OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

June 28, 2021

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

Re: Custodial Death on November 12, 2020
Death of Inmate Richard Spindola
District Attorney Investigations Case # S.A. 20-029
Orange County Sheriff's Department Case # 20-037932
Orange County Crime Laboratory Case # 20-53906

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 November 12, 2020, custodial death of 35-year-old inmate Richard Spindola.

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 Spindola. 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 November 12, 2020, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Theo Lacy Jail Facility in the City of Orange, where Spindola died while in custody. During the course of this investigation, the OCDASAU conducted six (6) interviews, contacted nineteen (19) additional witnesses during the supplemental inmate canvas, 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

On November 10, 2020 at 1:45 a.m., Spindola was arrested by the Anaheim Police Department (APD) for violations of the following Penal Code Sections: 261(a)(2) – Rape by Force or Fear, 286(a) – Sodomy, 288(c)(1) – Lewd and Lascivious Acts, 594(a)(2) – Vandalism and 417(a)(1) – Exhibiting a Deadly Weapon other than Firearm. After his arrest, Spindola was transported to APD to be booked. At 2:03 a.m., a medical screening was conducted on Spindola by APD Officer E. Bennett. During the medical screening, Spindola was asked a series of questions including whether he felt suicidal or whether he had ever tried to take his own life. Spindola answered "No" to both of these questions. Spindola further stated that he had been previously diagnosed with Post Traumatic Stress Disorder (PTSD), and was not taking any prescribed medications. Spindola was later transported from APD to OCSD Intake/Release Center (IRC).

At 7:23 a.m., another pre-booking medical screening was done on Spindola by APD Jailer D. Holt. Holt completed a Covid-19 screening and noted Spindola appeared to be under the influence of marijuana. At 3:44 p.m., Orange County Health Care Agency staff conducted a Receiving Screening on Spindola. Spindola disclosed his use of marijuana and methamphetamine but gave no indication

of his last use. Spindola again referenced his previous PTSD diagnosis and stated that he had never been hospitalized, nor made attempts to hurt or kill himself. The Health Care Agency staff recommended a mental health examination for Spindola. At 6:08 p.m., the attending Registered Nurse (RN) completed the recommended mental health examination of Spindola. She noted he appeared to be alert and responsive. Spindola again disclosed his previous PTSD diagnosis, reported that he did not take prescribed medications, and answered "No" when he was asked if he felt suicidal or had attempted suicide in the past. The RN cleared Spindola for regular housing and reported that no further mental health counseling was needed unless he requested it.

On November 11, 2020 at 8:18 a.m., Spindola was transferred to the Theo Lacy Jail Facility where he was placed in Module R, Sector 60, Cell 10. Spindola was housed in Cell 10 alone as a part of the quarantine process for new inmates. Module R was monitored by two (2) security cameras with no audio. The security cameras had a distant view of the door to Cell 10 and partial visibility into the cell. A review of the video surveillance of the cell revealed the following:

On November 12, 2020 at 12:12 p.m., a deputy can be observed conducting a safety check, passing Spindola's cell, who is seen lying on the lower bunk of his bed. At 12:31 p.m., Spindola is seen standing at the cell door, looking out into the module. Spindola then walks out of view of the surveillance camera before returning to the cell door to look out into the module. Spindola repeats these actions in excess of forty (40) times over the next eight (8) minutes. At 12:39 p.m., Spindola is seen standing inside of his cell manipulating a white sheet from his bunk. He appears to fashion a ligature with the sheet that is hanging from the end of the top bunk. Spindola then once again goes to the cell door, walks away, and returns to the door to look out into the module. He repeats these actions in excess of forty (40) times. At 12:50 p.m., Spindola moves to the end of the bunk, places his head into the sheet ligature, and takes a seat at the end of his bunk facing the cell door. He remains motionless for two (2) minutes before he removes his head from the ligature, stands up, and moves back to the cell door where he again looks out over the module. A deputy and nurse then enter the lower portion of the module to complete a safety check and provide medication to the inmates. Spindola moves towards the sheet and manipulates it as he looks out of the cell door. Spindola then stands at the cell door, blocking the view of the sheet ligature as the deputy and nurse walk by without stopping. After they pass, Spindola returns to his bunk, places his head in the sheet ligature, and sits on his lower bunk.

