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January 19, 2018

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

Re: Custodial Death on July 19, 2017
Death of Inmate Robert Gene Freeman
District Attorney Investigations Case # S.A. 17-020
Orange County Sheriff's Department Case # 17-028044
Orange County Crime Laboratory Case # 17-52957
Orange County Coroner's Office Case # 17-03281-YA

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 July 19, 2017, custodial death of 38-year-old inmate Robert Gene Freeman.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Robert Gene Freeman. 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 July 19, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Orange County Jail Intake Release Center, where Robert Gene Freeman died while in custody. During the course of this investigation, the OCDASAU interviewed 16 witnesses, and conducted a canvass of 25 inmates, as well as obtained and reviewed reports from the OCSD, Orange County Crime Laboratory (OCCL), Orange County Coroner's Office (OCCO), Orange County Global Medical Center (OCGMC), Orange County Fire Authority (OCFA), California Highway Patrol (CHP), Garden Grove Police Department (GGPD), incident scene photographs, medical response video, criminal history, 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 a veteran deputy district attorney for legal review. Deputy district attorneys from the Homicide, TARGET/Gang, and Special Prosecutions Units review fatal, as well as 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, 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.

All OCSD personnel consented to be interviewed by OCDA investigators except Correctional Safety Assistant ("CSA") Quentin Blakely. CSA Blakely declined to make a statement to the OCDA. While it would have been preferable to obtain a voluntary statement from CSA Blakely regarding his state of mind and observations of Freeman, his choice to decline to provide an interview may not legally and ethically be used to draw negative evidentiary inferences regarding CSA Blakely's conduct as it pertains to Freeman's death.

FACTS

On July 17, 2017, at approximately 8:05 a.m., Freeman was arrested by the California Highway Patrol. Freeman was the passenger in a stolen vehicle involved in a high speed chase and two separate hit and run collisions. Freeman had objective symptoms of being under the influence of narcotics, including bloodshot eyes, slurred speech, and continually nodding off. The driver possessed a usable quantity of heroin and methamphetamine on his person. Narcotics paraphernalia, ammunition, and stolen property were located in the vehicle.

Freeman was arrested for being under the influence of a controlled substance, possession of narcotics, possession of stolen property, and felon in possession of ammunition. Paramedics responded to the scene and did not detect any injury as it relates to Freeman. Freeman also stated he was not injured and refused treatment. Freeman was transported to the Orange County Jail (OCJ), but he was denied entry because he complained of back pain. Freeman was then taken to the OCGMC, where he was evaluated, deemed to be resting comfortably, with no signs of acute trauma, and medically cleared. Freeman did disclose a history of heroin addiction, methamphetamine dependence, and back pain.

At approximately 7:35 p.m., Freeman was returned to OCJ and booked. During screening, Freeman was asked if he used street drugs, or recently swallowed or placed a baggie of drugs into a body cavity. Freeman answered no to each question, although the date of his last use of narcotics was listed as July 17, 2017. Freeman did not complain of pain or medical distress. Prior jail records list admissions of heroin, methamphetamines, THC, pills, and detoxification medication use. Jail classification records on July 17, 2017, list methamphetamine use and identify Freeman as an assaultive inmate with an extensive criminal history.

On July 18, 2017, at 7:16 a.m., Freeman was placed in Module M, Section 21, Cell 14 of the Intake Release Center (IRC). Module M, Section 21 is a two-level, male inmate housing unit. There are eight cells on each level, which contain two inmates. There are no surveillance cameras in Section 21, but a permanently manned, glass guard station has a full view into each cell for constant supervision of all inmates. Cell 14 is enclosed by three block walls and a front panel and door composed of metal and glass. Two bunk-type beds are attached to the wall, and there is a recessed speaker and call button located in the wall so inmates can communicate with the guard station.

Freeman was placed with cellmate John Doe, whom he did not know, on the morning of July 18, 2017. On that same day, Freeman went to court before lunch and returned after dinner. According to John Doe, Freeman was sweating and appeared high. Freeman told John Doe he was, "going to kick bad," because he had been awake the last 10 days due to methamphetamine use. John Doe said Freeman appeared high and "out of it," slurred his words, couldn't hold a

conversation, and nodded off while on the toilet. Freeman also disclosed to John Doe that he brought in heroin and was trying to pass it, but John Doe did not know if Freeman was able to do so. Freeman then went to his assigned upper bunk and slept.

Deputies Arnold Deedrick and Shaun Stewart were assigned to Module M for the duration of their shift, which was from 6:00 p.m. on July 18, 2017, to 6:30 a.m. on July 19, 2017. The deputies were not told of any issues within Module M. Their duties were to personally and physically monitor inmate movement and safety, oversee medical and food distribution, and conduct mandatory safety and Module Book counts. CSA Blakely worked the same hours and was assigned to physically man the guard station, which was required to remain occupied at all times.

Deputies are required to conduct daily safety checks and Module Book checks on a specific and mandatory schedule. Safety checks are an hourly walk by each cell to make sure the inmates are safe and present, and there is no unusual activity. There is also an 11:30 p.m. body count. Module Book checks do not require interaction between the deputy and inmate. Distribution of medications and meals may also be considered as safety checks.

Module Book checks are to be conducted at approximately 8:00 p.m. and 4:00 a.m. During a Module Book check, all inmate movement is frozen. Deputies are required to approach each cell and physically compare every inmate with the picture and name in the Module Book, to confirm a match. If the inmate is asleep or his face is not visible, deputies will ask the cellmate to wake him, or personally enter the cell to observe the inmate, make the comparison, and obtain acknowledgment from the inmate. OCSD's policy is that all safety checks and Module Book checks are to be conducted by deputies, and every activity manually recorded in a computer log, entitled "Safety Check Log," by the CSA.

The Safety Check Log relating to this incident reads as follows:

July 18, 2017

Begin	End	Checked By	Check Type	Notes	Entered By
1611	1635	STELL/ BECKER	Safety	Chow Pass	Owens
1723	1744	BECKER	Mental Health Evals	All Secure	Owens
1843	1848	DEEDRICK	Safety	All Secure	BLAKELY #9454
1947	1953	DEEDRICK	Safety	All Secure	BLAKELY #9454
2005	2014	STEWART/ DEEDRICK	Count	Count Clear	BLAKELY #9454
2043	2116	STEWART	Safety	All Secure	BLAKELY #9454
2215	2221	STEWART	Safety	All Secure	STEWART
2320	2332	DEEDRICK	Count	Count Clear	STEWART

July 19, 2017

Begin	End	Checked By	Check Type	Notes	Entered By
0031	0039	STEWART	Safety	All Secure	BLAKELY #9454
0138	0144	STEWART	Safety	All Secure	BLAKELY #9454

0243	0250	STEWART	Safety	All Secure	BLAKELY #9454
0350	0357	DEEDRICK	Safety	All Secure	STEWART
0420	0428	STEWART/ DEEDRICK	Count	Count Clear	BLAKELY #9454
0432	0501	STEWART/ DEEDRICK	Safety	All Secure	BLAKELY #9454
0554	0559	STEWART/ DEEDRICK	Safety	All Secure	BLAKELY #9454
0659	0710	SMITH	Meds/Safety	All Secure	PICAZO
0736	0740	PANIAGUA	Meds/Safety	All Secure	PICAZO

John Doe stated that he did not sleep much on the evening of July 18, 2017, because Freeman's snoring kept him awake. John Doe said deputies would do their hourly checks and come to the window, and they looked in the cell multiple times. According to John Doe, during a count on July 18, 2017, the deputy did try to rouse Freeman but Freeman was not budging. The deputy kicked the door and opened it before he saw that Freeman was breathing and snoring. The deputy made the comment, "Wow, he's unbelievable," and walked out. John Doe said Freeman was gurgling and sounded like he was trying to swallow something all night. John Doe was concerned about Freeman because Freeman would briefly stop breathing while he was asleep, but John Doe did not share this information with the deputies.

Deputy Deedrick had been a sworn peace officer for five months and was assigned to the IRC. He conducted the 8:05 p.m. Module Book check on John Doe and Freeman. Deputy Deedrick said he had John Doe try to wake Freeman and Freeman would not look at him. Deputy Deedrick went into Cell 14 and yelled at Freeman, who was lying on his back. Deputy Deedrick was able to look at Freeman's face, which was free of any fluid or debris. Freeman moaned, which Deputy Deedrick described as sounding like attitude rather than Freeman being in pain, and rolled over and away from Deputy Deedrick. Deputy Deedrick said John Doe told him Freeman was "kicking it," which Deputy Deedrick interpreted to mean Freeman was detoxing from drugs. Deputy Deedrick did not see any signs of distress and did not think Freeman's behavior presented any differently than other inmates with substance abuse issues. Deputy Deedrick felt John Doe was monitoring Freeman and would alert the deputies if anything out of the ordinary occurred. According to Deputy Deedrick, CSA Blakely conducted the 4:20 a.m. Module Book count of Sections 21 through 23, which included Freeman's cell. Deputy Stewart felt ill and stayed in the guard station. According to Deputy Deedrick, CSA Blakely did not mention Freeman.

