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Southern California

"I'm getting weaker as each day passes..."

An Analysis of Death and Dying in Orange County Jails

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Executive Summary

No one should expect to lose their life while held in custody. Yet, people are dying every year inside Orange County jails — many within days of being booked. Despite declining jail populations, deaths continue to rise, often dismissed by the Orange County Sheriff's Department as the result of "life choices." This report, based primarily on 119 in-custody death records obtained through public records requests and cross-referenced with District Attorney investigations, shows otherwise. The conditions of incarceration, including medical neglect, untreated withdrawal, exposure to violence, and severe mental health strain, directly contribute to premature and preventable deaths. The findings reveal a system in which internal investigations lack transparency and accountability: not one of the 119 deaths reviewed resulted in the District Attorney finding the Sheriff's Department at fault.

The data expose a pattern of systemic failure. Nearly half of those who died did so within one month of booking, and many were struggling with substance use disorders, mental illness, or chronic health conditions that were ignored or mishandled. Black and Latine residents are vastly overrepresented in Orange County's jail population and are among those who die there, underscoring deep racial disparities in who is subjected to these conditions. This report concludes that incarceration itself is the primary risk factor. Jails are ill-equipped to provide medical or mental health care and yet are filled with those who need it most. The most effective way to prevent deaths in custody is to reduce reliance on incarceration by investing in community-based treatment, housing, and diversion programs that keep people safe and alive outside of jail.

Introduction

Record numbers of people are dying in jails across the state of California, despite decreasing jail populations.[1] As of October 2025, at least eight people incarcerated in jail facilities run by the Orange County Sheriff's Department ("OCSD") have died this year.[2] When people die inside the jails, OCSD issues a press release with a few short sentences that include the person's name, age and race, and the charge for which the person was in custody. These press releases do not address crucial questions that we must ask ourselves as a community: Why are people dying inside the jails? Are these deaths preventable? Are there patterns that can help explain what went wrong? This report is an attempt to answer those questions.

Orange County Sheriff Don Barnes has his own explanation for deaths in custody: "People who are dying in our care . . . [are] not dying because they're in jail. They are dying from things that are life choices. . . ."[3] This report will explain in detail why Sheriff Barnes is wrong on at least two grounds. First, there is ample evidence that jail itself contributes to these deaths. The conditions of incarceration, including the stress and trauma of confinement, lack of adequate medical care, exposure to violence, and disruption of vital support systems, can precipitate or accelerate fatal outcomes. This is particularly true for those with chronic illness or mental health conditions. Many of these deaths may not have occurred outside of jail.

Second, framing these deaths as the result of "life choices" ignores the systemic factors that determine who ends up incarcerated in the first place. Jails are disproportionately filled with people who suffer from substance use disorders,[4] houselessness, severe economic insecurity,[5] and chronic health problems.[6] Arrest, booking, and incarceration do not happen in a vacuum; they are applied unevenly across society and tend to ensnare the most vulnerable. Sheriff Barnes's logic obscures this reality and diverts attention from the role the jail system plays in exacerbating harm. These systemic factors beg a different question: Why are we incarcerating people whose health and circumstances make them especially vulnerable to death in custody?

Key Findings

- The most common reasons for death in custody were issues related to the jails' intake "triage" process, suicide, physical violence, substance use, and medical neglect.
- Of the 119 people in our dataset, at least 60 (half of the sample) died within a month of booking. Of those, at least 35 died within a week of booking.
- The Orange County District Attorney's Office did not find OCSD at fault for any of the 119 deaths in the dataset.

1 CalMatters, *Locked Up and Dying: California jails see record inmate deaths*, https://calmatters.org/series/california-jails-inmate-deaths/.
2 Orange Cnty. Sheriff's Dep't, *Custody Death Reporting*, https://www.ocsheriff.gov/about-ocsheriff/orange-county-jail-custody-death-reporting/.
3 CalMatters, *Prop. 36 and California Jail Deaths*, https://calmatters.org/newsletter/prop-36-california-jail-deaths/.
4 The Pew Charitable Trs., *Over 1 in 9 People with Co-Occurring Mental Illness and Substance Use Disorders Are Arrested Annually*, https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/02/over-1-in-9-people-with-co-occurring-mental-illness-and-substance-use-disorders-arrested-annually.
5 California Local News, *Homelessness and Crime: California's Hot-Button Political Issues Are Even More Complex Than You Think*, https://californialocal.com/localnews/statewide/ca/article/show/6215-homelessness-crime-california/.
6 Prison Pol'y Initiative, *Chronic Punishment*, https://www.prisonpolicy.org/reports/chronicpunishment.html.

Methods, Data, and Limitations

ACLU SoCal obtained internal documents from the Orange County Sheriff's Department via a California Public Records Act (PRA) request concerning 119 in-custody deaths over an approximately ten-year period. We cross-referenced these documents with publicly available reports from the Orange County District Attorney's Office ("OCDA") to better understand how and why people in Orange County are dying in custody. The report that follows is structured around representative cases from that sample.

In Orange County, the Sheriff is also the coroner. Any death that occurs in custody must be reported to and investigated by the Coroner's Division of the Sheriff's Department.[7] In an effort to "eliminate any perceived conflict of interest," OCSD entered into a memorandum of understanding with OCDA in 2010 that transferred ultimate responsibility for in-custody death investigations from the Sheriff's Department to the District Attorney's office. Our set of records for deaths begins when this new investigatory process took effect and includes all reported in-custody deaths between 2010 and 2021.

For most of the deaths in this report, we examined internal documents obtained from OCSD, and the formal investigative report from OCDA. The former includes internal memoranda about the death; booking information and housing assignments; charge information; and internal communications relating to the death, while the latter is a single document that includes a chronology of the events leading up to the death and a brief summary of the autopsy. For more recent cases, the OCDA website will sometimes also include security camera footage of the death.

We are acutely aware of the limits of a report analyzing in-custody deaths using sources primarily supplied by the county actors who were responsible for keeping these incarcerated people safe. Despite this, the county documents still reveal stories of medical neglect, deputy violence, and hazardous conditions. In each of the 119 cases analyzed for this report a life was lost, and this number is merely from an eleven-year span. Out of respect for the stories we will never hear, we have attempted to read the OCSD and OCDA sources with a critical eye.

Even when analyzing these documents on their own terms there are visible and concerning discrepancies. During our analysis we discovered that 20 of the recorded deaths in the documents acquired from OCSD had no corresponding reports from OCDA. When we contacted OCDA about this discrepancy, they provided no response. Some OCSD document packets contain no record of internal investigation into the death, merely miscellaneous documents concerning the person's prior incarceration.

For those cases for which we have both OCSD and OCDA records, we have attempted to read them against each other to identify and evaluate contradictions and inaccuracies. Some of the inconsistencies are minor. Others are major and deeply concerning. There are multiple instances where OCSD and OCDA documents report contradictory vital signs of the incarcerated person preceding their death; the kind of medical care people received; when and where paramedics were called; or the state in which a body was found. One such example is discussed in more detail later in the report.

7 Orange Cnty. Sheriff's Dep't, *Reportable Deaths*, https://www.ocsheriff.gov/sites/ocsd/files/import/data/files/7341.pdf.

Beyond missing documents and internal contradictions, the investigative and reporting methodologies of each agency lack transparency. OCDA reports detail the charges of the deceased even when these details are irrelevant to the in-custody death while the autopsy summary is rarely longer than a few sentences. OCDA's conclusions cannot be properly assessed without a full autopsy report and transparent discussion of investigative methodology. The fact that there was not a single case in the 119 we examined where OCDA found OCSD at fault for the death is itself worthy of scrutiny. This report is not intended to be an exhaustive analysis of each case, but rather an examination of specific deaths which we believe illustrate problems endemic to incarceration in Orange County and beyond.

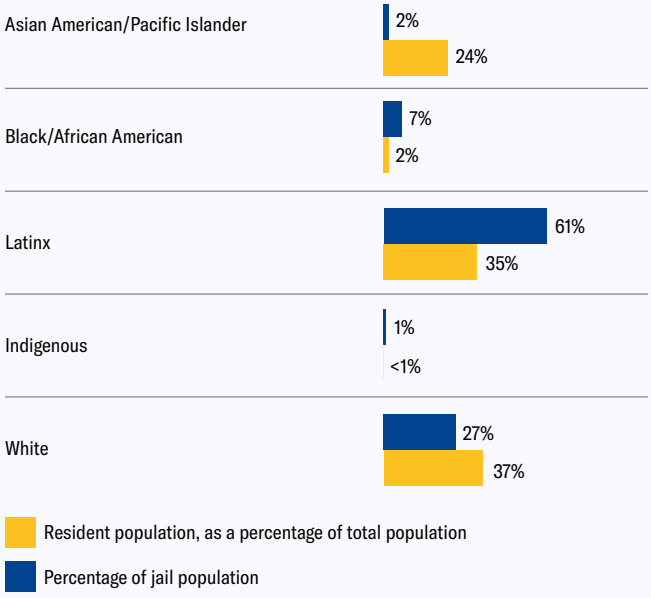
While the case studies in this report are drawn only from the data ranging from 2010-2021, the data visualizations in this report also include deaths from 2021-2024 using data obtained from the California State Department of Justice ("CA DOJ"). This composite dataset includes information on 153 people who died in-custody in the Orange County jail system from 2010 to 2024. These data include date of death, race, sex, age at death, and "Manner of Death" as determined by the OCDA official autopsy reports. We shared this data with the Carceral Ecologies Lab, a team of researchers and data scientists, who generously provided the data visualizations in this report.

All documents that ACLU SoCal received from OCSD in response to a Public Records Act request are on file with ACLU SoCal and are available upon request.

Racial Context

One of the greatest disparities of incarceration in America is the disproportionately high rates of incarceration for Black, Latine, and Indigenous people.[8] This disparity extends to Orange County, with Black and Latine people experiencing higher rates of incarceration in particular. Black/African American residents comprise only 2% of the Orange County population but 7% of the jail population. Latine residents comprise 35% of the county but 61% of the jail population.[9] White residents, on the other hand, make up 37% of the general population and only 27% of the jail population.[10]

Figure 1: Racial Disparities in Incarceration



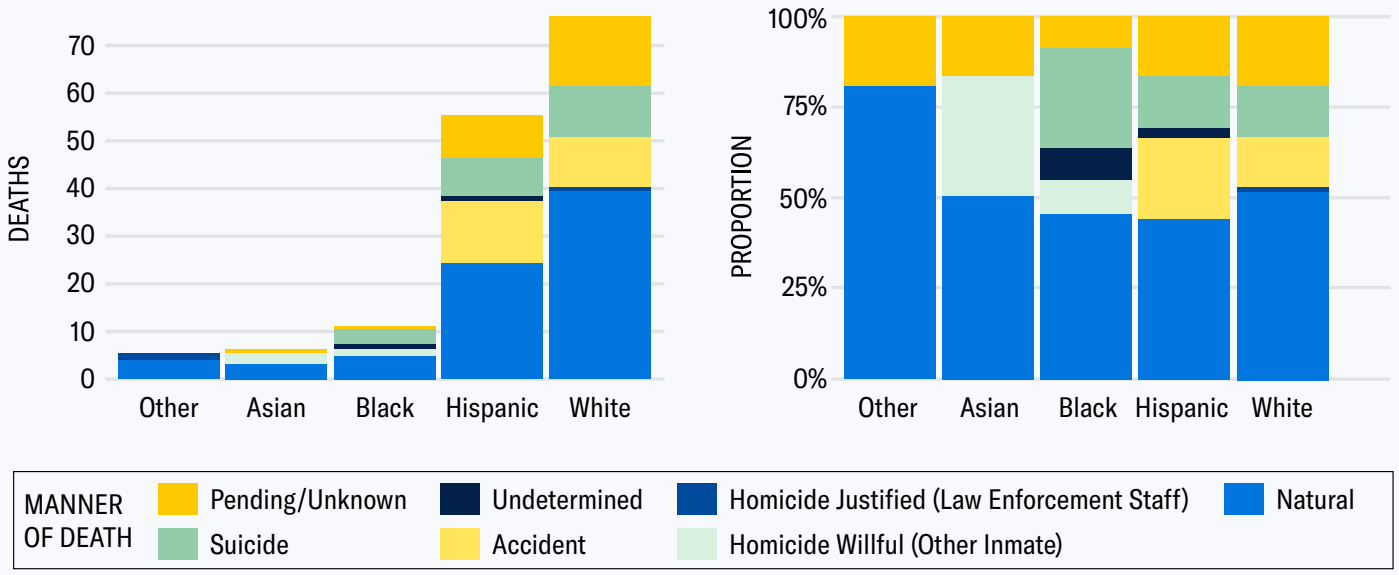
Data drawn from Vera Incarceration Trends Database: https://trends.vera.org/state/CA/county/orange_county .

8 The Sentencing Project, *One in Five: Ending Racial Inequity in Incarceration*, https://www.sentencingproject.org/reports/one-in-five-ending-racial-inequity-in-incarceration/.
9 Vera Inst. of Just., *Orange County, CA*, https://trends.vera.org/state/CA/county/orange_county.
10 *Id.*

We note that there are problems with the broad categorizations used by county actors: for example, race in the booking documents is sometimes conflated with nationality and may be listed as "Vietnamese" or "Korean," while other times use the categorization "Asian." Even when consistent, these labels are inherently flawed and simplistic, grouping diverse populations into the same socially constructed category based on skin color and appearance. Analyzing these categories can nonetheless provide insights into how groups, linked by their unique but still shared experiences of marginalization and racialization, are disproportionately harmed by systems of incarceration.

