SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO
SOUTHERN DIVISION

THE PEOPLE OF THE STATE OF CALIFORNIA

Plaintiff,

vs.

Carlos Orlando Chacon

Defendant.

DECLARATION IN SUPPORT OF ARREST WARRANT

Case No. CS320628

D.A. No. BCI903

I, Micheal Brown, declare I am a peace officer employed by the San Diego County District Attorney's Office and currently assigned to the Bureau of Investigations. I have either personally investigated the following, or have reviewed business records, law enforcement reports and court records pertaining to this case, which I believe to be true and reliable. All events took place in the County of San Diego, California, unless otherwise specified.

On approximately 11/01/21, the Medical Board of California provided the San Diego County District Attorney's Office with the results of its investigation of the death of 36-year-old Megan Espinoza following her breast augmentation surgery at Divino Plastic Surgery on 12/19/2018. The following synopsis was prepared to inform the reader of the general details discovered during the Medical Board's investigation.

On 12/19/2018, at approximately 1230 hours, Megan Espinoza entered the surgery room of the Divino Surgery Center, located at 180 Otay Lakes Road, Suite 110, in the City of Bonita to receive breast augmentation surgery. Dr. Carlos Chacon of Divino Plastic Surgery was the surgeon that conducted the procedure. It should be noted that Dr. Chacon is not a board-certified surgeon or anesthesiologist. Registered Nurse Heather Vass (previously known as Heather Lang) was the person who administered anesthesia during the surgery. It should be noted that RN Vass is a regular RN with no certification for anesthesiology. Vass administered Versed, Fentanyl, Zofran, Ketamine and Ancef to purportedly induce, "conscious sedation." The American Society of Anesthesiologists defines conscious sedation as, "a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate."

Sedation began at approximately 1235 hours. The surgery began at approximately 1305 hours. At approximately 1422 hours, Espinoza experienced a drop in oxygen saturation from 100 % to 48% and shortly thereafter went into cardiac arrest. Dr. Chacon connected an automated external defibrillator (AED) to Espinoza, which indicated no shock was necessary. Chacon provided approximately 10 chest compressions and Espinoza's pulse was restored. Espinoza was administered Epinephrine, Narcan and Romazicon during the resuscitation efforts. After Espinoza's pulse was restored, Vass used an Ambu bag (also known as a bag

valve mask) to assist Espinoza with breathing, because Espinoza was not breathing regularly on her own and had not resumed consciousness. While Espinoza remained unconscious and on breathing support, Chacon stepped out of the operating room for several extended periods of time to communicate with anesthesiologists, Dr. Michael Dinh and Dr. Jesus Lozano, leaving Vass and several untrained, or poorly trained, medical assistants to monitor Espinoza's condition.

Chacon did not contact 911 to request emergency assistance until 1724 hours, approximately 3 hours after Espinoza's cardiac arrest. During the 911 call, Chacon told 911 operators that Espinoza was conscious. Chacon further stated, "She's not following commands. She's being bagged. She's, you know, waking up from anesthesia. Her eyes are open. She's making movements and moaning. That's what we have." Paramedics arrived at the Divino Surgery Center at 1727 hours. Espinoza was transported to Scripps Hospital, in Chula Vista. Upon her arrival at the hospital, doctors intubated Espinoza to establish a secure airway and placed her on a ventilator. Doctors discovered she had a pressure induced pneumothorax as a result of prolonged and aggressive bagging. Espinoza had also sustained undue stress to her heart as a result of the prolonged bagging. Espinoza was admitted to the Intensive Care Unit of Scripps Hospital. A chest tube was inserted and over the next five days Espinoza's pulmonary function improved. However, her neurological function remained critical.

On 12/24/18, Espinoza was transferred to UCSD Medical Center's Neurological Intensive Care Unit, where her condition continued to deteriorate. Physicians notified Espinoza's husband and mother that she was not expected to regain neurological function. The family chose to place Espinoza on palliative/compassionate care. Espinoza never regained consciousness, or the ability to breath on her own. On 01/28/19, at 2226 hours, Espinoza passed away. An autopsy was performed. The autopsy determined the cause of death to be, "Ischemic Encephalopathy due to resuscitated cardiac arrest following anesthesia for elective surgery." Ischemic Encephalopathy is defined as a brain dysfunction caused by a lack of blood flow and oxygen to the brain.

On 12/28/18, Don Sullivan of American Medical Response filed an Online Complaint Summary with the Medical Board of California on behalf of the paramedics who transported Espinoza from Divino Plastic Surgery to the hospital. The complaint was filed because of concerns that Dr. Chacon had waited almost 3 hours to call 911 to request emergency medical assistance, which is standard protocol when CPR is performed, as defined by the American Heart Association. As a result of the complaint, the Medical Board of California conducted an investigation of the incident. Two medical experts, Dr. Gundappa Neelakanta and Dr. John Shamoun, were consulted by the Medical Board of California. Both provided the opinion that Dr. Chacon's handling of Espinoza's surgical procedure was an extreme departure or deviation of the standard of care. Dr. Shamoun went on to say, "It is medically probable and with reasonable certainty that this patient sustained a prolonged unnecessary hypoxic event more likely from over sedation and less likely from either, tension pneumothorax, aspiration, fentanyl induced stiff chest syndrome, serotonin syndrome, or Marcaine or Lidocaine toxicity. It is also my professional opinion that regardless of which of the above hypoxic etiologies occurred (if

treated appropriately and expeditiously) none of the above causes should have resulted in her eventual untimely and unnecessary death."

