OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

March 28, 2022

Chief of Police Tom DaRe
Garden Grove Police Department
11301 Acacia Pkwy
Garden Grove, CA 92840

Re: Custodial Death on October 24, 2020
Death of Guadalupe Garcia Tinoco
District Attorney Investigations Case # SA 20-026
Garden Grove Police Department Case # 20-056743
Orange County Crime Laboratory Case # 20-52900

Dear Chief DaRe,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the October 24, 2020, custodial death of 48-year-old Guadalupe Garcia Tinoco (Tinoco).

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Tinoco. In this letter, the OCDA describes the criminal investigative methodology employed, the evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of any Garden Grove Police Department (GGPD) personnel or any other person under the supervision of the GGPD in connection with this custodial death incident.

On October 24, 2020, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Garden Grove Medical Center Emergency Room, where Guadalupe Tinoco was pronounced dead by Garden Grove Medical Center medical personnel while in GGPD custody. During the course of this investigation, the OCDASAU interviewed 12 witnesses, as well as obtained and reviewed reports from the GGPD and Orange County Crime Laboratory (OCCL), incident scene photographs, and other relevant materials.

REPLY TO: ORANGE COUNTY DISTRICT ATTORNEY'S OFFICE

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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 GGPD personnel or any other person under the supervision of the GGPD. The OCDA will not be addressing any possible issues related 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, TARGET/Gangs, and Special Prosecutions Units review fatal and non-fatal officer-involved shootings and custodial death cases and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer-involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of an 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 October 24, 2020, at approximately 3:28 p.m., GGPD dispatch received a 911 call for service to a residence located at 11402 True Way in the city of Garden Grove. At approximately 3:31 p.m., GGPD Officers Yniguez, Ferreira, and Quiroz were dispatched to the residence. Dispatch advised the officers were responding regarding a former tenant, Guadalupe Tinoco, who had returned to the residence, was "415" (reference Pen. Code 415, disturbance/challenge to fight) with the calling party (R1), hitting a neighbor, and the calling party (R1) sounded very upset on the call. While en

route, dispatch advised the "415" (disturbance) was audible on the call, and the dispatcher could hear someone screaming, "there's a fight in the house, get someone here now."

Officers Yniguez, Ferreira, and Quiroz arrived at the residence at approximately 3:35:00 p.m. (the following times are based on officers' body-worn cameras – BWC). The officers approached the open front door to the residence and could hear the occupants yelling out. Officer Yniguez was the first to approach the door and entered the residence at 3:35:15 p.m. He saw Tinoco, a 48-year old woman, lying face down on the entryway floor with R2 lying on top of her and holding her wrists/hands down. R1 was standing on top of Tinco's legs while R3, the homeowner in her 80s, was standing nearby.

All three residents told officers that Tinoco was acting "crazy," she was "fighting" them, she "broke in" and "wouldn't leave," was "on something," and had attacked them. Officer Yniguez described seeing Tinoco moving when he approached her on the ground, however, based on his BWC, her movements appeared to be involuntary, reflexive, and potentially caused by R2 moving Tinoco's body. Based on Yniguez's BWC, Tinoco appeared to be motionless from the time officers arrived on the scene.

At 3:35:21 p.m., Officer Yniguez directed Tinoco to stay on the ground. R2 moved off of Tinoco and to her side while officers started to place handcuffs on her. Officer Yniguez moved Tinoco's left arm around her back telling her to "relax" indicating her arms were stiff and involved effort on Yniguez's part to move. Officer Yniguez placed the first handcuff on Tinoco at 3:35:35 p.m. Officer Ferreira moved Tinoco's right arm behind her back at approximately 3:35:50 p.m. The residents relayed Tinoco had been coming to the house "all night" and was attacking them. Officer Yniguez assisted R2 up off the ground due to R2's limited mobility from a disability, while Tinoco remained still on the floor.

At 3:36:19, officers started to speak with Tinoco but she did not respond. At 3:36:25 p.m., Officer Yniguez tried to move Tinoco's arm, but she was unresponsive. At 3:36:44 p.m., Officers Yniguez and Ferreira rolled Tinoco to her side and saw her lips were turning blue. Officers quickly realized Tinoco was not breathing. Officer Ferreira checked Tinoco for a pulse at 3:37:07 p.m. Finding no pulse, officers removed Tinoco's right handcuff and rolled her onto her back. At 3:37:30 p.m. Officer Yniguez started chest compressions.

At 3:37:43 p.m. Officer Yniguez paused chest compressions to see if Tinoco had started breathing. Tinoco's condition had not changed, so at 3:37:55 p.m., Officer Yniguez resumed chest compressions. Officers Yniguez, Ferreira, and Quiroz alternated in applying chest compressions to Tinoco until the Orange County Fire Authority (OCFA) arrived on the scene to take over Tinoco's medical treatment.

At 3:38:22, Officer Ferreira suggested Officer Quiroz get Narcan. Officer Quiroz immediately ran to his unit to retrieve Narcan. Officer Ferreira asked the residents, "what did she use?" The residents replied that Tinoco said she had taken methamphetamine, heroin, and PCP. Officer Quiroz returned with the Narcan at approximately 3:38:50 p.m. and administered an intranasal dose of Narcan at 3:39:04 p.m. with no discernable effect.

At 3:39:32 p.m., Officer Ferreira took over chest compressions from Officer Yniguez. Officer Yniguez began asking the residents what happened leading up to the officers' arrival. They

relayed, in essence, Tinoco used to live at the residence, was recently kicked out, and had come to the residence approximately three times early that morning causing issues and threatening the residents. Tinoco arrived at the house that afternoon, made her way inside the residence, and was "fighting, kicking, screaming" so the residents detained her by holding her on the floor until police arrived. All three residents are handicapped, have limited mobility, and R3 (homeowner) is in their 80s. According to R2, Tinoco was fighting, so R2 held her hands. Tinoco and R2 slipped and fell onto the ground. R2 held Tinoco's arms (on top of her) for approximately five minutes until GGPD arrived.

OCFA arrived on the scene at approximately 3:43:16 p.m. Officer Yniguez relayed pertinent medical information to OCFA personnel. An OCFA captain and paramedic assessed Tinoco's condition and observed the following: she was unresponsive, pulseless, and not breathing. OCFA personnel did not see any visual signs of trauma or blood on Tinoco's body. OCFA personnel attached a heart monitor to Tinoco which confirmed she was asystole (pulseless). OCFA personnel used an automated chest compression device to provide Tinoco with continual chest compressions at 100 beats per minute. OCFA personnel provided Tinoco oxygen through a Laryngeal airbag valve mask and placed an intravenous (IV) line in Tinoco's right antecubital. OCFA started a Saline drip and administered 8mg of Narcan and three 0.1 MG/ML doses of epinephrine.

OCFA personnel observed no change in Tinoco's condition, reported Tinoco's condition to the base hospital (UCI), and requested permission to make an in-field death pronouncement. However, the request was declined and they were directed to transport Tinoco, Code 3 (lights and siren), to Garden Grove Hospital and Medical Center (GGMC) located at 12061 Garden Grove Blvd, Garden Grove.

OCFA transported Tinoco to GGMC and arrived with her at approximately 4:11 p.m. The GGMC medical team noted Tinoco was still asystole and unresponsive. The GGMC medical team provided Tinoco with an ampule of sodium bicarbonate, an ampule of calcium chloride, four (4) milligrams of Narcan, half a liter of fluids, and a round of epinephrine. They conducted two (2) rounds of CPR and two pulse checks, Tinoco remained in asystole with no pulse. At 4:20 p.m. one of the doctors at GGMC pronounced Tinoco deceased.

R2 had visible scratches to his face, ear, arm, and hand. R2 had a possible bite mark on his left arm. R1 had visible scratches on her arms.

Further interviews with individuals close to Tinoco confirmed Tinoco had a history of substance abuse and informed OCDASAU Investigators Tinoco had Lupus and high blood pressure but was inconsistent with taking her medication.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Drug paraphernalia – clear glass pipe with green tip and bubbler
- Drug paraphernalia – clear glass pipe
- Drug paraphernalia – aluminum foil with small pieces of a green substance
- Drug paraphernalia – step of clear glass pipe
- Swabs of Tinoco's hands
- Swab from a bite mark on R2's left arm

- Buccal swab from R2
- 142 digital color photographs documenting the scene
- 40 digital color photographs of the autopsy

AUTOPSY

On October 27, 2020, Forensic Pathologist Dr. Young-Son Kim of the Orange County Coroner's Office conducted an autopsy on the body of Tinoco. At the conclusion of the autopsy, Dr. Kim stated there were no signs of trauma on Tinoco's body. No evidence of any recent fractures (Tinoco had an old fracture to the right posterior rib #8) were noted. No evidence of damage to internal organs due to trauma were noted. Tinoco's eyes were bloodshot, but there was no petechia. Tinoco's heart was severely enlarged, as well as slightly dilated and hypertrophic. There was fluid in her lungs and her brain was slightly swollen. Dr. Kim noted signs of a bladder infection as well. After receiving toxicology results (specific results detailed below), Dr. Kim determined the cause of death was acute polydrug intoxication (the combined effects of ethanol, amphetamine, and methamphetamine) compounded with a fatty liver, cardiomegaly with a dilated and hypertrophy (enlarged heart), and acute cystitis (bladder infection). The manner of death was determined to be accidental.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	POSTMORTEM BLOOD	BRAIN
Ethanol	0.036 ± 0.004 % (w/v)	
Acetaldehyde	Detected	
Amphetamine	0.191 ± 0.020 mg/L	0.590 ± 0.044 mg/kg
Methamphetamine	1.74 ± 0.13 mg/L	5.35 ± 0.38 mg/kg
Caffeine	Detected	
Naloxone	Detected	
N-desmethulcycliobenzaprine	Detected	

BACKGROUND INFORMATION

Tinoco had a State of California Criminal History record that revealed arrest for the following violations:

- 245(a)(1) PC; 273.5a(b) PC; Assault with a Deadly Weapon and Willful Cruelty to a Child
- 12500 VC; Drive Without a License
- 530.5(a) PC; 487(a); 496(a); 11364 HS – Identity Theft; Grand Theft; Possession of Stolen Property; Possess Control Substance Paraphernalia Felony Convictions for 487(d)(1) PC; 530.5(a) PC; 470(a) PC; 11364 HS – Grand Theft; Identity Theft; Forgery; Possess Control Substance Paraphernalia
- 11378 HS; 12022.1 PC – Possess Control Substance for Sale; Committed while out on Bail
- 11550(a) HS; 11364 HS – Under the Influence of a Controlled Substance; Possess Control Substance Paraphernalia
- Violation of Parole
- 240/242 PC – Assault and Battery

- 240/242 PC – Assault and Battery

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 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:

> "[T]he most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable than an inmate may be at risk of harm.... Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

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

> "[A] public employee, and the public entity where the employee is acting within the

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

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

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

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

LEGAL ANALYSIS

Here, there is no evidence of express or implied malice on the part of any GGPD personnel. As a result, 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. As discussed below, there is insufficient evidence to prove beyond a reasonable doubt that any GGPD Officers breached their duty of care either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

GGPD Officers Yniguez, Quiroz, and Ferreira arrived on scene at approximately 3:35 p.m. and within approximately two and a half minutes, they had detained Tinoco, observed she was not breathing, checked for her pulse, started chest compressions, and radioed for medical assistance (OCFA). While waiting for OCFA to arrive, officers administered Narcan in an effort to counteract a potential drug overdose, spoke with the residents on scene to obtain pertinent medical information for OCFA, and continued to conduct chest compressions until medical personnel arrived.

Tinoco appeared to be unresponsive from the time she is first seen on BWC.

Tinoco's autopsy showed her death was caused by polydrug intoxication compounded with preexisting conditions. Once responding officers realized Tinoco was unresponsive and not breathing, they reacted quickly to provide her with appropriate medical care by requesting OCFA paramedics, then applying chest compressions and intranasal Narcan while waiting for OCFA to arrive on scene.

OCFA and GGMC personnel continued applying chest compressions and administered additional medical interventions but Tinoco's condition never changed from the time officers first arrived on the scene.

Based on the evidence discussed above, there is insufficient evidence to prove beyond a reasonable doubt that any GGPD Officers on the scene failed to perform a legal duty.[1] Accordingly, there is insufficient evidence to prove beyond a reasonable doubt that any GGPD personnel committed murder or manslaughter.

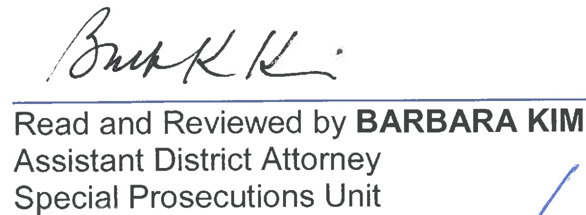
CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding that any GGPD personnel failed to perform a legal duty causing the death of Tinoco.

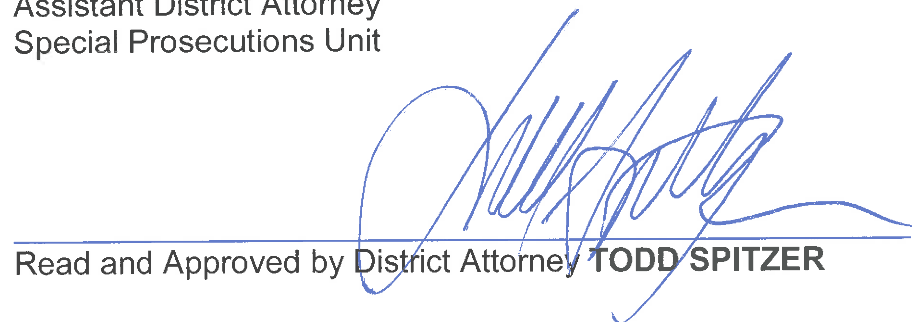
Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,

MALLORY MILLER
Deputy District Attorney
GANGS Unit



Read and Reviewed by **BARBARA KIM**
Assistant District Attorney
Special Prosecutions Unit



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

1 This letter does not address any potential issues of potential criminal conduct by any other persons not employed by GGPD. A separate legal analysis was conducted by the OCDA Homicide Unit regarding any potential criminal liability on the part of the residents who detained the decedent.