County of Orange

Independent Review of OCSD Custodial Death: Nicholas Brown

May 2026

Office of Independent Review
601 N. Ross St., 2nd Floor
Santa Ana, CA 92701

Contents

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 is reviewing custodial deaths that occurred in the year 2022.[3] This report, and the conclusion and recommendations that it contains, rely on the review of both publicly available and confidential information.

On April 9, 2022, Nicholas Brown ("Brown") was booked into the Orange County Jail's Intake Release Center (IRC).[4] Brown exhibited delusional behavior during booking and, following a mental health evaluation, he was flagged as "Gravely Disabled." On April 12, 2022, Brown was housed by himself in Cell 5 in Sector 19 of Module L, an Acute Mental Health Housing Unit, where he remained until his death.

During his time in custody, Brown experienced periods of delusion, refused or was not given prescribed medication, did not wear clothing, and rarely communicated in a coherent manner with staff. Brown also reportedly flooded his cell, which resulted in jail staff shutting off the water to his cell, though it is unknown when the water was shut off and for how long.

Brown did not receive regular meals while in custody. Despite the OCSD having a regular meal distribution policy, Brown received only six out of 13 meals from April 16, 2022, through his discovery on April 20, 2022. Most of the meals that Brown did not receive were placed by jail staff on a table outside of his cell, where he did not have access to them.

On April 20, 2022, at approximately 8:28 a.m., Brown was discovered unresponsive in his cell by a deputy and a nurse distributing medication in the module. Various personnel attempted to rouse Brown from the threshold of the cell. When additional deputies arrived three minutes later, they entered the cell and moved Brown outside to treat him. He had no pulse, no respirations, and his pupils were fixed. Medical staff and deputies performed cardiopulmonary resuscitation (CPR) continuously until paramedics arrived.

Paramedics arrived on scene at approximately 8:41 a.m. and assumed care of Brown. They determined Brown had no pulse, no respirations, no pupillary response, and no heart rhythm.

---

[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] "In-custody death" means the death of a person who is detained, under arrest, or is in the process of being arrested, is en route to be incarcerated, or is incarcerated in the Orange County jail system. "In-custody death" also includes deaths that occur in medical facilities while in law-enforcement custody.
[4] Factual information contained in this report comes from verified information in the publicly available District Attorney letter ("DA letter") regarding Brown's death, as well as other publicly available information.

Brown's skin was cyanotic, cold to the touch, and he showed signs of rigor mortis.[5] Brown was pronounced deceased at 8:43 a.m.

An autopsy was conducted on April 27, 2022. The forensic pathologist determined Brown's cause of death was dehydration due to probable lack of water intake. The manner of death was undetermined.

The Orange County District Attorney's Office (OCDA) investigated Brown's death and issued a letter on December 1, 2023, concluding that Brown passed away "due to his own lack of personal care" and that there was "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 Brown."

While the scope of the OCDA review was expressly limited to determining whether any criminal conduct occurred, the investigation failed to discover several important issues. Those issues include that Brown was not provided over half of his meals in the days leading up to his death; that medical personnel inaccurately documented Brown's alleged refusal of medication and labs; and that deputies generally did not allocate the time or attention needed during safety checks to ascertain Brown's physical condition.

Had all the relevant facts surrounding this custodial death had been fully identified, the OCDA may have reached a different conclusion whether the evidence supported a finding that OCSD personnel did not fully meet their legal obligations.

Decedent Information

The decedent, Nicholas Brown, was a 28-year-old incarcerated male who was taken into OCSD custody on April 8, 2022. He was being held on misdemeanor charges. He had a history of delusional behavior and hypertension. Brown was pronounced deceased on April 20, 2022.

Factual Background

On April 8, 2022, Brown was taken by his mother to Anaheim Global Medical Center (AGMC) due to his erratic behavior and delusions. An ER physician examined Brown, and found that while Brown exhibited delusional behavior, he did not have a psychiatric disorder that required an involuntary mental health commitment. Brown's toxicology screening tested positive for THC, and no other drugs or alcohol were detected.

Following events that transpired at the hospital, Brown was transported and booked into the IRC on April 9, 2022.[6] During intake, Brown made several delusional statements and disclosed a previous mental health diagnosis of delusional behavior. The following day, a mental health screening was

[5] Cyanosis is a bluish or purplish discoloration due to deficient oxygenation of the blood. https://www.merriam-webster.com/dictionary/cyanotic. Rigor mortis is the postmortem stiffening/rigidity of the body. https://www.ncbi.nlm.nih.gov/books/NBK539741/

[6] During the course of the investigation into Brown's death, information and court records were reviewed, which were subsequently sealed by the Orange County Superior Court pursuant to Penal Code section 851.93. Accordingly, such information will not be disclosed in this report.

completed. Brown was in his cell, naked and mumbling to himself. Though he recited his name, he was otherwise unable to appropriately answer questions. Based on these observations, Brown was flagged as "Gravely Disabled" and referred to Module L, an Acute Mental Health Housing Unit.

A psychiatric evaluation was conducted on April 11, 2022. The psychiatrist noted that Brown talked incoherently to himself, yelled profanities, made "bizarre" hand gestures, and appeared to be hallucinating. The psychiatrist prescribed an antipsychotic medication; however, records indicate that Brown refused to take them.

On April 12, 2022, Brown was transferred to Module L, Sector 19, where he was housed by himself in Cell 5. Deputies conducted safety checks in Module L approximately every 30 minutes.

Brown's physical and mental well-being continued to deteriorate in the following days. Brown experienced periods of delusion, and records indicate that he refused to take medication, wear clothing, or engage with staff. Staff also reported that Brown's cell was flooded and littered with food and trash. A mental health evaluation concluded that Brown "does currently possess a major mental illness/disorder" based on an "unspecified psychosis."

On April 14, 2022, a doctor attempted to assess Brown. Based on a review of Brown's lab test results from AGMC, the doctor was concerned that Brown may have rhabdomyolysis.[7] The doctor recommended that Brown take more water and that he be monitored.

On April 15, 2022, a psychiatrist went to assess Brown. After that contact, the psychiatrist created a psychiatric progress note documenting her observations. In that note, the psychiatrist indicated she was informed the water in Brown's cell had been turned off because he had repeatedly flooded his cell. The psychiatrist noted she was informed that Brown was provided with water and Gatorade on a regular basis.

On April 16, 2022, Brown's breakfast was not given to him at the meal distribution. Instead, it was placed on a table outside of his cell. Brown's lunch was also not given to him and instead placed on the same table outside of his cell. At dinner, Brown's dinner and the other two meals and liquids were placed into his cell.

On April 17, 2022, Brown did not receive a dinner meal. Instead, it was placed on the table outside of his cell and eventually tossed in the trash approximately four and a half hours later. On April 18, 2022, Brown did not receive breakfast. It was left on a table for approximately 11 hours and then eventually given to another inmate. On April 19, 2022, Brown did not receive breakfast or dinner. Brown's breakfast was left on the table for approximately 10 hours and then thrown away. Brown's dinner was also left on a table for approximately four and a half hours and then thrown away. On April 20, 2022, Brown did not receive breakfast. Instead, it was once again placed on a table outside of his cell and was still sitting there almost five hours later when he was discovered deceased.

[7] Rhabdomyolysis is a condition that can arise following muscle injury, in which the contents of dead muscle fibers enter the bloodstream. If left untreated, the condition can lead to renal failure, and in rare cases, death.

On April 20, 2022, at approximately 8:28 a.m., a licensed vocational nurse ("LVN 1") was escorted by a deputy while distributing medication within Module L. When they arrived at Brown's cell, the nurse saw Brown lying naked and prone on the bunk. After an unsuccessful attempt to rouse him by knocking on the cell window, the nurse alerted the deputy that Brown was not responding.

Over the next three minutes, various personnel attempted to rouse Brown from the threshold of the cell. They called out to Brown, splashed water on his legs, rolled an orange toward him, and tossed a small milk carton at his legs. The deputies waited for additional personnel to arrive before entering the cell.

At approximately 8:31 a.m., additional deputies arrived, and they entered Brown's cell. Brown was not conscious and not responsive. Deputies moved Brown outside the cell to treat him, and they noticed he was cold to the touch. The nurse checked Brown's vital signs and determined that he had no pulse, no respirations, and his pupils were fixed. The nurse placed an ammonia stimulant under Brown's nose, but there was no response.

CPR was initiated at approximately 8:33 a.m. and paramedics were requested at that time. Medical staff and deputies performed chest compressions and provided oxygen via an AMBU bag. An AED cycled several times, which advised not to administer a shock and to continue CPR. CPR was performed continuously until paramedics arrived.

Orange County Fire Authority paramedics arrived on scene at approximately 8:41 a.m. and assumed care of Brown. Paramedics determined Brown had no pulse, no respirations, and no pupillary response. He was connected to a cardiac monitor and found to be asystole.[8] Brown's skin was cyanotic, cold to the touch, and he showed signs of rigor mortis. Brown was pronounced deceased at 8:43 a.m.

On April 27, 2022, forensic pathologist Dr. Scott Luzi conducted an autopsy on Brown's body. Dr. Luzi determined Brown's cause of death was dehydration due to probable lack of water intake. The manner of death was undetermined.

Custodial Death Evidence Review

On April 20, 2022, investigators from the Orange County District Attorney Special Assignments Unit (OCDASAU) responded to the IRC where Brown died. During their investigation of Brown's death, the OCDASAU interviewed 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 OCDA provided redacted copies of reports, photographs, and audio files. The OIR also requested records and logs, reports, videos, photographs, and policies and procedures from the OCSD, which were also provided.

[8] Asystole, also known as "flat-line," is when the heart's electrical system fails, causing the heart to stop pumping. https://my.clevelandclinic.org/health/symptoms/22920-asystole.

OCDA Custodial Death Investigation Report

On December 1, 2023, the OCDA issued a public letter summarizing its review of the custodial death of Brown. While the letter's focus was the determination of whether any criminal conduct occurred on the part of OCSD personnel, it provided valuable insight into the overall investigation of this custodial death.

The OCDA's letter summarized the findings of facts beginning with Brown being taken to the hospital on April 8, 2022. The letter detailed Brown's behavior while in custody, as well as the events surrounding his death on April 20, 2022. The OCDA's letter concluded that based on all the evidence provided and reviewed, there was no evidence to support a finding that the OCSD breached its duty of care, either intentionally or through criminal negligence, in a way that would rise to the level of individual criminal conduct.

Video

The OIR reviewed several videos related to the custodial death of Brown. The videos consisted of fixed overhead jail surveillance and handheld video footage.

Fixed Overhead Surveillance Footage

The OIR received overhead jail surveillance footage showing Brown arriving at the IRC, being processed at reception, and being escorted and placed into a cell. Footage from April 12, 2022, shows Brown being transferred in a wheelchair to Cell 5 of Module L, Sector 19.

The overhead security camera showing Cell 5 is located outside of Module L, Sector 19. The camera's field of view looks through the open "dayroom" area and covers the front of the sixteen cells located within the sector. The camera has limited visibility into the cells and has no audio.

Movement

The OIR was able to review video of Sector 19 covering April 16, 2022, through April 20, 2022. On April 16, 2022, Brown can be seen through the windows on the door and adjacent wall, standing and moving inside his cell. The last time Brown is clearly seen standing or moving about in his cell is April 17, 2022, at 10:31 a.m. On April 18, 2022, a deputy brought a tablet to Brown's cell and passed it through the hatch. While Brown is not seen in the video, the lit-up tablet could be seen in use inside his cell. After several minutes, the deputy left carrying the tablet.

The DA letter indicates that Brown's last recorded movement on video was on April 19, 2022, at 7:40 p.m. While there is some type of movement in the cell at that time, the video does not clearly depict Brown or a discernable part of Brown's body.

Medical

From April 16, 2022, through April 20, 2022, numerous medical staff can be seen at or near Brown's cell.

On the morning of April 16, 2022, LVN 1 stopped at Brown's cell three times. The first time was during medication pass at 8:15 a.m. Next, at 9:34 a.m., LVN 1 stood in front of Brown's cell for approximately 10 seconds. He returned to Brown's cell at 10:14 a.m. and appeared to offer liquids to Brown. Approximately nine minutes later, a registered nurse ("RN 4") stood in front of Brown's cell and appeared to take notes on a piece of paper for about 25 seconds before moving on to the next cell. At 1:57 p.m., a nurse practitioner spent about 15 seconds standing in front of Brown's cell. LVN 3 can also be seen standing in front of Brown's cell for about 15 seconds during evening medication pass at 7:49 p.m. before moving on to complete medication pass. Finally, at 10:34 p.m., another registered nurse ("RN 5") and a deputy walked to Brown's cell, and the deputy opened Brown's door for approximately 10 seconds. After the door was closed, RN 5 and the deputy remained at Brown's cell for another 25 seconds before leaving the sector.

On April 17, 2022, at 8:03 a.m., a mental health clinician ("MHC 1") stopped at Brown's cell. MHC 1 spent approximately 20 seconds in front of Brown's cell before moving on to the next cell. At 8:12 a.m., LVN 1 approached Brown's cell and spent about five seconds looking into his cell before continuing with the morning medication pass. Finally, at 7:48 p.m., LVN 3 and a deputy stood in front of Brown's cell for approximately 10 seconds before continuing with the evening medication pass.

While conducting medication pass at 8:12 a.m. on April 18, 2022, LVN 4 can be seen walking past Brown's cell without stopping. Eight minutes later, a psychiatric doctor ("MD 1") can be seen stopping in front of Brown's cell. MD 1 knocked on Brown's door and looked into Brown's cell. MD 1 spent about a minute and a half in front of Brown's cell before moving on to the next cell. At 12:17 p.m., a member of the medical staff entered the sector and went to Brown's door. She remained in front of his door for approximately three seconds and then left the sector. At 3:43 p.m. another member of the medical staff entered the sector and walked to Brown's cell. He remained in front of Brown's door for approximately two seconds and then turned and left the sector. Finally, at 7:43 p.m., LVN 5 walked past Brown's door without stopping while conducting medication pass.

On April 19, 2022, MHC 1 stopped in front of Brown's cell at 7:49 a.m. She remained in front of Brown's cell for a little over a minute while she looked inside and appeared to be taking notes.

Fifteen minutes later, two medical staff members who were in the sector walked past Brown's cell. One of them stopped and looked into Brown's cell from a distance before both left the sector. At 8:09 a.m., LVN 1, who was conducting medication pass, walked past Brown's cell without stopping. An hour later, RN 1 can be seen going to Brown's cell and standing in front of it for about a minute. At 9:51 a.m., a member of the medical staff went to Brown's cell and stood in front of his door for about 25 seconds while writing on a piece of paper. At 10:53 a.m., LVN 1 entered the sector and picked up a bottle off a table. He approached Brown's cell and stood in front of the cell for approximately 10 seconds before turning and leaving the sector. At 11:10 a.m., a member of the medical staff looked into Brown's cell as he was going to an adjacent cell. He did not stop. Similarly, at 6:09 p.m., a member of the medical staff passed by Brown's cell without stopping on the way to another cell. Finally, at 7:42 p.m., LVN 5, who was conducting medication pass, walked in front of Brown's cell, then turned back to return to the previous cell. Both LVN 5 and a deputy then walked past Brown's cell without stopping.

Safety Checks

The OIR observed the safety checks that were conducted from 12:00 a.m. on April 16, 2022, through the discovery of Brown at 8:28 a.m. on April 20, 2022. During that period, deputies were required to conduct checks every thirty minutes, which resulted in a total of 209 checks. After reviewing the video, the OIR was able to confirm that deputies conducted all but one of those safety checks.

During the majority of the safety checks, deputies can be seen walking in front of Brown's cell at a brisk pace without breaking stride. Some deputies did not look towards Brown's cell as they performed safety checks. The time that it took most deputies to walk from one side of Brown's cell to the other during a safety check was roughly one to two seconds.

On April 20, 2022, the day Brown was discovered, the oncoming shift began safety checks at 6:30 a.m. Deputy 4 conducted that first check. Deputy 4 can be seen on video turning his head to look toward Brown's darkened cell as he walked past without stopping or breaking stride.

Deputy 2 performed the 7:00 a.m. safety check. The lights in the sector and cells are now on. Deputy 2 walked past Brown's cell. After passing the cell, Deputy 2 backed up, looked inside Brown's cell again for about two seconds, and then continued with his safety check of the sector.

Deputy 3 conducted the 7:30 a.m. safety check. Deputy 3 turned his head to look toward Brown's cell, but did not stop or break stride.

Deputy 4 conducted the 8:00 a.m. safety check. While walking in front of Brown's cell, he slowed slightly while looking at the cell, but did not stop.

Meals

Meal service was also observed on video from 12:00 a.m. on April 16, 2022, through the discovery of Brown at 8:28 a.m. on April 20, 2022. Incarcerated persons are provided three meals per day. Breakfast is typically around 4:00 a.m., lunch is around 11:00 a.m., and dinner is around 3:00 p.m.

On April 16, 2022, Brown stood in his cell while breakfast was being served. An inmate and correctional services assistant (CSA) approached Brown's cell with a breakfast tray. They stood in front of his cell door for approximately four seconds, and then placed Brown's food on the dayroom

table outside of his cell. Brown was not able to leave his cell to retrieve the food tray from the table. Breakfast service was completed, and everyone left the sector.

Later, when deputies and a CSA arrived to serve lunch, Brown's breakfast was still on the table outside of his cell and Brown can be seen walking back and forth in his cell. A deputy stopped in front of Brown's cell for a second while the CSA placed Brown's lunch on the dayroom table next to his breakfast. The CSA and deputies then completed the lunch service and left the sector. When dinner was served, Brown's breakfast and lunch were still on the table outside of his cell. A deputy approached Brown's door, and Brown can be seen standing on the other side. The deputy turned and walked away, and Brown's dinner was left on the same table. Approximately 40 minutes later, Deputy 2 and another deputy returned and brought the breakfast, lunch, and dinner trays from the dayroom table into Brown's cell.

During the breakfast service on April 17, 2022, a CSA approached Brown's cell. The CSA spent approximately 40 seconds in front of Brown's door, and then directed the inmate worker to place Brown's breakfast on the table outside of his cell. Two minutes later, a deputy retrieved the food from the table and gave it to Brown. At lunchtime, Brown was given his meal at the same time as the other incarcerated persons in the sector. At dinnertime, a deputy and inmate worker stood outside of Brown's cell for approximately 40 seconds, after which Brown's dinner was placed on the table outside of his cell. Four and a half hours later, a CSA and inmate worker entered the sector with a trash can. Brown's dinner was removed from the table and thrown away.

On April 18, 2022, a CSA and inmate worker entered the sector to serve breakfast. The CSA placed Brown's breakfast on the table outside of his cell without even approaching Brown's cell. When lunch was served, Brown's breakfast was still on the table. It appears that a deputy opened the hatch to Brown's cell and an inmate worker placed his lunch inside. Brown's breakfast remained on the table until 2:34 p.m. when a deputy conducting a safety check retrieved it and gave it to another inmate. At dinner, a deputy opened Brown's cell door, and his meal was placed inside of his cell.

On April 19, 2022, a CSA approached Brown's cell with a tray during breakfast. After a second the CSA provided the tray to a different cell. Brown's breakfast was then placed on the table outside of his cell. Brown's breakfast was still on the table when lunch was served. It appears that a deputy opened the hatch to Brown's cell and an inmate worker placed his lunch inside. Brown's breakfast remained on the table until 2:01 p.m. when a deputy conducting a safety check can be seen throwing it away. At dinner, Deputy 5 and an inmate worker approached Brown's cell with a tray. After approximately five seconds, Deputy 5 instructed the inmate worker to place Brown's meal on the table outside of his cell. Brown's dinner was then thrown out by a CSA at 7:37 p.m.

On April 20, 2022, a CSA placed a breakfast meal on the dayroom table outside of Brown's cell. No deputy was present directing or monitoring this meal service. The meal was still on the table over four and a half hours later when Brown was discovered.

Handheld Video Footage

The OIR reviewed a handheld video that depicted Brown lying on a mattress naked and handcuffed outside of a cell while he was surrounded by jail personnel. It was recorded on April 20, 2022, after Brown was taken out of his cell by jail personnel but before OCFA paramedics arrived at the scene. The video is 18 minutes and 26 seconds long and contains audio.

The video begins with medical personnel and deputies taking turns administering chest compressions. An AED was being used from the start of the video, which repeatedly analyzed Brown's condition and advised to continue CPR and not to administer a shock. The video shows a nurse using an AMBU bag to provide oxygen to Brown. Other nurses can be seen checking Brown for a pulse and for breathing. While Brown was being treated, two deputies can be seen entering Brown's cell and looking around.

Approximately eight minutes into the video, paramedics arrived at the scene. A paramedic asked the jail staff when Brown was last seen alive. Based on the responses, it was determined that it was unknown when he was last seen alive. The paramedic also determined that Brown was in asystole, and that he had no pulse or lung sounds. Paramedics stopped all medical aid and announced "8:43" as Brown's time of death.

The camera remains aimed at Brown's body while jail personnel can be heard in the background discussing the circumstances around Brown's death. Due to the amount of noise at the scene, the majority of the conversations cannot be understood. One individual asked if anyone saw Brown talking this morning, and a nurse responded no, and that shift change occurs around 6:30. Deputy 1 can be heard stating he found Brown at approximately 8:30 when he and LVN 1 were doing med call. A deputy can be seen covering Brown's body with a blanket, and the video ended a few minutes later.

Interviews

The OIR also reviewed interview transcripts, summaries, and audio files of interviews. The OCDASAU investigators conducted interviews with various IRC personnel, including five members of the nursing staff, six deputies, a sergeant, and a CSA. Interviews were also conducted with 13 inmates housed within Module L, Sector 19, as well as the paramedic who treated Brown at the scene. Lastly, an interview was conducted with Brown's mother. Following the OCDA investigation, the OCSD interviewed 14 employees, including nine deputies, four CSAs, and one sergeant.

OCDASAU Interviews

Interview of LVN 1

LVN 1 was interviewed on April 20, 2022, the day Brown was discovered. During this interview, LVN 1 explained how he was escorted by Deputy 1 around 8:30 a.m. as he distributed medication within Module L. He stated that when he arrived at Cell 5, he saw Brown naked and lying face down on his bunk. He described the cell as dirty with trash on the floor. LVN 1 stated he tried to rouse Brown by knocking on the cell window, and then became concerned when Brown did not move. He indicated that, for safety reasons, he wanted additional deputies present before entering the cell and checking on Brown. He then went to grab a medical kit and ask for assistance from medical staff.

Once deputies opened the cell, LVN 1 said he tried to rouse Brown by throwing some water on Brown's leg, rolling an orange toward him, and tossing a small milk carton onto Brown's leg. As he received no response, deputies then entered the cell and a deputy shook Brown. They then placed Brown on the mattress and moved Brown outside of the cell.

LVN 1 indicated he checked Brown for signs of life. He determined Brown was not breathing, he had no pulse, and his pupils were fixed. LVN 1 placed an ammonia stimulant under Brown's nose and

saw no response. He applied an AED to Brown and CPR was initiated. He administered breaths using an AMBU bag connected to oxygen. He estimated paramedics arrived about ten minutes later, and then he stepped back so Brown could be treated.

During his interview, LVN 1 was asked whether he had any contact with Brown prior to April 20, 2022. LVN 1 responded that he had tried to offer Brown medication the day before, but Brown was not taking them. The investigator asked whether Brown refused, and LVN 1 indicated that he had. The investigator then asked LVN 1 how many times before April 19th LVN 1 had offered Brown medication, and Brown refused. LVN 1 stated that Brown had refused on the 19th, and every time that he had worked in the sector. LVN 1 was asked to quantify how many days he worked in the sector where he would have offered medications to Brown, and LVN 1 indicated five or six times. The investigator followed up by asking if most of those times, Brown basically refused his medications, to which LVN 1 replied "yes."

Interview of Deputy 1

Deputy 1 was interviewed on April 25, 2022, five days after the discovery of Brown. During this interview, Deputy 1 explained how he and LVN 1 found Brown unresponsive during medication distribution on the morning of April 20, 2022. He stated that when he arrived at Cell 5, he noticed Brown lying face down and naked on his bunk. He knocked on the cell door, opened the door and called out to Brown, and flashed his flashlight to get Brown's attention. He noted he did not see any rise of Brown's chest. At that point, he walked over to another sector to get assistance from other deputies, while he assumed LVN 1 went to get assistance from medical staff.

Once additional deputies arrived, Deputy 1 stated they entered the cell and moved Brown outside. He touched Brown's right ankle and noted that it was cold. Additionally, he felt resistance in Brown's arms and observed they were up off of his chest. The rigor in Brown's arms led him to believe Brown was possibly deceased.

Deputy 1 then went to the radio and notified main control to request paramedics and to request a sergeant come to the area. Deputy 1 indicated he was the third person to do chest compressions on Brown, who remained unresponsive. He noticed brown discharge coming out of Brown's mouth. After doing CPR, Deputy 1 stated he went into Cell 5 to see if any potential evidence was present, such as drugs or contraband, but he did not see any. He estimated that paramedics arrived in approximately ten minutes, and he observed as they treated Brown and then declared him deceased.

Interview of RN 3

RN 3 was interviewed on April 20, 2022. During this interview, RN 3 stated that he was treating an inmate in Sector 20 when a deputy came to ask for help regarding an inmate in Sector 19 who was not moving. RN 3 rushed over to Brown's cell, where he stated deputies were inside trying to see if there were signs of life. When Brown was turned over, RN 3 noticed signs of rigor mortis and felt that Brown was cold to the touch. He stated he attempted to insert an IV but was unsuccessful due to the rigor mortis. He also observed foam around Brown's mouth. RN 3 stated he did not observe any signs of life.

Interview of Deputy 2

Deputy 2 was interviewed on April 25, 2022. During this interview, he indicated he completed a safety check of the lower tier cells in Sector 19 at 7:00 a.m. on April 20, 2022. When asked how a safety check works, Deputy 2 stated "I walk up to the cell and then I just, I take a glance, take a look, make sure that everything looks good. Secure no one's ah, they're not in any type of distress and then I keep on moving forward."

Deputy 2 was asked about what he was actually looking for when he conducts a safety check. He indicated that he checks for signs of life, to make sure that the incarcerated person is breathing, and that they are not in distress. When asked how he verifies an incarcerated person is breathing, Deputy 2 indicated that he looks for the rising of their chest and movement of their toes, fingers, and arms.

When asked about his observations during the 7:00 a.m. safety check, Deputy 2 stated he walked by Brown's cell, then turned around to double check because Brown was lying on top of his bed naked. Deputy 2 thought Brown was sleeping and "looked fine", so he kept moving forward. Later in the interview, Deputy 2 stated he had double checked Brown's cell because food smeared on the cell's window prevented him from being able to see easily into the cell.

Later that morning, Deputy 2 stated he heard on the radio a request for assistance due to a possible man down, and he walked over to assist. He observed Brown lying face down in his cell and not responding. He believed this was the same position Brown was in at the time of the 7:00 a.m. safety check. When Deputy 2 helped to move Brown out of the cell, he noticed Brown was cold to the touch, which led him to think Brown was "possibly not alive". He further observed that Brown's hands and arms were very rigid, and that he had bubbles in his mouth. He performed CPR on Brown before paramedics arrived.

During his interview, Deputy 2 indicated that he recalled seeing Brown in his cell on April 19th around noon. Deputy 2 stated that Brown was "fine, he was walking around." Deputy 2 went on to state that Brown was just standing there talking to himself, and then he laid down to sleep by his door.

Interview of Deputy 3

Deputy 3 was interviewed on April 25, 2022. During this interview, he indicated he completed a safety check of the lower tier cells in Sector 19 at 7:30 a.m. on April 20, 2022. He further indicated that he may have done another safety check earlier that day, but he could not recall what time. When asked to describe what a safety check is, Deputy 3 responded, "We go through. We check to make sure that they're there and then we're also ascertaining their, um, their appearance. We look to see if they are in distress or anything like that. Make sure they're not hanging from a noose from their, their in cell table or, or chair or something like that." He explained that his distance to the cells during a safety check is "[f]our or five feet or something but close enough to ascertain there's someone there." Regarding duration of a safety check, he stated "[i]t's usually pretty brief. Um, it's pretty much as long as it, it takes to take a scan of the, of the cell, check the inmate, make sure he's, looks like he's doing fine and then kind of scan the rest of the cell to make sure there's really nothing."

When asked what he recalls about the 7:30 a.m. safety check, Deputy 3 responded that he remembered Brown lying on his stomach on his bunk and that Brown was naked. He indicated he did not notice anything out of the ordinary in Brown's cell.

Interview of Deputy 4

Deputy 4 was interviewed on April 25, 2022. During this interview, he indicated he completed a safety check of the lower tier cells in Sector 19 at 8:00 a.m. on April 20, 2022. When asked to describe how a safety check is performed, Deputy 4 explained that a deputy walks through the sectors, looks at the inmate, and makes sure nothing is suspicious. He was asked if the deputy is looking for anything specific when looking at an inmate, and Deputy 4 responded, "some sort of life but if you're sleeping, they're sleeping." The investigator then asked Deputy 4 whether he would get the attention of an inmate who appeared to be sleeping during a safety check, and Deputy 4 stated, "Not on a safety check. I want him to sleep."

When asked what he recalls about the 8:00 a.m. safety check, Deputy 4 responded that he recalled Brown's cell being dirty, but that he did not recall Brown personally and he did not see anything suspicious or out of the ordinary.

Deputy 4 indicated he went to assist when Brown's body was discovered, and he helped move Brown out of the cell. He was asked about his observations of Brown, or Brown's body, at that time. Deputy 4 stated that Brown's leg felt cold to the touch, but that he looked normal.

Interview of Paramedic

The OCFA Captain/Paramedic was interviewed on May 4, 2022. He recalled that when he arrived at the scene on April 20, 2022, he observed that Brown was handcuffed and his arms were stiff and pointing upwards. He also observed rigor in Brown's jaw. In addition, he said Brown was cyanotic. The paramedic stated that he declared Brown deceased at 8:42 a.m.

Interview of Brown's Mother

Brown's mother was interviewed on November 15, 2022. She indicated Brown had a history of mental health issues and had been hospitalized in a mental health facility several times.

Interview of RN 9

RN 9 was interviewed on December 1, 2022. The investigator contacted RN 9 regarding two entries she made in Brown's medical record. On April 19, 2022, at 4:18 a.m., RN 9 entered the following information into Brown's medical chart, "Pt refused labs X3. Educated about treatment compliance. Explained risks and benefits, but pt continued to refuse. Will continue to offer."

The investigator asked RN 9 how she came to make the entry as it related to Brown. RN 9 indicated that she gives to the deputies a list of inmates or patients who have lab orders, especially if the inmate or patient has a history of aggression. According to RN 9, "we are not allowed to be near the cell so when that list is done and the deputies check on them one by one then they do report back and let us know if the inmates or patients refused. And they do know to remind them that it is important for them to come out for labs." The investigator followed up by asking RN 9 if she would rely on the deputy to provide information about a patient refusing labs or if she would go to the cell herself. RN 9 indicated that she would not go to the cell herself, unless the deputy let her know there was an emergency situation or something medical that the inmate needs.

The investigator then asked RN 9 about an entry she made in Brown's chart on April 20, 2022, at 4:08 a.m. RN 9 entered the following "Pt refused labs x3. Educated about tx compliance, but continued to refuse and remained unpredictable. MHCR scheduled." RN 9 indicated that she followed the same process as the day before, where she would have asked the deputies to report back, and they reported back to her. RN 9 did not have any recollection of interacting with Brown herself.

Interview of Sergeant 1

Sergeant 1 was interviewed on December 14, 2022. She is an administrative sergeant assigned to the IRC and knowledgeable about jail operational procedures. Sergeant 1 explained the procedure for turning off the water to a cell in Module L, Sector 19. She stated the three common reasons for shutting off water were to prevent the flushing of drugs down a toilet; to prevent an inmate at risk of suicide from submerging their face in water; and to clear a clog that was caused by an inmate purposefully clogging the toilet to flood their cell. She indicated that if the water were shut off, it would only be off for as long as it took to remedy the issue. Lastly, she stated there was no policy requiring documentation of the water shut off.

OCSD Interviews

Interview of Deputy 5

Deputy 5 was interviewed on July 10, 2024, over two years after Brown's death. During this interview, Deputy 5 was shown a clip of surveillance video of dinner meal service at approximately 3:00 p.m. on April 19, 2022. The video showed Deputy 5 looking into Brown's cell during meal service, then pointing to a dayroom table, where an inmate worker placed a meal for Brown. He explained that if he knows an inmate has a combative history, he will typically leave the meal on a dayroom table. Deputy 5 could not recall why he had the meal placed on the dayroom table on this day but speculated that Brown either did not wake up when he tried to contact him or it must have been unsafe to open the hatch or door to leave the meal in the cell. When asked if it is common to use this level of caution if an inmate appears to be sleeping, Deputy 5 responded that he has experience with inmates who are deceptive and try to assault deputies while pretending to sleep.

Deputy 5 was asked if Brown refused this meal, and he responded that he could not recall any communication with Brown. Deputy 5 was then asked if he considers a sleeping inmate to be a meal refusal. In response, Deputy 5 said Brown could have told him that he wanted the meal or could get the attention of medical staff to assist. He stated food is readily available in the module and if Brown requested food, they could have easily accommodated.

Deputy 5 was informed during the interview that Brown never received this meal during the rest of his shift, and he was asked if anyone informed the oncoming night shift of the missed meal. Deputy 5 stated it was common practice to do so, but he did not remember telling the night shift.

Interview of Deputy 6

Deputy 6 was interviewed on May 24, 2024. He stated he had heard Brown was a problem for deputies during booking and was "CAC'd" as a result.[9] Deputy 6 explained that inmates who are "CAC'd" are held down inside of their cells while medications are administered by medical personnel. Following the administration, Deputy 6 said an inmate may be "knocked out" for about a week.

During this interview, Deputy 6 was shown a clip of surveillance video of breakfast meal service at approximately 3:30 a.m. on April 20, 2022. Deputy 6 described that he was opening cell door hatches in preparation for chow distribution. When the interviewer pointed out that some hatches were opened and some were not, Deputy 6 said he will usually not open the hatch for a cell that has a towel outside the cell door because those inmates are "flooders" who present an issue because of their unpredictability. He explained hatches are opened for meals based on the history with each inmate, and if he knows an inmate will cause issues, he will not open the hatch. He said a meal will be left on a nearby dayroom table for deputies to provide to the inmate.

Deputy 6 was asked about the procedure for providing meals to inmates who are sleeping. He stated if an inmate does not wake up to eat, he treats that as a meal refusal. However, he also stated inmates are not awakened to eat at mealtime and that inmates who were sleeping or who were uncooperative would have an opportunity to eat at a later time.

The interviewer stated policy requires every inmate to be offered a meal and asked how Deputy 6's meal practice satisfies this policy. Deputy 6 said the meal was left for the inmate to eat when he woke up, and he did not feel he was doing anything outside of policy. When questioned further, he admitted this practice was not "textbook policy."

Deputy 6 stated he was not aware that breakfast on April 20, 2022, was the second meal Brown did not receive due to meals being left on the table. He said if he knew this was the second meal Brown "refused," he would have briefed the next shift.

The interviewer also stated that policy required a deputy to supervise meal service, and that no deputy can be seen doing so in the video clip. Deputy 6 responded that neither he nor his partner monitored meal service at that time, and the CSA handling meal service in Sector 19 was not supervised. He stated that he was distributing meals simultaneously in another sector to be more efficient.

OIR Interview

Interview of Dr. Scott Luzi

On October 16, 2025, the OIR interviewed Dr. Scott Luzi, the independent forensic pathologist who conducted the post-mortem examination of Brown. The OIR and Dr. Luzi discussed Brown's actual time of death. Dr. Luzi indicated that the time of 8:27 a.m. listed in the Coroner Findings sheet was the time that Brown was discovered, not the time that he actually died. He indicated that Brown's actual time of death could only be narrowed to sometime less than 12 hours before the coroner

[9] "CAC" is a slang term derived from California Code of Regulations, Title 15, Section 3999.344, which provides the authority to involuntarily administer psychiatric medication to inmates. A search of the medical database from April 9-20, 2022, showed there was no record of Brown involuntarily receiving medication.

investigator made his observations of Brown at 11:45 a.m. on April 20th. When asked what Dr. Luzi relied on for this 12-hour window, he stated he used livor and rigor mortis, which provide insight into how long someone has been deceased.

The OIR and Dr. Luzi also discussed Brown's cause of death. The OIR shared Brown's lab results from AGMC and the medical note from the IRC physician stating Brown probably had rhabdomyolysis. Dr. Luzi indicated he did not specifically look for rhabdomyolysis during the post-mortem examination as testing for this condition is beyond the scope of a general autopsy. However, based on the medical records, Dr. Luzi indicated rhabdomyolysis could not be ruled out as a contributing factor to Brown's cause of death.

Logs

The OIR reviewed various OCSD logs related to this incident, including those pertaining to safety checks, inmate movement, dayroom use, recreation time, equipment inventory, and activities such as meal service and medication distribution.

Safety Checks

The Safety Check Logs indicate that between April 16-20, 2022, deputies conducted safety checks in Module L approximately every thirty minutes. Each of these safety checks was logged with the notation "All secure."

There was a discrepancy in one log entry. All the safety checks were captured on video with the exception of a check that was logged as beginning at 10:00 a.m. and ending at 10:04 a.m. on April 17, 2022. The OIR reviewed the surveillance footage and observed that while a deputy performed a check of the upper tier cells, no one performed a safety check of the lower tier, where Brown's cell was located.

Meals

The OIR obtained Activity Logs for April 17, 2022, through April 20, 2022. During this period, Brown was not served three breakfasts, and the Activity Logs for Module L simply referenced "chow distribution." Brown also did not receive two dinners. The Activity Logs for those two meals indicated, "Begin chow distribution/inmates given at least 15 minutes to eat." None of the Activity Log entries contained additional notes regarding specific inmates who refused or did not receive a meal, and there was no reference to Brown's missed meals.

Medical

The OIR reviewed the Drug Administration Log for Brown. The log indicates that beginning on April 11, 2022, through April 13, 2022, Brown refused his once-a-day Olanzapine medication. The log also shows that beginning on April 14, 2022, through April 19, 2022, Brown refused his twice-a-day Olanzapine medication. The log identifies the person who made each particular entry and the time it was entered.

Photographs

Copies of photographs from the Orange County Crime Lab and Orange County Coroner's Office were also reviewed by the OIR. The photos depict Brown's body, medical equipment, Cell 5, and Sector 19.

Some photos of Brown's body were taken at the scene on April 20, 2022, outside of Cell 5 at the IRC. They show Brown's body lying supine on the mattress and with a towel covering his groin. The photos show Brown's hands handcuffed in front of his torso and pointing upwards, with apparent rigor mortis in his arms. Other photos of Brown's body were taken during the autopsy one week after his death. These photos show different parts of Brown's body as they were examined by the forensic pathologist.

Additional photos showed the interior of Cell 5 from the scene examination on April 20, 2022. The photos show the cell's concrete bed attached to the left wall, a metal toilet/sink feature mounted on the back wall, and a metal table and seat affixed to the right wall. It cannot be determined from the photo whether the water was on for the toilet/sink feature. The floor and table are covered with food debris and trash, including seven styrofoam food containers, three brown paper bags, five empty milk cartons, plastic wrap, and plastic utensils. There is also what appears to be some type of brown debris smeared on the ground.

OCSD Policies

The OIR reviewed relevant policies contained in the OCSD's Policy Manual and the Custody and Court Operations Manual (CCOM). The following policies and procedures were in effect at the time of Brown's death:

CCOM 2615.2.1 – Hunger Strike Procedures

When an inmate initiates a hunger strike, CCOM section 2615.2.1 outlines the actions to take to provide for the inmate's safety and well-being while minimizing disruption to the jail facility operations. Section 2615.2.1 requires the water supply in the inmate's cell to remain on to allow access to drinking water. If the water supply must be shut off for any reason, section 2615.2.1 requires staff to provide drinking water to the inmate at least once an hour and to document on the door log whether or not the water was consumed.

CCOM 3002.7 – Inmate Meals

CCOM section 3002.7 provides that every inmate will be offered a tray of food. The policy states that each tray is to contain a complete meal, beverage, and utensils. The policy has specific requirements related to inmates housed in Module L, including that a CSA serves the meals under the direction of a deputy, inmates eat their meals in their cells, and a Prowler Deputy visually monitors the meal service. The cells in Sector 19 of Module L are equipped with ports in the doors to pass the tray of food into the cell. Section 3002.7 also states that combative or hostile inmates are not to be served hot items.

The policy goes on to state that staff are required to return unconsumed food and drink to the kitchen and ensure that inmates do not store food. Additionally, the policy requires that the CSA "return to the first inmates that were served and begin collecting trays, uneaten food, paper trash and utensils."

Section 3002.7 also states that the Module Deputy will note in the Module Log any inmate who refuses to eat two meals in succession. Additionally, the deputy will send a memo to the nurse identifying inmates who have refused two successive meals.

CCOM 1716 – Safety Checks

At the time of Brown's death, section 1716 of the CCOM set forth the requirements for safety checks. Section 1716.1 defined a safety check as "a direct visual observation of each inmate located in an area of responsibility." The section stated the "purpose of conducting safety checks is to maintain the safety and health of inmates and the security of our facilities."

Section 1716.2 stated that while the methods of conducting safety checks may vary throughout jail facilities, all staff must "conduct timely, thorough safety checks." Further, 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." Additionally, staff must pay special attention to areas with low visibility, as well as investigate any unusual circumstances or situations.

The following policies were implemented after Brown's death:

Policy 902 – Inmate Safety Checks

Policy 902 updated and replaced CCOM Section 1716 – Safety Checks. The policy was added to the OCSD's Policy Manual by June 2023. The current version of Policy 902 defines a safety check as "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."

Policy 902 updated the OCSD's safety check language to articulate that the purpose of a safety check "is to ensure there are no inmates displaying obvious signs of distress requiring assistance, maintaining the safety and welfare of each inmate, and ensuring the security of the facilities." The policy also now requires deputies to check for obvious signs of life, such as talking, eating, head movement, or movement of the inmate's extremities. For an inmate who appears to be sleeping, deputies are required to check for obvious signs of trauma or distress, as well as obvious signs of life.

Policy 902 adopted much of the language of CCOM 1716.2, stating that methods of conducting safety checks may vary, but deputies will "conduct timely, thorough inmate safety checks." Safety checks must be conducted from a location which provides a clear, direct view of each inmate, and deputies must be close enough to each inmate to ascertain their presence and apparent physical condition. Deputies must also investigate any unusual circumstances or situations.

Policy 902 requires that a safety check must begin within forty-five minutes from the previous check, except for designated behavioral health housing locations, where safety checks must begin within thirty minutes. Every safety check must be documented in a log.

CCOM 1803 – Response to Intentional Flooding of a Cell

Section 1803 was added to the CCOM after Brown's death. This section was present in the version of the CCOM dated February 23, 2023, and remains in the CCOM to date. Under the current section 1803 requirements, if water in an occupied cell has to be turned off due to intentional flooding, a sergeant must be notified prior to turning off the water. An entry must be made on the Guard Station Log documenting the cell, affected inmate, circumstances requiring the water to be turned off, and the sergeant who was notified.

Section 1803 also states that the water will be turned back on after six hours have elapsed. If circumstances warrant the water remaining off for longer than six hours, Watch Commander approval is required and must also be documented in the Guard Station Log. Finally, section 1803 states that water must be offered to the inmate during every safety check.

Coroner's Autopsy Report

On October 27, 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. Luzi on April 27, 2022, at 8:00 a.m. Dr. Luzi identified Brown's conditions including delusional disorder and a history of hypertension. He determined the cause of death to be dehydration due to probable lack of water intake. The manner of death was undetermined.

OCSD Investigation

Once the OCDA completed its investigation into Brown's custodial death in December 2023, the OCSD initiated an internal investigation. The OIR reviewed reports from the internal investigation, including an Administrative Review Board presentation, internal memoranda, and notices of discipline.

From April through July of 2024, the OCSD interviewed 14 employees, including nine deputies, four CSAs, and one sergeant. The department analyzed potential violations of 15 distinct policies and determined that seven policies were violated by personnel. The violations of policy related to performance of duty; incurring liability; conducting safety checks; inmate meals; module book count; issuance of radios; and uniform and equipment. Allegations of policy violations were sustained for six deputies and one CSA. The employees were notified of disciplinary action in October 2024, and shortly thereafter, the case was closed.

Analysis

Access to Water

Cell Water Status

Each cell has a steel fixture affixed to the rear wall. The fixture has a toilet on the lower portion and a sink and water fountain on the top. According to the administrative sergeant, the fixture has two water shut off valves, with one controlling the water to the toilet and the other controlling the water to the sink and water fountain.

On April 13, 2022, MD 1 completed a psychiatric progress note indicating that Brown's cell was partially flooded. The next day, MD 2 conducted a quick medical sick call and documented that Brown flooded his entire room.

On April 15, 2022, MD 3 completed a psychiatric progress note indicating that staff had reported that Brown has been flooding his cell, that the water was turned off, and that they were providing him with water and Gatorade on a regular basis. The OIR requested records or logs of when the water was turned off and on in Module L, Sector 19, Cell 5 from April 9, 2022, through April 20, 2022. The OCSD indicated that they "did not have a policy in place at the time of this incident to

record water being turned off." As a result, the MD 3 progress note is the only record provided to the OIR that indicates that the water to Brown's cell was turned off.

The OIR also reviewed video beginning April 16, 2022, through Brown's discovery on April 20, 2022, and observed that a towel was on the floor on the outside of Brown's cell door to prevent water from spreading into the dayroom. None of the information provided by the OCSD indicates when the towel was placed. The towel was on the floor in front of Brown's cell for all the days captured on video.

On April 17, 2022, RN 6 submitted a mental health report, which included that Brown's cell was flooded. The next day, April 18, 2022, MD 1 completed another psychiatric progress note indicating that Brown's cell was partially flooded.

It is reasonable to infer that at some point the water in Brown's cell was turned off. However, given the OCSD's lack of documentation, it is impossible to conclusively establish when it was turned off or how long it was off.

Following Brown's death, the OCSD added section 1803 to the CCOM addressing the response to intentional flooding of a cell.[10] Under the current policy, if water in an occupied cell is turned off due to intentional flooding, a sergeant must be notified beforehand. Additionally, an entry must be made on the Guard Station log "documenting the cell, affected inmate, circumstances requiring the water being turned off, and the Sergeant who was notified."[11]

CCOM Section 1803 requires that the water be turned back on after six hours have elapsed. If circumstances warrant the water remaining off for longer than six hours, documented Watch Commander approval is required.[12] "[T]he cell, affected inmate, circumstances requiring the water being turned off and the Watch Commander who approved the extension" must also be documented.[13]

One of the issues encountered by the OIR in conducting this review was determining whether the water in Brown's cell was on or off, and when. While CCOM Section 1803 provides guidance and ensures some documentation in situations where water to a cell is turned off, it could still be improved. Although the policy requires documentation when the water is turned off or the shutoff is extended, there is no requirement that an entry be made when the water is turned back on. As important as it is to document that the water to a cell has been turned off, it is equally, if not more important, to document that the water for an incarcerated person has been restored and when.

Recommendation

Update CCOM section 1803 to require that restoration of water to a cell be documented in the Guard Station Log.

[10] CCOM 1803 – Response to Intentional Flooding of a Cell (February 23, 2023)
[11] CCOM 1803 – Response to Intentional Flooding of a Cell (September 2, 2025)
[12] CCOM 1803 – Response to Intentional Flooding of a Cell (September 2, 2025)
[13] CCOM 1803 – Response to Intentional Flooding of a Cell (September 2, 2025)

Provision of Liquids

On April 15, 2022, MD 3 completed a psychiatric progress note which indicated that staff reported they were providing Brown with water and Gatorade on a regular basis. In order to determine when, and how frequently, drinking water or Gatorade was provided to Brown, the OIR requested water and Gatorade distribution logs or records from the OCSD. The OCSD responded that they "did not have a policy in place at the time of this incident to record water distribution." The OCSD also indicated that medical staff "does not maintain log(s) for recording Water and Gatorade distribution." As a result, the MD 3 progress note is the only record that was provided to the OIR indicating that Brown received water or Gatorade on a regular basis.

The OIR also reviewed interviews of jail and medical staff conducted by OCDA investigators. None of the interviews contained questions related to Brown receiving liquids or having access to water. This is likely because Brown's cause of death of dehydration was not known at the time the interviews were conducted.

The OIR reviewed video from April 16, 2022, through Brown's discovery on April 20, 2022, to verify that Brown received liquids on a regular basis. On April 16 at 10:14 a.m., LVN 1 and a deputy went to Brown's cell carrying a water bottle and cups. The hatch to Brown's cell was opened, and Brown can be seen coming to the door. LVN 1 spent about 40 seconds in front of Brown's cell. LVN 1 then turned to the table outside of Brown's cell, where he filled two cups from the water bottle. LVN 1 then left the sector, leaving the cups on the dayroom table. Brown did not receive breakfast or lunch, which would have included a beverage. Instead, those meals were placed on the table outside of his cell. During dinner service, Brown was given the earlier meals, as well as dinner and the two cups left by LVN 1. Later in the evening, Brown's cell door was opened, and he was given a brown bag by LVN 3. There is no record of what was contained in the bag.

On April 17, Brown received both breakfast and lunch, which would have included a beverage. He did not receive the dinner meal, and no one was observed providing Brown with any other liquids on the 17th.

Similarly, on April 18, Brown received lunch and dinner, which would have included a beverage. However, Brown did not receive breakfast, and no one was observed providing him with any other liquids on the 18th.

On April 19, LVN 1 conducted medication pass at 8:00 a.m. In addition to carrying the medication, LVN 1 was carrying a water bottle in his pocket. LVN 1 walked past Brown's cell without stopping and provided no liquid. At 10:53 a.m., LVN 1 approached Brown's cell with a water bottle. He stood looking into Brown's cell for about seven seconds and then turned and left without providing any liquid to Brown. Brown only received lunch on April 19, which would have included a beverage. Brown did not receive breakfast or dinner, and no one was observed on video providing him any other liquids.

On April 20, Brown did not receive breakfast, and no one was observed on video providing him with any liquids.

In the five days of video reviewed by the OIR, only one instance of liquid being provided without a meal was observed. Coupled with the fact that Brown was served less than half of his regularly

scheduled meals, it is unlikely that Brown received water or Gatorade on a regular basis if the water to his cell was off for any prolonged period during the dates reviewed.[14]

As previously mentioned, the OCSD recently updated its policy related to responding to intentional flooding of a cell. The updated policy now requires that "[w]ater will be offered to the inmate on every safety check."[15] However, it may not be sufficient to address the issue of dehydration to merely "offer" water to an inmate, especially if that inmate is housed in a unit for individuals with serious mental health conditions.

Brown was classified as gravely disabled, and medical staff repeatedly noted that he was unable to engage with them or follow their directions. Inmates housed in mental health modules, like Brown, often have difficulty communicating coherently. As such, any time the water to an occupied cell is shut off, water should be provided, rather than simply offered, to the affected inmate.

Recommendation

Update CCOM section 1803 to require that when the water to a cell has been turned off, deputies provide the inmate with drinkable water, or ensure the cell already contains drinkable water, during every safety check.

When an inmate is on a hunger strike and the water to their cell has been shut off, the CCOM requires staff to document in a log every hour whether the inmate has consumed the provided drinking water.[16] Notably absent from the CCOM is a requirement that staff document whether an inmate who is not on a hunger strike, but who is housed in a cell without access to water, has consumed drinking water. There is no reason to differentiate the procedures for water shutoff documentation based on whether an inmate is flooding his cell or participating in a hunger strike.

Recommendation

Update CCOM section 1803 to require documentation of the distribution of drinking water to an inmate housed in a cell with the water turned off, as well as whether the drinking water was consumed.

In fact, any situation in which water is turned off to an occupied cell for an extended period should result in the same documentation requirements and regular distribution of drinking water. As CCOM section 1803 is limited and specific to situations where a cell has been intentionally flooded, the OCSD should expand the policy to include other situations where the water to a cell may be turned off, such as inmate self-harm and the disposal of drugs or contraband.

Recommendation

Expand CCOM section 1803 to address situations other than intentional flooding where the water to a cell may be turned off.

---

[14] Because MD 3's progress note did not contain more specific details, it is not possible to determine when the water was off in Brown's cell.

[15] CCOM 1803 – Response to Intentional Flooding of a Cell (September 2, 2025)

[16] CCOM 2615.2.1(e) – Hunger Strike Procedures (April 29, 2025)

Failure to Provide Meals

As part of viewing video to determine whether Brown was provided with liquids, the OIR had an opportunity to observe meal distributions from April 16, 2022, through Brown's discovery on April 20, 2022. Based on this review, the OIR determined that Brown was not provided meals during seven of the last 13 meal distributions that occurred before he was found unresponsive in his cell. Given that video was only reviewed for the last days of Brown's time in custody, it is unknown if Brown missed any additional meals in prior days.

BROWN MEAL DISTRIBUTION

Meals	4/16/2022	4/17/2022	4/18/2022	4/19/2022	4/20/2022
Breakfast	N	Y	N	N	N
Lunch	N	Y	Y	Y	
Dinner	Y	N	Y	N	

During the five days reviewed, Brown was not given lunch one time. He received only one breakfast and two dinners.

There were at least three occasions where it is likely that Brown went 24 hours without receiving a meal. The OIR began its video review at 12:00 a.m. on April 16, 2022. On that day, Brown's breakfast and lunch were not given to him at the regularly scheduled time. Instead, they were left on the dayroom table in front of his cell. The first meal that Brown received was at dinner time. A deputy placed his dinner, as well as some liquid and the breakfast and lunch trays from earlier in the day, into his cell. Assuming Brown was given dinner on April 15, 2022, Brown did not receive any food for 24 hours until dinner was served again on April 16.

Brown also went 24 hours between meals after lunch on April 17. He received lunch on April 17, but did not receive dinner that night or breakfast the following morning. Brown received lunch on April 18, which meant he once again went 24 hours without meals.

On April 19, Brown's breakfast was once again placed on the dayroom table outside his cell. It sat on the table for ten hours until a deputy threw it away. Brown received lunch on April 19. His dinner was placed on the dayroom table, and then thrown away by a CSA about four and a half hours later.

Brown's breakfast on April 20 was also placed on the dayroom table outside his cell. It was still in the same place when Brown was discovered at 8:28 a.m. After missing breakfast on April 20, Brown's next scheduled meal would have been lunch. As a result, if Brown had not been discovered deceased, it is likely he again would have gone at least 24 hours without a meal.

The chart above clearly shows that there were two days in which Brown received only one regularly scheduled meal. More concerning is the fact that there were no days in which Brown received all three meals.

Meal Policies

Under section 3002.7 of the CCOM, every inmate is required to be offered a tray of food.[17] Inmates in Module L eat their meals in their cells, and all cells in sector 19 are equipped with a hatch in the door to pass the meals into the cell.[18] The video reviewed by the OIR contains no audio, so it is not possible to determine whether Brown was actually offered a tray of food on certain occasions when a meal was not served to him.

The Module Deputy is required to note in the Module Log any inmate who refuses to eat two meals in succession.[19] The deputy is also required to send a memo to a nurse identifying inmates who have refused two successive meals.[20] In this incident, none of the missed meals were documented in the Module Log. Similarly, the OIR was not provided with any memos sent to nursing staff identifying Brown as an inmate who refused or, on three occasions, did not receive, two successive meals.

Internal Investigation

During its internal administrative investigation, the OCSD identified that Brown was not provided dinner on April 19, 2022, and breakfast on April 20, 2022. The OCSD investigation did not, however, uncover the five other missed meals from April 16 through April 19 that were observed by the OIR. As part of the administrative investigation, the deputies who failed to provide dinner on April 19 and breakfast on April 20 were interviewed by the OCSD. The interviews took place in May and July 2024, more than two years after Brown's death.

When Deputy 5 was asked why he told an inmate worker to place Brown's dinner on the dayroom table instead of giving it to Brown, he could not recall the reason. He speculated Brown either did not wake up for dinner or it was unsafe to open the hatch on the door.

Deputy 6 was interviewed regarding not providing Brown breakfast on the morning that he was found. Deputy 6 indicated that he would usually not open hatches for cells that have a towel outside of them because inmates in those cells are "flooders" who present an issue because of their unpredictability. He explained that hatches are opened for meals based on the history with each inmate. If he knows an inmate will cause issues, he will not open the hatch and will instead leave the meal on a nearby dayroom table for deputies to provide to the inmate.

There are no stated exceptions in current policy, or the policies in place at the time of Brown's death, to the requirement that every inmate be offered a tray of food. Both deputies who failed to provide a meal to Brown referenced safety reasons when asked about their conduct. However, while CCOM section 3002.7 states that combative or hostile inmates are not to be served hot items, there is no indication in the policy that meal service for these inmates can be skipped entirely. As such, according to the Department, both deputies violated CCOM section 3002.7 - Inmate Meals.

[17] CCOM 3002.7 – Inmate Meals (October 21, 2021)
[18] CCOM 3002.7 – Inmate Meals (October 21, 2021)
[19] CCOM 3002.7 – Inmate Meals (October 21, 2021)
[20] CCOM 3002.7 – Inmate Meals (October 21, 2021)

Missed Opportunity

Brown's body was examined at 11:45 a.m. on April 20, 2022, by a Deputy Coroner. According to the Department's administrative review presentation, the Deputy Coroner had difficulty assessing Brown's time of death and estimated Brown had been deceased for approximately eight hours. This estimate places his time of death around 3:45 a.m., which is consistent with Dr. Luzi's estimate that Brown's death was sometime less than 12 hours before the Deputy Coroner made his observations of Brown.

At 3:31 a.m., Deputy 6 entered the sector and opened the hatch of all occupied cells except Brown's. Video shows Deputy 6 walking past Brown's cell without stopping. After he opened all the other hatches, Deputy 6 left the sector. In doing so, he missed the opportunity to check on Brown's health and safety.

Similarly, at 3:44 a.m. breakfast was served, and no one approached Brown's cell. Instead, Brown's meal was placed on the dayroom table outside of his cell. The CSA and inmate workers then proceeded to go to all the other cells and serve breakfast. It cannot be definitively determined Brown was alive at 3:44 a.m. However, by failing to serve him breakfast, the jail staff missed the opportunity to check on his well-being or notice if he was in medical distress.

Quality of Safety Checks

A safety check is a direct visual observation of an inmate performed at random and varied intervals.[21] California Code of Regulations section 1027.5 sets forth the requirements for safety checks in local detention facilities. CCR section 1027.5 requires that safety checks "be conducted at least hourly through direct visual observation of all inmates."[22]

According to the Ninth Circuit Court of Appeals, "pre-trial detainees do have a right to direct-view safety checks sufficient to determine whether their presentation indicates the need for medical treatment."[23] To corroborate its analysis, the Ninth Circuit incorporated a post-incident District Court case describing the purpose of safety checks.[24] In this case, the District Court noted that safety checks are designed to ensure that inmates are alive-and-well and to determine whether they need any medical treatment.[25] The District Court went on to indicate that failure to perform proper safety checks increased an inmates' risk of harm and could threaten their health or, at the very least, delay medical assistance and emergency response.[26]

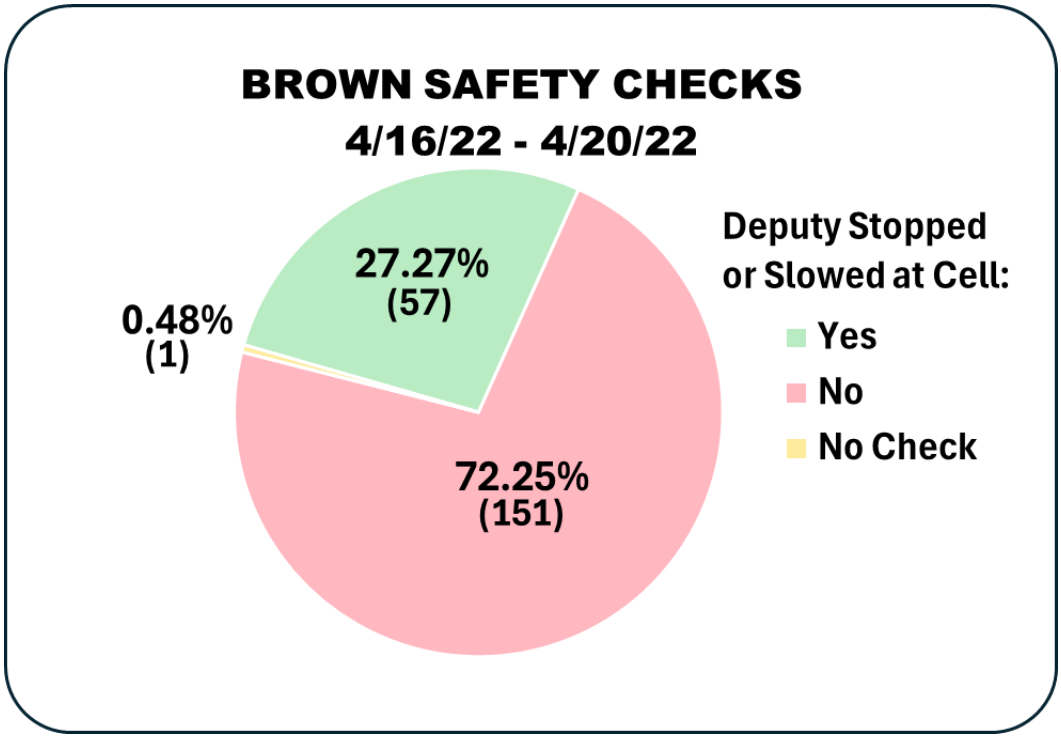
At the time of this incident, the CCOM set forth the requirements for safety checks in Orange County jails. The CCOM indicated that "[t]he purpose of conducting safety checks is to maintain the safety and health of inmates and the security of our facilities."[27] In the second quarter of 2023, the OCSD created Policy 902 – Inmate Safety Checks. Policy 902 updated and replaced CCOM section 1716 – Safety Checks. The safety check language was updated to articulate that "[t]he

---

[21] Policy 902.1 Inmate Safety Checks – Definition and Purpose (4/9/2025)
[22] 15 CCR 1027.5 (2021)
[23] *Gordon v. Cty. of Orange* (9th Cir. 2021) 6 F.4th 961, 973
[24] *Gordon v. Cty. of Orange* (9th Cir. 2021) 6 F.4th 961, 972, fn. 6
[25] *Medina v. County of L.A.*, 2020 U.S. Dist. LEXIS 130732, *44
[26] *Medina v. County of L.A.*, 2020 U.S. Dist. LEXIS 130732, *44
[27] CCOM 1716.1 – Safety Checks (October 21, 2021)

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."[28]

Both the CCOM and Policy 902 provide that staff will conduct timely, thorough safety checks.[29] Because Module L is a designated behavioral health housing location in the IRC, safety checks are required to be conducted at least every thirty minutes.[30] During an inmate safety check, deputies are required to check for obvious signs of life, which can include talking, eating, or movement.[31] For an inmate who appears to be sleeping, deputies are required to "check for obvious signs of trauma or distress, as well as obvious signs of life."[32]



Via surveillance footage, the OIR observed every safety check that was conducted from April 16, 2022, through Brown's discovery on April 20, 2022. Deputies were required to conduct checks every thirty minutes, which resulted in a total of 209 checks during that period. One out of those 209 safety checks was not conducted. In 151 of the 209 checks, the deputy conducting the safety check did not stop or slow down while passing Brown's cell.

The safety checks conducted on the day Brown was discovered deceased clearly failed to ascertain signs of life. Seventeen safety checks were conducted on April 20, 2022, from 12:00 a.m. until Brown was discovered during medication pass at 8:28 a.m. As mentioned previously, Dr. Luzi indicated that Brown's actual time of death can be narrowed to sometime less than 12 hours before

[28] Policy 902 – Inmate Safety Checks
[29] CCOM 1716.2 (October 21, 2021)
[30] CCOM 1716.3 (October 21, 2021); Policy 902.6 Frequency of Inmate Safety Checks (4/9/2025)
[31] Policy 902.1 Inmate Safety Checks – Definition and Purpose (4/9/2025)
[32] Policy 902.1 Inmate Safety Checks – Definition and Purpose (4/9/2025)

the coroner investigator made his observations of Brown at 11:45 a.m. Additionally, according to the Department's administrative review presentation, the coroner investigator indicated that Brown was deceased for eight hours before the on-scene examination took place. As such, Brown's estimated time of death was likely somewhere between 11:45 p.m. on April 19 and 3:45 a.m. on April 20. Therefore, most, if not all, of the 17 safety checks on April 20 took place when Brown was likely already deceased.

Deputies who completed the safety checks at 7:00 a.m., 7:30 a.m., and 8:00 a.m. on April 20, 2022, were interviewed by OCDA investigators. No obvious signs of life were identified during those interviews. Several of the interviewed employees who were present when Brown was treated at the scene commented on their observations of rigor mortis of his body, which demonstrates that deputies repeatedly passed by him and failed to notice he was already deceased.[33]

In reviewing each safety check conducted in the 24 hours leading up to the discovery of Brown's body, the OIR determined the majority of these safety checks were inadequate as deputies generally did not allocate the time or attention needed to ascertain Brown's physical condition. Out of the 48 safety checks conducted in the 24-hour period, 13 safety checks were conducted in approximately one second and 24 safety checks were conducted in approximately two seconds. Only 23% of the safety checks lasted longer than two seconds. The longest safety check during this time period was 13 seconds.

Presuming Brown's time of death was around 3:45 a.m., the safety check closest in time took place at 4:03 a.m. The deputy walked by Brown's cell without breaking stride in approximately one second. The surveillance video shows the deputy to be looking down at paper in his hands, and he does not appear to even look inside Brown's cell.

[33] According to Dr. Luzi, the forensic pathologist, rigor mortis sets in within two to four hours after death.

It is possible to quickly ascertain the physical condition of incarcerated persons during a safety check if they are up and moving about 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. In addition, when an inmate's face is not visible, it is more difficult to perceive signs of life. Brown was not up and moving about his cell the morning of April 20, 2022. Rather, he was lying face down on his bunk, which would have made it difficult for deputies to ascertain his physical condition without stopping to observe signs of life and determine whether he needed medical assistance.

Policy 902 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 considers it important to unequivocally state that a deputy must stop in front of a cell where they believe an incarcerated person is sleeping.

Effective monitoring of incarcerated persons is crucial to prevent self-harm, injury, or other safety issues. Safety checks when 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. Brief observation of 1 to 2 second safety checks did not provide sufficient time for a thorough assessment of Brown's well-being or the condition of his cell. A safety check that is too brief risks delaying necessary medical treatment and increases the likelihood of harm to incarcerated persons, contravening their constitutional rights.

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.

Medical Care

The OCSD contracts with the Orange County Health Care Agency (OCHCA) to provide health care services in the County's jail facilities. Correctional Health Services (CHS), a division of OCHCA, provides medical and mental health care to inmates. CHS staff are responsible for evaluating the medical needs of inmates and providing treatment necessary to prevent deterioration, improve medical conditions present on admission, and treat medical conditions arising during the period of detention. OCSD staff and Medical and Mental Health Services staff are required to maintain necessary communications in order to ensure awareness of the general health condition of inmates.

CHS Policy 3013 concerns the administration of medication to inmates. Pursuant to the policy, CHS licensed nurses issue, administer, monitor, and document administration of all medications ordered by CHS prescribers. In Module L, security staff accompany a licensed medication nurse during routine medication passes at two scheduled times per day. The nurse is required to document the administration of medication in the inmate's electronic health record as soon as possible.

Inmates have the right to refuse recommended health care while in custody. Under Policy 3013 and CHS Policy 5001 – Refusal to Accept Treatment, when an inmate refuses a prescribed medication, the medication nurse is required to obtain a completed "Refusal to Accept Treatment and Release of Liability" form. This form should include the specific health care being refused; the reason for the refusal using the inmate's words; education given to the inmate regarding possible consequences to the inmate's health; and the inmate's signature acknowledging their understanding and assuming the risks associated with the refusal. If an inmate refuses to sign a refusal form, an additional staff witness signature is to be obtained.

By signing a refusal form at any one particular time, an inmate does not waive their right to subsequent health care. Unless an inmate states they choose to refuse all future treatments and sign a one-time refusal, the "Refusal to Accept Treatment and Release of Liability" form is to be completed each time an inmate refuses care. As such, even if an inmate has refused a medication at one particular time, the medication nurse must continue to make that medication available to the inmate at routine medication passes for as long as a valid order is in place. Additionally, all medication refusals obtained by an LVN are to be screened and reviewed by an RN for medication adherence counseling.

The OIR reviewed the medical care Brown received while in custody. On April 11, 2022, an OCHCA psychiatrist performed a psychiatric evaluation of Brown. During the evaluation, Brown was hallucinating and talking incoherently to himself. The psychiatrist prescribed an antipsychotic medication, Zyprexa (Olanzapine), to be taken once a day. Records indicate Brown refused the medication that day and the following day.

On April 13, 2022, an OCHCA psychiatrist attempted to assess Brown. Brown was observed to be naked and pacing back and forth. He spoke illogically and incoherently while making shooting hand gestures. The psychiatrist was unable to engage Brown in conversation, and increased the administration of the Olanzapine prescription from once to twice a day. However, records indicate Brown continued to refuse his prescribed medication and to consent to providing samples for laboratory testing.

Medication Refusals

Medication pass typically took place around 8:00 a.m. and 8:00 p.m. in Sector 19. Various issues were observed concerning the performance and documentation of medication pass on April 16-19, 2022.

BROWN MEDICATION REFUSALS

Morning	4/16/2022	4/17/2022	4/18/2022	4/19/2022
Medical Stopped at Cell	Y	Y	N	N
Refusal Form Completed	Y	N	Y	Y
Medication Given	N	N	N	N
Evening	**4/16/2022**	**4/17/2022**	**4/18/2022**	**4/19/2022**
Medical Stopped at Cell	Y	Y	N	N
Refusal Form Completed	N	N	N	N
Medication Given	N	N	N	N

On April 16, during morning medication pass, LVN 1 stopped at Brown's cell to offer him his medication. It appears Brown refused the medication, and therefore the LVN completed a refusal form. This is the only occasion in which medication pass appears to have complied with CHS policy during this period.

During evening medication pass on April 16 and both medication passes on April 17, an LVN stopped at Brown's cell but did not complete a refusal form. The refusal of medication was repeatedly documented in the Drug Administrations log in Brown's health record with the entry "Not Administered – Refused". However, no refusal form was completed, which would have contained information including the medication or treatment being refused, the reason for refusal, the staff member who offered the medication, the witness to the refusal, and whether it was a one-time refusal or a refusal of all future doses. No refusal form was completed for morning medication pass on April 17 or for any of the evening medication passes.

More alarming are the occasions where an LVN completed a refusal form despite never stopping at Brown's cell to offer him his medication during medication pass. On the morning medication passes for April 18 and April 19, a medication refusal was documented and witnessed even though Brown's medication was not offered to him, and refusal was therefore impossible.

On April 18, at 8:12 a.m., LVN 4 and a deputy can be seen on surveillance footage conducting medication pass in the sector. While LVN 4 was interacting with an inmate in the adjacent cell, the deputy paused outside Brown's cell for about 4 seconds. The deputy then continued walking and LVN 4 walked past Brown's cell without stopping. LVN 4 completed a refusal form, documenting "no reason given" for Brown's reason for refusing his medication.

On April 19, at 8:09 a.m., LVN 1 and a deputy conducted medication pass in the sector. No one stopped at Brown's cell to offer medication. LVN 1 and the deputy conducted medication pass and left the sector without ever interacting with Brown. Despite no interaction with Brown, LVN 1 completed a refusal form, documenting "no comment" for Brown's reason for refusing his

medication. The refusal forms for these two medication passes also included the signatures of witnesses to the refusals, despite a refusal not actually taking place.

Finally, during the evening medication passes on April 18 and April 19, no one stopped at Brown's cell to offer him his medication. LVN 5 and a deputy walked past Brown's cell without stopping on both occasions. No refusal form was completed for these occasions. However, the Drug Administrations log in Brown's health record contains entries stating, "Not Administered – Refused."

Brown did not receive and take his prescribed medication at any time while in custody. It is not known if Brown would have ever taken his medication if made available to him during medication pass. However, on at least four medication passes during his final two full days in custody, the medication was not even offered to him.

Pursuant to CHS Policy 3013 – Medication Administration, "all medication refusals obtained by LVN's shall be screened and reviewed by a RN for medication adherence counseling." The policy requires the RN to enter a note into the inmate's health record documenting the reason the inmate refused the medication along with the education and counseling provided. There were no notes found in Brown's health record indicating an RN screened and reviewed the medical refusals obtained by the LVNs.

The OIR brought these issues about Brown's medical care to the attention of CHS. The CHS director observed the surveillance footage of the medication passes that were conducted while Brown was in custody and explained the proper procedure. She explained that the expectation is that the LVN will physically go speak to the patient face to face and offer them their medication. While there is no specific length of time this interaction needs to take, there needs to be a discussion. Even if an inmate has previously refused a medication, the LVN must stop at the inmate's cell and offer the medication during every single medication pass. She explained that unless a doctor ordered discontinuation of a medication, the LVN is required to continuously offer the medication to the inmate in case the inmate should change their mind. The CHS director confirmed that the medication passes she observed in the surveillance footage in which LVNs did not stop at Brown's cell to offer medication did not comply with CHS policy.

The CHS director further explained that if an inmate refuses medication during the interaction with the LVN, the LVN should find out the reason for the refusal and complete the refusal form. The LVN is responsible for obtaining a refusal form each time the inmate refuses their prescribed medication. The OIR asked the director to confirm if an entry in the Drug Administration log stating "Not Administered – Refused" means medical staff actually went to the patient at the date and time listed in the log and the patient refused the medication. She confirmed this is the expectation, and that the surveillance footage shows this is not what happened here.

The OIR also asked if the medication refusals that were obtained by LVNs were screened and reviewed by an RN for medication adherence counseling as required by Policy 3013. The CHS director stated each refusal is supposed to be screened and reviewed by an RN, and that these actions, if completed, should have been documented in the progress notes. She reviewed the progress notes in Brown's health record and observed that many appeared to be incomplete. She explained that the most important documentation is not the refusal form, but the progress notes

that accompany the refusal form which state what action the medical staff took. For every refusal, she stated there should be an RN or LVN note that goes with it to document their own action.

Lab Refusals

During Brown's psychiatric evaluation on April 11, 2022, MD 4 prescribed an anti-psychotic medication and ordered screening lab tests. On April 14, 2022, MD 2 completed a medical progress note stating that based on Brown's lab results from the hospital, Brown probably had rhabdomyolysis. MD 2 stated he intended to recheck a comprehensive metabolic panel and creatine kinase levels. MD 2 then went to see Brown and completed another progress note. The second note documented that Brown likely had "some level of rhabdo" but that he was not cooperating with getting labs checked. Brown's medical records indicate he repeatedly refused to consent to lab testing.

As with the medication refusals, discrepancies were found in the documentation of lab refusals. Lab refusals were documented, including that Brown was counseled about the consequences of refusing treatment, despite the RN not actually going to Brown's cell.

For example, on April 19, 2022, RN 9 completed a progress note stating, "Pt refused labs x3. Educated about treatment compliance. Explained risks and benefits, but pt continued to refuse. Will continue to offer." RN 9 entered a similar note on April 20, 2022, stating "Pt refused all labs x3. Educated about tx compliance, but continued to refuse and remains unpredictable." Based on a review of the surveillance footage, RN 9 did not go to Brown's cell.

During RN 9's interview with the investigator, she stated she relies on the deputies to find out if a patient is refusing labs, and that she personally does not go to the cells. RN 9 did not have any recollection of interacting with Brown herself.

As with the medication refusals, it is not known if Brown would have consented to the lab testing if it had actually been offered to him. However, on at least two occasions, the OIR verified that medical staff documented a lab refusal despite not interacting with Brown.

When this issue was presented to the CHS director, she stated it is not correct for an RN to rely on the deputies to convey medical information and that RN would have needed to see the patient themselves. She explained that every refusal should result from medical staff actually seeing the patient.

A few weeks after this discussion, the CHS director informed the OIR that their Medication Refusal Audit form had been updated to include video footage review. The form now states that CHS will review surveillance footage to verify the accuracy of staff documentation. The new questions to be addressed during an audit include whether staff is seen at the patient's door as reported on the refusal form, whether staff appear to be communicating or providing education during the time and date reported, and whether the person who signed as a witness is seen with the staff during the refusal. The CHS director further stated that they have begun auditing the medication refusal process in modules L and K with video review.

Recommendation

Update OCSD policy and procedure to require collaboration with CHS staff to conduct audits of inmate treatment refusals at regular intervals. OCSD and CHS staff should review surveillance footage against documentation in order to ensure treatment was actually offered, the refusal was accurately documented, and the deputy serving as a witness was present to hear the refusal.

Involuntary Treatment

California's Lanterman-Petris-Short (LPS) Act governs involuntary treatment for individuals with severe mental health conditions. The IRC has an LPS unit to provide mental health housing and treatment for inmates with mental health disorders.[34]

On April 18, 2022, MD 1 completed a psychiatric progress note documenting that Brown "would not likely improve without psychiatric medication" and he would be "referred to LPS unit for involuntary treatment." An LPS conservatorship would have granted legal authority to OCHCA to provide involuntary care to Brown. Establishing an LPS conservatorship following a referral requires an independent investigation by the Office of the Public Guardian, the filing of a petition with the Court, and evidence demonstrating beyond a reasonable doubt that the conservatorship is necessary. Medical staff at the IRC were not permitted to provide involuntary care to Brown before an LPS conservatorship was in place. Brown passed away before a treatment evaluation at a mental health facility took place. When meeting with the CHS director during the course of this review, she indicated CHS has made several improvements to its LPS unit procedures in the time since Brown's death. In 2022, admittance into LPS housing was based on a first come, first served system. CHS has since updated the waitlist evaluation procedures to be based on severity, and now determines which inmate on the waitlist has the greater need for LPS housing. Additionally, CHS expanded its LPS housing capacity in the IRC, increasing the number of beds for male inmates from 5 to 10.

Delay in Emergency Response

Pursuant to Policy 1018.33 – Incurring Liability, members of the OCSD must "exercise extreme caution and good judgment to avoid occurrences that might give rise to liability chargeable against the Department, the Sheriff-Coroner, or the county." In this incident, nearly four minutes passed from when OCSD personnel discovered Brown unresponsive until the time they entered his cell and checked on him.

During Deputy 1's administrative interview with OCSD, he explained how he tried different methods to get Brown's attention, such as slamming the door and verbal commands, when Brown did not wake up during med pass. When those methods were unsuccessful, he went to the connecting door to Sector 20 for assistance. Deputy 1 said he gave Deputy 4 a quick verbal update, and Deputy 4 advised that Brown had been combative previously and to not enter the cell without additional deputies. Deputy 1 said Deputy 4 went back to Sector 20 to get additional deputies while he continued to try to get Brown's attention through the cell door.

The interviewer asked Deputy 1 if there was a reason he did not use his radio to communicate the situation and need for additional deputies. Deputy 1 responded that he had been instructed to use

[34] CCOM 3002.20 Correctional Health Services Lanterman-Petris-Short (LPS) Unit (October 21, 2021)

the resources they had within the module before getting on the radio, unless there were some sort of obvious exigent circumstances. The interviewer informed Deputy 1 that from the time he opened Brown's cell door to when he went inside the cell to assess Brown was a little under four minutes, and he asked Deputy 1 if he thought that was a reasonable response time. Deputy 1 said he could have gone a little faster, and if he could go back and redo the situation, he would use the radio to request assistance.

Deputy 4 similarly described in his OCSD administrative interview how he responded when Deputy 1 asked for help. Deputy 4 said once they got to Brown's cell, they determined Brown was either in need of medical attention or "playing possum." He explained that "playing possum" is when an inmate acts as if they are unresponsive and then attacks staff when they enter the cell. At this time, Deputy 4 was at Brown's cell with Deputy 1 and two members of medical staff when he left to call for additional deputies. When questioned why additional deputies were needed with the amount of personnel already present, Deputy 4 responded, "just to be safer." He was asked what about Brown caused him to use such a high level of caution, and he stated he could not recall. The interviewer then asked what Deputy 4's reasoning was to heavily prioritize officer safety and delay medical intervention. Deputy 4 indicated he could not recall why he used such a high level of caution, but that he knew from past experience that inmates "play possum," and so he wanted additional deputies to hold Brown down.

Deputy 4 was also asked about not using a radio to call for help. He explained radios are not used in the early stages of an incident because there are plenty of deputies assigned to the module who can determine what is going on before needing to elevate the situation. He stated he usually carries a radio, and later agreed it would have been good to use a radio during this situation. The interviewer pointed out that the video shows Deputy 4 did not have a radio with him during the incident.

Deputy 4 was informed of the nearly four-minute delay in intervention, and he was asked if that was a reasonable response time. He responded it could have been quicker and agreed that waiting that amount of time to intervene could incur liability to the department.

Upon discovery of an unresponsive inmate, failure to provide immediate medical intervention can greatly increase the risk of severe harm or death. Additionally, the OIR agrees with the OCSD that an unreasonable response time could incur liability to the County.

Observations

Cleanliness of Brown's Cell

The conditions under which an inmate is confined are subject to scrutiny under the Eighth Amendment.[35] In its prohibition of "cruel and unusual punishments," the Eighth Amendment imposes a duty on custodial officials to provide humane conditions of confinement.[36]

[35] Farmer v. Brennan, 511 U.S. 825, 832 (1994)
[36] Farmer v. Brennan, 511 U.S. 825, 832 (1994)

During this review, the OIR observed that Brown's cell was littered with trash and old food, with food and waste smeared on the cell floor, walls, and door.

Jail staff were aware that Brown's cell was unclean. On April 15, 2022, the psychiatrist who went to assess Brown noted that his cell was littered with empty food containers and food was strewn "over the entire cell." Another mental health clinician noted on April 17, 2022, that the cell was cluttered with trash. Five out of the six deputies interviewed by the OCDASAU investigators commented on the unclean condition of Brown's cell. For example, Deputy 1 said that when he discovered Brown unresponsive, Brown's cell had a build up of trash and food smeared everywhere, and it smelled of urine. Deputy 3 stated Brown was always smearing urine and fecal matter on the cell walls and door.

In November 2020, the U.S. Supreme Court reversed the Fifth Circuit Court of Appeals' grant of qualified immunity in a conditions of confinement case.[37] That case involved correctional officers confining the inmate for six full days in "a pair of shockingly unsanitary cells" that were covered in massive amounts of bodily wastes.[38] The court held that no reasonable correctional officer could have concluded it was constitutionally permissible to house an inmate in such deplorably unsanitary conditions for such an extended period of time.[39] As such, the condition of a cell,

[37] Taylor v. Riojas, 141 S. Ct. 52 (2020)
[38] Taylor v. Riojas, 141 S. Ct. 52, 53 (2020)
[39] Taylor v. Riojas, 141 S. Ct. 52, 53 (2020)

especially as it relates to sanitation, can violate the Eighth Amendment's prohibition on cruel and unusual punishment.

The OIR was unable to ascertain if and when Brown's cell was cleaned while he was housed there. The OIR requested information and records about how often Cell 5 was cleaned between April 9 and April 20, 2022. The OCSD responded that a formal cleaning schedule for the cells of mental health inmates was implemented after this incident.[40] However, at the time of this incident, the department did not have a formalized cleaning schedule or a directive to document cell cleaning. According to the OCSD, inmates are provided cleaning supplies to care for their own cells, except for mental health inmates. As Brown was gravely disabled and housed in a sector where he was not provided cleaning supplies, the OCSD should have carried out its duty to ensure Brown was housed in a cell that was kept in sanitary conditions.

Any time jail personnel enter an inmate's cell is an opportunity to more directly ascertain the inmate's physical condition and well-being. By not regularly going into Brown's cell to clean, jail personnel missed an opportunity to check on him.

Recommendation

Issue a training bulletin reminding deputies of their individual obligation to ensure that inmates are housed in conditions that are sanitary and do not violate the Constitution.

OCDA Investigative Concerns

The OIR reviewed the OCDA's investigation of Brown's death in custody and had concerns about the thoroughness and accuracy of the investigation.

The greatest concern about the OCDA investigation is the failure to discover that Brown was not provided several meals leading up to his death. The OIR determined that Brown was not provided meals during seven of the last 13 meal distributions that occurred before he was found unresponsive in his cell. During each of these mealtimes, jail staff placed Brown's meal on the dayroom table outside of Brown's cell, where he did not have access to it. Because the OIR only reviewed surveillance footage of Sector 19 from Brown's final five days in custody, the OIR is unable to determine if jail staff regularly failed to provide Brown with meals in the prior days. The OCDA's letter makes no reference to this failure to feed Brown.

Considering the OCDA was aware that Brown's cause of death was dehydration due to probable lack of water intake, the most reasonable course of action would be to investigate Brown's access to food and water during his time in custody. The OCDA stated in its letter that OCSD jail logs confirm there were regular meal distributions to Module L while Brown was in custody. As a result, the OCDA stated that "[f]ood, water, and Gatorade were provided on a regular basis." The OCDA does not appear to have independently corroborated that Brown actually received food, water, and Gatorade on a regular basis while in custody. Rather than utilizing the surveillance footage which shows that there was no day from April 16-20 in which Brown received all three meals, the OCDA

[40] The OIR requested the formal cleaning schedule of Sector 19 that was implemented by the OCSD following this incident; however, the OCSD did not provide it.

appears to have relied solely on the OCSD's logs, which make no reference to Brown not receiving meals.

The OCDA concluded that there was no evidence "that anyone acted individually or collectively with such recklessness as to create a high risk of death or great bodily injury to Brown." The OCDA further stated that Brown "passed away from dehydration due to his own lack of personal care." As Brown was reliant on jail staff to provide him with meals and liquids, and the OCSD failed to provide these to Brown on at least seven occasions, the OCDA's conclusions are inherently flawed.

The OCDA goes as far as to conclude that Brown's "death was a natural one." However, a District Attorney is neither qualified nor authorized to determine a manner of death. In this case, the Orange County Sheriff-Coroner found that the manner of death was undetermined, indicating there was insufficient evidence to determine that the death was, in fact, natural.