The Medical Board of California has provided a copy of its investigative reports and supporting documentation to the San Diego County District Attorney's Office for review. Espinoza's family hired Gomez Trial Attorneys to file a lawsuit against Divino Plastic Surgery and Dr. Chacon for wrongful death. Depositions were taken of Dr. Chacon, Heather Vass and numerous Divino employees and percipient witnesses. Based in part upon information provided by the Medical Board of California and information contained in the transcripts of the depositions, the District Attorney's Office obtained warrants to search Divino Plastic Surgery, the Divino Surgery Center and the residence of Carlos Chacon. The warrants were served on 12/10/21. On 12/15/21, the District Attorney's Office filed the following charges against the following individuals:

Count 1: PC 192(b) Involuntary Manslaughter against Carlos Chacon and Heather Vass

Count 2: B & P 2052(b) Conspiring to Treat the Sick or Afflicted without a Certificate against Carlos Chacon and Heather Vass

Count 3: B & P 2052(b) Conspiring to Treat the Sick or Afflicted without a Certificate against Carlos Chacon

Based on information discovered in the ongoing investigation by the District Attorney's Office, on 07/13/22, an amended complaint was filed adding the following counts to the case:

Count 4: B & P 2052(b) Conspiring to Treat the Sick or Afflicted without a Certificate against Carlos Chacon (Victim, Maria G)

Count 5: B & P 2052(b) Conspiring to Treat the Sick or Afflicted without a Certificate against Carlos Chacon (Victim, Jennifer R)

Count 6: B & P 2052(b) Conspiring to Treat the Sick or Afflicted without a Certificate against Carlos Chacon (Victim, Maria C)

Since those charges were filed, the District Attorney's Office investigation has continued. Key employees of Divino Plastic Surgery have been reinterviewed by District Attorney Investigators. These interviews provide a clearer picture of what occurred during Espinoza's surgery. Two anesthesiologists whom Chacon contacted during the incident have been reinterviewed and have provided additional information. Patients who were listed on Divino Plastic Surgery's 12/19/18 schedule have been positively identified and interviewed. Additional medical doctors have been consulted and have provided expert opinions regarding their observations of what occurred at Divino Plastic Surgery on 12/19/18. In addition, Divino's surgical center accreditation consultant has been interviewed regarding Divino's policies and procedures.

Based upon the following information, I believe probable cause exists to believe Carlos Orlando Chacon is guilty of PC 187(a) Second Degree Murder with Malice Aforethought. PC

188(a)(2) states malice is implied when the circumstances attending the killing show an abandoned and malignant heart. The Judicial Council of California Criminal Jury Instruction 520 for Second Degree Murder with Malice Aforethought (Pen Code 187), states in pertinent part as follows:

To prove that the defendant is guilty of this crime, the People must prove that:

1B. The defendant had a legal duty to care for Megan Espinoza and the defendant failed to perform that duty and that failure caused the death of Megan Espinoza.

AND

2. When the defendant failed to act, he had a state of mind called malice aforethought.

There are two kinds of malice aforethought, express malice and implied malice. Proof of either is sufficient to establish the state of mind required for murder.

The defendant had implied malice if:

1. He intentionally failed to act;

2. The natural and probable consequences of the failure to act were dangerous to human life;

3. At the time he failed to act, he knew his failure to act was dangerous to human life;

AND

4. He deliberately failed to act with conscious disregard for human life.

A failure to act causes death if the death is the direct, natural, and probable consequence of the failure to act and the death would not have happened without the failure to act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes. In deciding whether a consequence is natural and probable, consider all of the circumstances established by the evidence.

There may be more than one cause of death. A failure to 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.

I believe Carlos Chacon began a pattern of conscious disregard for human life prior to beginning Megan Espinoza's surgery. This is evidenced by the following summary of information. I have obtained Megan Espinoza's medical file, via search warrant, from Chacon's medical records service provider. The records indicate Chacon charged Espinoza $2000.00 for anesthesia. I have reviewed the transcript of her husband's, Moises Espinoza, sworn testimony during a civil deposition. Mr. Espinoza stated he had been present when Mrs. Espinoza

discussed anesthesia with Chacon. Chacon told Mrs. Espinoza that an anesthesiologist who had privileges with two different Sharp Hospital locations would be coming to Divino to provide the anesthesia. I have reviewed Chacon's informed consent form which states, "I understand there is a **remote** risk of death or serious disability with any surgical operation or procedure." This statement indicates Chacon is aware that even under the best circumstances, surgical procedures can be dangerous to human life. I have reviewed Chacon's sworn testimony during a civil deposition. The following has been copied from the transcript regarding what Chacon discussed with Megan Espinoza regarding anesthesia:

Question: What risk, if any, did you discuss with Ms. Espinoza about the anesthesia?

Answer: Adverse drug reactions, brain damage, nerve injury or death, in addition to those that we discussed, which would be injury to dental work, damage to vocal cords, respiratory problems, heart problems, and damage to arteries and veins, including nerves.

Question: Do you discuss with Ms. Espinoza or patients about how you handle these adverse reactions to anesthesia at Divino Plastic Surgery?
Answer: I do.

Question: What do you explain to them?

Answer: Well, I discuss that **we have protocols in place and we're an accredited facility**. That **we have all the necessary emergency equipment and are prepared to transfer as needed to a local hospital should it be required**.

Question: **So as part of this process, you assure patients like Mrs. Espinoza that you would get her to an acute care hospital in the event of a life-threatening emergency; is that true?**

A: **That's true.**

I have interviewed Patricia Ferrigno, the consultant Chacon hired to assist Divino Plastic Surgery with obtaining accreditation as an outpatient surgical center. Ferrigno told me that accreditation is required by the State of California in order to provide any level of anesthesia on a surgical center's premises that compromises a patient's life protective reflexes. Ferrigno went on to say the State of California has been even more restrictive on surgical centers by prohibiting a surgical center from performing conscious sedation (sedation that does not depress the ability of patients to protect their airway) on the premises without being accredited. In order to obtain accreditation, a surgical center must have established policies and procedures outlining how to handle emergencies that occur on the premises. Ferrigno provided Divino with copies of the required policies and procedures in October of 2017. One of the policies she provided to Divino was a code blue protocol. That protocol states the following, "While life-saving treatment is being administered, the receptionist will summon emergency help by dialing 911." Ferrigno stated that Chacon's failure to immediately call 911 was not a policy problem, it was simply a failure of Chacon to follow his own policy. I have reviewed policy and procedure manuals that were located in the Divino Surgery Center during the service of a search warrant. The manuals contained Joint Governing Body/Medical Staff

Meeting Minutes. The minutes indicate Chacon approved Divino's policies and procedures on 10/01/17.

