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September 28, 2015

La Habra Police Department
Chief Jerry Price
150 N. Euclid Street
La Habra, CA 90633

Re: Custodial Death on Jan. 2, 2015
Death of Inmate Daniel Roberto Oppenheimer
District Attorney Investigations Case # SA 15-001
La Habra Police Department Case # 15-00021
Orange County Crime Laboratory Case # 15-40026

Dear Chief Price,

Please accept this letter detailing the investigation of the Orange County District Attorney's (OCDA) Office and legal conclusion in connection with the above-listed incident involving the Jan. 2, 2015 custodial death of 49-year-old inmate Daniel Roberto Oppenheimer.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Oppenheimer. This includes 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 La Habra Police Department (LHPD) personnel or any other person under the supervision of the LHPD.

On Jan. 2, 2015 OCDA Special Assignment Unit (OCDASAU) Investigators responded to LHPD, where Oppenheimer died while in custody. During the course of this investigation, the OCDASAU interviewed eight witnesses, obtained and reviewed reports from the LHPD and Orange County Crime Laboratory (OCCL), and reviewed incident scene photographs, video surveillance, 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 LHPD personnel or any other person under the supervision of the LHPD. 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. 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, who is an Assistant District Attorney. 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

Oppenheimer was diagnosed anxiety disorder and a methamphetamine addiction. He also had a criminal record dating back to 1981. Oppenheimer had no known attempts of suicide prior to this incident.

On Jan. 2, 2015, shortly after 9:30 a.m., Oppenheimer got into a physical altercation with his wife during which he allegedly strangled her almost to the point of asphyxiation. At approximately 9:43 a.m., an unidentified citizen telephoned LHPD dispatchers to report the domestic disturbance coming from the Oppenheimer residence. At approximately 9:46 a.m., LHPD Officer Travis Nelson, LHPD Corporal William Irwin, and LHPD Officer Chris Koelber arrived at the Oppenheimer residence. After investigating the scene, the officers arrested Oppenheimer and Officer Nelson brought him in to the police department. Oppenheimer was cooperative during the arrest.

When Oppenheimer arrived at the police department, Custodial Officer Tanna Williams collected his clothing, which had possible evidentiary value. Oppenheimer was then issued a red, one-piece zippered jail jumpsuit. Oppenheimer was allowed to keep the socks he was wearing upon arrival. Oppenheimer was then placed inside booking room 2, located along the north side of the jail. Meanwhile, Officer Nelson completed a "La Habra Police Department Officer Observation" form regarding Oppenheimer. Question 7 on the form asked, "Does the inmate's behavior suggest the risk of suicide...Close supervision, suicide watch and/or transport to OCJ as soon as feasible?" Officer Nelson circled "no."

Custodial Officer Williams then initiated the pre-booking process by asking Oppenheimer standardized medical screening questions. Oppenheimer admitted to having a drug problem and to using methamphetamine daily, including the previous day. He also admitted to taking Zoloft medication for anxiety. When asked, Oppenheimer denied being suicidal or having attempted suicide in the past. Custodial Officer Williams indicated that Oppenheimer was calm as he provided the answers to the medical triage questions and that she did not notice any problems with him, nor did she sense he would cause problems with her or any other staff member.

Custodial Officer Williams completed the pre-booking assignment in the booking office, where she could visually observe Oppenheimer through a window between the booking cell and booking office. At one point, Oppenheimer stood up, removed his socks, and wrapped them around his head covering his eyes. Oppenheimer stood in the booking room against the wall for several minutes before sitting on the concrete bench in the cell with his eyes still covered. Custodial Officer Williams indicated that Oppenheimer's demeanor appeared odd at this point and made her feel uncomfortable. Typically, Custodial Officer Williams would have had Oppenheimer live-scanned at this point, but because of the behavior Oppenheimer was demonstrating, she felt uncomfortable and decided to wait to conduct the live-scan. Thereafter, Custodial Officer Williams left the booking office for approximately 10 minutes to eat lunch. Upon her return, she noticed Oppenheimer was still seated on the bench, but had removed the socks from his eyes and appeared to be meditating with his head back, eyes closed, and hands resting on his knees.

