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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 Sept. 24, 2015
Death of Inmate Yasir Flores
District Attorney Investigations Case #SA 15-018
Orange County Sheriff's Department Case #15-212609
Orange County Crime Laboratory Case #15-55408

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 Sept. 24, 2015, custodial death of 38-year-old inmate Yasir Flores.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Flores. 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 Sept. 24, 2015, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Anaheim Global Medical Center, where Flores died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed two 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 Sept. 18, 2015, at approximately 3:32 a.m., officers from the Placentia Police Department (PPD) were working patrol in the City of Placentia. While conducting a patrol check of McFadden Park, located on 900 S. Melrose Street in Placentia, they observed two male subjects sleeping on the handball courts after hours in violation of Placentia Municipal Code 14.018.030. The officers approached one of the subjects, who was identified as Flores, and were informed by Flores that he was homeless and had nowhere else to sleep. A records check on Flores conducted by PPD Dispatch revealed three outstanding warrants for his arrest and Flores was subsequently arrested and transported to the PPD, where he was booked and issued a citation for being in violation of Placentia Municipal Code 14.018.030. According to the arresting officers, Flores did not appear to be under the influence of drugs or alcohol at the time of his arrest. At approximately 7:06 a.m., Flores was released from the PPD to the custody of the OCSD and he was transported to the Orange County Men's Central Jail Intake Release Center (IRC) due to his outstanding bench warrants.

On Sept. 19, 2015, at approximately 10:15 p.m., OCSD Deputy Joshua Wiggs, who was assigned as a Male Identification Deputy at the IRC, was performing a routine cell safety check when he noticed Flores was standing at his cell window sweating profusely, had tremors in both hands, and was unable to respond to basic commands. Deputy Christopher Anderson contacted the jail medical staff and they arrived at approximately 10:25 p.m. to evaluate Flores, who was cleared by the attending nurse after Flores refused to consent to medical treatment stating in Spanish, "I feel okay." Flores was authorized to be kept in a low bunk and to have no work assignments while being monitored for his symptoms. Flores was also prescribed Oxazepam, Vitamin B, a multi-vitamin, and aluminum-mag hydroxide-simethicone by the attending jail physician.

On Sept. 20, 2015, at approximately 3:05 a.m., Deputy Wiggs conducted another safety check and noticed Flores was continuing to sweat profusely, appeared agitated, was unable to answer basic questions, and was hitting and kicking the cell door. It was also indicated that Flores was trying to open his cell door and attempted to run out of his cell. Flores was subsequently taken to the triage area of the IRC where he was evaluated by the attending nurse. The attending nurse determined that Flores was exhibiting signs of alcohol withdrawal and delirium tremens and requested Flores be treated at the hospital. At approximately 5:20 a.m., Flores was transported to the medical jail ward at Anaheim Global Medical Center. Upon admission, Flores was diagnosed with acute alcohol hepatitis and dehydration associated with hypernatremia. Detox medications were prescribed and Flores continued to be observed by medical staff. Hard wrist and ankle restraints were initially authorized during Flores' medical treatment in part after Flores tried to remove his Intravenous (IV) therapy. Later that day, only soft wrist restraints were used.

On Sept. 23, 2015, at approximately 8:00 p.m., Flores was transferred from Custodial Medical Services at Anaheim Global Medical Center to the Intensive Care Unit (ICU) for treatment of a high fever, seizures, and possible sepsis. The attending nurse assessed Flores and determined that his blood pressure was low. At approximately 9:50 p.m., Flores exhibited pulseless electrical activity (PEA), which indicated he had heart rhythm but no pulse, and was unresponsive. A "Code Blue" medical emergency was initiated to provide advanced cardiac life support treatment for Flores. Cardiopulmonary resuscitation (CPR) was administered and Flores was given blood pressure medications and one-milligram of epinephrine on two occasions. At 10:35 p.m., Flores regained a normal heart beat. At 10:40 p.m., Flores was administered one-milligram of epinephrine and the "Code Blue" was stopped after approximately 50 minutes of critical care. Initially medical staff had difficulties with

intubation due to swelling and a deviation. The on-call anesthesiologist responded to the ICU to assist, and the intubation tube was successfully inserted. A central line was also inserted into Flores' jugular vein.

On Sept. 24, 2015, at approximately 7:00 p.m., Flores received the maximum dosage allowance of vasopressin, epinephrine, dopamine, norepinephrine, and neo-synephrine. Flores' pupils were fixed and dilated, and he had non-pulsatile blood pressure. At approximately 10:20 p.m., the "Code Blue" emergency was again initiated and the attending physician attempted to resuscitate Flores using CPR while the medical staff administered one-milligram of epinephrine on three occasions. When Flores went into cardiac arrest in the ICU, CPR and other lifesaving measures were implemented by the advanced cardiac life support team including the Emergency Room (ER) physician, two ER nurses, two respiratory therapists, three ICU nurses, and a nursing supervisor. However, Flores' condition did not change and he did not regain a pulse or any electrical activity in his heart.

At approximately 10:34 p.m., the attending ER physician pronounced Flores deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Muscle standard
- Bags from hands

AUTOPSY

On Sept. 26, 2015, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Flores. Dr. Luzi noted minor abrasions on Flores' extremities, including on his wrists consistent with the use of restraints, but found no signs of trauma attributable to Flores' death. The autopsy and microscopic examinations of Flores revealed scarring and inflammation of the liver, possibly caused by chronic alcohol abuse. Prior statements by Flores during his initial treatment indicated daily alcohol use. Dr. Luzi determined the of death was "natural," and that Flores was developing cirrhosis of the liver.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Flores postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Lorazepam	Postmortem Blood	0.0183 ± 0.0012 mg/L
Midazolam	Postmortem Blood	0.0474 ± 0.0020 mg/L

BACKGROUND INFORMATION

Flores had a State of California Criminal History record that revealed arrests for local ordinance violations and warrants for failure to appear in court.

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 than an inmate may be at risk of harm.... Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

> "A public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he/she acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he/she acts is so different from how an ordinarily careful person would act in the same situation that his/her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

In the present case, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty. Although the OCSD owed Flores 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).

Flores had a medical history of acute alcoholic hepatitis and the autopsy examinations revealed pre-existing conditions of hepatic cirrhosis. While in custody, Flores was experiencing symptoms of alcohol withdrawals and delirium, and he was immediately assessed by the jail medical staff. Flores' symptoms did not improve, and he was transferred to the hospital via an ambulance for treatment where he was stabilized. When Flores went into cardiac arrest in the ICU, CPR and other lifesaving measures were implemented by the advanced cardiac life support team including the ER physician, two ER nurses, two respiratory therapists, three ICU nurses, and a nursing supervisor. However, Flores' condition did not change and he did not have a pulse or any electrical activity in his heart despite the lifesaving efforts. There is no evidence whatsoever to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty. Flores' death was a tragic event but it was not the result of any criminal conduct by any OCSD personnel or any individual under the supervision of the OCSD.

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 Flores died as a result of complications of chronic alcohol abuse which resulted in cirrhosis of the liver.

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

Respectfully submitted,

Andrew Bugman
Deputy District Attorney
TARGET/Gangs Unit

Read and Approved by **Ebrahim Baytieh**
Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit