OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

June 8, 2023

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

Re: Custodial Death on April 17, 2022
Death of Inmate Mark Francis Morrell
District Attorney Investigations Case # 22-001165
Orange County Sheriff's Department Case # 22-012541
Orange County Crime Laboratory Case # 22-44478

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion regarding the April 17, 2022, custodial death of Mark Morrell.

OVERVIEW

This letter describes the criminal investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of all Orange County Sheriff's Department (OCSD) personnel involved with this incident as well as any other individuals working under the supervision of the OCSD.

On April 17, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to University of California, Irvine Medical Center (UCIMC) in the City of Orange, where Morrell died after receiving medical treatment. At the time of the events surrounding Morrell's death, he was in the custody of OCSD and was incarcerated at its Theo Lacy Facility (TLF). Accordingly, investigation of the matter falls within the purview of OCDASAU.

During the course of this investigation, the OCDASAU interviewed 37 witnesses, reviewed reports from the OCSD and the Orange County Crime Laboratory (OCCL), and obtained 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 does not address issues relating to policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating the deaths of individuals occurring in Orange County 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. Additional OCDA investigators assigned to other units in the OCDA are trained to assist when needed. On average, eight investigators respond to an incident within an hour of being called. These investigators perform a variety of functions that include witness interviews, scene processing, evidence collection, and other responsibilities as needed. Naturally, the specific scope of each investigation depends, to a degree, on the circumstances surrounding the death and the information provided by witnesses or obtained through records, photographs, and autopsy findings. The OCDASAU audio records all interviews, and the OCCL processes all physical evidence related to each investigation.

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. Thus, when the lead OCDASAU Investigator has concluded the investigation, the file is turned over to an experienced deputy district attorney for legal review. If necessary, the reviewing prosecutor will send the case back for further investigation.

Throughout the review process, the assigned prosecutor will consult with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting reports and correspondence. It is also common for the matter to be reviewed by several experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews and approves all officer involved shootings and custodial death letters.

FACTS

On April 6, 2022, at 6:53 p.m., Morrell was arrested by the Westminster Police Department (WPD) for outstanding warrants. At approximately 9:12 p.m., Morrell completed a COVID-19 Screening Questionnaire administered by a WPD jailer and answered "yes" to having experienced fever/chills, shortness of breath or difficulty breathing, fatigue, muscle aches, headache, and nausea or vomiting in the last 48 hours. He was then transported to the Orange County Jail Intake/Release Center (IRC). At the IRC, an Orange County Health Care Agency (OCHCA) custodial care nurse attempted to conduct a Medical and Mental Health Receiving Screening of Morrell, however he became agitated and uncooperative. At one point, he began banging his head against the wall and the screening was halted. Morrell was then examined for any self-inflicted physical injuries and nothing visible was observed. He was subsequently referred to Mental Health Triage and booked into the IRC.

On April 7, 2022, at 8:46 a.m., an OCHCA registered nurse (RN) completed Morrell's Medical and Mental Health Receiving Screening. Morrell was diagnosed with hypertension and Hepatitis-C. He denied having a history of alcohol or drug abuse and denied experiencing any fever, chills or body aches. Morrell disclosed he was previously treated for depression and psychosis while incarcerated and had been prescribed medication, however he stated that he no longer took the medication. Morrell was given a 20-milligram dose of Lisinopril to treat his hypertension and a follow-up medical exam was scheduled for April 21, 2022. Morrell was then cleared for regular housing.

At approximately 12:35 p.m., Morrell was transferred from the IRC to the TLF and housed in COVID-19 Quarantine Module-M, Sector 27, in Cell 11. Cell 11 is a two-man cell that Morrell shared with another inmate.

At 4:40 p.m., an OCHCA provider completed a Mental Health Screening of Morrell. Morrell was alert and responsive, and oriented to person, place, time, and situation. He was cooperative, appropriate in his appearance, and denied any prior suicide attempts or current suicidal ideations.

OCHCA personnel checked Morrell's vital signs daily between April 7, 2022, and April 11, 2022. Each time his blood pressure was observed to be normal and stable. During a follow-up evaluation by an OCHCA Mental Health Clinician on April 12, 2022, Morrell reported he was eating and sleeping well. He denied any suicidal or homicidal ideations, and he appeared clean, mildly unkept, calm, and cooperative.

On April 14, 2022, at approximately 11:07 a.m., Morrell complained of shortness of breath and abdominal discomfort to OCHCA personnel. An RN from OCHCA examined Morrell and noted he appeared anxious, but was alert and oriented. Morrell's blood pressure was 102/68, his pulse was 85, and his respirations were even and unlabored. Initially, Morrell was cooperative with the RN and willing to answer questions. However, he later became agitated and refused to answer questions. He was given Gatorade, 50 mg of Benadryl, and referred to an OCHCA Nurse Practitioner (NP).