At approximately 11:45 a.m., Custodial Officer Williams left the booking office again for approximately 10 minutes to attend to issues within the police station. Upon her return to the booking office, Custodial Officer Williams was not able to see Oppenheimer through the window and believed he may have been seated on the floor, up against the common wall between the booking office and booking room 2, where the telephone is located, as inmates are known to do from time to time. Officer Williams walked around to the jail door and looked into booking room 2 from the window in the door. Custodial Officer Williams then observed Oppenheimer with a ligature made from the zipper of his jail-issued jumpsuit around his neck. The ligature was attached to the telephone cord and Oppenheimer was hanging from the cord, with his feet out, in what appeared to be a squatting position. Custodial Officer Williams noticed that Oppenheimer had discoloration to his face and drool emitting from his mouth and she immediately radioed for assistance, requesting the watch commander to respond.

LHPD Sergeant Jeff Baylos responded to the booking cell after hearing Officer Williams' call for assistance on the radio. Sergeant Baylos and Custodial Officer Williams entered booking room 2 together and attempted to lift Oppenheimer and remove the ligature but they were unsuccessful. Custodial Officer Williams exited the cell to locate an instrument to cut the ligature holding Oppenheimer suspended from the telephone cable. Lieutenant Jason Forgash entered booking room #2 almost as Custodial Officer Williams exited and had a Spyderco brand knife on his person, which he utilized to cut the material between the telephone cord and the ligature around Oppenheimer's neck. Once Oppenheimer was freed from the telephone cord, he was placed on the floor. Lieutenant Forgash then used the knife to cut the second ligature around Oppenheimer's neck. As soon as the ligature was cut, Oppenheimer made an audible exhaling sound, which led the LHPD personnel present at the scene to believe he was still alive.

Sergeant Baylos and Lieutenant Forgash began administering Cardiopulmonary Resuscitation (CPR) to Oppenheimer. LHPD civilian employee Rita Ramirez arrived with a bag valve mask. Sergeant Baylos administered chest compressions while Lieutenant Forgash used the bag valve mask to provide ventilations. Corporal Irwin then responded to the scene with an Automated External Defibrillator (AED), which was attached to Oppenheimer. The AED did not advise that a shock was to be applied so Sergeant Baylos and Lieutenant Forgash continued their CPR efforts until the arrival of Los Angeles County Fire Department (LAFD) paramedics.

At approximately 12:07 p.m., LAFD Station #191 was dispatched to the LHPD jail in response to a call for assistance. LAFD Paramedic Assessment Unit #191 responded to the scene and arrived at approximately 12:09 p.m., with the following LAFD personnel: Captain Ernest Ramirez, Firefighter/Paramedic Eduardo Rodriguez, and Engineer/Paramedic Javier Torres.

Upon arrival, Paramedic Rodriguez requested that the personnel performing CPR move Oppenheimer out of the cell to provide more space in which LAFD personnel could work. Thereafter, Oppenheimer was moved into the hallway outside of the jail cell, where there was more space. Paramedic Rodriguez assessed Oppenheimer, who was still warm to the touch and appeared to be "cyanotic", or displaying a blue skin coloring from lack of oxygen. Once Oppenheimer was in the hallway, Paramedic Torres took over CPR compressions, while Captain Ramirez provided respirations to Oppenheimer via a bag valve mask. Paramedic Rodriguez established an intravenous line (IV) in Oppenheimer's right arm and removed the AED pads that had been affixed to him prior to their arrival. Paramedic Rodriguez connected Oppenheimer to an electro cardiogram (EKG) machine to check his heart for electrical activity. Once connected, the EKG showed Oppenheimer had no pulse, but showed an electrical heart rhythm, which Paramedic Rodriguez referred to as pulseless electrical activity (PEA).

LAFD personnel provided advanced life savings (ALS) measures on Oppenheimer at the scene for approximately 10 minutes, and then prepared him for transportation, as La Habra 2, an ambulance housed at LAFD station #192, had responded to LHPD to provide transportation services.

