OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

May 14, 2024

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

Re: Custodial Death on April 13, 2023
Death of Inmate Brian Robert Schaar
District Attorney Investigations Case # 23-001160
Orange County Sheriff's Department Case # 23-013306
Orange County Crime Laboratory Case # FR 23-43237
Orange County Coroner's Office Case # 23-02301-BK

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 April 13, 2023, custodial death of 38-year-old inmate Brian Robert Schaar.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Schaar. 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 April 13, 2023, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), where Schaar died while in custody. During the course of their investigation of Schaar's death, the OCDASAU interviewed 11 witnesses and obtained reports, incident scene photographs, jail surveillance footage, medical records, and other relevant materials from the OCSD, the Orange County Fire Authority (OCFA), 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.

FACTS

On April 6, 2023, at approximately 5:33 p.m., OCSD Deputy Robert Pequeno arrested Schaar for six Orange County Superior Court arrest warrants. OCSD transported Schaar to the Orange County Jail for booking, processing, and housing.

At approximately 7:49 p.m., an Orange County Health Care Agency (OCHCA) Critical Care Nurse (CCN) completed a medical receiving screening questionnaire form with Schaar in the booking loop.

Schaar disclosed the following medical and mental health conditions:

- Congestive Heart Failure
- Diabetes
- Pneumonia

Schaar stated he also wanted to hurt or kill himself and had thoughts of killing other people. At that time, Schaar was referred for a mental health screening. Additionally, a chest X-ray was ordered. An OCHCA physician prescribed Schaar the following medications:

- Lisinopril – 5 mg — Once a day at bedtime
- Spironolactone – 25 mg — Two times a day
- Carvedilol – 3.125 mg — Two times a day
- Jardiance – 10 mg — Once a day at bedtime
- Olanzapine – 10 mg — Once a day at bedtime

Additionally, check-ups for blood glucose, vital signs, and alcohol withdrawal were ordered.

At approximately 8:59 p.m., Schaar had a chest X-ray completed. The X-ray revealed he had a small right pleural effusion.[1]

At approximately 9:29 p.m., Schaar was booked into the OCSD Intake Release Center (IRC).

On April 7, 2023, at approximately 2:39 a.m., an OCHCA Registered Nurse (RN) completed a mental health screening questionnaire form with Schaar. He disclosed the following information about mental health conditions:

- "I'm severely mentally ill"
- Schizophrenic/Bipolar
- History of psychiatric hospitalization
- Feelings of paranoia
- Hallucinations
- Suicidal
- Prior history of inflicted self-injury

Based on Schaar's statements and mental health conditions, immediate mental health housing was requested and suicide protocols were enacted with a follow-up request for a psychiatric evaluation. Schaar remained housed in the IRC.

At approximately 12:52 p.m., Schaar was transferred from the IRC to Module J.

At approximately 6:14 p.m., Schaar was transferred to mental health housing and was housed in Module L, Sector 18, Cell 14. Module L, Sector 18 is two stories with cells on both stories of the north side of the sector. There is an open dayroom located south of the cells. The cells are two-man cells. Cell 14, Schaar's cell, is on the second floor and has a bunk bed located on the west wall of the cell and a table with two seats on the east wall. The cell has a south-facing door which has a viewing window and another viewing window to the east of the door. Schaar was the sole occupant of the cell.

There are security cameras located within Module L, Sector 18, including one that observes approximately nine cells on each of the two stories. The location of the security camera, combined with the relatively small observation window on the door, provides a partial view into Schaar's cell. While the bunk bed and seating area are visible, the lower half of the cell is out of view.

On April 10, 2023, at approximately 1:22 p.m., an OCHCA RN completed a nursing assessment on Schaar. Schaar was not distressed and did not request medical aid or complain of any medical issues. The RN instructed Schaar that if he needed medical aid to ask. Schaar indicated that he understood.

On April 11, 2023, at approximately 11:43 a.m., Schaar was seen by an OCHCA physician during a follow-up check of the pleural effusion and for severe facial swelling due to a sunburn. No symptoms from the pleural effusion were observed. During the check-up, the doctor noted that Schaar had abdominal distension causing him to be concerned about possible cirrhosis and

[1] A pleural effusion is a collection of fluid around the lungs.

ascites.[2] As a result, the doctor scheduled an off-site ultrasound appointment for April 14, 2023. During the check-up, Schaar did not request any medical aid or complain of any medical issues.

On April 12, 2023, at approximately 10:54 a.m., an OCHCA Physician completed a psychiatric progress note. Schaar spoke to the physician and was engaging appropriately, made good eye contact, and denied any desire to injure or harm himself. Schaar did not request any medical aid or complain of any medical issues.

Despite being ordered by the OCHCA physician, Schaar refused all blood glucose, vital signs, and alcohol withdrawal check-ups between April 8, 2023, and April 12, 2023. In addition, he refused to participate in laboratory tests scheduled for him on April 13, 2023.

Schaar did take all prescribed medications when offered to him.

