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OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

August 26, 2019

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

Re: Custodial Death on July 31, 2018
Death of Inmate Lisa Janice Martinez
District Attorney Investigations Case # 18-026
Orange County Sheriff's Department Case # 18-030610
Orange County Crime Laboratory Case # 18-50775

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 July 31, 2018, custodial death of 52-year-old inmate Lisa Janice Martinez.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Lisa Martinez. 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 August 1, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC) where Lisa Martinez had died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed one witness, as well as obtained and reviewed reports from the OCSD, Orange County Crime Laboratory (OCCL), OCGMC medical records, 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 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 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 several experienced 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 June 26, 2018, Martinez was arrested by the Anaheim Police Department (APD) for an arrest warrant. Officers discovered Martinez was in possession of a controlled substance and drug paraphernalia during a search related to her arrest. Martinez was transported to Anaheim city jail where a secondary search of her was conducted. During the secondary search, Martinez was found with an additional controlled substance. Martinez was then transported to Orange County Jail (OCJ), where Martinez underwent a Comprehensive Detox Screen. Martinez indicated that she drank more than five alcoholic drinks per day. Martinez stated that she would awaken sweating, with her body shaking, desperately wanting to drink. Martinez indicated that drinking alcohol relieved her symptoms that caused her to wake up regularly. Martinez also disclosed to the OCJ staff that she had a seizure disorder. Martinez's blood pressure was 141/90. Due to Martinez's statements and symptoms, OCJ staff referred her to the Medical Doctor Triage for alcohol abuse and hypertension.

On June 28, 2018, Martinez pleaded guilty to all charges. Martinez was sentenced to 60 days in OCJ with credit for six days already served. On July 3, 2018, Martinez was given a Manual Urine Drug Screen Test. The screening reported that Martinez tested positive for Methamphetamine and Benzodiazepines. Martinez was also displaying behavior issues. Due to Martinez's health and behavioral symptoms, she was examined by a medical doctor. The physician determined Martinez had a history of alcohol abuse and was displaying withdrawal symptoms related to alcohol detoxification, hypertension, and anxiety disorder from illicit drug use.

In the late evening on July 5, 2018, a registered nurse at OCJ posted in Martinez's medical record that Martinez told a deputy "Something isn't right. I'm retarded or had a stroke or something. I don't know why else I stutter now. I can't remember things. They don't give me that red pill anymore?" Due to Martinez's statements she was rehoused, monitored, and scheduled to see the doctor the following morning.

On July 6, 2018, the treating physician examined Martinez. That physician ordered that Martinez be transported to the hospital for symptoms of a stroke. Martinez was transported to OCGMC for further evaluation. Martinez told OCGMC medical staff she had been experiencing symptoms of an unsteady gait and temporary vision loss from her right side. Martinez informed hospital staff during intake that she had been seen the day prior (July 5, 2018) after she had complained of having two weeks of gait unsteadiness and right sided weakness. Information was initially provided to OCDASAU suggesting Martinez had been complaining to jail staff about her symptoms for two weeks. This was in error and not supported by any records. In actuality, the medical records, jail records, and statements by the witness indicate that Martinez had the symptoms for possibly two weeks, but no one was notified of them until July 5, 2018.

Martinez underwent a CT scan of the brain, which revealed she had suffered a left parietal lobe stroke. Martinez was then admitted to the hospital for further evaluation and care. Two ventriculostomies were placed on Martinez due to blood in the ventricles to help manage the swelling.

Martinez continued to suffer strokes and her health rapidly declined for the following weeks that she was in the hospital. On July 25, 2018, it was determined that Martinez had completed her jail sentence and was released from custody, which allowed Martinez's family to visit her in the hospital. On July 30, 2018, a physician conducted a brain study and pronounced Martinez brain dead. On July 31, 2018, a second physician conducted a required, second brain scan, and confirmed Martinez was brain dead. OCGMC medical staff met with Martinez's family and the decision was made to withdraw care. At approximately 10:28 p.m. on July 31, 2018, Martinez was pronounced deceased.

AUTOPSY

On August 8, 2018, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Lisa Martinez. There were no major or minor injuries found or obvious signs of trauma on Martinez's body. However, natural disease and pre-existing conditions were found. The autopsy revealed that the preliminary cause of death was hemorrhagic stroke, enlarged heart and hypertension. Once the final autopsy report was completed and toxicology reports were reviewed, the Forensic Pathologist concluded that the final official cause of death was intra-cerebral hemorrhage due to hypertensive heart disease, and the manner of death was determined to be natural.

