OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

August 26, 2019

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

Re: Custodial Death on August 6, 2018
Death of Inmate Rene Rome Donahue
District Attorney Investigations Case # SA18-027
Orange County Sheriff's Department Case # 18-027899
Orange County Crime Laboratory Case # 18-51129

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusions in connection with the above-listed incident involving the August 6, 2018, custodial death of 57-year-old inmate Rene Rome Donahue.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Donahue. 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 August 6, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center, where Donahue had died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed six 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, 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. 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 reviews all officer-involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On Saturday, July 7, 2018, at approximately 4:32 p.m., Donahue was arrested by the Brea Police Department (BPD) for violation of Vehicle Code section 23153(a), Driving Under the Influence Causing Injury, Vehicle Code section 23153(b), Driving Under the Influence Causing Injury – BAC (Blood Alcohol Level) over .08, and Vehicle Code section 20001 Hit & Run. It was determined at the time of his arrest that Donahue had an outstanding arrest warrant issued out of Los Angeles County. The warrant was for violation of Penal Code section 273.5(a), Corporal Injury to Spouse with a bail amount set at $50,000. Donahue was arrested on this warrant in addition to the above listed violations.

Donahue was transported and booked into the Orange County Intake Release Center (IRC). At approximately 8:27 p.m., the assigned Registered Nurse (RN) conducted the initial medical screening of Donahue as part of the booking process. During the initial screening, Donahue denied having any medical conditions and denied taking any medication. Donahue responded “NO” on the Receiving Screening Addendum to questions regarding previous treatment or hospitalization for alcohol problems and suffering from alcohol withdrawal. On July 8, 2018, at approximately 10:27 a.m., Donahue was transferred from the IRC to the Theo Lacy facility and was housed in Barrack H.

On July 10, 2018, the OCDA rejected the BPD DUI case against Donahue indicating that further investigation was needed. Donahue remained in custody at the Theo Lacy Facility due to an outstanding bench warrant he had against him from LA County.

On July 11, 2018, Correctional Services Assistant (CSA) Roberts completed a request for housing change regarding Donahue indicating that he was causing a disturbance within the housing area and needed closer supervision. At approximately 6:05 p.m., Donahue transferred from the Theo Lacy

Facility to the IRC. After arriving at the IRC, the medical staff conducted a mental health screening of Donahue and found him to be psychiatrically stable.

On July 12, 2018, Donahue was placed in the IRC awaiting transfer to the Men's Central Jail. While there, he was referred to the jail medical staff due to his bizarre behavior. The medical staff heard Donahue saying that there were bugs all over the cell and found him shaking. The medical staff consulted with the attending Nurse Practitioner (NP) and the determination was made that Donahue must go to the hospital for further evaluation. While waiting in his holding cell to transfer to the hospital, Deputy Sheriff Curtin observed Donahue kneeling in the back of the cell, and then observed him sliding to the ground where he began to shake. Deputy Curtin notified the medical staff and an RN responded to the cell. The RN determined that Donahue needed immediate transport and requested paramedics. At approximately 5:00 p.m., Orange County Fire Authority (OCFA) Engine 75 and CARE Ambulance arrived at the IRC. The Paramedics found Donahue conscious but confused. He was transported to the Orange County Global Medical Center (OCGMC). At approximately 5:30 p.m., Donahue arrived to the Emergency Room at the OCGMC where the attending physician examined him and diagnosed him as likely suffering from Delirium Tremens, liver failure, and hepatic encephalopathy. Because Donahue was in critical condition, he was transferred from the Emergency Room to the Intensive Care Unit (ICU). While in the ICU, the attending physician determined that Donahue was in critical condition and should remain in the ICU.

On July 13, 2018, at approximately 6:56 p.m., Theo Lacy Facility sent a deputy to take over guarding Donahue at the hospital. After several days of Donahue's condition not improving, an IRC Records Supervisor contacted the Los Angeles Court that issued the warrant. The warrant was recalled which allowed OCSD to start the process of releasing Donahue from custody.

On July 14, 2018, Donahue's medical condition declined and he was intubated. Donahue eventually received a tracheostomy to assist him in breathing and was then placed on life support. Donahue was completely unresponsive.

