OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

April 10, 2020

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

Re: Custodial Death on May 23, 2019
Death of Inmate Anthony Bernie Aceves
District Attorney Investigations Case # SA 19-010
Orange County Sheriff's Department Case # 19-019594
Orange County Crime Laboratory Case # FR 19-16659
Orange County Coroner's Office Case # 19-02384-RA

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 above-listed incident involving the May 23, 2019, custodial death of 37-year-old inmate Anthony Bernie Aceves.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Aceves. 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 May 23, 2019, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the UCI Medical Center Emergency Room, where Aceves died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 13 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 relating 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, 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 Senior Assistant District Attorney supervising the Operations IV Division of the OCDA, who will eventually review and approve 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.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On Monday, April 22, 2019, Aceves was arrested by the Santa Ana Police Department for Felony Probation Violation. The following day, Aceves was booked into the OCSD Intake and Release Center (IRC). Initial medical screening reported Aceves was diagnosed as schizoaffective and prescribed Depakote, Prozac, and Benadryl. He admitted being non-compliant with treatment since he was last released from custody on February 20, 2019. He admitted daily use of methamphetamine and tetrahydrocannabinol (THC) while out of custody. He told Mental Health Staff he had attempted suicide eight times. The last time was by overdose a couple of weeks prior to his arrest. He had previously attempted suicide by jumping off a pier and by eating heroin. He voiced suicidal ideations with a plan to cut his wrists. Aceves was placed in Mental Health Housing classified as a Protective Custody (PC) Mainline inmate.

On Wednesday, April 24, 2019, Aceves was cleared for regular housing at the IRC. The following day, Aceves was transferred to TLF and housed with another PC Mainline inmate.

On Saturday, May 18, 2019, Aceves signed a Release of Liability when he refused to take his medication and stated he did not want to take it anymore. The following day, John Doe 1 was transferred into the same cell as Aceves. John Doe 1 was classified as a PC Mainline inmate because he had been assaulted while in custody and there were concerns for his safety if left in General Population. Aceves signed another Release of Liability the following day, when he refused to take his Benadryl medication.

On Wednesday, May 22, 2019, between 2 p.m. and 8 p.m., the security camera in Aceves' sector recorded Aceves walking around in his cell, in the Dayroom, and interacting with inmates within the sector. At approximately 8 p.m., Aceves received medication during Medical Call and appeared to ingest the medication. The medication included Divaproex Sodium Oral 1000mg used to treat seizures; Fluoxetine HCI Oral 20mg used to treat depression and anxiety; and Diphenhydramine HCI Oral 50mg, an antihistamine which he refused. He returned to his cell and closed the door. John Doe 1 and Aceves remained locked in their cell for the rest of the night. Between 8 p.m. and 11:07 p.m., other inmates in the sector were in and out of their cells for Medical Call and Dayroom Activities. At approximate 8:12 p.m., security video showed inmate John Doe 2 approach a different cell, not his own, appearing to pass something under the cell door. John Doe 2 then approached Aceves' and John Doe 1's cell, and appeared to pass something under that cell door. At approximately 11 p.m., Aceves was recorded on security video moving around inside his cell. According to John Doe 1, Aceves rarely slept; he would talk to himself and laugh out loud all night. However, on Wednesday May 22, 2019 Aceves went to sleep and snored loudly, according to John Doe 1.

Throughout the night OCSD deputies conducted hourly Safety Checks in Aceves' sector. On Thursday, May 23, 2019, at approximately 4:52 a.m., OCSD deputies were conducting the Module Book Count in Aceves' sector, when Aceves was found on his bunk, unresponsive. When deputies entered the cell, Aceves was cold and without vital signs. Cardio Pulmonary Resuscitation (CPR) was initiated at this point. TLF Medical Staff used an Automated Electronic Defibrillator (AED) and Narcan to revive Aceves, without success. At approximately 5:05 a.m., Orange Fire Department (OFD) arrived in Aceves' sector and found Aceves in respiratory and cardiac arrest. OFD transported Aceves to the UCI-Medical Center Emergency Room where he was pronounced deceased at 5:47 a.m.

OCSD organized a team of eleven (11) OCSD deputies and two (2) OCSD K-9 handlers to search all cells in Aceves' sector for illegal narcotics and contraband. No contraband or illegal narcotics were located.

Four inmates, John Doe 2, John Doe 3, John Doe 4, and John Doe 5, were transported by OCSD deputies to IRC and scanned for narcotics concealed in their bodies with negative results. John Doe 2, John Doe 3, John Doe 4, and John Doe 5 each said the objects passed under the doors of each of their cells were cookies. None of the other inmates in the sector provided information of value which could not be corroborated regarding drugs in the sector.

Another inmate, John Doe 6, was interviewed and told the investigators that he did not know if Aceves overdosed or committed suicide. If it was an overdose, John Doe 6 admitted to knowing who had the drugs and who brought them into the jail. John Doe 6 stated he knew there had been fentanyl in the sector and had seen other inmates in the Dayroom under the influence of narcotics.

John Doe 1 stated that he never saw Aceves with drugs, but he did see Aceves with a white powder which appeared to be a crushed pill. However, John Doe 1 denied providing drugs to Aceves, or any involvement with Aceves' death.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Blood sample.
- Deep muscle tissue sample.
- Paper bags.
- Swabs from the hands, fingernails, face and neck.

AUTOPSY

On May 29, 2019, independent Forensic Pathologist Dr. Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Aceves. Following the autopsy, Dr. Luzi stated the preliminary cause of death was pending toxicology and microscopic tests.

On January 21, 2020, Dr. Luzi issued his findings in the death of Aceves. Dr. Luzi indicated the cause of death was acute Fentanyl intoxication and the manner of death was an accident.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Aceves' postmortem blood was collected for testing and yielded the following results:

DRUG	POSTMORTEM BLOOD	ANTEMORTEM BLOOD
Fentanyl	0 0122 ± 0 0013 mg/L	N/A
Norfentanyl	Detected	N/A
Fluoxetine	Detected	N/A
Norfluoxetine	Detected	N/A
Valproic Acid	Detected	N/A
Naloxone	Detected	N/A
Caffeine	Detected	N/A

BACKGROUND INFORMATION

Aceves had a State of California Criminal History record that revealed arrests for the following violations:

- Assault with a Deadly Weapon likely causing Great Bodily Injury
- Assault with a Deadly Weapon not a Firearm
- Assault on a Peace Officer or Emergency Personnel
- Battery Against a Police Officer
- Obstructing a Public Officer
- Obstructing or Resisting an Executive Officer
- Battery
- Possession of a Destructive Device
- Spousal Battery
- False Imprisonment
- Violation of an Order to Prevent Domestic Violence
- Criminal Threats
- Burglary
- False Identification to a Peace Officer
- Trespassing
- Trespassing to Obstruct a Business Operation

- Unauthorized Entry on Posted Land
- Under the Influence of Toluene
- Under the Influence of a Controlled Substance
- Possession of Unlawful Paraphernalia
- Disorderly Conduct
- Drunk in Public
- Vandalism
- Vandalism of Power Lines
- Violation of a Protective Order
- Violation of Post Release Community Supervision
- Probation Violation
- 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 human being;
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/she acted he/she knew his/her 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:

"The 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/she 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/she acts is so different from how an ordinarily careful person would act in the same situation that his/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 whatsoever in this case 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 Aceves a duty of care, the evidence does not support a finding beyond a reasonable doubt that this duty was in any way breached either intentionally or through criminal negligence. The OCSD deputies conducted hourly safety checks on the inmates in the sector and did not notice anything unusual throughout the night. OCSD deputies conducted their duties in a reasonable manner and provided Aceves with the proper care at the moment they realized he was unresponsive.

On May 22, 2019, the day before his death, Aceves showed no signs raising concerns to OCSD staff or other inmates. Between 2 p.m. and 8 p.m., the security camera in Aceves' sector recorded Aceves walking around in his cell, in the Dayroom, and interacting with inmates within the sector. At approximately 11 p.m., Aceves was recorded on security video still moving around his cell. John Doe 1 stated Aceves went to sleep that night and snored loudly.

It wasn't until the morning around 4:52 a.m. that the OCSD deputies had reason to notice Aceves was unresponsive. It was at this time that Deputy Alegria followed protocol by pressing the emergency button and directed Correctional Service Assistant (CSA) Rivera to have Orange County

Health Care (OCHC) medical personnel and paramedics respond immediately. As soon as OCHC personnel arrived, Aceves was taken off the top bunk, placed on the floor, and provided emergency medical care until paramedics arrived and transported to UCI Medical Center.

There is certainly evidence supporting a conclusion that drugs were unlawfully present inside the jail, and that certain inmates were involved in providing such drugs. However, in order for the OCDA to be able to file criminal charges relating to the death of Aceves, we have to be able to prove beyond a reasonable doubt criminal culpability, including causation, as listed above. The OCDA is not able to meet this burden of proof based on all the available evidence. Thus, there is a lack of sufficient evidence to support a finding beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD acted in a manner that caused the death of Aceves or failed to perform a legal duty causing the death of Aceves.

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 a lack of sufficient evidence to support a finding beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Aceves. The evidence shows that Aceves died as a result of an accidental drug overdose and that the death was a natural one.

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

Respectfully submitted,

ROBBIE GOODKIN
Deputy District Attorney
GANGS Unit

READ AND APPROVED BY **EBRAHIM BAYTIEH**
SENIOR ASSISTANT DISTRICT ATTORNEY – OPERATIONS IV

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