OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

March 21, 2024

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

Re: Custodial Death on September 1, 2022
Death of Inmate Chris Anthony Villalobos
District Attorney Investigations Case # 22-002771
Orange County Sheriff's Department Case # 22-029700
Orange County Crime Laboratory Case # 22-49521

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 September 1, 2022, custodial death of 57-year-old inmate Chris Anthony Villalobos.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Villalobos. 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 Thursday, September 1, 2022, at approximately 12:10 p.m., Villalobos was discovered unresponsive in his cell at the Orange County Sheriff's Department Theo Lacy Jail Facility (TLF). He was transported to Saint Joseph's Hospital, 1100 West Stewart Drive, Orange, CA 92868 (SJH), where he was pronounced deceased at 1:13 p.m. The OCDASAU responded to that location at 2:07 p.m. and began their investigation. OCDASAU interviewed 29 witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, jail surveillance footage, 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 and approves all officer involved shootings and custodial death letters.

FACTS

On Saturday, August 27, 2022, Villalobos was arrested by the Anaheim Police Department (APD) for burglary and an outstanding probation violation warrant. Villalobos did not request any emergent or non-emergent medical services when he responded to questions on the APD Statement of Booking Officer. At approximately 4:11 p.m., Villalobos was evaluated by an Orange County Health Care Agency (HCA) Comprehensive Care Nurse (CCN) during the Receiving Screening at the OCSD Intake / Release Center (IRC). He did not disclose any medical issues. The CCN noted Bilateral Edema which Villalobos explained as, "I am homeless so I walk all the time." He was cleared for Regular Housing at TLF in Orange.

On Sunday, August 28, 2022, at approximately 12:04 p.m., Villalobos was transferred to TLF and housed in Module (Mod) R, Sector 58, Cell 6. A review of the Mod security video showed his arrival. When he entered Sector 58 he carried a rolled mattress on his left shoulder, climbed the stairs to the upper tier without apparent difficulty. At approximately 9:43 p.m., Villalobos' cell door opened remotely, and he left the cell in apparent distress. He walked across the upper tier supporting himself on the rail with his right hand and clutched his chest with his left hand. He stopped partway down the stairs and sat. He entered the Mod R Medical Exam Room and was evaluated by an HCA CCN. He complained of "bad pain" in the middle of his chest. He denied a history of acid reflux, but was given 420 mg of Calcium Carbonate with two cups of Gatorade. He was prescribed Calcium Carbonate Antacid orally and told to eliminate foods which cause gastrointestinal distress. He said, "I'm okay," and walked back to his cell.

On Wednesday, August 31, 2022, Villalobos was transferred from Mod R to Mod N. At approximately 9:06 p.m., Villalobos arrived in Mod N and complained of heartburn, nausea and vomiting. He was seen by an HCA CCN for acid reflux and was once again given 420 mg of calcium carbonate and Gatorade. He was again cleared for regular housing. At approximately 9:44 p.m., Villalobos entered Mod N, Sector 33 and was escorted to Cell 12.

Cell 12 was also occupied by another inmate, Inmate Doe. Cell 12 contained two bunks. Inmate Doe slept on the upper bunk while Villalobos occupied the lower bunk. When later interviewed, Inmate Doe stated that Villalobos complained about stomach pain, and said he would drink water and then vomit.

On Thursday, September 1, 2022, at approximately 2:41 a.m., an HCA Registered Nurse (RN) checked Villalobos' vital signs. His blood pressure was observed to be 100/75, temperature 97.3, pulse 89, respirations 16 and oxygen saturation 99. At approximately 6:45 a.m., Deputy Martin Tellez, Deputy Diego Gonzalez and Correctional Services Assistant (CSA) Charlie Ogdon began their work shift in Mod N. Deputies Tellez and Gonzalez performed safety checks, inmate movement, and other duties within the module. CSA Ogdon was assigned to the Guard Station and completed the logs.

In reviewing footage from the jail video security system, Villalobos could be seen between approximately 6:29 a.m. and 9:08 a.m. moving around his cell, at times hunched over on the floor near the door and intermittently vomiting in the toilet. On one occasion, Villalobos appeared to fall to the floor near the cell door, but thereafter continued to move around the cell. Four safety checks were conducted during the time period with no problems reported. Deputies Tellez and Gonzalez performed the checks. They reported that when they began their shift they were briefed by members of the previous shift and informed that Villalobos had been seen twice by medical staff for stomach issues and was cleared for housing in Mod N each time. Both deputies indicated they were aware Villalobos was scheduled for a medical follow-up at 9 a.m. Additionally, Deputies Tellez and Gonzalez stated Villalobos did not report any issues to them during their safety checks, and he did not appear in distress.

At approximately 9:12 a.m., Deputies Tellez and Gonzalez escorted an HCA RN to Cell 12 for the medical follow-up where she conducted a hydration check of Villalobos and provided Gatorade packets. Villalobos was sitting on the floor near the cell door and told her his stomach hurt. She conducted a visual assessment of Villalobos. Based on her observations, she concluded he was not in distress, did not have shortness of breath or nausea, and was not sweating or vomiting. She did not see anything which caused her further concern with his condition, so she did not take him to the clinic for further evaluation. At approximately 10:49 a.m., when Inmate Doe left the cell for his work detail, Villalobos was kneeling on the floor with his back toward the door facing the toilet. At approximately 11:33 a.m., Inmate Doe returned from his work detail and entered Cell 12. He had to squeeze past Villalobos who was sitting on the floor in front of the door. Villalobos was still vomiting, so Inmate Doe told him to keep the cell clean. Villalobos replied "okay" and said his stomach hurt. Inmate Doe climbed into his bunk, but could hear Villalobos making noises similar to snoring. He asked Villalobos if he was okay several times, to which Villalobos responded, "Yeah."

At approximately 12:10 p.m. on September 1, 2022, Deputy Tellez approached Cell 12 during a safety check and stopped. He told Inmate Doe to get down from the top bunk and wake Villalobos, but Villalobos did not move. Villalobos appeared to no longer be breathing. Deputy Tellez signaled

the Guard Station to open the cell door. Deputy Tellez attempted to locate a pulse and radioed there was a man down. Additional deputies and medical personnel responded. Cardiopulmonary resuscitation (CPR) was initiated. Villalobos was given multiple doses of Narcan in case of an overdose. An automated external defibrillator was attached, but never delivered a shock over multiple activations. Paramedics were summoned.

At approximately 12:30 p.m., the Orange City Fire Department (OFD) arrived in Sector 33 and assumed care of Villalobos. He was transported to SJH and was admitted to the Emergency Room in cardiac arrest. SJH medical staff took over treatment and were unsuccessful in reviving Villalobos. At approximately 1:13 p.m., Villalobos was pronounced deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Clothing - orange jail shirt, orange pants and black socks.
- Blood vials.
- Red substance in paper bindle (north storage shelf under top bunk in Cell 12), this substance was tested and determined to be 2-Methyl-4-(Methylthio)-2-Morpholinopropiophenone, commonly referred to as "bath salts."[1]

AUTOPSY

On Friday, September 9, 2022, at approximately 8:00 a.m., Forensic Pathologist Doctor Scott Luzi conducted the postmortem examination of Villalobos. After the autopsy, Dr. Luzi stated there were no significant signs of trauma to the body. Dr. Luzi noted pleural effusions, degenerative joint disease, pulmonary congestion and edema, cardiomegaly, moderate coronary atherosclerosis, mild to moderate peripheral atherosclerosis, nephrosclerosis and a perforated peptic ulcer. After a review of medical records, toxicology, and examination of the microbiological slides the cause of death was determined to be acute methamphetamine intoxication, with hypertensive and atherosclerotic cardiovascular disease listed as other conditions.

Toxicological Examination

A sample of Villalobos's postmortem blood and brain yielded the following results:

Drug/Alcohol	Postmortem blood	Brain
Methamphetamine	0.316 ± 0.023 mg/L	0.578 ± 0.041 mg/kg
Amphetamine	0.0677 ± 0.0050 mg/L	0.164 ± 0.013 mg/kg
Naloxone	Detected	Not tested

BACKGROUND INFORMATION

Villalobos had a State of California Criminal History record with prior arrests for the following violations:

- Robbery
- Assault with a Firearm
- Assault with a Deadly Weapon Not a Firearm

[1] There is no evidence to suggest Villalobos ingested bath salts. The toxicology results only indicated the presence of methamphetamine, amphetamine, and nalaxone. Bath salts do not metabolize as any of these substances.

- Threaten a Crime with the Intent to Terrorize
- Receiving Stolen Property
- Obtaining Credit Using Another's Identification
- Appropriation of Lost Property
- Possession of Tear Gas
- Burglary
- Driving Under the Influence of Alcohol or Drugs
- Possession of a Controlled Substance
- Possession of Paraphernalia
- Probation Violation

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 Villalobos 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). Villalobos displayed no signs of being under the influence of methamphetamine, and OCSD and HCA staff had no evidence to suggest he was suffering from methamphetamine poisoning. When medically evaluated, Villalobos never indicated that he had ingested methamphetamine, and in fact indicated to medical staff at least once as well as to his cellmate that although he was feeling pain, he was "okay."

Villalobos was found unresponsive in his cell by Deputy Tellez at 12:10 p.m., at which time life saving measures were performed and paramedics were requested. In the 30 minutes prior to when he was found unresponsive, Villalobos had been communicating with his cellmate, and although vomiting, had indicated that he was okay. During his incarceration at OCSD, each time Villalobos complained of discomfort he was seen by medical staff and treated. It appears that all reasonable steps were taken to provide Villalobos with medical care under these circumstances. 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 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 Villalobos.

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

Respectfully submitted,

ANNA MCINTIRE
Deputy District Attorney
Homicide Unit

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

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