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April 17, 2017

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

Chief Raul Quezada
Anaheim Police Department
425 S. Harbor Boulevard
Anaheim, CA 92805

Re: Custodial Death on June 3, 2016
Death of Inmate Aaron Jackson Ryan
District Attorney Investigations Case S.A. # 16-020
Orange County Sheriff's Department Case # 16-134477
Orange County Crime Laboratory Case FR # 16-49516

Dear Sheriff Hutchens and Chief Quezada,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the above-listed incident involving the June 3, 2016, custodial death of 23-year-old inmate Aaron Jackson Ryan.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Ryan. 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) and Anaheim Police Department (APD) personnel or any other person under the supervision of the OCSD or APD.

On June 3, 2016, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Anaheim Regional Medical Center, where Ryan died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed three witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), APD and Anaheim Detention Facility (ADF), incident scene photographs, APD body worn camera (BWC) video, Orange County Jail (OCJ) surveillance video, ADF surveillance video, 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 and/or APD personnel, or any other person under the supervision of the OCSD or APD. 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/Gangs, and Special Prosecutions Units review fatal, as well as 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 supervising 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

On Sunday, May 29, 2016, at 12:23 a.m., APD Officers Daniel Heffner and Eddie Delgadillo were on patrol when they noticed Ryan coming from behind a closed business. Officers Heffner and Delgadillo approached Ryan and initiated a consensual encounter. The encounter was recorded on a body worn camera. Ryan told the officers that he was in possession of hypodermic syringes and had an active arrest warrant for theft. Officer Heffner conducted a records check of Ryan and learned that he had a $5,500.00 misdemeanor arrest warrant for a violation of Penal Code section 484(a) out of the North Justice Center. At 12:48 a.m., Officer Heffner arrested Ryan and transported him to the ADF. All of Ryan's movements throughout the ADF were recorded via surveillance cameras. While at the ADF, Ryan stated that he did not have any medical problems. During the initial screening and body search process, Ryan was not strip-searched, but he was asked to pull his pant legs up to his knees. At approximately 2:47 p.m., Ryan was transported to the OCJ for booking. All of Ryan's movements throughout the OCJ were recorded via surveillance cameras. While at OCJ, Ryan was medically screened by a registered nurse who noted that there were no obvious abrasions, abscesses, bruises, cuts, infection, needle marks, rash, skin lesions, trauma, or head lice. On the medical screening questionnaire, Ryan stated the following: (1) he did not have any pain; (2) he did not have any medical or mental conditions that he would like to speak to someone about in private; (3) he did not have a serious infectious disease in the past such as a bad skin infection; (4) his mobility and dexterity were not restricted due to bandages, cast, deformity, splints, or injury; he did not have any other special health requirements; and (5) he did not have any medical reason why he could not work in jail. Ryan was assigned to an appropriate housing location.

On Tuesday, May 31, 2016, at 11:38 p.m., Ryan complained of leg pain and he was brought from Module F via wheelchair to be medically checked. Ryan told the nurse, "I have had this abscess for a few days from shooting heroin and speed. I have been using for eight years. It started hurting since yesterday, but now the pain is really bad and I can't even walk." The nurse noted Ryan's left groin showed superficial reddening of the skin and bruising from old injection sites. Ryan's anterior thigh was tender to the touch, warm, and firm. Ryan complained of radiating pain to his suprapubic region. The nurse felt Ryan needed to be seen by a physician urgently, but she did not feel it rose to the level of an emergency. The nurse advised Ryan he should be seen at a hospital and Ryan agreed. The nurse notified OCJ main control that she

needed an ambulance. However, after the ambulance had been ordered, Ryan told the nurse he would go to the hospital on his own when he was released. The nurse had Ryan sign a Refusal to Consent to Medical Treatment and Release of Liability form.

On June 1, 2016, at 1:14 a.m., after a total of three days in custody, Ryan was released from the custody of OCJ. At 2:20 p.m., Ryan walked into Anaheim Regional Medical Center (ARMC) Emergency Room (ER). Ryan complained of pain in his upper left leg and groin area and requested to see a physician. An examination of Ryan revealed redness, swelling, and inflammation of the skin and tissue on the left thigh. The lab work revealed an elevated level of infection. The attending physician determined that Ryan's prognosis was "grave" and due to the level of infection Ryan should be transferred to "a higher level of care." Arrangements were made for Ryan to be transferred to the University of California, Irvine-Medical Center (UCIMC). However, at approximately 7:30 p.m., before Ryan could be transferred to UCIMC, he went into cardiopulmonary arrest. Ryan was intubated, resuscitated, and transferred to the Intensive Care Unit (ICU).

On June 2, 2016, at approximately 11:00 p.m., a physician performed surgery on Ryan's left thigh. After surgery, Ryan was placed in the ICU. On June 3, 2016, at approximately 5:50 a.m., Ryan went into cardiopulmonary arrest. At 6:15 a.m., the attending physician pronounced Ryan deceased and determined that Ryan's death was due to metabolic acidosis and sepsis.

At 12:04 p.m. on June 2, 2016, Jane Doe arrived at the hospital and provided a statement. According to Jane Doe, Ryan was a heavy heroin user and had been for ten years. Ryan had been homeless for the last seven years of his life. Ryan contacted Jane Doe in October of 2015 seeking help with enrollment into a drug rehabilitation program. On June 1, 2016, Ryan's mother contacted Jane Doe and informed her that Ryan was at ARMC and asked her to visit Ryan. Jane Doe visited Ryan at ARMC on the same day. Jane Doe noticed Ryan was detoxing from heroin and was verbally abusive toward the nurses. Ryan told Jane Doe he was arrested for petty theft, and Jane Doe asked Ryan if he had cellulitis on his upper left thigh prior to going to jail and he said he did. Jane Doe asked Ryan if he told the jail staff about the cellulitis on his upper left thigh and he said he did not. When Jane Doe asked Ryan if he was limping when he went into jail, he said he was but did not tell the jail staff.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Anaheim Detention Facility video
- Anaheim Police Department body worn camera video
- Orange County Jail video

AUTOPSY

On June 11, 2016, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Ryan. Dr. Luzi noted that Ryan did not have any major or minor injuries. Dr. Luzi determined that the cause of Ryan's death was natural disease and pre-existing conditions. Dr. Luzi also noted that Ryan had a clinical history of the following: [redacted].

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
[redacted]	Postmortem Blood	0.0191 ± 0.0012 mg/L
[redacted]	Postmortem Blood	0.0266 ± 0.0018 mg/L

[redacted]	Postmortem Blood	0.0139 ± 0.0019 mg/L
[redacted]	Postmortem Blood	0.0666 ± 0.0067 mg/L

BACKGROUND INFORMATION

Ryan had a State of California Criminal History record that revealed arrests for the following violations:

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 proved beyond a reasonable doubt:

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 the person 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 than 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 this case, there is no evidence whatsoever of express or implied malice on the part of any OCSD and/or APD personnel, or any inmates or other individuals under the supervision of the OCSD and the APD. 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 and APD owed Ryan a duty of care, the evidence does not support a finding that this duty was in any way breached, either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). Ryan was arrested on a misdemeanor warrant and taken to the ADF. While at the ADF, Ryan stated that he did not have any medical problems. The detention officers conducted an initial screening and body search, but did not require Ryan to remove his clothing. At one point, the detention officers had Ryan pull his pant legs up to his knees to check for weapons or contraband.

Once he was taken to the OCJ, Ryan was medically screened by a registered nurse who noted that Ryan did not have any obvious abrasions, abscesses, bruises, cuts, infection, needle marks, rash, skin lesions, trauma, or head lice. On the medical screening questionnaire, Ryan denied having any pain or skin infections. However, two days later, Ryan started complaining about pain in his leg radiating to his suprapubic region. Ryan told the nurse, "I have had this abscess for a few days from shooting heroin and speed. I have been using for eight years. It started hurting since yesterday, but now the pain is really bad and I can't even walk." The nurse noted Ryan's left groin showed superficial reddening of the skin and bruising from old injection sites. Ryan's anterior thigh was tender to touch, warm, and firm. As a result of these observations, the nurse decided to made arrangements to have Ryan transported to a hospital. When the nurse ordered an ambulance to take Ryan to the hospital, Ryan refused and told the nurse he would go to the hospital on his own when he was released. The nurse had Ryan sign a Refusal to Consent to Medical Treatment and Release of Liability form. Ryan was released from OCJ custody the next day at 1:14 a.m. At 2:20 p.m., Ryan walked into the ER at ARMC. Ryan had redness, swelling, and inflammation of the skin and tissue on the left thigh. The lab work revealed an elevated level of infection. Because of his grave condition, the physician suggested transferring Ryan to a facility that could provide a higher level of care. Ryan went into cardiopulmonary arrest before being transferred.

The APD transferred Ryan to OCJ for booking without any knowledge of his health problems. Initially, Ryan denied having any health problems when he was being screened at OCJ. Once OCSD personnel became aware of Ryan's health issues, they made arrangements for him to be transferred to a hospital via ambulance. Ryan refused to be transported to the hospital and insisted that he would seek treatment once he was released from custody. The OCSD and APD personnel did not withhold needed treatment from Ryan, but rather Ryan refused the treatment that was offered to him. Based on the totality of the facts, and based on Ryan's affirmative action in refusing to be taken to the hospital, the prosecution will not

be able to prove beyond a reasonable doubt that a crime was committed by any OCSD and APD personnel, or that any individual under the supervision of the OCSD or APD 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 no evidence to support a finding of criminal culpability on the part of any OCSD and APD personnel or any individual under the supervision of the OCSD or APD. The evidence shows that Ryan died from complications resulting from natural disease and pre-existing conditions after he refused medical treatment offered to him by OCSD.

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

Respectfully submitted,

Stefanie Marangi
Senior Deputy District Attorney
TARGET/Gangs Unit

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