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November 30, 2015

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

Re: Custodial Death on April 11, 2015
Death of Inmate Ryan Anthony Hall
District Attorney Investigations Case # S.A. 15-007
Orange County Sheriff's Department Case # 15-070340
Orange County Crime Laboratory Case # 15-45616; 15-4329

Dear Sheriff Hutchens,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the April 11, 2015, custodial death of 25-year-old inmate Ryan Anthony Hall.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Hall. In this letter, the OCDA describes the investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to determine whether criminal culpability exists on the part of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD.

On April 11, 2015, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center Santa Ana (WMCSA), where Hall died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 15 witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), as well as incident scene photographs and other relevant materials.

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

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating custodial deaths within Orange County when an individual dies while in custody. An OCDASAU Investigator is assigned as a case agent and is supported by other OCDASAU Investigators, as well as Investigators from other OCDA units.

Six Investigators are assigned to the OCDASAU on a full-time basis. There are additional OCDA Investigators assigned to other units in the Office trained to assist when needed. On average, eight Investigators respond to an incident within an hour of being called. The Investigators assigned to respond to an incident perform a variety of investigative functions that include witness interviews, scene processing, evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the OCCL processes all physical evidence related to the investigation.

When the OCDASAU investigator has concluded the investigation, the file is turned over to a veteran deputy district attorney for legal review. Deputy district attorneys from the Homicide, TARGET, or Gangs Units review fatal, officer-involved shootings and custodial death cases and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the supervising Assistant District Attorney in the Special Prosecutions Unit, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

Hall had a history of mental illness and two prior suicide attempts beginning when he was 19 years old when after being in an incident that damaged his brain. Hall was diagnosed by the State of New York as "bipolar and schizophrenic." Hall also had a history of refusing to take the mental health medications prescribed to him. In addition, Hall had a history of alcohol, marijuana, and cocaine use.

On Nov. 29, 2014, Hall was arrested by the Santa Ana Police Department (SAPD) for attempted murder and resisting arrest. Hall was arrested after he used a knife to stab the victim eight times in the face and back. In addition to injuries to the face and back, the victim also sustained a punctured lung during the attack. Hall was initially booked into the Santa Ana City Jail. Later that same day, Hall was transferred from the Santa Ana City Jail and booked into the OCSD's Men Central Jail (Central Jail). Hall completed a preliminary medical and physiological screening and the paperwork associated with Hall's booking indicated that he was designated a "mental health expedite" and a "medical" booking. In addition, the paperwork indicated that Hall was gravely disabled and a danger to others. Hall's bail was set by the court at $1 million, and he remained in custody pending trial.

On Dec. 6, 2014, Hall obtained a jail-issued razor blade from a fellow inmate and attempted suicide by cutting himself multiple locations, including his neck, arms, wrists and thighs. Hall resisted the OCSD deputies' attempts to provide lifesaving intervention by punching and kicking in the air. Hall also grabbed his own face and began twisting his head back and forth in what appeared to be an attempt to break his own neck. Hall repeatedly told the deputies, "Go away, I want to go to heaven, just let me go." Hall was successfully subdued and handcuffed by the responding OCSD personnel so that he could not further injure himself or others. Medical staff at the jail and paramedics from the Orange County Fire Authority (OCFA) provided Hall with first aid and medical intervention prior to transporting him to the hospital at WMCSA for treatment of his injuries.

On Dec. 7, 2014, Hall was being evaluated by the hospital's nursing staff and his hand restraints were removed to provide medical treatments. A nurse attempted to give Hall some medication during which time Hall told the OCSD deputies who were guarding him, "I want to go to heaven, please shoot me, I want to die." Hall then became agitated and began flailing his arms around in an aggressive manner toward the nurse. OCSD deputies attempted to restrain Hall to prevent further injury to himself and others. During the struggle, Hall grabbed the handle of a deputy's gun and attempted to remove it from its holster. Hall continued yelling, "Shoot me, I want to die!" while pulling on the OCSD deputy's gun in an attempt to remove it from its holster. Hall ignored all verbal commands from the deputies to stop fighting and to sit back down in his bed. Hall had also attempted to head butt the deputies and nursing staff during the struggle. Two OCSD deputies received minor injuries as a result of Hall's attack, including a bloody nose and several scratches. On Dec. 18, 2014, Hall was released from the hospital and returned to Central Jail, where he was assigned to be housed in a one-person cell in Module L for his safety. Module L is the location where inmates who need medical and mental health care are housed.

On April 6, 2015, at approximately 7:10 a.m., Hall was let out of his jail cell so he could use the facility's day room. At approximately 7:13 a.m., Hall decided to leave the dayroom and he returned to his jail cell. At some point after entering his cell, Hall closed his own cell door. A fellow inmate went to Hall's cell and spoke with Hall for about one minute. According to the inmate, Hall did not say anything that made the inmate think Hall wanted to hurt himself. Approximately 10 minutes later, at 7:25 a.m., that same inmate came back to the area of Hall's cell and saw Hall with a sheet around his neck. The inmate immediately informed the jail staff of what he saw. OCSD deputies and jail nurses immediately responded to Hall's cell. Upon arrival at Hall's cell, deputies saw Hall sitting with his back to the door, slightly elevated off of the ground with a bed sheet tied around his neck, and he was not moving. The bedsheet appeared to be stuck in the door frame of the jail cell. Additional jail staff and OCFA paramedics were immediately requested to respond to the location. Upon examination by the jail's medical staff, Hall did not have a pulse and was not breathing so the jail doctors and nurses present began Cardio Pulmonary Resuscitation (CPR) and lifesaving intervention. Hall was also given rescue breathing and an intravenous line (IV). CPR on Hall continued for approximately 15 to 20 minutes until OCFA personnel arrived at approximately 7:45 p.m. Upon their arrival, OCFA paramedic personnel took over the lifesaving intervention on Hall. OCFA personnel noted that Hall was unconscious and not breathing but had a heartbeat and pulse. The OCFA paramedics stopped performing CPR because Hall had a pulse and blood pressure at the time and instead established an airway and started ventilating Hall. The OCFA paramedics noted that there were no visible signs of trauma to Hall's body or neck area.

At approximately 8:14 a.m. on April 6, 2015, Hall was transported by ambulance to WMCSA. Hall was treated in the emergency room and eventually he was admitted into the Critical Care Unit (CCU). Hall was later diagnosed with severe brain damage, and was placed on life support. Hall was breathing on his own with the assistance of a ventilation tube, but the status of his condition was pending a future follow up and prognosis after testing. On April 7, 2015, Hall's treating doctor informed OCSD that Hall's medical condition was deteriorating and that Hall may not live much longer. The hospital's medical staff requested that Hall's next of kin be notified. Hall's mother was contacted at her home in New York and subsequently traveled to Orange County on Friday, April 10, 2015. Hall's mother immediately met with the hospital's doctors responsible for treating her son and was advised that her son was brain dead and there was no anticipated prognosis of recovery. On Saturday, April 11, 2015, at 2:45 p.m., Hall's mother requested that all lifesaving intervention and care for Hall be stopped. At 3:10 p.m., medical staff removed all life support equipment attached to Hall and stopped the intravenous flow of medications. Hall was pronounced dead at 3:24 p.m. on April 11, 2015.

AUTOPSY

On April 18, 2015, a post-mortem examination of Hall was conducted by independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services. Following the autopsy, Dr. Luzi concluded that the cause of Hall's death was consistent with a ligature hanging.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Olanzapine	Postmortem Blood	<0.1 mg/L
Levetiracetam	Postmortem Blood	<8.6 mg/L
Propofol	Postmortem Blood	<0.45 mg/L
Morphine	Postmortem Blood	0.0343 ± 0.0034mg/L
Lorazepam	Postmortem Blood	0.490 ± 0.032 mg/L

BACKGROUND INFORMATION

Hall had a California Criminal History record that revealed arrests for violations, including disorderly conduct/under the influence of drugs, resisting/obstructing arrest, and attempted murder.

THE LAW

Homicide is the killing of one human being by another. Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. To prove that a person is guilty of murder, the following must be proven:

a. The person committed an act that caused the death of another human being;
b. When the person acted he/she had a state of mind called malice aforethought; and
c. He/she killed without lawful excuse or justification.

There are two kinds of malice aforethought, express malice and implied malice. Express malice is when the person unlawfully intended to kill. Implied malice requires that a person intentionally committed an act, the natural and probable consequences of the act were dangerous to human life, at the time he/she acted he/she knew his/her act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

A person can also commit murder by his/her failure to perform a legal duty, if the following conditions exist:

a. The killing is unlawful (*i.e.*, without lawful excuse or justification);
b. The death is caused by an intentional failure to act in a situation where a person is under a duty to act;
c. The failure to act is dangerous to human life; and
d. The failure to act is deliberately performed with knowledge of the danger to, and with conscious disregard for, human life.

A person can also commit involuntary manslaughter by failing to perform a legal duty, if the following conditions exist:

a. The person had a legal duty to the decedent;
b. The person failed to perform that legal duty;
c. The person's failure was criminally negligent; and
d. The person's failure caused the death of the decedent.

In *Giraldo v. California Dept. of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 250-251, the court held that there is a "special relationship" between jailer and prisoner:

> "The most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable that an inmate may be at risk of harm.... Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

> "A public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he/she acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he/she acts is so different from how an ordinarily careful person would act in the same situation that his/her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

In the present case, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Hall a duty of care, the evidence does not support a finding beyond a reasonable doubt that this duty was in any way breached – either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). Knowing Hall's past suicide attempts and mental health issues, OCSD staff properly classified Hall as a mental health expedite and a medical booking upon his entry to Central Jail. His first suicide attempt was accomplished by obtaining a razor blade from a fellow inmate. While OCSD deputies and medical staff tried to provide medical treatment to Hall, he fought with deputies to the point Hall had to be physically restrained in order to prevent him from hurting himself further. After the first suicide attempt, Hall was placed in December 2014 in a one-person cell in Module L of the Central Jail for his safety. After Hall's placement in Module L, Hall made no further suicide attempts until April 6, 2015. Further, Hall never indicated to fellow inmates or OCSD personnel he was contemplating suicide. In fact, a fellow inmate spoke with Hall minutes before Hall hanged himself, and Hall said nothing about wanting to hurt himself.

In addition, OCSD staff responded swiftly and immediately upon learning of Hall's condition and requested additional emergency medical support from OCFA. OCSD staff performed CPR until OCFA arrived. Immediately upon arrival, OCFA was able to detect that Hall had a pulse. OCFA provided emergency medical treatment and transported Hall to the hospital where he was treated in the emergency room. Thus, there is no evidence to support a finding beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is a lack of sufficient evidence to support a finding of criminal culpability beyond a reasonable doubt on the part of any OCSD personnel or any individual under the supervision of the OCSD in connection with the death of inmate Ryan Anthony Hall.

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

Respectfully submitted,

MICHAEL BARDEEN
Deputy District Attorney
TARGET Unit

Read and Approved by **EBRAHIM BAYTIEH**
Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit