OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

January 2, 2024

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

Re: Custodial Death on April 20, 2022
Death of Inmate Nicholas Edward Brown
District Attorney Investigations Case # 22-001214
Orange County Sheriff's Department Case # 22-012929
Orange County Crime Laboratory Case # 22-44651

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 April 20, 2022, custodial death of 28-year-old inmate Nicholas Edward Brown.

## OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Brown. 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 April 20, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the OCSD Intake Release Center (IRC), where Brown died while in custody. During the course of this investigation, the OCDASAU interviewed 12 witnesses, contacted 13 inmates, and obtained reports, incident scene photographs, and other relevant materials from 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 investigative 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 consult 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. Ultimately, the District Attorney personally reviews and approves all officer involved shooting and custodial death letters.

**FACTS**

On April 8, 2022, Nicholas Brown was taken to the Anaheim Global Medical Center ("AGMC") [redacted]. An AGMC Emergency Room physician examined Brown and noted that his urine sample tested positive for THC, his blood pressure was elevated, and that his heart rhythm demonstrated tachycardia. The physician further noted that Brown was displaying delusional behavior, but did not feel that Brown had a psychiatric disorder requiring a mental health commitment at that time. The physician believed Brown would be able to follow up at a later time as an outpatient at the psychiatric clinic. Brown was cleared for discharge from AGMC.

On April 9, 2022, at approximately 2 p.m., Brown was transported and booked into the IRC. During the screening process, Brown denied having any pre-existing medical conditions or taking any prescribed medications. He disclosed a previous mental health diagnosis of delusional behavior and admitted using marijuana. Additionally, Brown admitted to previously having suicidal ideations, but denied having any current suicidal or homicidal ideations. Based on Brown's delusional statements during intake, he was referred for a mental health screening.

The following day, April 10, 2022, at approximately 7:30 a.m., this mental health screening was completed. When initially contacted, Brown was naked in his cell, disorganized, and was mumbling to himself. Brown recited his name, but was unable to otherwise appropriately answer questions. Based on these observations, Brown was flagged as "Gravely Disabled" and referred to Module L, the housing unit for inmates with mental health issues.

On April 11, 2022, at approximately 1:48 p.m., a psychiatric evaluation of Brown was performed by an OCHCA clinical psychiatrist. The psychiatrist noted that Brown appeared to be actively responding to internal stimuli (hallucinations). He was talking incoherently to himself and making "bizarre" hand gestures amongst other conduct. Brown was offered Zyprexa (Olanzapine), an antipsychotic, but he refused. Nevertheless, the psychiatrist prescribed Brown 10 mg Olanzapine, to be taken once a day at bedtime.

On April 12, 2022, at approximately 8:14 a.m., an OCHCA registered nurse (RN) attempted to take Brown's vital signs. Due to his unpredictable behavior and inability to follow directions, she was unable to obtain them.

Shortly thereafter, another OCHCA registered nurse conducted a mental health assessment of Brown. He was initially observed in his cell, wearing only jail issued pants. When the nurse approached, Brown then exposed his buttocks to her, and remained naked throughout the assessment. Brown refused to take his Olanzapine.

[redacted]

At approximately 10:15 p.m., Brown was transferred to Mod L, Sector 19. He was housed by himself in Cell 5, Mod L, Sector 19. This area of IRC was equipped with video surveillance; however, it provided limited visibility inside Cell 5.

On April 13, 2022, at approximately 10 a.m., an OCHCA clinical psychiatrist attempted to assess Brown. He was observed to be naked, pacing back and forth, and had partially flooded his cell. Brown made hand gestures toward the psychiatrist, as if he was shooting him and spoke illogically and incoherently, jumping between several unrelated topics. Due to Brown's irrational and erratic behavior, the psychiatrist was unable to engage Brown in conversation, and increased the administration of his 10 mg Olanzapine prescription from once to twice a day.

At approximately 8:56 p.m., an OCHCA RN observed Brown naked in his cell, talking to himself, and unable to follow instructions. Once again, Brown refused to take his prescribed dose of Olanzapine or consent to providing samples for follow-up laboratory testing.

