OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

December 13, 2023

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

Re: Custodial Death on July 3, 2022
Death of Inmate Eric Garcia
District Attorney Investigations Case # 22-002005
Orange County Sheriff's Department Case # 22-021461 and 22-021986
Orange County Crime Laboratory Case # FR 22-47308 and 22-47419
Orange County Coroner's Office Case # 22-03900-CE

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 July 3, 2022, custodial death of 40-year-old inmate Eric Garcia.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Garcia. 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 as well as those under the supervision of the OCSD involved in this custodial death incident.

On July 3, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the University of California, Irvine-Medical Center (UCIMC), where Garcia died while in custody. During the course of their investigation of Garcia's death, the OCDASAU interviewed three witnesses, and obtained reports, incident scene photographs, jail surveillance footage, medical records and other relevant materials from the OCSD and the Orange County Crime Laboratory (OCCL).

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

FACTS

On June 25, 2022, at approximately 7:49 a.m., Garcia was arrested by the Garden Grove Police Department (GGPD) for an outstanding warrant for vandalism.

At approximately 11:05 a.m., GGPD booked Garcia into the Orange County Jail (OCJ)-Intake Release Center (IRC), 550 North Flower Avenue, Santa Ana. GGPD Officer Annette Phillips noted on the Statement of Booking that Garcia appeared to be in good health and was not a danger to himself or others.

During the intake process, an Orange County Health Care Agency (OCHCA) Comprehensive Care Nurse (CCN) completed a Comprehensive Detox Screen evaluation, a Clinical Institute Withdrawal Assessment for Alcohol evaluation, and a Receiving Screening on Garcia.

During these evaluations, Garcia reported he consumed alcohol regularly and used street drugs such as marijuana. Garcia reported having a history of mental problems and was previously

treated while in-custody. Garcia was given a Mental Health Triage Referral and scheduled for a re-check on July 2, 2022.

At approximately 12:41 p.m., an OCHCA Nurse Practitioner completed a Withdrawal Orders-Alcohol Screening of Garcia. Garcia was prescribed the following medications:

- Thiamine 11 mg
- MVI with Folate
- Maalox
- Oxazepam
- Vitamin B-1
- Multi-Vitamin/Minerals
- Aluminum hydroxide, Magnesium Hydroxide & Simethicone

At approximately 5:15 p.m., an OCHCA medical staff member completed a Mental Health Screening of Garcia. Garcia had previously been diagnosed with depression and reported that he was currently feeling depressed. Garcia was not taking or currently prescribed medication for his depression, but stated he used methamphetamine daily. A mental health referral was noted for further mental health chronic care and coping. Garcia was cleared for regular housing in a lower bunk and remained in the booking loop.

At approximately 10:09 p.m., Garcia was transferred from the IRC to the Theo Lacy Jail (TLJ) facility. Garcia was later placed in Module (MOD) M, Sector 27, Cell 8, a two-inmate cell. His cellmate was inmate John Doe 1. There is a jail surveillance system that captures the exterior of the cell and a portion of the cell's interior via a cell door window. Though Garcia was cleared for a lower bunk, he ended up sleeping in the upper bunk. This bunk can be partially seen during the video recordings.

On June 29, 2022, at approximately 1:39 a.m., the jail surveillance video captured an OCSD deputy conducting a routine safety check of Garcia's Cell. The OCSD deputy does not appear to notice anything unusual.

At approximately 2:01 a.m., Garcia is seen on jail surveillance video rising from his bunk, climbing down, and moving toward the cell door. Garcia goes in and out of view of the jail surveillance camera.

At approximately 2:09 a.m., Garcia is captured returning to his top bunk to lie down. Garcia can be seen moving in his bunk at approximately 2:11 a.m.

At approximately 2:17 a.m., John Doe 1 can be seen on jail surveillance video rising from his bed. He then goes out of view of the camera. A minute later, John Doe 1 can be seen climbing onto Garcia's bunk. John Doe 1 is on his knees and appears to lean forward, moving his head toward the area of Garcia's head. John Doe 1 rose from this position and repeated the movement twice before climbing down from the bunk.

At approximately 2:19 a.m., John Doe 1 returned to his lower bunk.

