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June 18, 2012

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

Re: Custodial Death on January 16, 2011
Death of Inmate Robert Eric Oropeza
District Attorney Investigations Case #11-003
OCSD DR # 11-009
Orange County Crime Laboratory Case # 11-40755

Dear Sheriff Hutchens,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the Jan. 16, 2011, custodial death of inmate Robert Eric Oropeza.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the Jan. 16, 2011, custodial death of inmate Oropeza. 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) deputy or any other person under the supervision of the OCSD.

On Jan. 16, 2011, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center in Santa Ana (WMCSA) after inmate Oropeza died while in custody and while being treated at the hospital. The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD deputies or personnel. The OCDA will not be addressing 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 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 and evidence collections, 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. Prosecutors assigned to the Special Prosecutions Unit review the non-fatal officer-involved shooting cases for possible criminal filings. Throughout the review process, the assigned prosecutor will be in consultations with his or her supervisor, and this Assistant District Attorney 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

Oropeza was a 50-year-old male who had a history of long-term narcotic abuse and medical problems, including Hepatitis C and liver problems. For the past 20 years, Oropeza had been married to Nancy Oropeza.

According to his wife, Oropeza had liver damage due to his long-term heroin and alcohol use, and he had been diagnosed with Hepatitis C. Oropeza had been using heroin since he was 21 years old. Most recently, Oropeza was injecting heroin into his body three times per day. She described the dosage of heroin as "two balloons" in the morning, "two balloons" at lunch, and "two balloons" at night. Heroin is commonly packaged in balloons, and he would inject the heroin into his skin, a method known as "skin popping."

On Jan. 13, 2011, at approximately 1:43 a.m., Oropeza was arrested by the La Habra Police Department (LHPD) for possessing 15 individually packaged balloons containing heroin, with the total weight of 6.69 grams. He was transported to the LHPD jail for booking. The arrest was documented under LHPD case # 11-233.

During the booking process at LHPD, the jail staff asked a series of medical screening questions. The medical screening form indicated Oropeza "drinks alcohol, goes through heroin withdrawals on occasions." He was subsequently transported to the Orange County Sheriff's jail facility.

At 11:25 a.m., Oropeza was booked at the OCSD Intake/Release Center (IRC). Oropeza's "Intake Screening and Triage" form indicated he used "4 – 5 grams of heroin, intravenously, per day." He also uses methadone and drinks a pint of "hard stuff nightly and goes through DT's." His last use was indicated as Jan. 12, 2011. He was subsequently housed in holding cell D-1.

At approximately 6:27 p.m., IRC deputies were informed of a "man down" in holding cell D-1. Oropeza was located lying on the ground and shaking. He was placed on a wheelchair and escorted to the Correctional Medical Services (CMS) Triage Unit and evaluated by a CMS phsycian.

After the medical evaluation, it was determined that Oropeza needed to be transported to WMCSA for further medical treatment. He was transported via Santa Ana paramedics.

At WMCSA, Oropeza was diagnosed with gastro-intestinal bleeding, cirrhosis of the liver and Hepatitis C. He was admitted into the Critical Care Unit. According to a WMCSA nurse, Oropeza was admitted to the hospital with methamphetamine and opiates detected in his blood screen test.

Oropeza subsequently telephoned his wife, advising that he had been arrested, was in the hospital, and had been given four pints of blood. During their brief conversation, he did not mention any altercations or confrontational issues with the arresting police officers or OCSD personnel.

On Jan. 15, 2011, at 3:38 a.m., Oropeza posted bond regarding his pending criminal charges; however, he was unable to

leave the hospital due to his medical condition.

Oropeza was administered a wide variety of medications while in the hospital including, but not limited to, epinephrine, bicarbonate, atropine, calcium gluconate, plasma, blood and dopamine.

On Jan. 16, 2011, at 3:50 a.m., Oropeza's condition deteriorated and he was diagnosed with active rectal bleeding.

At approximately 8:15 a.m., Oropeza's heart stopped beating; however, medical personnel were able to resuscitate him.

