



OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA

TODD SPITZER

August 14, 2026

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

Re: Custodial Death on January 17, 2025
Death of Inmate Scott Theodore Remick
District Attorney Investigations Case # 25-000085
Orange County Sheriff's Department Case # 25-0011880
Anaheim Police Department Case # 2025-2183
Orange County Crime Laboratory Case # FR 25-40593
Orange County Coroner's Office Case # 25-00328-LM
Orange City Fire Department Case # 02500874

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 January 17, 2025, custodial death of 51-year-old inmate Scott Remick.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Remick. 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 January 17, 2025, OCDA Special Assignments Unit (OCDASAU) Investigators responded to the University of California, Irvine-Medical Center (UCIMC), where Remick died while in custody. During the course of their investigation of Remick's death, the OCDASAU interviewed two witnesses, obtained police reports, incident scene photographs, jail surveillance footage, medical records, and other relevant materials from the OCSD, the UCIMC, the Orange County Crime Laboratory (OCCL), and the Orange County Health Care Agency.

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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 while in custody within Orange County. 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 correspondence. 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.

FACTUAL SUMMARY

On January 4, 2025, the Anaheim Police Department (APD) received a call reporting that a neighbor, identified as Remick, was standing in the reporting party's driveway holding a large butcher knife and yelling at the reporting party's son. The son fled into the residence, after which Remick walked back to his own residence. At that time, the reporting party declined to pursue prosecution.

APD officers spoke with Remick's sister, Jane Doe 1, who informed officers that Remick had been diagnosed with paranoid schizophrenia approximately ten years ago but had consistently refused to seek medical treatment or take prescribed medication.

On January 5, 2025, at approximately 1:22 p.m., APD officers were dispatched to Remick's residence in response to a report of a felony assault. While family members were visiting, without provocation, Remick reportedly emerged from his bedroom, wielding a large butcher knife and threatened his uncle, stating that he needed to leave, or he would be killed. Fearing for their safety, all family members immediately exited the residence, and Jane Doe 1 contacted APD to report the incident.

Officers from APD attempted to negotiate Remick's exit from the residence, but he refused. The APD Special Weapons and Tactics (SWAT) Team was deployed to continue negotiations for a peaceful surrender. After several hours of noncompliance, APD SWAT Operator Reuben Hasani deployed chemical agents into the residence. Remick then surrendered and was treated on scene by APD Paramedics. APD officers transported Remick to Anaheim Regional Medical Center for medical clearance before booking him at the APD Jail.

On January 6, 2025, Remick was transported from the APD Jail for booking into the Orange County Jail (OCJ), Intake-Release Center (IRC).

At approximately 1:18:57 a.m., an OCHCA registered nurse (RN) conducted a Centers for Disease Control (CDC) Screening and Medical Receiving Screening of Remick. Remick denied any medical history issues, drug or alcohol abuse, or pain and discomfort. He had slightly elevated blood pressure (143/86) but otherwise appeared healthy and was cleared for work and general housing.

At approximately 2:01 a.m., Remick was booked into the OCJ IRC and was later transported to the OCJ Theo Lacy Facility (TLF) for housing. He was assigned to the general population in the G-West Barracks.

The TLF G-West Barracks were equipped with two surveillance cameras which recorded the day room, shared bathroom, and bunk areas, including a clear view of Remick's bunk.

On January 7, 2025, at approximately 1:30 p.m., Remick was transported to the IRC for his first court appearance in Department CJ1. He remained in custody following that court appearance and was transported back to the TLF.

On January 15, 2025, at approximately 8:30 a.m., Remick was transported to the North Justice Center for a preliminary hearing in Department N12. Following the hearing, Remick was returned to the TLF.

On January 16, 2025, at approximately 8:12:00 p.m., the surveillance video captured Remick using the shared restroom and then exiting 43 seconds later. A staircase obstructs the view of the restroom.

At approximately 8:13:12 p.m., Remick returned to his bunk and lay supine on the bottom bunk with his head perpendicular to the wall. Remick remained lying on his bunk, periodically moving his hands, arms, and legs. Other inmates walked freely around his bunk, but he did not engage or interact with any of them.

At approximately 8:48:33 p.m., an OCSD Deputy conducted a safety check and walked past Remick. There was no interaction between Remick and the OCSD deputy.

At approximately 8:57:45 p.m., Remick sat up on the edge of his bunk for several seconds, then stood up and walked to the restroom.

At approximately 9:00:45 p.m., Remick returned to his bunk and lay down on his back again.

At approximately 9:31:18 p.m., Remick was lying on his side when an OCSD deputy conducting a safety check walked past and spoke with him. Remick lifted his head, responded to the deputy, and the deputy moved on.

Remick remained on his bunk for several hours. During that time, he sat up a few times and removed his shoes, sweater, and orange jail shirt before lying back down.

Deputies conducted safety checks at approximately the following times and did not note anything unusual about Remick:

- 10:13:53 p.m.
- 11:28:05 p.m.
- 12:53:12 a.m.

On January 17, 2025, at approximately 1:35:03 a.m., OCSD Deputy Luis Carcano conducted a safety check and stopped at Remick's bunk.

According to Deputy Carcano's incident report, while performing the safety check, he observed that Remick was exhibiting abnormal breathing. Remick was conscious but appeared to be having trouble breathing. Deputy Carcano used his department-issued radio to initiate a "Man Down" call, thereby alerting additional deputies and medical staff to respond.

At approximately 1:41:12 a.m., RNs from the TLF Medical Staff responded to Remick's bunk to treat him.

After an assessment, the RNs recommended that Remick be transported to the hospital for further evaluation. Paramedics were called to transport Remick to the hospital.

At approximately 1:58:37 a.m., Orange City Fire Department Rescue 6, Engine 6, arrived at the G-West Barracks.

At approximately 2:01:00 a.m., Remick stood up from his bed, and paramedics assisted him onto the gurney.

At approximately 2:14:00 a.m., Remick was transported to the UCIMC via ambulance by the Orange City Fire Department.

At approximately 2:30 a.m., Remick arrived at the UCIMC Emergency Room (ER). According to UCIMC staff and medical reports, Remick was in full cardiac arrest upon arrival. Cardiopulmonary resuscitation (CPR) was initiated immediately.

At approximately 2:39 a.m., Remick regained a pulse, and hospital staff decided to intubate him to assist with breathing.

Remick was continuously monitored for his Glasgow Coma Scale (GCS) score. According to a UCIMC Clinical Nurse II (CN), Remick's GCS score was very low. In an interview with OCDASAU investigators, the CN explained that during GCS testing, medical staff evaluate a patient's pupil

response and level of alertness. The CN stated that Remick showed no response during these assessments, and his condition continued to decline. The CN further stated that Remick's oxygen levels were low. Remick was treated with antibiotics, intravenous fluids, and vasopressor medications to support cardiac function; however, these interventions did not improve Remick's condition. UCIMC medical reports further indicated that an X-ray scan revealed fluid in Remick's right lung, indicating possible pneumonia.

At approximately 7:44 a.m., Remick went into cardiac arrest again. CPR was administered, and the medical staff successfully regained a pulse.

At approximately 8:00 a.m., Remick suffered another cardiac arrest. CPR was again administered, and a pulse was regained.

At approximately 9:02 a.m., Remick experienced a third cardiac arrest. CPR was performed, and a pulse was re-established.

At approximately 9:21 a.m., Remick went into cardiac arrest for a fourth time. CPR was administered, and a pulse was once again regained.

At approximately 9:42 a.m., Remick experienced a fifth cardiac arrest. Although CPR was administered, Remick could not be revived.

A UCIMC physician made the decision to cease resuscitation efforts due to multiple organ failure and pronounced Remick deceased at 10:06 a.m.

AUTOPSY

On January 22, 2025, at approximately 12:00 p.m., Forensic Pathologist Scott Luzi conducted the post-mortem examination of Remick at the Orange County Sheriff-Coroner Forensic Science Center.

During the autopsy, an OCCL Forensic Scientist (FS) collected a blood standard from Remick, and an OCCL Forensic Specialist (FSP) took 57 color digital photographs.

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

On August 21, 2025, Dr. Luzi issued the final cause and manner of death. The cause was determined to be Community-Acquired Pneumonia, with other significant conditions being Hypertensive Cardiovascular Disease. The manner of death was classified as "Natural."

EVIDENCE COLLECTED

An OCCL Lead Forensic Specialist (LFSP) took 52 digital color photographs documenting the hospital scene. No other evidence was collected.

A blood sample that was drawn from Remick shortly after his arrival was retained by UCIMC.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Remick's antemortem and postmortem blood was collected and examined for the presence of drugs and alcohol. The following results and interpretations were documented:

Drug	Postmortem blood	Antemortem Blood
Acetaminophen	Detected	
Atropine	Detected	
Etomidate	Detected	Detected

BACKGROUND INFORMATION

Remick had no criminal history or arrest record.

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 a 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 that 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 section 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.

The OCSD owed Remick a duty of care. There is no evidence, however, that the duty was breached- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

OCSD deputies conducted safety checks, per protocol, every 45 minutes. They did not notice anything unusual during these checks, and video surveillance footage does not show Remick to be in any distress.

When Deputy Carcano observed that Remick was breathing abnormally, he immediately issued a "Man Down" call. OCSD medical personnel arrived quickly to assess Remick. The RNs requested emergency services, and they arrived promptly. Remick was transported to UCIMC, where he was admitted to the ER and received emergency medical care. Remick suffered multiple cardiac arrests, and following the fifth event, unfortunately, Remick could not be revived. Dr. Luzi found the cause of death to be Community-Acquired Pneumonia with Hypertensive Cardiovascular Disease. He found the manner of death to be natural.

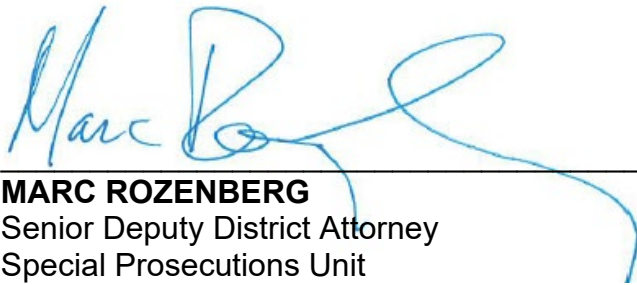
There is nothing to indicate that Remick's death was the result of inaction or improper action of OCSD personnel or those under the supervision of OCSD.

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 Scott Theodore Remick.

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

Respectfully submitted,



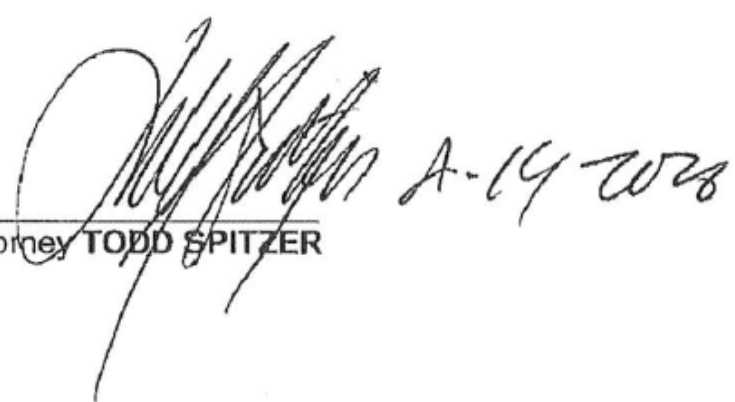
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