At 1:00 p.m. Spindola is seen seated at the edge of his lower bunk. He moves his lower extremities forward, off the bunk and into a kneeling position. His full weight appears to be on the ligature and his body is seen jerking violently for approximately one (1) minute. At 1:01 p.m., he is seen in the same position, but is no longer moving. For the next few minutes, slight movement is seen until movement stops altogether at 1:05 p.m.

At 1:54 p.m., Deputy R. Murillo conducts a health check with the attending Behavioral Health Technician (BHT) who is seen walking ahead of Deputy Murillo before noticing a liquid substance on the floor in front of Cell 10. She then looks into the cell and observes Spindola hanging with the white sheet around his neck. He appears to be lifeless in a seated position with his heels resting on the floor. The BHT immediately notifies Deputy Murillo who looks into the cell before radioing for medical assistance. Deputy Murillo then enters the cell and moves behind Spindola in an attempt to lift his body weight to relieve the pressure from of his neck.

Spindola appeared pale and was not breathing. Sergeant J. Ackerman heard Deputy Murillo's request for help and ran to assist him in Cell 10. Sergeant Ackerman entered the cell and removed the sheet from Spindola's neck. Deputy Murillo and Sergeant Ackerman then laid Spindola on the

ground. Deputy Murillo located no pulse and began CPR. Sergeant Ackerman left the cell to retrieve medical equipment and returned at 1:58 p.m., at which point he began to provide oxygen to Spindola through an Ambu air bag valve mask. Additional Deputies arrived at the cell as well as three Registered Nurses. At 2:09 p.m., an RN attached an AED to Spindola's chest. When the AED device indicated shock was not advised, CPR was continued. As the RN placed a cervical collar around Spindola's neck, she noticed red abrasions. Deputies moved Spindola out of the cell onto the exterior landing of the module where he was given one (1) dose of Narcan, which had no effect. The RN attempted to administer an IV but was unsuccessful. The AED went through three (3) cycles while affixed to Spindola, advising no shock each time. Spindola appeared lifeless, had no pulse, was not breathing and his pupils were fixed/dilated.

At 2:10 p.m. the Orange City Fire Department (OFD) arrived, at which time Spindola was asystole. An intraosseous was established and four (4) separate one (1) milligram doses of epinephrine were administered to no effect. At 2:15 p.m., UC Irvine Medical Center (UCIMC) was contacted for medical advisement. A UCIMC Doctor gave orders through an RN to stop CPR. Spindola was pronounced dead at 2:32 p.m. by the base hospital physician.

AUTOPSY

On November 19, 2020, at 1:13 p.m., independent Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Spindola. Dr. Luzi observed a 44cm long red/brown ligature furrow on the skin of the neck, as well as a small abrasion on the front of the neck. No other injuries were noted. At the conclusion of the Coroner's investigation, Dr. Luzi determined the cause of death to be hanging, and the manner of death to be suicide.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	POSTMORTEM BLOOD	BRAIN
Amphetamine	0.0752 ± 0.0056 mg/L	0.109 ± 0.009 mg/kg
Methamphetamine	0.126 ± 0.009 mg/L	0.184 ± 0.014 mg/kg
THC	0.0038 ± 0.0006 mg/L	
Carboxy – THC	0.0410 ± 0.0056 mg/L	

BACKGROUND INFORMATION

In addition to his November 10, 2020 arrest, Spindola had a State of California criminal history record that revealed arrests dating back to 2013 for the following violations:

- Failure to Appear
- Possession of a Controlled Substance for Sale
- Inflicting Corporal Injury on a Spouse/Cohabitant
- Violation of a Protective Order
- Possession/Sale of Metal Knuckles
- Driving While Under the Influence
- Driving on a Suspended License
- Driving Without a Valid License

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/she acted, he/she knew his/her act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

A person can also commit murder by his/her failure to perform a legal duty, if the following conditions exist:

a. The killing is unlawful (*i.e.*, without lawful excuse or justification);
b. The death is caused by an intentional failure to act in a situation where a person is under a duty to act;
c. The failure to act is dangerous to human life; and
d. The failure to act is deliberately performed with knowledge of the danger to, and with conscious disregard for, human life.

A person can also commit involuntary manslaughter by failing to perform a legal duty, if the following conditions exist:

a. The person had a legal duty to the decedent;
b. The person failed to perform that legal duty;
c. The person's failure was criminally negligent; and
d. The person's failure caused the death of the decedent.

In *Giraldo v. California Dept. of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 250-251, the court held that there is a "special relationship" between jailer and prisoner:

> "The most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable than an inmate may be at risk of harm…. Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

> "A public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he acts in a reckless way that creates a high risk of

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

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

In this present case, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Spindola 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. On November 10, 2020, Spindola was given a medical screening following his arrest per booking procedures. He denied any history of suicide attempts or having suicidal thoughts. Spindola disclosed that he had been previously diagnosed with PTSD and had not been taking any prescribed medication for treatment. Spindola underwent another medical screening upon being transferred to the IRC, where he once again disclosed that he had been previously diagnosed with PTSD and had not been taking any prescribed medications for treatment. Upon this disclosure, he was recommended for a mental health screening where he again denied feeling suicidal or attempting suicide in the past. He also mentioned his PTSD diagnosis. Spindola appeared to be alert and responsive during his screening and the RN who conducted the screening found that no further mental health counseling would be required unless requested by Spindola.

Spindola was housed alone in a cell per the OCSD's jail quarantine protocol. The IRC conducted regular safety checks of the inmates, including Spindola. No unusual behavior was reported during these safety checks. The surveillance video footage shows Spindola checking the module from his cell door numerous times and blocking view of the manipulated sheet on the bunk during the safety check. No unusual behavior was noted during Spindola's final check before he was found unresponsive. Interviews of other inmates confirmed that no unusual behavior was noticed during this time frame. During the time between the checks, Spindola placed the ligature he fashioned out of a bedsheet around his neck and acted to apply his full weight onto it until his death. Immediately after he was discovered, Deputy Murillo called for medical assistance and attempted to relieve the pressure of the ligature around Spindola's neck. Sergeant Ackerman arrived within minutes and removed Spindola from the sheet ligature. Spindola was placed on the floor and Deputy Murillo began CPR as Sergeant Ackerman retrieved an Ambu bag valve mask to aid in supplying Spindola with oxygen. Shortly thereafter, medical staff arrived and continued care. The AED advised "no shock" and the medical staff and deputies continued CPR. Medical staff attempted to but were not able to administer an IV. Administration of Narcan was also unsuccessful in aiding Spindola, and the AED repeatedly advised "no shock." Despite multiple life saving measures, Spindola's condition remained unchanged. When OFD paramedics arrived, they placed an EKG on Spindola and administered four (4) separate doses of epinephrine with no effect. Spindola appeared lifeless,

without a pulse and with fixed/dilated pupils. The base hospital physician ultimately pronounced Spindola 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 properly classified as criminally negligent. On one of the frequent sector checks, OCSD staff acted immediately and appropriately upon discovering Spindola lifeless in his cell to provide medical assistance. Deputy Murillo called for medical assistance within moments, and deputies and medical staff responded to assist. Spindola was removed from the sheet ligature, placed on the floor outside of the cell, and provided with emergency medical care until OFD paramedics arrived on scene. When the medical care that was provided prior to the arrival of paramedics did not improve Spindola's condition, paramedics administered additional emergency care to no effect until UCIMC advised to cease medical care and Spindola was pronounced dead.

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 or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Spindola. The evidence shows that Spindola's death was consistent with suicide by hanging.

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

Respectfully submitted,

CLIFF BODLEY
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**