OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

August 14, 2020

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

Re: Custodial Death on August 31, 2019
Death of Inmate Robert Anthony Moreno
District Attorney Investigations Case # SA 19-020
Orange County Sheriff's Department Case # 19-030529
Orange County Crime Laboratory Case # FR 19-51595

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 August 31, 2019, custodial death of 22-year-old inmate Robert Anthony Moreno.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Moreno. 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 31, 2019, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Theo Lacy Facility (TLF), where Moreno died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 15 witnesses, conducted 23 canvass interviews, 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, 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 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.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

At approximately 3:48 p.m. on August 27, 2018, Moreno was arrested by La Habra Police Department (LHPD) for a robbery. LHPD transported Moreno to the Orange County Jail Intake-Release Center (IRC) where he was booked. Later that day, Moreno was transferred to OCJ Main. The following day, Moreno was transferred from OCJ Main to the Theo Lacy Facility (TLF) and placed in Module J.

On July 25, 2019, Moreno was placed in TLF, Disciplinary Isolation in Module N. On August 3, 2019, he was transferred back to TLF, Module J and placed in Cell 4, on the upper bunk.

On August 30, 2019, John Doe 1 was arrested, then transported to IRC and booked. The following day, inmate John Doe 1 was transferred to Module J, Cell 4 with Moreno and assigned to the lower bunk.

On August 31, Moreno participated in dayroom, interacted with inmates, and ate meals as provided; no inmates or deputies noted Moreno acting unusual or out of character. At

approximately 5:43 p.m., dayroom ended; all inmates returned to their cells and the cell doors were locked closed.

After dayroom had ended, surveillance video footage shows Moreno stood at the window looking out toward the dayroom as a deputy walked past his cell. For the next 45 minutes, Moreno and John Doe 1 moved about the cell and appeared to interact with one another. At approximately 6:31 p.m., Deputy Randall Lum conducted a safety check of the entire sector. As Deputy Lum walked past Moreno and John Doe 1's cell, Moreno was seated on the stool nearest the window.

A few minutes later, Moreno and John Doe 1 stood up and appeared to begin straightening up the cell and their bunks. After straightening up, Moreno sat back down on the stool nearest the window. At about 6:48 p.m., Moreno stood up, put on his shirt, walked over and sat on the far end of the bottom bunk, away from the window. At this time, the doors to the cells were remotely opened and the inmates could now freely move about the sector. At approximately 6:51 p.m., Moreno walked over to the stool nearest the window and sat down. Moreno remained seated on that stool for 18 minutes, while John Doe 1 moved around the cell, talking with Moreno and to other inmates through the glass. During that time, John Doe 1 received and passed unknown items under the door to several inmates. At approximately 7:08 p.m., John Doe 1 helped Moreno, who appeared unconscious at this time, off the stool and to the floor. Inmate John Doe 2, who was walking by the cell, stopped and looked inside the cell. John Doe 1 spent approximately 90 seconds kneeling over Moreno before he apparently passed something under the door to John Doe 2. John Doe 2 immediately walked downstairs to Cell 3, where he appeared to pass something under the door to Inmate John Doe 3. At approximately 7:20 p.m., John Doe 1 moved Moreno up onto the bottom bunk. For the next 33 minutes John Doe 1 paced around the cell and on occasion appeared to check on Moreno.

At approximately 7:33 p.m., Deputies David Swalley and Daniel Parker conducted a safety check and mail delivery for the entire sector. Deputy Swalley completed the top tier safety check. When Deputy Swalley delivered mail to Cell 4, John Doe 1 was standing at the cell door and Moreno was lying on the bottom bunk. John Doe 1 did not alert Deputy Swalley to Moreno's condition at this time. Deputy Swalley likewise did not observe anything out of the ordinary when completing the safety check. John Doe 1 stated that Moreno was still breathing when Deputy Swalley passed by. About 20 minutes later, medication distribution began. The doors to Cell 2, 4, 6, and 8 were remotely opened. John Doe 1 exited the cell, went downstairs, and received his medication. Moreno stayed in the cell as he was not scheduled to receive medication. John Doe 1 then returned to his cell and appeared to check on or tend to Moreno. About 5 minutes after that, John Doe 1 moved Moreno off the bottom bunk and onto the floor. John Doe 1 began to pace back and forth. He took a white T-shirt or towel from the foot of the upper bunk then carried it toward Moreno.

The doors to cells 10, 12, 14 and 16 were then remotely opened. John Doe 2 left his cell and walked immediately over to Cell 4. John Doe 1 came to the window and spoke with John Doe 2. Several other inmates stopped at Cell 4 and looked inside and/or spoke with John Doe 1. John Doe 1 spent much of the next 13 minutes bent over Moreno. John Doe 2, along with other inmates, claimed they had asked John Doe 1 if Moreno was doing alright and John Doe 1 assured them Moreno was fine. At approximately 8:19 p.m., John Doe 1 pushed the emergency button and reported Moreno had fallen off the bunk and was vomiting. John Doe 1 later admitted this to be false, but did not want Moreno to get in trouble. Deputies Swalley and Parker responded to the sector. CSA Jasmine Gonzalez ordered all inmates to return to their cells and summoned TLF medical personnel. Once all inmates were secured in their cells, Deputies Swalley and Parker entered the sector.

Deputies Swalley and Parker opened Cell 4 and ordered John Doe 1 out of the cell. They entered the cell and found Moreno unconscious leaning against the far wall. They checked Moreno for vitals but they were unable to locate a pulse. Deputy Swalley broadcasted via his hand held radio that he had a man down, who was not breathing and had no pulse. He requested paramedics respond immediately.

Deputy Swalley laid Moreno flat on the ground and initiated chest compressions, while Deputy Parker returned to the guard station and retrieved the medical bag. Deputies Parker and Swalley moved Moreno out on to the landing. Deputy Swalley continued chest compressions and Deputy Parker administered "at least one" ampule of Narcan nasal spray up Moreno's nostril. Within 7 minutes, Orange County Health Care personnel arrived. An automated external defibrillator (AED) was placed on Moreno. The AED analyzed Moreno and recommended no shock. A dose of Narcan was provided intramuscularly and CPR was continued until paramedics arrived. At 8:31 p.m., Orange City Fire Department (OFD) arrived. After performing the necessary medical treatment, Moreno was placed on a backboard equipped with an Autopulse. The Autopulse performed CPR on Moreno while he was transported Code 3 (emergency lights and siren) to the University of California Irvine, Medical Center (UCI), where his care was relinquished to UCI emergency room personnel. After stabilizing Moreno, lab results showed his venous blood gas level was 6.96; a level incompatible with life. CT scans showed significant cerebral edema, consistent with anoxic brain injury (oxygen deprivation). Moreno's grandparents decided at that time to transition Moreno to "Comfort Care" which would allow for a natural death.

On September 1, 2019 at approximately 1:36 a.m., Moreno's heart stopped and the attending physician pronounced him deceased.

All 29 inmates housed in Module J Sector 11 at the time of the incident were interviewed. The majority of the inmates indicated that they were unaware anything was wrong until they saw OCSD deputies remove Moreno from his cell and initiate CPR on him.

After conducting interviews with the inmates, it was determined from statements given by John Doe 1, that Moreno ingested a brownish powder, resembling Play-Dough, from a "spork"; he dissolved the substance in water, and then snorted the substance up his nose. John Doe 1 reported that a couple minutes later, Moreno went unconscious and fell out of his chair. John Doe 1 indicated that he conducted CPR on Moreno, when Moreno vomited, before the deputies had arrived to deliver mail.

Interviews with two inmates suggested that John Doe 1 gave the drugs to Moreno, which ultimately led to his death. One inmate, John Doe 4, was a friend of Moreno and made it clear he believed John Doe 1 could have prevented Moreno's death. At the time of the investigation John Doe 4 was in custody for a murder and had previously been in custody for bank robberies. Despite suggesting that it was John Doe 1 who provided Moreno with drugs, John Doe 4 never saw John Doe 1 supply anyone with drugs nor had John Doe 4 ever spoken to John Doe 1 about drugs. John Doe 4 was relying on statements given to him by Moreno in which Moreno told John Doe 4 that John Doe 1 possessed drugs.

The second inmate, John Doe 5, came forward with this information well after the event. Additionally, John Doe 5 displayed a clear animosity toward John Doe 1 referring to John Doe 1 as a "piece of shit." In an interview conducted on October 30, 2019, John Doe 5 indicated that he knew John Doe 1 both from time spent in prison together as well as through mutual friends. John

Doe 5 stated that he had personally received narcotics from John Doe 1 and that the day after Moreno's death, John Doe 1 admitted to giving narcotics to Moreno on the day of the incident. Further, John Doe 5 claimed that John Doe 1 told him that he hid the remaining drugs he had within his person. Though John Doe 5 was not told how much drugs John Doe 1 hid within him, he believed it to be a lot. John Doe 5 acknowledged he was facing active charges and suggested that he desired help with his own situation for the information he provided as he came forward to OCSD personnel after he received a "write up" in jail.

John Doe 1 denied providing Moreno with any narcotics. John Doe 1 was searched after this event and sewn into the lining of his boxer shorts were five (5) suboxone strips. John Doe 1 was further searched with a body scan, which revealed no additional contraband. Moreno and John Doe 1's cell was likewise searched and revealed no narcotics. There was a brownish liquid in a cup, which was believed to be coffee at the time of the search. Subsequent testing indicated that the liquid contained caffeine, however no controlled substances were detected.

All cells in Module J Sector 11 were searched and no narcotics were found other than the suboxone strips found within John Doe 1's boxer shorts.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- One white bed sheet.
- One sample of apparent vomit.
- One sample of dark liquid from plastic cup.

AUTOPSY

On September 6, 2019, Forensic Pathologist Dr. Scott Luzi of Clinical and Forensic Pathology Services conducted an autopsy on the body of Moreno. At the conclusion of the autopsy, Dr. Luzi stated there were no signs of trauma on the body. The cause of death was pending review of medical records, toxicology and examination of the microbiological slides.

On April 16, 2020, Dr. Luzi issued his findings in the death of Moreno. Dr. Luzi indicated the cause of death was multiple drug intoxication of fentanyl, methamphetamine, and morphine and that the manner of death was an accident.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	POSTMORTEM BLOOD	ANTEMORTEM BLOOD
4-ANPP	Detected	Detected
Amphetamine	0.0650 + 0.0040 mg/L	Detected
Fentanyl	0.049 + 0.0006 mg/L	0.0032 + 0.0004 mg/L
Methamphetamine	5.10 + 0.37 mg/L	3.05 + 0.22 mg/L
Morphine (Free)	0.0730 + 0.0078 mg/L	0.175 + 0.0019 mg/L
Norfentanyl	Detected	

BACKGROUND INFORMATION

Moreno had a State of California Criminal History record that revealed arrests dating back to 2016 for the following violations:

- Under the Influence of Controlled Substance
- Obstruct Public Officer
- Driving Under the Influence of Drugs
- Failure to Obey Lawful Order
- Inflict Corporal Injury
- Battery of Cohabitant
- Vandalism
- Shoplifting
- Robbery

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

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 Moreno a duty of care, the evidence does not support a finding beyond a reasonable doubt that this duty was in any way breached, either intentionally or through criminal negligence. Review of surveillance video, and all other relevant evidence, shows that OCSD personnel conducted hourly safety checks, which included walking by Moreno's cell. OCSD deputies conducted their duties in a reasonable manner and responded to the scene effectively and appropriately upon discovery of Moreno's situation.

A review of all evidence shows that a safety check was done by an OCSD Deputy at approximately 6:31 p.m. and there was no indication of Moreno being in any trouble or distress. After this safety check, Moreno was seen moving about his cell. Another safety check was conducted by an OCSD Deputy at approximately 7:33 pm and again there was no indication that anything was out of the ordinary to the Deputy. Further, as the Deputy conducted the safety check, Moreno's cellmate John Doe 1 did not alert the Deputy to any sort of problem. Once OCSD personnel was informed of trouble, when the panic button of Moreno's cell was activated at approximately 8:19 p.m. all OCSD personnel involved gave an immediate and appropriate response.

Moreno's toxicology results revealed a substantial amount of illegal narcotics in his system. Further, the final autopsy report indicates that Moreno's cause of death was multiple drug intoxication of fentanyl, methamphetamine, and morphine. It is apparent from all of the gathered evidence that Moreno acted independently and on his own accord to procure these illegal narcotics. It should also be noted that the OCDA has reviewed all of the available evidence and determined that there is a lack of evidence to prove beyond a reasonable doubt that any particular inmate provided these drugs to Moreno. As soon as the deputies became aware of Moreno's unresponsive and distressed condition, each and every personnel acted within the protocol and immediately administered emergency medical care.

Though review of the surveillance video shows that inmates passed items back and forth to one another, there is no evidence to show beyond a reasonable doubt that any of these items were narcotics. Likewise there is no evidence to show any OCSD personnel were aware of narcotics being passed between the cells. Hourly checks were done in which deputies walked by all of the inmates' cells. Further, all cells in Module J Sector 11 were searched, yet none of these searches revealed any narcotics. The only controlled substance of any kind that was found throughout the investigation were five (5) suboxone strips which were sewn into John Doe 1's boxer shorts.

The evidence in this case does show that two inmates, John Doe 4 and John Doe 5, suggest John Doe 1 provided Moreno with the drugs that ultimately led to his death. However, this evidence is insufficient to prove beyond a reasonable doubt that John Doe 1 in fact gave Moreno the drugs or breached a duty to him. John Doe 4, is currently awaiting trial for murder, and had no firsthand knowledge of John Doe 1 possessing drugs. John Doe 4 believed John Doe 1 supplied the drugs based on alleged and unverifiable statements given to him by Moreno in which Moreno allegedly indicated that John Doe 1 had narcotics in the cell. Likewise, John Doe 5's information also lacks sufficient reliability to prove that John Doe 1 breached a duty to Moreno. John Doe 5 displayed a clear animosity toward John Doe 1, referring to him as a "piece of shit," and further only provided this information to law enforcement after he received a "write up" while in custody and at times indicated that he wanted to help himself. Furthermore, despite John Doe 5's claims, all cells in Module J Sector 11 were searched shortly after the event and no narcotics were found. Likewise, though John Doe 5, claimed John Doe 1 told him he hid narcotics within himself, a body scan was performed on John Doe 1 and this also did not indicate the presence of any narcotics. Therefore, though there is some evidence to suggest John Doe 1 may have provided drugs to Moreno, such evidence lacks the necessary reliability to prove beyond a reasonable doubt that John Doe 1 breached any duty toward Moreno.

In total, there is no evidence to support a finding beyond a reasonable doubt that any OCSD personnel failed to perform a legal duty. Likewise, there is insufficient evidence to prove beyond a reasonable doubt that any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Moreno.

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 beyond a reasonable doubt that any OCSD personnel failed to perform a legal duty causing the death of Moreno. Further, there is insufficient evidence to establish beyond a reasonable doubt that any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Moreno. The evidence shows that Moreno died as a result of an accidental drug overdose and that the death was a natural one.

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

Respectfully submitted,

SHAUN ABUZALAF
Deputy District Attorney
Gangs Unit

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

Read and Approved by District Attorney **TODD SPITZER**