A related concern about the OCDA investigation was an absence of key questions from investigators during their interviews of deputies and jail staff that would allow them to uncover all of the facts. For example, the investigators interviewed three deputies who conducted safety checks on the morning of Brown's death, and asked the deputies to describe how a safety check works. However, there was a lack of follow up questions about what the deputies actually observed during their safety checks of Brown on the day he died. For instance, Deputy 2 repeatedly remarked that Brown "looked fine" during the 7:00 a.m. safety check. The investigator did not ask what led the deputy to believe Brown "looked fine" or if the deputy actually observed any signs of life.

Regarding the 7:30 a.m. safety check, the only question the investigator asked about the safety check of Brown's cell was whether the deputy "noticed anything out of the ordinary." Deputy 3 responded "no," and the investigator moved on to another topic. The purpose of a safety check, however, is not only to identify circumstances out of the ordinary, but to ascertain whether an inmate is showing signs of life.

Similarly, though the investigators learned Brown's cause of death was dehydration, and they discovered the water to Brown's cell had been shut off, the investigators did not follow up to ask interviewed employees any questions about providing Brown with water or Gatorade.

Lastly, the OIR observed a missed opportunity in the OCDA's investigation regarding the scene examination. An investigator was assigned to examine the scene and did provide a description of Cell 5 at the time of Brown's death. The investigator noted that a metal toilet/sink fixture was mounted to the south wall of the cell. The information not included is whether the investigator checked whether the sink fixture was operational on the day of Brown's death, and whether Brown would have had access to water. The OCDA should make it a routine step in their investigation of a custodial death to check the status of the cell, including whether the water is on.

Recommendation

Update policy and procedure to require an OCDA investigator conducting a scene examination of a cell to check whether the water to the toilet/sink fixture is turned on.

OCSD Investigative Concerns

The OIR also had some concerns about the thoroughness of the OCSD's investigation. Regarding the missed meals, the OCSD identified that Brown was not provided dinner on April 19, 2022, and breakfast on April 20, 2022. Their investigation did not appear to uncover any of the previous missed meals.

Despite recognizing some of the missed meals, the Administrative Review Board stated that "meals appeared to have been distributed in accordance to CCOM Policy: 3002.7." As CCOM Policy 3002.7 requires every inmate to be offered a tray of food, the review board's conclusion of compliance with policy does not logically follow the evidence that Brown was repeatedly not offered a tray of food.

The Administrative Review Board also reviewed compliance with CCOM section 1716.3 and noted that safety checks were determined to be within 30 minutes of each other. Though the review board evaluated the frequency of the safety checks, their presentation did not include information about the actual performance of those safety checks.

The other main concern with the OCSD investigation is timeliness. Though Brown died on April 20, 2022, the OCSD's Internal Affairs Bureau did not conduct its investigation until two years later. The OCSD waited until the OCDA completed its independent investigation before commencing the internal investigation. Though the OCDA issued its letter on December 1, 2023, the Internal Affairs investigation still did not begin for approximately another five months.

The deputies and jail personnel involved in this incident were not interviewed until April through July of 2024. Because so much time had passed, the interviewed employees' memories of the events that took place were not fresh and they frequently answered that they could not recall in response to the interviewer's questions. Investigatory deficiencies based on recollection could be reduced if OCSD either conducted their interview of an employee at the same time as the OCDA interview, or conducted their own interviews shortly after the event at issue regardless of the status of an OCDA investigation.

Recommendation

Update policy and procedure to require Internal Affairs investigators to conduct initial interviews of involved personnel within a specific time frame after a custodial death.

Conclusion

In completing its review of Nicholas Brown's death in custody, the OIR reviewed evidence and information provided by the OCDA and OCSD, including reports, logs, photographs, videos, interviews, and policies.

Brown's cause of death was dehydration due to probable lack of water intake. The OCDA uncovered that the water to Brown's cell had been turned off and claimed that he was provided water and Gatorade on a regular basis. However, the OIR was unable to determine when the water was shut off and if or when Brown was provided with water or Gatorade. The OCDA stated Brown passed away due to his own lack of personal care, and that his condition of dehydration could not be reasonably and independently discovered by OCSD personnel. The OCSD failed to provide

Brown with seven meals during his final five days in custody, and it is not known if jail personnel regularly failed to provide Brown with meals in the prior days. The OCDA failed to discover that Brown was not being provided with meals.

Despite safety checks every half hour, Brown was likely deceased for at least five hours before he was discovered. The OIR recommends the OCSD implement additional training on how to accurately ascertain an incarcerated person's physical and psychological condition during safety checks.

Recommendations

1. Update CCOM section 1803 to require that restoration of water to a cell be documented in the Guard Station Log.
2. Update CCOM section 1803 to require that when the water to a cell has been turned off, deputies provide the inmate with drinkable water, or ensure the cell already contains drinkable water, during every safety check.
3. Update CCOM section 1803 to require documentation of the distribution of drinking water to an inmate housed in a cell with the water turned off, as well as whether the drinking water was consumed.
4. Expand CCOM section 1803 to address situations other than intentional flooding where the water to a cell may be turned off.
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. Update OCSD policy and procedure to require collaboration with CHS staff to conduct audits of inmate treatment refusals at regular intervals. OCSD and CHS staff should review surveillance footage against documentation in order to ensure treatment was actually offered, the refusal was accurately documented, and the deputy serving as a witness was present to hear the refusal.
7. Issue a training bulletin reminding deputies of their individual obligation to ensure that inmates are housed in conditions that are sanitary and do not violate the Constitution.
8. Update policy and procedure to require an OCDA investigator conducting a scene examination of a cell to check whether the water to the toilet/sink fixture is turned on.
9. Update policy and procedure to require Internal Affairs investigators to conduct initial interviews of involved personnel within a specific time frame after a custodial death.

OCSD RESPONSE

ORANGE COUNTY
SHERIFF'S DEPARTMENT

SHERIFF-CORONER DON BARNES

OFFICE OF THE SHERIFF

April 15, 2026

Via Email

Stella Lim
Interim Executive Director
Office of Independent Review
601 N. Ross St., 2nd Floor
Santa Ana, CA 92701
stella.lim@oir.oc.gov

Re: OIR In-Custody Death Review – Nicholas Brown (Booking#3233780)

Dear Mrs. Lim:

Thank you for the comprehensive report from the Office of Independent Review (OIR) regarding the in-custody death of Nicholas Brown on April 20, 2022. The collaborative effort between the Orange County Sheriff's Department (OCSD) and OIR related to this incident reflects our shared commitment to transparency and continuous improvement. In furtherance of that commitment, the OCSD provided the OIR with extensive *unredacted* materials, including surveillance footage, handheld video recordings, safety check logs, activity logs, medical records, interview transcripts and audio files, internal investigation reports, Critical Incident Review Board materials, Administrative Review Board materials, policies and procedures, and notices of employee discipline. We believe this level of access and transparency is a hallmark of a healthy oversight relationship and we remain committed to that standard.

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.

OCSD acknowledges that there were failures in this case. Documentation deficiencies related to water shutoff, meal distribution, and medication administration were identified, and corrective action was pursued immediately and decisively. It is important to note that the OCSD initiated the majority of its systemic reforms well before the OIR commenced its formal review of this incident. On the night of the incident, the OCSD's Administrative Response Team responded to the scene and provided an Executive Briefing on April 22, 2022, within 48 hours of the incident. Next, on June 9, 2022, OCSD convened the Critical Incident Review Board, which members of

OIR and County CEO Risk Management attended. Within 60 days of Brown's death—OCSD met multiple times to critique policies and procedures, evaluate staff performance, and assign corrective action items. Subsequently, OCSD held Administrative Review Board reviews on August 30, 2022 and September 24, 2022. As a result of these reviews, policy and procedural updates, staff accountability measures, and technological improvements were underway beginning in 2022 and continued through 2024. These internal reviews and self-initiated corrective measures reflect the Department's commitment to prompt and thorough examinations of in-custody deaths.

Another overarching safeguard to prevent lack of documentation and promote transparency in these situations is the implementation of Body Worn Cameras (BWC) inside Custody Operations. On July 18, 2025, the pilot program began in the booking areas of the Intake Release Center (IRC). Phase 3 of the IRC of the BWC pilot program began on November 21, 2025. Under CCOM 1707, all mental health housing modules (including Modules K, L and M) will have documentation of the actions of our staff when engaging the persons in our care. We are confident that had this additional recordkeeping been available, many of the open questions in this matter would have clearly been addressed. We are thankful to have this resource moving forward.

Furthermore, the OIR's report fails to consider one major infrastructure factor allowing for communication between staff and inmates. OIR assumes that Mr. Brown was not offered his meals at distribution because contact with him is not on video. However, all communication with inmates are not in person. Mr. Brown's cell, along with all those in his housing location, are equipped with two-way communication devices. These devices are integrated into the cell's interior wall, and they play a crucial role in facilitating communication between inmates and staff members in the housing unit's guard station.

The system is designed so that a call can be initiated by either the inmate or the staff member. When an inmate initiates a call, both an audible and visual alarm are triggered in the guard station, ensuring staff are promptly alerted. The alarm can only be silenced when the staff member presses a button to start communication. If a staff member initiates the conversation, the device functions as a speakerphone, allowing a hands-free exchange without the inmate needing to interact further with the device. Additionally, staff members can activate the device at any time to monitor the cell audibly or begin a conversation with the inmate(s). These communication devices have been operational and in place since the facility's construction in 1988. Unfortunately, these communications cannot be recorded, but, if available, would have contained valuable information regarding meal offerings and rejections by Mr. Brown. I am confident that had better documentation existed of our staff's actions, these assumptions by OIR could be dispelled.

That said, we recognize that the OIR's examination directly prompted one significant and meaningful improvement: the collaborative audit process between OCSD and Correctional

Health Services (CHS) for inmate treatment refusals. This recommendation, provided to the OCSD while the report was pending, was implemented in February 2026 and represents a genuine enhancement to accountability and the accuracy of medical care documentation. We are grateful for the OIR's role in bringing this forward.

Attached you will find a detailed summary prepared by Custody Operations regarding changes made since the passing of Mr. Brown. Below, we briefly address each of the nine OIR recommendations:

Recommendation #1: Update CCOM section 1803 to require that restoration of water to a cell be documented in the Guard Station Log.

Previously Implemented — Policy in place, March 2023: Following Brown's death, OCSD added CCOM Section 1803 to address the response to intentional flooding of a cell. This section was implemented in February 2023 and requires documentation of the water shutoff, supervisor notification, and all related actions in the Guard Station Log. The requirement to document the restoration of water to a cell was incorporated into this policy framework. OCSD acknowledges that at the time of Brown's death, no such policy existed, and that the absence of documentation created an inability to conclusively establish when water was turned off or restored. This gap has been corrected.

Recommendation #2: Update CCOM section 1803 to require that when the water to a cell has been turned off, deputies provide the inmate with drinkable water, or ensure the cell already contains drinkable water, during every safety check.

Previously Implemented — March 2023: CCOM Section 1803 was modified requiring water to be *offered* to an inmate during every safety check when the water to a cell has been turned off. While OCSD believes offering water, in combination with the broader framework of clinical oversight by CHS and the updated mental health housing procedures, provides a meaningful safeguard, OCSD has further refined the policy language. As of March 24, 2026, water will now be *provided* on every safety check. Please note, whether the individual chooses to consume the water will still be their prerogative.

Recommendation #3: Update CCOM section 1803 to require documentation of the distribution of drinking water to an inmate housed in a cell with the water turned off, as well as whether the drinking water was consumed.

Previously Implemented — March 2023: CCOM Section 1803 was updated to require documentation of water distribution and consumption for inmates housed in cells where the water has been shut off. OCSD agrees that consistent documentation in this area is essential, particularly for inmates whose mental health conditions may prevent them from advocating for their own needs, and this requirement is now embedded in policy.

Recommendation #4: Expand CCOM section 1803 to address situations other than intentional flooding where the water to a cell may be turned off.

Previously Implemented — March 2023: CCOM Section 1803 was written broadly to encompass the range of circumstances under which water to a cell may be turned off, including inmate self-harm and the disposal of drugs or contraband, consistent with the OIR's recommendation. OCSD recognizes that any shutoff of water to an occupied cell carries potential health implications and warrants the same documentation and oversight requirements regardless of the reason.

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.

Previously Implemented —March 2023: Changes to our practices began in March of 2023, while the policy updates were approved and implemented. On June 20, 2023, Policy 902 – Inmate Safety Checks replaced CCOM Section 1716. The update removed these changes from the department's procedural manual into our department's policy manual. Policy 902 requires deputies to check for obvious signs of life—including talking, eating, head movement, and movement of extremities—and for inmates who appear to be sleeping, to check for obvious signs of trauma, distress, and signs of life. The policy requires safety checks to be conducted from a location providing a clear, direct view of each inmate, and that deputies be close enough to ascertain the inmate's presence and apparent physical condition.

OCSD respectfully notes that the current policy language, while slightly different in phrasing from the OIR's specific recommendation, imposes a substantive obligation that is consistent with the OIR's intent. A deputy who fails to spend sufficient time in front of a cell to observe obvious signs of life, trauma, or distress is not in compliance with Policy 902. OCSD acknowledges, however, that the safety checks conducted during Brown's final hours fell significantly short of this standard, and that deputies' failure to allocate adequate time and attention during those checks represents a serious deficiency that led directly to disciplinary action. In 2024, the Jail Compliance and Training Team (JCATT) issued training bulletins reaffirming these requirements, and deputies are re-briefed annually on the significance of thorough, direct observation.

Recommendation #6: Update OCSD policy and procedure to require collaboration with CHS staff to conduct audits of inmate treatment refusals at regular intervals. OCSD and CHS staff should review surveillance footage against documentation in order to ensure treatment was actually offered, the refusal was accurately documented, and the deputy serving as a witness was present to hear the refusal.

Implemented — February 2026: OCSD acknowledges that this recommendation was directly the result of the OIR's examination of this case and was provided to OCSD while the report was pending. The documentation deficiencies identified by the OIR—including instances where medication refusals were recorded despite no interaction with the patient ever taking place—were deeply concerning and unacceptable. In response, CHS developed a formal Medication Refusal Audit process that incorporates video footage review and collaboration with OCSD. Senior nurses or nursing supervisors now review surveillance footage to confirm that treatment was actually offered, refusals were accurately documented, and required witnesses were present. This process was implemented in February 2026 and represents a direct and meaningful outcome of the OIR's oversight work. OCSD is grateful for the OIR's identification of this issue.

Recommendation #7: Issue a training bulletin reminding deputies of their individual obligation to ensure that inmates are housed in conditions that are sanitary and do not violate the Constitution.

Previously Implemented — April 2024: In April 2024, the Behavioral Health Bureau (BHB) and JCATT issued a training bulletin reminding deputies of their duty to maintain sanitary living conditions in compliance with department policy and constitutional standards. The bulletin also addressed procedures for hygiene and sanitation management in mental health housing, including incentives for voluntary compliance and, when necessary, clinical authorization for cell extraction to facilitate cleaning. OCSD acknowledges that the conditions of Brown's cell during his time in custody were unacceptable, and that the absence of a formalized cleaning schedule at the time of the incident was a gap that has since been corrected.

Recommendation #8: Update policy and procedure to require an OCDA investigator conducting a scene examination of a cell to check whether the water to the toilet/sink fixture is turned on.

Not Applicable to OCSD: This recommendation is directed at the Orange County District Attorney's Office and does not fall within OCSD's operational authority or jurisdiction. OCSD defers to the OCDA regarding the implementation of this recommendation within their investigative protocols.

Recommendation #9: Update policy and procedure to require Internal Affairs investigators to conduct initial interviews of involved personnel within a specific time frame after a custodial death.

Under Consideration — With Reservation: OCSD appreciates the intent and motivation behind this recommendation and acknowledges that the delay in conducting internal administrative interviews in this case—stemming from the Department's practice of waiting for the OCDA's criminal investigation to conclude before initiating its own administrative review—resulted in employees being interviewed more than two years after the incident. Memory degradation was

a clear consequence of this timeline, and OCSD recognizes the investigative limitations this created.

However, OCSD must respectfully note that the sequencing of criminal and administrative investigations requires careful consideration of employees' constitutional and statutory rights, as well as the integrity of any parallel criminal proceedings. Internal Investigations will, as a matter of practice, prioritize criminal interviews and investigation prior to administrative ones. OCSD is committed to exploring mechanisms that would allow for earlier administrative engagement within the boundaries of applicable law and employee rights protections. We will continue to evaluate this recommendation in consultation with legal counsel.

OCSD remains committed to the principles of transparency, accountability, and continuous improvement that this oversight process is designed to promote. We are proud of the significant systemic improvements that have been made in the wake of this tragedy—many of which were initiated proactively by the Department—and we welcome the OIR's continued partnership in ensuring the safety and dignity of all individuals in our care.

Sincerely,

Don Barnes
Sheriff-Coroner

Comprehensive Review and Systemic Improvements Following the In-Custody Death of Nicholas Brown

OVERVIEW OF INCIDENT AND INITIAL RESPONSE

The in-custody death of Nicholas Brown, which was ultimately attributed to dehydration, led to an extensive evaluation of existing policies, procedures, and staff conduct. This process resulted in a series of corrective actions and systemic changes designed to prevent similar incidents in the future.

WATER ACCESS AND DOCUMENTATION POLICY REVISIONS

At the time of the incident, the Orange County Sheriff's Department did not have established policies or procedures regarding the intentional shutoff of water in an inmate's cell. Although the District Attorney's investigation referenced repeated flooding by Brown, there was no documentation confirming either the occurrence of flooding or the shutoff of water. In response, new provisions were added to the Custody and Court Operations Manual (CCOM) to guarantee access to drinking water and to require appropriate documentation when water service is interrupted. The updates mandate that deputies verify all cells have functioning water before occupancy and prohibit the use of any cell lacking running water. When water must be shut off due to flooding, staff must notify a supervisor, document the situation in the Guard Station Log, and supply inmates with water during every safety check. Water service must be restored within six hours unless an extension is approved by the Watch Commander, with all actions properly documented. These measures are intended to promote accountability and prevent prolonged deprivation of water.

MEAL DELIVERY AND OVERSIGHT ENHANCEMENTS

The review revealed significant deficiencies in meal delivery and documentation. Video evidence showed that Brown received only six meals over four days, with no written record of missed meals or a verification system for meal distribution. Although policy required supervision of inmate workers and visual monitoring by deputies, as well as documentation and medical notification after two consecutive missed meals, these requirements were not enforced. Following the incident, an Internal Affairs investigation concluded that personnel involved failed to adhere to policy, resulting in disciplinary actions. To address these issues, Custody Operations introduced Guardian RFID technology to track inmate movements and meal distribution. Paired with a forthcoming Jail Management System (JMS), this

technology will provide automated alerts when inmates miss consecutive meals, greatly improving accountability and oversight.

EMERGENCY RESPONSE PROTOCOLS

Regarding emergency response, approximately three minutes elapsed before deputies entered the cell after Brown was found unresponsive. The existing policy allowed deputies to exercise discretion to balance officer safety with prompt response, especially in high-risk mental health housing units. Brown was classified as Acuity Level 2, indicating severe mental health concerns and unpredictability. Policies at the time required deputies to weigh safety risks and ensure adequate personnel were present before cell entry. These guidelines remain essential for protecting staff during emergencies.

SAFETY CHECK PROCEDURES AND IMPROVEMENTS

A critical failure was identified in the execution of safety checks. Despite the 16 checks that were conducted during the approximately eight hours Brown was deceased, none recognized his unresponsiveness. Policy required staff to verify an inmate's presence and apparent physical condition but lacked clarity on assessing signs of life. The Internal Affairs investigation found that deputies did not follow policy, resulting in disciplinary action. The safety check policy has since been expanded to define expectations, including the observation of specific signs of life such as movement, responsiveness, or other indicators of physical state, to improve the effectiveness of safety checks.

SANITATION AND HYGIENE IMPROVEMENTS IN MENTAL HEALTH HOUSING

Concerns about Brown's living conditions included a lack of cell cleaning over several days, with unsanitary conditions, accumulated trash, and food trays. Brown also did not shower or participate in dayroom activities. In response, the Behavioral Health Bureau (BHB) and Correctional Health Services (CHS) established new procedures for hygiene and sanitation management in mental health housing, particularly for uncooperative inmates. These procedures incorporate incentives for voluntary compliance and, when necessary, clinical authorization for forced cell extraction to facilitate cleaning. A training bulletin issued in 2024, reminded deputies of their duty to maintain sanitary living conditions as required by department policy and constitutional standards. Restrictions on Brown's movement and activities were confirmed to have been directed by CHS due to his mental health status.

MEDICAL CARE OVERSIGHT AND TREATMENT REFUSAL AUDITS

Additional corrective actions were taken to enhance oversight of inmate medical care, particularly regarding treatment refusals. Correctional Health Services developed formal guidelines for medication refusal audits, creating a structured review process that includes

collaboration with the Orange County Sheriff's Department. Senior nurses or nursing supervisors now review surveillance footage to confirm proper offering of medical treatment, accurate documentation of refusals, and the presence of required staff during interactions. This approach strengthens accountability and the reliability of medical care records.

ADMINISTRATIVE REVIEW BOARD (ARB) PROCESS EVALUATION

The Administrative Review Board process was also assessed. Although the initial presentation documented the timing of safety checks, it did not emphasize the deficiencies in quality. It also suggested compliance with meal distribution despite conflicting video evidence. Nevertheless, the ARB reviewed the evidence and initiated personnel investigations into both safety check and meal distribution practices. These investigations confirmed policy violations and resulted in disciplinary measures. The board chairman assigned action items to update policies related to safety checks, inmate meals, and the management of mental health housing units, demonstrating the ARB's effectiveness in identifying and addressing deficiencies.

CLARIFICATION OF TIMELINE AND LAST SIGNS OF LIFE

Discrepancies regarding Brown's last confirmed signs of life were also resolved. The ARB presentation cited movement observed on video at 7:40 PM on April 19, while Correctional Health Services documented a direct interaction earlier that morning. Clarification established that both observations were valid and incorporated into the overall timeline assessment.

SUMMARY OF CORRECTIVE ACTIONS

Together, these corrective actions constitute a comprehensive strategy for addressing identified failures, including policy development, technological upgrades, staff accountability, targeted training, enhanced auditing, and procedural clarity. The collective efforts aim to strengthen inmate safety, improve operational oversight, and minimize the risk of similar incidents in the future.

OCDA RESPONSE

OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

April 15, 2026

Stella Lim, Interim Executive Director
Office of Independent Review
601 N. Ross St., 2nd Floor
Santa Ana, CA 92701

Dear Interim Executive Director Lim,

Thank you for sharing the Office of Independent Review's ("OIR") draft report on the custodial death of Nicholas Brown and providing the Orange County District Attorney's Office ("OCDA") with the opportunity to review and respond. Based on a re-review of the evidence gathered in the investigation of Mr. Brown's death, including all surveillance video recordings and supplemental witness interviews, we ultimately stand by our conclusion that Mr. Brown's death, although tragic, was not the product of criminal intent, recklessness, or negligence.

On October 27, 2022, six months after Mr. Brown's death, OCDA was informed that the cause of Mr. Brown's death was "dehydration" due to "probable lack of water intake." The manner of death was "undetermined."[1] Once informed of Mr. Brown's cause of death, we investigated his access to water. There were some inconsistencies between Mr. Brown's Orange County Health Care Agency ("OCHCA") medical records and our investigation. According to Mr. Brown's OCHCA medical records, which are separate and independent from OCSD's logs, Mr. Brown's cell was highly cluttered with empty food cartons, food waste, and trash on the table and flooring, and there were wet towels on the floor outside his cell. A psychiatric progress note from April 15, 2022, indicated that Mr. Brown's cell had scattered empty food containers and food strewn over the entire cell.[2] This note also stated that staff reported that Mr. Brown had been flooding his cell, so the water was turned off and staff were providing Mr. Brown with water/Gatorade on a regular basis.

---

[1] OCDA did not conclude that Mr. Brown's "death was a natural one." The OCDA agrees that the Orange County Sheriff-Coroner found that the manner of death was undetermined.
[2] It should be noted that liquids were also provided as part of meal distributions to Mr. Brown. While the OIR report states that he "did not receive regular meals while in custody," which would tend to suggest an intentional deprivation of food and water, our review of the evidence does not support this inference.

REPLY TO: ORANGE COUNTY DISTRICT ATTORNEY'S OFFICE

WEB PAGE: http://orangecountyda.org/

☒ MAIN OFFICE
300 N. FLOWER ST.
SANTA ANA, CA 92703
P.O. BOX 808 (92702)
(714) 834-3600

☐ NORTH OFFICE
1275 N. BERKELEY AVE.
FULLERTON, CA 92832
(714) 773-4480

☐ WEST OFFICE
8141 13TH STREET
WESTMINSTER, CA 92683
(714) 896-7261

☐ HARBOR OFFICE
4601 JAMBOREE RD.
NEWPORT BEACH, CA 92660
(949) 476-4650

☐ JUVENILE OFFICE
341 CITY DRIVE SOUTH
ORANGE, CA 92868
(714) 935-7624

☐ CENTRAL OFFICE
300 N. FLOWER ST.
SANTA ANA, CA 92703
P.O. BOX 808 (92702)
(714) 834-3952

OCDA Investigators met with Orange County Sheriff's Department (OCSD) personnel to discuss OCSD's jail operational procedures, namely the procedure for turning off the water to a cell. They were informed that there were two water shut off valves for each cell, one for the toilet and one for the sink and water fountain. If the toilet were to become clogged, typically only the valve controlling the toilet would be turned off and would only be turned off until the clog was cleared. The valve for the sink and water fountain would not be shut off. Jail facility operations staff would request a plumber to clear the clog. Once it was cleared, the water would be turned back on. Normally, it would only take a few hours to resolve a clogged toilet.

The Facilities Operations Manager for OCSD was contacted to determine if any plumbing problems had been reported for Mr. Brown's cell. He reported that there were no records of a maintenance request for a clogged toilet in April of 2022 for Mr. Brown's cell. We requested video footage of the plumbing tunnels for April of 2022 to ascertain whether the water had been turned off for Mr. Brown's cell. However, we were informed that the video cameras were installed in July of 2022 and were not present at the time of Mr. Brown's death. Because we were unable to independently verify whether the water to Mr. Brown's cell had been turned off or not, we relied on OCHCA's representations in their notes regarding the water being turned off and the provision of water/Gatorade which is within the province of medical staff.

Recently, we conducted a re-review of all the evidence gathered during Mr. Brown's custodial death investigation. We also contacted the psychiatrist who authored the April 15, 2022, psychiatric progress note which stated that the water to Mr. Brown's cell had been turned off and that he had been provided with water/Gatorade on a regular basis. She indicated that she did not remember this specifically but that, in all likelihood, nursing staff assigned to Mr. Brown would have verbally provided her with this information. She stated that this was not documented anywhere because it was a verbal communication. Based on our re-review, it has become clear that we cannot independently verify that the water to Mr. Brown's cell was ever turned off.

By contrast, several facts indicate that Mr. Brown had continuous access to water in his cell. First, there was no documentation of a maintenance request for a clogged toilet or any other plumbing issues in Mr. Brown's cell, necessitating the water to his toilet being turned off. Second, even if the toilet had been clogged, only the valve controlling the water to the toilet would have been turned off. The valve controlling the water to the sink and water fountain would have remained on. Finally, video from the jail shows towels placed in front of Mr. Brown's cell from April 17, 2022 – April 20, 2022. Surveillance video recordings from April 19 show OCSD staff spraying the towels with disinfectant. The presence of the towels and the need for disinfectant support not only the psychiatrist's note that Mr. Brown had been flooding his cell, but that the problem was ongoing due to Mr. Brown's continuous access to water.

While we appreciate the OIR's investigatory recommendation, we believe it is important to provide some context regarding what OIR characterizes as a "missed opportunity" in the scene investigation. When we conducted our initial investigation, our focus was not on the provision of meals or water because we did not have any information on Mr. Brown's cause of death. Therefore, what OIR observed as a missed opportunity regarding scene investigation, including checking for the presence of running water in the cell, can only be characterized as such when viewed through the lens of hindsight.

Mr. Brown's death was a tragedy, but the evidence does not demonstrate that it was the product of criminal action or inaction by OCSD personnel. Although Mr. Brown had access to water, it was still his choice to drink it, and he could not legally be forced to do so. Prior to his death, a psychiatrist noted that Mr. Brown was to be admitted into the Lanterman-Petris-Short (LPS) Unit for possible conservatorship because he was refusing to take his medicine. LPS conservatorships may be established for individuals who have been deemed gravely disabled or are a danger to themselves or others as a result of a mental health disorder. In Mr. Brown's case, it would have granted legal authority to OCHCA to provide involuntary care for Brown. Establishing an LPS conservatorship following a referral requires an independent investigation by the Office of the Public Guardian, the filing of a petition with the Court, and evidence demonstrating beyond a reasonable doubt that the conservatorship is necessary. Unfortunately, Mr. Brown died before the conservatorship could be established.

Based on our re-review of the evidence gathered in the investigation of Mr. Brown's death, we affirm our conclusion that Mr. Brown's death was not due to criminal intent, recklessness, or negligence.

Sincerely,

TODD SPITZER
District Attorney