OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

December 16, 2021

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

Re: Custodial Death on May 6, 2021
Death of Inmate Frank Topete
District Attorney Investigations Case #21-001520
Orange County Sheriff's Department Case #21-014275 and #21-015062
Orange County Crime Laboratory Case # FR 21-45693

Dear Sheriff Barnes,

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 May 6, 2021 custodial death of 37-year-old inmate Frank Topete.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Frank Topete. 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 May 6, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center where Frank Topete died while in custody after receiving medical treatment at the hospital for decompensated liver disease, secondary to chronic alcohol abuse, coagulopathy, and esophageal varices. During the course of this investigation, the OCDASAU interviewed 1 witness, and obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, medical records, 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 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, TARGET/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 Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review 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

On Monday, January 18, 2021, Frank Topete, a 37-year old male, was arrested by the Anaheim Police Department (APD), under Case #2021-8531 for violating Penal Code section 166(C)(1)-violation of a restraining order. At the time of his arrest, Topete also had two outstanding warrants out of Los Angeles County, one of which was a no bail warrant. On January 19, 2021, Topete was transported to the Orange County Jail Intake Release Center (IRC) for booking.

During the booking process, Topete was screened by Orange County Heath Care Agency (OCHCA) medical and mental health professionals. Topete communicated well and was oriented to person, place, and time. He displayed no abnormal behavior. During that screening, Topete stated that he had cirrhosis of the liver and esophageal varices due to his chronic abuse of alcohol. According to his medical records, Topete's last drink was a few hours before this initial medical screening. Topete denied any mental health issues at that time; however, he said that while he was incarcerated in 2017, he was treated for unknown mental health issues. Topete was prescribed Mirtazapine and Oxazapam for anxiety and alcohol withdrawal. He was also prescribed Prozac and Remeron for depression. Topete was referred to medical and mental health for follow-up and was ultimately cleared for regular housing. At 11:06 p.m., Topete was transferred from the IRC to the Theo Lacy Facility (TLF), where he was housed in Module (Mod) J, Sector 10, Cell 8, Bunk 1.

On Monday, January 25, 2021, Topete was seen by a doctor from OCHCA. The doctor diagnosed Topete with severe alcoholism, cirrhosis of the liver, and pancytopenia/thrombocyte.

On Monday, February 8, 2021, Topete was seen by another doctor from OCHCA. Topete told the doctor that he was diagnosed with cirrhosis of the liver approximately three weeks prior. Topete also indicated that one year earlier, while he was in the custody of the Los Angeles County Sheriff's Department (LASD), Topete was sent to USC Medical Center where he underwent an esophagogastroduodenoscopy (EGD) and colonoscopy. After these tests were administered, he was diagnosed with hepatic cirrhosis, splenomegaly, and trace perihepatic ascites. Once Topete was released from Los Angeles County Jail, he did not seek additional medical treatment and he did not take any prescribed medications. In addition, Topete indicated that he continued to drink "a lot" of alcohol.

On Wednesday, February 10, 2021, Topete was sent to the Oncology Institute of Hope for an exam related to his pancytopenia. The same day, Topete reported to jail medical staff that he was experiencing abdominal pain. As a result, Topete was examined, given Tylenol for pain, and he was told to notify staff if his pain increased. A follow-up doctor's appointment was made for Topete at that time as well.

On Wednesday, February 24, 2021, Topete was seen by a doctor who had previously examined him. Topete's face and eyes were visibly swollen during that examination. The doctor suspected that Topete could have been having an allergic reaction, so the doctor gave Topete Benadryl and Prednisone in order to reduce the swelling. In addition, the doctor temporarily stopped all of Topete's prescription medications. Topete was subsequently referred to immunology for further evaluation.

On Wednesday, March 3, 2021, Topete had a scheduled Gastroenterology appointment, but chose to miss the appointment so he could meet with his attorney. As a result, the Gastroenterology appointment was rescheduled. That same day, Topete's face and eyes began to swell again. The same doctor who examined Topete on February 24, 2021 examined Topete again and suspected Topete had hereditary angioedema. The doctor decided to eliminate the iron supplement from Topete's daily medicine regiment and reintroduced Topete's previously discontinued prescription medications.

On Wednesday, March 17, 2021, Topete submitted an "Inmate Health Message Slip" and requested medical care for abdominal pain. The next day, medical staff examined Topete and determined that Topete had ascites on the right side of his abdomen in addition to mild jaundice. Topete was scheduled for a follow up appointment with a physician and he was further instructed to notify staff if his condition worsened.

On Monday, March 22, 2021, Topete was seen again by a doctor who had previously examined him. At that time, Topete reported that he had difficulty breathing, back pain, and an enlarged abdomen. The doctor had Topete transferred to Anaheim Global Medical Center (AGMC) for further evaluation. Topete was treated in the emergency room at AGMC and then admitted into the hospital. Topete remained at AGMC for ten days. During that time, two large distal esophageal varices were banded, a paracentesis was performed, and 4.7 liters of fluid were removed from Topete's abdomen. On Thursday, April 1, 2021, Topete was discharged from AGMC and returned to the IRC. He was placed in Mod N, Sector 32, Cell 2, pursuant to Covid protocols.

On Friday, April 16, 2021, Topete received his first dose of the Pfizer vaccine. At that time, he was scheduled to receive his second dose on May 7, 2021.

On Sunday, April 18, 2021, Topete requested a waistband for his hernia. That same day, however, Topete refused to attend an appointment for a previously scheduled abdominal CT scan. Topete was given the requested waistband the next day.

On Wednesday, April 21, 2021, Topete was transported to AGMC for a follow up visit related to his previous hospitalization. An EGD was completed on the two esophageal bandings and he was then returned to IRC.

On Thursday, April 29, 2021, at approximately 1:35 p.m., Topete contacted jail staff and reported that he was not feeling well. Topete reported that he fainted and had diarrhea, abdominal pains, and back pain. Topete was escorted by wheelchair to medical where he was examined. During that examination, OCHCA staff noted Topete was grimacing, moaning, and appeared restless. His blood pressure was 88/59 and his heart rate was 89. Topete's skin was pale and his lips were dry and chapped. After receiving hydration, Topete's skin tone improved but his blood pressure remained low. Topete told the doctor that he had been experiencing dizziness and abdominal pains all day and that the abdominal pain radiated into his back. Topete denied vomiting or experiencing melena. Topete appeared frail, confused, slow to respond, and was unable to stand without assistance. After the doctor noted Topete's heart rate and blood pressure, Topete was given a GI cocktail and moved to medical housing, MOD O. When Topete's vitals were re-checked, his blood pressure was 74/48 and his heart rate was 90. At approximately 1445 hours, the doctor decided that Topete was going to be moved to the medical dispensary to await transport to OCGMC for further evaluation.

At 5:05 p.m. that same day, Topete was taken to the OCGMC Emergency Room (ER). He was treated by the ER doctor for low blood pressure, agitated mental state, and vomiting of blood. The ER doctor diagnosed Topete with decompensated liver disease, secondary to chronic alcohol abuse, and esophageal varices.

On Friday, April 30, 2021, Topete's condition deteriorated. He became lethargic and lab work showed that he had a very low platelet count. Shortly thereafter, on May 1, 2021, Topete began to suffer from acute renal failure and he was transferred to the Intensive Care Unit (ICU).

After being transferred into the ICU, medical staff noticed a discernible decline in Topete's mental status. As a result, the ICU doctor requested that a Cranial Computed Tomography (CT) scan be completed. The CT scan revealed that Topete had suffered an intracranial hemorrhage (ICH), possibly due to a stroke, with a midline shift. Topete was diagnosed by the ICU doctor with decompensated liver disease, secondary to chronic alcohol abuse, coagulopathy, and esophageal varices. That same day, Topete was intubated and placed on a ventilator to protect his airway. Topete's condition continued to deteriorate and he remained unconscious and unresponsive.

On Wednesday, May 5, 2021, the ICU doctor met with Topete's sister. After Topete's sister consulted with the doctor, she authorized OCGMC to withdraw Topete's life support. At approximately 8:45 p.m., Topete was extubated, placed on comfort care, and provided with pain medication as needed. On Thursday, May 6, 2021, at approximately 3:12 a.m., Topete's heart stopped. The attending physician pronounced Topete deceased at that time.