An esophagogastroduodenoscopy with variceal banding procedure was performed on Oropeza. This procedure consisted of bands being placed around varicose veins in Oropeza's esophagus to stop bleeding from that area. During the procedure, a large blood clot was noted in his stomach.

At approximately 2:00 p.m., Oropeza's heart stopped again and medical personnel again resuscitated him. Nancy Oropeza discussed Oropeza's medical condition with his treating physician. She was advised of his deteriorating condition and the attempt to stop his esophageal bleeding. Based on that conversation, Nancy Oropeza requested that future advanced life saving measures be ceased, and she told hospital staff not to resuscitate him for a third time.

At approximately 3:42 p.m., Oropeza's heart stopped again. Based on the family's wishes, no lifesaving measures were attempted.

At 3:47 p.m., Oropeza was pronounced dead by hospital staff.

AUTOPSY

On Jan. 19, 2011, at approximately 9:10 a.m., the post-mortem examination of Oropeza was conducted by Dr. Joseph Cohen at the Orange County Sheriff-Coroner Forensic Science Center. The autopsy revealed that Oropeza had blood throughout his small intestine, large intestine, and colon. The stomach contained a substantial amount of blood and clots. The liver was scarred and the spleen was enlarged. There was evidence of acute gastrointestinal hemorrhaging and medical intervention attempting to minimize the hemorrhaging. The right anterior ribs 2 through 7 were fractured, consistent with that of the cardiopulmonary resuscitation procedure. No non-medical external trauma was located on the body.

Following the autopsy, Dr. Cohen concluded that the cause of death was acute gastrointestinal hemorrhaging with other medical complications.

EVIDENCE ANALYSIS

Toxicological Examination:

DRUG	MATRIX	RESULT
Amphetamine	Post mortem Blood	0.014mg/L
Methamphetamine	Post mortem Blood	0.11mg/L
Diphenhydramine, Ketamine	Post mortem Blood	Detected
Methadone, Methadone metabolite	Post mortem Blood	Detected
Methamphetamine	Ante mortem Plasma	Detected
Morphine (Free)	Ante mortem Blood	Detected

BACKGROUND INFORMATION

Oropeza's criminal history, which included various arrests for drugs, thefts, and assaults, was taken into consideration.

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, it must be proven:

a. The person committed an act that caused the death of another person;
b. When the person acted he had a state of mind called malice aforethought; and
c. He 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 deliberately acted with conscious disregard for human life.

A person can also commit murder by his 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;
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 *Girardo v. California Department of Corrections and Rehabilitation* (2008) 168 Cal.App.4th231,251, the court establishes that there is a "special relationship" between custodian and inmate:

> "The most important consideration in establishing duty is foreseeability. It is manifestly foreseeable that 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

There is no evidence of express or implied malice on the part of any OCSD deputy 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 inmate Oropeza a duty of care, the evidence does not support a finding that this duty was breached – either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

Oropeza had preexisting medical conditions, including Hepatitis C and liver problems, likely due to his history of alcohol abuse and intravenous heroin abuse. Oropeza went through medical screening at the time he was booked through the OCSD Intake/Release Center. Approximately seven hours later, when it became apparent he needed medical attention, he was promptly taken to the CMS Triage Unit and evaluated by a physician. There, it was determined he needed further medical treatment and was transported to WMCSA, where he was treated until ultimately succumbing to his condition. Based on the family's wishes, no additional lifesaving measures were attempted.

There was no evidence of foul play or criminal negligence on the part of any person who came into contact with Oropeza prior to his death. Oropeza's death was the result of pre-existing medical conditions.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA and pursuant to applicable legal principles, 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 OCSD. Evidence shows that inmate Oropeza died as a result of acute gastrointestinal hemorrhaging with other medical complications.

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

Respectfully Submitted,

Brett Brian
Deputy District Attorney
Gang Unit

Read and Approved,

Dan Wagner
Assistant District Attorney
Head of Homicide Unit