Deputy Stewart had been a sworn peace officer for five years, assigned to the IRC, and was a CSA with OCSD two years prior. He maintained that CSA Blakely conducted the 8:05 p.m. Module Book check the night before, while he stayed in the guard station due to illness, and Deputy Stewart did the 4:20 a.m. Module Book check of Freeman's cell. Deputy Stewart stated he did not go into the cell, but compared Freeman's face with the book, and saw him breathe because he was on his bunk on his back, shirtless, and not covered by a blanket. Deputy Stewart said he did not see any signs of distress or vomit, but recalled Freeman being a heavy sleeper because John Doe was unable to wake him. Deputy Stewart said Freeman was not snoring or moaning. Deputy Stewart later stated that CSA Blakely did the 4:20 a.m. Module Book count on July 19, but Deputy Stewart observed Freeman during breakfast distribution at Freeman's cell at approximately 4:30 a.m. Deputy Stewart did recall going to Freeman's cell and speaking with John Doe, who informed Deputy Stewart that Freeman was "kicking hard." Deputy Stewart said it is common for inmates to be detoxing from drugs and feel too ill to get up. Deputy Stewart also stated he did not make any entries in the Safety Check Log.

At approximately 4:30 a.m. on July 19, 2017, breakfast was delivered to Cell 14. John Doe retrieved breakfast for himself and Freeman. John Doe stated that he shook Freeman a little, but he was still snoring, although not as loud and deep as the previous night. John Doe wanted to eat with Freeman, so he went back to sleep. Both Deputies Deedrick and Stewart recall doing the final safety check at 5:54 a.m. and did not see any signs of distress.

A new shift started at 6:00 a.m. on July 19, 2017, which included CSA Kristen Picazo, Deputy Jeremiah Henry, and Deputy Robert Smith. During briefing, there were no issues raised regarding Module M or Freeman.

When John Doe awoke after 7:00 a.m., he did not hear any noises from Freeman. John Doe got up and felt Freeman's chest for a heartbeat, but was unable to find one. John Doe said Freeman was cold and not breathing. John Doe contacted an inmate in another cell to ask what he should do. The inmate told John Doe to use the emergency button to contact the guard station. At 7:10 a.m., John Doe used the emergency button in his cell to contact the guard station.

CSA Picazo answered John Doe, who told her Freeman was not moving and did not appear to be breathing. CSA Picazo immediately contacted the closest deputy, Deputy Smith, who was with a nurse passing out medication. Deputy Smith went immediately to Freeman's cell and entered it. John Doe said a deputy and nurse arrived in less than one minute, and moved him to the dayroom. He heard them state, "Man down," and start chest compressions. CSA Picazo contacted medical personnel and the fire department. Other deputies and nurses heard the radio transmission, obtained medical equipment, and went to Cell 14 to assist.

Deputy Smith said he went to Freeman's cell as soon as he was notified. He shook Freeman and was not able to detect a pulse or breath, so he began to administer CPR. Black fluid emerged from Freeman's mouth with each compression. Black fluid was also present on Freeman's bedding. Nurses arrived and moved Freeman from the top bunk to the floor. The first nurse to arrive noted that Freeman was gray in color, had a fixed stare, and appeared to be deceased. They took over his medical care with CPR, the Ambu bag and suction. They activated the AED machine, which went through several cycles, but did not advise activity. Both the nurse and OCFA personnel indicated the black fluid was consistent with a gastrointestinal bleed, which is indicative of substance abuse. Freeman was declared deceased at 7:24 a.m.

There were no signs of trauma on Freeman and no indication he had any physical contact or altercation with any inmate. A search of Freeman's bunk revealed three cellophane baggies. It should be noted that on May 9, 2017, GGPD arrested Freeman. Prior to booking, he was treated at UC Irvine Health for oral heroin ingestion, which he stated occurred because he was being chased by the police. He was later medically cleared.

This investigation revealed deviations from OCSD's protocol with the Module Book count, and inconsistencies in the Safety Check Log and statements of staff members. These irregularities, however, when combined with the statements of John Doe and the evidence collected, do not appear to have affected Freemans' death, or the legal conclusions reached following this investigation.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Post-mortem blood
- Plastic bags from underneath upper bunk mattress
- Clothing from decedent
- Sheets from upper bunk and beneath decedent
- Piece of plastic recovered from decedent's body
- Plastic bindle with dark tarry substance recovered during post-mortem cleaning process, later determined to be .714 grams of heroin

AUTOPSY

On July 22, 2017, independent Forensic Pathologist Dr. Scott Luzi of Clinical and Forensic Pathology Services conducted an autopsy on the body of Robert Gene Freeman. The cause of death was determined to be the result of multiple drug

intoxication, and the manner of death as an accident. During the autopsy, a brown-black rectangular fragment of plastic was recovered from Freeman's colon. During post-mortem procedures, a baggie of similar type material containing heroin was recovered from Freeman's rectum as listed above in the "Evidence Collected" section.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Freeman's post-mortem blood was collected and examined by a forensic scientist at the OCCL. Amphetamine, Methamphetamine, Codeine, and Morphine were detected.

