OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

June 15, 2022

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

Re: Custodial Death on June 16, 2021
Death of Inmate Andrew Curcio
District Attorney Investigations Case #21-002217
Orange County Sheriff's Department Case #21-020134
Orange County Crime Laboratory Case #21-47758

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the June 16, 2021 custodial death of 30-year-old inmate Andrew Curcio.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Andrew Curcio. 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 June 16, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Theo Lacy Facility in response to the reported custodial death of Andrew Curcio. During the course of this investigation, the OCDASAU interviewed 37 witnesses, obtained and reviewed reports from both the OCSD and Orange County Crime Laboratory (OCCL), reviewed both incident scene photographs and video recordings and all other relevant materials including but not limited to the decedent's intake documentation.

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 policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating custodial deaths within Orange County. An OCDASAU Investigator is assigned as a case agent and is supported by other OCDASAU Investigators, as well as Investigators from other OCDA units where necessary.

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 as 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 to 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 read and review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors in advance of approval. The District Attorney personally reviews all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On June 15, 2021, Andrew Curcio, a 30-year old male, was arrested by the Costa Mesa Police Department under case #21-009723 for a violation of Health and Safety Code (H&S) 11364(a) - Possession of Drug Paraphernalia. At the time of arrest, Curcio was on probation with an active warrant for Penal Code (PC) 1170(h)(5) - Violation of Mandatory Supervision. Subsequent to arrest, Curcio was transported to the Orange County Jail Intake/Release Center for booking.

During the booking process at the Intake/Release Center, it is customary for booking staff to inquire about various issues that could impact an inmate's health and safety while in custody, including drug use. In response, Curcio indicated he was a current user of marijuana and amphetamines. He detailed he ingested both heroin and fentanyl within the past 12-48 hours. In addition, Curcio identified prescriptions for Buprenorphine and Klonopin, ingested within the past 12-48 hours. When asked about mental health, Curcio described himself as diagnosed with schizoaffective disorder but denied suicidal ideation. Booking staff noted during intake Curcio appeared to be under the influence of drugs. However, staff further noted Curcio appeared alert and oriented to person, place, and time, had no apparent barriers to communication and did not have an abnormal physical appearance. Curcio was referred for Triage Prescriber and Mental Health Triage and was cleared for transfer to the Theo Lacy Facility.

At 11:49 a.m. on June 16, 2021, OCSD transported Curcio to the Theo Lacy Facility. Theo Lacy staff placed Curcio in Module (Mod) Q, Sector 52, Cell 15, where he occupied the top bunk. According to OCSD logs and incident video, Curcio and his cellmate, Witness 1, arrived at their cell at approximately 12:26 p.m. Cell 15 is slightly obscured from video surveillance. However, Curcio and Witness 1 can be seen settling into their cell. Shortly thereafter, Witness 1 can be seen seated at the table with his back to the video vantage point. According to Witness 1, both he and Curcio were feeling the effects of detoxification from drugs. Witness 1 advised OCDASAU investigators that he had obtained a small amount of a substance believed to be fentanyl while at the Intake/Release Center and asked Curcio if he wanted "to get high." Witness 1 described dividing the powdered substance into two lines and observing Curcio ingest (snort) the first line. Witness 1 stated he then ingested the second and they both entered their respective bunks to sleep. This statement is corroborated by the video surveillance wherein both inmates can be seen leaning over the table, fist-bumping, then laying in their bunks.

Over the next seven hours, ten safety checks were conducted. In addition, a bagged meal was provided via the small hatch in the cell door. During these periods of contact, nothing was reported out of the ordinary. However, deputies noted in their OCDASAU statements that these contacts were brief and not designed to act as a wellness check but rather to simply determine if there were any apparent dangers present.

At 12:53 p.m., video surveillance shows both inmates in their respective bunks. Curcio's hand can be seen moving in the area of his bunk. This is believed to be the last time Curcio was observed alive. Deputies did a "count check" at 2:09 p.m. to ensure all inmates remained in their assigned locations. This check, again, was a brief count and not deemed a wellness check.

At 7:30 p.m., medical staff provided medication as indicated to the sector. Witness 1 and Curcio were contacted by the guard station via the intercom system within cell 15 to respond to the medical office to see the nurse. Witness 1 exited cell 15 and apparently complied. However, Curcio did not respond. At the conclusion of his nurse visit, Witness 1 told OCSD staff Curcio did not wake for his call. In response, staff again attempted to contact Curcio via the intercom system within cell 15. When Curcio again did not response, Witness 1 was instructed to check on Curcio. At 8:03 p.m., Witness 1 advised OCSD that Curcio was unresponsive. Witness 1 reported to OCDASAU that at the time of this check, Curcio appeared stiff, was cold to the touch and had a darkened complexion.

OCSD staff communicated with Witness 1 via intercom system and simultaneously radioed staff to respond to cell 15 for a wellness check on Curcio. At 8:06 p.m., Deputy J. Ceja #10795, Deputy A. Aguirre #11277, and a registered nurse (RN) responded to the cell and found Curcio laying down unresponsive on the top bunk. The nurse attempted to revive Curcio via Narcan to no avail. Officers then transferred Curcio from the top bunk to the cell floor and began performing CPR on him. Due to the constricted space, Curcio was moved to the area of Sector 52's day room, just outside cell 15 where CPR resumed.

When the Orange County Fire Authority (OCFA) paramedics arrived at the Theo Lacy Facility, RN's and Theo Lacy personnel were actively providing care. RN staff had pushed two doses of Narcan and established an 18g intravenous (IV) line in Curcio's right arm. An automated external defibrillator (AED) was applied to Curicio's torso and completed three cycles with no shock being advised for any of the cycles. Rigor mortis had set into Curcio's jaw and lower extremities, he did not react to painful stimuli, his skin was purple and cold to the touch, and lividity began to show on his right side. Obvious death was indicated and thus no further resurrective measures were taken by paramedics.

Rather, an Orange City Fire Department (OFD), Truck #6, Engineer Paramedic pronounced Curcio deceased on June 16, 2021 at 8:26 p.m.

Forensic Scientists from the Orange County Crime Laboratory and the Coroner arrived to process the scene and take custody of the decedent'.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- OCSD Mod Q, Sector 52 surveillance video
- A sample of Curcio's postmortem blood
- A heart blood standard
- 84 OCCL jail scene photographs
- 61 OCCL autopsy photographs
- 20 post embalming photographs
- 32 OCCO (Coroner) photographs
- OCHCA medical records
- Audio recording of 19 interviews with Sector 52 inmates [none had any knowledge of Curcio]
- 18 audio recordings of interviews with: two Licensed Vocational Nurses, three Registered Nurses, Curcio's father, an OFD Paramedic, Curcio's cellmate, Witness 1, OCSD Custodial Services Assistant, Sergio Altamirano, OCSD Deputy Sheriff, Andrew Colangelo, OCSD Deputy Sheriff, Carlos Chavez, OCSD Deputy Sheriff, Brandon Espinosa, OCSD Deputy Sheriff, Alfredo Garcia, OCSD Deputy Sheriff, Jesus Ceja, OCSD Deputy Sheriff, Jorge Mejia, OCSD Deputy Sheriff, Adrian Aguirre, OCSD Deputy Sheriff, Randall Lum, and OCSD Custodial Services Assistant, Ralph Youngblood.

AUTOPSY

On June 23, 2021, Forensic Pathologist Dr. Scott A. Luzi of Orange County Coroner's Office conducted an autopsy on the body of Andrew Curcio. The autopsy revealed no major (life-threatening) or minor (non-life-threatening) injuries. Natural disease and pre-existing conditions found include skin erosions on the neck, back, and upper extremities, a healing contusion on the right thigh, healing abrasions and contusions on the legs, cerebral edema, pulmonary congestion and edema, cardiomegaly, and mild peripheral atherosclerosis. The cause of death was found to be an acute fentanyl overdose and the death deemed an accident. Other conditions included recent methamphetamine use.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Amphetamine	Postmortem Blood	0.0315 ± 0.0024 mg/L
Methamphetamine	Postmortem Blood	0.0258 ± 0.0019 mg/L
Cannabinoids	Postmortem Blood	Not Detected

Fentanyl	Postmortem Blood	0.0266 ± 0.0025 mg/L
4-ANPP	Postmortem Blood	Detected
Acetaminophen (Free)	Postmortem Blood	3.33 ± 0.31 mg/L
Naloxone	Postmortem Blood	Detected

BACKGROUND INFORMATION

Andrew Curcio had a State of California Criminal History record that revealed many arrests for the following violations:

- 11350 (A) H&S – Possession of Narcotic Controlled Substance
- 11377 (A) H&S – Possession of Controlled Substance
- 11364.1 (A) H&S – Possession of Unlawful Paraphernalia
- 602.5 (A) PC – Enter Noncommercial Dwelling
- 485 PC – Appropriating Lost Property
- 460(B) PC – Burglary: Second Degree
- 11550 (A) H&S – Under Influence of a Controlled Substance
- 23152 (F) Vehicle Code (VC) – DUI – Any Drug
- 148 (A) (1) PC – Obstruction of a Public Officer
- 135 PC – Destroy / Conceal Evidence
- 11375 (B) (2) H&S – Possession of Controlled Substance Without a Prescription
- 496 PC – Receiving Stolen Property

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 the 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 that 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

There is no evidence of express or implied malice on the part of any OCSD personnel or other individuals under the supervision of the OCSD given the lack of any act or conduct by OCSD directed at the decedent. As such, the only appropriate analysis given these circumstances is an evaluation of the existence of a failure to perform a legal duty.

Although the OCSD owed Andrew Curcio a duty of care, the evidence does not support a finding this duty was in any way breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). The OCSD found Curcio unresponsive and performed all necessary medical care to no avail until the Orange City Fire Department arrived on scene and pronounced Curcio deceased.

Andrew Curcio was given proper medical and psychological care upon booking. After being transferred to the Theo Lacy facility, Curcio voluntarily ingested an unknown substance with his

cellmate and laid on his bunk to sleep. There were ten safety checks performed and one meal given during which nothing seemed out of the ordinary. By all accounts, Curcio appeared to be sleeping which is customary after the long booking process.

At the very first sign of an extraordinary circumstance, to wit, Curcio missing his medical call, OCSD immediately reacted. First, officers attempted to contact Curcio over the intercom in his cell. When Witness 1 advised Curcio was not waking up, Witness 1 was advised to check on Curcio. When Witness 1 reported Curcio nonresponsive officers reported to Curcio's cell and began appropriate resurrective measures. Unfortunately, none were successful. It would appear based on Witness 1's initial observations and the time lapse since Curio ingested the unknown substance, he was already deceased and had been for some time. Rigor mortis takes an average of two to six hours to set in and the initial responding staff noted rigor mortis had begun to set in. While the efforts of OCSD and personnel is admirable, there was very likely nothing that could have been done to revive Curcio. Orange City Fire Department noted obvious signs of death and pronounced Curcio deceased very shortly after their arrival, consistent with this opinion. The evidence supports the conclusion that OCSD and personnel took all necessary and appropriate measures to provide Curcio a safe environment.

Thus, there is insufficient evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty. Given this finding, there is insufficient evidence to support a finding of criminal liability on the part of OCSD or its personnel.

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 insufficient evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Andrew Curcio. The evidence shows that Andrew Curcio died as a result of acute fentanyl intoxication and that the death was accidental.

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

Kristin R. Bracic
Senior Deputy District Attorney
Gang Unit

READ AND REVIEWED BY **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

READ AND APPROVED BY DISTRICT ATTORNEY **TODD SPITZER**