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September 6, 2017

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

Re: Custodial Death on January 10, 2017
Death of Rogelio Villagomez Morales
District Attorney Investigations Case # SA 17-002
Orange County Sheriff's Department Case # 17-001266
Orange County Crime Laboratory Case # 17-40611
Orange County Coroner's Office # 17-00181-MR

Dear Sheriff Hutchens,

Please accept this letter detailing the investigation and legal conclusion by the Orange County District Attorney's Office (OCDA) in connection with the above-listed incident involving the Jan. 10, 2017, custodial death of 59-year-old inmate Rogelio Villagomez Morales.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Morales. 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 Jan. 10, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to University of California – Irvine Medical Center (UCIMC), where Morales died while in custody after receiving medical treatment at the hospital. During the course of this investigation the OCDASAU conducted five interviews. Additionally, OCDASAU obtained and reviewed: OCSD reports; Orange County Crime Laboratory (OCCL) reports; laboratory and identification reports; autopsy reports; medical reports; incident scene photographs and videos; 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/Gangs, 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 ultimately review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On Friday, Nov. 25, 2016, at approximately 1:50 a.m., Morales was involved in a traffic collision with a parked vehicle in the city of Anaheim. During the resulting investigation by the Anaheim Police Department (APD), Morales was arrested for violating Vehicle Code sections 23152 and 20002, driving under the influence of alcohol or drugs (DUI) and hit and run, respectively. Additionally, it was determined that Morales was in violation of his probation for a previous 2016 DUI conviction. Following his arrest, Morales was transported to the APD for booking and subsequent transfer to Orange County Jail.

On Nov. 27, 2016, at approximately 3:00 p.m., Morales was transported to the OCSD's Intake/Release Center (IRC) in the city of Santa Ana. Morales was medically screened by an Orange County Health Care Agency (OCHCA) Registered Nurse upon arrival. Morales answered "no" to all medical questions and did not disclose any previously existing medical conditions. At approximately 3:09 p.m., Morales was booked into Men's Central Jail without incident.

On November 30, 2016, Morales was transferred to the Theo Lacy Jail Facility and housed in G-Barracks, General Housing Population. The following day, Dec. 1, 2016, Morales was moved from the G-Barracks to the F-Barracks, Inmate Worker Housing. F-Barracks can house a maximum of 384 inmates; 192 per side on both the upper and lower tiers.

On Friday, Dec. 23, 2016, around 10:25 a.m., another inmate, Inmate 1, was walking back to his bunk in the F-Barracks from the upper tier shower when he observed Morales sitting on a bottom bunk. Inmate 1 stated that Morales "did not look right." Morales did not seem to "have his bearings" about him and was "not coherent at all." Inmate 1 did not associate with Morales within the jail environment. However, through their brief interactions, Inmate 1 did not believe Morales was using drugs and did not know Morales to have any problems with deputies or other inmates while incarcerated. Upon observing Morales, Inmate 1 contacted two other inmates whom Morales did associate with, Inmates 2 and 3, and told them that something was wrong with Morales.

Inmate 2 immediately approached Morales and observed him sitting on top of his bunk, eyes closed, and unresponsive to basic questions. It appeared to Inmate 2 that Morales was able to hear sounds based on Morales' head movements. However, it did not appear that Morales could verbally respond to questions. Inmate 2 also described that Morales was making gagging noises, as though he was trying to vomit. Inmate 2 asked Morales if he wanted to go to medical and

Morales appeared to nod, somewhat affirmatively, in response. Therefore, Inmate 2, with the assistance of other inmates, carried Morales down to the first floor.

Inmate 3 similarly observed Morales sitting on top of his bunk, unresponsive to basic questions. It was apparent to Inmate 3 that there was something wrong with Morales. Both Inmate 2 and 3 described Morales as a quiet, elderly man who kept to himself; neither saw Morales drink alcohol, use drugs, or have any problems with deputies or other inmates.

At approximately 10:26 a.m., a nearby surveillance camera captured and recorded Inmate 2 and three other inmates carrying Morales down the staircase to the first floor. OCSD Deputy Chadwick Ensil made near-immediate contact with the four inmates at approximately 10:27 a.m., and instructed them to seat Morales on the floor. Deputy Ensil attempted to engage in conversation with Morales but his attempts were unsuccessful and he radioed for medical personnel to immediately respond to the area. While awaiting medical assistance, Morales can be observed on surveillance video seated on the floor; he appears to be dazed. At one point, Morales almost falls over but is caught by a nearby inmate prior to hitting the floor.

At approximately 10:31 a.m., a Registered Nurse and three additional medical personnel responded to Morales' location. After a quick evaluation, the Registered Nurse determined that Morales was alert, unable to answer questions appropriately, and displaying an altered level of consciousness. At approximately 10:35 a.m., Morales was transported to the Theo Lacy Facility Dispensary for further evaluation and it was soon after determined that Morales required medical treatment unavailable within the Theo Lacy Facility. Orange City Fire Department (OCFD) paramedics were requested and arrived on-scene at approximately 10:50 a.m. Morales was then loaded into an ambulance and transported to UCIMC, where he arrived at approximately 11:15 a.m.

Morales was admitted to the UCIMC Intensive Care Unit (ICU) upon arrival, presenting, according to UCIMC medical personnel, signs of a "fairly large ... left-middle cerebral arterial stroke." Morales had been awake and interactive when he arrived to UCIMC, but he presented with aphasia (difficulty expressing himself) and impaired language functions. Morales' condition did not improve, and it continued to deteriorate over the next few weeks during treatment at UCIMC.

UCIMC medical personnel determined that Morales had previously undergone a heart valve replacement surgery, requiring Morales to take a medication called Coumadin to thin his blood and prevent clotting. Approximately one week after Morales' initial stroke at the Theo Lacy Facility, UCIMC personnel began administering Morales a blood thinning medication to prevent clotting. However, on Jan. 6, 2017, soon after Morales received this medication, he suffered another stroke. The bleeding from the second stroke caused increased swelling in Morales' brain and his overall condition began to significantly worsen. Morales lost most of his brain function.

Surgery was attempted to relieve the building pressure inside Morales' skull, caused by the swelling of his brain, and reverse Morales' declining condition. However, this surgery was unsuccessful and Morales' condition only continued to deteriorate. Morales soon fell into a coma, required ventilator life-support, and lost most of his brain stem reflexes. A CT scan of Morales' brain showed that he continued to have severe brain swelling and that his brain had shifted its position, causing further damage to previously undamaged areas. According to UCIMC medical personnel, Morales' condition was not survivable. As a result, Morales was placed on comfort measures; his breathing tube was removed, and his medications were continued until he passed away. Morales was pronounced deceased on Jan. 10, 2017, at 12:54 p.m.

According to UCIMC medical personnel, Morales' initial stroke was not suspected to be the result of an assault, nor was it the type of injury consistent with an assault. Instead, they suspected Morales' initial stroke was likely the result of a blood clot associated with Morales' mechanical heart valve.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- 22 Inmate/Hospital Room Photographs
- Jail Clothing [Morales]

- Leg Chains and Locks [Morales]
- 19 Photographs of Clothing, Chains, and Locks
- 67 Autopsy and Post-Embalming Photographs
- Heart Bloodstain [Morales]

AUTOPSY

On Jan. 12, 2017, independent Forensic Pathologist Doctor Scott Luzi from Clinical and Forensic Pathology Services conducted the autopsy of Morales. During the autopsy, Dr. Luzi observed that Morales had an enlarged heart and bleeding of the brain. There was no evidence of trauma or external injuries. Dr. Luzi concluded that Morales' manner of death was natural due to intra-cerebral hemorrhage associated with a hypertensive heat disease. Dr. Luzi also concluded that Morales suffered a recent ischemic cerebral infract.

EVIDENCE ANALYSIS

Toxicological Examination

Samples of Morales's postmortem and antemortem blood yielded the following results:

DRUG	*MATRIX*	*RESULTS & INTERPRETATIONS*
Sevoflurane	Antemortem Blood	Detected
Midazolam	Postmortem Blood	0.331 ± 0.014 mg/L
Fentanyl	Postmortem Blood	0.0104 ± 0.0012 mg/L
Citalopram	Postmortem Blood	Detected
Metoclopramide	Postmortem Blood	Detected

BACKGROUND INFORMATION

Morales had a State of California Criminal History Record that revealed arrests dating back to 2001 for Disorderly Conduct while Under the Influence of Drugs, and Driving Under the Influence of Alcohol or Drugs

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/she acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he/she acts is so different from how an ordinarily careful person would act in the same situation that his/her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes. There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

In this case, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel or any 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 Morales 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).

Morales did not inform anyone at OCSD that he suffered from a pre-existing medical condition upon his arrival at the jail. Further, there were no signs, apparent or otherwise, that would have alerted anyone at OCSD that Morales was at risk of suffering a stroke or that a stroke was imminent. Deputy Ensil immediately summoned medical assistance for Morales once he determined Morales was unable to communicate, and medical staff responded to Morales' location within four minutes. Morales was evaluated without delay, and it was quickly determined that he required medical care not available at the Theo Lacy facility. Paramedics were requested to, and did so, respond to the location to transport Morales to UCIMC. There is no evidence that Morales was not treated or assessed in a timely matter, and it is obvious that OCSD personnel made every effort to ensure that Morales was properly cared for after discovering he was having a medical issue.

Consequently, there are no facts to support any inference that the OCSD intentionally breached their duty of care to Morales. There is also no evidence to support criminal negligence on the part of anybody connected with the OCSD. Criminal negligence is established when a person 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. There is no evidence that any OCSD personnel or anyone under their supervision acted in a reckless manner.

According to UCIMC medical personnel, Morales' condition was not the result of any physical assault by OCSD personnel or other inmates. Unbeknownst to OCSD, Morales had previously received an artificial heart valve transplant which resulted in an increased risk of suffering blood clotting and stroke. These risks could be, in part, mitigated by medication. Morales did not disclose any previously existing conditions or required medications during the booking process. Instead, when asked about the existence of any medical conditions, Morales responded in the negative. The booking process and initial evaluation of Morales was conducted without incident, and OCSD personnel only became aware of Morales' condition once alerted by other inmates.

Once alerted to Morales' condition, OCSD personnel quickly determined that Morales required medical treatment not available at the Theo Lacy facility. Thereafter, Morales was transported to UCIMC, without unnecessary delay, where he underwent surgery at the hands of skilled medical professionals. While at UCIMC, Morales unexpectedly suffered a second stroke and his condition continued to deteriorate to the point where it was clear to medical professionals that he would not survive.

Thus, there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD was criminally negligent or failed to perform a legal duty owed to Morales.

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 Morales died from natural causes as a result of suffering two strokes related to complications with his artificial heart valve.

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

Respectfully submitted,

JEFFREY KIRK
Deputy District Attorney
Special Prosecutions Unit

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