OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

November 3, 2023

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

Re: Custodial Death on October 21, 2022
Death of Inmate Jose Mariano Gasperin
District Attorney Investigations Case # 22-003224
Orange County Sheriff's Department Case # 22-036009
Orange County Crime Laboratory Case # FR 22-51018
Orange County Coroner's Office Case # 22-06159-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 October 21, 2022, custodial death of 62-year-old inmate Jose Mariano Gasperin.

OVERVIEW

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

On October 21, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Providence St. Joseph Hospital Orange (PSJHO), located at 1100 W. Stewart Drive, Orange, where Gasperin died while in custody. During the course of their investigation of Gasperin's death, the OCDASAU interviewed six witnesses, as well as obtained and reviewed reports from the OCSD and the Orange County Crime Laboratory (OCCL), incident scene photographs, jail surveillance footage, medical records, 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 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.

FACTS

On September 29, 2022, at approximately 7:08 p.m., the Anaheim Police Department (APD) arrested Gasperin for assault with a deadly weapon, brandishing a knife, and criminal threats. Gasperin was later found to have an outstanding bench warrant related to alleged possession of a controlled substance and possession of drug paraphernalia.

Gasperin was subsequently booked and housed in the APD City Jail facility. Gasperin did not disclose any medical or other issues at the time of his booking. Gasperin admitted prior alcohol and cannabis use, but informed jail staff that he was not experiencing alcohol or drug withdrawal.

On September 30, 2022, at approximately 2:00 p.m., APD transported and booked Gasperin into the Orange County Jail Intake/Release Center (IRC). The Orange County Health Care Agency (OCHCA) completed a medical/mental health pre-screening on Gasperin, which resulted in clearance for regular booking. After completion of the booking process, Gasperin was temporarily housed within the IRC booking-loop holding area. However, because Gasperin appeared malnourished and was missing multiple teeth, jail medical staff placed him on a mechanical soft diet with liquid supplement. A mechanical soft diet is a texture-modified diet that restricts foods that are difficult to chew or swallow. Foods can be pureed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a pureed diet, which includes foods that require no chewing

On October 1, 2022, at approximately 12:15 p.m., Gasperin was transferred to the Theo Lacy Jail Facility (TLF), where he was housed as a new booking quarantine inmate in Module R. Over the course of the next several days, Gasperin was moved to multiple housing locations within the facility.

On October 13, 2022, Gasperin submitted an "Inmate Health Message Slip" (IHMS) requesting mental health care for feelings of suicide, depression, and anxiety.

On October 13, 2022 at approximately 9:02 p.m., medical staff contacted Gasperin regarding the mental health request. Gasperin indicated that the IHMS was a mistake and advised that he was not experiencing any feelings of suicide, depression, or anxiety.

On October 14, 2022, Gasperin submitted an IHMS requesting medical care for vomiting.

On October 14, 2022 at approximately 11:30 p.m., OCSD medical staff examined Gasperin. Gasperin advised that deputies forced him to eat too quickly, resulting in an upset stomach and vomiting. Medical staff directed that Gasperin be assigned to a "slow eater table," allowing him ample time to consume his meals without becoming ill.

On October 16, 2022, at approximately 8:02 p.m., medical staff in the TLF Dispensary attended to Gasperin. He was still experiencing nausea, vomiting, and weakness. Fluid replacement was attempted by encouraging Gasperin to drink Gatorade. During this contact with Gasperin, medical staff determined he needed medical housing within the facility.

At approximately 8:13 p.m., Gasperin was moved to Module O, a medical housing module.

On October 18, 2022, at approximately 8:06 p.m., a deputy conducting an inmate count in Module O contacted Gasperin, who was asleep in his assigned bunk. Gasperin was difficult to awaken, and during conversation efforts, Gasperin appeared confused and visibly weak. The deputy relayed his observations to the medical staff.

At approximately 8:34 p.m., medical staff examined Gasperin at the Module O Nurse's Station. At that time, Gasperin had a blood sugar level of 57. Two doses of instant glucose were administered, and an Intravenous (IV) Line was established with a Dextrose 10% in Water solution. Medical staff determined that Gasperin needed hospital care, and a 9-1-1 paramedic response was initiated.

At approximately 8:50 p.m., Orange City Fire Department (OCFD) paramedics arrived and assumed patient care of Gasperin. Per protocol, an IV line was established with normal saline, and Gasperin was administered two 4mg tablets of Zofran by mouth for nausea relief.

At approximately 9:05 p.m., OCFD transported Gasperin to PSJHO and arrived at approximately 9:17 p.m., where emergency staff assumed patient care.

Medical Staff at PSJHO diagnosed Gasperin with pneumonia and sepsis. He was subsequently admitted to the medical intensive care unit (MICU), where his treatment included broad-spectrum antibiotics and further diagnostic testing. Gasperin's condition, however, continued to decline, and he slipped further into septic shock, ultimately resulting in multi-organ failure.

On October 20, 2022 at approximately 10:00 p.m., Gasperin's heart went into rapid atrial fibrillation. MICU staff, however, were able to stabilize him with blood pressure medication.

On October 20, 2022, at approximately 11:29 p.m., Gasperin's heart rate slowed to the point that it no longer registered on the monitor. A Code-Blue was called, and he was successfully resuscitated.

On October 21, 2022, at approximately 2:14 a.m., Gasperin's heart rate became asystolic with no pulse. A second Code-Blue was called, and he was again successfully resuscitated.

At approximately 02:58 a.m., Gasperin's heart rate again became asystolic with no pulse, and a third Code-Blue was called.

At approximately 3:01 a.m., despite resuscitation efforts by hospital personnel, Gasperin expired and was pronounced deceased by Dr. Kia Ghiassi.

EVIDENCE COLLECTED

OCCL Forensic Specialist Chelsey Covert took 48 digital color photographs of the hospital scene and Gasperin's body.

AUTOPSY

On October 27, 2022, at approximately 11:13 a.m., Forensic Pathologist Scott Luzi conducted the post-mortem examination of Gasperin at the Orange County Sheriff-Coroner Forensic Science Center, located at 1071 West Santa Ana Boulevard, Santa Ana.

OCCL Forensic Specialist Hilary Velardo took 48 color digital photographs during the post-mortem examination, and OCCL Forensic Scientist Greg Hogrebe collected the following:

- Bloodstain Standard (Gasperin)
- Muscle Standard (Gasperin)

After the post-mortem examination, Dr. Luzi indicated that Gasperin had fluid in his lungs and damage to his heart, kidneys, and other vital organs. The cause and manner of Gasperin's death would be pending until toxicological and microscopic testing results were evaluated.

On May 31, 2023, Dr. Luzi amended his report, identifying the cause and manner of Gasperin's death. Dr. Luzi concluded that the cause of death was community-acquired pneumonia. He also noted other associated medical conditions, including hypertensive and atherosclerotic cardiovascular disease. Dr. Luzi classified the manner of death as natural.

EVIDENCE ANALYSIS

Toxicological Examination

Samples of Gasperin's ante-mortem and post-mortem blood were collected and examined for the presence of drugs and alcohol.

The following result and interpretations were documented:

DRUG/ALCOHOL	ANTEMORTEM BLOOD	POSTMORTEM BLOOD
Ethanol/Volatiles	Postmortem Blood	Not Detected

BACKGROUND INFORMATION

Gasperin had a California criminal history arrest record dating back to 2005 for the following violations:

- Unlicensed Driver
- Possession of Controlled Substance
- Possession of Drug Paraphernalia
- Criminal Threats
- Brandishing a Knife
- Assault with a Deadly Weapon

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 Gasperin 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). Gasperin was evaluated by HCA personnel upon admittance to the IRC on September 30, 2022. As a result of the examination, Gasperin was placed on a soft diet with liquid supplement. On October 13, 2022, and after being transferred to TLF, when it was believed that he had submitted an "Inmate Health Message Slip" for mental health, he was promptly evaluated.

On October 14, 2022, when Gasperin complained of vomiting, he was immediately attended to by a qualified medical professional. This resulted in an eating accommodation to alleviate the problem.

On October 18, 2022, when a deputy noticed Gasperin to be lethargic, medical personnel were immediately called. As a result of that examination, Gasperin was transported to the hospital for treatment.

The evidence shows that at all times OCSD personnel followed protocols and provided immediate medical care to Gasperin.

Although legally still in-custody at PSJHO, Gasperin received extensive medical care for what was diagnosed to be pneumonia and sepsis. At PSJHO he was transferred to the MICU, where he received antibiotics, further testing, and placement on a ventilator.

On October 20 and 21, 2022, Gasperin suffered three Code-Blue incidents. Though he was revived during the initial two incidents, he could not be revived after the third. His manner of death was ultimately deemed to be natural.

As with the care he received at TLF, there is no evidence to show that once transported to PSJHO that any OCSD personnel, or any individual under the supervision of the OCSD, failed to perform a legal duty owed to Gasperin.

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 Jose Gasperin.

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**