OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TONY RACKAUCKAS, DISTRICT ATTORNEY

JIM TANIZAKI
CHIEF ASSISTANT D.A.

SCOTT ZIDBECK
SENIOR ASSISTANT D.A.
FELONY OPERATIONS IV

TRACY MILLER
SENIOR ASSISTANT D.A.
FELONY OPERATIONS III

EBRAHIM BAYTIEH
SENIOR ASSISTANT D.A.
FELONY OPERATIONS II

KEITH BOGARDUS
SENIOR ASSISTANT D.A.
FELONY OPERATIONS I

HOWARD P. GUNDY
SENIOR ASSISTANT D.A.
BRANCH COURT OPERATIONS

PAUL M. WALTERS
CHIEF
BUREAU OF INVESTIGATION

JENNY QIAN
DIRECTOR
ADMINISTRATIVE SERVICES

SUSAN KANG SCHROEDER
CHIEF OF STAFF

November 6, 2018

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

Re: Custodial Death on February 11, 2018
Death of Kevin Morris
District Attorney Investigations Case # SA 18-006
Orange County Sheriff's Department Case # 18-005778
Orange County Crime Laboratory Case # 18-42612

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 Feb. 8, 2018, custodial death of 31-year-old inmate Kevin Michael Morris.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Morris. 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 Feb. 11, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Mission Hospital, where Morris died while in custody after receiving medical treatment. During the course of this investigation, the OCDASAU interviewed 14 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 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 their 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 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 Felony Operations II Division of the OCDA, 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.

FACTS

Kevin Morris was a 31-year-old male with a prior criminal history of arrests for drug abuse, grand theft, and domestic violence. At the time of the incident, Morris was living at his parents' home in the garage as a temporary arrangement until he found a job and a place of his own. On Jan. 29, 2018, his parents left Morris a note that he would be evicted from the garage if he failed to find a job within two weeks.

On Feb. 8, 2018, Morris was acting strange and made some comments to his parents indicating that something was going to happen that day. After a verbal altercation with his mother, Morris' father took Morris for a walk in the late afternoon. Upon returning, Morris was expected to apologize to his mother, but instead entered the house, grabbed his mother, threw her against a wall and then down on the ground where he began punching her in the head with closed fists. In defense of his wife, Morris' father obtained a baseball bat in an attempt to stop Morris' violent assault against his mother. At 5:52 pm, Morris' mother called 9-1-1 while exiting the back door of her residence and yelling for help.

Morris' father used the metallic bat to strike Morris in his legs. As Morris' father tried to stop him, Morris escaped to the garage. When Morris' father chased after Morris, he noticed blood on Morris' forehead. Morris told his father that he "wanted it to look like a real fight." According to neighbor John Doe, who was in his backyard barbequing when he witnessed Morris' mother exit the back door of her home yelling, "Help, call the police" and "he's beating us up." John Doe observed blood on Morris' mother and immediately called 9-1-1. John Doe also had a partial view of the inside of the Morris' home where he saw Morris and his father fighting and called 9-1-1 a second time.

At approximately 5:54 p.m., OCSD Deputies Chris Quenault, Gregory Fisher, Islam Hamdallah, Eric Madrigal, and Ernest Ragadio were dispatched to the parent's residence reference a 9-1-1 call in which a woman could be heard moaning and screaming for help. Deputies responded with a "Code 3" to the location. According to Deputy Ragadio, as he drove to the location he was broadcasting that the subject had mental problems and was bloody. At 5:59 p.m., Deputy Ragadio arrived at the scene and did not see or hear anything unusual; however, as additional deputies arrived they could hear yelling coming from the backyard.

As more deputies arrived to the location they began to position themselves in a tactical method preparing less lethal ammunition. Deputy Ragadio observed Morris exit from the side yard of the house and run towards the other deputies. Deputy Ragadio then heard Deputies Quenault and Fisher identify themselves as the "Sheriff's Department" and gave an order to Morris to "stop" from entering the premises. As Morris ran south across the driveway Deputy Quenault then fired two less than lethal beanbags at Morris to prevent him from entering the house. It did not appear to the deputies that Morris had been struck by the less than lethal shots as Morris continued to run towards the front door of the residence. It was later determined at least one beanbag round struck Morris on the backside of his right thigh.

Deputies Quenault, Hamdallah, Ragadio and Fisher positioned themselves near the pedestrian door of the garage making an announcement for Morris to come out, and within a few seconds he complied. As Deputies Ragadio and Fisher grabbed each of Morris' arms, they guided him to the ground to a prone position on his stomach and assisted Deputy Hamdallah to handcuff Morris. Morris slightly resisted when Deputy Ragadio pulled Morris' left arm from underneath his body and placed it behind his back before being handcuffed.

Shortly after being handcuffed, Morris stopped breathing and went into cardiac arrest. Deputy Fisher immediately removed the handcuffs; he and Deputy Hamdallah performed Cardio Pulmonary Resuscitation (CPR) on Morris. The Deputies immediately requested paramedics and continued to perform CPR until the paramedics arrived to the residence. At approximately 6:00 p.m., the Orange County Fire Authority (OCFA) personnel from Engine #31 were dispatched to the scene and they arrived to the location at approximately 6:11 p.m.. Paramedics provided Morris with basic life support protocols and initiated an Intravenous line (IV) with normal saline and administered three separate rounds of Epinephrine.

Morris was transported by ambulance to Mission Hospital in the city of Mission Viejo. Morris was admitted to the Cardiac Intensive Care Unit (CICU) where he received medical treatment. At approximately 9:48 p.m., OCDA and OCSD Investigators arrived at the hospital and began their hospital scene investigation. The investigators interviewed Morris' attending physician who indicated that Morris had three rib fractures on each side of his rib cage, consistent with receiving chest compressions during CPR. Morris also aspirated into his lungs, which is common with cardiac arrest patients. Morris had acquired few lacerations and bruises on his body, which did not require sutures.

Morris was in a medically-induced coma. His prognosis for recovery was poor and he was considered to be in grave condition. The attending physician also determined Morris was under the influence of methamphetamine, failed to make improvements to his condition, and had permanent damage to his heart. Morris also had renal failure and was placed on dialysis during his treatment at the hospital. On Feb. 10, 2018, Morris' sister met with the attending physician and placed Morris on "comfort care" protocols. Thereafter, Morris' sister authorized the medical staff to remove Morris from all life support.

On Feb. 11, 2018, at 11:14 a.m. Morris was extubated and removed from all life support equipment by medical staff. Morris was unable to sustain life and was pronounced deceased at 11:15 a.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Metal baseball bat
- Remington 12 gauge less than lethal shotgun and eight shot shells
- Shot shells, bean bag sock, and shot shell components
- Cigarette butt
- Water bottle
- Tissue with apparent blood

AUTOPSY

On Feb. 13, 2018, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Morris. Dr. Luzi conducted an extensive examination of the body and found no significant physical injuries or trauma. Dr. Luzi also concluded that Morris did not, in fact, have any rib fractures or compression related injuries and there was no evidence of any affixation. Morris was found to have several hemorrhages to his heart and his cause of death was a heart attack. A microscopic examination during the autopsy found: pulmonary congestion, hepatic steatosis, cardiomegaly, acute myocardial infarction, and arteriolosclerosis.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Morris' postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Lorazepam	Postmortem Blood	0.0194 ± 0.0013 mg/L
Midazolam	Postmortem Blood	0.211 ± 0.009 mg/L
Amphetamine	Postmortem Blood	0.186 ± 0.012 mg/L

Methamphetamine	Postmortem Blood	1.29 ± 0.09 mg/L
Acetaminophen (Free)	Postmortem Blood	1.39 ± 0.16 mg/L
Fentanyl	Postmortem Blood	0.0188 ± 0.0022 mg/L
Morphine (Free)	Postmortem Blood	0.030 ± 0.0037 mg/L
Nor meperidine	Postmortem Blood	0.0482 ± 0.0075 mg/L

BACKGROUND INFORMATION

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

- Grand theft from a person
- Domestic battery
- Possession of marijuana

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:

> "[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/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 Morris 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).

The autopsy report found no significant physical injuries or trauma. Morris died of a heart attack. The less lethal bean bag shots deployed by Deputy Quenault only caused bruising on the backside of Morris' right thigh and did not keep him from continuing to run at the time he was struck. Upon arrest, Morris slightly resisted by "squirming around" and the deputies used minimal force to handcuff him on the ground. After placing Morris in handcuffs, no further resistance was reported. When the deputies noticed Morris stopped breathing, they immediately removed the handcuffs and performed CPR until the paramedics arrived to the location. The OCFA's personnel were promptly dispatched to the scene of the incident, and the the OCFA Paramedic made contact with Morris in the front yard. Morris was reported to have mental problems with previous arrests for domestic battery and drugs. He assaulted his parents immediately before his contact with the OCSD deputies, causing injuries to both of his parents. There is no evidence to support a rationale conclusion that any OCSD personnel or any individual acting under the supervision of the OCSD caused or contributed to Morris' death or failed to take reasonable action to summon medical care.

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 of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that Morris died as a result of complications of chronic substance abuse with hypertrophy and dilation of the heart causing a heart attack.

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

Respectfully submitted,

JANINE MADERA
Senior Deputy District Attorney
Gang/TARGET Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney
Felony Operations II