OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

March 1, 2024

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

Re: Custodial Death on December 23, 2022
Death of Inmate Sean Conroy Whiting
District Attorney Investigations Case# 22-003948
Orange County Sheriff's Department Case # 22-043926
Orange County Crime Laboratory Case # FR 22-53097
Orange County Coroner's Office Case# 22-07637-TA

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 December 23, 2022, custodial death of 35-year-old inmate Sean Conroy Whiting.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Whiting. 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 December 23, 2022, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), located at 1001 North Tustin Avenue, Santa Ana, where Whiting died while in custody. During the course of their investigation of Whiting's death, the OCDASAU investigators interviewed eight 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 AND CUSTODIAL DEATH INCIDENTS 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 to release such evidence where it is legally appropriate to do so, the OCDA is making video/audio evidence publicly available in connection with this case. It is available on the OCDA webpage at:

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

FACTS

On December 21, 2022, at approximately 9:41 a.m., OCSD Deputy Robert Tomasko arrested Whiting for violating a temporary restraining order. He was transported to Orange County Jail, Intake Release Center (IRC).

At approximately 9:40 a.m., OCSD Deputy Brandon Saunders completed a Statement of Booking Officer form on Whiting and documented Whiting as being under the influence of alcohol.

At approximately 11:08 a.m., an Orange County Health Care Agency (OCHCA) Clinical Care Nurse completed a Clinical Institute Withdrawal Assessment for Alcohol (CIWA-AR) form and a Comprehensive Detox Screening on Whiting. Whiting reported feeling nauseated and stated he consumes alcohol regularly. Whiting said that after drinking he would experience symptoms such as sweating, shaking hands, and feeling frightened. Whiting told medical staff he had previously been through detoxification and experienced seizures and hallucinations after periods of abstaining from drinking.

The OCHCA Clinical Care Nurse also completed a Receiving Screening on Whiting. Whiting reported smoking regularly, but denied taking prescribed medication or using street drugs. At that time, Whiting was normal in appearance and oriented to place and time. Whiting was not considered a suicide risk but was found to have a prior history of mental illness. A follow-up check was scheduled for December 28, 2022.

Whiting was cleared for regular housing in a lower bunk before receiving an initial Mental Health screening. Whiting remained in the booking loop awaiting transport to the Theo Lacy Facility (TLF).

At approximately 7:04 p.m., Whiting was transported to TLF and housed in Module W, Cell F, Bunk 013.

At approximately 9:18 p.m., an OCHCA Registered Nurse completed a second CIWA-AR on Whiting. Whiting stated he was no longer experiencing nausea, vomiting, or diarrhea, but complained of mild itching, burning, and numbness under his skin. Whiting said he felt moderate tremors when extending his arms. Whiting also had paroxysmal sweats and mild visual disturbances. Whiting was prescribed medications for anxiety (Oxazepam) and stomach acid (Maalox), and was given multivitamins.

On December 22, 2022, at approximately 3:14 a.m., an OCHCA medical staff member completed an additional CIWA-AR screening on Whiting. Whiting's tremors were now mild or non-existent. Whiting, however, was becoming more agitated and his orientation as to place and time was declining.

During the day, Whiting received additional CIWA-AR evaluations, and his demeanor fluctuated from mild nausea to experiencing tremors, anxiety, agitation, and uncertainty about place and time.

At approximately 10:00 p.m., an OCHCA Behavioral Health Clinician evaluated Whiting and determined Whiting's mental health had declined and he was now classified as a danger to himself. Due to his condition, Whiting was restricted from day room privileges, outdoor recreation, education classes, church, work, commissary, bedding, and unsupervised use of towels and hygiene items. He was also not permitted to leave the facility to attend court appearances. A referral was made for Whiting to be transferred back to IRC.

At approximately 11:04 p.m., the OCHCA Behavioral Health Clinician completed a Mental Health Screening on Whiting. Whiting reported that he previously had been treated for mental health issues and provided medication. He said that he was currently feeling depressed and made statements that he wanted to kill himself and would stab himself in the neck, cut his wrists "or I'll figure out a way." Whiting also reported a prior incident of self-inflicted injury without suicidal intent. As a result of this screening, a suicide protocol was enacted and Whiting was placed on a suicide watch, given a safety gown, and a mental health referral. A follow-up mental health sick call was to occur the following day, December 23, 2022.

At approximately 11:20 p.m., Whiting was transferred from TLF back to IRC for additional medical care and observation.

At approximately 11:34 p.m., Whiting arrived at IRC and was moved to the Psychiatric Observation Unit (POU), an area equipped with a video surveillance system.

On December 23, 2022, at approximately 12:01 a.m., Whiting received a safety gown and a sack meal and was placed into Cell RO-6.

Cell RO-6 is rectangular. The cell has a glass door and a large observation window which allows for visual monitoring by jail personnel from the outside station. The cell has a floor mat next to the observation window. Behind the mat is a privacy wall and a commode. There are surveillance cameras inside and outside the cell.

Over the next four hours, the surveillance system captured OCSD Deputies contacting Whiting numerous times to communicate with him and check on his welfare.

At approximately 4:16 a.m., OCHCA medical staff provided Whiting with prescribed medication, Serax 30mg. Shortly after, Whiting was provided with an additional brown bag containing food and drink. On video, Whiting appeared to consume his meal, consisting of bread, bologna, a beverage, and an orange.

Surveillance video subsequently captured OCSD Deputies conducting routine safety checks every thirty minutes.

At approximately 11:07 a.m., an OCSD Deputy contacted Whiting and conducted an off-site court appearance using an iPad.

At approximately 11:26 a.m., Whiting was contacted by an OCSD Deputy and OCHCA medical staff to administer Serax. Whiting's cell door was opened at this time, but Whiting refused to take the prescribed medication. Whiting signed an OCHCA "Refusal to Accept Treatment" form.

At approximately 11:34 a.m., Whiting was removed from his cell to undergo a CIWA-AR Screening and Psychiatric Evaluation. Jail surveillance video shows that while Whiting was away for the evaluations, OCSD Deputies placed a white t-shirt, white boxers, green jail pants, orange sandals, and a sack meal in his cell.

At approximately 11:48 a.m., an OCHCA Medical Assistant performed a CIWA-AR evaluation on Whiting. Whiting was again restricted from day room activities, outdoor recreation, church and classes, work, and the commissary. He was not permitted to have bedding in his cell or attend court appearances in-person. Whiting was also restricted from obtaining a jail-issued ID card. Observation on Whiting was to continue.

At approximately 11:50 a.m., an OCHCA Mental Health Staff Member completed a Psychiatric Evaluation of Whiting. Whiting reported feeling well, but having poor sleep. Whiting now denied having any suicidal thoughts and denied having any auditory or visual hallucinations. Overall, Whiting reported feeling better and was to continue with current medications. The observation was to continue on Whiting, with future housing to be in the mental health module of IRC, "MOD L." Whiting remained in the booking loop at this time.

At approximately 11:53 a.m., OCSD Deputy Michael Penny-Guzman returned Whiting to cell RO-6 and provided him with a sack meal.

At approximately 12:11 p.m., Whiting was seen on jail surveillance cameras consuming food from his sack meal.

Over the next few hours, Whiting could be seen moving about his cell as numerous OCSD deputies walked past his cell.

At approximately 3:10 p.m., Deputy Penny-Guzman opened the door to Whiting's cell and tossed in an additional sack meal. Whiting became agitated after Deputy Penny-Guzman closed the cell door. He began to kick the glass window while on his back. Whiting appeared upset that Deputy Penny-Guzman slammed the cell door after tossing in his meal. Whiting threw food at the window as Deputy Penny-Guzman stood on the opposite side of the glass.

At approximately 3:14 p.m., Whiting was captured on a jail surveillance camera sitting on the floor mat and removing an orange from the sack meal. He then was seen moving behind the privacy wall adjacent to the commode. Whiting then began consuming the orange and orange peel and appeared to force additional orange peel into his throat. Whiting could then be seen convulsing as he walked back toward the front glass window, and then laid onto his back, on the mat.

Whiting, while seated on the mat, continued to remove food from his sack meal, then moved behind the privacy wall and forced additional food and orange peel into his mouth. He then moved back to the mat and lunch bag. Over the next five minutes, Whiting repeated this pattern five times. He removed food from the bag, went behind the privacy wall, forced the food into his mouth, and then returned to the mat.

At approximately 3:19:45 p.m., Whiting, while seated on the mat, gathered additional orange peel he had removed from oranges he had consumed earlier in the day. Whiting began consuming the additional orange peel and returned to the privacy wall, where he appeared to force-feed the orange peel down his throat.

At approximately 3:20:07 p.m., Whiting returned to the glass window and sat on the mat. Whiting then began thrashing around on his back and convulsing uncontrollably. Whiting hit the cell glass window with both hands, now clearly in distress.

At approximately 3:20:31 p.m., medical staff came to Whiting's cell to check on his welfare, as Whiting was now flailing on the floor and moving his arms uncontrollably. The medical staff immediately called for OCSD Deputy Penny-Guzman.

At approximately 3:21:25 p.m., Deputy Penny-Guzman arrived at the cell door and saw Whiting lying on the floor in distress.

Deputy Penny-Guzman, in a voluntary statement given to OCDA Investigators, indicated that he had been notified by medical staff that Whiting was in distress. He then went to the cell and saw that Whiting was thrashing around on the floor. He immediately called for backup deputies so that he could make entry into the cell. He indicated that the call for backup was according to OCSD protocol and for officer and medical staff safety.

While awaiting the backup deputies, medical staff prepared emergency medical equipment.

At approximately 3:22:22 p.m., OCSD Deputy Cameron Griggs arrived and both deputies entered the cell, followed by OCSD Deputy Nelson Ramirez. Deputy Penny-Guzman first contacted Whiting and then heard someone indicate Whiting may be choking. Deputy Penny-Guzman immediately began to apply the Heimlich maneuver with the assistance of Deputies Griggs and Ramirez. Deputy Penny-Guzman made numerous attempts before Whiting went limp and unconscious at approximately 3:23:14 p.m. After going limp, Whiting was moved to the floor by the deputies, and further lifesaving efforts were initiated, including attaching an automated external defibrillator **(AED).**

At approximately 3:24:42 p.m., Deputy Penny-Guzman checked Whiting's pulse. No pulse was found and the deputies and medical staff began administering cardio pulmonary resuscitation (CPR).

At approximately 3:25:54 p.m., a 9-1-1 call was placed requesting an Orange County Fire Authority (OCFA) emergency response.

CPR continued until the arrival of the OCFA at approximately 3:33 p.m. Paramedics reported finding Whiting unresponsive with an asystole heart rhythm. An airway was established through Whiting's trachea, and an intraosseous line was inserted in Whiting's left shin.

At approximately 3:45 p.m., Whiting was placed on a gurney and was loaded into an ambulance for transport to Orange County Global Medical Center (OCGMC).

While en route to OCGMC Whiting began to vomit.

At approximately 4:02 p.m., the ambulance arrived at OCGMC and Whiting's care was transferred to Emergency Room (ER) staff.

The treating OCGMC physician subsequently told OCDA Investigators that when Whiting arrived at the ER, he was pale, not breathing, and pulseless. Medical staff attempted to establish an airway and worked on Whiting for approximately 11 minutes. Whiting, however, could not be intubated due to the large volume of food lodged in his throat. Despite advanced lifesaving efforts, Whiting was pronounced deceased at 4:12 p.m.

EVIDENCE COLLECTED

An OCCL Lead Forensic Specialist took 96 digital color photographs of the scene and an OCCL Senior Deputy Coroner collected the following items of evidence:

- One (1) cut white T-shirt
- One (1) pair of green jail pants
- One (1) pair of boxers

AUTOPSY

On Wednesday, January 04, 2023, at approximately 8:00 a.m., Forensic Pathologist Scott Luzi conducted the post-mortem examination of Whiting at the Orange County Sheriff-Coroner Forensic Science Center. The autopsy was documented under OCCO case number 22-07637-TA.

An OCCL Forensic Specialist took 55 digital photographs. An OCCL Forensic Scientist collected a bloodstain and muscle samples and an orange peel recovered from Whiting's throat.

Dr. Luzi reported that the cause and manner of death would remain pending until the completion of toxicological and microscopic tests.

On May 31, 2023, Dr. Luzi issued an amendment to his report, identifying the cause of Whiting's death as "Choking" and the manner as "Suicide."

EVIDENCE ANALYSIS

Toxicological Examination

Samples of Whiting's postmortem blood were collected and examined for the presence of drugs and alcohol.

The following results and interpretations were documented:

	Postmortem Blood
Delta-9-Carboxy-THC	0.0063 + 0.0009 mg/L
Delta-9-THC	0.0030 + 0.0005 mg/L
Naloxone	Detected
Norchlorcyclizine	Detected
Oxazepam	Detected
Oxazepam-glucuronide	Detected

BACKGROUND INFORMATION

Whiting had a State of California Criminal History record that revealed a prior arrest for the following violation:

- Throwing a substance onto the roadway.

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 Whiting 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). Whiting was evaluated by OCHCA personnel upon admittance to the IRC on December 21, 2022. It was noted that he had a history of alcohol and mental health issues; however, he was not viewed as a suicide risk. He was given care for alcohol withdrawal symptoms and was scheduled for a follow-up mental health screening. The next day, when Whiting's mental health declined, he was appropriately deemed to be a danger to himself and was placed in a suicide protocol. A timely Mental Health Screening was conducted and resulted in him being housed in a POU for additional medical care and observation.

Once in the POU, OCSD personnel regularly checked on his welfare and provided him with prescribed medication.

During the approximately five-minute period where Whiting began to force orange peels down his throat, there was nothing to indicate that Whiting was attempting to commit suicide. He was always behind the privacy wall when forcing the peels into his mouth. When Whiting began to appear in distress and banged on the glass wall, OCSD Medical staff responded promptly and called for OCSD Deputy Penny-Guzman. Deputy Penny-Guzman was on the scene in less than a minute. Deputy Penny-Guzman immediately called for backup and OCSD Medical Staff gathered medical equipment. Backup arrived within a minute, and then immediately entered the cell to assist Whiting. Once Deputy Penny-Guzman realized Whiting was choking, he instantly began performing the Heimlich maneuver. When Whiting went limp, additional emergency life-saving measures began without delay and 9-1-1 was called. Lifesaving efforts continued until the arrival of the OCFA.

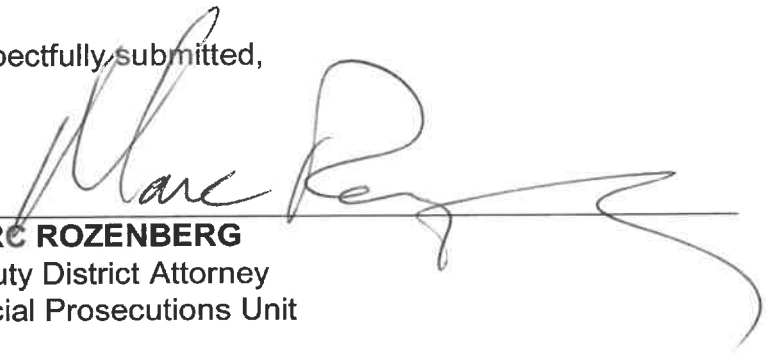
There is nothing to indicate that Whiting's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

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 Sean Whiting.

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

Respectfully submitted,



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