OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

June 3, 2019

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

Re: Custodial Death on August 11, 2018
Death of Infant Jane Doe
District Attorney Investigations Case # 18-028
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 Aug. 11, 2018, custodial death of female 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, ("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 Aug. 11, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Saint Joseph Hospital (SJH), where Infant Jane Doe died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed fifteen 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 who are 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, their supervisors, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On June 28, 2018, Jordan O. was eighteen weeks pregnant when she turned herself in to the Santa Ana Police Department for outstanding warrants. Jordan O's warrants were for violating the conditions she was assigned during "Drug Court." An OCDA Investigator interviewed inmate Jordan O. (Jordan) and obtained the following information. Jordan admitted to being a chronic heroin user and smoked heroin up until the date of her incarceration. Jordan informed the Orange County Jail (OCJ) staff that she was pregnant and was a regular heroin user at the time of her arrest. Jordan was prescribed Subutex to counteract her withdrawals from heroin. Due to Jordan's medical condition, she was housed in Module H of OCJ to meet her medical needs.

On August 10, 2018, at approximately 3:00 p.m., Jordan began to feel something "weird" with her pregnancy. Jordan was now approximately twenty four weeks pregnant with Infant Jane Doe. Jordan had been pregnant before and believed that the pain she was feeling was not normal. Jordan contacted an OCSD Deputy and explained that she believed her mucus plug was expelled. OCSD Deputies escorted Jordan to the medical ward and rehoused her in Infirmary Unit 7 for medical observation.

While Jordan was in the medical unit, OCJ medical staff performed a pelvic exam and found that Jordan's cervix was still closed and she had some minor bleeding. An OCJ nurse checked for a fetal heart rate and determined that it was 156 beats per minute. At approximately 7:28 p.m., Jordan notified the OCJ staff that her contractions were becoming more frequent, and the pain and bleeding increased. Orange County Health Care Agency (OCHCA) Doctors and OCJ staff determined Jordan needed to be transported to the hospital due to her symptoms.

At approximately 8:53 p.m., an ambulance transported Jordan to St. Joseph Health Hospital (SJH). Jordan was examined in the Emergency Room upon arrival, and was then transferred to Labor and Delivery, Room #LR11. At approximately 10:52 p.m., Jordan felt like she was delivering Infant Jane Doe, and was rushed to the hospital operating room. Before hospital staff could get Jordan to the

operating room, she delivered Infant Jane Doe. Infant Jane Doe was born alive and breathing but immediately went into medical distress.

The attending physician was notified of the premature birth of Infant Jane Doe and determined that she had a low heartrate, and was not breathing. The physician inserted a breathing tube and medical staff performed various lifesaving efforts on Infant Jane Doe. Cardio pulmonary resuscitation (CPR) was performed and epinephrine was administered via trachea to Infant Jane Doe. After fifteen minutes of unsuccessful CPR, all lifesaving efforts ceased and the attending physician pronounced Infant Jane Doe deceased at 11:21 p.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Placenta
- Blood Standard

AUTOPSY

On Aug. 17, 2018, Independent Pathologist Dr. Scott Luzi of Anatomic, Clinical and Forensic Pathology Services conducted an autopsy on the body of Infant Jane Doe. Infant Jane Doe was determined to have reached twenty four weeks of gestation. Dr. Luzi determined that the cause of death was consistent with complications of chorioamnionitis, premature birth, and stated that Infant Jane Doe's lungs were not able to sustain life. Dr. Luzi concluded that the manner of death was natural.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Infant Jane Doe's postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Buprenorphine	Peripheral Blood	0.0015 +/- 0.0003 mg/L
Norbuprenorphine	Peripheral Blood	0.0019 +/- 0.0004 mg/L
Acetaminophen	Peripheral Blood	5.23 +/- 0.56 mg/L

THE LAW

Homicide is the killing of one human being or fetus 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 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.

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.' [ ] 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 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 unlawful killing under the

theory of failure to perform a legal duty.
Although the OCSD owed Jordan and 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 Jordan was a chronic heroin user and consistently injected heroin during the first eighteen weeks of her pregnancy with Infant Jane Doe. The OCJ medical staff provided Jordan with medication to alleviate the withdrawal symptoms and housed Jordan in the appropriate module for her to have access to proper care for her medical needs.

In addition, OCJ responded to Jordan and placed her under further supervision when she began to feel she was experiencing "weird" symptoms. The medical staff administered a pelvic exam of Jordan and determined that she was not dilated but still kept her under medical supervision to ensure Jordan and Infant Jane Doe had access to appropriate medical care. Once Jordan began to experience further symptoms, the OCSD personnel, as well as individuals under their supervision, took reasonable and appropriate action to respond to Jordan's medical needs and transported her to SJH for further care. The medical staff at SJH performed a multitude of life saving efforts on Infant Jane Doe. However, due to Infant Jane Doe's gestational age of twenty four weeks, her lungs were determined to be incapable of sustaining life.

Thus, all available evidence supports the conclusion that the OCSD met their legal duties with the appropriate standard of care. Therefore, 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 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. The evidence shows that the death of Infant Jane Doe was due to her underdeveloped lungs that were incapable of sustaining life and complications of chorioamnionitis.

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

Respectfully submitted,

Respectfully submitted,

DANIEL FELDMAN
Senior Deputy District Attorney
Homicide Unit

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