A video surveillance camera located in the booking office captured a video recording of Oppenheimer's actions while in booking room 2. Three other cameras captured footage from other parts of the jail. The date/time stamp displayed on each of the cameras was one day later and approximately one hour later than the date and time of the actual recording. The following was observed on the video, with the corresponding time stamp:

- 11:09:50 Oppenheimer enters LHPD jail facility
- 11:14:20 Oppenheimer is placed into booking room 2 and is seen putting on his jumpsuit
- 12:55:20 Oppenheimer is seated on bench – video freezes
- 12:56:10 Video resumes – Oppenheimer is seen outstretched, holding hand above his head. His hand can be seen moving slightly
- 12:56:30 Oppenheimer's hand drops, his head disappears from view and his body remains still until officers enter
- 13:05:34 Sergeant Baylos and Custodial Officer Williams enter cell
- 13:05:45 Video freezes – Sergeant Baylos is seen lifting Oppenheimer
- 13:06:30 Video resumes – Sergeant Baylos and Officer Forgash are seen performing CPR
- 13:10:38 Oppenheimer seen being moved to hallway, where paramedics perform CPR
- 13:20:05 Oppenheimer transported from LHPD facility

Footage from each of the four cameras froze intermittently and at arbitrary times, independently of each other. For reasons discussed below, it appears the frozen footage is a result of an error within the recording system and can in no way be attributed to improper conduct of LHPD officers or anyone else.

At approximately 12:23 p.m., La Habra 2 left the scene en route to St. Jude Medical Center, Fullerton. The paramedics made initial contact with hospital personnel to inform them of Oppenheimer's condition during transportation. At approximately 12:23 p.m., one milligram of epinephrine was administered via the established IV line. After administering the epinephrine, Oppenheimer's pulse returned momentarily. Paramedics continued to provide saline solution via the IV line and rescue breathing was performed every 5-6 seconds. After approximately two minutes, Oppenheimer went into full cardiac arrest. At approximately 12:25 p.m., paramedics administered an additional one milligram dose of epinephrine via the established IV line. Oppenheimer did not respond to the additional dose of epinephrine and never regained a pulse.

At approximately 12:29 p.m., Oppenheimer arrived at St. Jude Medical Center, Fullerton, unconscious and in "full arrest." Paramedics continued to perform CPR on Oppenheimer, who was unable to sustain a pulse and was not breathing on his own. Oppenheimer was transported to Emergency Room #20, where the attending physician and medical personnel were waiting to provide medical treatment. Oppenheimer was intubated and IV lines were established in Oppenheimer's arms to administer epinephrine, sodium bicarbonate, and saline solution. After 28 minutes of providing advanced cardiac care, Oppenheimer was unable to sustain a pulse without advanced medical intervention. Oppenheimer was unable to breathe on his own and never regained consciousness. At 1:00 pm, the attending physician pronounced Oppenheimer deceased and all efforts to revive him were terminated.

AUTOPSY

An autopsy was performed on Jan. 5, 2015, at the Orange County Sheriff-Coroner Office by Forensic Pathologist Yong Son Kim. Dr. Kim concluded that the cause of death was ligature hanging and deemed the manner of death as suicide.

EVIDENCE ANALYSIS: Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Methamphetamine	Postmortem Blood	0.0318 mg/L
Amphetamine	Postmortem Blood	0.111 mg/L

BACKGROUND INFORMATION

Oppenheimer had a lengthy State of California Criminal History record that revealed several arrests.

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 present when a 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 the person acted he or she knew the act was dangerous to human life, and the person deliberately acted with conscious disregard for human life.

A person can also commit murder by his or 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 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.' 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 of express or implied malice on the part of any LHPD personnel or any inmates or other individuals under the supervision of the LHPD. Thus, there is no evidence that Oppenheimer's death was a result of murder. The only remaining type of homicide to analyze in this situation is manslaughter, under the theory of failure to perform a legal duty. Although the LHPD owed Oppenheimer a duty of care, the evidence does not support a finding beyond a reasonable doubt that this duty was in any way breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

LHPD personnel conducted an initial medical screening interview and, based on the totality of the available evidence, LHPD staff did not have any reason to believe Oppenheimer posed a danger to himself. Oppenheimer cooperatively answered all medical screening questions and indicated that he was not suicidal. When Custodial Officer Williams observed that Oppenheimer had blindfolded himself with his socks, she felt that his demeanor was "odd" and chose to keep him in the booking room rather than having him live-scanned at that time. At no time prior to or after placing his socks over his eyes did Oppenheimer display any other odd behavior. Significantly, while Oppenheimer's using his socks as a blindfold appeared "odd" to Custodial Officer Williams, nothing about this behavior would indicate to a reasonable observer that he was aggressive, despondent, or that he posed a threat to himself. While Oppenheimer had his socks over his eyes, Custodial Officer Williams left the booking office for 10 minutes; when she returned, Oppenheimer had removed his socks from his eyes and was sitting in the booking cell with his head back and eyes closed, with his hands resting on his knees and he appeared to be meditating. To a reasonable observer, it would appear Oppenheimer was calming himself. More importantly, this behavior was consistent with Oppenheimer's conduct during the initial booking process, in which Officer Nelson noted that Oppenheimer's behavior did not suggest the risk of suicide or warrant close supervision. Therefore, there is no reason to believe Oppenheimer's behavior should have alerted Custodial Officer Williams to a danger and it would not be possible to prove beyond a reasonable doubt that Custodial Officer Williams neglected a legal duty by failing to recognize that Oppenheimer posed a threat to himself or anyone else.

Although the video footage from the booking office froze as Oppenheimer began to hang himself, there are significant indications that this malfunction was in no way due to nefarious conduct on the part of the LHPD. During the morning of Oppenheimer's arrest, there were four cameras continuously recording in the LHPD, including Camera 04, which recorded Oppenheimer's booking cell, and Camera 01, which recorded the doorway outside of the booking cell. Cameras 02 and 03 recorded two other unoccupied cells and captured little or no movement of any kind during the hour preceding Oppenheimer's suicide. Each of these cameras froze intermittently, for brief periods and at arbitrary times, independently of each other. Because each of the cameras, including the ones that captured no movement whatsoever, froze intermittently and at arbitrary times, the freezing appears to be due to a malfunction within the recording system and there is no indication it is attributable to improper conduct on the part of LHPD personnel.

Of even greater significance is the fact that the footage from the booking office resumed while Oppenheimer was still upright and animated, alone in his cell, holding – and moving – his arm above his head. The footage continues for approximately 20 seconds before Oppenheimer slumps over and his hand drops from the air. To be clear, the only conceivable reason for purposefully concealing or destroying camera footage would be if it revealed officers inflicting harm on Oppenheimer or somehow forcing Oppenheimer to hang himself. Yet the footage resumes when Oppenheimer was upright and animated. As he was hanging from a telephone cord that was less than three feet from the floor, he would have been fully capable of saving

himself in the twenty seconds between the time the footage resumes and the time Oppenheimer slumps over, presumably losing consciousness. This contradicts any notion that LHPD personnel acted maliciously or used force of any kind and further supports the conclusion that the freezing was the result of a malfunction within the recording system.

Finally, the footage freezes for a total of 50 seconds, which is far less time than it would take for Oppenheimer to remove the zipper from his jumpsuit, attach it to the telephone, and loop it around his neck. Yet, while Oppenheimer's face and hands are out of the camera's range for several minutes before the footage freezes, his legs are visible. During these minutes his legs do not move a significant amount and it is clear he is sitting still in his cell – all during the time he must have been removing and preparing his zipper for use as a ligature. The footage thereby corroborates the statements of Officer Nelson and Custodial Officer Williams and confirms that, even up to the moments prior to hanging himself, Oppenheimer remained calm and appears to have made every effort to avoid alerting LHPD officers of his intent to harm himself.

Once Custodial Officer Williams discovered Oppenheimer hanging in his cell, she immediately radioed for assistance and waited for another officer to arrive. This conduct by Custodial Officer Williams follows LHPD policy, which provides that custodial officers are not to enter the cells alone. Sergeant Baylos immediately responded to the call, at which time he and other LHPD personnel took immediate and significant measures to resuscitate Oppenheimer. From all the available evidence, there is no indication of foul play or negligence on the part of any person who came into contact with Oppenheimer prior to his death. The evidence supports the conclusion that Oppenheimer's death was due to his own tragic decision to end his life.

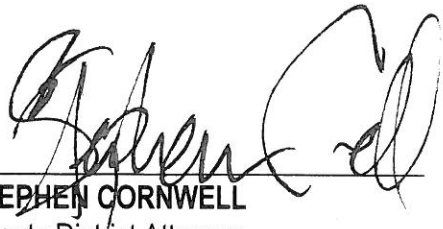
Accordingly, there is no evidence to support a finding beyond a reasonable doubt that any LHPD personnel or any individual under the supervision of the LHPD failed to perform a legal duty as required by law.

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 beyond a reasonable doubt a finding of criminal culpability on the part of any LHPD personnel or any individual under the supervision of the LHPD in connection with Oppenheimer's conduct of committing suicide while in the custody of LHPD.

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

Respectfully submitted,



STEPHEN CORNWELL
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