OFFICE OF THE
# DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

September 28, 2023

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

Re: Custodial Death on November 6, 2022
Death of Inmate Roderick Dunning
District Attorney Investigations Case # 22-003395
Orange County Sheriff's Department Case # 22-038065
Orange County Crime Laboratory Case # FR 21-55233
Orange County Coroner's Office Case # 22-06482-CO

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the November 6, 2022 custodial death of 58-year-old inmate Roderick Dunning.

## OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Dunning. 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 November 6. 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), 1001 North Tustin Avenue, Santa Ana, where Dunning died while in custody. During the course of their investigation of Dunning's death, the OCDASAU interviewed two witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, jail surveillance footage, medical records 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 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 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.

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 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 memos. It is also common for the case to be reviewed by several experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews all officer involved shootings and custodial death letters.

## FACTS

On Friday, May 22, 2020, Dunning was arrested by the Santa Ana Police Department (SAPD) for robbery, assault with a deadly weapon, resisting a peace officer, causing harm to an elder, and possession of an open container of alcohol. The following day, May 23, 2020, he was booked into the OCSD Men's Central Jail (OCJ).

On Wednesday, August 19, 2020, at approximately 9:00 a.m., Dunning was declared mentally incompetent by the Orange County Superior Court. He was subsequently transferred to the California Department of State Hospitals for participation in the Jail-Based Competency Treatment Program.

On Monday, February 21, 2022, Dunning was returned from the Metropolitan State Hospital in Norwalk and was booked into the OCJ Intake / Release Center (IRC). At IRC, Dunning was screened by personnel from the Orange County Health Care Agency (HCA). During this screening Dunning did not exhibit any abnormal health issues. He was noted, however, to have a prior history of schizophrenia.

The following day, he was transferred to IRC Module L, Sector 15, Cell 15. Module L is a housing unit for inmates with mental health and medical issues.

On Thursday, October 20, 2022, at approximately 8:00 a.m., HCA medical staff were distributing medications and providing medical treatment to inmates in Module L. At that time, Dunning complained of nausea and vomiting. He was examined by an HCA physician and complained of chest pain. An electrocardiogram (EKG) was administered and blood sample analysis was ordered. From the EKG, Dunning's heart was observed to have abnormal heart rhythms.

At approximately 8:30 a.m., Orange County Fire Authority (OCFA) paramedics were requested. At approximately 8:36 a.m., Dunning, with the assistance of medical staff, walked out of his cell and was seated at a table in the Dayroom area of Sector 15. From there, he was cared for by the medical staff while awaiting paramedics.

At approximately 8:42 a.m., OCFA paramedics arrived and at 8:46 a.m., assumed care for Dunning. He was subsequently transported to OCGMC.

Following his arrival at OGCMC at approximately 9:18 a.m., Emergency Room personnel began caring for Dunning. Another EKG showed he had suffered an ST-Elevation Myocardial Infarction (STEMI)[1] and a lesion to the left anterior descending artery. At that time, a balloon angioplasty was performed.[2]

On Monday, October 24, 2022, a Repeat Heart Catheter was inserted in Dunning's heart due to cardiogenic shock,[3] a condition most often caused by a severe heart attack. The following day, two stents were placed in Dunning's heart.

On Friday, October 28, 2022, a medical procedure was performed to remove the intra-aortic balloon.

On Friday, November 4, 2022, at approximately 3:58 p.m., OCGMC staff detected that Dunning had rectal bleeding. Dunning was told he would need blood transfusions and an endoscopy. Dunning refused the recommended transfusion and endoscopy, even after being advised by OCGMC medical staff that doing so would be potentially life-threatening.

On Saturday, November 5, 2022, at approximately 1:10 p.m., Dunning was diagnosed with hematochezia[4] and agreed to a transfusion, but continued to refuse an endoscopy. One of Dunning's attending OCGMC attending physicians ordered the transfusion and again explained to Dunning the possible life-threatening risk of not performing the endoscopy. Dunning again refused to consent to the endoscopy. The physician noted in the medical records the advisement and Dunning's refusal.

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[1] STEMI is a form of heart attack in which a coronary artery is completely blocked.
2 Angioplasty is a minimally invasive surgical procedure during which a balloon is inserted into an artery.
[3] Cardiogenic shock is a life-threatening condition in which the heart is unable to pump sufficient blood throughout the body. It is most often the result of damage to a portion of the heart muscle resulting from a lack of oxygen-rich blood due to a heart attack.
[4] Hematochezia is a condition in which blood is being passed through the rectum.

On Sunday, November 6, 2022, at approximately 7:35 a.m., Dunning experienced a possible seizure, which was followed by cardiac and respiratory arrest. Cardiopulmonary resuscitation and advanced cardiac life support measures were initiated by OCGMC medical personnel to revive him. The efforts were unsuccessful.

At approximately 7:49 a.m., Dunning was pronounced deceased.

In a December 6, 2022, interview with an OCDA Investigator, OCGMC Registered Nurse Jane Doe 1, stated that she and several doctors advised Dunning that refusing the treatments could lead to death. She indicated that she was aware of the schizophrenia diagnosis and that Dunning was receiving medication for the condition. She indicated that during the time she was caring for him, he was always alert, oriented and able to make cognitive decisions.

## EVIDENCE COLLECTED

Forty-two digital color photographs of the hospital scene and body were collected as part of this investigation.

## AUTOPSY

On Tuesday, November 15, 2022, at approximately 9:50 a.m., Forensic Pathologist Doctor Chanikarn Lopez conducted the post-mortem examination of Dunning.

After the autopsy, Dr. Lopez stated the preliminary diagnosis was atherosclerosis of the aorta, atherosclerotic cardiovascular disease, narrowing of the left anterior descending artery, myocardial infarction, old myocardial infarction with left ventricular thrombus, and status post-stent placement.

On May 31, 2023, Dr. Lopez determined the final cause and manner of death was from complications of myocardial infarction due to atherosclerotic cardiovascular disease, and the manner of death was determined to be natural.

## EVIDENCE ANALYSIS

### Toxicological Examination

Samples of Dunning's ante-mortem and post-mortem blood were collected for testing. The following results and interpretations were documented:

| DRUG | MATRIX | RESULTS & INTERPRETATIONS |
|---|---|---|
| Ethanol/Volatiles | Postmortem Blood | Not Detected |
| Caffeine | Detected | Detected |
| Haloperidol | Not Detected | Detected |
| N-desmethylcyclobenzaprine | Detected | Detected |
| Norquetiapine | Detected | Detected |
| Quetiapine | Detected | Detected |

## BACKGROUND INFORMATION

Dunning had a criminal history arrest record dating back to 1990 from California and Nevada for the following violations:

- Arson
- Trespass to Build Fires
- Robbery with a Deadly Weapon
- Harm or Death of an Elder / Dependent Adult
- Assault with a Deadly Weapon, not a Firearm, with Great Bodily Injury Likely
- Assault with a Deadly Weapon, not a Firearm, on a Peace Officer or Firefighter
- Assault with a Deadly Weapon
- Battery on a Peace Officer or Emergency Personnel
- Obstructing a Public Officer
- Threaten a Crime with the Intent to Terrorize
- Exhibiting a Deadly Weapon, Not a Firearm
- Burglary
- Petty Theft
- Fighting or Challenging to Fight in Public
- Loitering About Schools
- Possessing an Open Container of Alcohol in a Vehicle
- Consuming or Possessing an Open Container of Alcohol Where Purchased
- Assault
- Littering
- Vandalism
- Trespassing
- Trespass / Obstruct a Business Operation
- Being Under the Influence of Drugs
- Disorderly Conduct
- Challenge to Fight Disorderly Conduct
- Destruction of the Property of Another
- Transportation and Sales of Narcotic / Controlled Substance
- Possession of a Narcotic / Controlled Substance
- Probation Violation
- Driving While License is Suspended or Revoked

## 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 or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Dunning 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). Dunning was evaluated by HCA personnel upon re-admittance to the OCJ in April of 2022. The examination found nothing abnormal, and he remained in custody without incident until October of 2022.

On October 20, 2022, when Dunning complained of nausea, vomiting and chest pain, he was immediately attended to by a qualified medical professional. When an EKG yielded an irregular heartbeat, paramedics were requested, and he was transported to the emergency room of OCGMC. The evidence shows that OCSD personnel at IRC followed all protocols and provided immediate medical care to Dunning.

Although legally still in custody at OCGMC, Dunning received extensive medical care for what was diagnosed to be a heart attack. When OCGMC medical personnel observed on November 4, 2022, that Dunning was suffering from rectal bleeding, they sought his consent for an endoscopy and transfusion. Despite being advised of the potentially life-threatening consequences, Dunning initially refused. The following day, and after again being advised of the risks of his leaving his condition unaddressed, Dunning consented to the transfusion, but not the endoscopy.

On November 6, 2022, Dunning suffered cardio and pulmonary arrest. Although he received immediate and advanced medical care at OCGMC, he could not be revived.

Similar to the care he received at IRC, there is no evidence to show that once transported to OCGMC that any OCSD personnel, or any individual under the supervision of the OCSD, failed to perform a legal duty owed to Dunning.

## CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Roderick Dunning.

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

Respectfully submitted,

**MARC ROZENBERG**
Deputy District Attorney
Special Prosecutions Unit

Read and Reviewed by **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

Read and Approved by District Attorney **TODD SPITZER**