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ORANGE COUNTY, CALIFORNIA
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ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER
CHIEF OF STAFF

December 6, 2016

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

Re: Custodial Death on Dec. 31, 2015
Death of Inmate Devin John Morneau
District Attorney Investigations Case # SA15-022
Orange County Sheriff's Department Case #15-290943
Orange County Crime Laboratory Case #15-60792

Dear Sheriff Hutchens,

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 Dec. 31, 2015, custodial death of 49-year-old inmate Devin John Morneau.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Morneau. In this letter, the OCDA describes the investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to determine whether criminal culpability exists on the part of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD.

On Dec. 31, 2015, OCDA Special Assignment Unit (OCDASAU) Investigators responded to University of California, Irvine Medical Center (UCIMC), where Morneau received medical treatment while in custody and died shortly after receiving a compassionate release from custody for his grave condition. During the course of this investigation, the OCDASAU interviewed five witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, medical records of Morneau 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 a veteran deputy district attorney for legal review. Deputy district attorneys from the Homicide, TARGET/Gangs, and Special Prosecutions Units review fatal, as well as 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 Assistant District Attorney supervising the Special Prosecutions Unit, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTUAL SUMMARY

Background

Morneau was a 49-year-old male who had a history of substance abuse, including the use of methamphetamine, heroin and ethyl alcohol for over 18 years. Morneau was diagnosed with HIV in 1989 and had a history of Hepatitis C and hypertension.

On Dec. 1, 2015, Morneau was treated in the emergency department of Community Hospital of Long Beach for urinary retention, a urinary tract infection and nephrolithiasis. For at least one year prior to this visit to the hospital, Morneau had been off medications for his HIV treatment. On Dec. 1, 2015, Morneau was discharged with prescriptions for Keflex, Flomax, and Norco.

Summary of Events

On Dec. 16, 2015, at approximately 6:22 p.m., University of California Irvine Police Department officer Matthew Wroblewski arrested Morneau for the following violations:

- California Vehicle Code section 10851(a) – Vehicle Theft
- California Vehicle Code section 12500(a) – Driving without a license
- California Penal Code section 666.5 – Auto Theft with Prior Auto Theft Conviction
- California Penal Code section 496d(A) – Receiving Stolen Vehicle

On Dec. 16, 2015, at approximately 8:23 p.m., Morneau was booked into the OCSD Intake and Release Center (IRC), and his bail was set at $25,000. On Dec. 17, 2015, he was transferred to the OCSD Theo Lacy Facility, Module Q, Sector 5825, Cell 14. Cell 14 was a two person cell and Morneau's cellmate was John Doe.

On Dec. 28, 2015, at approximately 10:53 p.m., OCSD Deputy Robert Zika was working inside the Module Q guard station when the emergency button from Morneau's cell was activated by inmate John Doe. Using the intercom system, John Doe notified the deputy that Morneau had fallen off the top bunk and was bleeding. Morneau was sitting on his bunk bed, legs hanging down off the side when he fell six feet forward in a head down direction to the concrete floor. Deputy Zika and Deputy Mark Zwirner immediately responded to the cell and found Morneau lying face down next to the toilet. While Deputy Zwirner requested the jail medical staff, Deputy Zika asked Morneau what happened and he responded, "I think I fell." Medical staff arrived and immediately called for paramedics. At approximately 11:25 p.m., Morneau was initially conscious and answering questions when Orange City Fire Department Paramedics arrived and took over medical care. Morneau had an approximately 1-inch cut to his forehead and a 1 inch cut on his left cheek with significant visible swelling on both, consistent with falling from a bunk and hitting his head. At approximately 11:36 p.m., while being treated by Paramedics, Morneau became unresponsive and unconscious. Morneau was then transported to UCIMC at approximately 11:45 p.m.