At approximately 2:22 a.m., an OCSD deputy conducted a routine safety check past Cell 8.

At approximately 2:40 a.m., John Doe 1 can be seen rising from his bunk once again. John Doe 1 is then mostly out of view of the jail surveillance camera.

At approximately 2:42 a.m., John Doe 1 walked to the door, which had been opened for medication distribution, and exited the cell. John Doe 1 left the cell door slightly ajar, walked downstairs, and left the sector.

At approximately 2:45 a.m., John Doe 1 returned to the sector and back to Cell 8. John Doe 1 turned toward the guard shack that oversaw the sector and began to waive his arm for attention. John Doe 1 saw a fellow inmate, John Doe 2, enter the sector and called him to Cell 8. John Doe 2 responded, and within seconds, John Doe 1 used the cell intercom to notify OCSD deputies that Garcia was unconscious.

At approximately 2:49 a.m., OCSD deputies and jail medical staff responded to Garcia's cell and found him unresponsive. Upon finding Garcia unresponsive, an OCSD deputy requested paramedics. Garcia was then taken out of the cell and laid on the front landing. Deputies administered Narcan to Garcia as cardiopulmonary resuscitation (CPR) was initiated.

At approximately 2:52 a.m., Orange Fire Department (OFD) Engine 6 was dispatched to TLJ.

At approximately 3:01 a.m., an OCSD deputy searched Garcia's cell and did not locate any narcotics or other contraband.

At approximately 3:02 a.m., OFD paramedics arrived on scene. Garcia was supine on the floor while TLF medical personnel and deputies were performing CPR. Garcia was unresponsive, unconscious, apneic, and pulseless. He was also observed to have no eye movement or motor responses.

An OFD paramedic initiated an intravenous line, and administered epinephrine and sodium bicarbonate. An automated external defibrillator (AED) was attached to Garcia, and at least one shock was administered. A slight pulse was detected. The OFD paramedic contacted the UCI Medical Center (UCIMC) base hospital, advised them of Garcia's condition, and was ordered to transport him to UCIMC.

At approximately 3:26 a.m., Garcia was transported to UCIMC.

At approximately 3:33 a.m., Garcia arrived at the UCIMC Emergency Room (ER). Garcia was treated pursuant to cardiac protocol and intubated upon arrival. Garcia became pulseless twice, but was revived both times. Garcia remained unconscious, with no reflexes and no brain activity. UCIMC, could not locate Garcia's family to discuss his medical condition and establish a do-not-resuscitate (DNR) order or decision. Therefore, Garcia was stabilized and placed on a ventilator.

A sample of Garcia's blood was taken at UCIMC and tested positive for the presence of fentanyl.

Later that morning at approximately 11:45 a.m., an OCSD Custody Intelligence Investigator reviewed the jail surveillance video and interviewed both John Doe 1 and John Doe 2 at TLJ.

In his interview, John Doe 2 stated that after medication distribution, he walked back upstairs toward his cell. John Doe 2 saw John Doe 1 and he looked scared. John Doe 1 told him that Garcia was unresponsive. They entered the cell and started yelling at Garcia but received no response. Garcia was lying on his back with his feet crossed and arms on his chest. John Doe 2 noticed that Garcia's skin looked a different color. He described that color as "Dead." John Doe 2 did not see Garcia's face, but he was unresponsive, and when John Doe 2 tried to move him he

did not move. John Doe 1 did not mention anything about narcotics to John Doe 2, and John Doe 2 had no knowledge of any narcotics in Module M.

John Doe 1, in his interview, stated that he woke up and saw Garcia lying on his top bunk, uncovered, with his arms on his chest and feet crossed. John Doe 1 thought this was odd, as Garcia was always cold. He tried to wake Garcia, but Garcia did not respond. John Doe 1 said he climbed onto Garcia's bunk and placed his head next to Garcia's mouth, but only heard "faint breathing and a growling sound." John Doe 1 said he "freaked out" and panicked. When the cell door popped for medication distribution, John Doe 1 tried to wake Garcia up again, but he remained unresponsive. John Doe 1 went downstairs and told the deputy, "He's not getting up." John Doe 1 stated, however, that he did not inform the deputy with a sense of urgency and that he then got in line to get his medications. After getting his medication, John Doe 1 returned to his cell. When John Doe 2 walked upstairs, John Doe 1 told John Doe 2 about Garcia's condition and they then notified the deputies that something was wrong. John Doe 1 said that he fell asleep before Garcia on the night of the incident. John Doe 1 said he was awakened when he heard Garcia flushing the commode in the cell and said this was the last time he saw Garcia conscious.

