OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

November 13, 2019

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

Re: Custodial Death on December 7, 2018
Death of Inmate Christopher Louis Mariano
District Attorney Investigations Case # SA 18-038
Orange County Sheriff's Department Case # 18-048598
Orange County Crime Laboratory Case # 18-57345 (Scene), 18-57772 (Coroner Toxicology)

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 December 7, 2018, custodial death of 34-year-old inmate Christopher Louis Mariano.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Mariano. 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 December 7, 2018, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Central Men's Jail (CMJ). Mariano died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU conducted 15 individual interviews and 27 canvass interviews, as well as obtained and reviewed reports from the OCSD, the Tustin Police Department, and the 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 December 6, 2018, at about 12:41 a.m., an officer with the Tustin Police Department (TPD) arrested Mariano for multiple arrest warrants. While en route to TPD, Mariano stated he needed to go to the hospital and that he had open sores. While at TPD, Mariano admitted to having fractures, sprains, and other ailments. Additionally, Mariano admitted to ingesting heroin, cocaine, methamphetamine, and/or speed five hours prior.

Mariano was then transported to the Intake Release Center (IRC) at Orange County Jail for booking; however, IRC medical staff rejected Mariano due to his open sores requiring further medical evaluation. Therefore, at approximately 1:56 a.m., the TPD officer transported Mariano to the Orange County Global Medical Center (OCGMC) for a medical evaluation. OCGMC medical staff evaluated and cleared Mariano for booking at IRC. Consequently, the TPD officer transported Mariano back to IRC for booking. IRC accepted Mariano and conducted a medical screening on Mariano. At no time during the medical screening did Mariano make a request for medical treatment. Mariano also refused detoxification.

During the booking process at IRC, OCSD deputies searched Mariano. In Mariano's possession, OCSD deputies located tin foil containing a brown substance with a distinct odor. An officer opined that it was heroin, a controlled substance. Subsequently, Mariano was booked for knowingly bringing a controlled substance into a custodial facility, a crime.

Later that day, at 2:10 p.m., Mariano was housed in a four-person cell already occupied by two other inmates, John Doe 1 and John Doe 2. No on-duty jail staff or inmates reported any fights or signs of distress occurring that afternoon until the following day. Further, the video surveillance cameras facing Mariano's cell did not capture any unusual activity.

On the morning of December 7, 2018 at about 5:37 a.m., Mariano went to the dining hall for breakfast and returned to his cell at approximately 5:49 a.m. While in their cell, John Doe 1 stated both he and Mariano laid on their bunks to sleep. Approximately five minutes after they returned from breakfast and before Mariano went to sleep, John Doe 1 noticed Mariano gasping for air or breathing loudly.

Between approximately 6:15 a.m. and 9 a.m., OCSD staff made announcements about the dispensing of medications and court appearances. During these announcements, John Doe 1 heard OCSD staff call out Mariano's name, however, Mariano did not respond. Following the announcement, John Doe 2 attempted to wake Mariano up, but he did not wake up.

Thereafter, John Doe 1 notified OCSD staff that Mariano would not wake up. At approximately 9:05 a.m., OCSD staff entered Mariano's cell. John Doe 1 and John Doe 2 subsequently exited their cell and proceeded to court. OCSD deputies found Mariano unresponsive lying on his bunk. As a result, the deputies initiated a "man-down" call, notified medical staff, and requested Orange County Fire Authority (OCFA) paramedics to respond. Furthermore, while awaiting medical staff to respond, OCSD personnel determined Mariano was not breathing and performed Cardio Pulmonary Resuscitation (CPR).

At approximately 9:13 a.m., CMJ medical staff arrived and continued to perform CPR and other medical aid. At approximately 9:17 a.m., the paramedics arrived and took over performing CPR on Mariano. Paramedics noticed Mariano had no pulse and was not breathing, so they attached an EKG monitor and defibrillator pads onto Mariano to evaluate his condition. The EKG monitor returned a reading of "Asystole." Subsequently, the paramedics continued to perform CPR and further medical aid but Mariano's condition remained the same.

While still assisting Mariano, paramedics contacted OCGMC and relayed information regarding Mariano's condition. However, after approximately twenty minutes of continuous CPR, the OCGMC's base station agreed with the paramedics' treatment/findings and it was agreed that no further CPR was necessary on Mariano. Mariano was pronounced dead at 9:38 a.m.

John Doe 1 and John Doe 2 both provided voluntary statements and stated they did not notice anything unusual with Mariano. Neither recalled Mariano complaining about feeling ill, being assaulted, or having problems with anyone in the jail. Furthermore, canvass interviews conducted with other inmates in Mariano's Module revealed similar information.

EVIDENCE COLLECTED

The following items of evidence were collected and submitted to the OCCL's Evidence Control Unit:

- Swabs from hands, neck and face of Mariano
- One inmate white shirt and white boxers
- Heart blood standard
- Bloodstain standard

AUTOPSY

On December 10, 2018, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Mariano. At the conclusion of the autopsy, Dr. Luzi concluded that he found no obvious signs of trauma, the hyoid bone was intact, and no petechial hemorrhaging was observed. The cause of death was determined to be acute exacerbation of chronic methamphetamine abuse, and the manner of death was determined to be accidental.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Mariano postmortem blood yielded the following results:

DRUG	POSTMORTEM BLOOD	BRAIN
1-(4-Chlorobenzhydryl)-piperazine	Detected	
Acetaminophen (free)	1.64 ± 0.18 mg/L	Detected
Amphetamine	0.0643 ± 0.0048 mg/L	0.153 ± 0.012 mg/L
Hydroxyzine	Detected	
Loperamide	Detected	1
Methamphetamine	0.206 ± 0.015 mg/L	0.309 ± 0.022 mg/L
Morphine (Free)	0.0141 ± 0.0015 mg/L	1
Nicotine	Detected	
Orphenadrine	0.530 ± 0.098 mg/L	
Trimethoprim	Detected	

BACKGROUND INFORMATION

Mariano had a State of California Criminal History record that included arrests for the following law violations:

- Penal Code (PC) 4573, Bringing Controlled Substance Into Prison
- PC 422, Criminal Threats
- PC 166.4, Disobeying a Court Oder
- PC 487(a), Grand Theft
- PC 470(d), Fraudulent Checks
- PC 475(a), Possession of Counterfeit Items
- PC 21310, Possessing/Concealing a Dirk or Dagger
- PC 484(a)-488, Petty Theft
- PC 496(a), Possession of Stolen Property
- PC 466, Possession of Burglary Tools
- PC 594(B)(2)(A), Vandalism under $400.00
- PC 530.5(c)(3), Identity Theft
- PC 211, Robbery
- PC 602(k), Unlawful Trespass
- Health & Safety Code (HS) 11377(a), Possession of a Controlled Substance
- HS 11550(a), Under the Influence of a Controlled Substance
- HS 11364 (a), Possession of Drug Paraphernalia
- Vehicle Code (VC) 23152(a), Driving Under the Influence of Drugs/Alcohol

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 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 present 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 Mariano 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). Immediately after the TPD officer brought Mariano to IRC, OCSD staff, out of concern for his open wounds, rejected him and requested he receive further medical evaluation. OCSD staff did not take Mariano into custody until he was both examined and cleared for booking by OCGMC staff. Once booked into OCJ, OCSD staff placed Mariano in a four-person cell occupied with two other inmates. At no point while at OCJ did Mariano request medical assistance or care. Further, no interviews suggest that Mariano complained of his condition nor were there any reports of any assaults or problems with other inmates.

On December 7, 2018, the day of his death, Mariano showed no signs raising concerns to OCSD staff or other inmates. Mariano attended and ate breakfast, and he then returned to his cell where he fell asleep. No reports suggest any of Mariano's actions were unusual or out of the ordinary.

Further, once made aware of Mariano's condition, OCSD staff responded immediately and appropriately. Within minutes of discovering Mariano's condition, OCSD deputies cleared Mariano's cell, initiated a "man-down" call, notified medical staff, requested OCFA paramedics, and began to perform CPR. When CMJ medical staff and OCFA arrived on scene, life-saving attempts continued until Mariano was pronounced dead by medical personnel.

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 causing the death of Mariano.

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 Mariano. The evidence shows that Mariano died as a result of acute exacerbation of chronic methamphetamine abuse.

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

Respectfully submitted,

DOMINIC BELLO
Deputy District Attorney
Gangs Unit

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