OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

February 2, 2022

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

Re: Custodial Death on February 9, 2021
Death of Inmate Randy Jay Shelton
District Attorney Investigations Case #21-000429
Orange County Sheriff's Department Case #21-004541
Orange County Crime Laboratory Case #21-41663

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the February 9, 2021 custodial death of 43-year-old inmate Randy Jay Shelton.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Randy Shelton. 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 February 9, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Central Men's Jail, where Randy Shelton died while in custody having been discovered hanging from his bedsheet. During the course of this investigation, the OCDASAU interviewed more than twenty 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 related 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 Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On November 7, 2018, Randy Jay Shelton was arrested by the Orange Police Department for attempted murder. Upon his initial intake screening, Shelton denied having any history of mental health issues or suicidal ideations. While in custody, Shelton received mental health services for suicidal ideations. In February 2019, Shelton was attacked by fellow inmates. Thereafter, Shelton expressed suicidal ideations to medical staff. He was placed into protective custody in March of 2019. As part of this protective custody, Shelton was in a single man cell and not allowed out at the same time as other inmates.

In June of 2019, Shelton was overheard telling another inmate that he (Shelton) was going to use suicidal ideations as a means to be moved into a different housing location, and during the movement was going to pass something. A registered nurse (RN) spoke with Shelton. Shelton told the RN that he received a phone call from his family that left him feeling depressed and suicidal. He was sent to the Psychiatric Module under full precautions and was subsequently seen by mental health staff. Shelton denied any suicidal or homicidal ideations. He also consented to taking medication. Eventually, the medication was discontinued because he repeatedly refused to take it. However, Shelton still attended periodic mental health evaluations and reported that he was doing well.

On February 2, 2021, Shelton had a routine follow-up with a mental health care professional where he expressed that he was "doing good" and denied any suicidal ideations, homicidal ideations,

auditory hallucinations, or visual hallucinations. He was scheduled to follow-up again in sixty (60) days.

On February 9, 2021, at approximately 3:45 a.m., Shelton was housed in Module C, Tank 13, Cell 7. While delivering breakfast to inmates, Deputy Bowen placed Shelton's breakfast on the bars of Shelton's cell. Deputy Bowen saw Shelton on Shelton's bunk and did not disturb him. When breakfast was delivered, one of Shelton's fellow inmates (Inmate 1) recalled seeing Shelton in his cell through the reflection of an enclosed glass corridor. After breakfast was delivered, another inmate (Inmate 2) asked Shelton if he wanted Inmate 2's cereal. Shelton declined Inmate 2's offer. A different inmate (Inmate 3) heard gurgling sounds coming from Shelton's cell after receiving his breakfast. Inmate 3 thought that Shelton was only throwing up, otherwise he would have reported it. At approximately 4:00 am, Deputy Zavala conducted a physical count of inmates. Due to COVID-19 protocols, the count was done from the enclosed glass corridor. Deputy Zavala saw Shelton in his bed and observed Shelton's body moving. Deputy Zavala logged Shelton as being present during the count.

Deputies Bowen, Zavala, and Perez conducted safety checks from the corridor at approximately 5:05 a.m., 5:50 a.m., and 6:50 a.m., respectively. None of the deputies reported seeing anything out of the ordinary. Deputy Vasquez conducted a safety check at approximately 7:40 a.m. from the corridor and did not report anything unusual or out of the ordinary. Deputy Vasquez recalled seeing Shelton but did not recall what he was doing or how he was dressed.

At approximately 7:45 a.m., on February 9, 2021, a Correctional Service Technician (CST) assisted by four inmate workers, performed a clothing exchange. During the clothing exchange, Shelton's body was observed by the CST hanging from a bedsheet near the back of his cell. The bedsheet was tied around Shelton's neck. The CST mistakenly broadcasted over the radio that there was a "Man Down" in Tank 7, then corrected it to Tank 13, Cell 7. At approximately 7:47 a.m. several OCSD deputies arrived at Shelton's cell.

Deputies observed Shelton in Shelton's cell near the back-right corner. Shelton was unresponsive and a sheet was around Shelton's neck up to the bars that were in front of the light in back of the cell. Shelton's body felt cool/cold. Deputy Popelar lifted Shelton to relieve some of the tension from the sheet being wrapped around Shelton's neck. Additionally, deputies worked to free Shelton from the sheet and quickly move Shelton's body from the cell onto the floor in front of Shelton's cell. Deputies checked for and could not find a pulse. Shelton was pale, unresponsive, and his eyes were wide open. Deputy Popelar began to administer Cardiopulmonary Resuscitation (CPR) with Deputy Vasquez giving breaths with a bag valve mask. The deputies alternated performing CPR until jail medical staff arrived shortly thereafter.

Typically, inmates who require a "Man Down" radio transmission have overdosed, so an RN administered Narcan nasally and then intramuscularly. That same RN attached an Automated External Defibrillator (AED) device to Shelton. Deputies and the RN alternated performing CPR on Shelton while the AED ran three (3) cycles.

At 8:00 a.m., the Orange County Fire Authority (OCFA) arrived and contacted Shelton. OCFA personnel observed Shelton as being nonresponsive, pale, cold, and his pupils were fixed and dilated. Paramedic 1 attached a heart rate monitor to Shelton and discovered that he was in asystole. OCFA pronounced Shelton dead at 8:02 a.m.

During the investigation, OCSD deputies described Shelton as a quiet inmate who kept to himself. They did not notice any change in his behavior prior to his death. His fellow inmates described him

as a lively man, who had been acting differently within the last week. Rather than his usual self, Shelton had become withdrawn, was not eating, stopped shaving, and was working out frequently. Shelton told the inmates that he was fine.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- White boxers
- White sheet from Shelton's cell
- Bloodstain standard
- 55 Autopsy photographs
- 18 Post embalming photographs
- 93 OCCL scene photographs

AUTOPSY

On February 17, 2021, independent Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Randy Shelton. On July 12, 2021, Dr. Luzi amended his final findings of Shelton's death, determining the cause of death to be hanging and the manner of death as a suicide.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Shelton's postmortem blood yielded no significant findings or results. The postmortem blood may have contained caffeine but no additional testing was done to confirm this.

BACKGROUND INFORMATION

Randy Shelton did have a State of California Criminal History record that revealed arrests for: Robbery, Carrying a Loaded Firearm, Assault with a Firearm, Shooting at an Inhabited Dwelling, Attempted Murder, Battery by a Prisoner, Exhibiting a Deadly Weapon, and Obstructing an Officer.

THE LAW

Homicide is the killing of one human being by another. Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. To prove that a person is guilty of murder, the following must be proven:

a. The person committed an act that caused the death of another person;
b. When the person acted he/she had a state of mind called malice aforethought; and
c. He/she killed without lawful excuse or justification.

There are two kinds of malice aforethought, express malice and implied malice. Express malice is when the person unlawfully intended to kill. Implied malice requires that a person intentionally committed an act, the natural and probable consequences of the act were dangerous to human life, at the time he acted he knew his act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

A person can also commit murder by his/her failure to perform a legal duty, if the following conditions exist:

a. The killing is unlawful (*i.e.*, without lawful excuse or justification);
b. The death is caused by an intentional failure to act in a situation where a person is under a

duty to act;
c. The failure to act is dangerous to human life; and
d. The failure to act is deliberately performed with knowledge of the danger to, and with conscious disregard for, human life.

A person can also commit involuntary manslaughter by failing to perform a legal duty, if the following conditions exist:

a. The person had a legal duty to the decedent;
b. The person failed to perform that legal duty;
c. The person's failure was criminally negligent; and
d. The person's failure caused the death of the decedent.

In *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:

> "[T]he 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 acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he acts is so different from how an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

This is not a case involving express or implied malice. Rather, the only issue is whether there was a murder or involuntary manslaughter for failure to perform a legal duty that caused Shelton's death. Due to Shelton's incarceration, OCSD owed him a duty of care.

Although the OCSD owed Shelton a duty of care, the evidence does not support a finding that this duty was in any way breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). Shelton's history of mental health struggles was well-documented and the appropriate care was exercised at each turn. He was placed in the Psychiatric Module for safety, even after Shelton was overheard saying he was going to use suicidal ideations as a reason to be transferred. Shelton was also reassigned to protective custody for his safety. He was prescribed medication and was consistently meeting with jail medical staff for follow-up evaluations.

Furthermore, Shelton's suicide was not foreseeable. Safety checks were conducted within each hour, and no deputies documented anything unusual. Prior to Shelton's death, Shelton had met with jail medical staff, denied any suicidal ideations, and said that he was doing well. Though Shelton's fellow inmates had noticed some changes in his behavior, none of them reported such changes to the deputies or jail medical staff. Shelton also did not alter his behavior towards the deputies. The deputies had no reason to believe that Shelton would kill himself on February 9, 2021.

After the CST reported finding Shelton hanging in his cell, deputies responded promptly. They attempted lifesaving measures and continued to do so after the arrival of jail medical staff. Then, the jail medical staff continued to attempt life saving measures until paramedics arrived. Paramedics then promptly discovered Shelton was in asystole and pronounced him dead.

Thus, 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.

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 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 Shelton. The evidence shows that Shelton died as a result of ligature hanging and that the death was a suicide.

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

DOMINIC BELLO
Deputy District Attorney
Gangs/Target Unit

READ AND REVIEWED BY **BARBARA KIM**
Assistant District Attorney
Special Prosecutions Unit

2-3-2022

READ AND APPROVED BY DISTRICT ATTORNEY **TODD SPITZER**