Topete's OCHCA medical records revealed that from the date that Topete was arrested (January 18, 2021) up until his death (May 6, 2021), he refused medical treatment that was either offered or scheduled, a total of eighteen times.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- A sample of Topete's postmortem blood
- A heart blood standard
- 31 OCCL hospital scene photographs
- 41 OCCL autopsy photographs
- 18 OCCL post embalming photographs
- 11 OCCO photographs
- 1 audio recording of a registered nurse employed by OC Global Medical Center
- OCHCA medical records
- OCGMC medical records

AUTOPSY

On Tuesday, May, 11, 2021, at approximately 9:55 a.m., Independent Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Frank Topete. At the conclusion of the autopsy, Dr. Luzi stated that there were no significant signs of trauma to the body. Dr. Luzi noted that Topete's liver was diseased and that there was a large blood clot on the brain indicative of an intracerebral hemorrhage. Dr. Luzi ultimately determined that the manner of death was natural, and the cause of death was due to complications of chronic alcohol abuse. In addition, the following "other conditions" existed: cirrhosis with liver failure and gastro-esophageal varices, intra-cranial hemorrhage, pneumonia, and hypertensive cardiovascular disease.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethanol/Volatiles	Postmortem Blood	Not detected
Amphetamine and Related	Postmortem Blood	Negative
Barbiturates	Postmortem Blood	Negative
Methamphetamine and Related	Postmortem Blood	Negative
Cannabinoids	Postmortem Blood	Negative
Ethanol/Volatiles	Antemortem Blood	Not Detected
Amphetamine and Related	Antemortem Blood	Negative
Barbiturates	Antemortem Blood	Negative
Methamphetamine and Related	Antemortem Blood	Negative
Cannabinoids	Antemortem Blood	Negative

Acetaminophen	Antemortem Blood	Detected
Caffeine	Antemortem Blood	Detected
Caffeine	Postmortem Blood	Detected
Hydrocodone	Postmortem Blood	0.0178 +/- 0.0017 mg/L
Lidocaine	Postmortem Blood	Detected
Lidocaine	Antemortem Blood	Detected
Mirtazapine	Postmortem Blood	Detected
Mirtazapine	Antemortem Blood	Detected
Morphine (Free)	Postmortem Blood	0.568 +/- 0.061 mg/L
N-desmethylmirtazapine	Postmortem Blood	Detected
N-desmethylmirtazapine	Antemortem Blood	Detected
Propanolol	Antemortem Blood	Detected

BACKGROUND INFORMATION

Frank Topete had a State of California Criminal History record that revealed arrest for the following violations:

- 245 (A) (2) PC – Assault with a Firearm
- 422 PC – Threaten Crime with Intent to Terrorize
- 11364 H&S – Possession of Control Substance Paraphernalia
- 273A (B) PC – Willful Cruelty to a Child
- 243 (E) (1) PC – Spousal Battery
- 591.5 PC – Damage Wireless Communication Device
- 594 (A) (3) PC – Vandalism
- 148 (A) (1) PC – Obstruct Public Officer
- 166 (A)(4) PC – Disobey Court Order
- 273.5 PC – Inflict Corporal Injury on Spouse/Cohabitant
- 273.6 (A) – Violation of Court Order to Prevent Domestic Violence
- 245 (A) (1) PC – Assault with a Deadly Weapon (not a firearm)
- 236 PC – False Imprisonment
- 646.9 (A) PC – Stalking

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 person;
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 acted he knew his 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:

> "[T]he 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 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

Here, there is no evidence of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. As a result, 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 Frank Topete a duty of care, the evidence does not support a finding that this duty was in any way breached - either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). When Topete was originally taken into custody, he was evaluated and screened by OCHCA medical staff. It was determined that Topete arrived in the custody of OCSD with pre-existing medical conditions: cirrhosis of the liver and esophageal varices due to his chronic abuse of alcohol. However, when he was participating in the initial medical screening, he communicated well and displayed no abnormal behavior. Topete was prescribed Mirtazapine and Oxazapam for anxiety and alcohol withdrawal. He was also prescribed Prozac and Remeron for depression. He was referred to medical and mental health for follow up and was ultimately cleared for regular housing.

Topete was seen by a doctor from OCHCA one week later. The doctor diagnosed Topete with severe alcoholism, cirrhosis of the liver, and Pancytopenia/Thrombocyte. There is no evidence to suggest that Topete was experiencing any medical issues or emergencies during this examination. A little over a week after that, Topete met with another OCHCA doctor. During that examination, Topete explained that a year earlier, he was diagnosed with hepatic cirrhosis, splenomegaly, and trace perihepatic ascites. After Topete was made aware of that diagnosis a year earlier, Topete did not seek additional medical treatment and he did not take any prescribed medications. Rather, he continued to drink alcohol. There is no evidence to suggest that Topete was experiencing any medical issues or emergencies during this examination.

During Topete's time in custody with OCSD, whenever he expressed that he was having medical issues, jail medical staff and doctors were responsive. On February 10, 2021, Topete told jail medical staff that he was experiencing abdominal pain. Medical staff examined him and gave him Tylenol for his pain. Topete was also instructed to notify staff if his pain increased. On February 24, 2021, when Topete met with a doctor from OCHCA, he was experiencing facial swelling and eye swelling. The doctor treated Topete and gave him Benadryl and Prednisone to help reduce the swelling. On March 3, 2021, Topete willfully skipped a scheduled Gastroenterology appointment, but after Topete's face and eyes began to swell again, he met with and was again treated by the same doctor from February 24, 2021. The doctor suspected Topete had hereditary angioedema and decided to eliminate the iron supplement from Topete's daily medicine regiment and reintroduced Topete's previously discontinued prescription medications. On March 17, 2021, Topete requested medical care for abdominal pain and he was examined the next day. During his examination, it was determined that Topete had ascites on the right side of his abdomen and had mild jaundice. Medical staff scheduled him for a follow up appointment and Topete was instructed to notify hospital staff if his condition worsened. On March 22, 2021, Topete was examined again by one of his previous doctors. During this examination, Topete reported that he had difficulty breathing, back pain, and an enlarged abdomen. The doctor decided to transfer Topete to AGMC for further evaluation. Topete remained at AGMC for ten days and was treated during his stay there. On April 21, 2021, Topete was transported back to AGMC for a follow up visit related to his previous hospitalization. An EGD was completed on the two esophageal bandings and he was then returned to IRC.

When Topete contacted jail staff on April 29, 2021 to report that he had fainted, was experiencing diarrhea and had abdominal and back pain, jail medical staff once again provided treatment to Topete. He was escorted by wheelchair to medical where he was examined, treated, and monitored. Topete's condition ultimately caused the treating doctor to have Topete taken to the OCGMC Emergency Room. Once in the ER, Topete was treated by the ER doctor and diagnosed with decompensated liver disease, secondary to chronic alcohol abuse, and esophageal varices. The next day, Topete's condition worsened and he was subsequently transferred to the ICU on May 1, 2021. Topete continued to be treated and monitored, but he ultimately had to be intubated and placed on a ventilator. Topete's condition continued to deteriorate and he remained unconscious and unresponsive. As a result of Topete's declining health, Topete's sister was consulted and she made the decision to have OCGMC withdraw Topete's life support and Topete passed away shortly thereafter.

It is clear that Topete received an abundance of treatment and medical care while he was in custody; however, Topete also refused medical examinations and/or treatment on numerous occasions. For example, on March 3, 2021, Topete had a scheduled Gastroenterology appointment, but chose not to attend that appointment so he could meet with his attorney. In addition, on April 18, 2021, Topete requested a waistband for his hernia, but then refused to attend a previously scheduled abdominal CT scan. In response to Topete's request for the waistband, medical staff provided Topete with the requested waistband the next day. In total, Topete refused medical treatment and/or examinations on 18 separate occasions while he was in the custody of OCSD.

The OCSD provided Topete with necessary and responsive medical care throughout the duration of his time in custody. When he requested treatment, he received it. When follow up appointments were appropriate, such appointments were scheduled. When medical conditions were observed or diagnosed, he was treated at the jail or transported to the hospital depending on the circumstances. At no time did the OCSD fail to act, act recklessly, or act with gross negligence to cause Topete's death. The evidence suggests the contrary. When Topete requested medical assistance, it was provided. When medical issues or conditions were observed and/or diagnosed, he was treated.

Unfortunately, Topete came into the care and custody of the OCSD with serious health problems. Even though he was treated by medical professionals throughout his time in custody, Topete's health declined as a result of those pre-existing health problems. OCSD was aware of those pre-existing medical problems from the date that Topete went into custody, and he was repeatedly provided with medical care from that date, until the date of his death.

Given the evidence discussed above, there is insufficient evidence to prove beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty. Since there is insufficient evidence to prove that there was a failure to perform a legal duty in this case, there is likewise insufficient evidence to prove beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD committed murder or manslaughter.

CONCLUSION

Based on all of the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is insufficient evidence to prove 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 Frank Topete. The evidence shows that Frank Topete died as a result of complications of chronic alcohol abuse and that the death was natural.

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

M. CASEY CUNNINGHAM
Deputy District Attorney
Homicide Unit

READ AND REVIEWED BY **BARBARA KIM**
Assistant District Attorney
Special Prosecutions Unit

READ AND APPROVED BY District Attorney **TODD SPITZER**