On April 13, 2023, jail security cameras captured Schaar moving around his cell throughout the day. The video also captures regularly scheduled safety checks conducted by OCSD Deputies. The checks occurred at approximately 30-minute intervals. Additionally, OCSD Correctional Services Assistant (CSA) Tommie Boyd was assigned to work Module L. One of the CSA's duties is to monitor the security camera video feeds. When contacted by OCDASAU investigators, CSA Boyd stated he could not recall much information about this incident and provided no further statement.

At approximately 5:00 p.m., OCSD deputies could be seen conducting a safety check. At the time, Schaar was lying in his bunk.

At approximately 5:09 p.m., Schaar rose from his bed and looked out the window in the direction of the dayroom.

At approximately 5:12 p.m., Schaar proceeded to lie back down on the lower bunk.

At approximately 5:14:37 p.m., Schaar stood up from the lower bunk.

At approximately 5:14:40 p.m., Schaar appeared wobbly and disoriented.

At approximately 5:14:48 p.m., Schaar then lost his balance and collapsed onto the floor and out of view of the security camera.

At approximately 5:30:15 p.m., OCSD Deputies Francisco Avelar and Steven Prentice were inside Module L, Sector 18, conducting a regularly scheduled 30-minute safety check of the inmates.

In a statement given to OCDASAU Investigators, Deputy Avelar stated that when he was conducting the safety check, John Doe 1, an OCSD Inmate was out of his cell, unrestrained, and on the telephone along the south wall in the dayroom of the first floor of Module L, Sector 18. As Deputy Avelar walked up the staircase to the second tier, John Doe 1 began "yelling and screaming" that he wanted to see his mom and make a phone call. Deputy Avelar and Deputy Prentice both indicated that John Doe 1 had a history of acting in a volatile manner. Deputy Avelar stopped momentarily at the bottom of the staircase, faced John Doe 1, and started talking to him while Deputy Prentice conducted his safety check of the first-floor cells. Deputy Avelar then

[2] Ascites is a condition in which fluid collects in spaces within the abdomen.

continued walking up the stairs while talking to John Doe 1. Deputy Avelar reached the top of the staircase at approximately 5:30:15 p.m.

At approximately 5:30:17 p.m., Deputy Avelar turned his head to the left, looked down at John Doe 1, and continued talking to him while he remained on the telephone.

At approximately 5:30:21 p.m., Deputy Avelar quickly looked into Schaar's cell. He subsequently told OCDASAU Investigators that he saw Schaar "laying down on his side ... in a curled position ... kinda' like a fetal position." Deputy Avelar stated that inmates routinely sleep on the ground, so Schaar looked "normal," and "nothing out of the ordinary stood out from the way his body was positioned." He didn't appear to be in distress or require any help.[3]

Deputy Avelar then left Sector 18 to continue his safety check in an adjacent sector.

Additionally, in a statement to OCDASAU Investigators, Deputy Prentice also indicated that inmates in the module would often sleep on the floor.

At approximately 6:00:06 p.m., Deputy Avelar and Deputy Stephen Hipple entered Module L, Sector 18, to conduct another safety check of the inmates. Deputy Avelar walked up the staircase to the second tier while Deputy Hipple conducted a check of the first-floor cells.

At approximately 6:00:23 p.m., Deputy Avelar reached the top of the stairs and walked up to Schaar's cell and looked inside. Deputy Avelar stated to OCDASAU Investigators that he had to do a "double take because I can see him in a very awkward position. He's on the floor, facing up, next to his bed, he has his left hand over his chest and his right hand like, up to the side. Something is not normal for somebody like him." Deputy Avelar knocked on Schaar's cell door, but he did not respond. Deputy Avelar called out to Deputy Hipple for assistance.

At approximately 6:02:01 p.m., Deputies Avelar, Hipple, and Prentice entered Schaar's cell. Deputy Avelar stood over Schaar, checked his pulse, and found none.

At approximately 6:02:41 p.m., Deputy Avelar started cardiopulmonary resuscitation (CPR). Deputy Hipple radioed for medical assistance. Deputy Avelar and another assisting deputy, Deputy Francisco Romero, performed chest compressions until medical staff arrived at approximately 6:03:03 p.m. The medical staff then placed an Automated External Defibrillator

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[3] The OCSD Policy 902.1 governs inmate safety checks.

1. An inmate safety check is a direct visual observation (i.e., direct personal view of the inmate/area without the aid of audio/video equipment), performed at random and varied intervals of each inmate located in an area of responsibility. The purpose of conducting safety checks is to ensure there are no inmates displaying any obvious signs of distress requiring assistance, maintaining the safety and welfare of each inmate, and ensuring the security of our facilities.
    (a) During inmate safety checks, deputies will check for obvious signs of life, which can include but are not limited to the following:
        1. Talking/eating
        2. Head movement (i.e., lifting their head from their mattress)
        3. Movement of the inmate's extremities
2. For an inmate who is sleeping or appears to be sleeping, deputies will check for obvious signs of trauma or distress as well as obvious signs of life.

(AED) on Schaar and a bag valve mask to perform rescue breathing. The AED advised no shock, and Deputy Avelar and the medical staff continued giving CPR. Medical staff gave Schaar two nasal sprays of Narcan and one intramuscular injection on the right deltoid.

At approximately 6:05:53 p.m., the OCFA was summoned.

At approximately 6:11:53 p.m., OCFA paramedics arrived on the scene and took over advanced life support measures. Paramedics determined Schaar's heart was in an asystolic rhythm, continued CPR, and administered normal saline and epinephrine.

At approximately 6:32:19 p.m., Schaar's heart remained in asystole, and he was transported to OCGMC.

At approximately 6:39:32 p.m., paramedics arrived at the hospital and transferred care to emergency room medical staff.

At approximately 6:40 p.m., Schaar was intubated, and a bag valve mask was placed on him to perform rescue breathing. Schaar's heart continued in an asystolic rhythm.

At approximately 6:50 p.m., after failing to respond to all life-saving measures, Schaar was declared deceased by an OCGMC physician.

AUTOPSY

On April 26, 2023, at approximately 7:58 a.m., Forensic Pathologist Scott Luzi conducted a postmortem examination of Schaar at the Orange County Sheriff-Coroner Forensic Science Center.

An OCCO Forensic Specialist took 61 digital color photographs, and an OCCL Forensic Scientist collected a muscle standard.

After the autopsy, Dr. Luzi stated the cause and manner of death were pending.

On October 26, 2023, Doctor Luzi issued an amendment to the initial autopsy report. Dr. Luzi documented the cause of death as dilated cardiomyopathy,[4] and the manner of death was natural.

EVIDENCE COLLECTED

An OCCL Forensic Specialist took 20 digital color photographs of the hospital scene and body, located at OCGMC. No other evidence was collected.

EVIDENCE ANALYSIS

Toxicological Examination

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

The following results and interpretations were documented:

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[4] Dilated cardiomyopathy is a condition in which the left ventricle, the heart's main pumping chamber, is enlarged, affecting the heart's ability to pump enough blood to the rest of the body.

Drug/Alcohol	Postmortem Blood
Ethanol/Volatiles	Not Detected
Barbiturates	Negative
Cannabinoids	Negative
Olanzapine	0.118 ± 0.016 mg/L
Caffeine	Detected

BACKGROUND INFORMATION

Schaar had a State of California criminal history record that revealed prior arrests for the following violations:

- Burglary
- Robbery
- Grand Theft
- Receiving Known Stolen Property
- Disorderly Conduct
- Criminal Threats
- Obstructing/Resisting Executive Officer
- Driving Under the Influence
- Under the Influence of a Controlled Substance
- Vandalism

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 Schaar 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). Schaar was evaluated by medical personnel upon admittance to the IRC on April 6, 2023. His significant physical and mental health history was documented, including statements regarding a desire to hurt himself. He was subsequently housed in a mental health module and placed on a suicide protocol with a follow-up psychiatric evaluation. He was prescribed Olanzapine, an anti-psychotic medication. Medical testing was performed and medication for blood sugar, high blood pressure, and heart failure were prescribed. Follow-up monitoring of these conditions was regularly conducted, and Schaar did not show signs of distress.

Additionally, follow-up testing for a distended abdomen was ordered when a physician became concerned that Schaar might have cirrhosis or ascites. Schaar, however, did not seem to be in distress nor did he complain about feeling ill. A review of the jail video before the medical incident shows Schaar acting normally and exhibiting no signs of distress. He was continually in and out of his bunk and moving around his cell. While Schaar had medical conditions, there was nothing to indicate that they were acute or required special attention. Module L is a Mental Health Unit, not a Medical Unit. Unless someone was watching the security video and focused on Schaar's cell at the very moment he collapsed, there would be nothing to indicate he was potentially in distress. Whether CSA Boyd actually witnessed Schaar's collapse at approximately 5:14:48 p.m. is unknown and indeterminable, however, CSA Boyd stated that he did not recall anything about the incident.

When Schaar was initially observed on the floor by Deputy Avelar, he did not think Schaar was in distress. His position at that time gave Deputy Avelar the impression that he was sleeping, which was not unusual for inmates in the mental health housing module. Furthermore, Deputy Avelar was following OCSD safety check protocol both as to the time and manner in which safety checks are to be conducted. When Deputy Avelar again observed Schaar 30 minutes later, he was no longer in the same position, and it did not appear to be "normal." At that time, he immediately checked on Schaar.

Upon discovering that Schaar was in distress, OCSD personnel acted promptly and appropriately. OCSD administered multiple doses of Narcan and performed CPR. Medical personnel were summoned and arrived within one minute. Emergency services were called shortly thereafter. Lifesaving efforts continued until OCFA paramedics arrived.

Ultimately, it was a sudden medical incident, namely dilated cardiomyopathy, that caused Schaar's death. There is nothing to indicate that Schaar'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 Brian Schaar.

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**