OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

June 15, 2022

Chief David Valentin
Santa Ana Police Department
60 Civic Center Plaza
Santa Ana, CA 92701

Re: Custodial Death on June 25, 2021
Death of Inmate Darryle Marcell Samuel, Sr.
District Attorney Investigations Case # 21-002347
Santa Ana Police Department Case # 21-13541
Orange County Crime Laboratory Case # 21-48216

Dear Chief Valentin,

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 June 25, 2021 custodial death of 28-year-old inmate Darryle Marcell Samuel, Sr.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Samuel. In this letter, the OCDA describes the criminal investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of any Santa Ana Police Department ("SAPD") personnel or any other person under the supervision of the SAPD in connection with this custodial death incident.

On June 25, 2021, OCDA Special Assignment Unit ("OCDASAU") Investigators responded to Santa Ana City Jail, where Samuel died while in custody in his cell by ligature hanging. During the course of this investigation, the OCDASAU interviewed 62 witnesses, as well as obtained and reviewed reports from the SAPD, Orange County Crime Laboratory ("OCCL"), and Orange County Coroner's Office, incident scene photographs, video footage, phone call audio files, 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 SAPD personnel or any other person under the supervision of the SAPD. The OCDA will not be addressing policy and any possible issues related to 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 an experienced deputy district attorney for legal review. Deputy district attorneys from the Homicide, TARGET/Gangs, and Special Prosecutions Units review fatal and non-fatal officer-involved shootings and custodial death cases, and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the Assistant District Attorney of the OCDA, who will eventually review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On May 24, 2021, the United States Marshals Service transferred Samuel into the Santa Ana Detention Facility ("SADF"). During the intake process, a NaphCare Charge registered nurse completed a mental health screening on Samuel. During the screening, Samuel disclosed he was bipolar and had been diagnosed with Post Traumatic Stress Disorder ("PTSD") in 2013. Samuel denied ever planning, preparing, or attempting to take his life. SADF housed Samuel by himself in Module 4C, Cell 17 ("C17"). The registered nurse referred Samuel to mental health for evaluation.

On June 13, 2021, Samuel met with a psychiatric registered nurse. Samuel told her he was bipolar and schizophrenic and suffered from PTSD and depression. Samuel told the psychiatric nurse he had previously taken mental health medications, but he did not like them. He refused the psychiatric nurse's suggestion he take the mental health medications again. Samuel revealed that in 2012, he attempted suicide by drug overdose, but he denied any current suicidal ideations.

SADF Phone Calls
On Friday, June 25, 2021, the day of his death, Samuel made four separate phone calls to his longtime girlfriend, starting at 7:16 a.m., and ending at 9:08 am.

The first call to his girlfriend was at 7:16 a.m. Samuel told her he was hurt and upset with his girlfriend because he believed she was pregnant with "another man's baby." Samuel told her he wanted to die. Samuel specifically stated he wanted to kill himself. Samuel demanded his girlfriend tell him who the baby's father was; his girlfriend refused and kept referring to the unborn child as "God's Child."

The second call to his girlfriend occurred at 7:50 a.m. that same morning. During that call, she admitted to Samuel she had sexual relations with another man. Samuel told her he hated her and hated the world. Samuel accused his girlfriend of cheating on him four different times. He then followed up with the statement, "If I die and kill myself, I will haunt you for the rest of your life!"

The third phone call to his girlfriend occurred at 8:18 a.m., that same morning. Samuel again accused his girlfriend of serial infidelity. Samuel stated, "I'm going to kill myself...you're going to have the next man's baby! My life is destroyed! You destroyed me! ...You're not going to get this unless I kill myself... I have a point to prove to you. I am going to prove that point...because you take me as a joke! ...I need help, I need help, I am going to lose my mind. I hate your guts, you are Satan himself!"

The fourth phone call to his girlfriend occurred at 8:51 a.m., that same morning. Samuel persisted in asking the identify of his girlfriend's sexual partner. After berating his girlfriend, Samuel stated, "I'm through with life. You must think I'm playing. Today is my last day on this earth. I'm through. My brain can't take it, my heart can't take it. I can't take it...the one person I truly loved and gave everything I had, fucked me over...fucked me over the hard way...you ruined my family!"

Behavior Immediately Following the Phone Calls
After talking with his girlfriend on the phone, Samuel got in line to receive and take his medication. As he walked back to his cell, he stopped by a group of inmates watching television. He watched television for a short time and talked with the other inmates. On the video footage from SADF, Samuel is seen laughing with the inmates. He reached his cell at approximately 9:15 a.m., where he remained until he was found by an inmate worker at 11:18 a.m.

Routine Check By Correctional Officer Tolone
At 9:15 a.m., all inmates in Module 4C were sent back to their cells with their doors shut and the module was secured. At 9:31 a.m., just 16 minutes after Samuel entered his cell, Correctional Officer Tolone is seen on video completing a safety check on Samuel's cell. Correctional Officer Tolone looked into the window of Samuel's cell and walked away[1]. A review of the Module 4C safety check log indicated that SADF correctional officers did not conduct any safety checks on any inmate between 9:32 a.m. and 11:18 a.m.

Samuel's Death
At 11:18 a.m., an inmate worker, who was cleaning Module 4C, discovered Samuel hanging by a sheet in his cell. As the inmate worker wiped the door handle to Samuel's cell, C17, he looked

[1] All the correctional officers involved in this incident declined to provide a statement to assist in the investigation.

through the door window and saw Samuel hanging from a bedsheet by his neck. The inmate worker pulled on the door handle and the door opened. The inmate worker then called out to Santa Ana Correctional Officer Esteban Gonzalez who was on the floor below.

An inmate, hearing the inmate worker yelling, left his cell and ran over to the inmate worker standing outside C17. The inmate looked inside and saw Samuel hanging from a shelf by a sheet cover wrapped around his neck. The inmate did not enter the cell; rather, he returned to his own cell as instructed by correctional officers. The inmate did notice that Samuel looked blue. As the inmate returned to his own cell, he made motions to his neck which were visible on the camera footage.

Correctional Officer Gonzalez was at the officer's podium on the first floor when he heard the inmate yelling. He immediately ran to C17, radioing on the way that a man was down and for additional staff and medical personnel to proceed to Module 4C. Another radio call went out indicating that the specific cell was C17.

Correctional Officer Gonzalez was first on scene and rendered aid to Samuel. Correctional Officer Zavala arrived shortly thereafter. Three other correctional officers arrived at C17 and assisted in giving aid. Because SADF correctional officers did not provide a statement, it is unknown which correctional officer moved Samuel's body from the hanging position to where Samuel was later located by medical personnel.

A licensed vocational nurse ("LVN") arrived and entered C17 shortly after the correctional officers, entered C17. When she arrived, she saw Samuel supine on the floor with his head to the right of the toilet, on the left-hand side of the cell, and his feet extending out towards the opposite wall, on the right-hand side of the cell. Based on her observations, it is clear the correctional officers moved Samuel's body from the position where he was hanging to the floor of the cell.

The LVN checked for a pulse and started administering cardiopulmonary resuscitation ("CPR") to Samuel. She stated that there was no sign of life when she started CPR. A second LVN, three registered nurses and a nurse practitioner arrived at the cell shortly thereafter.

SADF's medical staff only stopped CPR so that the applied automated external defibrillator ("AED") could evaluate Samuel. Each time medical staff checked, the AED advised not to shock. A pulse oximeter was also applied to Samuel; it only registered the chest compressions from the CPR and did not register anything when CPR was paused for the AED evaluations.

Orange County Fire Authority ("OCFA") arrived at C17 at 11:31 a.m. OCFA administered a mask ventilation and mask airway, an intravenous line, and continued CPR by an automated device. OCFA also administered saline, one round of Narcan, three rounds of Epinephrine, and one round of sodium bicarbonate. All procedures and treatments had no effect on Samuel. They rendered aid until time of death, which was called at 11:47 a.m.

A registered nurse stated when she arrived at the Samuel's cell, she saw an LVN performing chest compressions on Samuel. Among other things she observed, the registered nurse described Samuel as unresponsive and cool to the touch.

Inmate Interviews
Samuel was described by various inmates as being a happy guy. Multiple inmates said that Samuel had recently learned of his birth parents' names and was getting in touch with them. Samuel was excited about the prospect of talking with them. Other inmates described him as being a depressed and angry person in the days leading up to his death. Inmates heard him yelling at someone on the phone on multiple occasions. Inmates believed he was talking to his wife or girlfriend.

Mental Health
Samuel claimed to have PTSD and depression. None of these claims were officially verified prior to Samuel's death. Levetiracetam was found in his system after his death. Levetiracetam has multiple side effects, including exacerbating depression.[2] Given the short period of time Samuel was in custody at SADF, there is no data indicating whether Samuel experienced any side effects of taking Levetiracetam. Samuel claimed to have attempted suicide in 2012, but denied any current suicidal ideations.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Clothing
- Apparent blood on left hand
- Ligature
- Apparent blood on sheet
- Bloodstain standard
- Audio recordings of canvass interviews

AUTOPSY

On June 29, 2021, a forensic pathologist, Dr. Yong-Son Kim of the Orange County Coroner's Office, conducted an autopsy on the body of Samuel. A furrow was found on Samuel's neck. It was approximately three to four inches in width and was very shallow and flat. It was marked by a band of erythematous congestion, one inch in width. The furrow moved upward direction towards the ears. The furrow was located nine inches from the top of the head anteriorly, slightly above the thyroid incisure. The pathologist determined the cause of death to be ligature hanging in a manner of suicide.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Caffeine	Postmortem Blood	Detected
Levetiracetam	Postmortem Blood	Detected
Nalozone	Postmortem Blood	Detected

[2] Silver, Jonathan., *Levetiracetam and Adverse Psychiatric Events: Who is at Risk?* (Feb 8, 2019) NEJM Journal Watch.

BACKGROUND INFORMATION

Samuel did have a State of California Criminal History record that revealed arrests for the following violations:

- Driving Without a License
- Brandishing a Firearm Replica
- Participating in a Criminal Street Gang
- Obstructing a Public Officer
- Shoplifting
- Grand Theft
- Grand Theft from a Person
- Taking Vehicle without Owner's Consent/Vehicle Theft
- Contempt
- Carjacking
- CCW in Vehicle
- Grand Theft Auto
- Receive Stolen Property
- Robbery
- Exhibiting a Deadly Weapon, Not a Firearm
- Attempted Robbery
- Possession of a Stolen Vehicle
- Violation of Parole

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 person;
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 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:

> "[T]he 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 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. A person acts with criminal negligence when the way he acts is so different from how an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act. Put differently, a person acts with criminal negligence when they lack "due caution and circumspection." (*People v. Penny*, (1955) 44 Cal.2d 861, 869, *citations omitted.*)

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

Based on the interviews conducted, the autopsy reports, viewing the surveillance video for the period in question, and all other evidence, there is no evidence of express or implied malice on the part of SADF personnel or any inmates or other individuals under the supervision of the SAPD. Samuel hung himself in his jail cell between the hours of 9:31 a.m., and 11:18 a.m.

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 SADF personnel owed Samuel a duty of care, the evidence does not support a finding this duty was in any way breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

SADF correctional staff possessed no reliable evidence to suggest Samuel intended to commit suicide. The U.S. Marshalls booked Samuel into the facility on May 24, 2021. Thirty-two days later, Samuel took his own life. There was not a significant period of time for SADF personnel to discover Samuel's suicidal intent.

Medical staff interviewed Samuel when booked. Samuel identified two psychiatric disorders he believed he had; however, he denied to the intake registered nurse of ever planning, preparing or attempting to take his life. The intake registered nurse referred Samuel to mental health for evaluation. On June 13, 2021, the psychiatric nurse interviewed Samuel. There, he claimed to have attempted suicide in 2012, but denied any current suicidal ideations. His claim of attempted suicide is in direct conflict with the statement he told the intake registered nurse a few weeks earlier. The conflicting information about suicide left SADF personnel with a reasonably unclear perception about the true nature of Samuel's mental health. Furthermore, Samuel refused the psychiatric nurse's recommendation to take mental health medication previously administered to him. Samuel's conflicting statements about suicide, his current claim he did not possess any suicidal ideations, and his refusal to take previously administered mental health medication made his suicide unforeseeable to a reasonable person.

Even the fellow inmates who Samuel lived with had an incomplete understanding of Samuel's mental health. Some inmates described Samuel as a happy guy. Some inmates described Samuel as depressed[3] and angry leading up to June 25, 2021. Despite having four incredibly disturbing phone calls with his longtime girlfriend the morning he committed suicide, Samuel maintained his composure and behaved in a manner inconsistent with one who possessed suicidal ideations. After the four phone calls the morning of his death, Samuel got in line to receive and take his medication. On his way back to his cell, he stopped by a group of inmates watching television. He watched television for a short time and talked with other inmates. On the video footage from SADF, Samuel appeared happy. Samuel then went back to his cell at approximately 9:15 a.m. Samuel killed himself shortly thereafter during the lockdown period.[4] This behavior is inconsistent with someone contemplating death; and therefore, Samuel's suicide would not have been foreseeable to SADF personnel.

SADF correctional staff failed to conduct a safety check of Samuel's cell as required by law. (*Cal. Code Regs.*, tit.15 § 1027.5 [Safety checks shall be conducted at least hourly through direct visual observation of all inmates.]) The last safety check occurred at 9:31 a.m., by Correctional Officer Tolone. A safety check should have been completed by 10:31 a.m. However, this oversight does not amount to criminal negligence. Criminal negligence must be of such a nature that there is a lack of due caution and circumspection. (*People v. Penny*, *supra*, 44 Cal.2d 861, 869.) Simply missing one safety check does not meet that standard because "criminal liability cannot be

[3] "Depressed" not in a clinical sense but in describing Samuel's behavior.

[4] A registered nurse described Samuel as "cool" to the touch when medical staff first discovered him. Most likely, Samuel's time of death occurred closer to 9:31 a.m. than 11:18 a.m., due to the fact his body felt cool to the touch.

predicted on every careless act merely because its carelessness results in injury to another." (*People v. Villalobos* (1962) 208 Cal.App.2d 321, 327.) At 11:18 a.m., one hour and forty-seven minutes after the last safety check, the inmate worker discovered Samuel's body. He immediately notified SADF personnel. Both medical and correctional staff arrived immediately. Medical staff promptly performed lifesaving procedures. SADF personnel promptly called OCFA who arrived quickly. SADF personnel appropriately responded once Samuel's body was discovered.

Immediately prior to committing suicide, Samuel spoke to his longtime girlfriend between the hours of 7:16 a.m. and 9:08 a.m., on June 25, 2021. He reportedly learned she had sexual relations with another man and was pregnant with that man's baby. This information caused Samuel significant distress and Samuel made several statements indicating his desire to kill himself. He said he "wanted to die." He told his girlfriend, "If I die and kill myself, I will haunt you for the rest of your life!" He also said, "I'm going to kill myself...you going to have the next man's baby! My life is destroyed! You destroyed me! ...You're not going to get this unless I kill myself... I have a point to prove to you. I am going to prove that point...because you take me as a joke! ... I need help, I need help, I am going to lose my mind. I hate your guts, you are Satan himself!"

If these statements were not clear enough, Samuel also reportedly stated, "I'm through with life. You must think I'm playing. Today is my last day on this earth. I'm through. My brain can't take it, my heart can't take it. I can't take it...the one person I truly loved and gave everything I had, fucked me over...fucked me over the hard way...you ruined my family."

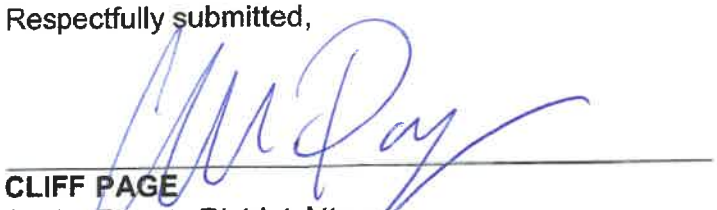
There is no evidence that SADF personnel had knowledge of these conversations. During all four conversations, Samuel utilized the telephone nearest his cell which was on the second tier out of earshot of most individuals. There is also no evidence jail personnel were aware of the nature of the conversations taking place between Samuel and his girlfriend. Furthermore, there was little chance of jail personnel discovering these conversations, given Samuel took his life almost immediately after these conversations ended.

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 insufficient evidence to support a finding that any SADF personnel or any individual under the supervision of the SAPD failed to perform a legal duty which rose to the level of legally causing the death of Samuel. The evidence shows that Darryle Marcell Samuel, Sr. unforeseeably died as a result of ligature hanging and that the death was a suicide.

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

Respectfully submitted,



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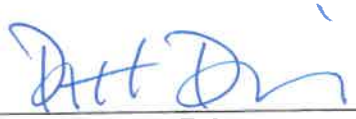

Read and Reviewed by **Brett Brian**
Assistant District Attorney
Special Prosecutions Unit

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