The graph below shows the interaction of race and manner of death as determined by OCDA. The manner of death for Black people was disproportionately classified as "undetermined." This cause of death means that "information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of all available information."[11] Especially given the disproportionate incarceration of Black people in Orange County, the proportion of their deaths without a defined cause is alarming.

Figure 2: Orange County Jail Deaths by Race and Manner of Death (2010-2024)



Data visualization provided by Carceral Ecologies Lab.

11 The Orange County Chief Executive Office (CEO), *C2EH Agenda Packet — June 19, 2024* (June 19, 2024), https://ceo.oc.gov/sites/ceo/files/2024-06/C2EH%20June%2019%202024%20Agenda%20Packet.pdf.

Manner of Death

Figure 3: Manners of Death in Orange County Jails

Total Deaths by Manner of Death	
Manner of Death	**Deaths**
Homicide Justified (Law Enforcement Staff)	1
Undetermined	2
Homicide Willful (Other Inmate)	3
Suicide	21
Accident	25
Pending/Unknown	26
Natural	75

Data visualization provided by Carceral Ecologies Lab.

Due to the sparse details of the OCDA autopsy reports, we are reliant on their official "Manner of Death" categories, listed in the chart above. These categories are quite broad, and often collapse complexity and hide many of the details essential for understanding what caused a person's death. The size of the "Pending/Unknown" category illustrates this difficulty.

In spite of this report's reliance on OCDA and OCSD documents, we attempted to avoid replicating these "Manner of Death" categories or creating our own. Instead, we identify common circumstances or facts to analyze trends in these deaths. The most common patterns of death we observed were **issues related to the jails' intake "triage" process, suicide, physical violence, substance use, and medical neglect**. Each of these forms a **section** of the report, complete with analyses of representative cases. This report's focus is on a small set of deaths chosen because they are particularly reflective of these broader trends within the jails and, we believe, the carceral system.

The quotation that forms the title of this report was drawn from a grievance submitted by Michael Finnerty on March 20, 2020. He died 9 days later, having lost over 30 lbs in two months of incarceration.[12] We chose to include the names of people who died in Orange County jails in the case studies that follow because these were real human beings, not statistics. Their names were already released in OCSD's and OCDA's publicly available custodial death reports. But those reports present these deaths in abstract, sterile terms that often obscure the human reality behind them. We hope that including the names of people who died reminds readers that each "case" was a person whose life mattered.

12 OCSD PRA Record Finnerty 3, 4, 39.

Triage

Following their arrest by either OCSD or a local police department, people are typically taken to the Intake Release Center ("IRC") where OCSD enters the person's information into the booking system. The booking process involves the verification of identity, a review of documents, and a medical and mental health screening process called "triage." The triage process is intended to identify acute health concerns that need emergency or urgent medical attention, as well as to flag longer-term issues that Correctional Health Services ("CHS"), the county-run health provider for people incarcerated in the jails, should be aware of. Arrested people are categorized in one of three ways:

1. In need of emergency medical attention, which cannot be provided at IRC, in which case they are to be transferred to a hospital and not booked until they receive treatment;
2. In need of medical care within IRC, in which case this need is to be noted on their booking form and they are to be seen by medical staff within two hours; or
3. Not in need of urgent medical care and healthy enough to be booked and transferred to other parts of the jail.

OCSD POLICY MANUAL, SECTION 3000.2, PP 375.[13]

d) Medical Screening Station

1. All arrestees must be cleared by the medical staff in the medical screening station prior to being booked.
2. ...
3. Correctional Health Services (CHS) Staff personnel will complete the Intake Screening and Triage form on all arrestees. The arrestee's responses to the questions will be recorded on the form, which has been approved by the Facility Health Authority. The screening process will include information about:
   - i. Current illnesses and health problems, dental problems, venereal diseases or infection diseases.
   - ii. Medications being taken and/or special health requirements.
   - iii. Use of alcohol or drugs, types of drugs; frequency and most recent use that resulted in problems (e.g., convulsions, etc.).
   - iv. Current or past treatment for mental problems.
   - v. Any other physical problems of the arrestee.
   - vi. CHS observations of the arrestee's behavior, alertness, appearance, deformities, marks, and/or ability to move.

OCSD POLICY MANUAL, SECTION 3000.2, PP 375-376.

7. Arrestees requiring immediate medical attention not available at the CJX will not be booked until such treatment is administered. CHS will inform the arresting/transporting officer that the arrestee requires transport to a hospital for treatment. The arresting/ transporting officer will be required to arrange for the arrestee's transport to the hospital. If the officer refuses, he/she will be advised per Section 4015(b) of the California Penal Code that the CJX is not required to receive an arrestee until the arrestee's medical condition is such that the arrestee can be properly admitted into the jail. The medical screening nurse will make appropriate notations on the forms stating the reasons for hospital referral. Arrestees returned to the CJX after receiving such outside medical care must be re-examined by the medical screening staff.

8. Arrestees not requiring outside medical treatment, but who require follow-up medical or psychiatric treatment evaluation by the facility medical staff, will have their Pre-Booking forms marked in the "Medical Attention" box; the top of the form will be marked with "Medical." Any statements or entries made by the arresting agencies that suggest any form of mental impairment will be marked "Mental Health" in red letters at the top of the Pre-Booking form. After completing the booking process, these arrestees may be referred by the medical staff to a medical module.

9. If an inmate needs to be seen by the doctor, nurse practitioner or mental health staff, and no one is available during the initial triage screening, the medical staff will place a florescent orange paper wrist band on the inmate, identifying the inmate as one requiring medical/mental evaluation. These inmates will be returned to triage to be seen by the appropriate medical staff. Once properly uncuffed, the inmates will be placed into a holding cell.

10. Correctional Health Services (CHS) will evaluate these inmates within two hours of their initial booking.

Of the 119 people in our dataset, at least 60 died within a month of booking and triage, comprising approximately **half** of the in-custody deaths we examined. Of those, at least 35 died within a week of booking. The circumstances of these deaths include suicide, physical violence, substance use, and medical neglect. These deaths occurred both when official triage procedures described above were followed and when they weren't.

13 Orange County Sheriff's Department, *Department Manual* (Oct. 6, 2020), https://www.ocsheriff.gov/sites/ocsd/files/2020-10/Department%20Manual%20%2020201006.pdf.

Stephen Mott

Stephen Mott's death is an example of how the triage process, even when followed, does not guarantee safety. On October 11, 2011, Mott was arrested and taken to the IRC for booking.[14] When correctional health staff initially evaluated Mott, they noted a history of substance use disorder, specifically alcohol abuse, and referred him for further assessment as "an alcoholic who may need detoxification."[15] Although both Mott's autopsy and the legal analysis section of the OCDA report note that Mott suffered from "chronic alcoholism at the time he was placed into OCSD custody,"[16] the nurse practitioner in charge of his care decided that he was displaying no symptoms of withdrawal and, she noted, had consumed no alcohol for the past five days.[17] Later that night, another incarcerated person approached a different health staff member and advocated for Mott to be given medication for alcohol withdrawal. The staff member read through Mott's file and saw that a note had been made about alcohol-related problems, but had been crossed out.

After talking to Mott, who admitted to a consistently high level of alcohol consumption, the registered nurse ("RN") prescribed and provided him with medication for alcohol detox.

It is unclear why the note about alcohol-related problems had been crossed out, or why the nurse practitioner initially treating Mott seemed to believe he was not consuming alcohol when he admitted to a high level of daily consumption shortly after. What is clear is that Mott suffered from "chronic alcoholism," and was not provided treatment for withdrawal until another incarcerated person advocated for him.

Mott was first booked at 10:36 a.m. and did not receive medication for alcohol withdrawal until 11:35 p.m. By 2:30 a.m. that night, Mott was experiencing Delirium Tremens (DT), a symptom of severe alcohol withdrawal. Delirium Tremens typically develops 48 to 72 hours after cessation of alcohol consumption and is the "final major symptom" of severe withdrawal. It "does not develop all of a sudden," but rather is part of a "sequential timeline" of worsening symptoms.[18] Medical literature strongly suggests that Mott must have been experiencing symptoms prior to the onset of DT, but these are not noted anywhere in OCDA or OCSD documents. Mott arrived at the emergency room at 4:00 a.m. and was transferred to the ICU where he was intubated. His condition deteriorated further and at 8:36 p.m. on October 12 he was pronounced dead.

> The NP concluded that Mott had not consumed alcoholic beverages for five days, nor did he show signs of alcohol withdrawal symptoms. Based on her evaluation, the NP determined that Mott did not require the alcohol detoxification protocol. Since Mott had a history of alcoholism, however, the NP prescribed Thiamine and a multi-vitamin with folic acid. Due to Mott's physical injuries, he was assigned to the jail's medical ward, Ward D.
>
> On Oct. 11, 2011, at approximately 11:30 p.m., another CMS RN observed an order for crutches for Mott. This RN contacted Mott and found he already had a walker. As the RN walked away from Mott's bunk, another inmate told the RN that he believed Mott had an alcohol problem and needed Serax (Oxazepam). The RN then asked Mott about his alcohol consumption, to which Mott replied that he drinks "a lot" of alcohol during the day.
>
> The RN reviewed Mott's chart and observed an entry for the protocol for alcohol-related problems; however, it had been crossed out. The RN reviewed the notes, which were taken upon Mott's triage upon arrival to the facility, and observed that Mott stated he drinks six to seven "40s" a day. Although the RN did not observe Mott display any symptoms of alcohol withdraw, he believed Mott should be placed on the alcohol withdraw protocol due to his stated alcohol use on the triage notes. Mott was then placed on the alcohol withdraw protocol by a second NP, which included receiving a dose of Serax.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Steven Mott*[19] *(OCDA Report)*, page 2.

14 OCSD PRA Record Mott, 2-3.
15 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Steven Mott (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/investigation-letters/OCDA%20Report%20Custodial%20Death%20Investigation%20%E2%80%93%20Inmate%20Steven%20Mott.pdf.
16 *Id.* at 3-4.
17 *Id.* at 2.
18 Grover, S. et al., *Delirium Tremens: Assessment and Management*, 2018, https://pmc.ncbi.nlm.nih.gov/articles/PMC6286444/.
19 OCSD documents refer to the deceased as "Stephen Mott" while OCDA refers to "Steven Mott."

The autopsy, performed by Dr. Joseph Cohen, determined Mott's death to be complications from "chronic alcoholism."

> Following the autopsy, Dr. Cohen concluded that the cause of death was due to complications of chronic alcoholism.
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Steven Mott (OCDA Report)*, page 3.

The reports released by OCDA and OCSD provide no explanation as to why it took twelve hours for Mott to receive medication for alcohol withdrawal, nor do they explain the inconsistencies in his care, nor why his transfer to the ER took a full hour and a half.

In Mott's case, the triage procedure was followed – he was seen and evaluated by medical staff – but it was ineffective and failed to save his life. Despite his history of substance use, he was not provided with withdrawal medication until it was too late, and even then only because another incarcerated person went out of his way to advocate for Mott's safety.

Jason Holliday

A year and a half later, Jason Holliday was booked at IRC on the evening of May 16, 2013. Similar to Stephen Mott, Holliday struggled with substance use disorder. He also had a history of withdrawal-induced seizures which medical staff were made aware of during the triage process.[20] Holliday was prescribed withdrawal medication and his vitals were monitored. At 4:30 a.m. on May 17 an RN noted that Holliday was experiencing nausea and vomiting, though not tremors or hallucinations. Nausea and vomiting are early symptoms of alcohol withdrawal symptoms which can lead to seizures, especially in somebody like Holliday with a history of withdrawal-induced seizures.[21] Despite this, Holliday was not provided with any additional treatment or monitoring to ensure that his condition did not deteriorate. Holliday was not seen by medical staff again until 10 hours later, following his transfer to the Theo Lacy Facility, a maximum security jail complex. By that time, he was struggling to speak and seemed to be hallucinating, both of which are symptoms of severe alcohol withdrawal. [22]

> had not taken any HIV medication for approximately one year. In addition, Holliday was an alcoholic, consuming a fifth of vodka per day. Holliday also had a history of seizures as a result of alcohol withdrawal.
>
> On May 17, 2013, at approximately 4:30 a.m., the on-duty OCSD registered nurse checked Holliday while he was still in the OCJIRC booking loop. Holliday's vital signs were stable and he was alert. He complained of nausea and some vomiting, but he waws not experiencing tremors, hallucinations, headaches, pain, agitation, or anxiety. The following day, Holliday was transported to Theo Lacy Jail (TLJ) and housed in G Barracks East, F Cube, Bunk 16. That afternoon, a correctional medical services licensed vocational nurse went to the G Barracks to dispense medication to inmates. After all the medications were dispensed, the nurse noted that Holliday was the only inmate that had not received his medication. Minutes later, an inmate assisted Holliday to the nurse location. According to the nurse, Holliday tried to speak to her during their encounter but his speech was "gibberish, like babbling." The nurse did not observe any injuries on Holliday. Due to Holliday's strange behavior, a nurse alerted a correctional medical services senior registered nurse, who in turn requested that Holliday be sent to the medical unit for further evaluation.
>
> ... complained of pain in his right eye. Moreover, Holliday appeared extremely confused and unaware of his surroundings. Holliday was able to recite his name, but could not tell the Senior Nurse the date, their current location, or the name of the president of the United States. The senior nurse futher described Holliday as having audio and visual hallucinations...
>
> ... A Computed Axial Tomography (CAT) scan was completed on Holliday and revealed small areas of bleedings in the right frontal lobe and left temporal lobe of his brain. The medical staff concluded that Holliday had suffered a stroke.
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Jason Holliday (OCDA Report)*, page 2, 3.

20 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Jason Holliday (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/investigation-letters/jason_holliday_custodial_death_investigation.pdf.
21 Cleveland Clinic, *Alcohol Withdrawal*, https://my.clevelandclinic.org/health/diseases/alcohol-withdrawal.
22 *Id.*

He was soon transferred to a hospital where he deteriorated rapidly. Hospital staff concluded that he had suffered a stroke and a CAT scan detected bleeding in his brain.

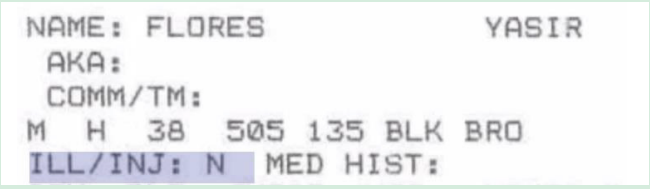
The official autopsy, conducted by Dr. Joseph Cohen, listed Holliday's cause of death as "complications" from untreated HIV. The report does not explain what those complications were, nor does it acknowledge the stroke and brain bleed diagnoses at the hospital. While untreated HIV can be fatal, it is rarely the virus itself that causes death; rather, it weakens the immune system, leaving the person vulnerable to other illnesses or injuries.[23] A vague attribution to "complications" therefore tells us little about what caused Holliday's death. The omission of any reference to the brain bleed documented by a hospital CAT scan is equally troubling, raising questions about the completeness and accuracy of the autopsy's findings.

AUTOPSY
On May 23, 2013, at approximately 1:10 p.m., a postmorten examination of Holliday was conducted by Doctor Joseph Cohen, a forensic pathologist on contract with the Orange County Sheriff-Coroner's Office. Following the autopsy, Doctor Cohen determined that Holliday's death was the result of complications of chronic human immunodeficiency viral infection.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Jason Holliday (OCDA Report)*, page 4.

Yasir Flores

In the above two cases, incarcerated people were triaged according to OCSD policy but did not receive the care they needed. In the case of Yasir Flores, we see that triage itself can fail to happen. Yasir Flores was arrested and booked at IRC at 7:00 a.m. on September 18, 2015. Neither OCDA nor OCSD records mention the triage process he should have undergone at booking. Indeed, documents from OCSD show that he was not marked as needing medical attention at booking. It is unclear if Flores was triaged at all and, if he was, why he did not receive medical care.


NAME: FLORES YASIR
AKA:
COMM/TM:
M H 38 505 135 BLK BRO
ILL/INJ: N MED HIST:

OCSD PRA Record Flores, 7.

Two days later, Flores was exhibiting signs of severe alcohol withdrawal, but there is no mention of treatment for substance use or the earlier stages of withdrawal.[24] The autopsy mentions "prior statements" from Flores concerning alcohol use, but these statements were made "during his initial treatment."[25]

According to the OCDA report a nurse was called to evaluate Flores, who by that time was "unable to respond to basic commands." A few minutes later, Flores reportedly refused medical treatment by saying "I feel fine" in Spanish, but then was also given some medication.[26] Flores was admitted to the ICU four days later due to a high fever, seizures, and possible sepsis.[27] He never regained consciousness.

23 Cory Martin, *Can HIV Kill You?*, Verywell Health (updated Oct. 12, 2025), https://www.verywellhealth.com/can-hiv-kill-you-5087885.
24 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Yasir Flores (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/investigation-letters/Yasir%20Flores%20custodial%20death%20investigation.pdf.
25 *Id.* at 3.
26 *Id.* at 2.
27 *Id.* at 3.

On Sept. 19, 2015, at approximately 10:15 p.m., OCSD Deputy Joshua Wiggs, who was assinged as a Male Identification Deputy at the IRC, was performing a routine cell safety check when he noticed Flores was standing at his cell window sweating profusely, had tremors in both hands, and was unable to respond to basic commands. Deputy Christopher Anderson contacted the jail medical staff and they arrived at approximately 10:25 p.m. to evaluate Flores, who was cleared by the attending nurse after FLores refused to consent to medical treatment stating in Spanish, "I feel okay." Flores was authorized to be kept in a low bunk and to have no work assignments while being monitored for his symptoms. Flores was also prescribed Oxazepam, Vitamin B, a multi-vitamin, and aluminum-mag hydroxide-simethicone by the attending jail physician.

On Sept. 23, 2015, at approximately 8:00 p.m., Flores was transferred from Custodial Medical Services at Anaheim Global Medical Center to the Intensive Care Unit (ICU) for treatment of a high fever, seizures, and possible sepsis.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Yasir Flores (OCDA Report)*, page 2.

The autopsy conducted by Dr. Scott Luzi states that Flores died from "natural causes," and notes that he was developing liver cirrhosis, damage associated with chronic alcohol use. It provides no detail as to what these "natural causes" were, nor does it mention the seizures and possible sepsis that Flores was treated for in the hospital.

Not only is there no record of Flores being triaged during the booking process in accordance with OCSD policy, but the official accounts of his final hours at IRC raise concerns about the medical care he was provided as his condition worsened. If he was unable to respond to basic commands, how was he able to communicate that he felt fine? Why weren't tremors, extreme sweating, and inability to communicate enough for Flores to be transferred to the hospital on the evening of September 19? The lack of detail in the autopsy is especially worrying given the events preceding Flores's death. Declaring his death due to "natural causes" without providing a more specific analysis makes it impossible to understand what happened to Yasir Flores.[28]

AUTOPSY
On Sept. 26, 2015, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Flores. Dr. Luzi noted minor abrasions on Flores' extremities, including on his wrists consistent with the use of restraints, but found no signs of trauma attributable to Flores' death. The autopsy and microscopic examinations of Flores revealed scarring and inflammation of the liver, possibly caused by chronic alcohol abuse. Prior statements by Flores during his initial treatment indicated daily alcohol use. Dr. Luzi determined the [cause] of death was "natural," and that Flores was developing cirrhosis of the liver.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Yasir Flores (OCDA Report)*, page 3.

The triage process in Orange County jails is marked by inconsistency, delay, and limited effectiveness. While it is intended to assess and initiate care, the cases of Stephen Mott and Jason Holliday show that even when triage procedures are followed, they do not reliably prevent serious harm. Mott was evaluated and flagged for possible detox, yet he did not receive medication until hours later, and only after another incarcerated person advocated for him. Holliday was seen and initially prescribed medication, but went nearly 10 hours without follow-up as his condition deteriorated. In Flores's case, it is unclear whether triage occurred at all. These cases highlight both how quickly health can decline in custody and how vulnerable people become when care is delayed or deficient. Rather than providing meaningful protection, triage often functions as a procedural step that fails to adequately meet health needs, while incarceration itself prevents people from relying on their own support networks and experience to potentially access care more quickly and effectively.

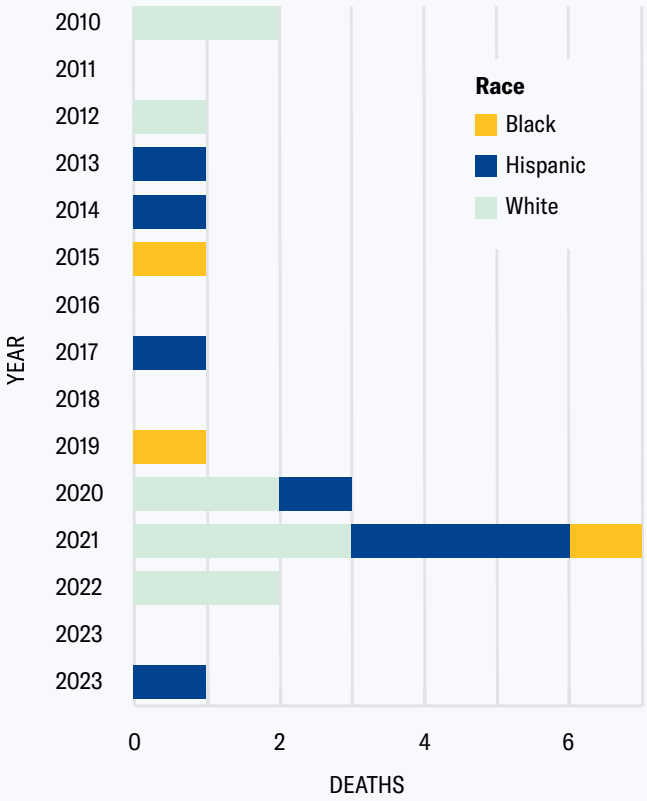
28 *See* Nicholas Shapiro & Terence Keel, *Naturalizing Unnatural Death in Los Angeles County Jails*, 38 Med. *Anthropol. Q.* 6 (2024), https://pubmed.ncbi.nlm.nih.gov/37853528/.

Suicide

Suicide prevention in jails is often focused on preventing the act of suicide — via surveillance, solitary confinement, and restricting access to items that could be used in a suicide attempt — rather than addressing the root causes of mental illness and suicidality. Incarceration is inherently damaging to mental health as it places people in a harsh environment and disconnects them from their support systems and agency over their own lives. These factors are especially detrimental for people who already have a history of mental illness or suicidal ideation.

Suicide rates in Orange County Jails spiked during the COVID-19 pandemic, with the number of suicides in 2021 equal to the previous seven years combined. One possibility for this spike is that the pandemic and related changes in jail conditions heightened the strain of incarceration. OCSD instituted an end to all in-person visitation and a 14-day quarantine for newly incarcerated people before they joined the general population.[29] Incarcerated people did not receive hot meals for over two years. ACLU SoCal supported measures to mitigate the spread of COVID-19 in jails, but some of the changes in jail processes heightened features of incarceration that are damaging to mental health. The complete suspension of in-person visits led to extreme isolation of incarcerated people from their families and support systems. They were not offered video calls as a substitute but provided merely two 5-minute free phone calls a week.[30] The surge in suicide rates should not be read as an indictment of measures to protect incarcerated people from COVID-19, but instead shows that incarceration is inherently damaging to physical and mental health, particularly during a pandemic.

Figure 4: Deaths from Suicide in Orange County Jails (2010-2024)



Data visualization provided by Carceral Ecologies Lab.

Brekka Lancaster

Brekka Lancaster was arrested at her home on July 22, 2014, due to an outstanding warrant. Her grandmother answered the door, and several minutes later Lancaster came to the door and left with the arresting officers.[31] During intake, Lancaster mentioned she had a history of anxiety and saw a psychiatrist. [32] While she "displayed bizarre behavior" and "disorganized thoughts" during the mental health evaluation, she denied suicidal ideation.[33] She was housed in the observation unit due to concerns about her mental health.[34]

29 Orange Cnty. Sheriff's Dep't, *Orange County Sheriff Implements Proactive Measures to Limit Exposure to COVID-19* (Dec. 8, 2020), https://ocsheriff.gov/news/orange-county-sheriff-implements-proactive-measures-limit-exposure-covid-19.
30 *Id.*
31 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Brekka Lancaster (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/investigation-letters/OCDA%20Report%20Custodial%20Death%20Investigation%20%E2%80%93%20Inmate%20Brekka%20Lancaster.pdf.
32 *Id.* at 3.
33 *Id.*
34 *Id.*

This unit has a higher level of surveillance with deputies walking through the unit every 15 minutes and a nurse conducting cell checks every half hour.[35] According to the OCDA report, the nurse assigned to watch over the women in the observation unit saw Lancaster sitting on the floor with her chin on her chest "making a 'clucking' noise."[36] The nurse did not see Lancaster move from this position at any point from 7:15 p.m. to 9:30 PM, and the nurse did not approach her to see if she was alright.[37] At 9:30 p.m., a deputy heard Lancaster's heavy breathing while passing by and attempted to speak to her, but Lancaster was unresponsive.[38]

> 7:15 p.m., Nurse Iorga made her rounds to distribute medicine. As Nurse Iroga walked past Lancaster's cell, she saw Lancaster sitting on the floor at the foot of her bunk. Lancaster's chin was resting on her chest and she waqs making a "clucking" noise. Nurse Iorga did not believe there was anything wrong with Lancaster, so she moved on to the next cell...
>
> Nurse Iorga conducted her cell checks on inmates in the FOU every half-hour from approximately 7:15 p.m. to 9:00 p.m. and did not observe any problems with the inmates. Nurse Iorga specifically remembered looking in Lancaster's cell during this time period and noticed she was still sitting on the floor and appeared to be breathing. Nurse Iorga assumed Lancaster preferred to sit on the floor instead of her bunk.
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Brekka Lancaster (OCDA Report)*, page 3.

At this point, OCSD and OCDA records diverge. According to OCDA records, Nurse Iorga was unable to measure Lancaster's blood pressure due to her loud breathing but remained to monitor her condition.[39] Paramedics were called to Lancaster's cell and measured her blood pressure as 160/120 (dangerously high), then transported her to the hospital.[40] However, OCSD records state that Lancaster was moved from her cell to correctional health services where a correctional health doctor measured Lancaster's blood pressure and then called paramedics to transport Lancaster to the hospital because Lancaster's blood pressure was too low.[41] These discrepancies — over her blood pressure, whether she was evaluated by a doctor, and whether she was moved to correctional health before paramedics were called — are uniquely troubling. They also raise serious questions about the accuracy of official accounts and the adequacy of care Lancaster received while under observation, particularly considering the apparent inaction by the correctional health nurse.

> ... Lancaster's breathing became labored. Nurse Iorga used an electronic monitor to meausre Lancaster's blood pressure, but she could not hear anything due to the loud noise Lancaster made as she breathed. Nurse Iorga attempted to use a manual blood pressure cuff to measure Lancaster's blood pressure, but she was unsuccessful because Lancaster continued to make loud "snoring noises" as she breathed. Nurse Iorga attempted to talk to Lancaster, but she was unresponsive, so Nurse Iorga instructed the deputies to call for paramedics. Nurse Iorga delivered oxygen to Lancaswter and monitored her breathing while waiting for paramedics to arrive...
>
> ... Paramedic Muro measured Lancaster's vital signs and noted that her blood pressure was 160/120 and her pulse was 150 beats per minute...
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Brekka Lancaster (OCDA Report)*, page 4.

> On Tuesday, July 22, 2014 at approximately 2130 hours, Deputy Garcia noticed Inmate Lancaster was breathing heavily as she sat in her cell with her chin resting on her chest. Garcia, along with Deputy Freeman and RN Iorga responded to the cell. I/M Lancaster was taken to medical. Doctor N. Ursua determined Lancaster needed to be sent to the hospital due to her low blood pressure, heavy breathing, and unresponsiveness.
>
> OCSD PRA Record Lancaster, 2.

35 *Id.*
36 *Id.*
37 *Id.*
38 *Id.*
39 *Id.* at 4.
40 *Id.*
41 *Id.* at 2.

By the time she reached the hospital, Lancaster's blood pressure had increased to 205/105, and her condition deteriorated.[42] Lancaster never regained consciousness and died several days later.[43] The autopsy conducted by Dr. Scott Luzi revealed that she had drunk antifreeze.[44] Two bottles of antifreeze were taken from the house where she was arrested, and her DNA was found on the lip of one of the bottles.[45] The autopsy states that it could take up to 24 hours after the ingestion of anti-freeze to result in physical symptoms and concludes that she drank anti-freeze before her arrest.[46]

> evidence clearly supports the conclusion that Lancaster ingested the ethylene glycol before she was arrested by OCSD. This conclusion is made even stronger by the presence of Lancaster's DNA on the rim of one of the jugs of anti-freeze collected from the garage where Lancaster was arrested.
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Brekka Lancaster (OCDA Report)*, page 7

Lancaster's story demonstrates that the jail's responses to mental health crises are not guaranteed to work. She was flagged at triage and placed under surveillance as a preventative measure, but signs of distress and ill health were still not acted upon until it was too late. Despite Lancaster's slumped posture and the strange noises that she was making, the nurse observing her did not check that she was physically sound.

Adiel Rivera Barrios

A year later, the death of Adiel Rivera Barrios was also categorized as a suicide by OCDA. Barrios was arrested in 2015 and was housed in protective custody following threats to his safety made by other incarcerated people.[47] In September 2015, his mother and girlfriend saw that he had injuries during a visit — a black eye and a split lip — and on September 27,[48] Barrios told his mother that "they [understood to be other incarcerated people] were out to 'get' him."[49] There is no record in the OCSD or OCDA reports that deputies noticed or investigated his injuries.

> In September 2015, Rivera-Barrios was visited by his girlfriend, Jane Doe 1, and his mother, Jane Doe 2. During this visitation, Jane Doe 1 and Jane Doe 2 noticed Rivera-Barrios had an injury to his lip and a black eye. However, Rivera-Barrios stated that he could not tell them what was wrong, but not to worry. On Sept. 27, 2015, during Jane Doe 1's last visit with Rivera-Barrios at TLF, Rivera-Barrios told Jane Doe 1 and Jane Doe 2 "they" were out to "get" him, but did not specify who "they" were. Jane Doe 1 felt as though Rivera-Barrios was telling them goodbye and to take care of the kids for him.
>
> ... wound by Rivera-Barrios. Rivera-Barrios believed he was in danger. Rivera-Barrios told deputies in the TLF in August 2015, and his girlfriend and mother in September 2015, about his belief of being in danger from other inmates.
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Adiel Rivera-Barrios (OCDA Report)*, page 2, 6.

42 *Id.* at 4.
43 *Id.* at 5.
44 *Id.* at 6.
45 *Id.*
46 *Id.*
47 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Adiel Rivera-Barrios (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/investigation-letters/Adiel%20Rivera-Barrios%20custodial%20death%20investigation.pdf.
48 *Id.* at 2.
49 *Id.*

On September 28, an incarcerated person notified deputies that there was blood on the floor of the showers.[50] Barrios was found lying in blood and feces in the showers with a laceration on the side of his neck.[51] According to deputies he was conscious, responsive, and able to get up and step out of the shower without assistance.[52] Deputies administered aid, but the next mention of Barrios's medical condition states that he was unresponsive with no pulse by the time he arrived at the hospital.[53] At the hospital, doctors discovered his carotid artery was transected and his jugular vein was lacerated.[54] He underwent surgery and was left quadriplegic, comatose, and on a respirator.[55] Barrios never recovered and was taken off life support two years later.[56]

> Rivera-Barrios was asked to step out of the shower and Rivera-Barrios was able to stand up on his own and walk out of the shower to the deputies. Deputies laid Rivera-Barrios on the floor and began to administer aid.
>
> Inmate 1, housed in the same Sector as Rivera-Barrios, was returning to his cell after receiving his Commissary, when he noticed blood on the shower floor. Inmate 1 noticed OCSD Deputy Corrales and OCSD Deputy Tangonan.
>
> ... Orange County Fire Department (OCFD) transported Rivera-Barrios to the University of California, Irvine-Medical Center (UCIMC). He arrived unresponsive and pulseless. There was a transection of the carotid artery, a laceration of the jugular vein, and he was in hypovolemic shock. Cardio Pulmonary Resuscitation (CPR) was performed and Rivera-Barrios was revived. Rivera Barrios underwent surgery, which found a penetrating neck injury with damage to the carotid artery, veins, and nerves in his neck. He was quadriplegic, comatose, and needed a respirator to breathe.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Adiel Rivera-Barrios (OCDA Report)*, page 3, 3, 3.

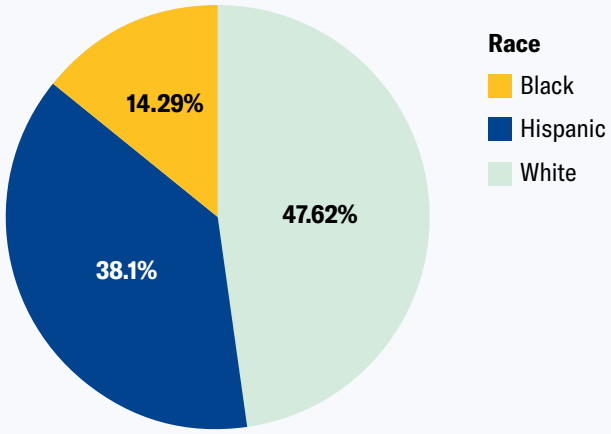
The autopsy, conducted by Dr. Scott Luzi, concluded that Barrios died due to multiple organ failure caused by sepsis from the laceration of his throat.[57] The OCDA report concludes that Barrios's death was a suicide because cells were locked, and deputies did not report seeing anybody else enter the shower.[58] However, this conclusion overlooks several inconsistencies in the investigation. If all other incarcerated people were in their cells, how was it an incarcerated person who first alerted deputies that there was blood on the shower floor? Video footage also includes a discussion between deputies which seems to partially contradict the report. A deputy states that they do not know the identity or cell number of the man found in the showers because it was during commissary and medication distribution,[59] and the incarcerated people were in "mixed cells." In other words, they were moving around and not confined to their cells. The deputy also adds that he doesn't know when Barrios entered the shower, that it could have been during commissary or day room.[60] If Barrios was not seen entering the shower, other people could have entered the shower without being noticed either. The OCDA report's assertion that Barrios's death must be a suicide because cells were locked is thus contradicted by the security camera audio. It makes clear that other incarcerated people were out of their cells, that the showers were not being observed. Finally, the records do not explain how Barrios was able to stand up and walk around with his jugular vein and carotid artery cut, nor how he deteriorated from this condition to pulseless and comatose. The records omit time stamps for his transfer to the hospital.

50 *Id.* at 3.
51 *Id.*
52 *Id.*
53 *Id.*
54 *Id.*
55 *Id.*
56 *Id.*
57 *Id.* at 4.
58 *Id.* at 5-6.
59 Commissary refers to the store or purchasing system where incarcerated people can buy items that are not issued as part of their standard supplies.
60 Day room is a period when incarcerated people are let out of their cells and given access to communal areas.

Barrios's death may have been a suicide, but the contradictions and errors in the investigation are deeply troubling. Barrios's case highlights how deaths are frequently labeled as suicides without thorough, independent inquiry. According to his mother and girlfriend, Barrios expressed fear for his safety just one day before his death and was already housed in protective custody due to threats made against him. Whether or not his death was by suicide, it is inseparable from a system that put him at risk and left him feeling trapped and helpless.

Suicides within the carceral system reflect a broader, systemic failure, where investigative focus is too often shifted onto the victim's mental health rather than the harsh conditions that make life unbearable. This is, perhaps, nowhere clearer than in the disproportionate rates of suicide among Black incarcerated people. Black people make up 7% of the incarcerated population and 7.2% of in-custody deaths, but 14.29% of all deaths ruled suicides. Neither OCDA nor OCSD documents acknowledge racism faced by Black people incarcerated in OC Jails. However, this data suggests that the conditions of incarceration experienced by Black people are particularly harsh, dehumanizing, and damaging to mental health. Every single suicide is a failure of OCSD and indicative of the cruelty and inhumanity of incarceration.

Figure 5: Suicides by Race in Orange County Jails (2010-2024)



Data visualization provided by Carceral Ecologies Lab.

Physical Violence

According to the OCSD policy manual, deputies are only authorized to use force against incarcerated people in certain situations. Use of force is defined as any incident where an OCSD official "overcomes resistance through the application of physical contact or any other force option," and that force is considered reasonable when it is "proportionate to the threat presented by, or the need to lawfully control, a subject in a particular moment."[61] When possible, deputies are encouraged to use "de-escalation techniques" in order to "persuade an individual to voluntarily comply."[62] It should be noted that very few forms of violence are explicitly banned in the Policy Manual; only the carotid restraint hold, choke holds, and forms of restraint that risk positional asphyxia are expressly prohibited.[63]

OCSD POLICY MANUAL SECTION 300.1.1 (pp 93), 300.1.1 (pp 93), 300.2.2 (pp 95), 300.4.5 (pp 98).

Use of Force: A use of force is defined as any incident in which a Member, either on or off duty, while performing a law enforcement function, overcomes resistance through the application of physical contact or any other force option.

Objectively Reasonable Force: Force that is proportionate to the threat presented by, or the need to lawfully control, a subject in a particular moment. The Threat or need would be perceived in that moment, and without benefit of hindsight.

when feasible, consider and utilize de-escalation techniques, crisis intervention tactics, and other alternatives to force that may persuade an individual to voluntarily comply or may mitigate the need to use a higher level of force to resolve the situation before applying force...

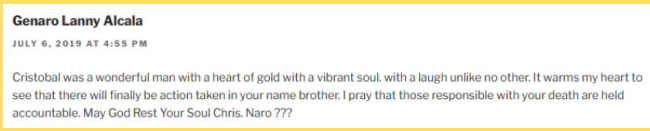
Members are not authorized to use any restraint, technique or transportation method that involves a substantial risk of positional asphyxia. "Positional asphyxia" means situating a person in a manner that reduces the ability to sustain adequate breathing. This includes, without limitation, the use of any physical restraint that causes a person's respiratory airway to be compressed or impairs the person's breathing or respiratory capacity, including any action in which pressure or body weight is unreasonably applied against a restrained person's neck, torso, or back, or positioning a restrained person without reasonable monitoring for signs of asphyxia (Government Code § 7286.5).

Cristobal Solano

In the case studies we examined that involve deputy violence, the word "uncooperative" frequently appears. In the case of Cristobal Solano, his alleged lack of cooperation led to an incident of deputy violence in which he lost his life. Solano was arrested and taken to IRC on April 30, 2018.[64] Deputies reported that he was cooperative for most of the search, but didn't open his mouth widely enough, and then covered his face with his hands when asked not to do so.[65] For certain custodial deaths, the OCDA releases security footage related to their investigation of the death of the person in custody. In footage of Solano's last moments, we see him hunched forward while sitting on a bench with his head in his hands.[66]

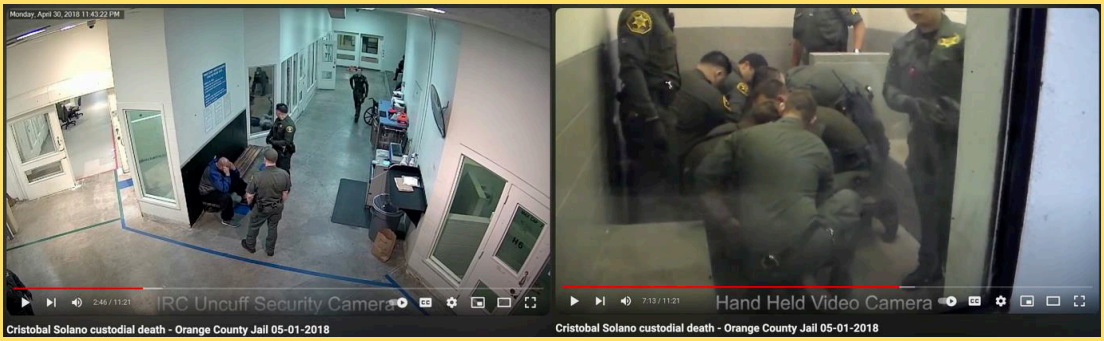
> Solano was released by OCSD Deputies Cody Eversgerd and Christian Higuchi for a search of his person prior to being placed into his holding cell. A pat-down for inmate and officer safety was conducted without incident. After the pat-down search, Solano was un-cuffed. Solano then became uncooperative during Deputy Eversgerd's search of Solan's mouth. Although Solano at first partially opened his mouth, but he refused to hopen his mouth wide as directed by Deputy Eversgerd several times. Solano covered his face when asked not to, and repeatedly ignored requests for cooperation. After numerous attempts, Deputy Eversgerd believed Solano had no intention of completing the search. Because jail procedures call for unsearched and/or uncooperative inmates to be placed in a cell alone for their safety, the safety of other inmates and jail staff, Deputy Eversgerd decided to place Solano in a cell by himself.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Cristobal Solano (OCDA Report)*, page 3.



R. Scott Moxley, *Lawsuit: Jail Deputies "Sadistically" Tortured and Killed Pretrial Inmate*, OC Weekly (Comments section, Apr. 5, 2019), https://www.ocweekly.com/orange-county-sheriff-jail-death.

61 Orange Cnty. Sheriff's Dep't, *Department Manual*, Policy § 300.1.1 (Oct. 6, 2020), https://www.ocsheriff.gov/sites/ocsd/files/2020-10/Department%20Manual%20%2020201006.pdf.
62 *Id.* § 300.2.2.
63 *Id.* § 300.4.5.
64 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Cristobal Solano (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/investigation-letters/Cristobal%20Solano%20custodial%20death%20investigation.pdf.
65 *Id.* at 3.
66 OrangeCountyDA, *Cristobal Solano Custodial Death — Orange County Jail (May 1, 2018)* (Dec. 11, 2018), https://www.youtube.com/watch?v=MEp8bltCy3s.



OrangeCountyDA, *Cristobal Solano Custodial Death — Orange County Jail (May 1, 2018)* (Dec. 11, 2018), https://www.youtube.com/watch?v=MEp8bItCy3s.

From this position, three deputies pulled him to his feet and pushed him towards a cell at which point the footage switches to a handheld camera with audio. Solano can be heard screaming in pain as several deputies pushed him into the cell and pinned him first on a bench and then on the ground. At one point there were nine officers in the cell with Solano and approximately six seemed to be kneeling or standing on him. It should be noted that this violates OCSD's own policy concerning positional asphyxiation which forbids "any action in which pressure or body weight is unreasonably applied against a restrained person's neck, torso, or back" (see above). OCSD officers claimed that Solano was resisting, and they can be heard in the footage telling him to stop resisting.

It is hard to see how Solano could have resisted, let alone posed a threat to, half a dozen men. Eventually Solano stopped screaming, but officers remained on and around him for several minutes before he was dragged out of the cell, unresponsive with a weak pulse.[67] Solano never regained consciousness, and when paramedics arrived had neither a pulse nor respiration.[68] By the time he arrived at the hospital, Solano was in full cardiac arrest and CAT scans showed a subarachnoid hemorrhage and a stroke.[69]

Despite this clear evidence of violent trauma, the medical examiner attributed Solano's death to methamphetamine use, framing it as accidental. His pre-existing health conditions were listed as explanatory factors, while the deputies' use of force went virtually unacknowledged.[70] This mirrors Sheriff Barnes's broader narrative that deaths in custody result from "life choices" rather than the violent conditions of confinement.

At approximately 11:43 p.m., five additional deputies responded to IRC in response to Solano's screams. The deputies surrounded Solano and tried to control him while a search was completed. Sgt. Frazee arrived at approximately 11:44 p.m. and, after observing Solano continue to resist and the deputies struggling to gain control, directed the deputies to move Solano into H-3 where he could be placed on the ground and searched for weapons and narcotics. During the struggle to get Solano into the cell, Solano was able to rip his arms and legs away from the assisting deputies numerous times. Solano thrashed and screamed "Help, please help" and deputies repeatedly told Solano to "stop resisting." Solano denied he was resisting.

At approximately 11:45 p.m., deputies took positions around Solano to lower him to the ground from a bench inside cell H-3 he had leaned on during the struggle. Deputy Johnson held Solano's head to ensure it would not impact the ground. Deputies Leland and Higuchi each placed a knee in the center/upper portion of Solano's back. Deputy Recinos placed his knee on Solano's right shoulder blade and Deputies Parker, Gouirand and Johnson had Solano's legs crossed with his feet bent toward his buttocks. Solano continued to resist, despite repeated requests by deputies.

When Solano arrived at OCGMC 10 minutes later, he was under full cardiac arrest asystolic.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Cristobal Solano (OCDA Report)*, page 3, 4.

67 OCDA Solano Report, *supra* at 4.
68 *Id.*
69 *Id.*
70 *Id.*

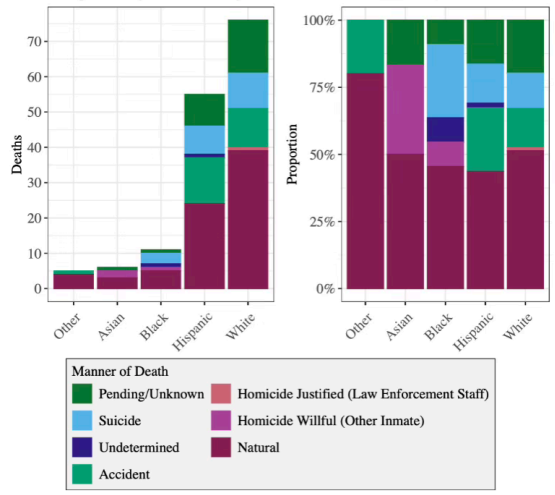
AUTOPSY
On May 9, 2018, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services performed Solano's autopsy. During the autopsy, Doctor Luzi found Solano displayed no signs of major, life- threatening injuries; there was no excess fluid in the pleural, pericardial, or peritoneal cavities, but the heart was enlarged. Doctor Luzi found the following pre-existing conditions: morbid obesity, cerebral edema, pulmonary congestion and edema, cardiomegaly, mild coronary atherosclerosis, and mild peripheral atherosclerosis. There were no outward signs of trauma. Examination of the micro slides revealed pulmonary congestion, pneumonia and cardiomegaly. Dr. Luzi concluded the cause of death was acute methamphetamine intoxication, and the manner of death was determined to be accidental.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Cristobal Solano (OCDA Report)*, page 4.

Being chronically ill or struggling with substance use disorder should never diminish the value of a person's life, nor serve as an excuse to overlook state violence. Regardless of Solano's health conditions, the record shows that he endured extreme and unnecessary force in his final moments. The screams captured on video are testament to the pain Solano experienced. That violence was not incidental — it appears to have been a decisive factor in his death, one that the official reports minimize or ignore.

Solano's case in particular highlights why we must scrutinize the official "Manner of Death" categories provided by OCDA. Solano's death was ruled a drug overdose and thus accidental without any mention of the multiple deputies putting their body weight on him while he lost consciousness. Words such as "natural" or "accidental" make deaths seem inevitable and unrelated to incarceration, obscuring the circumstances of deaths like Solano's.

Figure 13: Orange County Jail Deaths By Race and Manner of Death



Data visualization provided by Carceral Ecologies Lab.

Kirk Price

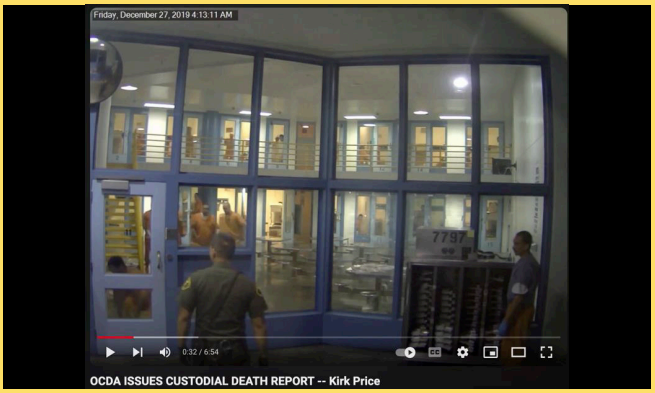
In addition to the regulations concerning how and when jail officials are allowed to use violence, deputies are also required to protect incarcerated people from violence they may face from other incarcerated people.

In January 2020, Kirk Price died due to injuries sustained from an incident where deputies failed to intervene when he was beaten by another incarcerated person. Price and another man ("Doe") had a history of conflict and Doe had repeatedly requested to be rehoused away from Price, even warning deputies that a fight would break out if he was not rehoused.[71] These messages were disregarded by deputies,[72] and on December 27, 2019, Doe attacked Price while they were both standing in line for meal distribution.[73]

71 Orange Cnty. Dist. *Att'y, Price-Kirk OCSD SA-20-001 Final Signed Letter* (July 31, 2023), https://orangecountyda.org/wp-content/uploads/2023/08/Price-Kirk-OCSD-SA-20-001-Final-Signed-Letter-7.31.2023.pdf.
72 *Id.* at 4-5.
73 *Id.* at 2.

Doe struck Price two times, causing Price to fall to the ground, at which point Doe continued to punch Price in the head at least 13 times.[74]

Video footage shows deputies watching the assault from the other side of a door and taking no action to intervene until after Doe had gotten off Price and moved away. Price was left paralyzed after the assault and died within a month from a blood clot in his lung.[75]



OrangeCountyDA, *Kirk Price Custodial Death — Orange County Jail (Dec 27, 2019)* (Aug. 31, 2023), https://www.youtube.com/watch?v=rbjDZJDYD8Y.

In his autopsy, Dr. Luzi stated that Price would not have died if not for his injuries from the assault and classified the death as a homicide.[76] Deputies have a duty to protect incarcerated people, and their failure to intervene constitutes a serious breach of that responsibility. The ignored housing requests from Doe show deputies were aware of a risk but did not act to prevent the attack. This neglect reveals systemic failures in responding to the threats made against an person under their care.

The deaths of Cristobal Solano and Kirk Price underscore that physical violence is ingrained in the carceral system. In both cases, policy violations likely occurred (Solano through positional asphyxiation and Price through deputies' failure to protect) but these incidents go beyond breaches of protocol. They reveal a system that reflexively labels incarcerated people as "uncooperative" or "resisting" to justify excessive force, while dismissing both the violence deputies inflict and the dangers incarcerated people report.

On September 17, 2020, Deputy Randall Lum told investigators that he worked in the Module where Price and Inmate Doe were housed, and was familiar with both of them. Deputy Lum recalled receiving two or three message slips from Inmate Doe asking to be rehoused. He believed the messages stated that Inmate Doe and Price were not getting along and that if they weren't housed separately, they were probably going to get in a fight.

On December 27, 2019 at 4:13 a.m., Price and Inmate Doe were standing in line for the morning meal distribution in Module J, Sector 11. Price reached for a food tray with his back to Inmate Doe. Inmate Doe struck Price in the back of the head two times causing Price to fall. As he was falling, Inmate Doe continued to punch Price in the face approximately four times. Price hit his head on the sector door feeding hatch and then fell back, hitting his head on the wall. While he was on the floor, Inmate Doe straddled Price and continued to punch him in the face 13 more times.

At 4:39 a.m., Price was transported to UCI Medical Center (UCIMC) where he was diagnosed with the following: mild contusion, loss of consciousness, left nasasl bone fracture, C4-C5 complete tear with traumatic disk injury, C5-C6 traumatic disk herniation and cord contusion, spinal cord injury, and T8-T9 mild spinal cord compression. Later that day, Price underwent cervical spine surgery. Price was later diagnosed with permanent paralysis.

pulmonary embolus, cardiomegaly, focal cardicac hemorrhage, and arteriolosclerosis. Dr. Luzi opined the cause of death was pumonary embous due to deep vein thrombosis and the manner of death was homicide. In a further telephonic statement, Dr. Luzi indicated that Price died because a blood clot traveled to his lungs. He further states that even considering Price's pre-existing conditions, this would not have happened if Price had not been paralyzed from the assault.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Kirk Price (OCDA Report)*, page 4, 2, 3, 5.

74 *Id.*
75 *Id.* at 3, 5.
76 *Id.* at 5.

Substance Abuse

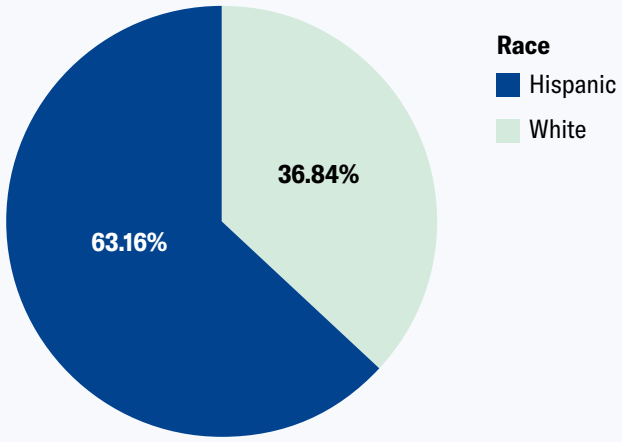
In 2023, drug overdoses were the single most common cause of death in the California Prison system.[77] While we do not have exact statistics for Orange County jails, we expect them to be comparable. To trace the reason for this massive proportion of in-custody deaths we must understand who is being incarcerated and why.

Substance Use Disorder (SUD) is a mental health disorder recognized in the DSM V[78] which affects approximately 5% of the US adult population.[79] Of those incarcerated in state prisons, 58% meet the diagnostic criteria, with that number rising to 63% in jails.[80] In other words, substance use disorder is nearly 13 times more prevalent among the jail population than the American population as a whole. Of those incarcerated in prisons, an additional 20% did not meet the diagnostic criteria for SUD but were under the influence of substances at the time of committing the crime they were convicted of.[81] A significant proportion of those incarcerated in both jails and prisons are charged or convicted of drug related offenses (1 in 5)[82], with 1 in 3 sentenced to state prison for committing a crime to obtain drugs or money for drugs.[83]

These statistics point to a criminalization of SUD and substance use more generally, a punitive response to a mental illness that requires a medical response. Risk factors for developing SUD include poverty, lack of access to housing, experiences of racial discrimination, and childhood abuse.[84] As such, those suffering from SUD are already more likely to come from disenfranchised and vulnerable communities. The over-representation of people suffering from SUD in the incarcerated population makes it abundantly clear that incarceration is being used as a response to a public health problem.

It should also be noted that this criminalization of SUD is not equally applied across communities. Black and Latine populations are disproportionately incarcerated for drug-related offenses in both state and federal prisons.[85] In Orange County, Latine people are massively overrepresented in in-custody overdose deaths. This is suggestive not only of the unequal criminalization of SUD in disadvantaged communities, but also of which incarcerated people are less likely to receive the mental health care they need. Here again, incarceration heightens and exacerbates existing trends of vulnerability and marginalization in our society.

Figure 6: Race of Drug Overdose Deaths in Orange County Jails (2015-2024)



Data visualization provided by Carceral Ecologies Lab.

77 California Corr. Health Care Servs., *Analysis of 2023 CCHCS Mortality Reviews* (2023), https://cchcs.ca.gov/wp-content/uploads/sites/60/Analysis-of-2023-CCHCS-Mortality-Reviews-ADA-Compliant.pdf.
78 Cleveland Clinic, *Drug Addiction (Substance Use Disorder)* (last reviewed Sept. 7, 2025), https://my.clevelandclinic.org/health/diseases/16652-drug-addiction-substance-use-disorder-sud.
79 U.S. Dep't of Justice, Bureau of Justice Statistics, *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (Jennifer Bronson & Jessica Stroop eds., June 2017, rev. Aug. 10, 2020), https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf.
80 *Id.*
81 National Institute on Drug Abuse, *Drug Use and the Criminal Justice System*, https://nida.nih.gov/publications/drugfacts/criminal-justice.
82 Prison Pol'y Initiative, *Mass Incarceration: The Whole Pie 2025*, https://www.prisonpolicy.org/reports/pie2025.html.
83 DrugAbuseStatistics.org, *Drug Related Crime Statistics* (2025), https://drugabusestatistics.org/drug-related-crime-statistics/.
84 Haw. Dep't of Health, Alcohol & Drug Abuse Division, *Risk Factors for Substance Abuse Prevention*, https://health.hawaii.gov/substance-abuse/prevention-treatment/prevention/risk-factors/.
85 Drug Pol'y All., *Drug War, Mass Incarceration, and Race: Fact Sheet* (June 2015), https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf.

Andrew Curcio

On June 15, 2021, Andrew Curcio was arrested for possession of drug paraphernalia.[86] During his booking he admitted to having used Fentanyl, Heroin, Klonopin, and Buprenorphine in the 12 to 48 hours preceding his arrest, and shared a diagnosis of schizoaffective disorder.[87] According to booking staff he was visibly under the influence of drugs at the time of his booking.[88] Although initially referred to mental health triage, he was subsequently cleared for booking and moved to Theo Lacy Facility shortly before noon the following day.[89] It does not appear that Curcio was provided any medical care to assist with detoxification or withdrawal symptoms.

Within an hour of his arrival at Theo Lacy Facility, Curcio was offered Fentanyl by another incarcerated person, which he consumed, and then laid down to sleep around 12:30 p.m.[90] The OCDA investigation reports that ten safety checks were conducted over the subsequent seven hours but notes that these are not considered "wellness checks."[91] Indeed, the last time Curcio was "observed alive" was 12:53 p.m. when his hand can be seen moving on a security camera.[92] This indicates that the safety checks did not involve any interaction with incarcerated people.

At 7:30 p.m., six and a half hours after Curcio was last seen alive, he did not report when called for a nurse visit.[93] At 8:06 p.m. a wellness check was conducted which discovered Curcio unresponsive and with rigor mortis setting in.[94] It should be noted that rigor mortis takes two to six hours to develop, suggesting Curcio had been dead long before his body was found.[95] The cause of death was ruled an acute Fentanyl overdose.[96]

OCSD failed Curcio. The mixture of substances in his system when he arrived were already a potentially deadly combination.[97] Not only was he not provided with treatment for withdrawal, but he was not placed on medical observation. The details of Curcio's booking show him to be in a vulnerable state at the time of his incarceration; he needed support, not a jail cell. Instead, Curcio was incarcerated for substance use charges, and died from substance use within 24 hours.

Juventino Ahuatlcabrera

In May of that same year, Juventino Ahuatlcabrera was arrested for violating probation on DUI and hit and run charges. The probation itself was due to DUI and hit and run charges from two years prior.[98] Two months later, at 1:21 a.m. on August 20, security cameras recorded him with a plastic bag full of a tinted liquid suspected to be pruno (an alcoholic beverage made using rudimentary fermentation by incarcerated people) and sharing it with another person.[99] At 2:42 a.m. and again at 3:05 a.m. he and another person snorted Subutex,[100] a narcotic used

86 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Andrew Curcio (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/2022/07/Curcio-OCSD-S.A.-21-2217-signed-Final-copy-1.pdf.
87 *Id.* at 2.
88 *Id.*
89 *Id.* at 2.
90 *Id.* at 3.
91 *Id.*
92 *Id.*
93 *Id.*
94 *Id.*
95 *Id.* at 7.
96 *Id.* at 4.
97 U.S. Food & Drug Admin., *Drug Safety Communication: FDA Warns About Serious Risks and Death When Combining Opioid Pain or Cough Medicines With Benzodiazepines; Requires Its Strongest Warning* (Aug. 31, 2016), https://www.fda.gov/media/99761/download.
98 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Juventino Gregorio Ahuatlcabrera (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/2023/01/Juventino-Gregorio-Ahuatlcabrera-SA-21-003129-Final-SIgned-Letter.pdf.
99 *Id.* at 3.
100 *Id.*

to treat opioid addiction.[101] The person from whom Ahuatlcabrera obtained Subutex was interviewed by OCDA for their investigation, and reports that he warned Ahuatlcabrera not to take too much as it was his first time trying the drug.[102]

CCTV footage shows Ahuatlcabrera was visibly unsteady while walking around until he got into bed a little after 4:00 a.m.[103] While safety checks were conducted, it was assumed he was sleeping and nobody went near him.[104] Shortly after 10:00 a.m., several incarcerated people tried to wake Ahuatlcabrera but he was unresponsive.[105] They called for help and deputies initiated life saving measures but Ahuatlcabrera never regained consciousness. He was pronounced dead at 11:10 a.m.[106] The autopsy declared Ahuatlcabrera's cause of death to be "community acquired pneumonia along with acute exacerbation of chronic alcohol abuse,"[107] but the legal analysis of the OCDA report says that the "only reasonable finding" is that he died "due to respiratory distress caused by the effects of Buprenorphine [Subutex] mixed with alcohol."[108]

Due to the difficulty of smuggling them in, substances available in carceral settings are typically compact and thus more potent.[109] Fentanyl, especially, is commonly smuggled into jails given it is cheap and potent, so only small amounts are needed.[110] Not only are the substances available in jails and prisons stronger, but decreased use while inside also impacts tolerance levels.[111] This is also seen in the high rates of overdose deaths shortly after release.[112] More potent substances alongside decreased tolerances mean incarcerated people struggling with SUD are more likely to accidentally overdose. For Ahuatlcabrera, it was exposure to an entirely new substance, for many incarcerated people it is the inability to know the potency of a substance or their own tolerance level which leads to an overdose. In both scenarios, the jail environment itself, by restricting access to safer, regulated substances, reducing tolerance through forced abstinence, and creating conditions where only the most potent drugs are circulated, directly increases the likelihood of fatal overdose.

The response to substance use in jails and prisons is typically punitive, focused on preventing substances from entering.[113] Yet these measures have consistently failed, and many drugs are in fact brought in by jail staff themselves.[114] By contrast, treatment programs are more effective in reducing overdose deaths, but they cannot eliminate the risk so long as incarceration itself remains the default response to substance use and mental illness. The combination of extremely potent substances, decreased tolerance from forced abstinence, fear of punishment for reporting overdose symptoms, and the severe physical and psychological stress of confinement makes jails and prisons uniquely lethal environments for people with substance use disorder. These deaths are not just the result of addiction; they happen because jail makes people more vulnerable and turns treatable health problems into deadly ones.

101 American Soc'y of Addiction Med., *Medication-Assisted Treatment (MAT) Program Overview* (Feb. 12, 2019), https://www.asam.org/docs/default-source/education-docs/mat-program-overview_2-12-2019239e2b9472bc604ca5b7ff000030b21a.pdf.
102 OCDA Ahuatlcabrera Report, *supra* at 5.
103 *Id.* at 3.
104 *Id.*
105 *Id.* at 4.
106 *Id.*
107 *Id.* at 5.
108 *Id.* at 9.
109 Beth Schwartzapfel & Jimmy Jenkins, *Inside the Nation's Overdose Crisis in Prisons and Jails*, The Marshall Project (July 15, 2021), https://www.themarshallproject.org/2021/07/15/inside-the-nation-s-overdose-crisis-in-prisons-and-jails.
110 E. Kaplowitz et al., *Fentanyl-Related Overdose During Incarceration: A Comprehensive Review, 108088 Drug Alcohol Depend.* (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7683355/.
111 *Id.*
112 Kaplowitz et al., *Fentanyl-Related Overdose During Incarceration*, *supra.*
113 Emily Widra, *Addicted to Punishment: Jails and Prisons Punish Drug Use Far More Than They Treat It*, Prison Pol'y Initiative (Jan. 30, 2024), https://www.prisonpolicy.org/blog/2024/01/30/punishing-drug-use/.
114 Beth Schwartzapfel, *Texas Prisons Stopped In-Person Visits and Limited Mail; Drugs Got In Anyway*, The Marshall Project (Mar. 29, 2021), https://www.themarshallproject.org/2021/03/29/texas-prisons-stopped-in-person-visits-and-limited-mail-drugs-got-in-anyway.

Compared to other states, California's use of Medically Assisted Treatment (MAT) in its Integrated Substance Use Disorder Treatment Program (ISUDT) is an effective harm reduction measure. [115] The efficacy of MAT compared to other treatment modalities has been well established in both carceral and non-carceral settings,[116] and we support its use and encourage its expansion. However, the rates of SUD in the incarcerated population and the high proportion of in-custody deaths due to substance use show that this issue cannot be fixed by in-custody treatment programs alone. Rather, we must ask why such a vulnerable population is so disproportionately incarcerated in the first place. These are not people dying, as Sheriff Barnes would say, due to irresponsible personal choices, but rather due to systemic societal failures. As long as SUD is criminalized, people will continue to die preventable deaths in custody.

115 California Corr. Health Care Servs., *Medication-Assisted Treatment in United States Jails and Prisons* (2023), https://cchcs.ca.gov/wp-content/uploads/sites/60/MAT-in-United-States-Jails-and-Prisons-Final.pdf.
116 *Id.*

Medical Neglect

Rates of chronic health conditions are significantly higher among the incarcerated population. According to the United States Department of Justice, it is estimated that 44% to 80% of incarcerated people suffer from chronic health conditions compared to 31% of non-incarcerated people.[117] Chronic conditions, which both cause poor quality of life and often lead to acute health problems, are difficult to manage while incarcerated. Most of the requests for assistance that ACLU SoCal receives from people incarcerated in OC Jails concern medical care. These requests include complaints of doctors dismissing symptoms, specialized care referral refusals, and incarcerated people being unable to see a doctor entirely. Incarcerated people have very little agency over their medical care and face discrimination from medical practitioners. These medical issues, along with limited access to healthy food, a high stress environment, and poor sanitation control exacerbate existing chronic illnesses and increase the chances of developing new ones. For example, incarcerated people are 1.5 times more likely to suffer from high blood pressure than the general population, but they often face obstacles when trying to access a healthier diet.[118]

Rates of asthma and tuberculosis are similarly higher among incarcerated populations (20.1% and 2.5% respectively in comparison to 11.4% and 0.4% in the general population).[119] Jails are poorly ventilated and incarcerated people have reported directly to ACLU SoCal that they are not permitted to wear face coverings in an attempt to shield themselves from airborne illnesses. As such, chronic health conditions are often exacerbated by the conditions of incarceration and lack of access to proper screenings, preventative care, lifestyle changes, and medical care more generally.

In both acute health crises and during chronic health deterioration, the lack of care endemic in the Correctional Healthcare System leads to people not getting the help they need in time for it to make a difference.

Patrick Russell

On January 24, 2016, a little over two weeks following his arrest, Patrick Russell died from an aortic tear,[120] also known as an aortic dissection. In the 24 hours leading up to his death he repeatedly sought help from medical services, but paramedics were not called until it was too late. Russell was first seen by CHS late on January 23. He was vomiting and hyperventilating. He was diagnosed with a panic attack. An hour and a half later he returned to medical services with chest pain and was sent to IRC for triage. When Russell arrived at IRC, he reported that he had vomited on the bus, was experiencing numbness in his hands and feet, and that his chest pain was radiating to his arm and jaw. He was given nitroglycerin, but his pain remained an "8-9 out of 10" and he had an elevated respiratory rate. Rather than send Russell to the hospital or run further tests, correctional health said the pain was due to muscle soreness and referred him to mental health.

> medical triage ward for a mental health assessment due to his anxiety. At approximately 1:08 a.m., Russell arrived at triage complaining of chest pain radiating to his arm and jaw. Russell informed medical staff that he vomited on the bus and was experiencing numbness in his hands and feet. The attending registered nurse administered Russell a dosage of nitroglycerin (NTG). Five minutesd after the NTG was administered, Russell complained his pain was 8-9 out of 10. The nurse palpated his chest and Russell's response was consistent with muscular pain. Russell continued to vomit, appeared anxious and was breathing rapidly. Vitals showed that Russell had an elevated respiratory rate of 26 breaths per minute. The attending physician was notificed of Russell's condition and referred him to mental health services.
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Patrick Russell (OCDA Report)*, page 2.

117 U.S. Dep't of Justice, Bureau of Justice Statistics, *Mortality in Local Jails, 2011–2012* (Dec. 2015), https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf; University of Pa., Upenn LDI, *The Flaws of U.S. Prisons and Jails Health Care System*, https://ldi.upenn.edu/our-work/research-updates/the-flaws-of-u-s-prisons-and-jails-health-care-system/.
118 ACLU SoCal, *Food Oppression in Orange County Jails Report* (2024), https://www.aclusocal.org/sites/default/files/field_documents/food-oppression-oc-jails-report.pdf.
119 U.S. Dep't of Justice, Bureau of Justice Statistics, *Mortality in Local Jails*, *supra.*
120 Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Patrick John Russell (OCDA Report)*, https://orangecountyda.org/wp-content/uploads/2024/12/Patrick-John-Russell.pdf.

At 2:00 a.m. on January 24, Russell was returned to his housing location, still complaining of pain and flu-like symptoms. He returned to medical services at 5:30 a.m. with chest pain which he now rated a 10/10. According to the OCDA's investigation, his vitals were "stable" and so he was again returned to his housing location shortly before 7:00 a.m. However, a wrongful death lawsuit filed by Russell's family states that he was tachycardic (unusually fast heart rate) and it is unclear why this was omitted from the OCDA report.[121]

At 10:20 a.m. he again returned to correctional health. His pain was still a 10/10, both his arms were numb, he was vomiting and dry heaving. It is unclear what his vitals were, or if they were even taken. It is also unclear why he was not taken to the hospital. Instead, Russell remained in the medical ward for two hours until he was seen "gasping for air" and soon became unresponsive. Russell never woke up and was declared dead at the hospital an hour later.

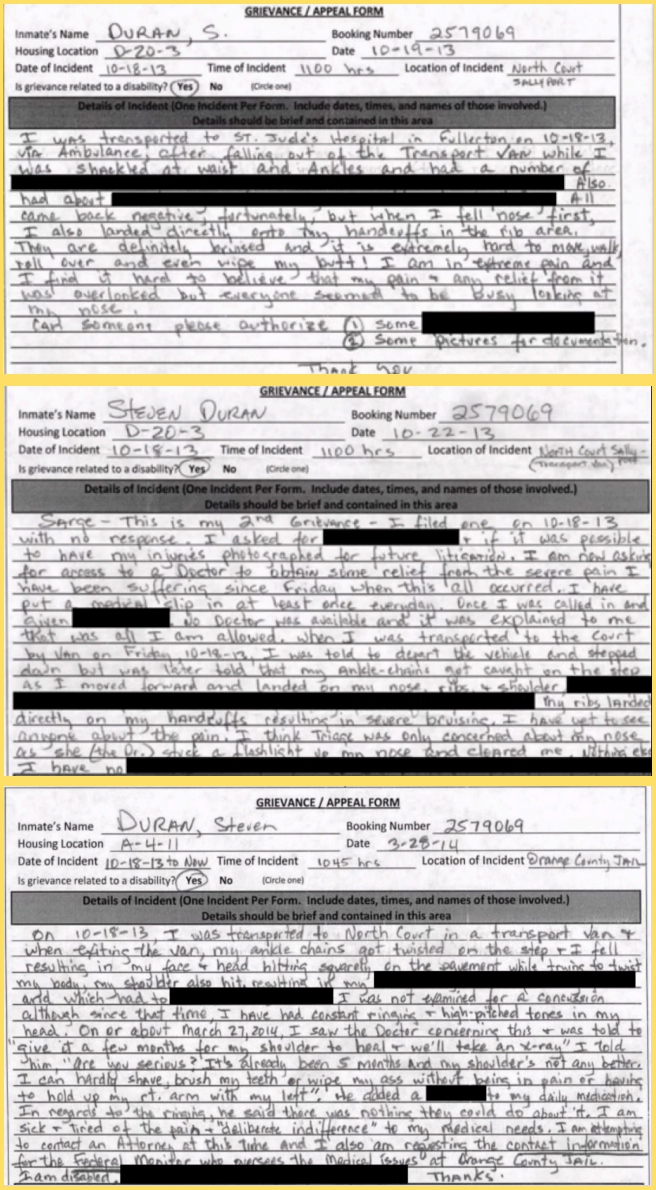
The autopsy, conducted by Dr. Scott Luzi, found Russell had died from a tear in the aorta, also known as an aortic dissection. The OCDA's own report admits that the nurses and doctor who treated Russell were "incorrect in their assessments" but states that this error did not rise to the level of criminal negligence. Russell's increasingly severe symptoms were repeatedly dismissed, leading to a serious delay in him receiving care. This medical neglect is emblematic of a system that does not take the pain and distress of incarcerated people seriously. Russell's medical emergency was not necessarily caused by his incarceration, but his inability to access medical care despite repeated attempts was.

> complaining of flu like symptoms. At approximately 5:32 a.m., Russell returned to the medical ward with chest pains assessed at a level 10/10. The on-call registered nurse check his vitals, which were stable...
>
> Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Patrick Russell (OCDA Report)*, page 2.

> Around 5:32 a.m., Russell returned to the medical ward complaining of severe chest pain. The severity of his pain was now a 10 out of 10, and he was hyperventilating. The First Amended Complaint states that at this point he was tachycardic (had a rapid heartbeat).
>
> *Russell v. Lumitap*, 31 F.4th 729 (9th Cir. 2022).

> At approximately 10:20 a.m., Russell returned to the medical ward where Deputy Joseph Martini was stationed and the Deputy escorted Russell to see the nurse. Russell complained that his chest pain was a 10/10 and that the pain was coming from his chest and down his throat and he had numbing in both arms. Russell denied any heart condition but indicated he had experienced high blood pressure after having surgery on his hand the previous year at Kaiser Hospital. Russell was dry heaving, forcefully coughing, and he vomited a moderate amount of liquid emesis. Russell indicated to the nurse that he felt better after vomiting, and continued to rest on the patient table inside the doctor's room. At approximately 11:40 a.m., Russell sat up to vomit and lay back down on the floor stating he still felt nauseated. Russell then returned to the patient's table. At approximately 12:20 p.m., the nurse was alerted by Russell's breathing and notified deputies of a "man down" inside the
>
> OCSD PRA Record Duran, 236, 238, 126.

121 *Russell v. Lumitap*, 31 F.4th 729 (9th Cir. 2022).



GRIEVANCE / APPEAL FORM

Inmate's Name DURAN, S. Booking Number 2579069
Housing Location D-20-3 Date 10-19-13
Date of Incident 10-18-13 Time of Incident 1100 hrs Location of Incident North Court Sally Port
Is grievance related to a disability? (Yes) No (Circle one)

Details of Incident (One Incident Per Form. Include dates, times, and names of those involved.)
Details should be brief and contained in this area

I was transported to St. Jude's Hospital in Fullerton on 10-18-13, via Ambulance, after falling out of the Transport Van while I was shackled at waist and Ankles and had a number of [redacted] Also had about [redacted] All came back negative, fortunately, but when I fell nose first, I also landed directly onto my handcuffs in the rib area. They are definitely bruised and it is extremely hard to move, roll over and even wipe my butt! I am in extreme pain and I find it hard to believe that my pain + any relief from it was overlooked but everyone seemed to be busy looking at my nose.
Can someone please authorize (1) some [redacted]
(2) Some pictures for documentation.
Thank you

GRIEVANCE / APPEAL FORM

Inmate's Name STEVEN DURAN Booking Number 2579069
Housing Location D-20-3 Date 10-22-13
Date of Incident 10-18-13 Time of Incident 1100 hrs Location of Incident North Court Sally Port (Transport Van)
Is grievance related to a disability? (Yes) No (Circle one)

Details of Incident (One Incident Per Form. Include dates, times, and names of those involved.)
Details should be brief and contained in this area

Sarge - This is my 2nd Grievance - I filed one on 10-18-13 with no response. I asked for [redacted] if it was possible to have my injuries photographed for future litigation. I am now asking for access to a Doctor to obtain some relief from the severe pain I have been suffering since Friday when this all occurred. I have put a medical slip in at least once everyday. Once I was called in and given [redacted] no Doctor was available and it was explained to me that was all I am allowed. When I was transported to the court by Van on Friday 10-18-13, I was told to depart the vehicle and stepped down but was later told that my ankle-chains got caught on the step as I moved forward and landed on my nose, ribs + shoulder [redacted] my ribs landed directly on my handcuffs resulting in severe bruising. I have yet to see anyone about the pain. I think Triage was only concerned about my nose, as she (the Dr.) stuck a flashlight up my nose and cleared me. Other than I have no [redacted]

GRIEVANCE / APPEAL FORM

Inmate's Name DURAN, Steven Booking Number 2579069
Housing Location A-4-11 Date 3-28-14
Date of Incident 10-18-13 to Now Time of Incident 1045 hrs Location of Incident Orange County Jail
Is grievance related to a disability? (Yes) No (Circle one)

Details of Incident (One Incident Per Form. Include dates, times, and names of those involved.)
Details should be brief and contained in this area

On 10-18-13, I was transported to North Court in a transport van + when exiting the van, my ankle chains got twisted on the step + I fell resulting in my face + head hitting squarely on the pavement while trying to twist my body, my shoulder also hit resulting in my [redacted] and which had to [redacted] I was not examined for a concussion although since that time, I have had constant ringing + high-pitched tones in my head. On or about March 27, 2014, I saw the Doctor concerning this + was told to "give it a few months for my shoulder to heal + we'll take an x-ray" I told him "Are you serious? It's already been 5 months and my shoulder's not any better. I can hardly shave, brush my teeth or wipe my ass without being in pain or having to hold up my rt. arm with my left". He added a [redacted] to my daily medication. In regards to the ringing, he said there was nothing they could do about it. I am sick + tired of the pain + "deliberate indifference" to my medical needs. I am attempting to contact an Attorney at this time and I also am requesting the contact information for the Federal Monitor who oversees the Medical issues at Orange County Jail. I am disabled. [redacted] Thanks.

OCSD PRA Record Duran, 236, 238, 126.

On Oct. 13, 2013, at 10:46 a.m., Duran was injured in a fall as he was exiting an OCSD transportation van at the North Justice Center in Fullerton. Duran injured his face and nose and was transported to the hospital by ambulance. Following the injury Duran complained of pain and tearing of his right shoulder rotator cuff. Duran filed numerous grievances in the jail requesting pain medication. On Dec. 15, 2014, Duran underwent shoulder surgery

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Steven Duran (OCDA Report)*, page 2

Steven Duran

The case of Steven Duran, who died on April 12, 2017, shows a longer pattern of medical neglect. On October 18, 2013, Duran fell while getting off an OCSD bus. He was handcuffed and unable to break his fall and sustained numerous injuries to his nose, shoulder, and ribs. Duran's file is replete with grievances and requests for medical care after this incident. He detailed severe pain and mobility constraints and reported he was triaged for his nose only, while the injuries to his ribs and shoulder were ignored.

In another grievance four months after the injury, he complained about continued ringing in his ears (he was never evaluated for a concussion), and lack of medical treatment for his shoulder injury which was still causing pain and poor mobility. Despite no improvement to his shoulder during those four months, a doctor told him to "give it a few more months to heal" before they would even take an x-ray. Duran continued to fight for treatment and pain management options by filing grievances and medical requests, until he finally underwent surgery for a rotator cuff tear in December 2014, over a year after the injury.

In 2015, Duran sued the Orange County Sheriff and Correctional Health Services for, among other things, medical indifference, malpractice, and neglect. He represented himself in court and lost the case, but his file nonetheless tells the story of a man desperately trying to access medical care — ranging from pain management to a heart healthy diet — as his health deteriorated behind bars. Duran's file is nearly 400 pages, the longest the ACLU SoCal has obtained. This is partly due to the length of his incarceration in OC jails, but also due to how much Duran advocated for himself.

One of the many obstacles to accessing healthcare while incarcerated is the amount of self-advocacy required. It takes several steps to even be seen by medical staff, let alone a specialist. The ACLU SoCal has received countless complaints from people whose concerns were dismissed by medical staff, just like Duran's. Ultimately, incarcerated people who are unable to advocate for themselves effectively—due to lack of knowledge about the system, language barriers, etc.—struggle to access even the most basic level of healthcare while incarcerated. As Duran's lawsuit and grievances show, even extensive self-advocacy is not always enough to receive adequate healthcare while incarcerated.

On June 18, 2015, Duran filed a civil suit in the OCSC naming the OCSD, OCSD Sheriff Sandra Hutchens, Correctional Health Services doctors, and others as defendants. Duran's lawsuit claimed general negligence in training, deliberate medical indifference, medical malpractice and neglect, along with physical and emotional pain and suffering related to the shoulder surgery and fall. Duran's lawsuit was ultimately dismissed with prejudice by OCSC Judge Linda Marks.

Orange Cnty. Dist. Att'y, *Custodial Death Investigation — Steven Duran (OCDA Report)*, page 2.

In November 2016, Duran was admitted to the hospital where he was diagnosed with stage IV liver cancer with bone metastases. After he lost his case against OCSD, Duran seems to have stopped filing grievances or inmate request slips. It is unclear what treatments he was offered or received, but his health steadily deteriorated as the cancer spread into his stomach, lungs, ribs, and spine, causing a fractured vertebrae which required surgery. Duran's condition was deemed terminal in early 2017 and he died in the hospital on April 12, 2017.

The deaths of Patrick Russell and Steven Duran highlight how medical neglect inside Orange County jails is not simply the result of individual mistakes, but a systemic failure that turns treatable or manageable conditions into fatal ones. Both men repeatedly sought care, yet their pain and worsening symptoms were minimized or ignored until it was too late. These cases show how incarceration itself heightens risk: chronic conditions are exacerbated by poor diet, inadequate screenings, and unsanitary environments, while acute emergencies are dismissed or minimized because of a culture that devalues the lives and suffering of incarcerated people. Far from being neutral spaces where people simply "happen" to die, jails cultivate the conditions that make death more likely: whether through untreated emergencies, neglected chronic illness, or barriers that prevent people from accessing basic medical care.

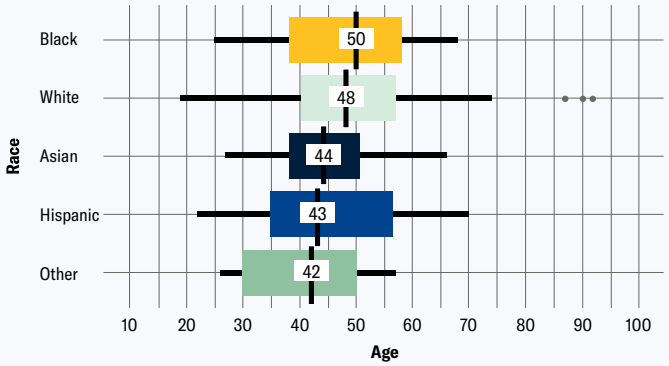
Conclusion

Throughout this report, we have detailed how Orange County Jails systematically puts people at risk. These failures range from inadequate triage and neglect of chronic and acute medical conditions, to lack of treatment for mental health disorders, to outright physical violence. Rather than argue for additional programs or safeguards, our analysis demonstrates that incarceration itself strips people of their humanity and dignity and, in the most extreme cases, their lives.

As shown by the graph to the right, there is no statistically significant difference between racial categories in age at death in the jails, but for all groups the median age at death is between 40 to 50. In the non-incarcerated population, average life expectancy is at least 70 years for Asian, Black, Hispanic, and white Americans.[122]

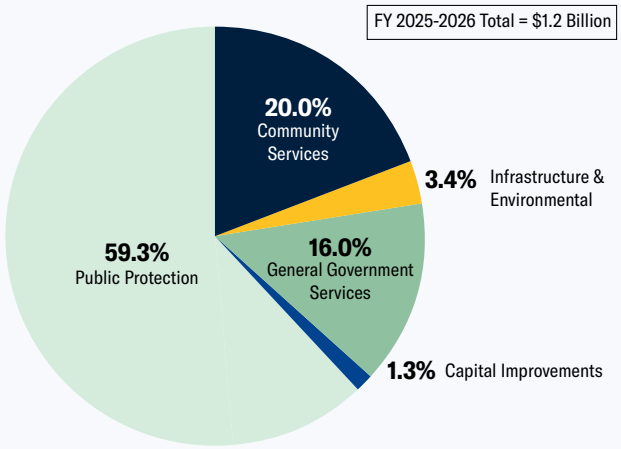
Throughout this report we have resisted Sheriff Barnes's contention that all those who die in custody would have died anyway. If the life expectancy for those incarcerated in Orange County Jails is at least 20 years lower than that of the general population then either incarceration causes premature death, or we are incarcerating the already sick and vulnerable. We believe both are true. We have shown how incarceration further victimizes the vulnerable. We have also shown how an endemic lack of care directly contributes to deaths through poor response times, and how the very features of incarceration itself can worsen mental and physical health.

Figure 7: Age at Death by Grouped Race in Orange County Jails (2010-2024)



Data visualization provided by Carceral Ecologies Lab.

Figure 8: General Fund Net County Cost (NCC) by Program



Orange Cnty. Bd. of Supervisors, FY 2025-26 Annual Budget Book (2025), https://bos.ocgov.com/finance/2026FN/ocbook_complete.pdf.

122 Kaiser Family Foundation, *What Is Driving Widening Racial Disparities in Life Expectancy?*, https://www.kff.org/racial-equity-and-health-policy/what-is-driving-widening-racial-disparities-in-life-expectancy/.

The persistence of these failures is not a result of insufficient resources but instead reflects how county assets are distributed. For FY 2025-26, over half of Orange County's General Purpose Revenue budget (the budget that the county has full discretionary control over) is allocated to "Public Protection" including the Sheriff's Department, the District Attorney, and the county jails while only 17% is allocated to community services. Almost half of the 17% allocated for "community services" is budgeted for healthcare in jail. The funding to provide robust social support in the community exists, but these services are not prioritized. Rather than invest in systems designed to assist vulnerable populations, the county continues to invest in incarceration.

Depopulation and diversion offer a more humane and effective alternative to the county's current overreliance on incarceration. Reducing jail populations lessens the risk of preventable deaths from overdose, medical neglect, suicide, and violence. This can be achieved through pretrial release, community-based treatment for substance use and mental health needs, and investment in supportive housing rather than jail expansion. Simply put, the most reliable way to prevent deaths in custody is to avoid placing vulnerable people in custody in the first place. By shifting resources away from incarceration and toward diversion programs and community services, Orange County could address underlying issues of poverty, addiction, and mental illness without subjecting people to the deadly conditions of jail.

Appendix

AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Southern California

July 14, 2022

Orange County Sheriff's Department
320 N. Flower Street
Santa Ana, CA 92703
ATTN: CPRA

Sent via email to prarequests@ocsheriff.gov

Re: California Public Records Act Request

Dear Orange County Sheriff's Department,

Pursuant to the California Public Records Act (hereinafter "CPRA") (California Government Code § 6250 et seq.), I am writing on behalf of the American Civil Liberties Union of Southern California to request information, policies, procedures, and documentation regarding internal processes for handling in-custody deaths at the Orange County Sheriff's Department.

In responding to this request, please note that the CPRA broadly defines the term "record." Specifically, the term includes "any writing containing information relating to the conduct of the people's business prepared, owned, used, or retained by any state or local agency regardless of physical form or characteristics."[1] The CPRA defines, in turn, a "writing" as any "means of recording upon any tangible thing any form of communication or representation."[2] The present request therefore applies to all paper documents, as well as to all emails, videos, audio recordings, text messages, or other electronic records within the Sheriff's possession or control.

Pursuant to the CPRA, we seek copies of the following records pertaining to the deaths of people incarcerated in the Central Men's Jail, Central Women's Jail, Santa Ana Jail, Theo Lacy Facility, James A. Musick Facility, Intake Release Center, or anywhere physically outside the jail facilities while still in the custody of the Orange County Sheriff's department, from January 1, 2010, through the date of this request, July 12, 2022:

[1] Gov't Code § 6252(e).
[2] *Id*. § 6252(g).

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(1) All discussions, findings, documentation, and reports included in any incarcerated person who died in custody's "death file", as described in OCSD Custody & Court Operations Manual, Section 2114.4(f);

(2) All "Casualty Reports" related to an in-custody death, as described in OCSD Custody & Court Operations Manual, Section 2114.4(k);

(3) All writings reflecting the policies, procedures, and protocols of the "initial review" conducted by OCSD and Correctional Health Services after every in-custody death, as required by Title 15 of the California Code of Regulations, Section 1046 and referenced in OCSD Custody & Court Operations Manual, Section 2114.6(a);

(4) All communications between OCSD and Correctional Health Services in conducting initial reviews of every in-custody death;

(5) All discussions, findings, and reports generated from or related to OCSD and Correctional Health Services' review of every in-custody death, including: (1) appropriateness of clinical care; (2) whether changes were made to the policies, procedures, or practices of the jail; and (3) any areas of concern that were identified and/or required further study or remedies;

(6) Any additional reports, findings, or documentation generated by the County's Risk Manager at the request of the death review team, per OCSD Custody & Court Operations Manual, Section 2114.6(a);

(7) Any communications or reports to the Orange County Board of Supervisors regarding any in-custody death; any communications or reports to the Orange County District Attorney's Office regarding any in-custody death.

The California Public Records Act requires a response within 10 days of your reception of this request. § 6253(c). If you deem that any portion of the records requested is not disclosable, you are required (1) to segregate and provide all information that is disclosable, § 6253(a), and (2) explain your reasons and provide legal support for denying our request in whole or part, § 6253(c). You are also required to assist us in obtaining the type of information we seek, and in "overcoming any practical basis for denying access to the records." § 6253.1. I am happy to assist you in providing the information we have requested. Please do not hesitate to contact me if you need any assistance or clarification.

Should you be inclined to decline our any part of our request, I would ask that you use your discretion to disclose more than the minimum that the CPRA requires. § 6253(e).

Please provide the names, titles or positions of every individual responsible for any denial of our request. Should any part of our request be denied, please also list any official from your agency (along with position or title) we may appeal to.

AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF SOUTHERN CALIFORNIA

I request that you waive any copying fees because the ACLU Foundation of Southern California is a non-profit civil rights organization and the information requested will be used to further the public's understanding of the Sheriff's internal processes regarding in-custody deaths. No part of the information obtained will be sold or distributed for profit.

I also request that you provide any public record identified above that exists in the following electronic formats to me in that electronic format, instead of in paper format: PDF format or all Microsoft Office formats, including Word, Excel, and PowerPoint. *See* California Government Code § 6253.9.

I look forward to working with you to obtain the public records we have requested and look forward to your response to this request within ten (10) days of receipt of this letter. See California Government Code § 6253(c). Please send all public records responsive to this request to my attention, either by mail or email:

Jacob Reisberg, Policy Counsel
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765 The City Drive, Suite 360
Orange, CA 92868
jreisberg@aclusocal.org
213-977-5262

Sincerely,

Jacob Reisberg
Policy Counsel
ACLU Foundation of Southern California