The NP noted Morrell showed no signs of distress and was conscious and alert. His lungs were clear and his vital signs were normal. Morrell initially responded to the NP's questions, but became increasingly agitated to the point of preventing the NP from completing the examination. The NP suspected Morrell had experienced a panic attack and recommended relaxation techniques, ordered Albuterol four times per day and Gatorade twice daily, and suggested Morrell follow-up with the Mental Health Unit.

On April 15, 2022, at 1:19 p.m., an OCHCA RN attempted to give Morrell his Gatorade. Morrell again became uncooperative and was returned to his cell. At 9:17 p.m., another OCHCA RN went to Morrell's cell to complete a medical assessment. This time Morrell accepted the Gatorade without difficulty. When asked to come out of his cell, Morrell responded, "No, I'm comfortable and I'm not getting up." He told the RN, "I feel so bad. I always feel like this." Despite his complaint, Morrell refused to provide any further details. He was advised to contact medical personnel and deputies if his condition changed or worsened, and the assessment was ended.

On April 16, 2022, inmates in Cells 11, 13, and 15 were allowed out of their cells between 2:30 p.m. and 5:20 p.m. for what is referred to as "Dayroom." During this time period, inmates are allowed to move throughout their sector. When subsequently interviewed as part of this investigation, Morrell's cellmate reported that Morrell stayed in the cell during Dayroom that day and spent most of his time sleeping on his bunk.

The security and safety of each TLF housing unit, including Module-M, is coordinated by a manned Guard Station, which is a secured area that inmates cannot typically access. Module-M consists of six sectors, including Sector 27 where Morrell was housed. From the Module-M Guard Station, assigned personnel can monitor all six sectors. At minimum, all TLF housing Guard Stations are staffed by a Guard Station Deputy, Sheriff's Special Officer, or Correctional Services Assistant (CSA). The Guard Stations are staffed 24 hours a day, 7 days a week. Because Guard Stations are fixed posts, assigned staff may only leave when properly relieved and may only leave a Guard Station unattended if directed by OCSD personnel with the rank of Sergeant or above.

On April 16, 2022, at 6:30 p.m., Deputy Jeremiah Gil and CSA Brendon Orozco began their shift in Module-M. CSA Orozco was assigned to the Guard Station. His responsibilities included assisting Module-M deputies with duties such as monitoring inmates, maintaining custodial logs, and operating mechanized jail doors. Although an additional deputy was assigned to Module-M between the hours of 6:30 p.m. and 8:30 p.m. and later between 2:00 a.m. and 6:00 a.m., Deputy Gil and CSA Orozco were the only OCSD staff assigned to Module-M between 8:30 p.m. and 2:00 a.m.

Between 6:30 p.m. and 10:36 p.m., eight Safety Checks, each approximately 45 minutes apart, were completed, as well as one Book Count. No incidents were reported. During that same timeframe, TLF security cameras captured Morrell getting off his bunk, using the toilet, and returning to his bunk eight times. Morrell and his cellmate were the only people in Cell 11 during this time period. Morrell and his cellmate did not appear to interact with each other, but Morrell's cellmate can be seen moving around the cell and periodically talking with other inmates through the closed cell door.

Deputy Gil can be seen on security camera recordings checking Morrell's cell at 11:21 p.m. as part of a Safety Check. This Safety Check was completed at approximately 11:24 p.m. After completing the Safety Check, Deputy Gil left Module-M at approximately 11:27 p.m. and went to the Booking Loop to pick up eight new Module-M prisoners. During this time period, CSA Orozco supervised Module-M alone from the secured Guard Station.

At approximately 11:32 p.m., Morrell was observed on security camera recordings slowly walking toward the southwest corner of the cell where an intercom is located. At 11:33 p.m. he activated the intercom, which in turn activated an emergency panel in the Guard Station. Morrell then stood upright, swayed side-to-side, forward and backward, and fell backward onto the floor out of view of security cameras. Morrell's cellmate later reported he heard Morrell press the intercom, but stated he did not know why Morrell had activated the intercom and could not hear what Morrell was saying.

Upon being alerted to the emergency activation from Morrell's cell, CSA Orozco looked out of the Guard Station toward Cell 11, in Sector 27, but saw no movement. He immediately utilized the intercom in an attempt to speak with anyone in the cell. During his subsequent voluntary interview, CSA Orozco stated that he initially heard a male briefly yell as if in pain, but then received no response from Cell 11. CSA Orozco stated that he could see Cell 11 from the Guard Station, but did not see anyone at the cell's intercom or any movement inside the cell. He decided to continue monitoring Cell 11 from the Guard Station until Deputy Gil returned.

