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October 11, 2016

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

Re: Custodial Death on Oct. 30, 2015
Death of Inmate Sylvia Ochoa
District Attorney Investigations Case #15-020
Orange County Sheriff's Department Case #15-243534
Orange County Crime Laboratory Case #FR15-57422

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 Oct. 30, 2015, custodial death of 43-year-old Inmate Sylvia Ochoa.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Ochoa. 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 Oct. 30, 2015, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the OCSD Women's Central Jail, where Ochoa died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed multiple 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 Oct. 28, 2015, Ochoa was involved in a traffic collision and fled from the scene. A witness followed Ochoa from the scene and notified the Santa Ana Police Department (SAPD). SAPD Officer Francois Nguyen contacted Ochoa, issued her a citation, and arrested her on an outstanding warrant for a probation violation. Officer Nguyen reported minor damage to the front of Ochoa's vehicle, but observed no obvious signs of trauma or medical injuries on Ochoa. SAPD Officer Nelson Menendez transported Ochoa to the Santa Ana Detention Facility for booking. Ochoa was later transferred that very same day to the Orange County Jail (OCJ) Intake Release Center (IRC). Ochoa was asked numerous health screening questions by a Registered Nurse when she arrived at the OCJ IRC. During this interview, Ochoa indicated that she had been diagnosed with bone cancer and had received skin grafts. At the conclusion of the screening, Ochoa was referred for medical and mental health triage and cleared for standard booking and housing. Ochoa was booked into OCJ at approximately 9:15 p.m. At approximately 11:54 p.m., a separate nurse conducted a mental health screening of Ochoa. During this screening, Ochoa stated that she had been diagnosed as being bipolar and suffered from both depression and anxiety. Ochoa also indicated that she was taking Ativan and Ambien while in hospice, but had not taken either medication for three days.

On Oct. 29, 2015, at approximately 10:30 a.m., Ochoa was ultimately housed in Module K, Sector 10, Cell 2. Additionally, a nurse practitioner created an opiate withdrawal order, and assigned Ochoa to a low bunk, due to her signs of withdrawal. Inmates assigned to Module K indicated they saw Ochoa enter the Module carrying her mattress and the majority of the inmates believed she was showing signs of drug withdrawal such as sweating and shaking.

Inmate Jane Doe was assigned to Cell 2 with Ochoa and recognized Ochoa from previous incarcerations. Jane Doe stated Ochoa appeared shaky, had a stooped walk, and was moaning. Ochoa told Jane Doe she was withdrawing but did not tell her what she was withdrawing from. At 4:02 p.m. on Oct. 29, 2016, a Marriage and Family Therapist (MFT) conducted a follow-up mental health evaluation of Ochoa. The MFT noted that Ochoa was previously in hospice and had a history of being bipolar. Ochoa also suffered from bone cancer, hepatitis C, and hypertension. Ochoa indicated that she was prescribed Zyprexa and Ativan for anxiety and depression, as well as methadone. Ochoa denied using street drugs. That same evening, cellmate Jane Doe stated that Ochoa screamed, yelled, and made guttural, animal noises throughout the night. Jane Doe also stated that she observed Ochoa sweating profusely. Additional inmates assigned to Module K also heard Ochoa vomiting, crying, and yelling.

On Oct. 30, 2015, at approximately 5:30 a.m., a nurse was dispatched to Module K to evaluate Ochoa after an OCSD deputy relayed Ochoa was nauseous, vomiting, and refusing to go to court. Prior to responding, the nurse reviewed Ochoa's medical chart and noticed that Ochoa had been placed on a withdrawal protocol. The nurse, accompanied by an OCSD deputy, entered Ochoa's cell and observed Ochoa sitting on the toilet. Ochoa was able to stand up and walk to a bench in the cell. The nurse observed that Ochoa had a steady gait and her skin color was normal. The nurse noted that the toilet water was yellow, leading her to believe that Ochoa had urinated. The nurse did not observe any stool or vomit in the toilet. Ochoa told the nurse that she was nauseous, had diarrhea, and could not stop vomiting. The nurse initially had difficulty getting a blood pressure

reading because Ochoa was moving around. When the nurse requested that Ochoa remain still, Ochoa became angry and said, "You just need to put me on a court hold."

With assistance from the OCSD deputy, the nurse took Ochoa's vitals. Ochoa's blood pressure was 168/84 and her pulse was 104. The nurse recognized that these readings were slightly elevated and attributed the readings to Ochoa being upset and not feeling well. The nurse was unable to take Ochoa's temperature because each time she attempted to place the thermometer in Ochoa's mouth, Ochoa started to gag. The nurse observed that Ochoa's saliva was moist and did not observe any signs or symptoms of trauma. At the conclusion of her evaluation, the nurse determined that Ochoa's symptoms were consistent with opiate withdrawal and that Ochoa was unable to go to court. The nurse instructed Ochoa to rest and recommended she contact medical staff if her symptoms worsened. The nurse also completed the paperwork required to have Ochoa removed from the list of inmates to be transported to court.

Several hours later, approximately 45 minutes before dinner, Jane Doe told Ochoa that she should get some rest and agreed to wake Ochoa up when her meal arrived. At first, Jane Doe could hear Ochoa breathing softly as she laid on her mattress. However, she soon heard Ochoa rapidly breathing deeply and making hysterical crying sounds. Moments later, Jane Doe looked at Ochoa and realized she could only see the whites of her eyes. Jane Doe observed Ochoa's mouth rapidly snap shut. She described Ochoa's eyes as fixed and noted several gasping, deep breaths. Jane Doe waited five seconds before pushing the emergency button in the cell to alert the deputies that something was wrong with Ochoa.

At approximately 3:58 p.m., Deputies Miguel Rangel and Norelly Mejiazea were distributing dinner trays in Sector 12 when they were advised via the connector door speaker phone that there was an unresponsive inmate in Sector 10, Cell 2. Deputies Rangel and Mejiazea immediately responded to Cell 2. Upon arrival, Deputy Mejiazea observed Ochoa lying on her mattress on her back, unresponsive, with her left eye open. Ochoa's head was facing the back of the cell, with her feet towards the front of the cell. The bed sheet was pulled up to her shoulders and a wool blanket was located behind her in the corner of the bunk. Deputy Mejiazea pushed the emergency alarm button in the cell to alert the medical triage team to come to the cell.

Deputy Mejiazea pulled the bed sheet down and observed that Ochoa was warm to the touch, pale in color, and appeared to be breathing. Approximately one to three minutes after the deputies entered the cell, two nurses arrived to assist with medical aid. One of the nurses described Ochoa as unresponsive, with no pulse, head tilted back and body warm. Deputy Mejiazea and a nurse moved Ochoa from the bottom bunk to the floor inside the cell and began cardio pulmonary resuscitation (CPR). While they continued to administer CPR, the other nurse placed the Automated External Defibrillator (AED) pads on Ochoa's torso area and used the Ambu Bag to assist Ochoa with breathing. The AED evaluated and recommended that Ochoa's heart be shocked. The AED delivered a total of four shocks to Ochoa's heart while CPR continued throughout and OCSD personnel requested the assistance of paramedics.

At approximately 4:03 p.m., Orange County Fire Authority (OCFA) Engine 75 was dispatched to the IRC regarding an unconscious female. Fire personnel arrived at the IRC at approximately 4:06 p.m., and arrived at Ochoa's location at approximately 4:09 p.m. The nurses were still performing CPR with the AED attached when OCFA arrived. With OCFA present, Ochoa was moved outside of her cell where life-saving measures continued and OCJ medical equipment was replaced with OCFA medical equipment. The responding paramedic assessed Ochoa and determined that she was in cardiac arrest and her heart rhythm was in ventricular fibrillation. Immediately, cardiac arrest protocol was followed; the defibrillator delivered a total of seven shocks and Ochoa was administered one milligram of epinephrine at 4:12 p.m., and 300 milligrams of amiodarone at 4:16 p.m. Ochoa did not regain a pulse.

At approximately 4:28 p.m., Ochoa was transported from the IRC, via Care Ambulance, to Orange County Global Medical Center (OCGMC). Paramedics continued advanced life-saving support while in route and administered an additional 150 milligrams of amiodarone at 4:32 p.m. Ochoa did not regain consciousness and was transferred to the care of the emergency room personnel at OCGMC.

At approximately 4:40 p.m., Ochoa arrived at OCGMC in full cardiac arrest. Hospital staff performed Advanced Cardiac Life Support procedures which included multiple attempts to chemically, and electrically stimulate Ochoa's heart. None were successful. At 4:58 p.m., Ochoa was pronounced deceased.

AUTOPSY

On Nov. 17, 2015, Forensic Pathologist Scott Luzi, from Clinical and Forensic Pathology Services, conducted an autopsy on the body of Ochoa. The autopsy revealed the following natural diseases and pre-existing conditions as the cause of Ochoa's death: chronic pulmonary congestion, hepatic steatosis and portal inflammation, cardiomegaly with remote myocardial infarction, and nephrosclerosis. Dr. Luzi indicated that there were no major or minor acute injuries and no obvious signs of trauma. Dr. Luzi noted the presence of a fracture of the sternum and ribs as evidence of cardiopulmonary resuscitation attempts.

EVIDENCE ANALYSIS

Toxicological Examinations

A sample of Ochoa's blood was analyzed. The resulting report showed Ochoa's blood tested negative for Hepatitis B, and positive for Hepatitis C. The OCCL conducted a toxicological examination of postmortem blood and brain tissue samples taken during the autopsy. Following are the results and interpretations:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Amphetamine	Postmortem Blood	0.0926 ± 0.0057 mg/L
Amphetamine	Brain	0.303 ± 0.019 mg/kg
Methamphetamine	Postmortem Blood	0.695 ± 0.046 mg/L
Methamphetamine	Brain	2.13 ± 0.14 mg/kg
Morphine (Total)	Postmortem Blood	0.0660 ± 0.0071 mg/L
Morphine (Free)	Brain	0.0260 ± 0.0026 mg/kg

BACKGROUND INFORMATION

Ochoa had a State of California Criminal History record that revealed arrests for the following violations:

- Receiving stolen property,
- Obstructing/resisting a public officer,
- Driving under the influence of alcohol/drugs and causing bodily injury,
- Being under the influence of a controlled substance,
- Driving on a suspended license,
- Possession of controlled substance paraphernalia,
- Possession of a hypodermic needle,
- Possession for sale of narcotic/controlled substance,
- Transportation/sale of narcotic and controlled substance,
- Possession of a controlled substance,
- False identification to a peace officer,
- Taking vehicle without owner consent and vehicle theft,
- Possessing a stolen vehicle,
- Bringing a controlled substance into prison,
- Possession of burglary tools,

- Purchase of cocaine base for sale,
- Possession of unlawful paraphernalia, and
- Probation violations.

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 there is a "special relationship" between jailer and prisoner:

> "The most important consideration 'in establishing duty is foreseeability.' [citation] 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/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 Ochoa 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). There is no evidence that OCSD intentionally breached any duty of care to Ochoa from the time she was booked into custody until the time that she died. Ochoa was medically evaluated and placed on an opiate withdrawal protocol based on the symptoms she was exhibiting to the intake nurse. Furthermore, as her symptoms worsened, a separate nurse evaluated Ochoa and determined that her symptoms were consistent with opiate withdrawal, but were not life threatening. The nurse then instructed Ochoa to get rest and contact medical staff if her condition deteriorated. Accommodations were made so that Ochoa could remain in her cell, instead of going to court. At no point did Ochoa request any additional medical help, nor was she denied any medical treatment by OCSD. There are no facts to support any inference that the OCSD intentionally breached their duty of care to Ochoa.

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. Deputies Rangel and Mejiazea immediately responded once notified that Ochoa was unresponsive and contacted medical staff without hesitation. Two nurses began deliberate and continuous life-saving measures within moments of their arrival at Ochoa's cell. OCFA was notified within a reasonable amount of time and arrived less than ten minutes following their initial dispatch. Efforts to resuscitate Ochoa began at the earliest opportunity and continued throughout her transportation and arrival at OCGMC.

Thus, there is no evidence in this case 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 Ochoa died from natural causes as a result of her 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