OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

July 8, 2020

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

Re: Custodial Death on July 15, 2019
Death of Inmate Eric Scott Denton
District Attorney Investigations Case # SA 19-013
Orange County Sheriff's Department Case # 19-026903
Orange County Crime Laboratory Case # FR 19-49190

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 July 15, 2019, custodial death of 44-year-old inmate Eric Denton.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Eric Denton. 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 July 15, 2019, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Theo Lacy Facility, where Denton was housed when he died. During the course of this investigation, the OCDASAU interviewed 11 witnesses and conducted 16 canvass interviews, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, surveillance videos, and other relevant materials.

The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and applicable legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD personnel or any other person under the supervision of the OCSD. The OCDA will not be addressing any possible issues relating to policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating custodial deaths within the County of Orange. 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, Gangs, and Special Prosecutions Units review fatal and non-fatal officer-involved shootings and custodial death cases, and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the Senior Assistant District Attorney supervising the Operations IV Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approved all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On August 17, 2017, Denton was arrested by the Cypress Police Department (CPD) for Health & Safety Code section 11364(a) - Possession of Unlawful Paraphernalia. The arrest was documented under CPD Case # 17-02129. On June 6, 2019, Denton was found guilty on the above listed charge (Case No. 17WM14187). He was sentenced to serve 25 days in county jail and ordered to report to Theo Lacy Jail Facility on or before July 12, 2019.

On July 10, 2019, Denton surrendered himself to the custody of the OCSD Intake Release Center (IRC) and was booked under OCSD booking number 3124319. At approximately 8:15 p.m., the attending Registered Nurse (RN) conducted a medical screening of Denton as part of the initial booking process. During the screening interview, Denton denied having any medical conditions, taking any medications, and denied any drug use. On July 11, 2019, while in IRC, Denton completed an Inmate Health Message Slip. He requested to see a nurse and indicated he was "very sick from detox." On July 12, 2019, Denton was transferred from the IRC to the Theo Lacy Facility (TLF). He was housed in F Barracks-East, Bunk 9. Inmates John Doe 1 and John Doe 2 recalled meeting Denton when he came into F barracks. John Doe 2 described Denton's appearance as sweating and

in distress. Denton told John Doe 2 he was withdrawing from heroin, but had not reported his condition to medical staff.

On Saturday, July 13, 2019, at approximately midnight, the attending RN completed a second medical screening of Denton. Again, Denton denied having any medical conditions or taking any medications. Denton was specifically asked if he used any street drugs, or if he was currently experiencing chills, fever, or body ache. Denton replied "No." Denton showed no signs of distress and had no complaints. Denton was cleared to work within the jail. On Sunday, July 14, 2019 at approximately 8:15 a.m., the attending RN saw Denton. During this examination, the RN noted Denton was sweating and having difficulty sitting; his pupils were dilated, he was experiencing mild discomfort, nasal stiffness, unusually moist eyes, and stomach cramps. Denton told the RN he last used heroin on July 10, 2019. Denton consented to a urine test; the test returned positive for amphetamines, cannabis, methamphetamine, and opiates. At the conclusion of that visit, Denton was cleared for regular housing and regular diet. He was prescribed Tylenol 650 mg, Zofran 4 mg, Benadryl 25 mg, and Imodium 2 mg, and instructed to have his vitals taken five (5) times a day. Denton returned to F barracks. During dinner, Denton told John Doe 2 he had been feeling nauseous and did not care to eat. Other inmates reported hearing that Denton was detoxing from drugs, was in need of sugar, and was sleeping all the time.

On Monday, July 15, 2019, at approximately 5:30 a.m., inmates began to wake up and leave the area for breakfast. Inmate John Doe 3, who was assigned the bunk directly above Denton noticed Denton was still in his bunk. Inmate John Doe 4 saw Denton was shivering. Denton told him he was sick and had a fever. Denton was still in his bunk when inmates returned from breakfast and began cleaning duties. At 7:05 a.m., Denton left his bunk and went to the medical health office. He was seen by the attending RN. The attending RN checked Denton's vitals and noticed that Denton had an accelerated resting heart rate, nausea, and loose stool. At approximately 7:20 a.m., Denton returned to F barracks and his bunk. Denton covered himself with a blanket and covered his face with a towel. At approximately 8:20 a.m., Denton rolled over onto his stomach then moved his right leg over and off the bunk. Denton appeared to be laboring or struggling. John Doe 3, who was in the bunk above Denton, heard strange noises and looked down; he saw that Denton was having a seizure. John Doe 2, who was a short distance away, noticed Denton was gasping for air. He went over and checked on Denton. He saw Denton was in medical distress and immediately called for assistance.

At 8:22 a.m., Deputy John Moreno was in the guard station located in barracks F. He was flagged down by inmates, requesting assistance. Deputy Moreno was directed to Denton; he saw Denton was gasping for air and experiencing labored breathing. Deputy Moreno left Denton for a short period, returned to the guard shack and summoned medical aid and assistance. Deputy Anthony Mercado arrived to assist and saw Denton was unresponsive and possibly hallucinating. Deputies saw saliva protruding from Denton's mouth, but noticed Denton was still breathing. At 8:25 a.m., Deputy Mercado radioed Theo Lacy medical staff for assistance and advised Denton was unresponsive. As the deputies looked back at Denton, they noticed he was no longer breathing. Deputy Mercado checked Denton for a pulse and found none. Deputy Christopher Korean responded to assist and the deputies moved Denton from the lower bunk to the floor to evaluate his condition and to perform cardio pulmonary resuscitation (CPR). At 8:28 a.m., Deputy Mercado began chest compressions and Deputy Moreno administered several rounds of Narcan through Denton's nostrils. Deputy Jared Hendee arrived with an automated external defibrillator (AED), followed by three RNs.

Deputy Hendee placed the defibrillator pads on Denton and used the AED in accordance with the manufacturer's instructions. The AED went through several cycles, and two shocks were administered. One of the RNs found no pulse on Denton; she was unsuccessful in initiating an intravenous line (IV). A second RN began to provide oxygen to Denton via a bag valve mask. Deputy Vincent Johnson arrived and began to look for anything suspicious or illegal adjacent to Denton's bunk but found none. Deputy Johnson relieved Deputy Mercado and continued with chest compressions until paramedics with the Orange City Fire Department (OFD) relieved him approximately five (5) minutes later.

At 8:37 a.m., OFD arrived at F barracks. They found deputies and medical staff performing CPR on Denton. A Paramedic assessed Denton and found he was not breathing and had no pulse. The Paramedic saw no signs of trauma or injection sights on Denton's body. The Paramedic had the OCSD deputies continue chest compressions and requested that another OFD Paramedic use a supraglottic device to establish an airway. The paramedics removed the AED the jail staff had applied to Denton, and replaced it with a cardiac monitor. The paramedics determined that Denton had no pulse, was not breathing, and was suffering ventricular fibrillation. The paramedics delivered an electrical shock to Denton and established an intraosseous line (IO) in Denton's shin and administered one (1) dose of epinephrine. An automatic CPR machine was placed on Denton to continue CPR chest compressions. Denton was placed on a gurney and defibrillated once again.

Denton was transported to the University of California, Irvine-Medical Center (UCIMC) by ambulance. While en route to the hospital, the paramedics defibrillated Denton three (3) times and administered three (3) doses of epinephrine. At approximately 9:01 a.m., Denton arrived at UCIMC. OFD relinquished care to UCIMC emergency room medical personnel. The attending physician treated Denton who was in cardiac arrest and had a temporary Combitube placed inside his airway. Denton was wearing an automatic cardiac compression machine, which was performing CPR as he arrived at the hospital. The attending physician removed the CPR device and began the Advanced Cardiovascular Life Support Protocol, which consisted of CPR, AED, and lifesaving medications such as Esmerol, Narcan, and Epinephrine. The attending physician also placed an endotracheal tube inside Denton's trachea. Denton was shocked numerous times with the AED along with manual shock paddles with no change in his condition or signs of life. At 9:21 a.m., the attending physician pronounced Denton deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Phillips Heartstart Automatic External Defibrillator (AED)
- 97 digital colored photographs of the scene
- Muscle Standard
- Postmortem Blood

AUTOPSY

On Thursday July 18, 2019, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Eric Denton. Dr. Luzi noted that Denton had an enlarged heart along with signs of long-term amphetamine use. After examining toxicology reports and microslides, Dr. Luzi determined that Denton's cause of death was hypertensive and atherosclerotic cardiovascular disease. Dr. Luzi determined the manner of death was natural.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	Postmortem Blood
Acetaminophen	Detected
Amphetamine	0.0724 ± 0.0054 mg/L
Carboxy-THC	0.0178 ± 0.0022 mg/L
Methamphetamine	0.0722 ± 0.0052 mg/L
Naloxone	Detected
THC	0.0028 ± 0.0004 mg/L

BACKGROUND INFORMATION

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

- Possession of a Controlled Substance
- Under the Influence of a Controlled Substance
- Robbery
- Burglary
- False Imprisonment
- Possession of Controlled Substance for Sale
- Possession of Drug Paraphernalia

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 human being;
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/she acted he/she knew his/her 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:

> "The 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 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/she 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/she acts is so different from how an ordinarily careful person would act in the same situation that his/]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 whatsoever in the present case 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 Eric Denton 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 manslaughter). The staff at the Theo Lacy Facility were initially unaware of any medical conditions or the use of any street drugs, based on Denton's denial of such during the intake questions. On July 14, Denton admitted to Theo Lacy medical staff that he was detoxing from heroin. The medical staff prescribed medication based on this admission, as well as the

symptoms that Denton exhibited. The staff also began to monitor his vitals on a regular basis. On July 15, when deputies were alerted that Denton was in medical distress, they began attending to Denton and called for medical care. Once Denton stopped breathing, the deputies and medical staff made multiple attempts to provide the necessary medical care. Deputies and medical staff administered CPR, AED, and other medical interventions in an attempt to save Denton's life. Orange City Fire was called to the scene, and transported Denton to the hospital. Multiple medical interventions were attempted during transport, and at the hospital, before Denton was pronounced deceased.

The OCSD deputies and Theo Lacy medical staff did not fail to perform a legal duty, nor can their actions be classified as criminally negligent. All efforts taken were reasonable based on the known circumstances. Additionally, Denton's death was not the result of any act, or failure to act, by OCSD personnel. On the contrary, the OCSD personnel took multiple actions intended to save Denton's life.

Considering all of the above, it is our conclusion that there is a lack of evidence to prove beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of inmate Denton.

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 beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Denton. The evidence shows that Denton died as a result of hypertensive and atherosclerotic cardiovascular disease, and that the death was a natural one.

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

Respectfully submitted,

MENA GUIRGUIS
Senior Deputy District Attorney
Homicide Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney, Felony Operations IV

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