



OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

August 30, 2023

Chief Amir El-Farra
Garden Grove Police Department
11301 Acacia Parkway
Garden Grove, CA 92840

Re: Custodial Death on September 1, 2021
Death of Ozzy Tavita Tuaila
District Attorney Investigations Case # 21-003501
Garden Grove Police Department Case # 21-46291
Orange County Crime Laboratory Case # 21-51653

Dear Chief El-Farra,

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 September 1, 2021, custodial death of thirty-one-year-old Ozzy Tavita Tuaila.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Tuaila. 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 Garden Grove Police Department (GGPD) personnel or any other person under the supervision of the GGPD in connection with this custodial death incident.

On September 1, 2021, OCDA Special Assignments Unit (OCDASAU) investigators responded to the ALDI Food Market (ALDI), located at 9901 Chapman Avenue, where Tuaila died while in custody of GGPD officers. GGPD officers had restrained Tuaila to stop him from hurting himself or others. GGPD officers requested paramedics to respond to the scene because of Tuaila's incoherent and intoxicated condition. Tuaila received medical treatment from Orange County Fire Authority (OCFA) paramedics. Tuaila was placed on a gurney and prepared for transport. Shortly thereafter, Tuaila became unresponsive, stopped breathing, and was observed to be pulseless. OCFA paramedics began chest compressions on Tuaila after they noticed he was unresponsive pulseless. Tuaila was transported to Garden Grove Hospital & Medical Center (GGHMC) where Doctor Kevin Truong was the emergency room (ER) doctor overseeing Tuaila's condition. Tuaila received advanced cardiac life support (ACLS) and cardiac medications. Tuaila, however, could not be resuscitated, and was pronounced dead by Dr. Truong. During the course of this investigation, the OCDASAU interviewed several witnesses, as well as obtained and reviewed

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reports from the GGPD 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 GGPD personnel or any other person under the supervision of the GGPD. 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 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. If necessary, the reviewing prosecutor will send the case back for further investigation.

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 reviews 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 September 1, 2021, at approximately 9:40 p.m., John Doe #1, John Doe #2, and John Doe #3 were all at the ALDI Food Market (ALDI) located at 9901 Chapman Avenue in the City of Garden Grove. The ALDI had closed for business at 9:00 p.m., but the front doors were open so that a contractor could clean the floors.

John Doe #1, an employee of Aldi, was outside the store when he saw Tuaila in the parking lot. Tuaila was rolling around on the ground and screaming incoherently. Tuaila then stood up and approached the front doors of the ALDI. Fearing a confrontation, John Doe #1 retreated into the store and tried to close and lock the front doors. One of the hoses being used to clean the floors, however, prevented the doors from closing. After reaching the front doors, Tuaila, whose face, wrists and hands were bloody, then began banging his hands and body against the doors and continued to scream incoherently.

John Doe #2, an employee of the cleaning company who was working inside the ALDI, observed Tuaila banging against the front doors. He stated that Tuaila was hitting his head against the glass door so hard that he thought he would knock himself unconscious. He said this banging occurred for four to five minutes and estimated that Tuaila hit his head against the glass doors 25 to 30 times.

Another cleaning company employee, John Doe #3, reported that he was working in the ALDI when he saw store employees attempting to lock the front doors. He heard what he described as an "incoherent" Tuaila say "water," and handed him a bottle of water. Tuaila poured the water over himself, and then proceeded to slam his body and head against the doors for several minutes. Eventually, Tuaila dropped and rolled around on the ground. This resulted in Tuaila becoming entangled in the cleaning hoses.

At approximately 9:56 p.m., John Doe #1 called GGPd, and reported that Tuaila attempted to enter the closed ALDI and was trying to break down the doors.

Prior to GGPd's arrival, Tuaila returned to the parking lot and began violently thrashing around on the ground. John Doe #3 exited the market and stood in the parking lot to prevent Tuaila from being struck by passing cars.

At approximately 9:58 p.m., GGPd officers were dispatched to ALDI market. The officers were informed there was a subject under the influence refusing to leave and attempting to break the store's door with his hands.

At approximately 10:01 p.m., GGPd Officer Broc Dudley arrived on scene. Corporal Edgar Valencia arrived at 10:02 p.m. followed immediately thereafter by Officer Robert Fresenius.¹ When they arrived, they saw Tuaila, who they recognized from numerous prior contacts, rolling around on the ground, banging his head against the asphalt and screaming incoherently. They noticed that Tuaila was bleeding from his head and knees.

Based on his prior contacts with Tuaila, Officer Dudley was aware of the fact that he was a chronic drug user and often acted erratically. Officer Dudley contacted Tuaila saying, "Ozzy, what are you doing?" He instructed Tuaila numerous times to stop moving around. Tuaila was non-compliant and continued thrashing.

Officer Dudley, fearing Tuaila may further, perhaps more seriously, injure himself if allowed to continue flailing around on the ground and slamming his head against the asphalt, elected to approach Tuaila and restrain him.

¹ GGPd's dispatch log lists Officer Fresenius arriving on scene at 10:20 p.m. This appears to be a typographical error in which the "0" and the "2" were transposed. Witness statements and officers' body worn camera recordings clearly show his arrival at 10:02 p.m.

Officer Dudley grabbed Tuaila's right arm and held him to the ground, while Corporal Valencia controlled his legs, and Officer Fresenius handcuffed his hands behind his back.

Once handcuffed, Tuaila again began to thrash around violently. Officer Fresenius, in order to prevent Tuaila from further injuring himself, took hold of his right arm and pressed Tuaila's left side to the ground while standing next to him. Despite this action, Tuaila continued to struggle. Multiple times the officers said "Ozzy stop!" and "Ozzy calm down!" Tuaila did not comply.

At approximately 10:03 p.m., Officer Valencia requested paramedics respond to provide Tuaila with medical aid.

At approximately 10:06 p.m., Officers Dudley and Valencia tried to restrain Tuaila from flailing and kicking about. Officer Fresenius placed a Hobble restraint just above Tuaila's knees.

Jane Doe #1 and John Doe #4 were employees at the neighboring Marshall's Department store. They, along with John Doe #2, observed the GGPD officers arrive and contact Tuaila. Their observations are all consistent with video obtained from the officers' BWCs.

Jane Doe #1 indicated Tuaila had been rolling around in the parking lot banging his head against the concrete for 20 to 30 minutes. She observed the three GGPD officers arrive on scene and attempt to stop Tuaila from harming himself. Tuaila kicked and punched the GGPD officers away from him. The officers then backed away from Tuaila shielding themselves from the kicks with their arms.

John Doe #4 made similar observations as Jane Doe #1. He added that prior to GGPD's arrival, every time Tuaila slammed his head to the ground, he could hear the thud. John Doe #4 said he stood 70 meters away when perceiving these events. When GGPD arrived, they attempted to prevent Tuaila from hurting himself. John Doe #4 confirmed that the GGPD officers never hit or choked Tuaila. He said the police did a good job and their actions were "smooth and good." He said that the officers' efforts to hold Tuaila's legs down appear to have been done to keep him from harming himself.

At approximately 10:08 p.m., paramedics from Orange County Fire Authority (OCFA) Engine 82 arrived. The paramedics recognized Tuaila from previous contacts and knew him to use methamphetamine. At this time, Tuaila was conscious, breathing, and had a pulse.

At 10:12 p.m., per standing protocol, the OCFA paramedics administered 5 mg of Midazolam, a sedative, intramuscularly to Tuaila's right arm.

At 10:16 p.m., paramedics placed Tuaila on a gurney and prepared him for transport.

At 10:17 p.m., Officer Fresenius removed the handcuffs placed on Tuaila.

At approximately 10:18 p.m., paramedics noted Tuaila was unresponsive. Upon further checking, paramedics found Tuaila was not breathing and had no pulse. Paramedics attached a cardiac monitor to Tuaila, which indicated Tuaila's heart lacked electrical or mechanical activity. Paramedics initiated manual cardiopulmonary resuscitation (CPR) and moved him into the ambulance. They then established a laryngeal airway and attached an automated LUCAS chest compression system to Tuaila. Paramedics continued CPR throughout the transport. An intraosseous venous access was established in Tuaila's right tibia to administer normal saline.

At 10:28 p.m., Tuaila was transported to GGHMC where he arrived approximately eight minutes later. Emergency room (ER) medical staff took over Tuaila's care from OCFA paramedics. GGHMC records described Tuaila as a 31-year-old male weighing 150 pounds. GGPD reports listed Tuaila as 6 feet in height.

Following his arrival, GGHMC medical staff took over Tuaila's medical care. Chest compressions continued. The ER medical staff provided advanced cardiac life support to Tuaila, including cardiac medications. At approximately 10:51 p.m., ER physician Dr. Kevin Truong pronounced Tuaila deceased.

Dr. Truong had recognized Tuaila from a previous hospital visit in August 2021. During the prior visit, Tuaila appeared agitated and his had blood tested positive for the presence of methamphetamine.

Hospital records from the September 1, 2021, admission state:

"Patient is well known to the emergency department for which he does have a history of amphetamine use and significant underlying cardiac disease. Patient's medical record was reviewed for which he does have multiple emergency department visits due to agitation...Most recently he was here on August 14."

On September 2, 2021, representatives from the Orange County Coroner's Office spoke to Tuaila's stepmother, who stated that he had been homeless for several years due to his chronic drug abuse, violent behavior, and refusal to seek help for his drug addiction. She also described Tuaila as violent and had unknowingly harmed himself in the past while using illegal substances.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- One (1) Hobble restraint, located in the front passenger door of GGPD Vehicle #1

AUTOPSY

On September 3, 2021, Forensic Pathologist Dr. Aruna Singhania of Orange County Coroner's Office conducted an autopsy on the body of Tuaila. Dr. Singhania observed multiple abrasions of various ages on the face, and the upper and lower extremities. The cardiovascular system was mostly unremarkable. The respiratory system was also mostly unremarkable. None of the findings revealed any sign of trauma. The toxicology report revealed the presence of several drugs in Tuaila's system.

Dr. Singhania found the cause of death to be the combined effects of amphetamine, methamphetamine, fentanyl, and alprazolam.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Amphetamine	Postmortem Blood	0.0435 ± 0.0032 mg/L
Amphetamine	Brain	0.0938 ± 0.0070 mg/kg

Fentanyl	Postmortem Blood	0.0044 ± 0.0005 mg/L
Fentanyl	Peripheral Blood	0.0042 ± 0.0004 mg/L
DRUG	MATRIX	RESULTS & INTERPRETATIONS
Fentanyl	Brain	0.0097 ± 0.0009 mg/kg
Methamphetamine	Postmortem Blood	0.384 ± 0.028 mg/L
Methamphetamine	Brain	0.749 ± 0.053 mg/kg
Alprazolam	Postmortem Blood	0.0165 ± 0.0020 mg/L
Caffeine	Postmortem Blood	Detected
Carboxy-THC	Postmortem Blood	Detected
Flumazenil	Postmortem Blood	Detected
Midazolam	Postmortem Blood	0.0202 ± 0.0028 mg/L

BACKGROUND INFORMATION

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

- Trespassing
- Vandalism
- Robbery
- Possession of a Controlled Substance
- Possession of Paraphernalia
- Shoplifting
- Petty Theft
- Loitering
- Appropriate Lost Property
- Obstruct Public Officer
- Theft of Personal Property
- Vehicle Theft
- Under the Influence of Controlled Substance
- Identity Theft
- Access Account without Consent
- Receive Stolen Property
- Elder Abuse
- Assault on Person
- 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 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 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 GGPD personnel. After reviewing all the evidence, including the body-worn camera recordings ("BWC") of all of the officers involved, and comparing those videos with the witness' statements, there is nothing to indicate that the officers' conduct was unlawful.

When arriving first on the scene, Officer Dudley observed Tuaila violently thrashing on the ground. Officer Dudley attempted to deescalate the situation by addressing Tuaila by his first name and asking him what he was doing. After receiving no response, Officer Dudley placed Tuaila in handcuffs to help them control Tuaila and prevent any further escalation of the event. By placing Tuaila in handcuffs and also using minimal force to control him, Officer Dudley prevented Tuaila from further hitting his head against the ground or other objects and otherwise hurting himself. The force used by GGPD officers was minimal and appropriate under the circumstances. Witness John Doe #4 confirmed that the officers acted appropriately, never hit or choked Tuaila, and that their actions were "smooth and good."

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.

GGPD owed Tuaila a duty of care; however, 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).

John Doe #1 called 911 at approximately 9:56 p.m. GGPD officers responded quickly to the dispatch request and acted promptly. Officer Dudley was dispatched at 9:58 p.m. and arrived on scene by 10:01 p.m. Corporal Valencia arrived at 10:02 p.m. with Officer Fresenius close behind him. Once they observed Tuaila thrashing about on the ground, the officers attempted to control him to prevent him from harming himself or others. Within a minute of his arrival, Corporal Valencia recognized that Tuaila needed medical assistance and promptly requested it. By 10:08 p.m., OCFA arrived and began treating Tuaila.

This indicates that GGPD officers provided the required level of diligence and care to Tuaila.

Finally, there is no evidence that the GGPD officers' restraint of Tuaila contributed to his death. At the time, Tuaila had multiple dangerous drugs in his system including amphetamine, fentanyl, methamphetamine, and alprazolam. Ultimately, it was the combined effects of these drugs that Dr. Singhania determined to be Tuaila's cause of death.

Many of the parties involved had previous experience with Tuaila and his drug addiction, including GGPD police officers, OCFA paramedics and the admitting ER doctor. The medical records provide several illuminating statements regarding Tuaila. "Patient is well-known to the emergency department," "history of amphetamine use and significant underlying cardiac disease," and "multiple emergency department visits due to agitation." Tuaila's stepmother described him as a violent, chronic, drug abuser who had harmed himself in the past while using drugs and refused to accept help for his drug addiction.

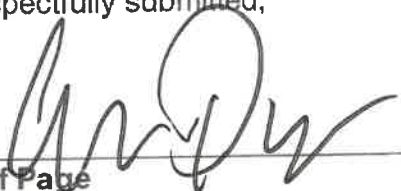
It is clear from all of the evidence, including witness statements, medical records, and body worn camera recordings, that Tuaila's death did not result from any lack of care by GGPD officers. GGPD officers acted in a way an ordinarily careful person would have acted in the same situation. GGPD officers' actions did not amount to disregard for human life or indifference to the consequences of an act that could have reasonably led to death of or great bodily injury to Tuaila.

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 or any individual under the supervision of the GGPD directly committed any act or failed to perform a legal duty causing the death of Tuaila. The evidence shows that Tuaila died as a result of the combined effects of amphetamine, methamphetamine, fentanyl, and alprazolam.

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

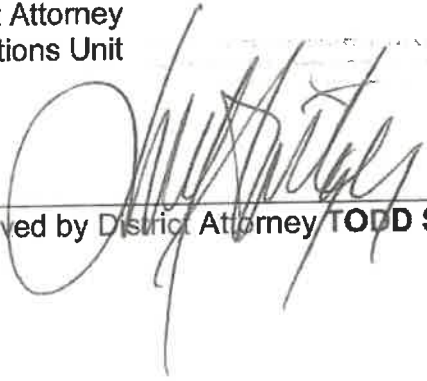
Respectfully submitted,



Cliff Page
Senior Deputy District Attorney
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Read and Reviewed by **BRETT BRIAN**
Assistant District Attorney
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Read and Approved by District Attorney **TODD SPITZER**