



OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

May 7, 2024

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

Re: Custodial Death on September 29, 2022
Death of Inmate Margarita Luna
District Attorney Investigations Case # 22-003052
Orange County Sheriff's Department Case # 22-033312
Orange County Crime Laboratory Case # FR 22-50395
Orange County Coroner's Office Case # 22-05757-AY

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 September 29, 2022, custodial death of 45-year-old inmate Margarita Luna.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Luna. 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 all Orange County Sheriff's Department (OCSD) personnel as well as those under the supervision of the OCSD involved in this custodial death incident.

On September 29, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), where Luna died while in custody. During the course of their investigation of Luna's death, the OCDASAU interviewed two witnesses and obtained reports, incident scene photographs, medical records, and other relevant materials from the OCSD and the Orange County Crime Laboratory (OCCL).

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 shooting and custodial death letters.

FACTS

On September 10, 2022, at approximately 6:46 p.m., Costa Mesa Police Department (CMPD) Officer Guyon Foxwell arrested Luna for grand theft from the Sephora store located at South Coast Plaza.

At approximately 6:59 p.m., Officer Foxwell transported Luna to the CMPD jail for booking, processing, and housing. During the jail medical screening, Luna told Jail Custody Officer Miguel Villana-Allende she had used two grams of cocaine and one gram of fentanyl before being arrested. Luna did not disclose any other medical problems.

At approximately 11:45 p.m., CMPD Officer Daniel Dominguez transported Luna to the Orange County Jail Intake/Release Center (IRC) for booking, processing, and housing.

On September 11, 2022, at approximately 12:38 a.m., an Orange County Health Care Agency (OCHCA) Nurse Practitioner (NP) completed a medical receiving screening on Luna. Luna told the NP she had the following medical issues:

- Seizure disorder
- Cocaine usage - 12 hours prior to arrest
- Fentanyl usage -12 hours prior to arrest
- Xanax usage - 12 hours prior to arrest
- Methadone usage daily - 155 mg daily

- Daily cigarette smoker
- Took (unknown) prescribed medication

Luna was subsequently medically cleared for booking and housing. Luna was housed in the IRC Women's Module N, Tank 30, Cell 07, Bunk 02.

Luna was prescribed a wheelchair for two weeks and assessed for opiate withdrawal.

Luna signed an Authorization to Use & Disclose Protected Health Information form. This allowed Recovery Solutions of Santa Ana (RSSA), a substance abuse rehabilitation center that had been treating Luna, to provide OCHCA with her treatment history information for purposes of continuity of care.

Based on information from RSSA, Luna had been receiving treatment for opiate abuse since March 27, 2019. As part of her treatment regimen, Luna was prescribed methadone. Originally, she was prescribed a dose of 30 mg, however over time, this dosage steadily increased. On March 29, 2022, Luna was prescribed a daily dose amount of 155 mg.

While in custody at IRC, Luna refused medical treatment and checkups on the following dates for the following reasons:

- September 11, 2022 - Opiate withdrawal treatment – No reason given.
- September 12, 2022 - Opiate withdrawal treatment, vital sign check – No reason given.
- September 13, 2022 - Opiate withdrawal treatment – "I don't want it. I'm OK."

On September 13, 2022, at approximately 9:14 p.m., an OCHCA registered nurse (RN) completed a standard nursing assessment on Luna. Luna told the RN she had severe abdominal pain in her upper left quadrant area. Luna stated the pain started the day prior but she had not requested medical aid. Luna told the RN she had two intestinal abdominal surgeries two years prior and that she felt "the same way" before the surgeries. This information was reviewed by a nurse practitioner who determined Luna should be sent to the hospital for further evaluation.

At approximately 10:53 p.m., LifeLine Ambulance service transported Luna to the Anaheim Global Medical Center's (AGMC) Emergency Room (ER) for an abdominal evaluation. At approximately 12:15 a.m., Luna was admitted to the hospital. Several examinations were completed which revealed Luna had two perforated gastric ulcers, a fungal infection, and sepsis.

A medical procedure was performed to repair the ulcers and Luna was sent to recovery in fair condition.