Substance Analysis

During the autopsy, a brown-black rectangular fragment of plastic was recovered from Freeman's colon. During post-mortem cleaning procedures, a baggie of similar type material was recovered from Freeman's rectum. The baggie contained a dark tar-type substance, which was open and oozing oil. It was tested by a forensic scientist at the OCCL and determined to contain .714 grams of heroin.

BACKGROUND INFORMATION

Robert Gene Freeman had a State of California Criminal History record consisting of the following:

- Possession of a Controlled Substance
- Being Under the Influence of a Controlled Substance
- Possession of Narcotics Paraphernalia
- Prison Escape
- Terrorist Threats
- Exhibiting a Firearm
- Possession of Ammunition by a Felon
- Brandishing a Deadly Weapon
- Carrying a Concealed Weapon
- Possession of a Switchblade
- Evading a Peace Officer Causing Great Bodily Injury
- Evading a Peace Officer
- Hit and Run
- Burglary
- Forgery
- Vehicle Theft
- Vehicle Theft with Prior
- Receiving of Stolen Property
- Petty Theft
- Possession of Burglary Tools
- Unlawful Possession of Master Vehicle Key
- Obstructing a Peace Officer
- False Information to a Peace Officer
- Driving Without a License
- Revocation of Post-Release Community Supervision
- Probation Violation
- Parole Violation
- Failure to Appear

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 Freeman a duty of care, the totality of all the available evidence does not support a finding that this duty was breached – either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

On July 17, 2017, Freeman was arrested following a vehicle pursuit with multiple collisions. Freeman was deemed to be under the influence of narcotics and he was charged with possession of heroin and methamphetamine, as well as narcotics paraphernalia. Freeman did not complain of injury and was medically cleared for booking by the OCGMC.

Two months earlier, following a different arrest, Freeman notified law enforcement he ingested narcotics. On July 17, 2017, during booking, Freeman disclosed substance addiction, but denied ingestion or secretion of drugs. Freeman did not complain of pain or medical distress at the time of his booking.

On July 18, 2017, Freeman was placed in Module M, Section 21, Cell 14, and he was able to travel to court without incident, and returned after dinner. John Doe, Freeman's cellmate, believed Freeman was still under the influence of narcotics. Freeman told John Doe he brought in heroin and was trying to pass it, but John Doe did not know if that occurred. Freeman also told John Doe he was going to "kick it bad," referring to detoxification, before going to sleep that evening. John Doe did not share this information with OCSD staff, and there is no evidence that Freeman complained of distress either before or after returning from court.

Although there are inconsistencies among jail staff regarding Module Book checks, John Doe confirms Freeman was snoring throughout the night, during the hourly safety checks and both Module Book checks, and during breakfast distribution at 4:30 a.m. John Doe was concerned about Freeman's breathing, but did not convey this to the deputies, although he did tell a deputy that Freeman was "kicking it hard." John Doe retrieved breakfast for both he and Freeman, and decided to wait until Freeman woke to eat together. Neither John Doe nor any jail staff saw at that time any signs of black liquid on Freeman or his bedding. Both Deputies Deedrick and Stewart recall doing the final safety check at 5:54 a.m. and did not see any signs of distress in Freeman's cell.

Freeman did not complain of pain or request the assistance of jail staff in Module M. There is no indication based on all the available evidence that deputies knew Freeman had ingested or secreted narcotics in his body. According to the deputies, Freeman's behavior was consistent with other inmates they had observed who were coming off of drugs, and did not appear to be unusual or require immediate medical care.

Once John Doe informed jail staff that Freeman had stopped breathing, the jail staff responded swiftly and appropriately to dispatch medical staff and gather necessary medical equipment. Although it appeared Freeman was deceased, they performed CPR, attempted to use the AED, and called paramedics. Freeman's cause of death was multiple drug intoxication by accident, and evidence from the autopsy indicated that Freeman ingested a baggie of tar heroin, which opened prior to exiting his rectum.

Therefore, 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 triggering any legal culpability on the part of OCSD or any individual under the supervision of OCSD.

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 Robert Gene Freeman died as a result of an accident relating to complications of multiple drug intoxication.

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

Respectfully submitted,

Erin Rowe
Deputy District Attorney
Special Prosecutions Unit

Read and Approved by **EBRAHIM BAYTIEH**
Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit