OFFICE OF THE
# DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

May 27, 2021

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

Re: Custodial Death on July 14, 2020
Death of Inmate Montes
District Attorney Investigations Case # 20-016
Orange County Sheriff's Department Case # 20-022735
Orange County Crime Laboratory Case # 20-47195

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 14, 2020, custodial death of 63-year-old inmate Guillermo Montes.

## OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Montes. 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 14, 2020, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Jail, where Montes had died while in custody. During the course of this investigation, the OCDASAU interviewed 12 witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, jail surveillance videos, 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/CHRONOLOGICAL HISTORY

On Thursday, **July 2, 2020**, at 1747 hours, Montes was arrested by the Santa Ana Police Department (hereinafter, "SAPD") for a violation of California Penal Code Section 422, Criminal Threats, and an active parole warrant (warrant #2001230471). The arrest was documented under SAPD Case #2020-13488. At the time of this arrest, Montes was complaining of dizziness, headache, and nausea.

Due to these complaints, Montes was transported by SAPD to Orange County Global Medical Center (hereinafter, "OCGMC") for a medical examination prior to booking at the Orange County Jail (OCJ). Prior to Montes' examination, he reported that he smoked cigarettes and admitted a history of using heroin and methamphetamine. Montes also reported that he was prescribed and taking the following medications: Asorbic Acid (500 mg, orally, daily), Depakote (1000 mg, orally, daily), Metformin (500 mg, orally, 2x's per day), RisperDal (1 mg, orally, 2x's per day), Senna (8.6 mg, orally, 2x's per day), and Zinc Sulfate (220 mg, orally, daily).

While at OCGMC, Montes was examined by an attending physician (Attending Physician #1). This examination included a chest x-ray, blood test, and psychiatric evaluation. Upon completion of the exam, Attending Physician #1 concluded Montes was medically stable and mentally coherent. Montes was then discharged from OCGMC and cleared for jail booking at OCJ.

On **July 3, 2020**, at 0005 hours, during the jail pre-booking medical screening, Orange County Health Care Agency (hereinafter, "OCHCA") staff conducted a COVID-19 screening of Montes. Montes claimed having a fever, cough, shortness of breath, sore threat, and loss of taste/smell. His temperature was reported to be 95.2 degrees.

In SAPD Officer Perna's Statement of Booking Officer, Perna indicated that Montes was under the influence of drugs, was unsteady, was having difficulty staying awake, and was expressing suicidal ideations. Perna's statement was reviewed and acknowledged by OCHCA medical staff.

At 0023 hours, a registered nurse ("RN") completed a Clinical Opiate Withdrawal Scale (hereinafter, "COWS") on Montes in which the following observations were documented: chills or flushing, difficulty sitting still, mid diffuse discomfort, stomach cramps, and irritability/anxious.

During the medical screening, Montes stated he had used methamphetamine within the last 12 hours and heroin within the last day. Montes also stated that he was prescribed Bactrim DS X7 and Keflex X7. Montes' current blood glucose reading was 196 and he was prescribed the following: Glucometer checks, Metformin 500mg, Bactrim DS X7 days, Keflex 500 mg X7, and DX Abscess. During the medical screening, Montes also stated that he had been previously diagnosed and treated for schizophrenia while incarcerated at Orange County Jail.

During this medical and mental health screening at OCJ, it was determined that Montes was mentally unstable and a danger to himself. Doctors recommended that Montes receive follow-up mental health care, psychiatrist care, drug/alcohol treatment, and be monitored for opiate withdrawal symptoms. Montes was also prescribed Tylenol 650mg, Zofran 4mg, Imodium 2mg, and Buprenorphine Protocol. Additionally, his blood glucose levels were to be checked twice a day from July 3, 2020 through July 5, 2020, and his vitals were to be checked daily until July 9, 2020. Further, it was recommended that Montes be housed in Module L, the mental health sector at OCJ. Montes was assigned to Module L, Sector 19, cell #8 (a one-inmate cell).

On **July 4, 2020**, Montes refused blood glucose checks and vital checks. Montes provided a urine sample which returned positive for amphetamines and opiates. An OCHCA psychiatrist evaluated Montes, diagnosed him with Opioid dependence and Schizophrenia, and prescribed him the following treatment: Hydroxyzine (25 mg), Seroquel XR (400 mg), follow-up lab/medical, and psychiatric follow-up daily.

On **July 6, 2020,** OCHCA medical staff tried three times to check on Montes' vitals and blood glucose levels, but were only successful once. His blood pressure was 153/80 and his blood sugar was 204. Montes took some of his medications but refused his Subutex medication.

On **July 7, 2020**, Montes signed several OCHCA "Refusal to Accept Treatment and Release of Liability" forms and refused his COWS assessment, blood sugar check, vital checks, and medications. At 0934 hours, a medical professional at OCJ attempted to complete a psychiatric progress review on Montes, but Montes refused to engage. Montes was asked to continue taking the following medications but refused: Buprenorphine (16 mg), Loperamide (2 mg), Tylenol (650 mg), Ondansetron (4 mg), Atorvastatin (10 mg), and Lisinopril (10 mg). At 2159 hours, an OCHCA nurse documented giving Montes the above prescribed medications.

On **July 10, 2020,** Montes entered a plea of guilty to one count of Penal Code Section 3000.08 (Parole Violation) and was sentenced to serve 180 days in jail, with no bail. On **July 11, 2020**, at approximately 0900 hours, Montes was moved from cell #8 to cell #2 within Module L. Cell #2 is also a one-inmate cell and was equipped with an intercom system that allows the occupant to contact jail staff if needed. Between **July 4 and July 13, 2020**, Montes repeatedly refused his COWS assessment, vital signs checks, and prescribed medications. He was uncooperative with medical staff and stated that he did not want or need medical treatment, often cursing at staff when they tried speaking with him. It was documented that Montes' cell was filthy and that on occasion he refused

to come out of his cell and participate for his psychiatric evaluations. Montes would generally cooperate and take his medications only once a day around 2000 hours.

On **July 14, 2020,** the OCJ security camera in Module L captured deputies making routine cell checks and are seen walking past cell #2 approximately every thirty minutes. Montes was provided food in a paper bag at 0431. At approximately 0547 hours, the security camera captured Montes as he appeared to be laying on the floor of his cell. Montes remained in that same area of the cell and his last observed movement was at approximately 0605 hours when he is observed sitting up then laying back down. There were two safety checks of Montes' cell conducted at approximately 0632 and 0704 hours, but there is no movement by Montes observed on video at those times. As explained in more detail below, jail deputies make entry to Montes' cell around 0716 and find him non-responsive.

**Voluntary Statement of Deputy Sheriff Dewie Ratanaptratum**

Deputy Dewie Ratanaptratum (hereinafter, "Deputy Ratanaptratum") gave a voluntary statement to OCDA Investigators. Below is a summary of Deputy Ratanaptratum's statement.

Deputy Ratanaptratum arrived to work the day of the incident at 6 a.m. His assignment for the day was trash collection and he reached Montes' cell, which is the last cell at the end of the upper tier, around 7:16 a.m. When outside Montes' cell, Deputy Ratanaptratum saw Montes face down on the ground so he attempted to get his attention by yelling out his name, but received no response. Deputy Ratanaptratum had checked on Montes many times in the past and each time Montes would give the deputy some sort of response letting the deputy know that Montes was okay. As a result of receiving no response, Deputy Ratanaptratum called his partner Deputy Hanley, who was located at the bottom of the stairs, to come up so that Deputy Ratanaptratum could conduct a welfare check on Montes.