Morneau was admitted to the Trauma Unit where the attending Neurosurgeon surgically inserted an External Ventricular Drain (EVD) into Morneau's brain. On Dec. 29, 2015, Morneau, still unconscious, was transferred to UCI's Surgical Intensive Care Unit, where the attending physician concluded Morneau suffered a right basal ganglia stroke and spontaneous bleeding due to long-standing untreated high blood pressure (hypertension). The physician also believed other significant medical issues including "poorly controlled, if not completely uncontrolled HIV" and immune thrombocytopenic purpura (prevents blood from clotting) contributed to Morneau's stroke, which caused him to fall from the bunk. It was determined that Morneau was likely to lose all his reflexes and die regardless of further medical treatment.

On Dec. 30, 2015, as a result of Morneau's grave condition, he was granted a compassionate release from custody. Morneau's sister, in consultation with the attending physician, decided to withdraw life support. On Dec. 31, 2015, at 7:11 p.m., Morneau's life support (breathing tube) was removed. At 9:42 p.m., Morneau was pronounced deceased.

INTERVIEWS

A total of five witnesses were interviewed in this case. This includes four interviews conducted by OCDASAU investigators, and one interview of Morneau's cellmate by OCSD Deputy Zika. John Doe was Morneau's cellmate in cell 14. After dinner on Dec. 28, 2015, Morneau told John Doe he was not feeling well, and went to sleep on his bunk. John Doe stated that Morneau sat up on his bunk a few hours later and seemed unsteady. John Doe asked if he needed help, to which Morneau responded "No, leave me alone." John Doe was standing by the door facing the quad when he heard a loud bang and noticed Morneau lying on the ground between the bunks and sink. John Doe stated that he did not know if Morneau hit the sink or the toilet. John Doe immediately pushed the emergency button to notify the jail deputies.

AUTOPSY

On Jan. 2, 2016, independent Forensic Pathologist Dr. Scott A. Luzi of Clinical and Forensic Pathology Services conducted an autopsy on the body of Morneau. Dr. Luzi determined that Morneau suffered bruises and lacerations on his face, head, and body which were consistent with a fall from a top bunk, and that he had an enlarged heart and bleeding of the brain. Dr. Luzi concluded Morneau's cause of death was a result of intracranial hemorrhage due to hypertension. On October 6, 2016, after a final review, Dr. Luzi again concluded that the death was from natural causes: Intracerebral hemorrhage due to hypertensive heart disease and other condition of Cirrhosis related to Hepatitis C being present.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Benzodiazepines/Sedative Hypnotic	Postmortem Blood	0.510 ± 0.021 mg/L

Morneau's Criminal History

Morneau's criminal history commenced in 1986 and continued through 2015. During that time frame, Morneau had an extensive State of California Criminal History record including, but not limited to, arrests for grand theft property, grand theft auto, prostitution, false identification to a peace officer, being under the influence of a controlled substance, possession of a controlled substance, burglary, trespassing, and violation of parole.

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 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 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/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

In this case, there is no evidence whatsoever 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 Morneau 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).

Morneau had preexisting medical conditions of HIV, Hepatitis C, and hypertension at the time he was placed in custody with OCSD. Morneau was medically examined and treated according to the established protocol. Tragically, Morneau suffered a right basal ganglia stroke and internal bleeding due to hypertension which caused him to fall off his bunk bed. Morneau's cellmate called for emergency medical assistance upon discovering Morneau's fall, and OCSD jail staff responded quickly and immediately requested additional medical support from OCFD Paramedics. OCFD Paramedics provided medical treatment and immediately transferred Morneau to UCIMC, where he was then treated in the Surgical Intensive Care Unit. Morneau showed no internal or external signs of injury or trauma consistent with an attack, assault or any type of foul play. There was no evidence of any type of assault inside of Morneau's cell. Morneau's cellmate was standing at the window facing toward the quad when Morneau fell and the cellmate immediately alerted the deputies for assistance. The facts and evidence in this case are consistent with the coroner's conclusion that Morneau died from intracranial hemorrhage due to hypertension. All available records support the conclusion that the OCSD performed their legal duty with the appropriate standard of care. Thus, there is no evidence whatsoever 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 of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that Morneau died due to natural causes as a result of intracranial hemorrhage due to hypertension.

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

Respectfully submitted,

Jennifer E. Walker
Senior Deputy District Attorney
Homicide Unit

Read and Approved by **Ebrahim Baytieh**
Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit