OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

December 22, 2021

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

Re: Custodial Death on March 3, 2021
Death of Inmate Richard Moran
District Attorney Investigations Case # 21-000711
Orange County Sheriff's Department Case # 21-004343
Orange County Crime Laboratory Case # FR 21-42716

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the March 3, 2021, custodial death of 70-year-old inmate Richard Moran.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Richard Moran. 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 March 3, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center (OCGMC) where Richard Moran died while in custody after he was transported to the hospital on February 7, 2021, and subsequently placed on life-support. During the course of this investigation, the OCDASAU interviewed a nurse with OCGMC who cared for Moran, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, videos from Orange County Jail (OCJ), 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 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 Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review 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.

FACTS

On December 18, 2020 at 10:15 p.m., Richard Moran was arrested by the Huntington Beach Police Department (HBPD) for vandalism, failure to register as a sex registrant, and failure to change his address as a registered sex offender (HBPD 20-014262). This arrest was filed as a misdemeanor vandalism and as a violation of Moran's probation. On December 23, 2020 Moran pled guilty to the misdemeanor vandalism and admitted his probation violation. Moran was sentenced to 150 days in The Orange County Jail (OCJ).

On December 19, 2020 at 1:57 a.m., Moran was booked into OCJ – Intake Release Center (IRC), located at 550 North Flower Street, Santa Ana, CA 92703. During the booking process, Moran was screened by Orange County Health Care Agency (OCHCA) medical and mental health professionals. During this screening, Moran reported the following pre-existing medical conditions: Type II Diabetes, High Cholesterol, and Hypertension. He reported taking Torvastat and Metformin. During the mental health screening, Moran expressed ideation of hurting others. He was housed in MOD L, Sector 18, Cell 8, under "observation precaution/mentally ill lockdown." On February 4, 2021, Moran was moved to Mod L, Sector 19, Cell 3.

While in custody, Moran was monitored frequently. He regularly refused to cooperate with medical and mental health professionals. Moran regularly declined medications, vital checks, treatments for various ailments, and medical examinations by medical professionals. While Moran exhibited mental health issues, his medical condition remained stable.

On February 5, 2021, an OCHCA Doctor contacted Moran in regards to Moran's report of left ear pain. The doctor prescribed Moran eardrops (Ofloxacin Otic) and evaluated Moran's overall medical condition. He reported Moran was stable and suffered from no other medical issues or complaints at the time.

On February 6, 2021 at 9:38 p.m., an OCHCA medical staff member was contacted by a jail deputy who reported that Moran had vomited. A standard nursing assessment was completed, which noted Moran's appearance as disheveled and Moran's demeanor as uncooperative. Moran refused medication.

Mod L, Sector 19 is equipped with a security camera with no audio. The camera has a distant view of the door to Cell 3 and limited visibility into the cell. A review of the video surveillance of the cell revealed the following:

On February 6, 2021, video footage shows safety checks being conducted by deputies approximately every 30 minutes. At approximately 5:33 p.m., immediately after a safety check was conducted on Moran's cell, there was movement within the cell that appears to be a possible fall. Safety checks were performed approximately every 30 minutes after the possible fall. At approximately 8:08 p.m., video footage shows deputies assist Moran from his cell and place him in a wheelchair. Moran is then transported to the nurse's station. Moran returned to his cell at approximately 8:17 p.m. The standard nursing assessment from that incident indicated Moran had vomited. Moran refused medication for both pain and vomiting as well as refused fluids. Moran was placed on a priority sick call for the next morning. Video footage shows deputies continuing to perform safety checks approximately every 30 minutes after Moran was returned to his cell and spending additional time during these safety checks observing and interacting with Moran, including opening Moran's cell door and appearing to communicate with Moran as well as using flashlights to look into Moran's cell. Video footage appears to show Moran moving within his cell throughout the night of February 6, 2021 and early morning hours of February 7, 2021. None of the deputies or OCHCA staff performing safety checks reported seeing any falls. None of the deputies or OCHCA staff noted any injury until February 7, 2021 at 6:05 a.m.

On Sunday February 7, 2021, at 6:05 a.m., an OCSD Deputy contacted Moran during the course of a safety check. The deputy noticed bruising and swelling on the right side of Moran's head. The deputy notified OCHCA medical staff of Moran's injury and medical staff examined him in his cell within minutes of the deputy noticing the injury. An OCHCA Registered Nurse contacted Moran and observed a large "hematoma" to Moran's right front parietal. The nurse noted Moran was frail, uncooperative, and refusing medical treatment. The nurse conferred with an OCHCA doctor over the phone. The doctor requested paramedics transport Moran to Orange County Global Medical Center (OCGMC) for a higher level of care.

At 6:35 a.m., Orange County Fire Authority (OCFA) paramedics contacted Moran who was seated at the nursing station. Moran had a visible injury to his right forehead, reported pain, and seemed confused. Moran was transported by Care Ambulance, from IRC to OCGMC Emergency Room (ER). Moran was stable during the entirety of transport to OCGMC ER.

At 7:00 a.m. Moran arrived at OCGMC ER. Moran was examined by a doctor upon arrival and a series of images were taken of Moran's head. Another doctor then interpreted the images and determined there was no fractures or dislocation present. Moran was treated with ice to his forehead. Moran was weak and agitated, but was aware of his surroundings and had a good appetite.

On February 8, 2021, Moran was transferred from OCGMC to Anaheim Global Medical Center (AGMC). Shortly after being transferred, Moran's medical condition began to decline. Moran experienced acute kidney failure and septic shock. He was diagnosed with streptococcus. A CT scan revealed cerebral venous sinus thrombosis (blood clots in the brain). Moran was diagnosed with bilateral cortical hemispheric strokes (brain strokes), sepsis (extreme reaction to infection), mastoiditis (ear infection), and fibrillation (a rapid heart rate).

On February 11, 2021, at 6:25 p.m., Moran was transferred back to OCGMC so he could receive a higher level of care. Moran was intubated upon arrival. OCGMC continued to treat Moran for acute encephalopathy, severe sepsis, acute respiratory failure, acute kidney injury, psychosis, atrial fibrillation, and acute thrombocytopenia.

Investigators interviewed a registered nurse who had been employed at OCGMC for approximately twelve years. She worked in the ER at OCGMC and oversaw the medical care of Moran while he was in the facility. She reported that Moran was transferred from AGMC to the critical care unit of OCGMC. She reported that Moran was unconscious since being her in her care. She said that Moran was unresponsive, had drainage in his ears, gargled speech, unequal pupils, and swelling in the brain. Moran was not sedated, was severely septic, had black toes, and was put on medication for sepsis.

She reported that an MRI completed at AGMC revealed Moran suffered from a few strokes and had swelling in the brain. Moran's condition did not improve at OCGMC and Moran's lower extremities became gangrenous. A compassionate release was requested to the court, but rejected shortly thereafter. Moran remained on life support, as hospital liaison workers contacted family to update them on Moran's failing medical condition.

On February 12, 2021, it was noted by an OCGMC doctor that Moran had diminished lung capacity and his toes and heels had a "purplish" discoloration. Moran was monitored daily and had no significant changes or improvements. Moran remained on a ventilator and comatose. Over the next several weeks there was no significant improvement. On February 26, 2021 the doctor noted Moran remained comatose, was suffering from intracranial swelling, and that Moran's feet were now gangrenous. There was discussion that Moran's feet would need to be amputated.

Moran's medical condition remained the same through the end of February. OCGMC was in contact with Moran's family regarding his medical condition. At the time, it was the family's wish that Moran remain on life support.

On March 2, 2021, at 3:01 a.m., Moran was released from OCSD custody, after serving a full sentence. Moran remained hospitalized at OCGMC due to his critical condition. Because Moran was released from OCSD custody, there were no law enforcement personnel present to control access to or preserve evidence at OCGMC. Moran's family was kept apprised of his condition, and they requested OCGMC to withdraw medical care. On March 3, 2021 at 3:35 p.m., Moran was pronounced deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Blood standard
- Muscle standard
- Fifty-three (53) digital photographs of the hospital scene and body
- Forty-five (45) digital photographs during the autopsy
- Nineteen (19) post-embalming photographs of Moran at the OCSD Coroner Division

AUTOPSY

On Wednesday, March 10, 2021, an independent forensic pathologist conducted an autopsy on the body of Richard Moran. The cause of death was multiple system organ failure due to sepsis, group A streptococcus bacteremia, and disseminated mastoiditis. The manner of death was natural.

Other conditions present were cerebral hypoxia associated with cerebral atherosclerosis, hypertensive and atherosclerotic cardiovascular disease, pneumonia, history of diabetes mellitus, and history of psychosis.

Other relevant autopsy findings are as follows:

- **Major Injuries**:
  - None
- **Minor Injuries**:
  - None
- **Natural disease and pre-existing conditions**:
  - Healing skin erosions and ulcers; face, sacrum, extremities
  - Ischemic necrosis, toes
  - Pleural effusions, pericardial effusion, and ascites
  - Healing subgaleal hemorrhage
  - Cerebral atherosclerosis
  - Changes consistent with hypoxic encephalopathy
  - Pulmonary congestion and edema
  - Cardiomegaly with left ventricular hypertrophy
  - Moderate coronary atherosclerosis
  - Moderate to severe peripheral atherosclerosis
  - Nephrosclerosis
  - Acute gastritis

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Morphine (Free)	Postmortem Blood	0.292 + 0.031 mg/L
Benztropine	Postmortem Blood	Detected
Levetiracetam	Postmortem Blood	Detected

BACKGROUND INFORMATION

Richard Moran had a State of California Criminal History record with arrests dating back to 2010 for the following violations:

- 20001 VC Hit and Run: Death or Injury
- 288(a) PC Lewd or Lascivious Acts w/ Child under 14
- 1203.2 PC Probation Violation
- 594(B)(1) PC Vandalism

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 person;
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 acted he knew his 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 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 acts is so different from how an ordinarily careful person would act in the same situation that his or 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 the present case, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel 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 Richard Moran a duty of care, the evidence does not support a finding that this duty was in any way breached, either intentionally or through criminal negligence. Review of video surveillance and other relevant evidence show that OCSD personnel consistently exercised reasonable care in treating and handling Moran.

Upon being arrested, Moran underwent a comprehensive medical and mental evaluation. From there it was determined that Moran suffered from pre-existing medical conditions and mental health issues, but was overall stable. Due to this evaluation, Moran was housed in Mod L, the mental health section for the majority of the time he was incarcerated.

Throughout Moran's time in custody, he repeatedly refused medication as well as medical and mental health evaluations, even when his conditions worsened. He often refused to cooperate with the deputies and medical staff. Even so, the deputies and medical staff continued to check on him and make available to him the medication he needed.

Safety checks were performed on Moran approximately every 30 minutes and medicine was distributed when necessary. On several occasions, deputies spent extra time monitoring Moran. The deputies performed these safety checks by looking inside the cell, using their flashlights to gain better visibility, and occasionally entering the cell and appearing to communicate with Moran. During the time in between checks, the surveillance footage shows movement within the Moran's cell. On two occasions during the evening of February 6, 2021, and in the early morning hours of February 7, 2021, Moran was removed from his cell and taken to the nurse's station for evaluation and treatment once, due to him vomiting, and a second time when the head injury was first observed. On the second occasion, the nurses in consultation with a doctor decided Moran needed to be transferred to the hospital.

Within a 13-hour window, the deputies checked on him a minimum of every 30 minutes and sometimes more frequently. During the safety check, when the deputy observed a head injury to Moran, the deputies acted immediately, alerting health care professionals who in consultation with a doctor determined Moran would need to be transported to a hospital. Once it was determined that Moran would need more intensive medical attention, the deputies assisted OCFA Paramedics in transferring him out of jail to a hospital. How the injury occurred is unknown, as it was not witnessed by any OCSD or OCHCA staff, nor is a fall itself captured on video. There is one possible, but

unconfirmed, fall at 5:33 p.m. on February 6, 2021 captured on surveillance. However, Moran was checked multiple times after that possible fall by OCSD staff and OCHCA staff, no injury or problems were noted. Additionally, Moran was seen moving in his cell on multiple occasions after that possible fall. After the decision was made to transport Moran to the hospital, Moran was stable, awake, and aware. During his initial testing at OCGMC Moran was aware and stable. Moran received constant medical care while hospitalized. However, he continued to decline over the course of multiple weeks in the hospital. Moran was placed on life support and eventually had care withdrawn by his family and was pronounced dead.

The evidence does not support a finding beyond a reasonable doubt that OCSD failed to perform a legal duty, or that their actions can be classified as criminally negligent. The OCSD provided the necessary medical care throughout Moran's time in custody. At no time did the OCSD fail to act, act recklessly, or act with gross negligence to cause Moran'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 Richard Moran. The evidence shows that Richard Moran died as a result of multiple system organ failure and that the death was a natural one.

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

Respectfully submitted,

SHANE MELZER
DEPUTY DISTRICT ATTORNEY
Gangs Unit

READ AND REVIEWED BY **BARBARA KIM**
Assistant District Attorney
Special Prosecutions Unit

12-22-2021

READ AND APPROVED BY District Attorney **TODD SPITZER**