Office (OCDA) in connection with the above-listed incident involving the April 15, 2016, custodial death of 56-year-old inmate Mario Rafael Chacon.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Mario Rafael Chacon. 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 April 15, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the OCSD Men's Central Jail Complex, where Chacon died while in custody after he was discovered unresponsive in his cell. During the course of this investigation, the OCDASAU interviewed 16 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 a veteran Deputy District Attorney for legal review. Deputy District Attorneys from the Homicide, TARGET/Gangs, and Special Prosecutions Units review fatal, as well as 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 Assistant District Attorney supervising the Special Prosecutions Unit, who will eventually review and approve any legal conclusions and resulting memos. 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 Tuesday, April 12, 2016, at approximately 9:19 a.m., Mario Chacon was the passenger in a vehicle that had been stopped by officers from the Santa Ana Police Department (SAPD). The vehicle had been reported stolen and the driver of the vehicle was arrested for auto theft and for possession of 11.8 grams of heroin. Chacon was arrested for having an outstanding warrant related to a probation violation in case number 15CF1503. Chacon was then transported to the SAPD for booking. At approximately 1746 hours, Chacon was taken by the SAPD to Orange County Global Medical Center (OCGMC) for a medical clearance prior to being transferred from the SAPD to Orange County Jail (OCJ). Chacon complained about a right thigh abscess, cellulitis, and chronic shoulder dislocation. Chacon also admitted daily use of alcohol as well as intravenous heroin, stating that he used about 1.5 grams of heroin a day. While at OCGMC, Chacon underwent a procedure to incise, drain, and pack his abscess. Chacon tolerated the procedure well with no apparent complications. Chacon was provided with aftercare instructions, medically cleared by OCGMC medical staff, and was booked into OCJ at approximately 2215 hours.

Chacon's medical history was reviewed upon his arrival at OCJ. Chacon's medical history included abscess incision and drainage, cellulitis, right shoulder dislocation, as well as heroin, methamphetamine, and marijuana addiction. In addition, Chacon had suffered from: arthritis, diabetes, renal failure, unstable left shoulder due to degenerative disk joint disease, hepatitis-c, anemia, thrombocytopenia, and chronic liver disease. Chacon's most recent medications included: Clindamycin, Aldactone, Furosemide, multivitamins, Percocet, and an Albuterol inhaler. During booking at OCJ, Chacon was medically evaluated, placed on the polysubstance withdrawal protocol, and approved to take medications associated with withdrawal symptomology including: Acetaminophen, Ondansetron, Serax, and Dicyclomine.

On April 14, 2016, at approximately 7:39 a.m., Chacon was treated by jail medical staff. During this visit, Chacon received his daily medications as well as new dressings for his abscess. Chacon complained of localized discomfort to the site of the abscess, but no further issues were reported or observed. On April 15, 2016, at approximately 9:30 a.m., Chacon again met with jail medical staff and received his daily medications as well as antibiotics for his abscess. Chacon exited his cell, walked down the stairs to retrieve his medications, and returned to his cell with no apparent issues or complaints. A video surveillance camera recorded Chacon on several occasions during the morning of April 15, 2016. Chacon was observed exiting and entering his cell several times and his gait and demeanor appeared normal. At approximately 10:22 a.m., Chacon was recorded exiting his cell and using the guardrail to support himself as he walked, and his appearance and demeanor were otherwise unremarkable. At approximately 10:24 a.m., Chacon re-entered his cell and was not recorded outside his cell thereafter. Nothing unusual was recorded outside his cell between 10:25 a.m. and 2:00 p.m. At approximately 1:35 p.m., OCSD Deputy Ernesto Escobar performed a routine check of the area where Chacon was housed. At that time, Chacon was in his bunk and appeared to be sleeping. Nothing appeared to be out of the ordinary.

At approximately 2:00 p.m., OCSD Deputy James Gotts and a nurse conducted a routine medication call to dispense medications to inmates. During the call, Deputy Gotts used a loudspeaker and called for Chacon to exit his cell to receive his medication. Chacon did not respond when his name was called. Instead, another inmate in Chacon's cell told Deputy Gotts that Chacon was unresponsive. When asked for clarification, the inmate signaled with an open hand across his own throat, indicating that Chacon may be dead or not breathing. Deputy Gotts immediately notified Deputies Chris Curtis and Ernesto Escobar who, in turn, called for additional deputies to respond to the Module.

When Deputies Gotts and Escobar entered Chacon's cell they observed that the inmate who had initially informed Deputy Gotts that Chacon was unresponsive was already inside the cell, attempting to shake Chacon awake. Chacon was laying

on his back on one of the top bunks in the cell, with blankets and sheets covering all but his head. Chacon's eyes were open and he was not cold to the touch. There were no apparent injuries or visible abnormalities. Deputies Gotts and Escobar worked together to locate a pulse and/or signs of respiration; they found neither. Deputy Escobar then requested additional assistance via radio as the nurse who was with them did not have any medical equipment. Deputies Curtis, Rombough, Perez, and Pickard arrived within minutes after the call for assistance went out over the radio. Working together, they lifted Chacon off his bunk and placed him on the floor on his back. Deputy Gotts immediately began Cardio Pulmonary Resuscitation (CPR) by doing chest compressions. Approximately 3-4 minutes later, medical staff arrived with a Phillips brand Heart Start Automatic External Defibrillator (AED) as well as an air mask, both of which were connected to Chacon. Attempts to resuscitate Chacon were ongoing and continuous with Deputies Perez, Gotts, and Pickard performing three or four sets of approximately thirty chest compressions before rotating to the next Deputy. During this process, the AED performed approximately five evaluations of Chacon's body to determine whether or not a shock of Chacon's heart was recommended; it was not. The Deputies followed the instructions of the AED and continued CPR until relieved by Orange County Fire Authority (OCFA) personnel.

OCFA personnel arrived on scene at approximately 2:17 p.m. and began an evaluation of Chacon immediately upon arrival. They noted that Chacon's pupils were fixed and dilated. Rigor mortis was apparent in Chacon's jaw. There were no lung sounds and there was bluing or cyanosis of the extremities, which were cold. Chacon's airway was not blocked. There was no breathing or circulation, and no viable signs of life. The monitor attached to Chacon did not show that any electrical activity was present in Chacon's heart. Consequently, Chacon was pronounced dead at approximately 2:21 p.m.

The other inmates in Chacon's cell were interviewed by OCDADAU Investigators. Inmate #1 stated that he thought Chacon looked "frail and unwell." Further, he relayed that Chacon previously indicated he was going through withdrawals from heroin. Also, at one point, Inmate #1 had complained to another inmate in the cell, Inmate #2, about Chacon's body odor, and said that Inmate #2 spoke to Chacon about taking a shower. However, Chacon declined to shower. Inmate #1 stated that he had no other contact with Chacon until he was found unresponsive.

Inmate #2 stated that he offered soap to Chacon so that Chacon could shower, but that Chacon declined a shower. Inmate #2 further stated that he had gone to get lunch with Chacon on April 15, 2016, and that Chacon had complained of leg pain. Inmate #2 last saw Chacon in his bunk before going to sleep.

Inmate #3 stated that he last saw Chacon alive when Inmate #3 went to take a shower at approximately 1:45 p.m. At that time, Chacon appeared to be asleep in his bunk. When Deputy Gotts called Chacon's name for medication call and Chacon did not respond, Inmate #3 assumed that Chacon was in a deep sleep. Inmate #3 went to check on Chacon, found Chacon unresponsive, and notified Deputy Gotts.