BACKGROUND INFORMATION

Lisa Martinez had Criminal History records from California with arrests dating back to 2006 for the following violations:

- Accessory to a crime
- Petty Theft
- Petty Theft with a Prior Theft
- Appropriating Lost Property
- Possession of a Shopping Cart
- Probation Violation
- Possession of Drug Paraphernalia
- Bringing a Controlled Substance into Prison
- Possession of a Controlled Substance
- Unlicensed Driving
- Driving Under the Influence of Alcohol/Drugs
- Driving While Licensed Suspended

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

There is no evidence in this case 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 Martinez 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. The evidence collected does not indicate that the OCSD staff involved in this incident caused or contributed to Martinez's death, nor does it show they acted with negligence in regard to Martinez's medical needs. Simply put, there is nothing to show that the OCSD staff acted differently than how an ordinary careful person would act in the same situation with the information the staff had at the time.

The evidence provided does not support a finding that any of the elements of murder have been met. While the OCSD staff had a duty to treat Martinez and keep her safe, there is nothing to suggest that there was an intentional failure to act by failing to provide Martinez treatment for her health condition. Quite the contrary, it appears from the evidence provided that once the staff was aware of the deteriorating health of Martinez, the staff took numerous steps to treat Martinez. This treatment included immediate evaluation by medical staff including nurses and doctors. This treatment also included constant medical care to address the health concerns as those concerns arose. There is a lack of evidence to show that any of the OCSD staff intentionally neglected the duty placed upon them.

During this investigation by the OCDASAU, there was a considerable focus on the timing of Martinez's symptoms, awareness of those symptoms, and action taken as a result of those symptoms. During that analysis, we cannot find any action in which the OCSD staff intentionally neglected to provide care as symptoms and concerns about Martinez's health were brought to their attention.

When evaluating the case under involuntary manslaughter, much of the same analysis applies. There is no question that the OCSD staff had a duty of care to Martinez. However there is nothing to support a finding that the staff failed in that duty. The first signs of Martinez's health issues seem to have been on July 3, 2018. It was at this time she was referred to medical treatment by an RN because of shaking in the right arm and difficulty answering questions. In hindsight, this may have been symptomatic of a stroke. However, she was referred for medical evaluation as a possible reaction to her detox treatment. Martinez had admitted to chronic alcohol abuse, she also had Methamphetamine detected in her system (despite saying she only drank alcohol). Martinez indicated that drinking did in fact alleviate her symptoms. To further complicate the diagnosis and

treatment, Martinez had a history of seizures. Medical attention was given to monitor and to determine the source of the symptoms.

While Martinez was not evaluated for a stroke until July 6, 2018, there is nothing to suggest that such a delay was a legal failure in a duty owed to Martinez. In fact, it was between July 3, 2018 and July 5, 2018 that Martinez was under medical care and being evaluated by nursing staff to find the cause of her condition.

On July 5, 2018, during the late evening, Martinez made statements that she believed she may have had a stroke. Martinez was evaluated by a nurse and rehoused so that she could be monitored for any medical conditions that may arise. The OCSD medical staff took the measures to ensure she was seen by a doctor early the next morning. There is nothing in the evidence to indicate that seeing a doctor immediately after her comments regarding a stroke was necessary. Further, the next morning, when she did see a doctor, there were no signs that her condition had worsened or that the overnight delay caused an issue. Once seen by a doctor, and at a doctor's recommendation, OCSD medical staff then immediately transported Martinez to OCGMC. Upon evaluations and testing, it was determined that Martinez had had a stroke. Martinez arrived at OCGMC to receive full medical treatment at the hospital for her health condition.

Again, there is nothing in the evidence to indicate that the medical staff should have known about Martinez's stroke, nor does it show that they failed in determining she in fact had a stroke. Further, there is also nothing to suggest that OCSD medical staff knew or should have known about Martinez's stroke. Further, even if they should have known, there is nothing to suggest that they failed to act. Finally, even if the OCSD staff failed to act, there is no evidence showing that such a failure caused the death of Martinez.

When Martinez arrived at the hospital she was alert and able to receive treatment. Over the month of July, 2018, OCGMC continued to provide care for Martinez. During this time, Martinez's condition worsened and multiple treatments were given to her to improve her health condition. These treatments included the administration of medication as well as multiple surgeries. Despite the treatment, Martinez suffered multiple strokes while in treatment, her condition deteriorated and she was pronounced dead on July 31st 2018.

There is no evidence Martinez's medical complications were caused by any OCSD staff. All available records support the conclusion that OCSD met their legal duty and appropriate standard of care. They responded to Martinez's health needs with reasonable care and diligence and thus all available evidence supports that OCJ, OCGMC and OCSD met all legal duties owed to Martinez.

Thus, there is no evidence indicating that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty or that any act (or failure to act) by the OCSD personnel caused the death of Martinez.

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 that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Martinez. The evidence shows that Lisa Janice Martinez died as a result of an intra-cerebral hemorrhage and that the death was a natural one.

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

Respectfully submitted,

BRADLEY SCHOENLEBEN
Senior Deputy District Attorney
TARGET/Gangs Unit

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