County of Orange

Independent Review of OCSD Custodial Death: Ronald Lucio

July 2025

Office of Independent Review
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EXECUTIVE SUMMARY

The Board of Supervisors, through County ordinance, has established the Office of Independent Review (OIR) to review specific incidents occurring in the Orange County Sheriff's Department (OCSD) which may identify systemic issues with regard to the performance and operations of the OCSD, and to provide a resource to ensure that high risk and potential liability issues are identified and addressed through corrective actions.[1] The OIR is authorized to investigate and review deaths and uses of force resulting in, or reasonably likely to result in, death or serious bodily injury in custody.[2]

Pursuant to the above-described authority, the OIR has begun to review all custodial deaths commencing in the year 2022. This report, and the conclusions and recommendations that it contains, relies on a review of both publicly available and confidential information.

On April 1, 2021, Ronald Lucio (Lucio) was arrested by officers from the Anaheim Police Department. He was booked into the Intake Release Center (IRC) on April 2, 2021.[3]

On March 18, 2022, Lucio was housed alone in the IRC, Module M, Sector 26, cell 3, a housing unit for incarcerated persons with mental health and medical issues. At 3:20 p.m., Lucio received an evening meal. After Lucio ate and drank, he sat on the lower bunk. Video surveillance last captured Lucio moving in his cell at 4:11 p.m.

Deputy 1 conducted safety checks of Lucio's cell at 4:34 p.m., 5:15 p.m., and 6:01 p.m. At 4:40 p.m., a nurse also approached Lucio's cell, leaned in, and glanced towards the cell for approximately half a second. At approximately 6:16 p.m., deputies completed a shift change. Deputy 2 conducted his first safety check of Lucio's cell at 6:47 p.m.

At approximately 7:11 p.m., Deputy 2 and a licensed vocational nurse (LVN) arrived at Lucio's cell to distribute Lucio's evening medication to him. Despite announcing their presence and knocking, Lucio did not respond. The LVN remarked to the deputy that he believed that Lucio had expired. The deputy went inside Lucio's cell for a wellness check and observed that Lucio was on the lower bunk lying on his right side facing the toilet. Lucio's feet were snow white, he was not breathing, there was vomited material around his mouth, and he appeared cyanotic.[4]

Lucio was removed from his cell and medical care was started. Paramedics were called and the Orange County Fire Authority (OCFA) arrived at 7:27 p.m. and took over treatment. The OCFA found Lucio pulseless, asystole, and apneic upon auscultation.[5] The paramedics also indicated that Lucio's "pupils

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[1] Section 1-2-225(b) and (c) of Codified Ordinances of Orange County.
[2] Section 1-2-226(e)(3) of Codified Ordinances of Orange County.
[3] Factual information contained in this report comes from verified information contained within the publicly available District Attorney letter ("DA letter") regarding Lucio's death, as well as other publicly available information.
[4] Cyanosis is a bluish or purplish discoloration due to deficient oxygenation of the blood. https://www.merriam-webster.com/dictionary/cyanotic
[5] Asystole is when the heart's electrical system fails, causing the heart to stop pumping. https://my.clevelandclinic.org/health/symptoms/22920-asystole. Apnea is defined as the cessation of respiratory airflow. https://emedicine.medscape.com/article/800032-overview. Auscultation is the assessment of airflow through the trachea-bronchial tree. https://pmc.ncbi.nlm.nih.gov/articles/PMC4518345/

were fixed and dilated" and that he was exhibiting the onset of rigor mortis.[6] OCFA personnel declared Lucio deceased at 7:30 p.m.

The Orange County District Attorney's (OCDA) Office investigated Lucio's death and issued a letter on November 16, 2023, finding that "there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Lucio." The District Attorney's determination was based in part, on an autopsy conducted by an independent forensic pathologist who determined that the cause of Lucio's death was choking. The manner of death was identified as accidental.

The OIR requested and received items related to Lucio's death from both the District Attorney and the OCSD. The OIR reviewed video, memoranda, records, and reports from the time that Lucio was at the IRC.

During its review, the OIR looked specifically to see if any OCSD personnel, actions, policies, procedures, training, or tactics may have contributed to Lucio's death. After a thorough review, the OIR found nothing that contradicts the findings of the independent forensic pathologist that Lucio's death was an accidental choking.

However, the OIR did make observations related to the thoroughness and effectiveness of the safety checks that were performed by deputies during the hours leading up to the discovery of Lucio in his cell. Additionally, based on the information reviewed by the OIR, it appears that Lucio may have been deceased for at least two hours prior to being discovered at 7:11 p.m.

DECEDENT INFORMATION

The decedent, Lucio, was a 38-year-old incarcerated male, booked into the IRC on April 2, 2021.

FACTUAL BACKGROUND

On April 1, 2021, Lucio was arrested by officers from the Anaheim Police Department for assault with a deadly weapon, firearm (Pen. Code, § 245(A)(2)), and willful discharge of firearm with gross negligence (Pen. Code, § 246.3(a)).

Following his arrest, Lucio was transported to the IRC and booked on April 2, 2021. Orange County Health Care Agency (OCHCA) personnel completed a medical and mental health pre-screening. OCHCA then referred Lucio for further assessment and temporarily placed him in a holding cell in the booking loop.

While in the cell, Lucio jumped off a four-foot privacy wall headfirst onto the concrete floor. Lucio sustained a head laceration and possible spinal injury. Lucio was taken to the hospital for medical treatment. On April 16, 2021, Lucio was evaluated by a psychiatrist and diagnosed with Schizophrenic Disorder and a history of alcohol abuse. Lucio was subsequently prescribed Depakote, Zoloft, and Zyprexa. On May 20, 2021, Lucio returned to the IRC and was housed in a unit for incarcerated persons with mental health and medical issues.

[6] Rigor mortis is the postmortem stiffening/rigidity of the body. https://www.ncbi.nlm.nih.gov/books/NBK539741/

On October 29, 2021, an Orange County Superior Court Judge ordered that Lucio undergo a mental health evaluation because he appeared to be suffering from depression, self-isolation, and disorientation.

On March 18, 2022, Lucio was housed alone in the IRC, Module M, Sector 26, cell 3, a housing unit for incarcerated persons with chronic mental or medical treatment needs. At 3:20 p.m., Lucio received an evening meal. After Lucio ate and drank, he sat on the lower bunk. Video surveillance last captured Lucio moving in his cell at 4:11 p.m.

Deputy 1 conducted safety checks of Lucio's cell at 4:34 p.m., 5:15 p.m., and 6:01 p.m. During the first two safety checks, the deputy walked adjacent to Lucio's cell, without stopping, while looking into the cell for approximately one second.

For the 6:01 p.m. safety check, the deputy did not walk adjacent to Lucio's cell like he did in his previous safety checks. Instead, the deputy looked at Lucio's cell for approximately one second, from a distance, while walking through the dayroom area with a table between himself and the cell. All three safety checks were logged as "all secure."

At 4:40 p.m., a nurse, walking from the right side of Lucio's cell, stopped short of Lucio's doorway and leaned over, on one leg, to look inside the cell. The entire visual check lasted for less than one second.

At approximately 6:16 p.m., deputies completed a shift change. Deputy 2 conducted his first safety check of Lucio's cell at 6:47 p.m. During that safety check, the deputy walked adjacent to Lucio's cell, without stopping, while looking into the cell for approximately one second.

At approximately 7:11 p.m., Deputy 2 and an LVN arrived at Lucio's cell to distribute Lucio's evening medication to him. The deputy observed Lucio on the lower bunk lying on his right side facing the toilet. Despite announcing their presence and knocking, Lucio did not respond. The LVN observed that Lucio's feet were white and remarked to the deputy that he believed that Lucio had expired. The deputy observed that Lucio's feet were very pale and went inside Lucio's cell for a wellness check. Lucio was not breathing. There was vomited material around his mouth, and he appeared cyanotic.

Deputy 2 made a "man down" call via radio. Additional deputies and medical staff arrived to assist. Deputy 2 and jail personnel moved Lucio out of the cell and into the dayroom. Medical personnel tried to feel for a pulse on his neck, and determined there was no pulse. Jail medical staff initiated Cardiopulmonary Resuscitation (CPR). Lucio was given two doses of Narcan nasally and three doses intravenously. An automated external defibrillator (AED) was connected to Lucio, but no shocks were advised or administered. Lucio was not responsive to any of the medical interventions.

Deputies called the paramedics and the OCFA arrived at 7:27 p.m. and assumed Lucio's medical care. OCFA found Lucio pulseless, in asystole, and not breathing. The paramedics also indicated that Lucio's "pupils were fixed and dilated" and that he was exhibiting the onset of rigor mortis. OCFA personnel declared Lucio deceased at 7:30 p.m.

On March 23, 2022, forensic pathologist Dr. Scott Luzi conducted an autopsy on the body of Lucio. The autopsy revealed evidence of choking. Specifically, Dr. Luzi noted food debris occluded the trachea, bronchi, and deep bronchial passages of both lungs. On July 28, 2022, Dr. Luzi issued an updated Coroner's Autopsy Report concerning Lucio concluding that the cause of death was choking, and the manner of death was accidental.

CUSTODIAL DEATH REVIEW

On March 18, 2022, the OCDA Special Assignments Unit (OCDASAU) Investigators responded to the IRC following Lucio's death in custody. During their investigation of Lucio's death, the OCDASAU interviewed 28 witnesses. They also gathered reports, incident scene photographs, and other relevant materials.

The OIR requested copies of the investigative material gathered and produced by OCDASAU Investigators. The DA's office provided redacted copies of reports, photographs, and audio files. The OIR also requested records, reports, and videos from the OCSD which were provided as well. The OIR reviewed all items provided as part of its process for preparing this report.

OCDA Custodial Death Investigation Report

On November 16, 2023, the OCDA issued a public letter summarizing its review of the custodial death of Lucio. While the letter's focus was on the legal analysis regarding whether OCSD members failed to perform a legal duty, it provided valuable insight into the overall investigation of this custodial death.

The DA's letter summarized its findings of facts beginning with Lucio's booking at the IRC on April 2, 2021. Eventually, Lucio was housed in a unit for incarcerated persons with chronic mental or medical treatment needs where he remained for the rest of his incarceration.

The DA's letter concluded that based on all the evidence provided and reviewed, there was no evidence to support a finding that any OCSD members failed to perform a legal duty causing the death of Lucio. The DA's letter included a determination that the evidence showed "that Lucio died as a result of an obstruction of his breathing passages by food particles and that the death was accidental."

Video

The OIR began its review by watching several videos related to the custodial death of Lucio from March 18, 2022. The videos began at approximately 3:20 p.m. and continued through Lucio being declared deceased by OCFA at 7:30 p.m. The videos consisted of fixed overhead jail surveillance and handheld video.

Fixed Overhead Surveillance Video

The first videos reviewed by the OIR consisted of fixed overhead jail surveillance footage in grayscale with no audio. The videos are from a camera with a wide-angle lens mounted high on a wall outside of Module M, Sector 26. A wall of windows separates the secure open common area on the ground level, known as the dayroom, from the outside hallway. The windows create a clear barrier allowing the camera to see the dayroom and cell doors inside of Sector 26. Sector 26 is a two-tier sector with cells on the lower and upper tiers. There are eight odd-numbered cells on the lower tier and eight even-numbered cells on the upper tier. There is a staircase inside Sector 26 on the right-hand side. The dayroom area has eight metal tables, and each table has four metal seats attached. There are three points of access into Sector 26. The first point of access is a door within the wall of windows that blocks off Sector 26 from a hallway. The two other points of access into Sector 26 are located on the bottom and top floor to the left of the camera. Deputies can be seen utilizing all three points of access at various times.

Lucio is housed in cell 3, on the ground level, left side, of Sector 26. When looking into cell 3 from the camera's vantage point, portions of the sink and toilet unit are partially visible along the back wall of the

cell. There is a table inside the cell with various items that are not clearly visible in the video. The bunks in the cell are out of view of the camera except for a small portion of the side edge of the upper bunk.

At 3:20 p.m., the video showed Lucio at his cell doorway, receiving a brown bag from a food cart. Lucio can then be seen standing at the table inside of his cell preparing something. Lucio then appeared to eat and drink from a cup.

At 3:24 p.m., the video showed Lucio staring outside of the cell, then turning around and walking to the back of his cell and then coming back to the doorway and staring out again.

At approximately 3:27 p.m., Lucio sat on the lower bunk, out of view from the camera. He did not appear to have anything in his hands when he sat down.

At 3:46 p.m., Deputy 3 walked adjacent to Lucio's cell, without stopping, while looking into the cell for approximately one second.

At approximately 4:10 p.m., the jail video surveillance system captured a portion of Lucio's head moving into view from the lower bunk area. This was followed by what appeared to be Lucio's left arm moving in and out of sight.

At approximately 4:11 p.m., the jail video surveillance system again captured Lucio's head move into camera view from the lower bunk area. It appeared that Lucio was looking downward towards the floor and then he moved back out of view towards the lower bunk. Within a few seconds, the same motion was repeated. These were the last recorded movements of Lucio in his cell.

At 4:34 p.m., Deputy 1 conducted a safety check of Lucio's cell that lasted approximately one second. Deputy 1 completed his entire bottom tier safety check in approximately 16 seconds. The video surveillance system captured the timing of the safety check as follows:

> At 4:34:14 p.m., Deputy 1 entered Sector 26.
>
> At 4:34:17 p.m., Deputy 1 walked past Lucio's cell without stopping.
>
> At 4:34:25 p.m., Deputy 1 completed his walk past cells 1 through 15 and headed for the exit.
>
> At 4:34:30 p.m., Deputy 1 exited Sector 26.

At 4:40 p.m., a nurse approached Lucio's cell, leaned in, and glanced towards the cell for less than one second. The video surveillance system captured the following:

> At 4:38:00 p.m., the nurse entered Sector 26.
>
> At 4:40:49 p.m., the nurse passed in front of cell 5.
>
> At 4:40:50.687 p.m., the nurse stopped short of Lucio's doorway (cell 3), leaned over on one leg, and looked inside Lucio's cell.
>
> At 4:40:51.487 p.m., the nurse turned away from Lucio's cell.
>
> At 4:40:52 p.m., the nurse passed in front of cell 5 heading towards cell 9.

At 5:15 p.m., Deputy 1 performed a safety check of Lucio's cell that lasted approximately one second. Deputy 1 conducted his safety check of the entire bottom tier in approximately 20 seconds. The video surveillance system captured the following:

At 5:14:59 p.m., Deputy 1 and Deputy 3 entered Sector 26.

At 5:15:14 p.m., Deputy 1 passed in front of cell 5.

At 5:15:15 p.m., Deputy 1 passed in front of cell 3.

At 5:15:16 p.m., Deputy 1 passed in front of cell 1.

At 5:15:19 p.m., Deputy 1 exited Sector 26.

At 6:01 p.m., Deputy 1 conducted a safety check of Lucio's cell that lasted approximately two seconds. While conducting the safety check, Deputy 1 passed in front of cell 3 from a distance with a table between him and the cell. Deputy 1 conducted his safety check of the entire bottom tier in approximately 24 seconds. The video surveillance system captured the following:

At 6:01:00 p.m., Deputy 1 and Deputy 3 entered Sector 26.

At 6:01:19 p.m., Deputy 1, from a distance and with a table between him and the cell, passed by the front of cell 3. As he walked by, Deputy 1 turned his head to the right in the direction of cell 3 and continued to walk towards the module exit.

At 6:01:21 p.m., Deputy 1 passed in front of cell 1 with his head still turned to the right.

At 6:01:24 p.m., Deputy 1 exited Sector 26.

At 6:47 p.m., Deputy 2 performed a safety check on Lucio's cell that took approximately one second. Deputy 2 conducted his safety check of the entire sector in approximately 57 seconds. The video surveillance system captured the following:

At 6:47:47 p.m., Deputy 2 entered Sector 26.

At 6:47:48 p.m., Deputy 2 passed in front of cell 1.

At 6:47:49 p.m., Deputy 2 walked past Lucio's cell (cell 3). As he walked, Deputy 2 turned his head in the direction of Lucio's cell and continued to walk without stopping.

At 6:48:07 p.m., Deputy 2 headed upstairs.

At 6:48:44 p.m., Deputy 2 exited Sector 26.

At 7:11 p.m., Deputy 2 and a nurse arrived at Lucio's cell. The nurse knocked on the exterior of the cell door multiple times. Deputy 2 unlocked the cell door.

At 7:12 p.m., Deputy 2 made entry into the cell alone. Deputy 2 touched Lucio then made a call on his radio, as he exited the cell. The nurse and Deputy 2 then both entered Lucio's cell.

At 7:14 p.m., additional deputies and medical personnel arrived. Jail personnel moved Lucio on his mattress from his bunk to the dayroom floor directly outside of his cell. Jail medical staff initiated CPR and used an Ambu-bag on Lucio.

At 7:27 p.m., OCFA paramedics arrived on scene and began treating Lucio. At 7:30 p.m., Lucio was declared deceased.

Handheld Video

The OIR reviewed three handheld videos. The videos depicted Lucio on a cell mattress outside cell 3. He was surrounded by 13 jail personnel.

The first video was recorded before paramedics arrived at the scene. The video showed medical personnel and a deputy administering CPR compressions for approximately 12 minutes and 41 seconds until the paramedics arrived. A nurse affixed an Ambu-bag to Lucio's mouth and provided him with oxygen every six seconds. Medical personnel administered Narcan to Lucio intranasally and intravenously. A nurse was instructed to dry Lucio's chest. The AED leads were connected to Lucio, but no shocks were advised throughout the video.

A dark colored liquid can be seen coming out of Lucio's mouth and nose while medical personnel administered CPR. Medical personnel turned Lucio on his side and wiped his face. A nurse checked Lucio's pulse on his neck and groin area. Three paramedics arrived and took over medical care of Lucio. They announced that Lucio was asystole and then checked Lucio's pupils, which were non-reactive and dilated. The paramedics also indicated that Lucio was not breathing. Shortly thereafter, they stopped all medical aid and declared Lucio deceased.

Reports

Coroner's Autopsy Report

On July 28, 2022, an updated Coroner's Autopsy Report was issued by Dr. Scott Luzi setting forth the autopsy findings, cause of death, and manner of death.

The report notes that the autopsy was conducted by Dr. Scott Luzi on March 23, 2022, at 8:03 a.m. During the autopsy, Dr. Luzi discovered that there was evidence of choking. Food debris was found occluding Lucio's trachea, bronchi, and deep bronchial passages of both lungs.

Dr. Luzi determined that the cause of death was choking, and the manner of death was found to be accidental.

Photographs

Copies of photos from the Orange County Crime Lab (OCCL) were also reviewed by the OIR. The photos were taken at the OCSD IRC, Module M, Sector 26, cell 3 and the surrounding area.

The photographs were taken after Lucio was removed from his cell. The photographs depicted a bluish-purple discoloration of Lucio's skin which was consistent with the onset of rigor mortis.

Two of the photographs depicted evidence of opened or unpackaged food in Lucio's cell. One of these photographs depicted an attached table with food and trash on it. The photos also showed a large plastic cup with brown residue, a plastic spoon with brown residue, an opened bag of Keefe Coffee mix,

an empty bag of Keefe Coffee mix, peanut butter packets, bread, a milk container, a mixed fruit jelly packet, soup, and an apple.

Logs

The OIR reviewed several OCSD safety check logs and activity logs related to the incident.

Safety Check Log

The safety check log for March 18, 2022, revealed the following information:

From 4:30 p.m. – 4:34 p.m., Deputy 1 completed a safety check of Mod M that was logged with the notation, "All secure."

From 5:15 p.m. – 5:17 p.m., Deputy 1 and Deputy 3 completed a safety check of Mod M that was logged with the notation, "All secure."

From 6:00 p.m. – 6:05 p.m., Deputy 1 and Deputy 3 completed a safety check of Mod M that was logged with the notation, "All secure."

From 6:45 p.m. – 6:50 p.m., Deputy 2 completed a safety check of Mod M that was logged with the notation, "All secure."

Activity Log

The activity log for March 18, 2022, indicates that there was a shift change at 6:16 p.m. and that there was a count of 104 incarcerated persons at this time. The log also documents that Deputy 2 began to pass out medication to incarcerated persons at 7:02 p.m.

Interviews

Redacted copies of audio interviews of witnesses, conducted by OCDASAU investigators were also reviewed by the OIR. The audio files contain interviews with involved deputies, jail medical personnel, OCFA medical personnel, incarcerated persons in Module M, and Lucio's relatives.

Interview of Deputy 2

Deputy 2 was interviewed on March 24, 2022, at 1:22 p.m. During this interview, Deputy 2 indicated that he began a safety check at approximately 6:45 p.m. on March 18, 2022. When asked about his observations of Lucio's cell during that safety check Deputy 2 indicated that he believed that "Lucio was sleeping in his bunk."[7] Deputy 2 noted that he did not remember what position Lucio was in, but he was satisfied that Lucio was "showing signs of life" as he walked by.[8]

Deputy 2 indicated that when he approached Lucio's cell at 7:11 p.m., the LVN stated "Lucio looked expired", so he opened and slammed Lucio's cell door. When Lucio didn't respond, Deputy 2 entered Lucio's cell and saw that "his face was a purplish [] color and it looked like there was some vomited material around his mouth. At that point in time it looked like the inmate was in distress."[9] Deputy 2 elaborated that it "did not look like he was breathing at the time."[10] Deputy 2 noted that "the nurse repeated that [Lucio] looked expired" and Deputy 2 made a "man down" call on the radio to seek

[7] Interview of Deputy 2, Pg. 8
[8] *Id.*
[9] *Id.*
[10] *Id.* at 15.

assistance."[11] Additional deputies and medical staff arrived, then jail personnel lifted Lucio on a mattress and pulled him out of the cell to receive medical treatment.

Interview of LVN1

LVN1 was interviewed on March 19, 2022, at approximately 12:15 a.m. During this interview, LVN1 indicated that when he and Deputy 2 approached Lucio's cell, he was preparing to distribute three medications to Lucio as part of the med pass. When they approached the cell, however, LVN1 observed that Lucio's "feet were like snow white" and he knew there was a problem.[12] LVN1 checked to see if Lucio was breathing, while Deputy 2 knocked on the door. LVN1 "did not see the rise and fall of [Lucio's] abdomen."[13] After entering the cell, LVN1 noted that Lucio was "blue, not breathing" and suggested initiating emergency response right away.[14] LVN1 indicated he was concerned that there was "no blood flow" to Lucio's lower extremities.[15] LVN1 stated that "I did not check for a pulse I just saw he wasn't breathing and his face cyanotic."[16] After additional deputies arrived and moved Lucio out of the cell, LVN1 indicated that he wiped Lucio's mouth and started bagging him.[17] LVN1 stated that the other medical personnel administered Narcan three times via injection and two times nasally.[18] LVN1 also stated that during life saving measures, Lucio never became responsive.[19]

Interview of Deputy 4

Deputy 4 was interviewed on March 24, 2022, at 2:01 p.m. Deputy 4 noted that he received the "man down" call and arrived within a couple of seconds. When Deputy 4 entered the cell, he observed that "the inmate was pretty blue so it's pretty apparent there's something going on."[20] Deputy 4 believed that this was an "obvious sign someone is not breathing."[21] Deputy 4 stated that he did not know if Lucio was deceased or not, so they got him out of the cell to do CPR.[22]

Deputy 4 stated that when he observed medical personnel administering CPR, he "saw kinda some vomit come out of his mouth…."[23] Deputy 4 further indicated that he "was looking around for if there's anything on his neck or anything but he had his shirt off. Shoes were off. I mean there was nothing obvious to me that it was anything like I don't know, I guess, like a suicide or something like that."[24]

When asked whether Lucio had any conditions that other deputies made him aware of, Deputy 4 indicated "pretty much all-day Lucio would sleep. He would sleep until you woke him up to do

[11] Interview of Deputy 2, Pg. 15-16
[12] Interview of LVN1, Pg. 7
[13] *Id.* at 11.
[14] *Id.*
[15] *Id.* at 12.
[16] *Id.* at 14.
[17] *Id.*
[18] *Id.* at 16-17.
[19] *Id.* at 17.
[20] Interview of Deputy 4, Pg. 7
[21] *Id.* at 12.
[22] *Id.*
[23] *Id.* at 14.
[24] *Id.* at 11.

something. And he would come out for dayroom every so often, not every day, maybe once or twice a week."[25]

Interview of Deputy 5

Deputy 5 was interviewed on March 24, 2022, at approximately 2:27 p.m. During the interview, Deputy 5 noted that he arrived at Lucio's cell after receiving the "man down" call. Deputy 5 noted that Lucio's face appeared blue and pale, and Lucio "didn't appear to be conscious or breathing. [Lucio] wasn't responsive."[26] Deputy 5 indicated that he put out the transmission for the paramedics as medical staff arrived at the cell.

Interview of RN2

RN2 was interviewed on March 18, 2022, at 11:48 p.m. During this interview, RN2 indicated that she went to Lucio's cell after hearing the "man down" call. RN2 entered the cell and "noticed that the patient was unresponsive. He was blue in color and in medical terms we call that cyanotic."[27] RN2 noted that she "knew that [Lucio] had no pulse and wasn't breathing."[28]

RN2 stated that after Lucio was moved out of his cell, she "checked his neck area for a pulse" multiple times.[29] She noted that "there was no indication of like ligature marks or injuries. I also did a femoral check for a pulse in the groin area. I did not get any pulses at all."[30] RN2 was the first to initiate CPR. RN2 stated that the AED was connected, but it indicated "no shock."[31] RN2 noted that Lucio was never responsive to the medication that they gave him and that while CPR was being given, she observed "some brown gastric contents coming out of his nose and mouth" that had to be wiped off several times. RN2 stated that "[f]rom what our observation is by the time they pulled him out, it, it was apparent that he may have been that way for some time. Uh, I'm not saying hours but it was… You know, just based on the color, it would [have] been minutes possibly that he was already like that."[32]

Interview of RN3

RN3 was interviewed on March 19, 2022, at 12:12 a.m. During this interview, RN3 stated that she went to Lucio's cell in response to a "man-down" call.[33] When RN3 arrived at the cell, Lucio was still in his cell. Deputies pulled Lucio out of his cell so that that CPR could be started. RN3 observed that Lucio was "blue in color."[34] According to RN3, Lucio was unresponsive, centrally cyanotic, and had no pulse. RN3 also indicated that during CPR a yellowish substance came out of Lucio's mouth.

Interview of RN4

RN4 was interviewed on March 19, 2022, at 12:02 a.m. During this interview, RN4 noted that she went to Lucio's cell in response to a "man down" call. When RN4 arrived at Lucio's cell, she observed that

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[25] *Id.* at 20
[26] Interview of Deputy 5, Pg. 7
[27] Interview of RN2, Pg. 6
[28] *Id.*
[29] *Id.* at 9.
[30] *Id.*
[31] *Id.* at 7.
[32] *Id.* at 9.
[33] Interview of RN3, Pg. 7-8
[34] *Id.* at 6.

Lucio was on the mattress on the lower bunk and that his "feet were awfully pale. He wasn't moving, not responding, or anything."[35] RN4 noted that Lucio's face was "totally blue."[36]

During her interview, RN4 indicated that as CPR was being administered, some gastric contents "started to come out and so we would stop and kind of turn him to the side so we wouldn't choke him."[37] RN4 went on to state that, based on her training and experience, the presence of gastric contents coming out would cause her to presume that the person is "probably well deceased at this point."[38]

Interview of RN5

RN5 was interviewed on March 19, 2022, at 12:22 a.m. RN5 was the last medical nurse to arrive on the scene. When she arrived, Lucio was on the mattress on the floor outside of his cell. When RN5 first observed Lucio, she was approximately 15 to 20 feet away and she noticed that he was unresponsive and "[p]ale. No respirations. No signs of life. No movement."[39] Another nurse was doing CPR. RN5 participated in providing three rounds of CPR prior to the paramedics arriving.

Interview of Paramedic

The OIR was also provided with a redacted copy of an interview with one of the paramedics who arrived on scene. The paramedic was interviewed on March 30, 2022, at approximately 9:24 a.m. In the interview the paramedic indicated that when he arrived, he saw OCSD custody personnel and jail medical staff on the dayroom floor adjacent to cell 3 actively performing chest compressions and ventilations on Lucio, who was lying in a supine position. The paramedic stated that OCFA staff conducted an initial assessment of Lucio and confirmed he was in cardiac arrest with no pulse and no respirations. Utilizing a heart monitor, asystole was also confirmed. Upon further examination, Lucio was found to be exhibiting obvious signs of death, which included cool, dry skin, no lung sounds, dilated/fixed pupils, and the presence of rigor. The paramedic observed vomit near Lucio's nose and mouth but noted no visible injuries. Because Lucio was pulseless, asystolic, apneic upon auscultation, and had no pupillary response, the paramedic and other OCFA medical staff felt the case met the criteria for pre-hospital determination of death.

The paramedic indicated in his interview that he was told that Lucio had last been seen alive and well between one and a half and two hours before they arrived.[40] The paramedic stated that Lucio's "pupils were fixed and dilated, which mean[t] that he was down for longer than an hour."[41] The paramedic also noted that Lucio had been exhibiting the onset of rigor. At approximately 7:30 p.m., all life-saving efforts were terminated, and the paramedic pronounced Lucio deceased.[42]

Interview of Relative 1

Relative 1 was interviewed on March 25, 2022, at 1:23 p.m. During this interview, Relative 1 indicated that she had visited Lucio on March 18, 2022, and that his eyes seemed a little glassy, but he was "talking cognit" to them. Relative 1 indicated that Lucio was upbeat, and they had discussed his upcoming court

[35] Interview of RN4, Pg. 7
[36] Interview of RN4, Pg. 8
[37] *Id.*
[38] *Id.*
[39] Interview of RN5. Pg. 2
[40] Interview of Paramedic, Time: 12:06
[41] *Id.*
[42] Interview Summary of Paramedic, Pg. 2-3

case and almost being out of jail. Relative 1 expressed her opinion that Lucio was overmedicated. Relative 1 noted that when she saw Lucio on March 11, 2022, he informed her that the medication he was taking was making him throw up.

Interview of Relative 1 and 2

On April 4, 2022, at approximately 1:20 p.m., both Relative 1 and 2 were interviewed. Relative 1 and 2 raised the issue of whether the District Attorney was investigating malpractice for the medications administered to Lucio or for overmedicating Lucio. Relative 1 expressed her belief that Lucio had choked on his vomit. Relative 1 indicated that on her visit with Lucio on March 11, 2022, he apologized for being 45 minutes late and indicated that he was late because he had just thrown up for the sixth time. Lucio went on to state that jail staff were giving him "a handful of medication now."

Relative 1 and Relative 2 noted that Lucio's eyes looked dilated, dry, and glassy when they visited him on March 18, 2022, but noted he was talking rationally. As part of the interview, Relative 1 and 2 provided a letter sent from Lucio to his kids before his death. In the letter, Lucio stated that "for most of the day, I do a lot of sleeping."[43]

Interview of Dr. Scott Luzi

On October 8, 2024, the OIR staff interviewed Dr. Scott Luzi, the independent forensic pathologist that conducted the post-mortem examination of Lucio. OIR staff and Dr. Luzi discussed three areas of interest: time of death, cause of death, and the manner of Lucio's death.

Time of Death

OIR staff asked Dr. Luzi to clarify how the 7:30 p.m. time of death, listed in the autopsy report, was established. According to Dr. Luzi the time of death in the autopsy report is the time that Lucio was declared deceased by the paramedics, which was also the time that medical personnel stopped attempting to resuscitate him.

Dr. Luzi indicated that he does try to identify livor, rigor, and algor mortis. The presence of these items, which really needs to be assessed when a body is found, can provide clues as to how long a person has been deceased.

Livor mortis is the settling of blood in the lowest-placed parts of the body. When livor mortis occurs, a bluish-purple discoloration appears in the areas of the body closest to the ground, due to the pooling of blood after circulation ceases. According to Dr. Luzi, livor mortis begins to develop within 30 minutes of death.

Livor mortis is then followed by blanching. Blanching is where the discoloration turns white when pressure is applied to areas of skin that are exhibiting livor mortis. According to Dr. Luzi, blanching can last a minimum of eight to twelve hours. After 12 hours, the discoloration becomes fixed and is no longer blanchable.

Dr. Luzi also indicated that rigor mortis, which is the stiffening of the joints and muscles of the body, sets in within two to four hours after death. Rigor mortis generally lasts up to two days before dissipating.

[43] Interview of Relative 1 and 2. Pg. 58

Dr. Luzi stated that because the autopsy in this case was completed five days after Lucio was declared deceased, the rigor mortis process would have completed by the time the autopsy was conducted.

Finally, Dr. Luzi indicated that algor mortis is a general cooling of the body temperature to the ambient temperature after death. Dr. Luzi stated that no liver or rectal temperature was taken by the coroner's investigator who responded to the scene.

Cause of Death

OIR staff also interviewed Dr. Luzi regarding Lucio's cause of death. Dr. Luzi indicated that at the time of Lucio's death, there did not appear to be anything other than food debris blocking Lucio's airway. The food debris, which was consistent with the food in his stomach, caused Lucio to choke. Dr. Luzi indicated that at the time of the autopsy, Lucio's airway was still blocked.

Manner of Death

The OIR staff asked Dr. Luzi about Lucio's manner of death. Dr. Luzi indicated that choking is almost always accidental and that he did not find anything that would cause Lucio's choking to be classified as undetermined or otherwise. Dr. Luzi also indicated that while he determines cause of death, the Orange County Coroner's Office makes the final determination as to the manner of death.

ANALYSIS

Time of Death

The OCDA's office investigated Lucio's death by interviewing witnesses and reviewing evidence. After reviewing the investigation, the OIR was left with questions regarding when Lucio actually died.

Obvious signs of medical distress

When Lucio was observed in his cell at 7:11 p.m., it appears that he was already showing signs indicating that he was deceased. Deputy 2 stated that Lucio was nonresponsive to verbal announcements and physical contact, and "his face was a purplish color…"[44] LVN1 stated that Lucio's feet were "snow white," his face appeared blue, and he was not breathing. RN4 indicated that upon arriving at Lucio's cell, his face was "just totally blue."[45] RN2 stated that when she arrived at Lucio's cell that "[h]e was blue in color…", and that "from what our observation is by the time they pulled him out, it, it was apparent that he may have been that way for some time. Uh, I'm not saying hours but it was… You know, just based on the color."[46] Given that many of the responding persons identified that Lucio was blue, it is most likely that lividity had begun at least 30 minutes prior to Deputy 2 and LVN1 discovering Lucio in his cell at 7:11 p.m.

Once Lucio was removed his cell, an AED was connected to Lucio, but no shocks were advised or administered. Lucio had no pulse and was unresponsive to all life saving measures. Both RN2 and RN4 noted in their interviews that gastric contents started to come out during CPR.[47] When asked what it

[44] Interview of Deputy 2, Pgs. 5-6.
[45] Interview of RN4, Pg. 6
[46] Interview of RN2, Pg. 9
[47] Interview of RN2, Pg. 9, Interview of RN4, Pg. 8

meant that gastric contents were coming out, RN4 responded that "if they're letting things go, or those muscles are relaxing, I usually presume that they're, they're probably well deceased at this point."[48]

When Lucio was pronounced deceased by OCFA paramedics at 7:30 p.m., the paramedics noted the onset of rigor. Rigor mortis generally takes approximately 2 hours after death to appear.[49] This would place Lucio's actual time of death sometime around, or before, 5:30 p.m.

Deficiencies Related to Time of Death

In conducting this review, the OIR observed that some additional information could have been obtained which may have led to a more accurate assessment of Lucio's time of death.

No Core Body Temperature

The first example relates to algor mortis, or the gradual cooling of a body after death.

Lucio's body temperature at the time he was declared deceased may have helped shed light on his actual time of death. "A rule of thumb states that there is a decrease of 1.5 degrees F every hour"[50] after death. Taking the core temperature of a body and comparing it to the ambient temperature of the area can, after considering other factors, give some indication of the time since death.

Unfortunately, no core temperature was obtained from Lucio. As a result, this method of obtaining an indication of time since death was not an option.

Recommendation

When the Orange County Sheriff-Coroner responds to the death of an incarcerated person in a county jail, the investigator should obtain the decedent's core temperature prior to transporting the decedent.

Missing Staff Interviews

The second area where relevant time of death information could have been obtained relates to interviewing jail personnel on duty during the shift prior to his discovery at 7:11 p.m. An interview of Deputy 1 was not provided to the OIR, and it appears that he may not have been interviewed. Deputy 1 conducted Lucio's safety checks at 4:34 p.m., 5:15 p.m., and 6:01 p.m. The observations of Deputy 1 could have helped determine whether Lucio was alive and well during his safety checks. Similarly, the OIR did not receive an interview from the nurse who was observed on video glancing briefly into Lucio's cell at 4:40 p.m.

Based on the information reviewed, it is highly likely that Lucio was deceased at 7:11 p.m. when he was discovered during medication pass. It is problematic that neither the OCSD nor the OCDA appear to have conducted interviews of Deputy 1 or the nurse who glanced into Lucio's cell at 4:40 p.m. to gain more information about Lucio's condition prior to 7:11 p.m. Since there was no interview of Deputy 1, no information was provided to indicate whether Lucio was alive and well during these safety checks.

These witnesses, if interviewed, could have provided some information as to whether Lucio was awake in his bed, whether he was moving when observed, or whether he was in the exact same position each

[48] Interview of RN4, Pg. 8
[49] Shrestha R, Kanchan T, Krishan K. Methods of Estimation of Time Since Death. [Updated 2023 May 30]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK549867/
[50] *Id.*

time a safety check was performed. Deputy 2 was the only deputy who was interviewed about the safety checks that he performed on the day of Lucio's death. However, he only entered the module for the 6:45 p.m. safety check.

Recommendation

When an incarcerated person dies in custody, interview all deputies and staff who conducted checks or had contact with the person since the person's last recorded movement was captured on video.

Delayed Interviews

Relevant information related to Lucio's time of death also may have been obtained by interviewing all witnesses while the information was still fresh in their minds.

The OIR's review of witness interviews indicated that five nurses who responded to the man down call were interviewed within approximately five hours of Lucio being declared deceased. However, three of the involved deputies were not interviewed until six days after Lucio died.

While the incident involving Lucio occurred on the evening of March 18th, Deputy 2 was not interviewed until March 24th. When asked about his observations of Lucio's cell during the 6:45 p.m. safety check, Deputy 2 indicated that he "believe[d] that, uh, inmate LUCIO was sleeping in his bunk." However, Deputy 2 could not remember what position Lucio was in during the interview conducted six days after the incident. Lucio's position on his bunk, when compared to earlier security checks, could have shed light on whether he was alive during those checks.

After a death in custody, deputies should be interviewed as soon as possible to ensure that information related to their contact with the incarcerated person is memorialized while it is fresh in their minds.

Recommendation

When an incarcerated person dies in custody, all deputies who conducted checks or had contact with the person since the person's last recorded movement captured on video, should be interviewed prior to concluding their shift. Deputies who concluded their shift prior to the discovery of the decedent should be contacted and interviewed as soon as reasonably possible.

Missing Follow Up Questions

Finally, additional information related to Lucio's time of death could have been developed through a more thorough interview of Deputy 2. When Deputy 2 described his first safety check of Lucio's cell at 6:47 p.m., he indicated that he believed "Lucio was sleeping in his bunk."[51] Deputy 2 noted that he did not remember what position Lucio was in, but he was satisfied that Lucio was "showing signs of life" as Deputy 2 walked by.[52] Deputy 2 was not asked any follow up questions to clarify what specific signs of life he observed during his 6:47 p.m. safety check. Nor did Deputy 2 elaborate on what caused him to believe that Lucio was sleeping rather than deceased at 6:47 p.m.

When the interview eventually focused on Deputy 2 entering Lucio's cell during the 7:11 p.m. medication pass, Deputy 2 indicated that for either a safety check or medication pass he would observe the "rise and fall of the chest." Deputy 2 also noted that Lucio was usually sleeping in his bunk, so Deputy 2 would look for movement of Lucio's feet or slight movements of the blanket. Unfortunately, after Deputy 2

[51] Interview of Deputy 2, Pg. 8
[52] *Id.*

described these criteria related to the 7:11 p.m. medication pass, he was not asked whether he observed any of these signs during his 6:47 p.m. safety check. As a result, the OIR is unable to determine whether Deputy 2 observed any signs of life during his 6:47 p.m. safety check.

Ultimately, if Lucio was deceased prior to being discovered during medication pass, additional statements from OCSD staff and deputies could have provided further insight into his actual time of death.

Quality of Safety Checks

California Code of Regulations §1027.5 sets forth requirements for safety checks in local detention facilities. CCR §1027.5 requires that safety checks "be conducted at least hourly through direct visual observation of all inmates."[53]

On July 26, 2021, the Ninth Circuit Court of Appeals held that "pre-trial detainees do have a right to direct-view safety checks sufficient to determine whether their presentation indicates the need for medical treatment."[54] The Ninth Circuit indicated that "law enforcement and prison personnel should heed this warning because the recognition of this constitutional right will protect future detainees."[55]

To further support their analysis, the Ninth Circuit cited to a District Court case describing the purpose of safety checks.[56] In that case, the District Court noted that safety checks are designed to ensure that incarcerated persons are alive-and-well and to determine whether they need any medical treatment.[57] The District Court went on to indicate that failure to perform proper safety checks increased an incarcerated person's risk of harm and could threaten their health or at the very least delay medical assistance and emergency response.[58]

At the time of the incident, the OCSD Custody and Court Operations Manual (CCOM) set forth the requirements for jail safety checks. The CCOM indicated that "[t]he purpose of conducting safety checks is to maintain the safety and health of inmates and the security of our facilities."[59] In the second quarter of 2023, the OCSD created Policy 902 Inmate Safety Checks. Policy 902 updated and replaced CCOM §1716 Safety Checks. As part of this policy change, the OCSD's safety check language was updated to articulate that "[t]he purpose of conducting inmate safety checks is to ensure there are no inmates displaying any obvious signs of distress requiring assistance, maintaining the safety and welfare of each inmate and ensuring the security of our facilities."[60]

Timeliness of Security Checks

Both the CCOM and Policy 902 provide that staff will conduct timely, thorough safety checks.[61]

Training materials in effect at the time of Lucio's death stated that safety checks must be done at least hourly through direct visual observation. Safety check/security rounds training provided to the OIR

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[53] 15 CCR 1027.5 (2021)
[54] *Gordon v. Cty. of Orange* (9th Cir. 2021) 6 F.4th 961, 973
[55] *Id.*
[56] *Gordon v. Cty. of Orange* (9th Cir. 2021) 6 F.4th 961, 972, fn. 6
[57] *Medina v. County of L.A.*, 2020 U.S. Dist. LEXIS 130732, *44
[58] *Id.*
[59] CCOM 1716.1 (October 21, 2021)
[60] Policy 902 – Inmate Safety Checks
[61] CCOM 1716.2 (October 21, 2021)

included a slide with a list of "things to look for" during a safety check. The list included, among other items, damage to property, signs of fights, and bizarre behavior of inmates. Noticeably absent from the training material and the CCOM, however, was any mention of "signs of life", or "signs of medical distress."

Policy 902 now requires that safety checks occur within 45 minutes of the previous safety check. The policy also now contains specific language mandating that deputies "check for obvious signs of life" and gives examples of what qualifies as a sign of life.

Lucio was in a cell with limited visibility from OCSD's overhead video surveillance. He was last seen on overhead surveillance footage moving in his cell at 4:11 p.m.

Deputy 1 can be seen conducting security checks at 4:34, 5:15, and 6:01 p.m. Deputy 2 can be seen conducting a safety check of Lucio's cell after shift change, at 6:47 p.m. All four security checks were considered to be within policy.

Thoroughness of Safety Checks

Video surveillance of Deputy 1's 4:34 p.m. safety check showed Deputy 1 performing the entire bottom tier sector safety check in 15 seconds. During this safety check, Deputy 1 walked by the cells, without stopping, and was only able to view Lucio's cell for approximately 2 seconds. This safety check was logged with the notation, "All secure."

Deputy 1 conducted the entire 5:15 p.m. bottom tier safety check in approximately 20 seconds. During this safety check, Deputy 1 walked by the cells briskly, without stopping, and was only able to view Lucio's cell for approximately 1 second. This safety check was also logged with the notation, "All secure."

Deputy 1 conducted his final safety check at 6:01 p.m. Video surveillance showed Deputy 1 performing the entire bottom tier sector safety check in 24 seconds. Deputy 1 conducted this safety check by passing in front of Lucio's cell from a distance, with a table and pathway between him and Lucio's cell. Deputy 1 was only able to view Lucio's cell for approximately 2 seconds and did not stop as he passed Lucio's cell. This safety check was also logged as, "All secure."

According to the CCOM, "safety checks must be conducted from a location which provides a clear, direct view of each inmate. *Staff shall be close enough to each inmate to ascertain their presence and apparent physical condition."*[62]

Deputy 1's 6:01 p.m. safety check could not reasonably have provided enough information to properly assess Lucio's physical and psychological condition. Deputy 1's position on the other side of a table did not provide a close enough vantage point to ascertain Lucio's condition. It was certainly possible to ascertain the physical condition of the incarcerated persons in cells 11 and 13 from Deputy 1's vantage point because those incarcerated persons were up and moving in their cells. However, when an incarcerated person is lying down in their cell, rather than standing or sitting, the visibility and assessment of their condition are inherently more challenging. Lucio was not up and moving about his cell. Instead, he was lying in the lower bunk which would have made it difficult for Deputy 1 to ascertain

[62] *Id.* (Emphasis added)

Lucio's physical condition without being closer to his cell and stopping to determine whether he needed medical assistance.

Recommendation

Provide additional training to deputies to remind them of Policy 902.4's requirement that they "be close enough to each inmate to ascertain their …. apparent physical condition."

A shift change occurred at 6:16 p.m. Deputy 2 conducted the next safety check of Lucio's cell at 6:47 p.m. Video surveillance showed Deputy 2 performing the entire bottom and top tier sector safety check in 59 seconds. During this safety check, Deputy 2 walked by Lucio's cell swiftly, without stopping, and was only able to view Lucio's cell for approximately 1 second. This safety check was logged with the notation, "All secure."

Six days after Lucio passed away, Deputy 2 was interviewed about the safety check that he conducted on the day of Lucio's death. When asked about his observations of Lucio during the safety check, Deputy 2 indicated that he believed that "Lucio was sleeping in his bunk."[63] Deputy 2 noted that he did not remember what position Lucio was in, but he was satisfied that Lucio was "showing signs of life" as he walked by.[64] Deputy 2 was not asked what signs of life Lucio was showing during this safety check nor did he elaborate on what caused him to believe that Lucio was sleeping rather than deceased at 6:47 p.m.

Effective monitoring of incarcerated persons is crucial to prevent self-harm, injury, or other safety issues. Situations where an incarcerated person is unconscious require more than a cursory glance in order to determine whether the person is merely sleeping, or in medical distress. Deputies did not stop in front of Lucio's cell during any of the four safety checks conducted between 4:34 p.m. and 6:47 p.m. Given that Lucio was laying in the lower bunk, it would have been difficult for deputies to ascertain Lucio's physical condition by only looking in the direction of his cell for 1 to 2 seconds while passing by.

Policy 902 updated and replaced CCOM §1716 Safety Checks. It now provides that "[f]or an inmate who is sleeping or appears to be sleeping, deputies will check for obvious signs of trauma or distress as well as obvious signs of life." While this new policy is certainly an improvement over the previous CCOM, the OIR believes that it is important to unequivocally state that a deputy must actually stop in front of a cell where they believe an incarcerated person is sleeping.

Recommendation

Update Policy 902 to require that, when a deputy encounters an incarcerated person that they believe to be sleeping, the deputy must actually stop in front of the cell and monitor the person until such time as the deputy observes obvious signs of life or the deputy determines, after observing the person's presentation, that they do not need medical treatment.

OBSERVATION

Technology

The provision of medical care for incarcerated persons is one of the most important obligations imposed on the Sheriff in his role as keeper of the jails. Courts have now identified "a detainee's right to direct-

[63] Interview of Deputy 2, Pg. 8
[64] Interview of Deputy 2, Pg. 8

view safety checks sufficient to determine whether their presentation indicates the need for medical treatment."[65] However, direct-view safety checks are not infallible, especially when an incarcerated person appears to be sleeping.

Today, there is wellness monitoring technology that may be able to assist the OCSD in ensuring that incarcerated persons are not in need of emergency medical treatment. Instead of wearables, at least three companies are now producing ceiling mounted life detection devices that use radar and other sensors to provide real time monitoring of incarcerated persons.[66] According to the literature available, these sensors can monitor health related items such as a person's temperature, heart rate, respiration, movement, and physical location.

The OIR believes that deployment of this type of technology in high-risk cells may increase the OCSD's ability to identify incarcerated persons who develop an immediate need for medical treatment. At the very least, it is worth the time and effort to thoroughly evaluate the viability of this type of technology.

Recommendation:
Conduct a study on the viability of life detection devices and the feasibility of installing them in cells that typically house incarcerated persons with increased medical needs, suicide concerns, or who are undergoing detoxification.

CONCLUSION

During this review, the OIR looked specifically to see if any OCSD personnel, actions, policies, procedures, training, or tactics may have contributed to Lucio's death. After a thorough review, the OIR found nothing that contradicts the findings of the independent forensic pathologist that Lucio's death was an accidental choking.

However, the OIR does have concerns related to the thoroughness and effectiveness of the safety checks that were performed by deputies during the hours leading up to the discovery of Lucio in his cell. These concerns are further compounded by the lack of interviews of any personnel who could say whether Lucio was alive when they observed him. Ultimately, these factors when combined with other indicators related to the actual time of death, lead to the conclusion that Lucio may have been deceased for at least two hours prior to being discovered at 7:11 p.m.

Since Lucio's passing, the OCSD has made significant changes to its Inmate Safety Check policy. However, there is room to improve upon the OCSD's good work. As such, the OIR has made several recommendations. Some of the recommendations, directed to the OCSD, are made to ensure that safety checks are performed in a way that provide the deputies with the best opportunity to detect medical distress. The other recommendations are directed at the OCSD and OCDA to help ensure that the investigation contains information necessary to allow the OCDA to accurately assess criminal culpability and the OCSD to make appropriate administrative changes after a death in custody.

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[65] Gordon v. Cty. of Orange (9th Cir. 2021) 6 F.4th 961, 973

[66] Xandar Kardian: https://xkcorp.com/solutions/healthcare/correctional-health/
Rahm Sensor Development, Inc.: https://www.cell-guardian.com/
IntegrityIQ Life Detection Radar: https://integrityq.io/

RECOMMENDATIONS

Orange County District Attorney's Office and Orange County Sheriff-Coroner

1. When an incarcerated person dies in custody, interview all deputies and staff who conducted checks or had contact with the person since the person's last recorded movement was captured on video.
2. When an incarcerated person dies in custody, all deputies who conducted checks or had contact with the person since the person's last recorded movement captured on video, should be interviewed prior to concluding their shift. Deputies who concluded their shift prior to the discovery of the decedent should be contacted and interviewed as soon as reasonably possible.

Orange County Sheriff-Coroner

3. When the Orange County Sheriff-Coroner responds to the death of an incarcerated person in a county jail, the investigator should obtain the decedent's core temperature prior to transporting the decedent.
4. Provide additional training to deputies to remind them of Policy 902.4's requirement that they "be close enough to each inmate to ascertain their …. apparent physical condition."
5. Update Policy 902 to require that, when a deputy encounters an incarcerated person that they believe to be sleeping, the deputy must actually stop in front of the cell and monitor the person until such time as the deputy observes obvious signs of life or the deputy determines, after observing the person's presentation, that they do not need medical treatment.
6. Conduct a study on the viability of life detection devices and the feasibility of installing them in cells that typically house incarcerated persons with increased medical needs, suicide concerns, or who are undergoing detoxification.

OCSD RESPONSE

July 29, 2025

Via Email and U.S. Mail

Robert Faigin
Executive Director
Office of Independent Review
601 N. Ross St., 2nd Floor
Santa Ana, CA 92701
Robert.Faigin@ocgov.com

Re: OIR In-Custody Death Review – Ronald Lucio (Booking# 3194210)

Dear Mr. Faigin:

Thank you for the comprehensive report from the Office of Independent Review (OIR) regarding the in-custody death of Ronald Lucio on March 18, 2022. The collaborative effort between the Orange County Sheriff's Department (OCSD) and OIR related to this incident—spanned from July 28, 2023 through June 30, 2025, and included providing access to all requested records, video, reports, and findings—reflects our shared commitment to transparency and continuous improvement.

The ultimate responsibility of OCSD is to safeguard the health and safety of every person in our custody. Every decision we make must be guided by the best available evidence and proven, evidence-based practices. Implementing changes that are grounded in research not only protects vulnerable individuals but fortifies public trust in our agency's integrity and professionalism.

Below, we address each of the four OIR recommendations applicable to OCSD:

Recommendation #3: When the Orange County Sheriff-Coroner responds to the death of an incarcerated person in a county jail, the investigator should obtain the decedent's core temperature prior to transporting the decedent.

Will Not Be Implemented: After extensive consultation with our Chief Forensic Pathologist, Dr. Anthony Juguilon, and review of current forensic standards, we have determined that obtaining a core temperature post-mortem does not reliably aid in time-of-death estimation due to environmental and physiological variables. Modern forensic practice relies on a synthesis of multiple findings (such as livor mortis, rigor mortis, scene investigation, and eyewitness accounts) which provide a more accurate, albeit still imprecise, estimate for time of death. Our Coroner Division continues to document all post-mortem observations and uses the time of discovery/pronouncement, as current science and standards recommend.

In the modern practice of Forensic Pathology, the time of death is estimated by synthesizing multiple findings when needed, including assessments of livor mortis, rigor mortis, eyewitness reports, and/or known last-alive times, as well as scene investigations. Using these factors in a death investigation is considered more reliable than taking a core temperature and can help estimate a time of death within about a 2-hour window. Furthermore, the Coroner Division's current practice when conducting a body examination in the field is to document all observed post-mortem findings in their report but use the time of discovery and/or pronouncement as the time of death. We no longer use estimated times of death. As always, we are committed to practices proven to enhance investigative accuracy and safety.

Recommendation #4: Provide additional training to deputies to remind them of Policy 902.4's requirement that they "be close enough to each inmate to ascertain their .... apparent physical condition."

Already Implemented: In 2024, the Orange County Jail Compliance and Training Team (JCATT) published two training bulletins reaffirming the policy's safety check requirements. Deputies are trained and re-briefed annually on the significance of thorough, direct observation during safety checks to quickly identify distress or medical emergencies.

This ongoing training underscores our commitment to maintaining a safe jail environment and protecting people in our custody using established best practices. The training also restated Policy 902: "The purpose of conducting inmate safety checks is to ensure there are no inmates displaying any obvious signs of distress requiring assistance, maintaining the safety and welfare of each inmate and ensuring the security of our facilities." The training curriculum includes the requirement to conduct "direct visual observation."

Recommendation #5: Update Policy 902 to require that, when a deputy encounters an incarcerated person that they believe to be sleeping, the deputy must actually stop in front of the cell and monitor the person until such time as the deputy observes obvious signs of life or the deputy determines, after observing the person's presentation, that they do not need medical treatment.

Will Not Be Implemented: Current OCSD policy already details deputies' obligation to directly observe all inmates—including those who appear to be sleeping—for signs of trauma, distress, or life, and to conduct checks "from a location which provides a clear, direct view." Failure to do so constitutes non-compliance. Our policies are designed according to evidence-based standards for correctional safety, ensuring all safety checks are meaningful and thorough.

Current Language of OCSD Policy 902, Safety Checks:

902.1- Definition and Purpose

1. An inmate safety check is a direct visual observation (i.e., direct personal view of the inmate/area without the aid of audio/video equipment), performed at random and varied intervals of each inmate located in an area of responsibility. The purpose of conducting inmate safety checks is to ensure there are no inmates displaying any obvious signs of distress requiring assistance, maintaining the safety and welfare of each inmate and ensuring the security of our facilities.

    a. During inmate safety checks, deputies will check for obvious signs of life, which can include but are not limited to the following:
        1. Talking/eating
        2. Head movement (i.e., lifting their head from their mattress)
        3. Movement of the inmate's extremities

2. For an inmate who is sleeping or appears to be sleeping, deputies will check for obvious signs of trauma or distress as well as obvious signs of life.

902.4 – Conducting Safety Checks

2. Deputies will conduct timely, thorough inmate safety checks. Due to the variety of housing designs within our facilities (modules, tanks, barracks, dorms, tents, holding cells, and areas such as dayrooms, showers, recreation and program related classrooms, etc.), methods of conducting inmate safety checks may vary. Inmate safety checks must be conducted in any area inmates are present, and from a location which provides a clear, direct view of each inmate. Deputies shall be close enough to each inmate to ascertain their presence and apparent physical condition. Deputies shall investigate any unusual circumstances or situations.

To satisfy department policy, safety checks must be conducted "from a location which provides a clear, direct view of each inmate" and they "shall be close enough to each inmate to ascertain their presence and apparent physical condition." Deputies are also required to "check for obvious signs of trauma or distress as well as obvious signs of life". From the department's perspective, a deputy would not be in compliance with policy if they failed to spend enough time in front of a cell, or be close enough to the cell, to observe obvious signs of trauma, distress, or obvious signs of life.

Recommendation #6: Conduct a study on the viability of life detection devices and the feasibility of installing them in cells that typically house incarcerated persons with increased medical needs, suicide concerns, or who are undergoing detoxification.

Agreed—In Progress. The Sheriff's Department continues to explore medical monitoring technologies that could further enhance safety for high-risk individuals. Our staff has engaged with experts and vendors at major corrections and medical conferences and recently evaluated new wearable sensor systems with improved reliability. While current technology was previously limited by battery life and connectivity issues, advances are making evidence-based solutions increasingly feasible for implementation.

Specifically, we have researched and examined the use of medical monitoring devices at:

- October 2022 – OCSD conducted an internal research project on the technology and available vendors.
- October 2023 – NCCHC National Conference
- May 2024 – American Jails Association - Conference & Jail Expo
- June 2024 – National Sheriff's Association – National Conference
- August 2024 – American Correctional Association – Congress of Corrections

We recently attended a webinar with a manufacturer of wearable sensors for incarcerated individuals. This system appears to have addressed our previous concerns, and it integrates with the system we are currently utilizing in our jails to track and monitor inmate movements and facility safety checks. Significant costs remain a challenge, but we will persist in seeking practical, research-backed tools to protect the wellbeing of all those in our care

If you have any questions or comments, please reach out.

Sincerely,

Don Barnes
Sheriff-Coroner

OCDA RESPONSE

OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

August 4, 2025

Robert Faigin
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Robert.Faigin@ocgov.com

SENT VIA EMAIL

Re: OIR In-Custody Death Review – Ronald Lucio (Booking #3194210)

Dear Mr. Faigin:

Thank you for the opportunity to review the comprehensive report regarding the in-custody death of Ronald Lucio on March 18, 2022. The Orange County District Attorney's Office Special Assignments Unit (SAU) conducts critical incident investigations for 21-city jurisdictions and the Orange County Sheriff's Department (OCSD). These investigations include officer-involved shootings, custodial-related deaths, and use-of-force incidents with serious injuries. The object of these investigations is to ensure an independent investigation by the District Attorney, thereby eliminating any perceived conflict of interest. This is to be performed in a professional and impartial manner while maintaining the trust of the public and the involved agencies.

Below are the two applicable OIR recommendations and the responses:

Recommendation R1

"When an incarcerated person dies in custody, interview all deputies and staff who conducted checks or had contact with the person since the person's last recorded movement was captured on video."

Response to Recommendation R1

While we agree that interviews with all staff involved at the time of discovering a critically injured or deceased inmate can be valuable, it is reasonable to believe deputies and medical staff would not continue their duties if they believed an inmate was in medical distress or deceased.

REPLY TO: ORANGE COUNTY DISTRICT ATTORNEY'S OFFICE
http://orangecountyda.org/

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Recommendation R2

"When an incarcerated person dies in custody, all deputies who conducted checks or had contact with the person since the person's last recorded movement captured on video should be interviewed prior to concluding their shift. Deputies who conducted their shift prior to the discovery of the decedent should be contacted and interviewed as soon as reasonably possible."

Response to Recommendation R2

We agree that interviews with personnel involved, conducted sooner rather than later, can be beneficial. The purpose of our investigation is to determine whether there was criminal culpability on the part of any personnel or other individuals under the agency's supervision in connection with the specific incident. Therefore, our interviews are voluntary, and we cannot dictate the timing and location of these interviews. Specifically, in OCSD investigations, a representative from the Association of Orange County Deputy Sheriffs (AOCDS) typically advises their members not to provide voluntary statements immediately. AOCDS arranges the timing of these interviews, which is standard across departments with representation by an association. However, our interviews with OCSD staff generally occur sooner than those with other agencies. We maintain a good working relationship with AOCDS and its members, which allows us to obtain voluntary statements. Not having these statements would negatively impact the investigations.

Furthermore, from an investigative standpoint, it is sometimes not prudent to rush interviews with deputies without sufficient time to review relevant videos and other materials needed for a comprehensive interview. We have one opportunity to conduct these interviews, and gathering as much information as possible about the incident beforehand is beneficial.

If you have questions or comments, please do not hesitate to contact me.

Sincerely,

Todd Spitzer
District Attorney