I have reviewed a Root Cause Analysis regarding Espinoza's surgery that was obtained during this investigation. I showed the document to Ferrigno. Ferrigno confirmed that she prepared the Root Cause Analysis based on information she obtained from Chacon. Ferrigno explained, accredited practices are assigned a clinical director by the accreditation agency and when there is an adverse event at a practice, a root cause analysis must be prepared by the practice and submitted to the clinical director. This clinical director reviews the root cause analysis and makes a recommendation to the agency's accreditation committee of whether or not the practice should remain accredited. Chacon did not notify Ferrigno of the adverse event related to Megan Espinoza's surgery. Ferrigno was notified of the adverse event by the accreditation agency in approximately March 2019. In order to prepare the root cause analysis, Ferrigno asked Chacon questions about what occurred during the incident. The information contained in this document was what Chacon told Ferrigno about what had occurred. The report states as follows: "Near the end of the procedure, the patient experienced a cardiac arrest. **Simultaneous with initiating appropriate resuscitative measures, emergency transport was requested.**" (emphasis provided). Ferrigno later had to amend the statement to: "Near the end of the procedure, the patient experienced a cardiac arrest. **We initiated appropriate resuscitative measures; emergency transport was requested.**" Ferrigno again based her report on what Chacon told her. Chacon did not tell Ferrigno there was a three-hour delay in calling 911. I believe the fact that Chacon lied in this report and both times omits the 3-hour delay shows consciousness of guilt and further proves Chacon was aware that his failure to call 911 immediately placed Espinoza's life in jeopardy.

My review of the transcript of Chacon's sworn testimony during the civil deposition revealed that Chacon admitted he did not specifically direct Nurse Vass what medications and dosages she should administer to Espinoza during the surgery. Instead, Chacon provided Vass with a two-page chart that listed drugs and dosage amounts that Vass could use during every surgery in which she provided anesthesia services for Chacon. The following was copied from the transcript of the deposition:

Question: You mentioned these charts that Ms. Lang can reference. When you were performing the procedure on Ms. Espinoza, were you providing the doses for the medications that were given to Ms. Espinoza? Or were you allowing Ms. Lang to go ahead and give those doses as she saw fit?

Answer: I let her exercise her judgment, having done these procedures with her other times, yes.

Question: So, the doses and the intervals of the medications given to Ms. Espinoza was a decision made by Ms. Lang during the procedure; true?

Answer: I supervised Ms. Lang during the procedure. And we had an understanding of what medications she could provide to the patient. The doses and intervals, she would have to adjust and provide based on her assessment of the patient throughout the procedure.

I have interviewed Dr. Michael Dinh and Dr. Jesus Lozano, two anesthesiologists whom Chacon contacted for advice after Espinoza's cardiac arrest. Dr. Dinh stated the following regarding a registered nurse providing anesthesia on their own. A registered nurse is not allowed to pick and choose the drugs and dosages and administer them to a patient. They can only act upon a physician's orders that are tailored to the specific patient's needs. I asked Dinh to explain in laymen's terms what an anesthesiologist could provide for a patient that a surgeon likely could not. He said an anesthesiologist is able to diagnose when a patient needs intubation and is able to perform the intubation when it is needed. Most surgeons would not have the skills to do so. Dinh stated intubation is required whenever the amount of anesthetic that is provided to the patient is such that it depresses their ability to protect their airway, or it depresses the patient's vital signs, such as breathing rate and oxygenation level. Whenever Dinh performed anesthesia for Divino, he intubated the patient. Therefore, Chacon routinely contacted Dinh for the major surgeries Chacon performed. The procedures that Dinh was called in for were breast augmentation, tummy tucks, liposuctions and rhinoplasties. Dinh made the choice to intubate patients that received the above listed procedures, because the quantity of drugs that Dinh would need to keep these patients comfortable and safe during these procedures would depress their airway reflexes and their vital signs enough such that their airways needed to be protected.

Dr. Lozano told me the following regarding the different roles of the person administering anesthesia and the surgeon. When Lozano performed anesthesia services at Divino, Chacon used a sterile drape between Chacon and Lozano. When Lozano performed anesthesia, he regularly conducted evaluations of the arousability of the patient as it pertains to their level of sedation. Chacon did not do any evaluations of the patient's level of sedation when Lozano was performing anesthesia. Lozano opined that it would be difficult for Chacon to evaluate a patient's level of sedation during surgeries, because Chacon would be focusing his attention on the surgical aspects. It would be the person providing anesthesia's responsibility to conduct such evaluations.

I have reviewed videos taken by Chacon during Espinoza's surgery. It should be noted that Chacon used a sterile drape, which blocked Chacon's view of what Heather Vass was doing. I have interviewed witness Zenia De Los Santos, who was in the surgical room during Espinoza's procedure. De Los Santos stated Chacon was playing loud music during the procedure that made it difficult for anyone in the room to hear what the others were saying, or to hear any auditory warnings from the surgical monitor.

The following information convinces me that Chacon had a legal duty to care for and rescue Megan Espinoza and he failed to perform that duty and that failure caused the death of Espinoza. In addition to failing to rescue Espinoza after her heart had ceased to beat by providing Espinoza with a proper airway, I believe the following proves Chacon committed a series of intentional acts for the express purpose of prohibiting others from caring for and rescuing Espinoza.

Heather Vass filled out a "Procedure Record Nursing Note" form in which she states what occurred on 12/19/18. The form shows: Megan Espinoza entered the surgical room at 1230

hours; Vass began administering sedation at 1235 hours; Chacon began the surgery at 13:05 hours. The chart documents medications given and Espinoza's vital statistics (blood pressure, heart rate, cardiac rhythm, respiration rate and oxygen saturation) in 5-minute increments beginning at 1235 hours. The chart indicates Espinoza stopped breathing at 1430 hours and her oxygen saturation dropped to 48. At that time, Vass used a bag valve mask and oral airway to begin breathing for Espinoza. Chacon performed 10 chest compressions and connected an AED (automated external defibrillator) to Espinoza. The AED indicated no shock was advised. Espinoza's oxygen saturation increased to 53 at 1435 hours, to 61 at 1440 hours, and to 95 at 1445 hours.

I have reviewed Vass's sworn testimony taken during her civil deposition. Vass confirmed that Chacon did not give her any verbal or written instructions regarding any of the medication and dosages she charted on the Nursing Note. She independently made those decisions based upon the two-page chart that Chacon discussed above. Vass admits she recognized the need to transfer Espinoza to a hospital for further care by approximately 1500 hours. Vass admitted that between 1440 hours and 1500 hours, someone other than Vass or Chacon gave Espinoza nine doses of Narcan at Chacon's direction to attempt to reverse the effects of the anesthesia. I know from reviewing the videos of the surgery that the person who provided those does of Narcan was Stephanie Cruz. Cruz is an unlicensed medical assistant.

Dr. Lozano told me on the day of Espinoza's surgery, Lozano was at Lozano's personal residence and noticed he had received a missed phone call from Chacon. In response, Lozano sent Chacon a text message at 1542 hours, asking him what he had wanted. Chacon responded to the text with, "call me." In response, Lozano called Chacon. I have reviewed Chacon's phone records, which document the incoming call from Lozano occurred at 1553 hours. During the call, Chacon presented Lozano with the clinical scenario of a patient who was having difficulty emerging from anesthesia. Chacon stated to Lozano that he had been doing a procedure and had given the patient medication. At some point, the patient had become unresponsive. They had used an Ambu bag, known as a bag valve mask, to bring the patient up to the appropriate level of oxygenation. Chacon stated he had used an AED, because the patient had become, "unresponsive." **Chacon specifically told Lozano that the patient had never lost a pulse, or blood pressure.** Chacon told Lozano the non-responsiveness had begun a little over an hour prior to this phone call. Chacon's demeanor during this call sounded very casual to Lozano. Lozano began running through his usual protocols in his mind as to what he would do to resolve a difficulty in awakening from anesthesia and explained to Chacon that he would administer Narcan and provided Chacon with dosage suggestions.

Chacon did not tell Lozano that he had already given the patient reversal agents prior to contacting Lozano. Chacon did not tell Lozano anything during this call that gave Lozano the impression that any type of emergency had occurred. This impression was based upon Chacon's affirmative statement to Lozano that the patient was stable. During the call, Lozano believed the patient was simply having a difficult time awakening from the anesthesia. When Chacon had mentioned that an AED was used, Lozano initially felt like he was missing some information, because AEDs are usually deployed only in emergency situations. However, when Chacon stated the patient was stable and that no pulse or blood pressure had ever been lost, this quelled any concerns that Lozano initially had. Lozano thought it was possible that Chacon

was just nervous about the difficulty in arousing the patient and that was what caused Chacon to connect an AED to the patient.

I showed Lozano a copy of Divino's Procedure Record Nursing Note that allegedly documents what had occurred during Espinoza's surgery. Lozano said that is not the clinical picture that Chacon had provided to Lozano during their phone calls. **If Chacon had described the scenario the chart indicates, Lozano would have called 911 himself.** I asked Lozano why he would have called 911 under this scenario. He said, "Because you want as much resources as possible." "You want all the help you can get." "I know working in surgery centers it is not always the case." "Even in hospitals, I'm calling 911 in the hospital even before it gets to this point, in anticipation, so it doesn't get to this point." Lozano said **what is charted on the document is an emergency situation. Calling 911 was the appropriate action to take under the charted circumstances.** Lozano said that based upon what Chacon knows about Lozano, Lozano believes Chacon would be aware that if Chacon informed Lozano of the details contained on the above listed document, Lozano would have called 911 himself. I asked Lozano at what point in his medical career he became aware that a scenario such as the scenario documented in Espinoza's chart, calling 911 was the appropriate response to that scenario. He said, "medical school." I asked Lozano if he had any doubt that Chacon would know that calling 911 for this type of scenario was the appropriate action. He said, "no."

I asked Lozano what a blood oxygenation level of 48, 53, and 61 meant to him as a physician. These numbers are listed on the Procedure Record Nursing Note for Espinoza's surgery. He said, "It's scary, I mean. Its, its, something immediately has to happen to bring those numbers up." "You have to intubate." "You have to do something." Chacon did not provide oxygenation levels to Lozano during their phone calls about the incident. I asked Lozano what he would have done if Chacon had provided those specific numbers to him. He said he would have told Chacon to call 911 and intubate. The appropriate response to seeing those numbers would be to call 911 and while waiting for EMS try to assist the patient with oxygenation. Lozano said any trained physician would be aware that the only appropriate action to take given the oxygenation levels discussed above would be to call 911 and intubate.

Lozano confirmed oxygenation levels of 48, 53 and 61 is a life-threatening condition. Using a bag valve mask on a patient exhibiting those numbers for any prolonged length of time would not be appropriate. Intubation is the appropriate response to that situation. During their conversations, Chacon never mentioned to Lozano that the patient was exhaling a pink frothy sputum (mucus that contains bubbles). Lozano did not become aware that this patient's heart had stopped during surgery until Lozano received notice of the lawsuit filed by Espinoza's family.

