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January 6, 2015

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

Re: Custodial Death on March 5, 2014
Death of Inmate Priscilla Miranda Munoz
District Attorney Investigations Case # S.A. 14-006
Orange County Sheriff's Department Case # 14-040145
Orange County Crime Laboratory Case # 14-43055

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 March 5, 2014, custodial death of 25-year-old inmate Priscilla Miranda Munoz.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Munoz. 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 March 5, 2014, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Orange County Sheriff's Intake/Release Center (IRC), where Munoz died while in custody. During the course of this investigation, the OCDASAU interviewed 12 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 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, and this Assistant District Attorney eventually will review and approve any legal conclusions and resulting legal 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

Munoz was a 25-year-old female with a history of toluene abuse. Munoz was diagnosed with schizophrenia and was taking psychotropic drugs prescribed by physicians.

At approximately 6:41 p.m. on Nov. 10, 2013, Munoz was arrested by the Orange Police Department (OPD) for burglary, possession of toluene, resisting arrest, and a probation violation. She was transported by OPD to Orange County Jail (OCJ) where she was booked and remained in custody until her death on March 5, 2014.

On Nov. 10, 2013, during the intake screening at OCJ, Munoz denied having any medical or mental conditions and she also stated that she was not currently taking any, or in need of any, prescribed medications. Munoz also advised, according to her intake screening, that she did not have any current psychiatric problems or past psychiatric hospitalizations.

On Nov. 13, 2013, Munoz was given a psychiatric evaluation by an OCJ mental health nurse. In the evaluation, Munoz admitted to being prescribed psychiatric medications and having a substance abuse history with inhalants. The evaluation of Munoz indicated objective clinical evidence of active auditory hallucinations and she presented as being a danger to herself and/or others.

Munoz was assigned to Module M, Section 22, Cell 9, at the Orange County Jail Intake/Release Center. On Feb. 27, 2014, Munoz was assigned to the same cell with inmate Jane Doe. Jane Doe slept on the top bunk and Munoz slept on the bottom bunk. Munoz's cell mate, Jane Doe, stated that on March 4, 2014, Munoz's behavior appeared to be withdrawn and Munoz appeared disturbed and angry. On March 4, 2014, Munoz's cell mate observed her drink six cups of coffee from single serving packets during the day. Munoz paced in her cell as she was talking and cursing to herself all night. Jane Doe observed Munoz vomit one time during the night. Munoz continued with her pacing and talking after the vomiting. Jane Doe had not previously observed this type of behavior from Munoz. Jane Doe did not press the button in the cell to notify jail staff of any problem.

At approximately 4:00 a.m. on March 5, 2014, Jane Doe was awoken by jail staff over the intercom system for the morning inmate count and breakfast call. When Jane Doe got up, Munoz appeared to be asleep on her bed and did not respond to Jane Doe when she verbally called out and asked her if she was going to get up and eat. Jane Doe believed Munoz was probably extremely tired from being up all night pacing back and forth. Jane Doe took her breakfast tray and returned to her cell to eat. After finishing her breakfast, Jane Doe returned her tray and went back to sleep.

At approximately 9:50 a.m., Jane Doe was called over the intercom system and awakened to retrieve her medication from staff. Jane Doe got up to receive her medication and again noticed that Munoz appeared to still be asleep. Jane Doe attempted to wake Munoz and shook her mattress. Munoz did not respond. Jane Doe reported to the nursing staff handing out the medication that Munoz was still asleep and not getting up to get her medication.

After Jane Doe reported to nursing staff that Munoz was not getting up for her medication, Jane Doe returned to her cell and heard jail staff calling Munoz over the intercom in an attempt to wake her. Munoz did not respond to the calls over the intercom. OCSD Deputies Heather Drummond, Taylor Hartman and a Licensed Vocational Nurse on the jail's medical staff responded to the cell in an attempt to wake Munoz.

The OCSD deputies and nurse were unable to find a pulse on Munoz. When the nurse turned Munoz over onto her back, she observed blood on the sheet from Munoz's nose. The nurse reported that Munoz had a blue and yellow discoloration on her face and stiffness in her legs. The deputies and nurse removed Munoz and her mattress onto the cell room floor. Deputy Hartman used his handheld radio to request additional assistance for a "man down" call while the attending nurse and Deputy Drummond initiated cardiopulmonary resuscitation (CPR). Deputy Hartman also retrieved an Ambu-Bag to assist with positive pressure ventilations during CPR.

At approximately 10:09 a.m., an Orange County Correctional Medical Services Registered Nurse (RN) received the "man down" call and was advised that Munoz was not breathing. The RN advised another Senior Registered Nurse, and both responded immediately to Module M. After moving Munoz into the day room, the responding Senior RN took over CPR test compressions, while a deputy continued providing ventilations via an Ambu-Bag. The nurses cut Munoz's jail issued shirt off and affixed the automatic external defibrillator (AED) pads to Munoz's torso. The AED advised "No Shock" and CPR was continued. The nurses also attempted to install an oral airway device to provide better oxygenation to Munoz; however, due to Munoz's stiff jaw, the installation was not successful. Additionally, on two occasions, one of the responding nurses unsuccessfully attempted to insert an intravenous line (IV) into Munoz's right arm.

Both responding nurses described Munoz's appearance as "cyanotic," meaning her skin had the appearance of being blue or purple in color. Munoz's jaw was stiff and shut. Her hands were also stiff and cold to the touch. Vomit was observed on Munoz's left upper arm. There were no visible injuries to Munoz's body.

Deputy Hartman stated that Munoz never regained consciousness or made any statements during their attempt to revive her. Deputy Hartman did not observe any signs of trauma or injuries on Munoz or her cellmate Jane Doe.

At approximately 10:08 a.m., Orange County Fire Authority (OCFA) Engine 71 arrived on scene. OCFA Firefighter/Paramedic Aaron Marshall relieved jail personnel to assess Munoz. Firefighter Marshall attached a Zol heart rate monitor/AED to Munoz. Firefighter Marshall observed obvious signs of Munoz's death on his initial assessment. Munoz was not breathing and had no pulse. Other signs of death included severe rigor mortis in her jaw, and she was a-systole (flat line, no heart activity) as measured and recorded by the OCFA Zol AED. These obvious signs of death indicated to Firefighter Marshall that Munoz had been deceased too long for resuscitation. Due to the observed signs of death and the a-systole reading, Firefighter Marshall indicated that no further treatment was necessary because Munoz was not a viable patient.

At approximately 10:30 a.m., Firefighter Marshall stopped any further assessment and recording of symptoms on Munoz.

AUTOPSY

At approximately 9:00 a.m. on March 8, 2014, a post-mortem examination of Munoz was conducted by Doctor Scott Luzi, an independent forensic pathologist on contract with the Orange County Sheriff-Coroner's office.

Doctor Luzi conducted an extensive visual examination of Munoz's body and found that there were no visible signs of injuries or trauma, and no obvious reasons for Munoz's death. Doctor Luzi also observed during the autopsy the presence of fluid in Munoz's lungs. On June 24, 2014, after reviewing toxicological and microscopic reports, Doctor Luzi determined that Munoz's cause of death was due to Sudden Death Associated with Schizophrenia.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Citlopram	Postmortem Blood	Detected
Olanzapine	Postmortem Blood	0.444 ± 0.073 mg/L
Olanzapine	Peripheral Blood	0.556 ± 0.091 mg/L
Olanzapine	Liver	3.77 + 0.62 mg/kg
Olanzapine	Stomach Contents	< 1.62 mg

BACKGROUND INFORMATION

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

- Possession of toluene
- Possession of substance or material similar to toluene
- Possession of controlled substance paraphernalia
- Possession of a controlled substance
- Disorderly conduct
- Burglary
- Possession of burglary tools
- Possession of stolen property
- Petty theft with prior conviction
- Obstruct/Resist Police Officer

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 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 *Girardo v. California Department of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 251, the Court of Appeal held that there is a "special relationship" between a custodian and an inmate:

> "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 the legal principle 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

In connection with the death of Munoz, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel, 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 Munoz 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). Two OCSD deputies and a jail nurse promptly responded to Munoz's cell when she did not respond to calls by staff over the intercom. Additional OCSD medical staff quickly responded to Munoz's cell after the "man down" call. Immediately after they were unable to locate a pulse on Munoz, the OCSD deputies and nurses began performing advanced life-saving measures – CPR, Ambu-Bag, and AED. When OCFD paramedics arrived on scene, they decided Munoz was not a viable patient because she had clearly been deceased for too long of a time to resuscitate.

Munoz had a history of long term abuse of inhalants. Munoz did not have any signs of injury or trauma to her body. She did not make any statements regarding being injured or assaulted while incarcerated in the OCJ. Thus, 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.

CONCLUSION

Based on all the evidence provided to, and reviewed by, the OCDA, and pursuant to applicable legal principles, it is our legal 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 in connection with the death of inmate Priscilla Miranda Munoz.

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

Respectfully submitted,

Mena Guirguis
Deputy District Attorney
TARGET Gangs Unit

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