[redacted], a mental health evaluation of Brown was conducted. Based on a review of Brown's medical file as well as input from a psychiatrist, an RN, and other members of the mental health treatment team, the corresponding evaluation report concluded that Brown "does currently possess a major mental illness/disorder" based on an "unspecified psychosis."

In the following days, Brown's physical and mental well-being continued to deteriorate. During that time, Brown experienced periods of delusion, refused to take medication, and flooded his cell. He displayed self-destructive behavior, such as refusing to wear clothes, slamming his palms on the floor, and refusing to engage with staff when they tried to assist him.

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[1] During the course of OCDA's investigation of Brown's death, information was gathered pertaining to [redacted] case 22NM04911. This information as well as all related court records were subsequently sealed by the Orange County Superior Court pursuant to Penal Code section 851.93. Accordingly, OCDA will not be publicly disclosing this information. To the extent it is included within this letter, it is provided to OCSD in accordance with the provisions of Penal Code section 851.92, subdivision (b)(6), and remains confidential. A redacted version of this letter will be made available to the public.

On April 14, 2022, at approximately 8:31 a.m., an OCHCA clinical psychiatrist attempted to assess Brown. Based on a review of Brown's lab test results from AGMC, the psychiatrist was concerned that in addition to his mental condition, Brown may have rhabdomyolysis. Rhabdomyolysis is a condition that can arise following muscle injury, in which the contents of dead muscle fibers enter the bloodstream. Untreated, it could lead to complications such as renal failure, and in rare cases, death.

The doctor found Brown in his cell, naked, pacing back and forth, and mumbling to himself. His cell was flooded and his mattress was destroyed. Brown refused to take his medication, and his behavior prevented staff from obtaining blood and urine samples needed for follow-up laboratory tests. The psychiatrist noted that Brown was to be admitted into the LPS (Lanterman-Petris-Short) Unit for possible conservatorship, because he refused to take his medicine.[2]

[redacted]

At approximately 4:11 p.m., an OCHCA RN recorded in a "Mental Health Progress Note" that Brown was disheveled, hostile, irritable, noncompliant, and refusing to engage.

On April 15, 2022, at approximately 2:06 p.m., another OCHCA clinical psychiatrist attempted to assess Brown. The psychiatrist found Brown's cell littered with empty food containers with food strewn "over the entire cell." Brown was naked, pacing, and slamming his hands against the cell window. When the psychiatrist introduced herself to Brown, he looked at her menacingly and refused to engage. Brown also refused an opportunity to be released from his cell for the assessment.

OCSD staff notified the psychiatrist that because Brown had repeatedly flooded his cell, the water had been turned off. She was also advised that Brown was being provided water and Gatorade on a regular basis as a replacement.

On April 16, 2022, at approximately 2:17 p.m., an OCHCA mental health nurse practitioner completed a "Mental Health Progress Note" for Brown. Brown, again, was naked in his cell, agitated, and pacing back and forth. He refused medication, and refused to speak with the nurse practitioner.

On April 17, 2022, at approximately 9;32 a.m., an OCHCA mental health clinician attempted to assess Brown's safety and coping. Similar to previous evaluations, Brown was found in his cell naked and agitated. He refused his medication and refused to engage. Wet towels were seen outside the cell door and the cell was again observed littered with empty food cartons and other trash. Due to Brown's refusal to engage, the assessment could not be completed.

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[2] LPS conservatorships may be established for individuals who have been deemed gravely disabled or are a danger to themselves or others as a result of a mental health disorder. In Brown's case, it would have granted legal authority to OCHCA to provide involuntary care to Brown. Establishing an LPS conservatorship following a referral requires an independent investigation by the Office of the Public Guardian, the filing of a petition with the Court, and evidence demonstrating beyond a reasonable doubt that the conservatorship is necessary.

The same day, a senior mental health registered nurse working in consultation with other members of the mental health team, authored a mental health report. The report stated that Brown continually refused medication and that he would be evaluated for placement in the LPS Unit.

On April 18, 2022, at approximately 9:19 a.m., an OCHCA psychiatrist returned to Brown's cell to assess him. Brown was again naked and described as internally occupied and displaying poor insight and self-care. Brown's cell remained filthy, and he refused to take his antipsychotic medication. A Psychiatric Progress Note authored by a psychiatrist stated that Brown was encouraged to keep his cell clean, maintain a regular dietary and sleep routine, and to consider taking his medication. Brown was to be referred to the LPS unit as the doctor believed Brown was not likely to improve without medication.

[redacted]

On April 19, 2022, at approximately 9:10 a.m., an OCHCA mental health clinician attempted to assess Brown's safety and coping. Brown was naked in his cell and declined to put on his clothes. Brown indicated his feet hurt, but refused to elaborate or engage further when asked. He also refused his medication. Within approximately 30 minutes, an OCHCA registered nurse went to his cell to speak with him about his foot pain. Brown was found naked on the floor of his cell, rambling and mumbling to himself. He refused to engage despite multiple requests, and the registered nurse was unable to examine Brown's feet.

On April 20, 2022, at approximately 8:28:16 a.m., OCSD Deputy Michael Penny-Guzman escorted an OCHCA licensed vocational nurse to distribute medication within Module L. When they arrived at Brown's cell, Brown was observed lying naked and prone on the bunk. After an unsuccessful attempt to rouse him by knocking on his cell window, the nurse alerted Penny-Guzman that Brown was not responding.

Multiple attempts by various personnel to rouse Brown from the threshold of his cell failed over the next approximately three minutes. For safety reasons, the deputies awaited the arrival of additional personnel before entering Brown's cell. During this interval, personnel called out to Brown, splashed his legs with a small amount of water, rolled an orange to him, and tossed a small milk carton at his legs.

When additional deputies arrived at approximately 8:31:42 a.m., entry was made into Brown's cell. Brown was observed to be unconscious and unresponsive. As deputies moved Brown outside of his cell to treat him, they noticed that he was cold to the touch. The licensed vocational nurse checked Brown's vital signs and determined that Brown had no pulse, no respirations, and his pupils were fixed. The licensed vocational nurse placed an ammonia stimulant under Brown's nose to rouse him, but there was no response.

At approximately 8:33:09 a.m., paramedics were requested and cardiopulmonary resuscitation (CPR) was initiated. Medical staff and deputies performed chest compressions, while oxygen was provided via an AMBU bag-value mask. The licensed vocational nurse applied two automated external defibrillator (AED) pads on Brown's upper torso. The AED cycled several times, each time

advising no shock and to continue CPR. Medical staff and deputies performed CPR on Brown continuously until paramedics arrived.

At approximately 8:41:19 a.m., Orange County Fire Authority (OCFA) paramedics arrived on scene and assumed care of Brown. Brown was connected to a cardiac monitor and his heart rhythm was found to be asystole. Paramedics determined Brown had no pulse, no respirations, and no pupillary response. Brown's skin was cyanotic, cold to the touch, and he showed signs of rigor mortis. Based on this information, OCFA paramedics pronounced Brown deceased at approximately 8:42 a.m.

Review of the Sector 19 jail video between 8:00 a.m. on April 19, 2022, through 8:30 a.m. on April 20, 2022, showed that OCSD deputies completed safety checks, without incident, every 30 minutes. Brown's last recorded movement on video was on April 19, 2022, at 7:40 p.m. OCSD jail logs confirm that in addition to safety checks, there were regular meal and medication distributions to Mod L while Brown was in OCSD custody. In addition to OCSD staff, 10 different medical professionals checked on Brown in some capacity while in custody.

## EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Handcuffs taken off of Brown
- Swabs
- Jail Pants
- Sector 19 Video Surveillance
- 56 Photographs of the scene
- 49 Digital Photographs
- Heart Blood Standard
- 23 OCCO Autopsy Photographs
- 19 OCCO Post Embalming Photographs

## AUTOPSY

On Wednesday, April 27, 2022, Forensic Pathologist Dr. Scott Luzi of the Orange County Coroner's Office conducted an autopsy on Brown's body at the Orange County Sheriff-Coroner Forensic Science Center, located at 1071 West Santa Ana Boulevard, Santa Ana. A forensic specialist was present at the autopsy and took 49 photographs.

After the post-mortem examination, Dr. Luzi found no significant signs of trauma on the body. Dr. Luzi noted the following natural disease and pre-existing conditions; a healing ulcer on the right forearm, soft tissue swelling on the left ankle, cerebral edema, thoracic spine scoliosis, pulmonary congestion, edema, cardiomegaly, mild coronary atherosclerosis, and mild peripheral atherosclerosis. Dr. Luzi classified Brown's manner of death as dehydration due to probable lack of water intake.

## EVIDENCE ANALYSIS

### Toxicological Examination

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

| DRUG | MATRIX | RESULTS & INTERPRETATIONS |
|---|---|---|
| Ethanol/Volatiles | Postmortem Blood | Not Detected |
| Barbiturates | Postmortem Blood | Negative |

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|---|---|---|
| Cannabinoids | Postmortem Blood | Presumptive Positive |
| QTOP Drug Identification | Postmortem Blood | Not Detected |
| Cannabinoids | Postmortem Blood | See Results/Interpretations |
| Alkaline Drugs | Postmortem Blood | Not Detected |
| Acidic Drugs | Postmortem Blood | Not Detected |

| **Drug** | **Results & interpretations** |
|---|---|
| Carboxy-THC | 0.0327 + 0.0045 mg/L |
| Hydroxy-THC | 0.0011 + 0.0002 mg/L |
| THC | 0.0022 + 0.0003 mg/L |

**BACKGROUND INFORMATION**

Brown had a Criminal History dating back to 2008 that included arrests in California and Florida for the following violations:

- Robbery
- Failure to Appear
- Trespassing
- Cause / Inflict Injury on an Elder
- Assault
- 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 manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Brown 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) in a way that would rise to the level of individual criminal conduct.

When initially booked into IRC, Brown was screened for any medical issues and mental health problems. Brown disclosed to the staff his previous mental health diagnosis and drug use. Because of this, the medical staff evaluated and prescribed medication to treat his symptoms accordingly. As Brown remained in OCSD custody, the medical staff attempted multiple times to provide him with medication and aid. Brown was contacted by medical staff on a daily basis. Over the course of his incarceration, this included 10 different medical professionals who repeatedly checked on and attempted to engage with him. Food, water, and Gatorade were provided on a regular basis.

Nevertheless, Brown routinely refused to cooperate and thwarted efforts to assess and treat him. When Brown made a specific medical complaint regarding foot pain, a registered nurse responded to him within 30 minutes. Brown then refused to communicate with the nurse, who could not evaluate him.

Therefore, there is no evidence that anyone acted individually or collectively with such recklessness as to create a high risk of death or great bodily injury to Brown, as is required to find criminal negligence. To the contrary, medical personnel attempted to care for Brown on a daily basis while he was in OCSD custody. He was given access to adequate health care and medication to treat his ongoing issues. His refusals to engage with various healthcare staff prevented a proper evaluation of his health and condition. At no point was there any indication that Brown was suffering from any life-threatening condition.

After repeated flooding by Brown, OCSD was obligated to turn off the water to his cell to prevent further damage and destruction of property, and avoid creating a dangerous condition for him and others in the module. However as a replacement, both water and Gatorade were provided to him on a regular basis. There is no evidence Brown ever complained of a lack of water, requested and was denied water or Gatorade, or was suffering from dehydration. In fact, given Brown's erratic and destructive behavior, it would have been virtually impossible to discern that Brown was drinking insufficient fluids, absent actual notice from him that he was becoming dehydrated.

From April 19, 2022, to April 20, 2022, the date of Brown's passing, OCSD conducted regular safety checks every 30 minutes and did not see Brown in need of any assistance. On April 20, 2022, medical staff discovered that Brown was not responsive. After multiple attempts to rouse him, lifesaving measures were immediately taken. OCSD appropriately called OCFA within two minutes of entering his cell. OCFA arrived roughly eight minutes after being called and assumed responsibility for Brown.

Ultimately, Brown passed away from dehydration due to his own lack of personal care. This was a condition for which Brown never complained, and could not be reasonably and independently discovered by OCSD personnel under the circumstances. Thus, 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 in a way that rises to the level of criminal negligence.

## 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 Brown. The evidence shows that Brown died as a result of dehydration.

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

Respectfully submitted,

**Shaun Abuzalaf**
Deputy District Attorney
TARGET / GANGS Unit

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

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