Lozano said after the first phone call, Lozano called Chacon by phone again at approximately 1642 hours. The purpose of the second call was to find out how the patient responded to the Narcan. Chacon's demeanor during this call was the same as in the first call. The conversation lasted less than 3 minutes. Chacon told Lozano he had administered the reversal agents and the patient's status had not changed. At this point, Lozano felt he may not be getting the full clinical picture of what was occurring, so he offered to come to Divino to assist. Chacon declined Lozano's offer, stating it was not necessary for him to come in.

Dr. Dinh told me the following. On 12/19/18, he received two phone calls from Chacon. He received the first call at **1649** hours. Chacon told Dinh he had performed breast augmentation surgery on one of his patients at approximately 1200 hours. At the end of the surgery, the patient was not responsive so Chacon had administered anesthesia reversal agents. Dinh asked Chacon for the patient's vital signs. Chacon provided numbers that indicated the oxygen saturations were, "extremely low." Dinh understood the patient was in trouble. Therefore, Dinh told Chacon his patient needed to be intubated. Dinh told me he knew Chacon does not know how to intubate. Therefore, Dinh suggested that Chacon call 911, so the patient could be intubated. Dinh described Chacon's demeanor during the call to be, "matter of fact." Chacon did not sound scared. Based on the numbers Chacon provided, Dinh would be in a panic scenario if he was in Chacon's situation. Chacon mentioned he had given the patient all of the reversal drugs already. If reversal agents hadn't worked, there is nothing else a doctor can do but intubate the patient.

I asked Dinh to explain what intubation would have done to improve the situation given the facts Chacon had described to Dinh. He said the purpose of intubation is to, "protect the patient's airway and improve the oxygenation." The concerns for a patient that is not intubated in this type of circumstance is the patient could aspirate, resulting in Pneumonia. The patient could also suffer neurological damage. Intubation introduces oxygen only into the lungs and not the stomach. It improves oxygenation and ventilation. Ventilation is the ability to excrete carbon dioxide. I informed Dinh that I had reviewed the transcript of Dinh's prior deposition and I remembered he had mentioned that Chacon mentioned something about a pink frothy sputum coming from the patient's mouth. Dinh told me a pink frothy sputum coming from a patient's mouth would indicate to Dinh that the patient was experiencing negative pressure pulmonary edema. This condition is most often seen in younger people. This condition would indicate someone has strong diaphragm muscles that are attempting to breath and **their airway was obstructed from, "not being intubated."** That is why Dinh recommended to Chacon that the patient be intubated. Because the airway is obstructed, the patient is attempting to breath so hard that they are pulling fluid from the capillaries in their lungs into their alveoli. This condition indicates the patient experienced, "a continued prolonged obstruction" of the airway.

Dinh received a second phone call from Chacon at **1703** hours. During that call, Chacon stated there had been no improvement in the patient's condition. Chacon's demeanor was the same as before. He continued to act, "robotic," as if he wasn't concerned. Chacon asked Dinh again what he would do. Dinh told Chacon he would call 911, so paramedics could intubate the patient. Dinh made it clear to Chacon that intubation was the only course of action that would help this patient.

A review of Moises Espinoza's sworn testimony taken during the civil deposition revealed that Mr. Espinoza stated he called Divino Plastic Surgery at approximately **1430** hours and asked why he had not received a phone call to pick up Megan. He was told that her surgery was almost done and they would call him back. Mr. Espinoza called Divino again at approximately **1530** hours and asked again when he should pick Megan up. He was told again that the doctor would call him as soon as the surgery was done. Chacon later called Mr.

Espinoza and told him his wife was being transported to Sharp Hospital. My review of Chacon's phone records indicates Chacon finally called Moises at **1741** hours.

I have listened to the recording of the 911 call made at 1722 hours and 51 seconds. I recognized the voice on the call was Chacon. The following description of Espinoza's condition was copied from the transcript of the call:

911 OPERATOR: And what's wrong with the patient?

UNIDENTIFIED 911 CALLER: The patient is not completely following commands. Her vitals appear to be stable, but she's not oxygenating on her own, so I'm a little concerned about some pulmonary fluid or edema.

911 OPERATOR: Okay. Is she awake now?

UNIDENTIFIED 911 CALLER: She's not following commands.

911 OPERATOR: But is she --

UNIDENTIFIED 911 CALLER: But she don't --

911 OPERATOR: awake or unconscious?

UNIDENTIFIED 911 CALLER: She's not following commands. She's being bagged. She's, you know, waking up from anesthesia. Her eyes are open. She's making movements and moaning. That's what we have.

911 OPERATOR: Okay. So, is she conscious, or no?

UNIDENTIFIED 911 CALLER: She's conscious, yes.

Dispatch records revealed the first paramedic arrived at Divino at 1727 hours, just 4 minutes after the 911 call was placed. The following was copied from the paramedic's report that described Espinoza's actual condition: "At fire arrival PT was found laying supine on operation table with grunting respiration at 10 66% RA, pale mottle skin, NPA placed in right nostril assisted respiration with BVM. BP 72/55 HR 120 Sinus tach. PT unresponsive. 20G left AC with 1000ML NS bag establish PTA, PT also received 400MEQ of Fentanyl, 4MG Versed and 4MG NARCAN. AX: arrived on scene to find PT laying supine on operation table. Pale mottle skin, 70% via BVM clear upper Rhonchi Lower. HR 120 Sinus tach. PT having unpurposeful movement with legs and arms (twitch like movement). PT surgery seem completed with clean surgical site and no bleeding. PT had bruising mark in upper chest area. PT was clinch at the teeth unable to open airway for suction or placement of OPA. PT had unknown substance coming out of NPA during some face of expiration. Story of what happen between 1422 and 1735 is unclear and unable to obtain clear story."

The report further indicates Espinoza's Glasgow Coma Scale score was 3, the lowest possible score a patient can receive. I have reviewed a National Library of Medicine report that indicates a score of 3 on the Glasgow Coma Scale is classified as severe and indicates acute traumatic brain injury with low possibility of survival.