On September 23, 2022, at approximately 6:00 p.m., Luna was discharged from the hospital with a medication order for her recovery. The following medications were prescribed for Luna:

- Methadone tablet - 155 mg oral daily.
- Omeprazole delayed-release capsule – 40 mg by mouth 2 times per day for 2 months.
- Acetaminophen (Tylenol) – 650 mg by mouth 4 times per day as needed.

Luna was then transported back to the IRC.

On September 28, 2022, at approximately 3:30 p.m., OCSD Deputies Kelly Chavez and Alyssa Maddalena observed Luna vomiting in her cell and notified medical staff.

An OCHCA RN and medical doctor responded to evaluate and treat Luna.

At approximately 3:37 p.m., the doctor determined Luna needed to be transported to the Orange County Global Medical Center (OCGMC) via paramedics for additional treatment due to shortness of breath, vomiting, and nausea. At approximately 3:39 p.m., a 911 call was made requesting an emergency response by the Orange County Fire Authority (OCFA).

At approximately 3:45 p.m., OCFA Engine 71 arrived on the scene. An OCFA Paramedic evaluated Luna and noted she had normal breathing and circulation and was alert. Luna was then transported to OCGMC by Care Ambulance Service.

At approximately 4:01 p.m., Luna arrived at OCGMC. Upon arrival, Luna told medical staff that she had been “vomiting” after she ate and had pain and shortness of breath. An ER doctor determined Luna had extremely low blood pressure, respiratory failure, and was septic. Luna was admitted to the hospital.

On September 29, 2022, at approximately 7:20 a.m., Luna was intubated. She received two units of blood for worsening anemia and several rounds of epinephrine; however, her medical condition continued to deteriorate. She went into cardiac arrest three separate times. Advanced life-saving measures were performed; however, they were unsuccessful and Luna was pronounced deceased at 2:12 p.m.

EVIDENCE COLLECTED

An OCCL Forensic Specialist took 39 digital color photographs of the scene and body.

AUTOPSY

On Thursday October 6, 2022, at approximately 10:30 a.m., Forensic Pathologist Doctor Scott Luzi conducted the post-mortem examination of Luna at the Orange County Sheriff-Coroner Forensic Science Center.

OCCL Forensic Specialists took 44 digital color photographs and collected blood and muscle standards.

Dr. Luzi noticed no obvious signs of significant trauma. Dr. Luzi found that Luna had pleural effusions, sub-diaphragmatic abscess, pulmonary congestion and edema, cardiomegaly with left ventricular hypertrophy, nephrosclerosis, and post peptic ulcer surgical correction. Dr. Luzi indicated the cause and manner of death would be determined following toxicological and microscopic tests.

On May 31, 2023, Dr. Luzi issued an amendment to his report. Dr. Luzi identified the cause of Luna’s death as “Acute Methadone intoxication” and the manner as “Accident.”

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Luna's antemortem and postmortem blood was collected and examined for the presence of drugs and alcohol.

The following results and interpretations were documented:

Drug	Postmortem Blood	Peripheral Blood	Liver	Stomach Contents	Antemortem Blood
EDDP	1.02 $\pm$ 0.09 mg	>3.2 mg/L	6.31 $\pm$.54mg/kg		0.481 $\pm$ 0.041 mg/L
EMDP	Detected				Detected
Lidocaine	Detected				
Methadone	2.65 $\pm$ 0.30 mg/L	1.25 $\pm$ 0.15 mg/L	12.5 $\pm$ 1.5 mg/kg	<0.22 mg	2.28 $\pm$ 0.26 mg/L
Midazolam	0.085 $\pm$ 0.012 mg/L				
Ondansetron	Detected				Detected

ADMINISTRATION OF METHADONE TO LUNA

Following her discharge from Anaheim Global Medical Center on September 23, 2022, Luna was administered 155 mg of methadone daily in accordance with her release prescriptions. Licensed vocational nurses (LVN) and psychiatric technicians (LPT) employed by Western Pacific Medical Corporation (WPM), a state-license addiction treatment organization, checked the medication out of their clinic location, brought it to the jail, and administered it to Luna.