On Friday August 3, 2018, Donahue was officially released from the Orange County Sheriff Department's custody. Because Donahue's condition continued to deteriorate, he was unable to sign his release paperwork. Donahue's family met with the medical staff at OCGMC and decided to remove him from life support. On August 6, 2018, Donahue was pronounced deceased by the attending physician at OCGMC.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Video surveillance from July 11, 2018, at the IRC and the Theo Lacy Jail
- Muscle standard from Donahue
- 46 autopsy photographs
- 20 post embalming photographs

AUTOPSY

On August 8, 2018, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Donahue. Dr. Luzi conducted an extensive examination of the body and found no major or minor injuries. Dr. Luzi determined that the cause of death complications of chronic alcohol abuse. Dr. Luzi noted the following other conditions: hypertensive and atherosclerotic cardiovascular disease; peptic ulcer disease with gastrointestinal hemorrhage. Dr. Luzi concluded that Donahue's manner of death was natural.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Morphine (Free)	Postmortem Blood	0.383 ± 0.041 mg/L
Levetiracetam	Postmortem Blood	Detected
Morphine-glucuronide	Postmortem Blood	Detected
Caffeine	Postmortem Blood	Detected

BACKGROUND INFORMATION

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

- Possession of control substance paraphernalia
- Driving while license suspended
- Inflict corporal injury to spouse/cohabitant
- DUI Alcohol
- DUI .08 Alcohol: Cause Bodily Injury
- Hit and Run: Death or Injury
- Hit and Run: Property Damage

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.' 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 Donahue 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).

When Donahue was initially arrested, he failed to report that he was a chronic alcoholic to the police. Additionally, when Donahue arrived at the IRC, he failed to report in his initial medical screening that he had an ongoing medical condition, cirrhosis of the liver, and that he was an alcoholic. Because of his failure to inform OCSD personnel of his medical issues and his alcohol abuse, OCSD personnel did not have the relevant information required to give Donahue the medical attention he required. It was not reasonably foreseeable to OCSD personnel that Donahue would be at risk for harm. OCSD did not know or have reason to know that Donahue was in need of immediate medical attention. Thus, OCSD did not intentionally breach their duty of care.

Furthermore, the available evidence in this case indicates that OCSD did not breach their duty of care through Criminal Negligence. 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. OCSD acted promptly by alerting medical staff of Donahue's bizarre behavior. When the medical staff heard Donahue state that he had bugs crawling all over him and witnessed him pour water on his head, the medical staff alerted the nurse practitioner who then determined that Donahue must go to the hospital for further evaluation. Further, Deputy Curtin notified medical staff immediately after witnessing Donahue sliding to the ground of his cell beginning to shake. This further shows that OCSD did not fail to perform their legal duty. OCSD took reasonable action to summon medical care. Thus, OCSD saw that it would be foreseeable that Donahue would be in further harm and they acted to preempt that harm by summoning the paramedics.

There is no evidence in this case to support a finding beyond a reasonable doubt that medical staff acted deliberately with a conscious disregard to human life, nor is there evidence to support a finding of criminal negligence. During the time that Donahue was at the hospital and still in custody of OCSD, the attending physicians determined that he was in critical condition and would need to stay in the ICU. After his condition continued to decrease, medical staff performed a tracheostomy and placed him on life support. Donahue's family made the decision to remove Donahue from life support. The evidence shows that OCSD provided Donahue with the proper medical attention and handled his sudden emergency in a reasonable manner. Furthermore, the available evidence supports a conclusion that OCSD did not legally cause Donahue's death. The Forensic Pathologist concluded that the manner of Donahue's death was natural due to complications from chronic alcohol abuse.

Thus, all available evidence supports the conclusion that OCSD met the legally required standard of care. The evidence does not 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 Donahue's death.

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 Donahue. The evidence shows that Donahue died as a result of complications from chronic alcohol abuse, and that the manner of his death was natural.

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

Respectfully submitted,

PATRICK MOSS
Deputy District Attorney
TARGET/Gangs Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney, Operations IV