



OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

May 29, 2019

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

Re: Custodial Death on November 12, 2018
Death of Infant Jane Doe
District Attorney Investigations Case # 18-036
Orange County Sheriff's Department Case # 18-032001
Orange County Crime Laboratory Case # 18-03634-GE

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the above-listed incident involving the November 12, 2018 custodial death of Infant Jane Doe.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of female Infant Jane Doe, (hereinafter "Infant Jane Doe"). 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 Nov. 12, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC), where Infant Jane Doe died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 16 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.

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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 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 Senior Assistant District Attorney supervising the Operations IV Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors and their supervisors. The District Attorney reviews all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On Nov. 6, 2018, Guadalupe R. was arrested by the Santa Ana Police Department for misappropriation of stolen property and bringing a controlled substance into the Orange County Jail (OCJ). While being booked into jail, OCJ staff conducted a medical screening of Guadalupe R. and at that time learned she was pregnant. Guadalupe R. was taken to OCGMC before being booked into OCJ jail because the jail staff believed her to be pregnant. While at OCGMC, Guadalupe R. told the medical staff that she smoked cigarettes and used methamphetamine daily, and she was experiencing abdominal pain. Guadalupe R. was diagnosed with a Urinary Tract Infection and prescribed Nitrofurantoin. OCGMC performed an ultrasound on Guadalupe R. and determined she was eighteen weeks pregnant. Guadalupe R. was then discharged from OCGMC and booked into OCJ.

On Nov. 7, 2018, Guadalupe R. was housed in accordance with her medical classification as being pregnant. At approximately 11:30 p.m. that evening, Guadalupe R. refused OCJ medical staff's request to obtain a urine sample. A "Refusal to Accept Treatment and Release of Liability" form was completed by OCJ medical staff.

On Thursday Nov. 10, 2018, at approximately 11:42 a.m., Guadalupe R. saw blood after urinating in the toilet. Guadalupe R. then flushed the toilet before OCJ staff could examine the contents. However, she was transported to OCGMC. At approximately 12:13 p.m., Guadalupe R. was examined in the emergency room and an ultrasound was performed. It was determined by the Obstetrician-Gynecologist (OB/GYN) that the fluid discharge Guadalupe R. saw in the toilet was from the previously diagnosed urinary tract infection. An ultrasound was performed and the amniotic fluid index was normal. Doctors then prescribed Guadalupe R. additional medications for her urinary tract infection and she was discharged.

On Nov. 11, 2018, at approximately 11:00 a.m., Guadalupe R. pressed the emergency button in her cell and informed the jail staff that she was pregnant and bleeding. About 10 minutes later, at 11:12

a.m., a Registered Nurse (RN) responded to Guadalupe R.'s cell where she provided her with feminine pads and instructed her to contact medical staff if symptoms continued.

On Sunday, Nov. 11, 2018, at approximately 11:30 p.m., an OCJ medical nurse was distributing medication when Guadalupe R. told the nurse that she was pregnant, experiencing bleeding and needed clean pants. The nurse that was distributing medicine communicated what Guadalupe R. was experiencing to the Senior RN in charge. At 11:50 p.m. the Senior RN went to Guadalupe R.'s cell, where she observed that Guadalupe R. was asleep. Guadalupe R. was able to stand up without difficulty and told the RN that she had thrown out her soiled pants. The RN inspected the cell and observed "minimal" spots of dry blood on the bed sheet. Guadalupe R. told the RN that she was no longer experiencing bleeding and had no cramping. The RN told Guadalupe R. she wanted to conduct a fetus heart tone check and Guadalupe R. declined. Guadalupe R. stated "I just want to rest, the morning nurse checked." A "Refusal to Accept Treatment and Release of Liability" form was completed and signed by the RN and Guadalupe R. At this time, the RN told OCSD Deputy Lopez to make sure that Guadalupe R. was given new underwear, sheets and feminine pads. Deputy Lopez told two Correctional Service Agents that Guadalupe R. needed these items, however they both failed to provide them.

At 5:32 a.m., the following morning of Nov. 12, 2018, the attending RN arrived and observed that Guadalupe R. was coherent and able to move around without complication. However, the RN did observe dried blood on Guadalupe R.'s underwear and bedding. The RN recommended Guadalupe R. be moved to medical housing. At 10:12 a.m. Guadalupe R. was examined by the attending OB/GYN who determined that Guadalupe R. had experienced an umbilical cord prolapse and requested she be transported to OCGMC.

On Nov. 12, 2019, at approximately 10:19 a.m., Orange County Fire Authority (OCFA) was dispatched to render medial aid at OCJ. At 10:35 a.m. Guadalupe R. was transported to OCGMC and her condition was monitored by the paramedics. Guadalupe R. was conscious and coherent during transport to OCGMC. At 10:57 a.m., Guadalupe R.'s care was turned over to OCGMC. A approximately 3:35 p.m., the attending OB/GYN at OCGMC determined that Guadalupe R.'s amniotic sac had ruptured, the umbilical cord was prolapsed and the fetus was absent a heartbeat. The attending OB/GYN determined that the fetus of Guadalupe R. was 18 weeks and was nonviable. At approximately 5:53 p.m., the attending OB/GYN administered medication to induce Guadalupe R. and at 11:25 p.m., Guadalupe R. delivered a stillborn female fetus.

AUTOPSY

The Orange County Coroner's Office did not respond to OCGMC or conduct an autopsy due to the Fetus, Infant Jane Doe, being less than 20 weeks old.

BACKGROUND INFORMATION

Guadalupe R. had a California Criminal History record that revealed the following arrests:

- Driving on a Suspended License
- Possession of Drug Paraphernalia
- Appropriate Lost Property
- Bring Controlled Substance Into Jail

THE LAW

Homicide is the killing of one human being by another. 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 or a fetus;
- 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 an unlawful killing 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.

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 may also in certain circumstances give rise to a breach of a legal duty. 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 death of Infant Jane Doe, 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 under the theory of failure to perform a legal duty.

Although the OCSD owed Infant Jane Doe a duty of care, the evidence does not support a finding that this duty was in any way breached, either intentionally or through criminal negligence. Inmate Guadalupe R. admitted to being a chronic methamphetamine user while pregnant as well as a consistent smoker throughout the 18 weeks of her pregnancy.

The OCJ medical staff provided Guadalupe R. with medication for her urinary tract infection and expedient medical assistance with all medical related issues she experienced. OCJ medical staff ensured Guadalupe R. was taken to the hospital multiple times for her to obtain the appropriate level of medical care. Unfortunately, Guadalupe R. was a noncompliant patient. In addition, Guadalupe R. refused recommended medical treatment in the form of urine tests and fetal heartbeat monitoring. While OCSD personnel did not provide Guadalupe R. with feminine pads following the Nov. 11, 2018 request made by the RN, that failure does not rise to the level of criminal neglect and in all likelihood had little bearing on the tragic demise of Guadalupe's fetus. The RN noted only "minimal" spotting on Guadalupe R.'s bedding at 11:50 p.m. on Nov. 11, 2018. Some five hours later, the RN inspected Guadalupe R.'s bedding again finding additional amounts of dried blood. Thus, Guadalupe R. was only deprived of feminine pads for a few hours and the RN would have noted excessive amounts of fresh discharge upon inspection of the bedding during that short time frame. She did not.

Furthermore, while the RN found additional blood on Guadalupe R.'s bedding, this fact did not necessarily create an emergency based upon Guadalupe R.'s recent medical history. On Nov. 10, 2018, Guadalupe R. was hospitalized with the same symptoms and upon medical examination found to have normal amniotic fluid levels. Under the circumstances, it was an appropriate decision by the medical staff to move the inmate to the medical ward for examination by the OB/GYN. In evaluating all the facts available to OCSD staff between Nov. 6 and 12, 2018, Guadalupe R. and her unborn child received appropriate and expedient care under the circumstances, and the treatment she received did not rise to the level of a breach of a legal duty. Therefore, there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty resulting in the death of Infant Jane Doe.

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 Infant Jane Doe died as a result of pregnancy complications that was caused by premature loss of the amniotic fluid and subsequent prolapsed umbilical cord.

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

Respectfully submitted,



DREW HAUGHTON
Deputy District Attorney
TARGET/GANGS Unit



Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney – Operations IV