I have reviewed the transcript of sworn testimony provided by the reporting paramedic, Alexander Linde, during a civil deposition. Linde reported that he was so disturbed by the severe condition Espinoza was in when he arrived that he eventually reached out to his training supervisor for guidance. It was this contact that caused Don Sullivan of AMR to contact the Medical Board and report the incident.

I have interviewed two of Chacon's medical assistants, who were in the surgical room during the surgery. Carla Hernandez was the surgical technician who assisted Chacon during the surgery. Zenia De Los Santos was assigned the role of circulator, a person who acts as a conduit between the sterile personnel in the surgical room and outside personnel and supplies. Hernandez told me the following. She attended college for two years as a business major. However, she did not complete the course and received no degree. Hernandez holds no certifications related to being a medical assistant. Hernandez has never been told what a medical assistant can and cannot do while performing their duties. Hernandez was hired by Divino in June of 2018. Her duties consisted of setting up the operating room in preparation for upcoming surgeries, assisting Chacon during surgeries and assisting during postoperative patient consultations.

Hernandez admitted she had personally injected Espinoza with anesthetics, prior to the surgery's commencement. She explained that it was Chacon's practice to have Hernandez, or other medical assistants, inject his patients with anesthetic, prior to Chacon beginning surgery. Hernandez described the following events occurred during the procedure. Hernandez first knew that something had gone wrong during Espinoza's surgery when the first implant was in. At that time, Espinoza's color began changing and the surgical monitor began making some sort of beeping sound. In response to the noise, Chacon asked Vass if everything was okay. Espinoza's color turned, "purplish blue," somewhere around the top of her breasts. Because Hernandez recognized something was wrong, she kicked the surgical room door to get someone's attention. Stephanie Cruz, another medical assistant, came into the room with a new monitor. After the second monitor arrived, the beeping noise stopped.

At this point in time, Hernandez, Chacon and Vass were the only people in the room with Espinoza. Chacon continued the surgery. Shortly thereafter, the second monitor began beeping. Chacon asked Vass again if everything was okay. Shortly thereafter, Chacon tore down the curtain that had covered Espinoza's face. Chacon instructed Hernandez to get some help from someone else in the office. Cruz was passing by and entered the operating room to help. Daniel Carmona, the former office manager, also came into the room. Someone, possibly Carmona, opened the crash cart and began handing items from the cart to Chacon. Hernandez remembered that Chacon had performed CPR on Espinoza. After Espinoza's heart had begun beating again, Chacon instructed Cruz to get specific medications from the black metal cabinet in the operating room. Chacon told Cruz how much of the medications she should draw into the syringe. Hernandez saw Cruz drawing medications into syringes and

injecting medications into the IV line that was connected to Espinoza. When asked why Vass wasn't administering the medications, Hernandez said she believed Vass was busy keeping Espinoza's airway open.

Chacon stepped out of the operating room. He was gone for, "quite a while." Hernandez, Zenia De Los Santos and Cruz had several conversations in the surgery room about calling 911. The three asked Vass if they should call 911. Vass said, "No. It's doctor's orders." When Chacon returned to the operating room, he was on the phone. Hernandez could hear the sound of a male voice on the phone, but she doesn't know who it was. Chacon left the room again. Hernandez said she knew Chacon, "had patients he went out to see." She also knew Espinoza's husband had called. Hernandez described the changes she observed in Espinoza's body during the three-hour delay. She observed the following:

The rising and falling of Espinoza's chest while being bagged appeared exaggerated.
Espinoza's legs became shaky and/or they twitched.
Espinoza's skin became pale.
Espinoza's skin felt cold to the touch.
Espinoza would not wake up, despite repeated verbal requests for her to do so.

From the time the emergency began, there was very little communication from Chacon to anyone during the times he was actually in the operating room. From the time Espinoza's of cardiac arrest through the time the ambulance arrived, Hernandez could only remember Vass using the Ambu bag to assist Espinoza with her breathing. Vass eventually became tired as a result of squeezing the bag for so long and she needed a break to use the restroom. When Chacon was out of the operating room, Hernandez, De Los Santos, Cruz and Vass discussed calling 911 on multiple occasions. Vass said the doctor had instructed them not to call. Hernandez believed nobody called 911, because they were all afraid of Chacon. At some point in time, employee, Hannah Link, came into the surgical room and told them that Espinoza's husband was on the phone waiting to speak with someone. Chacon told Link to tell the husband that Espinoza was still in surgery. They would call him back later.

Hernandez said Espinoza remained unconscious from the time her heart stopped through the time of arrival of the ambulance. During that time period, Hernandez observed that Espinoza's feet seemed to splay outwards, as she laid on the table. Hernandez said Vass was squeezing the bag valve mask on a regular basis from the time of Espinoza's cardiac arrest through the time that the ambulance arrived, indicating to Hernandez that Espinoza wasn't breathing adequately on her own. Hernandez said there were still patients in Chacon's office when Vass, Hernandez, De Los Santos and Cruz were alone in the surgical room trying to maintain Espinoza's breathing. Hernandez was, "assuming," Chacon met with these patients for their appointments, because Chacon was not in the operating room helping Espinoza.

Zenia De Los Santos told me the following. De Los Santos did not finish high school. She dropped out of high school in her third year. She did not obtain her GED until after she quit her employment with Divino Plastic Surgery. She explained that she was very anxious to get out into the workplace and she discovered she could seek a certificate as a medical assistant at 17 ½ years of age. To pursue this desire, she attended and graduated from a nine-month

course with UEI College. I asked De Los Santos to tell me everything she remembers about the day of Megan Espinoza's surgery. I let her speak freely, with minimal interruptions on my part. De Los Santos made the following statement in summary, but not verbatim. It should be noted that I have placed quotation marks in specific portions of the following statement that specify direct quotes.

De Los Santos recalled, "One thing I do remember, and I didn't even say it during the deposition is the music was always on loud. We had music on." "It was loud, like to the point where like, I'd be like, he'd say something and I'm always scared that I can't hear him, because of how loud the music is and like you can't tell him anything." I remember being closer to Heather. "I now remember I could swear the pulse-ox was beeping, but Heather was saying like something's up with the pulse-ox." "I don't know, but something's wrong with it." "She kept readjusting it and I almost think now, because the music was so loud, like maybe she just wasn't paying attention in my memories." "I'm just like, maybe it was already happening, like."

I just see doctor like panicked. It just happened within seconds it felt like. He just tears off the sterile sheet and talking about, "She's turning blue in her hands." He takes off whatever he's wearing and Heather's taking off her cover from the face. I feel from there was like a blur. "I just know that doctor did like, sorry for the word, it looked like half-assed CPR to me." I get mad at that. Who am I to know? He's a doctor. He knows if she was out already. "Maybe that's why he gave up." I just feel like his intention wasn't there to keep going. He was just so panicked with who to call for help. But then I told do we call 911? "He's like no nobody call like anywhere yet."

De Los Santos goes on to describe ineffective efforts at resuscitation, feeling overwhelmed and abandoned by Chacon, "What got me the most upset is that during everything it was just me, Heather and Carla. So, while this was all happening, we were trying to give her air. He was calling everybody. He had a black headset Bluetooth thing on and you could hear him calling. **But, for the most part he wasn't even in that room after he did CPR and gave her the meds.** He was like out of the room, just making calls and trying to figure out what to do. All I remember is asking Heather every minute, "Heather are we going to call 911?" "He has to give the orders." Even I am like, I think we should call. Heather was even like, "We should call." He's like telling me not to call. I was like, Heather can we call? She was like, Zenia, the doctor said not to call, so I'm just waiting. Even she was like panicked, but we didn't even say much. **It was me, Carla and Heather were there. "I felt abandoned by him!" "He just barely even came in." "Throughout the whole time he was doing calls."** I was like what is he doing. He just has us taking care of the patient. **I don't even know what I'm doing. I'm not here for this. I don't know what to do. Shouldn't somebody else be here?** Yah, he was stressed, but it wasn't like the care you would expect to see from a doctor to a patient. His priority should have been getting whatever help he could for her, not saving his business. Other than that, it was just a lot of whispering to each other. I was just stuck in that room. We just kept rotating her to her side. She was bubbling. **We didn't know what to do. We weren't prepared for it. It was hard.** Eventually 5 o'clock came around and I was like okay the businesses are gonna close. I think it was like 30 minutes after that and he was making sure that everybody was gone. That's when the ambulance and everybody came in.

Because the witnesses described long periods of time where Chacon was not in the surgical room, I interviewed every identifiable patient who was listed on Divino's schedule for that day to find out what Chacon was doing. I located four patients whom Chacon saw while Vass, Hernandez and De Los Santos were providing care for Espinoza. To avoid violations of HIPPA (Health Insurance Portability and Accountability Act) rules the patients will be identified as patients 1-4. They provided the following statements.

Patient 1
Appointment time: 3:15 P.M. to 3:30 P.M. (post-op follow-up)

Patient 1 remembered attending her appointment. Chacon asked her how she had been feeling and examined her. The meeting with Chacon lasted less than 5 minutes.

Patient 2
Appointment time: 3:30 P.M. to 3:45 P.M. (post-op follow-up)

Patient 2 confirmed she attended the appointment. She met with Dr. Chacon personally.

Patient 3
Appointment time: 3:45 P.M. to 4:00 P.M. (Pre-op Visit)

Patient 3 confirmed she attended the appointment, which was a pre-op appointment to discuss whether she would like to receive breast augmentation surgery in the future. During the appointment, Chacon went over what he was going to do during her procedure. After Chacon left the room, nobody at the practice assisted her. Chacon entered the room and asked her who had helped her. She explained that nobody had helped her. Chacon subsequently yelled at his staff members for not helping her.

Patient 4
Appointment time: 4:45 P.M. to 5:00 P.M. (post-op follow-up)

Chacon made Patient 4 sit in the waiting area longer than he normally did. Even though she was the last patient of the day, Chacon didn't see her right away. She overheard two phone calls that were answered by a female at the reception desk. She formed the impression that a surgery was still going on, because the female's response to the caller was something to the effect of the doctor will call you as soon as they are done. Patient 4 estimated she was in the office somewhere between 20 and 30 minutes, before she was taken to an exam room, where she met with Chacon. She estimated she had arrived at the office approximately 15 minutes prior to closing time. She believes Divino Plastic Surgery closes at 5:00 P.M. When Chacon finally came into the exam room, he was very quick to complete his consult. She estimated Chacon spent approximately 5 minutes speaking with her in the exam room. Chacon appeared to be in a hurry. After the consult was over, she left the office. She sat in her vehicle for approximately 5 minutes and saw Chacon exit the building holding the phone up to his ear. He appeared to be nervous because he was pacing back and forth in the parking lot. Shortly thereafter, an ambulance arrived in the parking lot.

I have reviewed the expert medical opinions of Dr. John Shamoun, a medical doctor Board Certified in Plastic Surgery, and Dr. Gary Vilke, a medical doctor Board Certified in Emergency Medicine. Both Dr. Shamoun and Dr. Vilke noted the life-threating danger of a cardiac arrest and found Chacon's failure to promptly call 911 was an extreme departure from the standard of care. Dr. Shamoun found Chacon's explanation for delaying his call to 911 to be "ludicrous and absurd, ... cavalier, dangerous, and reckless." Dr. Vilke specifically noted that Chacon "did not consider other causes for the cardiac arrest and low oxygen levels. He did not do any additional therapies or evaluations over this time. But these deviations should have been moot, in that he should have called 911 immediately. Mrs. Espinoza would have been taken to an emergency department where these actions would have been addressed by a trained emergency physician." Dr. Vilke specifically found Chacon's failure to promptly call 911 was the cause of Megan Espinoza's death. Both Dr. Shamoun and Dr. Vilke noted Chacon's conduct was inexplicable for a trained physician and may be the result of intentional concealment.

I have interviewed Dr. Glenn Wagner. Wagner was the San Diego County Chief Medical Examiner at the time Megan Espinoza's autopsy was performed. Wagner assisted with the autopsy. At the time the autopsy report was prepared, Dr. Wagner was not aware the anesthesia given to Espinoza was administered by a registered nurse, rather than by an anesthesiologist, a doctor, or a certified registered nurse anesthetist, and that neither had the ability to intubate the patient. Dr. Wagner added, the Hippocratic oath taken by doctors dictates a doctor will "do no harm" to a patient. Adverse events happen frequently in surgeries and physicians have an obligation to take timely action to resuscitate the patient. Not establishing an adequate airway as soon as possible after an adverse medical event is doing harm. Intubation was the appropriate method of establishing an airway in Espinoza's situation. Dr. Wagner told me if he had been aware of these facts, he would have listed the manner of death in this case as, "homicide."

I believe the above listed facts establish a pattern of conscious disregard for human life, a depraved indifference to human life and an abandoned and malignant heart. Therefore, I believe probable cause exists to believe that Carlos Chacon is guilty of PC 187(a), 189(b) Murder in the 2nd Degree, via Implied Malice. Chacon began the pattern of conscious disregard for Megan Espinoza's life prior to beginning her surgery by failing to provide an anesthesiologist to assist in Megan Espinoza's procedure and allowing a registered nurse not trained in anesthesiology to pick and choose medications and dosages that were administered into Espinoza based upon her discretion, not at Chacon's direction. Chacon could not see or monitor Espinoza's vital signs, because a sterile drape was blocking his view of Espinoza's face and the surgical monitor. In addition, Chacon could not hear the monitor clearly, or hear any input from Nurse Vass, because the music that was playing in the surgical room was too loud.

Chacon continued to show conscious disregard for Megan Espinoza's life after she had a cardiac arrest at approximately **2:30 P.M.** and failing to call 911 for emergency assistance and intubation. Chacon made this choice despite the fact that his own procedure manual dictates an immediate call to 911 after a cardiac arrest. In addition, I believe the above listed

information proves Chacon made the conscious decision to stop others from providing emergency lifesaving efforts on at least 7 occasions. This is evidenced by the following:

Chacon ordered his employees not to call 911.

Moises Espinoza called Divino at approximately 2:30 P.M. to check on his wife. Chacon instructed his employees to lie about her condition. Moises would likely have called 911 himself if he had been told about his wife's true condition.

Moises Espinoza called Divino at approximately 3:30 P.M. to check on his wife. Chacon instructed his employees to lie about her condition.

Chacon lied to Dr. Lozano, stating the patient had never lost a pulse, or blood pressure. If Lozano had been informed of the true facts, he, **"would have called 911 himself."**

Chacon made a second call to Lozano, again hiding the true facts. Chacon then declined Dr. Lozano's offer to come in and assist.

Chacon called Dr. Dinh at 4:49 P.M. and hid the fact that Espinoza's heart had stopped. Dinh told Chacon to call 911, but Chacon did not.

Chacon called Dr. Dinh at 5:03 P.M. and hid the fact that Espinoza's heart had stopped. Dinh told Chacon to call 911, but Chacon did not.

I believe Chacon engaged in an effort to conceal his conscious disregard for Megan Espinoza's life by:

Lying to Dr. Lozano and Dr. Dinh about Megan Espinoza's true condition. Chacon's calls to these doctors were for plausible deniability and an attempt to spread the blame for how he mishandled the emergency.

Lying to the 911 Dispatcher about Megan Espinoza's true condition to create a false official record and cover up her dire physical condition.

Lying to the accreditation representative and omitting the almost 3-hour delay in calling 911.

Lying in his civil deposition about what he told Dr. Lozano and Dr. Dinh during his phone calls regarding Megan Espinoza's cardiac arrest and his ineffective resuscitation efforts.

Bail Considerations:

I believe the above listed information proves that Carlos Chacon is a danger to the public. Chacon currently holds a valid medical license and is free to continue performing surgical procedures. Chacon showed conscious disregard for Megan Espinoza's life. There is no indication he would show regard for the lives of others if permitted to continue performing

surgery. I also believe Chacon is a flight risk. Although he is currently facing charges for involuntary manslaughter, the exposure for Murder in the Second Degree is much greater. If Chacon is no longer allowed to practice medicine as a result of this charge, he no longer has an incentive to remain in this state, or in the United States. To the contrary, it may provide Chacon with the incentive to flee to Mexico, where he may be free to practice medicine. Therefore, I respectfully request that no bail be authorized.

WHEREFORE, your declarant prays for the issuance of a warrant for the arrest of the above-named defendant for the above listed violations.

The description of Carlos Orlando Chacon is as follows:

DOB: 11/13/1974; EC: Brown; HC: Brown; HT: 5'10"; WT: 200 LBS.; RACE: Hispanic;
SEX: Male; California DL#: F4506877; SSN: 600-62-0678

I declare on information and belief that the foregoing is true and correct under penalty of perjury.

Executed in San Diego County, California, on the day of April 4, 2023.

M. Brown 159

Declarant

Scheduled bail: None
Bail Recommendation: $5 Million.

Reviewed for legal sufficiency by
Gina Darvas
Deputy District Attorney

Declaration read;
bail
Probable cause to arrest found;
Warrant to issue.

Judge of the Superior Court

The defendant is to be admitted to

in the sum of Nobail ~~dollars~~.
~~RC1275.1 request checked above[ ] IS~~
~~[ ] IS NOT granted~~ GGJ
4/6/23
Date