OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

January 18, 2023

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

Re: Custodial Death on December 2, 2021
Death of Inmate Roddy Lyman Giacomini, Jr.
District Attorney Investigations Case # SA 21-005335
Orange County Sheriff's Department Case # 21-040780
Orange County Crime Laboratory Case # FR 21-55233
Orange County Coroner's Office Case # 21-07094-LM

Dear Sheriff Barnes,

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 December 2, 2021, custodial death of 44-year-old inmate Roddy Lyman Giacomini, Jr.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Roddy Lyman Giacomini, Jr. 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 all Orange County Sheriff's Department (OCSD) personnel involved with this custodial death incident as well as any other individuals working under the supervision of the OCSD.

On December 2, 2021, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Theo Lacy Facility, where Giacomini died while in custody having been discovered hanging from his bedsheet. During the course of this investigation, the OCDASAU interviewed fifteen (15) witnesses and twenty-three (23) additional persons during the jail canvass, 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 does not address any issues relating 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.

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. Thus, when the OCDASAU Investigator has concluded the investigation, the file is turned over to an experienced deputy district attorney for legal review. If necessary, the reviewing prosecutor will send the case back for further investigation.

Throughout the review process, the assigned prosecutor will consult with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will review any legal conclusions and resulting memos. It is also common for the case to be reviewed by several experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews and approves all officer-involved shooting and custodial death letters.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING AND CUSTODIAL DEATH INCIDENTS 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 to release such evidence where it is legally appropriate to do so, the OCDA is making video/audio evidence publicly available in connection with this case. It is available on the OCDA webpage at:

http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On November 30, 2021, at approximately 3:40 p.m., Giacomini was arrested by OCSD for inflicting corporal injury on a spouse or cohabitant. During the booking process at the OCSD Intake/Release Center (IRC), a registered nurse (RN) from the Orange County Health Care Agency (OCHCA) completed a medical screening of Giacomini and cleared him for regular booking. Under the presiding COVID-19 protocols at the time, Giacomini was assigned housing in a New Inmate/COVID-19 Quarantine Unit.

Thereafter, on December 1, 2021, at approximately 12:46 p.m., Giacomini was transferred to the Orange County Theo Lacy Facility (TLF). Giacomini was housed in Module Q, Sector 50, Cell 7,

which he initially shared with another inmate. When interviewed following Giacomini's death, the inmate indicated there had been no communication between himself and Giacomini.

Module Q was equipped with a video surveillance system, which was in operation during the period Giacomini was housed there. A review of the footage recorded by the system, along with witness interviews, revealed the following sequence of events: On December 2, 2021, at approximately 11:40 a.m., Giacomini's cell mate was transferred out of Module Q, leaving Giacomini as the sole occupant of Cell 7. At approximately 3:02 p.m., Giacomini entered his cell in Section 50 and closed the door behind him.

At approximately 3:10 p.m., Giacomini removed a white sheet from the top bunk of Cell 7. Moments later, at approximately 3:11 p.m., Deputy Omar Torres and Deputy Angel Vallejo conducted a safety check of both tiers of Section 50 without incident.

At approximately 3:15 p.m., Giacomini stood up and walked around his cell while holding the white sheet. He then walked to the area of the cell where the top bunk is attached to the wall at the foot of the bed. Giacomini then appeared to tie the sheet to the foot of the upper bunk as he sat at the foot of the lower bunk below. At 3:16 p.m., Giacomini moved around the cell before returning to the foot of the lower bunk and appeared to continue tying the sheet to the top bunk. At 3:17 p.m., Giacomini returned to the area of the tied sheet, then paced around the cell for several seconds before grabbing an additional sheet from the top bunk, which he appeared to tie with or adjacent to the first sheet.

At approximately 3:18 p.m., Giacomini sat down on the lower bunk and appeared to continue tying the sheets. At 3:19 p.m., Giacomini slid down off the lower bunk toward the cell door, which was followed by his lower extremities moving and shaking. At approximately 3:21 p.m., the final movements from within Giacomini's cell were recorded by the surveillance cameras.

The next routine safety check began at approximately 3:47 p.m. At 3:48 p.m., Deputy Torres arrived outside Giacomini's cell and found him hanging from a bedsheet connected to the foot of the top bunk. The bedsheet was wrapped around Giacomini's neck. Giacomini was unresponsive in a seated position and facing the dayroom, with his head slumped down and his arms hanging at his sides. Deputy Torres described Giacomini as pale, not breathing, eyes wide open with unmoving dilated pupils, and his tongue protruding from his mouth. Deputy Torres stated he never saw any signs of life during the time he observed Giacomini.

Immediately upon discovering Giacomini, Deputy Torres broadcasted that there was a "Man Down" and made entry into the cell. Deputy Torres attempted to lift Giacomini to relieve the tension from the bedsheet wrapped around his neck but was unsuccessful. Consequently, Deputy Torres pressed the emergency button in Cell 7, and an OCSD Correctional Services Assistant requested instant assistance for a suicide via the facility radio system.

Within seconds, Deputy Vallejo and Deputy Eric Rodriguez arrived to assist Deputy Torres in freeing Giacomini from the bedsheet, and then moved his body from the cell onto the floor directly outside Cell 7. Deputies checked for and did not locate a pulse. Giacomini remained pale, unresponsive, and his eyes were wide open. Deputy Rodriguez began to perform Cardiopulmonary Resuscitation (CPR), while Deputy Torres ran to the nearby guard station to retrieve an Automatic External Defibrillator (AED), as well as a medical supplies bag. Minutes after Deputy Torres attached the AED to Giacomini's torso, the jail medical staff arrived.

The AED analyzed Giacomini's condition, advised no shock, and CPR was resumed. At this time, Giacomini remained without a measurable pulse or respirations, in addition to no discernable pupillary response. As deputies continued to alternate performing CPR, the jail medical staff inserted an oropharyngeal airway and began delivering oxygen to Giacomini via bag-valve-mask.

Often when inmates are found unconscious, it is at least partially the result of an overdose. Consequently, an RN administered three intramuscular doses of Narcan and two intramuscular doses of epinephrine to Giacomini between 3:50 and 4:00 p.m. Giacomini did not respond to the medications, so CPR was continued while the AED ran approximately five (5) cycles. Several unsuccessful attempts were also made by the jail medical staff to establish an intravenous (IV) line. Despite the efforts of both the deputies and the jail medical staff, Giacomini's condition did not improve.

At approximately 4:04 p.m., the Orange City Fire Department (OFD) Rescue #6 arrived and made contact with Giacomini. OFD personnel observed Giacomini was nonresponsive, and his skin was pale and cyanotic. Furthermore, the OFD personnel confirmed there was no pulse, no respirations, no blood pressure, and no pupillary response. Due to Giacomini having pulseless electrical activity, paramedics established contact with the University of California, Irvine Medical Center (UCIMC). During this time, deputies continued to perform CPR and an intraosseous infusion (IO) line was placed in Giacomini's right tibia. Between 4:08 and 4:12 p.m., OFD personnel administered 250 ml of saline and two doses of epinephrine, both of which failed to produce any change in Giacomini's condition. The deputies continued to perform CPR until the UCIMC doctor pronounced Giacomini dead at 4:16 p.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Clothing – orange jail shirt and pants, white t-shirt, and black socks
- Debris from Giacomini's neck and right armpit
- White bedsheet (ligature) from Giacomini's cell
- Seventy (70) OCCL scene photographs
- Seventy-four (74) OCCL autopsy photographs
- Twenty-two (22) OCCL post-embalming photographs
- Twenty-five (25) Orange County Coroner's Office (OCCO) scene photographs

AUTOPSY

On December 10, 2021, Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Giacomini. There were no signs of trauma to the body, nor evidence of damage to internal organs. A cluster of abrasions - 0.2 to 0.3 cm - over the glabella by the left eyebrow were noted. In his report, Dr. Luzi also listed a number of natural diseases and pre-existing conditions, including pulmonary congestion and edema, cardiomegaly, mild peripheral atherosclerosis, and nephrosclerosis. At the conclusion of the autopsy, Dr. Luzi made a preliminary finding that Giacomini's cause of death was consistent with hanging ligature strangulation, pending toxicology and examination of microbiological slides. On July 28, 2022, Dr. Luzi amended his final findings regarding Giacomini's death, determining the cause of death to be hanging and the manner of death a suicide.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Roddy Lyman Giacomini, Jr.'s postmortem blood yielded the following results:

DRUG	POSTMORTEM BLOOD	BRAIN
Amphetamine	0.255 ± 0.019 mg/L	0.559 ± 0.042 mg/kg
Methamphetamine	0.767 ± 0.055 mg/L	1.41 ± 0.10 mg/kg
THC	0.0022 ± 0.0004 mg/L	
Carboxy-THC	0.0064 ± 0.0009 mg/L	
Ethanol/Volatiles	Not Detected	
Barbiturates	Negative	

BACKGROUND INFORMATION

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

- Criminal Conspiracy
- Possession of a Controlled Substance
- False Identification to a Peace Officer
- Obstructing/Resisting a Public Officer
- Possession of a Controlled Substance for Sale
- Selling Hypodermic Needle/Syringe without a Permit
- Assault with a Deadly Weapon – Not a Firearm: Great Bodily Injury Likely
- Maliciously Deface With Paint
- DUI – alcohol/drugs
- Hit and Run – Property Damage
- Parole Violation
- Driving with a Suspended License
- Receive Known Stolen Property
- Taking a Vehicle Without the Owner's Consent/Vehicle Theft
- Under the Influence of a Controlled Substance
- Assault and Battery
- Threaten Crime with Intent to Terrorize
- Inflicting Corporal Injury on Spouse/Cohabitant

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 acted he knew his 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

In this present case, there is no evidence of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Rather, the only issue is whether there was a murder or involuntary manslaughter for failure to perform a legal duty that caused Roddy Lyman Giacomini's death. Due to Giacomini's incarceration, OCSD owed him a duty of care.

Although the OCSD owed Giacomini a duty of care, there is insufficient evidence to prove beyond a reasonable doubt that any OCSD personnel breached their duty of care either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). A review of OCSD medical aid reports and all other relevant evidence reveals that OCSD personnel exercised reasonable care to Giacomini. When OCSD initially took custody of Giacomini, they provided him with a medical screening, after which he was cleared for regular booking and was transferred to TLF. There, he was housed in area undesignated for inmates with mental health and well-being concerns. Moreover, Giacomini was not diagnosed, nor had a known history of mental health issues.

Furthermore, Giacomini's death was not foreseeable. Safety checks were conducted approximately every forty-five (45) minutes, with additional informal safety checks during inmate book counts, medical and meal distribution, and as time allowed. Prior to Giacomini's death, Deputy Torres stated that Giacomini appeared "normal" during the scheduled safety check, similar to any other inmate that was observed. Additionally, Giacomini's fellow inmates did not report witnessing unusual behavior by Giacomini while he was in the dayroom. Deputies Torres, Vallejo, and Rodriguez did not witness Giacomini altering his behavior towards them, and therefore, had minimal contact with him outside of the scheduled safety checks. Thus, the deputies had no reason to believe that Giacomini would commit suicide by hanging on December 2, 2021.

After Deputy Torres reported finding Giacomini hanging in his cell, Deputy Torres and the other deputies responded rapidly. They employed potential lifesaving measures before and after the arrival of jail medical staff. Jail medical staff also implemented life saving measures until OFD personnel arrived. In conjunction, the deputies, the jail medical staff, and OFD personnel continuously attempted to revive Giacomini until Giacomini was pronounced dead by a doctor from UCIMC.

Based on the evidence discussed above, 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. Accordingly, there is insufficient evidence to prove beyond a reasonable doubt that any OCSD 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 OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Giacomini. The evidence shows that Roddy Lyman Giacomini died as a result of ligature hanging and that the death was a suicide.

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

CLIFF BODLEY
Senior Deputy District Attorney
Gangs/TARGET Unit

Read and Reviewed by **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

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