OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

November 16, 2023

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

Re: Custodial Death on March 18, 2022
Death of Inmate Ronald Garcia Lucio, Jr.
District Attorney Investigations Case # 22-000799
Orange County Sheriff's Department Case # 22-009022
Orange County Crime Laboratory Case # 22-43330

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 March 18, 2022, custodial death of 38-year-old inmate Ronald Garcia Lucio, 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 Lucio. 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 incident as well as any other individuals under the supervision of the OCSD.

On March 18, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the OCSD Orange County Jail/Intake Release Center (IRC) Jail Facility, where Lucio died while in custody. During the course of this investigation, the OCDASAU interviewed 28 witnesses, as well as obtained and reviewed reports from the OCSD and the 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 the deaths of individuals within Orange County that occur while they are 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 additional experienced prosecutors and their supervisors. Ultimately, the District Attorney personally reviews and approves 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 April 2, 2021, Lucio was arrested by officers from the Anaheim Police for violations of Penal Code sections 245(a)(1), assault with a deadly weapon (firearm), and 246.3(a), willful discharge of a firearm with gross negligence. Following his arrest, Lucio was transported to IRC for booking.

Upon arrival at IRC, Lucio was evaluated by a representative of the Orange County Health Care Agency for medical and mental health pre-screening. Based on that screening, Lucio was referred for a further mental health assessment and temporarily placed in booking loop-holding cell H5. During this brief holding period, Lucio was captured on jail video surveillance climbing a four-foot block privacy wall and diving headfirst to the concrete floor below. Lucio sustained injuries and treatment as a result.

During treatment for his head and spinal injuries, Lucio was evaluated by a psychiatrist. On April 16, 2021, Lucio was diagnosed with schizophrenic disorder and a history of alcohol abuse. He was prescribed Depakote, Zoloft, and Zyprexa. At the conclusion of his medical evaluation, Lucio

was returned to IRC. On May 20, 2021, Lucio was assigned to Mod L, Sector 18, Cell 13, a housing unit for inmates with mental health and medical issues.

Due to Lucio's initial cooperation with medical and mental health treatment efforts, he was moved on July 9, 2021, from Mod L to Men's Central Jail, Mod O, Sheltered Living Cell 12. This less-restrictive living environment was located adjacent to the facility's medical dispensary. While being escorted for a scheduled x-ray appointment on July 13, 2021, Lucio engaged in a physical altercation with the escorting deputy. It was determined the altercation was the result of disorientation, and Lucio was transported for outside medical and mental health treatment.

On July 14, 2021, Lucio was returned to IRC Mod L in order to further supervise his mental health treatment. With Lucio appearing to suffer from depression, self-isolation and disorientation, Orange County Superior Court Judge Jeffrey Ferguson ordered on October 29, 2021, that a mental health evaluation be conducted on Lucio.

On December 21, 2021, OCSD moved Lucio from Mod L to Mod M, Sector 26, Cell 3, a housing unit for inmates with chronic mental and/or medical treatment needs. He remained in this enhanced supervision unit until March 18, 2022.

On March 18, 2022, Lucio received his evening meal at his cell at 3:20 p.m. Jail surveillance video captured Lucio eating and drinking in his cell thereafter. At 3:27 p.m., Lucio was observed on surveillance video moving to his cell's lower bunk and out of view.

At 3:50 p.m., OCSD deputies completed a safety check of Mod M and determined the cells were "all secure." Surveillance video showed Lucio moving within his cell from 4:10 p.m. to 4:11 p.m.

At 4:34 p.m., another safety check within Mod M was completed and deemed "all secure." At 4:40 p.m., an IRC medical staff member performed a visual check of Lucio's cell and made no mention of anything out of the ordinary.

Other safety checks were completed at 5:17 p.m. and 6:05 p.m. OCSD Deputies completed a shift change at 6:16 p.m. which was followed by an additional safety check of Mod M at 6:47 p.m. Deputies noted that the Mod was "all secure" following each of the safety checks.

At 7:02 p.m., a deputy and vocational nurse began medication distribution within Mod M. At 7:11 p.m., they arrived at Lucio's cell and observed him lying on the lower bunk. Despite an announcement of their presence and knocking on the exterior of the cell door multiple times, they received no response from Lucio. The deputy opened and closed the cell door in an effort to gain Lucio's attention, but once again received no response. At this time, the nurse pointed out the pale look of Lucio's exposed feet and indicated his belief Lucio had expired.

At 7:12 p.m., the deputy and vocational nurse entered Lucio's cell for a wellness check. The deputy advised he observed Lucio laying in the lower bunk on his right side. He stated Lucio appeared cyanotic with vomited material around his mouth and had no sign of pulse or breathing. At this point, a "man down" call was made over the radio and additional deputies and jail medical staff responded to assist. At 7:14 p.m., deputies moved Lucio from the bottom bunk to the dayroom floor outside the cell to allow medical staff space to begin cardiopulmonary resuscitation. Suspecting possible opioid overdose, Lucio was given several doses of Narcan. Additionally, an automated external defibrillator was connected to Lucio. None of these measures had any effect.

At 7:27 p.m., Orange County Fire Authority (OCFA) paramedics arrived on scene and took over treatment of Lucio. The paramedics found Lucio pulseless, asystolic, and apneic upon auscultation. His pupils were dilated and fixed, and he was exhibiting the onset of rigor mortis. Based on their observations, Lucio was pronounced deceased at 7:30 p.m. by OCFA personnel.

Subsequently, forensic scientists from the OCCL and the Coroner arrived to process the scene and take custody of the body.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- OCSD Jail Surveillance videos from April 2, 2021; July 13, 2021; and March 18, 2022
- IRC Module M Logs for March 18, 2022
- IRC Module M Activity Log, Dayroom Log, Inmate Movement Log and Safety Check Logs for March 18, 2022
- OCSD Reports under DR numbers 21-023224 and 21-010919
- Bloodstain standard from Lucio
- 83 color digital photographs (scene)
- 53 OCCL autopsy photographs
- 18 OCCL post-embalming photographs
- 30 OCCO (Coroner) photographs
- 10 audio recordings of interviews of staff present on March 18, 2022
- 16 audio recordings of interviews of inmates in Mod M on March 18, 2022 [none of which had any knowledge of Lucio]
- 2 audio recordings of interviews with the parents of Lucio
- OCHCA Correctional Health Services Reports and Medical Reports
- Toxicology Report

AUTOPSY

On March 23 2022. Forensic Pathologist Dr. Scott Luzi of Orange County Coroner's Office conducted an autopsy on the body of Lucio. The autopsy revealed evidence of choking. Specifically, Dr. Luzi noted food debris occluded the trachea, bronchi, and deep bronchial passages of both lungs. A final cause of death was not listed at that time, pending toxicological examination results.

On July 28, 2022, Dr. Luzi issued an updated report concerning Lucio concluding that the cause of death was choking and the manner of death was accidental.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethanol	Postmortem Blood	0.020±0.004% (w/v)
Acetaldehyde	Postmortem Blood	Detected
Benztropine	Postmortem Blood	Detected
Buprenorphine	Postmortem Blood	Detected
Caffeine	Postmortem Blood	Detected

Citalopram	Postmortem Blood	0.399±0.074 mg/L
Naloxone	Postmortem Blood	Detected
Norcitalopram	Postmortem Blood	Detected
Olanzapine	Postmortem Blood	0.524 ± 0.067 mg/L
Valproic Acid	Postmortem Blood	25.0 ± 3.6 mg/L

BACKGROUND INFORMATION

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

- 496 PC – Receiving Stolen Property
- 459 PC – Second Degree Burglary
- 148(A)(1) PC – Obstructing a Public Officer
- 20002(A) VC – Hit and Run with Property Damage
- 245(A)(1) PC – Assault With a Deadly Weapon with Force Likely
- 245(A)(2) PC - Assault With a Firearm
- 246.3(A) PC – Willful Discharge with Gross Negligence

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 Lucio 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.

Upon his arrival at IRC, Lucio was given proper medical and psychological care. While in the care of deputies in Mod M, Lucio was properly supervised and his wellness checked at regular intervals. There is no evidence of any deviation from OCSD's standard protocol for checking on inmates regularly. Rather, it appears from the evidence Lucio choked on food provided as part of his evening meal, and that it occurred between safety checks.

When staff members discovered Lucio was unresponsive, they immediately called for assistance and initiated life-saving measures until OCFA paramedics arrived and began assessing Lucio. Unfortunately, neither the efforts of OCSD nor OCFA were successful in reviving Lucio.

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.

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 Lucio. The evidence shows that Lucio died as a result of an obstruction of his breathing passages by food particles and that the death was accidental.

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

Respectfully submitted,

KRISTIN R. BRACIC
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Gang Unit

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

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