After the cell door was opened, both Deputy Hanley and Deputy Ratanaptratum continued to call Montes' name but still received no response. Upon noticing that something was wrong with Montes, Deputy Hanley put out over the radio to call paramedics. While waiting for the paramedics, Deputy Hanley rolled Montes over and began performing Cardio Pulmonary Resuscitation (CPR). Deputy Ratanaptratum states that he did not personally check Montes' vitals but that Deputy Hanley checked Montes' pulse. Deputy Ratanaptratum did observe that Montes was not breathing.

Upon jail medical staff arriving on scene, Deputies Hanley and Ratanaptratum brought Montes outside of the cell so that medical staff could take over and start getting all of their equipment, including an Automatic External Defibrillator (AED), set up. Chest compressions continued to be administered during this period and Deputy Ratanaptratum started recording all the times, names, and what was going on. Eventually, paramedics from the Orange County Fire Authority (OCFA) arrived on scene and took over medical treatment. At no point after the arrival of medical and OCFA paramedics did Deputy Ratanaptratum partake in any treatment or medical assessment of Montes.

Deputy Ratanaptratum had previously checked on Montes several times before the incident and stated that nothing alerted him to any medical emergency prior to opening the cell door. Moreover, Deputy Ratanaptratum was not aware of any medical conditions possessed by Montes.

**Voluntary Statement of Deputy Sheriff Robert Hanley**

Deputy Hanley stated that it didn't appear to him that Montes was breathing, and as a result, he and Deputy Ratanaptratum entered the cell and rolled Montes over onto his back. Deputy Hanley noted that Montes looked lifeless, was cool to the touch, didn't have any signs of rigor mortis and there

weren't any signs of lividity. Upon checking Montes, Deputy Hanley stated that he couldn't find a pulse or signs of breathing. After checking Montes, Deputy Hanley broadcast on his radio: "IRC Main Control row 92, un-responsive, male, approximately 50 years old, mod L, Lima." Deputy Hanley stated he included Montes' age because OC Fire Authority wants a patient's age.

Deputy Hanley immediately began administering CPR after making his radio broadcast for help, stating that he probably did a CPR cycle of 30. Upon medical personnel's arrival, they took over medical treatment from Deputy Hanley and continued life-saving measures.

Deputy Hanley has had previous contacts with Montes prior to this incident. Deputy Hanley stated that it was normal for Montes to be face down on the floor of his cell because Montes would rest and sleep like that.

**Voluntary Statement of Deputy Sheriff William Kenny**

At the time of the incident, Deputy Kenny was collecting trash from the lower tier of Module L, Sector 18, when he observed Deputy Hanley go up the stairs to Deputy Ratanaptratum's location in front of Cell #2. Deputy Kenny then stopped his trash collection and went up the stairs to see what was happening, at which time he saw the deputies in the process of rolling Montes over and was informed that Montes was not responding. Deputy Kenny proceeded to order one of the deputies to call the paramedics and then yelled for the nurses to bring the response (medical) bag up right away to which they immediately complied.

After Deputy Hanley made the radio call for medical assistance, Deputy Kenny observed him performing CPR. Deputy Kenny, to assist in the life-saving measures, started moving some of the debris that blocked the doorway to the cell and assisted in moving Montes to the landing outside his cell due to space limitations. A registered nurse ("RN1") from the jail arrived shortly thereafter and took over performing CPR on Montes from Deputy Hanley. Deputy Kenny noted that he observed deputies and nursing staff doing sets of 30 CPR chest compressions for at least 10 to 12 minutes until they were relieved by paramedics from the Orange County Fire Authority.

Deputy Kenny did not partake in performing CPR, instead he stated that he took out a piece of scratch paper and was trying to jot down the times of who was doing what to keep track for the report. In addition to documenting the CPR, he also noted that nurses got out equipment

Although Deputy Kenny was not aware of Montes' medical background, he stated that the unit was a psychiatric mental health unit in which they get a lot of suicides and detoxing. He further stated that Montes has been known to come "to us" for a long time and that in the past Montes was always withdrawing from some type of drug.

**Voluntary Statement of Registered Nurse 1 ("RN1")**

RN1 has been a registered nurse for approximately nine years and is employed by the OCHCA. On July 14, 2020, at around 7:20 a.m., RN1 was on duty at the Men's Central Jail in Module L, where she has worked for the past five years. On the day of the incident, RN1 observed deputies enter cell #2. Upon Deputy Kenny calling out "Man down, medical, not breathing, bring the bag", RN1 grabbed the medical bag and responded to assist the deputies.

RN1 observed Deputy Hanley checking Montes' pulse and saying Montes had none. RN1 then directed the deputies to remove Montes from the cell to allow additional room for treatment.

RN1 stated that she noticed Montes was pale/cool and called out to other medical staff to help as she began chest compressions on Montes. RN1 continued to perform CPR for a little under five minutes before being relieved by a deputy or nurse, who were taking shifts with the life-saving measures.

As other staff began to arrive, RN1 directed a licensed vocational nurse ("LVN1") to check Montes' blood sugar levels since she knew that Montes was a diabetic. RN1 recalled that she knew Montes, and in the past, he would refuse blood sugar testing. RN1 noted that Montes' blood sugar testing was not required on his current incarceration at the facility. Montes' blood sugar level was 450 which RN1 noted was high. RN1 stated that, according to the medical chart, Montes was receiving all his required medications.

RN1 further stated that she observed another registered nurse, RN2, applying the AED pad on Montes and completing a cycle. The AED indicated not to apply shock on Montes, and so RN1 resumed administering CPR. RN1 continued lifesaving efforts on Montes until the Orange County Fire Department arrived and assumed care for Montes.

**Voluntary Statement of Registered Nurse 2 ("RN2")**

RN2 has been a registered nurse for fifteen years and a contract RN for the OCHCA for thirteen years. She works one day a week in the Orange County Men's Jail. On July 14, 2020, at around 7:16 a.m., RN2 was in triage when she was notified on a "man down" call in Module L, Section 19, Cell 2.

When RN2 arrived, she saw Montes supine on the landing outside his cell. She stated that RN1 was performing CPR on Montes, who was unresponsive and unconscious. RN2 further stated that other health care personnel were assisting Montes with breathing via the ABVW and that AED pads were placed on Montes. The AED went through several cycles, each time recommending no shock and indicating to continue chest compressions.

Medical personnel and deputies continued performing CPR as prompted by the AED until paramedics arrived. Upon the paramedics' arrival, RN2 released Montes to them. The paramedics placed Montes on a 12-lead monitor and determined he was deceased. RN2 stated that she observed no signs of trauma on Montes' body.

**Voluntary Statement of Licensed Vocational Nurse 1 ("LVN1")**

LVN1 has been a LVN for four years and employed by the OCHCA for two years. She has been assigned to Module L for the past two years. One of LVN1's first assignments each day is to prepare and distribute medications to the Module L inmates. Since Montes' arrival to Module L, LVN1 had given Montes Metformin, an oral diabetes medication that helps control blood sugar levels, every morning as prescribed.

On July 14, 2020, around 7:16 a.m., LVN1 was in Module L's nurse's station preparing inmate medications when she heard "man down" in Module L, Sector 19, Cell 2. LVN1 grabbed the "man down bag" and responded. Upon her arrival at Montes' cell, she saw Montes supine on the landing outside his cell. She stated that he was naked, unconscious, and unresponsive. She stated that there were several deputies and medical personnel rendering aid to him and that RN1 was performing chest compressions.

LVN1 removed the AED machine from the bag and handed the pads to a deputy who placed them on Montes' chest. She removed the ABVM from the bag, placed it over Montes' mouth and nose,

and began assisting him with breathing in conjunction with another licensed vocational nurse. LVN1 stated that medical personnel and deputies continued CPR, as prompted by the AED, until paramedics arrived. Upon the paramedics' arrival, they placed a heart monitor on Montes and determined he was deceased. LVN1 stated that she observed no signs of trauma on Montes' body.

**Voluntary Statement of Firefighter/Paramedic 1 ("Medic1")**

On July 14, 2020, around 7:20 a.m., OCFA Engine 75 (engine Medic1 was assigned to) was dispatched to a call of a cardiac arrest at the Orange County Jail Facility. Medic1 arrived on scene at around 7:23 a.m. where OCSD deputies escorted him to Montes.

Medic1 arrived to Montes' location around 7:26 a.m. where he observed Montes lying supine on the floor in front of his cell. OCSD deputies were performing CPR on Montes while the jail staff was ventilating him with an ABVM. In addition, Medic1 stated that he saw an AED attached to Montes.

Medic1 took over patient care and performed an initial assessment of Montes' condition where he did not see any noticeable signs of trauma. As part of this assessment, Medic1 connected Montes to a cardiac monitor which indicated Montes' heart rhythm was asystole, meaning there was no electrical activity from the heart (which continued throughout the entirety of the time Montes was on the cardiac monitor). In addition, Medic1 stated that Montes was not breathing.

Medic1 stated that his treatment of Montes included the administration of fluids via an intraosseous infusion, three 1mg doses of epinephrine, the continuation of CPR using a Lucas device, and an oral I-gel airway.

Base hospital contact was established with the Orange County Global Medical Center at about 7:39 a.m. and around 7:41 a.m. the base hospital physician pronounced Montes deceased. Medic1 and the other OCFA personnel cleared area, leaving Montes' body in place for processing by the Orange County Coroner's Office. Medic1 stated that Montes was unresponsive and made no statements during the entirety of his contact.

## EVIDENCE COLLECTED

The following items of evidence were collected from the scene and examined at the OCCL:

- Hand Swabs
- Fingernail Debris
- Blood Standard
- 72 Digital Photographs taken during the Autopsy
- 57 Digital Photographs of Mod L: Sector 19, Cell 2 and Montes
- 13 Digital Photographs Post-Embalming

## AUTOPSY

On July 23, 2020, independent Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Montes. The relevant autopsy findings are as follows:

- **Major Injuries:**
    - None
- **Minor Injuries:**
    - Abrasion, right elbow
    - Contusion, left shoulder
    - Abrasion, left wrist
    - Abrasion, left knee

- **Natural Disease and Pre-existing Conditions:**
    - Skin ulcers and erosions; back, buttocks, and left arm
    - Left pleural adhesions (lung damage)
    - Degenerative joint disease, thoracic spine
    - Pulmonary congestion and edema
    - Cardiomegaly (enlarged heart)
    - Mild coronary atherosclerosis
    - Moderate peripheral atherosclerosis
    - Cirrhosis of the liver
    - Status post cholecystectomy
    - Nephrosclerosis (hardening of the kidney)
    - Esophageal erosion
    - Hepatitis C

Dr. Luzi concluded that Montes' cause of death was renal failure associated with hypertensive cardiovascular disease and diabetes mellitus. Dr. Luzi also noted the following other conditions: cirrhosis, multiple substance intoxications (buprenorphine, quetiapine, and hydroxyzine). Dr. Luzi concluded that the manner of death was natural.

## EVIDENCE ANALYSIS

### Toxicological Examination

A sample of Montes' postmortem blood yielded the following results:

| DRUG | MATRIX | RESULTS & INTERPRETATIONS |
|---|---|---|
| Hydroxyzine | Postmortem Blood | 0.380 +- 0.035 mg/L |
| Buprenorphine (Free) | Postmortem Blood | 0.0050 +- 0.0008 mg/L |
| Methadone | Postmortem Blood | 0.0249 +- 0.0027 mg/L |
| Quetiapine | Postmortem Blood | 1.86 +- 0.35 mg/L |
| Quetiapine | Peripheral Blood | 1.01 +- 0.19 mg/L |
| Quetiapine | Liver | 11.5 +- 2.2 mg/kg |
| Quetiapine | Stomach | < 5.3 mg |
| 1-(4-cholorbenzhydryl)-piperazine | Postmortem Blood | Detected |
| Buprenorphine-glucuronide | Postmortem Blood | Detected |
| Cetirizine | Postmortem Blood | Detected (No interpretation can be made as to whether or not within the therapeutic range) |
| Citalopram | Postmortem Blood | Detected |
| Norcitalopram | Postmortem Blood | Detected |

| | | |
|---|---|---|
| Metformin | Postmortem Blood | Detected (No interpretation can be made as to whether or not within the therapeutic range) |
| Norbuprenorphine | Postmortem Blood | Detected |
| Norbuprenorphine-glucuronide | Postmortem Blood | Detected |
| Norquetiapine | Postmortem Blood | Detected |
| Diphenhydramine | Postmortem Blood | Detected |

**BACKGROUND INFORMATION**

Montes' criminal history was reviewed and considered. Montes' had a State of California Criminal History record that revealed arrests for the following violations dating back to 1976:

- Indecent Exposure
- Domestic Violence
- Delaying/Obstructing Public Officer
- Prevent/Dissuade Witness
- Disorderly Conduct
- Possession of Drug Paraphernalia
- Possession of Forged Notes
- Possession of Stolen Property
- Under the Influence of a Controlled Substance
- Transportation of a Controlled Substance
- Burglary – Second Degree
- Transportation of a Controlled Substance
- False Identification to Peace Officer
- Personate to Make Other Liable
- Auto Theft
- Violation of Parole

**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 that 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 Montes 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. Rather, review of OCJ records and all other relevant evidence reveals that OCSD personnel consistently exercised reasonable care in treating and handling Montes.

Prior to being booked at OCJ, multiple doctors and medical personnel did a comprehensive evaluation on Montes and it was determined he would be most safely housed in Module L, the mental health sector. Additionally, due to Montes' underlying medical and psychological problems, Montes' was placed in a single cell at the top of the stairs directly across from the OCSD watchtower. In the eleven days Montes was at OCJ prior to his death, OCSD personnel had attempted to administer all of Montes' medications and regularly evaluated him both medically and mentally and found no major concerns.

Multiple deputies had checked Montes' cell, as well as the other inmates' cells, twice per hour on the morning of July 14, 2020. Additionally, Montes can be seen on video moving about in his cell approximately one hour before Deputy Ratanaptratum first believed something was wrong when Montes did not respond to trash collection as he normally does. There is no evidence that before Deputy Ratanaptratum arrived at Montes' cell to collect trash that he knew, or had reason to know, that Montes was in need of immediate medical care as there were no outward signs of a medical emergency. Nonetheless, upon coming to that realization, the deputies immediately proceeded to initiate medical assistance for Montes.

Deputy Ratanaptratum called out to Deputy Hanley, opened Montes' cell, and immediately went to Montes' aid. Deputy Hanley checked Montes' vitals, dispatched "man down" over the radio to alert medical personnel (nurses, paramedics, and Orange County Fire Authority) that their assistance was needed, and started to perform CPR on Montes. From the time Montes was found to be unresponsive, all involved persons cooperated to administer advanced life saving measures but tragically Montes passed away.

There is no evidence to support a finding beyond a reasonable doubt that the OCSD failed to perform a legal duty, nor can their actions be classified as criminally negligent. In order for the OCDA to file criminal charges relating to Montes' death, the OCDA must be able to prove criminal culpability beyond a reasonable doubt, including legal causation as described above. The OCDA is not able to meet this burden of proof beyond a reasonable doubt based on all the available evidence. Additionally, the evidence does not support a finding beyond a reasonable doubt that Montes' death was the result of any act, or failure to act, by OCSD personnel. Thus, 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 casing the death of Montes.

**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 a lack of 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 Montes. The evidence shows that Montes' cause of death was renal failure associated with hypertensive cardiovascular disease and diabetes mellitus, and that the manner of death was natural.

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

Respectfully submitted,

**AVERY HARRISON**
Deputy District Attorney
Special Prosecutions Unit

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

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