In his voluntary interview, Deputy Gil stated that he returned from the Booking Loop with the prisoners, unchained the first two and told them where to go. CSA Orozco then informed him of what had occurred in Morrell's cell.

A review of TLF security video showed Deputy Gil returned to Module-M at approximately 11:36 p.m. with eight new inmates in waist chain restraint handcuffs. Two of the inmates waited outside the Guard Station while Deputy Gil admitted the six other inmates into the Module-M Outdoor Recreation Area. He then proceeded to un-handcuff each inmate individually. At approximately 11:38 p.m., Deputy Gil opened the door to the Guard Station and positioned himself partially inside while two inmates collected bedding stored nearby and made their way into a sector to the right of the Guard Station. At approximately 11:39 p.m. the door to Sector 27 opened remotely and Deputy Gil went inside to Cell 11.

Deputy Gil reported that using his flashlight, he was able to see Morrell through the cell door lying on the floor. Morrell's eyes were open and he appeared to be breathing. Morrell did not respond when Deputy Gill called out to him. Deputy Gil directed CSA Orozco to open the cell door from the Guard Station and then ordered Morrell's cellmate, who appeared to be sleeping on the top bunk, to exit the cell. Once the cellmate exited, Deputy Gil entered and found Morell unconscious and unresponsive with apparent vomit in his mouth.

At approximately 11:41 p.m., Deputy Gil requested medical personnel respond to Module-M via his handheld radio. He then proceeded to pull Morrell out of the cell in preparation of emergency services and placed Morrell on his left side in a recovery position. A second deputy, Deputy Danny Phabmixay, arrived to assist Deputy Gil at 11:42 p.m. and requested paramedics respond. As can be seen on video surveillance, an additional deputy and OCHCA medical personnel arrived within approximately three minutes of Deputy Gil's broadcast. The medical personnel included two OCHCA RN's who determined Morrell's respirations were agonal and his pulse was weak. Morrell was provided oxygen via an Ambu bag and was administered Narcan intra-nasally, which appeared to have no effect.

At 11:48 p.m., Morrell's heart stopped and his breathing appeared to cease. Deputies and medical personnel began cardiopulmonary resuscitation (CPR) and applied automated external defibrillator (AED) pads, however the AED recommended no shock. OCSD and OCHCA personnel continued CPR, waiting several times for the AED to analyze Morrell's heart rhythm until Orange Fire Department (OFD) paramedics arrived at 11:53 p.m. and began tending to Morrell. The paramedics utilized a LUCAS device to administer mechanical chest compressions, attached a four-lead heart monitor to Morrell's chest, and established an intraosseous line. On April 17, 2022, at 12:05 a.m., Morrell was transported by ambulance to UCIMC. During transport, Morrell's heart rhythm was observed as asystole and cardiac arrest protocols were initiated.

Morrell arrived at UCIMC at 12:19 a.m. in full cardiac arrest. The medical staff initiated advanced life-saving protocols, and Morrell's vital signs briefly began to improve. After a few seconds, however Morrell's condition quickly declined once again. A cardiac ultrasound was conducted and confirmed that Morrell's heart was no longer beating. The treating doctor determined that life-saving efforts were futile and ordered the termination of all medical interventions. Morrell was pronounced deceased at 12:41 a.m.

EVIDENCE COLLECTED

During the course of the investigation, the following items of evidence were collected and examined:

- Swabs from decedent's face, neck, and hands
- One (1) t-shirt
- One (1) pair of pants
- One (1) pair of boxer shorts
- Miscellaneous OCJ paperwork found in decedent's pant pockets
- Two (2) swabs of a brown stain of the floor of decedent's OCJ cell
- Twenty-four (24) photographs of the UCIMC hospital scene / decedent
- Thirty-eight (38) photographs of the jail scene
- Forty-eight (48) autopsy photographs
- Eighteen (18) post embalming photographs

AUTOPSY

On April 21, 2022, Independent Forensic Pathologist Scott Luzi, M.D., conducted an autopsy on the body of Morrell at the Orange County Sheriff-Coroner Forensic Science Center. The relevant autopsy findings are as follows:

- **Major Injuries:**
  - None
- **Minor Injuries:**
  - Contusion, left buttock
  - Contusion, right ante-cubital fossa
  - Contusions, right knee and leg
  - Contusions, left knee
- **Natural Disease and Pre-existing Conditions:**
  - Healing abrasions; forehead, right elbow, left elbow, right leg
  - Pulmonary congestion and edema
  - Cardiomegaly
  - Moderate coronary atherosclerosis
  - Moderate peripheral atherosclerosis
  - Nephrosclerosis
  - Chronic gastritis