On June 30, 2022, at approximately 9:36 a.m., two UCIMC doctors and the UCIMC Ethics Chair discussed Garcia's medical condition, and the fact that Garcia was unrepresented. Garcia was comatose with a grim neurological status. Collectively, after evaluating Garcia's medical condition, the doctors placed a DNR order on Garcia. Garcia's family was located later that day and advised of his medical condition and the DNR order.

On July 2, 2022, at approximately 2:19 p.m., a UCIMC neurologist and physician evaluated Garcia. Garcia was classified as having no brain activity. The UCIMC neurologist notified the Garcia family as Garcia remained on a ventilator.

On July 3, 2022, at approximately 1:00 p.m., Garcia was disconnected from the ventilator.

At approximately 1:26 p.m., Garcia's heart stopped, and he was pronounced deceased.

EVIDENCE COLLECTED

An OCCL Forensic Specialist took 39 digital color photographs of the scene and body.

AUTOPSY

On Friday, July 8, 2022, at approximately 8:00 a.m., Forensic Pathologist Doctor Scott Luzi conducted the post-mortem examination of Garcia at the Orange County Sheriff-Coroner Forensic Science Center.

OCCL Forensic Specialists took 44 digital color photographs and collected blood and muscle standards.

Dr. Luzi noticed no obvious signs of significant trauma. Dr. Luzi found that Garcia had an enlarged heart and vital organs showing signs of consistent and prolonged drug use. Dr. Luzi said the cause and manner of death would be determined following toxicological and microscopic tests.

On October 27, 2022, Dr. Luzi issued an amendment to his report. Dr. Luzi identified the cause of Garcia's death as "Acute fentanyl intoxication" and the manner as "accident."

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Garcia's postmortem blood was collected and examined for the presence of drugs and alcohol.

The following results and interpretations were documented:

Drug	Postmortem Blood	AnteMortem Blood
Norfentanyl	Detected	
Oxazepam-glucuronide	Detected	Detected
Fentanyl		0.0086 ± 0.0008 mg/L

BACKGROUND INFORMATION

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

- Destroy/Conceal Evidence
- Robbery
- Possession of Marijuana
- DUI Alcohol Drugs
- Child Cruelty
- Disorderly Conduct
- Burglary
- Possession of a Controlled Substance
- Conspiracy
- Grand Theft
- Possession of Drug Paraphernalia
- Petty Theft
- Vandalism
- Under the Influence of a Controlled Substance
- Obstruct/Resist Officer
- Violation of Court Order
- Domestic Violence
- Terrorist Threats
- 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 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

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. 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.

Although the OCSD owed Garcia 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). Garcia was evaluated by OCHCA medical personnel upon admittance to the IRC on June 25, 2022. It was noted that he had a history of drug usage and mental health issues; however, he was not viewed as a suicide risk. He was given follow-up mental health care as well as medical care and prescriptions.

On the day of the incident, jail surveillance video showed OCSD Deputies performing regular welfare checks. There were no outward indications of Garcia being in distress. Similarly, there was no evidence that Garcia possessed or had ingested any narcotics, including fentanyl, while in custody.

Due to the late hour, it was not uncommon for inmates to appear to be asleep in their bunks. While a deputy was notified by Garcia's cellmate that he was not waking up, John Doe 1 admitted he relayed that information without any sense of urgency, and that he simply went about getting his prescribed medication. When John Doe 1 and John Doe 2 eventually notified deputies that Garcia was unconscious, OCSD deputies and medical staff responded quickly. They administered appropriate medical and emergency treatment and promptly called for a 9-1-1 emergency response.

There is nothing to indicate that Garcia's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

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 Eric Garcia.

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

Respectfully submitted,

MARC ROZENBERG
Deputy District Attorney
Special Prosecutions Unit

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

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