Inmate #4 stated that he saw Chacon eat breakfast at 5:00 a.m. and lunch at 10:30 a.m. on April 15, 2016. According to Inmate #4, Chacon slept most of the day and was awakened by OCSD deputies when he needed to eat, take medication, or participate in a security count. Inmate #4 did not see Chacon engage in any type of altercation with deputies, medical staff, or fellow inmates and it appeared to Inmate #4 that Chacon was having heroin withdrawals.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- One OCJ-issued orange shirt and pants,
- One OCJ-issued white t-shirt and white boxers,
- Two black socks.

AUTOPSY

On April 17, 2016, at approximately 9:00 a.m., independent Forensic Pathologist Dr. Scott A. Luzi conducted an autopsy on the body of Chacon. The autopsy revealed no major injuries. However, several minor injuries were noted including contusions on the decedent's face, two contusions on the anterior right forearm, and three contusions on the dorsum of the right hand. An abrasion and contusion were also present on the dorsum of the left hand. The anterior aspects of left ribs seven and eight were discovered fractured.

The autopsy results further indicated a number of natural diseases and pre-existing conditions:

- Open skin and subcutaneous tissue wound, right thigh,
- Right hemothorax
- Hemopericardium
- Subarachnoid hemorrhage with obliteration of the right posterior communicating artery
- Pulmonary congestion and edema
- Mild coronary atherosclerosis
- Myocardial rupture
- Mild peripheral altherosclerosis
- Cirrhosis
- Nodule, liver
- Nephrosclerosis
- Esophageal varices
- Non-specific gastropathy

Dr. Luzi concluded that the cause of Chacon's death was a "subarachnoid hemorrhage associated with obliterated posterior communicating artery." Therefore, Dr. Luzi concluded that the manner of Chacon's death was "natural."

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Chacon's postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Oxazepam	Postmortem Blood	0.203 ± 0.012 mg/L
THC	Postmortem Blood	0.0046 ± 0.0006 mg/L
Hydroxy-THC	Postmortem Blood	0.0015 ± 0.0002 mg/L
Carboxy-THC	Postmortem Blood	0.0259 ± 0.0030 mg/L
Dicyclomine	Postmortem Blood	Detected
Morphine (Total)	Postmortem Blood	Detected

BACKGROUND INFORMATION

Chacon had Criminal History records from the states of California, Oregon and Idaho that revealed numerous arrests and convictions including:

- Burglary
- Grand Theft – Person
- Possession of a Narcotic Controlled Substance
- Possession for Sale of a Narcotic Controlled Substance
- Driving Under the Influence of Alcohol
- Possession of a Hypodermic Needle
- Possession of Paraphernalia
- Escape

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 in California 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 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 types of homicide to analyze in this situation are murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Chacon 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). Chacon had been medically evaluated at OCGMC prior to his booking at OCJ, and his health history was reviewed and evaluated by OCJ medical staff during the booking process. Throughout his incarceration, Chacon was provided with medications relating to pain management and withdrawal. Additionally, his abscess was monitored and the dressings were changed. There was no indication, apparent or otherwise, that Chacon was ever suffering from an immediate, life-threatening health concern. Chacon was never denied, and did not request, any additional medical treatment or assistance. Consequently, there are no facts to support any inference that the OCSD intentionally breached their duty of care to Chacon.

There is also no evidence to support criminal negligence on the part of anybody connected with the OCSD. Criminal negligence is established when a person 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. There is no evidence that any OCSD personnel or anyone under their supervision acted in a reckless manner. Deputy Gotts immediately responded to Chacon's cell upon learning Chacon was unresponsive. Deputy Gotts quickly assessed that Chacon was in medical distress and summoned additional assistance using the radio. OCSD Deputies worked together to lift Chacon from his bunk, attach medical equipment, and administer CPR. Their efforts to revive Chacon began immediately and were continuous until they were relieved by OCFA personnel.

Therefore, and based on the totality of all the facts, it is clear 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 owed to Ochoa.

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 Chacon died from natural causes resulting from pre-existing medical conditions.

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

Respectfully submitted,

Jeffrey Kirk
Deputy District Attorney
Special Prosecutions Unit

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