OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

July 25, 2023

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

Re: Custodial Death on January 18, 2020
Death of Inmate Kirk Vernell Price
District Attorney Investigations Case # S.A. 20-001
Orange County Sheriff's Department Case # 19-049148, 20-002236
Orange County Crime Laboratory Case # 20-40905
Orange County Crime Laboratory Case # 20-41063 (Coroner Toxicology)
Orange County Coroner's Office Case # 20-00335-AA

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 January 18, 2020, custodial death of 57-year-old inmate Kirk Vernell Price.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Price. 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 January 18, 2020, OCDA Special Assignments Unit (OCDASAU) Investigators responded to Custody Medical Services (CMS) at Anaheim Global Medical Center (AGMC), where Price died while in custody after receiving medical treatment. During the course of this investigation, the OCDASAU interviewed 16 witnesses and conducted 21 additional canvass interviews, 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 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 functions that include witness interviews, scene processing, evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and 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 forwarded 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 eventually review any legal conclusions and resulting correspondence. It is also common for the case to be reviewed by several other experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews all officer involved shootings and custodial death letters.

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 March 25, 2016, Price was booked into the Intake Release Center (IRC) by the Tustin Police Department after being arrested for violating California Penal Code section 187(a) (Murder) and Penal Code section 29900(a)(1) (Felon in Possession of a Firearm). Price was housed in Module M after booking. On October 29, 2019, Price was transferred to the Theo Lacy Facility (TLF) and housed in Module J with another inmate (Inmate Doe).

On December 27, 2019 at 4:13 a.m., Price and Inmate Doe were standing in line for the morning meal distribution in Module J, Sector 11. Price reached for a food tray with his back to Inmate Doe. Inmate Doe struck Price in the back of the head two times causing Price to fall. As he was falling, Inmate Doe continued to punch Price in the face approximately four times. Price hit his head on the sector door feeding hatch and then fell back, hitting his head on the wall. While he was on the floor, Inmate Doe straddled Price and continued to punch him in the face 13 more times and was heard yelling a racial slur at Price. In surveillance footage, Price appeared to have lost consciousness after the first two strikes to his head. Deputies became aware of the situation and ordered Inmate Doe and Price to stop fighting. Eyewitnesses later revealed that Price did not fight back during the assault. After the attack ended, deputies then ordered all inmates to return back to their cells and

requested medical help. Inmate Doe stepped away from Price, entered his cell, and closed the door behind him locking himself in. Deputies went to the area where Price has just been attacked and when they asked Price if he could get up, Price responded that he could not. Price suffered a contusion and laceration on the back of his head and a laceration over his eye. Deputies lifted Price and placed him onto a wheelchair to be transported to the hospital. He refused to talk to the deputies about what happened. Another deputy contacted Inmate Doe at his cell, handcuffed him, and escorted him down to the booking loop of TLF. Inmate Doe had no visible injuries, nor did he claim any injury.

At 4:39 a.m., Price was transported to UCI Medical Center (UCIMC) where he was diagnosed with the following: mild contusion, loss of consciousness, left nasal bone fracture, C4-C5 complete tear with traumatic disk injury, C5-C6 traumatic disk herniation and cord contusion, spinal cord injury, and T8-T9 mild spinal cord compression. Later that day, Price underwent cervical spine surgery. Price was later diagnosed with permanent paralysis.

On December 31, 2019, OCSD Classification Deputies interviewed Price at UCIMC regarding his assault. Price stated that he did not know why Inmate Doe had assaulted him because they did not have any problems with one another, but he was aware that Inmate Doe had made a request to be housed in another cell.

On January 3, 2020, Price was transferred from UCIMC to Custody Medical Services (CMS) at Anaheim Global Medical Center (AGMC). On January 5, 2020, after complaints of chest pain, Price was transferred from the CMS ward to the Intensive Care Unit at AGMC, where he was diagnosed with pneumonia after developing respiratory distress. On January 6, 2020, Price was re-housed at the AGMC CMS Ward.

Because of his paralysis, Price needed to be manually rotated frequently in order to prevent bed sores from forming. On January 18, 2020, at 3:40 p.m., Price asked a nursing assistant to reposition him. Both she and a registered nurse moved Price onto his side. The nursing assistant noticed that Price's breathing was abnormal and asked Price if he was okay. Price was unresponsive. The nursing assistant then left the room to seek additional assistance, and life-saving measures were initiated. Despite these measures, Price remained pale, unresponsive, and pulseless. At 4:26 p.m., an attending physician pronounced Price deceased.

In an interview with Inmate Doe, he stated that he assaulted Price because he was in fear for his safety due to prior problems with Price. He stated that before the cellmates were going to get their trays, Price told Inmate Doe that he was going to "f**k him up," and that is why Inmate Doe hit him. Inmate Doe also stated that he felt as though he had to assault Price because if he did not, it would cause further racial tensions. He stated that if he did not assault Price he would have become a target for assault by others because he tolerated disrespect from Price. According to jail deputies, this was consistent with longstanding practices common within the jail population, including if an inmate is causing problems, members of his own racial group are expected to address it with the problem inmate. In this case, both Price and Inmate Doe were African-American.

OCDA Investigators interviewed several other TLF inmates as a part of the investigation process. Inmate #1 was aware of some animosity between Price and Inmate Doe. He knew that they did not like each other, but noted that they respected each other. Inmate #1 described Price as "crazy" and said he would occasionally hit the walls and scream in the middle of the night. When he would do so, Inmate Doe and the other inmates would yell at Price to stop, and he would sometimes comply, but would only get louder at other times. Inmate #1 said that he never saw Price get into any verbal or physical interactions with Inmate Doe or any of the other inmates.

Inmate #2 stated that he had a few interactions with Price and thought of him as an aggressive person. He had heard that Price may have wanted to hurt Inmate Doe. He recalled Inmate Doe saying that he wanted Price to be moved from the area before the assault.

Some inmates who were interviewed had witnessed the assault. Inmate #3 recalled seeing Inmate Doe punching Price and it appeared that Price was not fighting back during the assault. Inmate #4 heard a commotion and saw deputies asking Price, who was on the floor, if he could stand.

At TLF, the inmates are housed based on certain classifications including their charges, criminal history, and other similar criminal characteristics. Inmates can submit grievance forms or message slips whenever they wish to have a change in accommodation. Grievance forms are logged and maintained as part of an inmate's jail file. No grievance forms pertaining to housing were located in either Inmate Doe's or Price's jail file.

Message slips are available to all inmates and are given to housing deputies, classification, or other units within the jail as appropriate. Once message slips are received by the corresponding units, they are followed up on and returned to the inmates. In contrast to grievance forms, OCSD does not keep copies of message slips, and no message slips from Inmate Doe or Price were recovered during this investigation.

On September 17, 2020, Deputy Randall Lum told investigators that he worked in the Module where Price and Inmate Doe were housed, and was familiar with both of them. Deputy Lum recalled receiving two or three message slips from Inmate Doe asking to be rehoused. He believed the messages stated that Inmate Doe and Price were not getting along and that if they weren't housed separately, they were probably going to get in a fight. Deputy Lum stated he forwarded the message slips to the Classification Unit, but never personally saw anything concerning between Inmate Doe and Price.

Deputy Lum explained that he receives as many as 50 message slips per shift, and that it wasn't uncommon or rare for inmates to use them to complain about their cellmates. He stated that he was aware that inmates have complained as a subterfuge to try and manipulate housing decisions in order to be housed with someone they like better, pass contraband, or be housed alone.

OCSD Deputy Luis Maldonado, who worked in the Classification Unit in December 2019, was interviewed regarding any message slips that Inmate Doe might have made requesting to be assigned new housing. He stated that he was not made aware of any messages that Inmate Doe ever wanted to be rehoused.

Deputy Maldonado knew about Price and knew that he was a high-notoriety inmate, but following several interviews with him, OCSD staff determined that there were no indications that Price should not have been housed in general population. Deputy Maldonado also stated that he was not aware of any reason as to why Price and Inmate Doe should not have been housed together and was not told of any complaints filed by Inmate Doe.

Deputy John Moreno, another Classification Unit deputy, stated he was unaware of any reason why Inmate Doe and Price should not have been housed together. He also said that he was aware of claims that message slips were submitted by Inmate Doe but believed it was a rumor.

Deputy Mario Aguilar, who was working in Classification at the time of the assault, stated that whenever they receive a message slip from an inmate having housing concerns, they follow up

with the inmate. Additionally, he stated that message slips from inmates that say they are not getting along with their cellmate are very common and if there is a serious concern, the cellmates are followed up with. If the cellmates appear to just have personal problems, they are not likely to be rehoused. He stated that it is common for inmates to attempt to change their housing location if they don't like the cell.

Deputy Vincent Marshall, who also worked in the Classification Unit, told investigators that it was common for inmates to not get along with their cellmate, but if there are no safety concerns, they will not be rehoused. Deputy Marshall further stated that inmates are rehoused when serious safety concerns arise between cellmates. It is common for cellmates to have personal problems with one another and not get along. However, these reasons do not necessitate rehousing. TLF receives dozens of message slips every day and are required to assess any level of potential safety concern and follow up with the inmates when they see fit. Deputies are aware of inmate tactics to attempt to manipulate housing assignments to change to a preferable location or to be housed with a different cellmate.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Blood Standard
- One (1) Hospital Gown

AUTOPSY

On January 21, 2020, Independent Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Price. Price had a laceration on the back right portion of his head that measured approximately 1.5-inches, a 6-inch healing vertical incision on the base of his neck, a small scabbed over abrasion or sore on his right buttock, a scabbed-over abrasion on his right ankle, and a large subconjunctival hemorrhage in the sclera of his left eye. His lungs were found to have vascular congestion, a focal airspace edema, and a pulmonary embolus with an alternating cluster of red blood cells and fibrin products. An exam of Price's cardiovascular system revealed myocardium with myocyte hypertrophy, interstitial fibrosis, and focal interstitial hemorrhage without associate myocyte necrosis. Dr. Luzi made the following microscopic diagnoses: pulmonary congestion and edema, pulmonary embolus, cardiomegaly, focal cardiac hemorrhage, and arteriolosclerosis. Dr. Luzi opined the cause of death was pulmonary embolus due to deep vein thrombosis and the manner of death was homicide. In a further telephonic statement, Dr. Luzi indicated that Price died because a blood clot traveled to his lungs. He further stated that even considering Price's pre-existing conditions, this would not have happened if Price had not been paralyzed from the assault.

After watching the jail video of the assault, Dr. Luzi did not have an opinion as to whether the manner in which Price was moved or placed into the wheelchair by deputies (rather than immobilizing his neck/spine with some apparatus) after the assault contributed to his paralysis.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Codeine (Free)	0.0273 ± 0.0020 mg/L	
Methocarbamol	5.7 ± 1.2 mg/L	
Diphenhydramine	0.0702 ± 0.0065 mg/L	0.0258 ± 0.0024 mg/L
Noroxycodone	Detected	
Guaifenesin	Detected	
Atropine	Detected	

BACKGROUND INFORMATION

Kirk Vernell Price had a State of California Criminal History record that revealed arrests for the following violations:

- 187(A) PC- Murder
- 241/243 PC- Assault/ Battery on Peace Officer, Emergency Personnel
- 240/242 PC- Assault and Battery
- 241 PC- Assault on Peace Officer
- 243 PC- Battery
- 242 PC- Battery
- 211 PC- Robbery
- 245(A)(2) PC- Assault with a Firearm on Person
- 459 PC- Burglary
- 236 PC- False Imprisonment
- 12020 PC- Possession, Manufacture, Sale of a Dangerous Weapon
- 11550(B) HS- Under Influence of a Controlled Substance
- 243(e)(1) PC- Battery on Spouse, Cohabitant
- 422 PC- Threaten with Intent to Terrorize
- 12500(a) CVC- Unlicensed Driver

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

Other than the actions by Inmate Doe, there is no evidence of express or implied malice on the part of any OCSD personnel, inmates, or other individuals under the supervision of the OCSD. Accordingly, the only remaining theory of liability that warrants further analysis in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Price 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).

OCSD housed Inmate Doe and Price together based on the results of criminal characteristic assessments completed on all inmates. There is no evidence that these assessments were incomplete, inadequate, or indicated that Inmate Doe was a danger to Price. Thus, there is no basis to find that OCSD personnel were negligent in their initial housing decision.

Prior to the altercation between Inmate Doe and Price, deputies were aware of message slips submitted by Inmate Doe, but did not see any serious concerns or reasons as to why Inmate Doe and Price should not have been housed together. There were never any previous physical or verbal confrontations or altercations between the two that were witnessed by deputies or inmates. Some inmates recalled Price as being "unstable" but did not think he was a serious threat. Inmates recalled Price typically keeping to himself. Therefore, it was reasonable for Deputies to believe that there were no bases to separate Price and Inmate Doe.

Immediately upon becoming aware of Inmate Doe's assault on Price, deputies responded, ordered inmates back into their cells, and called for medical assistance. Given the immediate safety concerns, namely being in an area accessed by numerous inmates who could overpower the deputies and further assault Price, it was reasonable to move Price into a wheelchair rather than waiting for an apparatus to immobilize his neck and spine. Once Price was safely secured, deputies ensured his transportation to the hospital. Accordingly, deputies at TLF provided reasonable care to Price, acted in accordance with their training, and upheld their duties owed to him.

Consequently, 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.

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 Price. The evidence shows that Price died as a result of a pulmonary embolus and that the death was a homicide, but not due to the actions of OCSD staff or anyone other than Inmate Doe.

Accordingly, the OCDA is closing its inquiry into this incident with respect to OCSD personnel.

Respectfully submitted,

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Special Prosecutions Unit

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

READ AND APPROVED BY **TODD SPITZER**
District Attorney