WPM records indicate that the following doses of methadone for Luna were checked out of the facility:

- September 24, 2022 - 155 mg of methadone. (LVN)
- September 25, 2022 - 155 mg of liquid methadone. (LVN)
- September 26, 2022 - 155 mg of liquid methadone. (LPT)
- September 27, 2022 - 155 mg of liquid methadone. (LPT)
- September 28, 2022 - 155 mg of liquid methadone. (LPT)
- September 29, 2022 - 155 mg of liquid methadone. (LPT)

The methadone checked out from WPM on September 29 was not administered to Luna, as she had been transported and admitted to OCGMC the previous day. According to the Director of

Operations at WPM, the medication was returned to the clinic and secured in a safe for destruction.

OCGMC records indicate that no methadone was administered to Luna while under their care on September 28 and 29.

No evidence was discovered during the course of the investigation to indicate that Luna had ingested methadone other than her prescribed doses.

Upon follow-up questioning, Dr. Luzi stated that a blood methadone concentration range between .0.4-1.8 mg/L is generally considered to be toxic, potentially resulting in death. The methadone concentration in Luna's antemortem and postmortem blood samples, 2.28 ± 0.26 mg/L and 2.65 ± 0.30 mg/L respectively, exceeded this range. Dr. Luzi, however, was unable to opine as to whether the level of methadone found in Luna's blood was consistent with her 155 mg daily dose or indicative of her having ingested additional methadone from a supplemental source.

Similarly, an OCCL Forensic Scientist stated that she could not correlate Luna's blood concentration with her prescribed dosage regimen, in part due to Luna's lengthy methadone usage. Nevertheless, she indicated that the concentration levels seen in the samples of Luna's antemortem and postmortem blood were above what she would expect for maintenance therapy.

BACKGROUND INFORMATION

Luna had a State of California Criminal History record with arrests dating back to 1997 for the following violations:

- Robbery
- Burglary
- Grand theft
- Cruelty to a child
- Possession of a controlled substance
- Driving under the influence
- Driving on a suspended license
- Falsely impersonate to make another liable
- Petty theft
- Possession of drug paraphernalia

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 that 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 Luna 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). Luna was evaluated by OCHCA medical personnel upon admittance to the IRC on September 11, 2022. It was noted that she had a history of drug usage and was receiving methadone as part of her treatment.

OCHCA personnel contacted RSSA, obtained her treatment information, and arranged for continued methadone treatment for Luna, consistent with her current dosage regimen. When Luna became ill, she was immediately sent to AGMC for treatment. Following surgery, she was returned to the IRC with prescriptions for medication, including a 155 mg daily dose of methadone. The OCSD had LVNs provide those doses per the prescription.

When Luna became ill again, OCSD administered appropriate medical treatment and promptly called for a 911 emergency response.

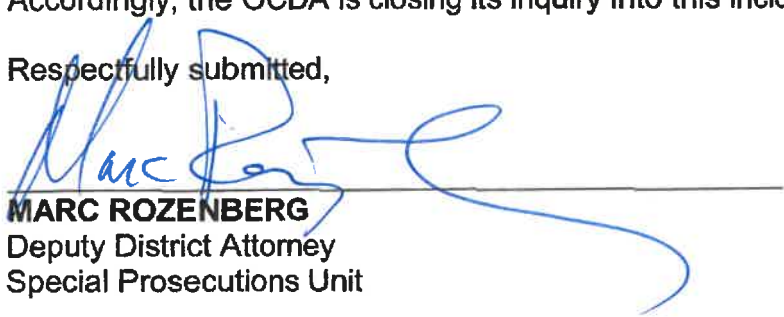
While the cause of death was identified as acute methadone intoxication, and there are indications that the levels found in Luna's blood were higher than what would be expected from someone receiving maintenance doses, there is no evidence that any methadone other than the physician-prescribed dosage was provided to Luna. Consequently, there is nothing to indicate that Luna's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

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 Margarita Luna.

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

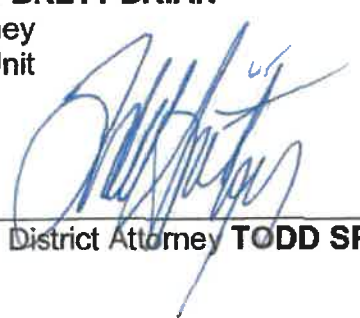
Respectfully submitted,



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