Dr. Luzi concluded that Morrell's cause of death was hypertensive and atherosclerotic cardiovascular disease. Dr. Luzi concluded the manner of death was natural.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Morrell's postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Diphenhydramine	Postmortem Blood	0.0648 +/- 0.0088 mb/L
Citalopram	Postmortem Blood	Detected
Norcitalopram	Postmortem Blood	Detected
Atropine	Postmortem Blood	Detected
Naloxone	Postmortem Blood	Detected
N-desmethyl cyclobenzaprine	Postmortem Blood	Detected
Ethanol / Volatiles	Postmortem Blood	Not Detected
Barbiturates	Postmortem Blood	Negative
Cannabinoids	Postmortem Blood	Negative

BACKGROUND INFORMATION

Morrell had a Criminal History Arrest Record from the States of California, Idaho, and Utah that revealed arrests for the following violations:

- Child Cruelty with Injury or Death
- Harm or Death of an Elder / Dependent Adult
- Arson
- Causing a Fire of a Structure or Forest Land
- Attempt to Aid, Counsel, or Procure Arson
- Assault on a Peace Officer or Emergency Personnel
- Obstructing a Public Officer
- Threaten a Crime with the Intent to Terrorize
- Burglary
- Petty Theft
- Battery
- Possession of a Blank Check to Defraud
- Defrauding an Inn Keeper
- Disturbing the Peace
- Vandalism
- Trespassing
- Entering a Non-Commercial Dwelling without Consent
- Being Under the Influence of a Controlled Substance
- Driving Under the Influence of Alcohol or Drugs
- Possession of a Controlled Substance
- Possession of Controlled Substance Paraphernalia
- Possession of an Open Container
- Parole Violation
- Probation Violation
- Violation of a Court Order
- Failure to Appear

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

There is no evidence of express or implied malice on the part of any OCSD personnel, 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 Morrell 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). Morrell was provided access to health care and assessed by OCHCA personnel multiple times while in custody prior to his death. However, Morrell was not always cooperative with medical staff.

On April 16, 2022, during the hours leading up to Morrell's death, deputies assigned to Module-M completed eight Safety Checks approximately 45 minutes apart without incident. Deputy Gil completed the eighth Safety Check at approximately 11:24 p.m., nine minutes before Morrell activated the intercom in his cell at 11:33 p.m. Deputy Gil reported that he looked in every cell during the safety check and nothing stood out to him as being unusual. He is also seen on jail security cameras checking Morrell's cell at approximately 11:21 p.m.

Based on the evidence, there is nothing to indicate that any OCSD personnel acted in a way that was so different from how an ordinary careful person would act in the same situation, as criminal negligence requires. Moreover, criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgement. When Morrell activated the cell's intercom and yelled, CSA Orozco immediately attempted to establish communication with Morrell from the Guard Station. CSA Orozco could see Cell 11 from his vantage point in the Guard Station, but he could not see any movement in the cell or anyone at the cell doorway. He indicated in his interview that he did not have reason to believe an assault was occurring. CSA Orozco also explained that he was familiar with Morrell insofar that Morrell would come out of his cell for "treatments." According to CSA Orozco, treatments involve nurses administrating inmates' items such as medication and electrolyte drinks. Nurses may also check inmates' vital signs during treatment. In regards to Morrell, however, CSA Orozco had "no idea" why Morrell was receiving treatment from medical staff.

Once Morrell activated the Cell 11 intercom, CSA Orozco chose to continue monitoring the cell while attempting to get a response from the Guard Station. This was in compliance with OCSD policy that prohibited CSA Orozco from leaving his post to personally check on Morrell. Morrell's cellmate never communicated with CSA Orozco via the intercom or otherwise indicated that Morrell was suffering a medical emergency. In other words, other than Morrell's initial use of the intercom, there is no evidence to indicate that CSO Orozco was or should have been aware of Morrell's condition or any need for medical intervention.

When Deputy Gil returned to the area with the newly acquired prisoners, CSA Orozco timely notified him of the situation. Once the prisoners were secure, Deputy Gil responded to Cell 11 at 11:39 p.m. and discovered Morrell on the floor of his cell unconscious but breathing. From that time, jail personnel immediately began administering lifesaving procedures until 11:53 p.m. when OFD paramedics arrived and assumed medical responsibility for Morrell.

Thus, there is insufficient evidence to support a finding that OCSD personnel or any individual under the supervision of the OCSD breached their duty of care to Morrell or failed to perform a legal duty. Once reasonably aware of Morrell's medical emergency, OCSD took all appropriate steps to provide him with immediate care.

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 that any OCSD personnel failed to perform a legal duty owed to Morrell. The evidence shows that Morrell died as a result of hypertensive and atherosclerotic cardiovascular disease, rather than the actions of OCSD personnel or those under OCSD's supervision.

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

ADAM ZAMORA
Deputy District Attorney
Gang/Target Unit

READ AND REVIEWED BY **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

READ AND APPROVED BY **TODD SPITZER**
District Attorney