OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

August 30, 2021

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

Re: Custodial Death on January 21, 2021
Death of Inmate Ahle Fang
District Attorney Investigations Case # 21-000178
Orange County Sheriff's Department Case # 21-000544
Orange County Crime Laboratory Case # 21-40968
Orange County Coroner Office Case # 21-00699-AZ

Dear Sheriff Barnes,

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 January 21, 2021, custodial death of 37-year-old inmate Ahle Fang.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Ahle Fang. 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 Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD in connection with this custodial death incident.

On January 21, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Providence St. Joseph Hospital located at 1100 West Stewart Drive, Orange, California 92868, where Ahle Fang died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed one witness, and obtained and reviewed reports from the OCSD, the Orange County Crime Laboratory (OCCL), medical records from the Orange County Health Care Agency (OCHCA), medical records from Providence St. Joseph Hospital, as well as 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 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 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 Senior Assistant District Attorney supervising the Operations IV Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney reviews all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

Around midnight on August 15, 2017, Ahle Fang threw a skincare product at his sister's head while she was sleeping. His sister's scream alerted their mother and when his mother intervened, Fang locked himself in his room, claiming that his sister had tried to poison him. Shortly afterwards, Fang exited his room and stabbed his mother with a knife. His mother fled from their apartment, collapsed, and eventually died at the hospital from her injuries. Fang also attacked his mother's boyfriend with the knife, stabbing him in the arm and chest. Fang fled on foot, but was arrested by the police when he returned to the apartment complex.

After being treated at the St. Jude Medical Center in Fullerton for minor injuries, Fang was booked into the Orange County Jail. During his intake screening, the Mental Health Unit noted that Fang was taking psychiatric medications for schizophrenia. While incarcerated at Orange County Jail, Fang continued to be administered psychiatric medication. However, on August 15, 2019, Fang, during a mental health assessment, informed the staff that he had stopped taking his psychiatric medication a week earlier and would not take any more medication. At numerous subsequent mental health evaluations, the staff repeatedly explained to Fang the

benefits of taking the psychiatric medication, but Fang remained resolute in his refusal to do so.

Fang was scheduled to take a COVID-19 test on December 19, 2020. However, Fang refused to take that test. On December 22, 2020, Fang again refused to take a test for COVID-19.

On the morning of December 29, 2020, Fang complained that his cell mate had punched him and tried to molest him every day. Deputies and his cell mate noted that Fang had been talking to himself more frequently. Fang was referred for a mental health assessment. During that assessment, Fang admitted he was hearing voices and seeing things, but said he felt fine. He also asked the staff how he could protect himself from getting COVID-19. That afternoon, the medical staff scheduled a COVID-19 test for Fang.

In the afternoon of December 30, 2020, the medical staff conducted a COVID-19 symptom check on Fang. They concluded, based on observation and Fang's reporting, that the only symptom was a dry cough. A COVID-19 test was conducted at 10 p.m. and two hours later, the results showed that Fang was positive for COVID-19.

On January 3, 2021, Fang reported a bad cough and requested medication. When he was examined on January 4, 2021, for COVID-19 symptoms, Fang denied experiencing shortness of breath and displayed no other COVID-19 symptoms.

Around noon on January 5, 2021, during a check for COVID-19 symptoms, Fang reported a dry cough, but had no other symptoms. When mental health staff examined him around 6:30 p.m., Fang coughed several times, but did not display any other symptoms of note. However, at 10:51 p.m., Fang's condition had worsened. He told the medical staff that he was feeling weak. His blood pressure was high at 143/88 and his oxygen saturation was at 90. The nurse also noted that there were sounds of crackling in the upper bilateral lobes of his lungs, which cleared after coughing. Fang was treated using an Albuterol inhaler, which improved his oxygen saturation to 92 within ten (10) minutes of use. Fang was also prescribed an Albuterol inhaler to self-treat his coughing and shortness of breath.

On January 6, 2021, around 9:30 a.m., Fang was again examined by the medical staff. He informed them that he had just used his medicine before they came and that he didn't feel any shortness of breath, but still needed to cough. He also shared that until his incarceration, he used to smoke a pack of cigarettes a day for the past twenty (20) years. His oxygen saturation was reported at 98, but within forty (40) minutes that fell to 90. As a result, the medical staff decided to send Fang to the emergency department for further evaluation. At 10:50 a.m., Fang was taken to Providence St. Joseph Hospital by paramedics. During the transport, the paramedics administered oxygen using nasal cannula, which improved Fang's condition.

Upon admission to the emergency room, the hospital staff noted that Fang was an obese male who was complaining of shortness of breath, had had intermittent fevers and chills, and had had difficulty breathing for the past week with his condition worsening in the past few days. Imaging showed that Fang had diffuse bilateral pulmonary parenchymal opacities consistent with pneumonia.

On January 8, 2021, in the morning, Fang refused to submit to blood work and refused anticoagulant medication. The medical staff explained to him the importance of blood work and the risks for stroke and blood clots in his lungs due to COVID-19 if he did not take the medication. This did not change Fang's mind. Fang was put on a non-rebreather mask due to his oxygen saturation levels continuing to fall into the 60s. However, Fang periodically removed his mask, causing his oxygen saturation to fall significantly.

On January 9, 2021, Fang again refused to submit to blood work and refused the anticoagulant medication. Later that day, due to his oxygen saturation continuing to fall, the medical staff placed Fang on a Bilevel Positive Airway Pressure (BiPAP) machine. Around 3:20 p.m., Fang removed his BiPAP, which resulted in the hospital staff calling a Code Blue due to Fang being in severe respiratory distress. Fang was able to recover with the assistance of the BiPAP. The hospital staff decided to continue with that course of treatment and not intubate Fang.

On January 10, 2021, Fang was transferred to the Step-Down Unit, which provides a greater level of care than the hospital floor but a lower level when compared to the Intensive Care Unit. Fang expressed his desire not to be intubated. The medical staff explained that in the event of worsening respiratory failure or respiratory arrest, he would die without intubation. Fang said he would like to die peacefully without intubation. The medical staff was unable to obtain any next of kin information, including from the Orange County Jail.

On January 11, 2021, the medical staff tried high flow nasal cannula (HFNC) on Fang without success, and then placed Mr. Fang back on BiPAP at the maximum level of oxygen. Fang continued treatment on BiPAP at the maximum level through January 17, 2021. Aside from intermittent fever, Fang's primary symptoms between January 11th and 17th continued to be a cough and difficulty breathing. Imaging taken on January 14, 2021, showed that the extensive bilateral pulmonary opacities had increased.

On January 18, 2021, the medical staff noted that despite being on BiPAP at the maximum level of oxygen, Fang was in acute respiratory distress and his oxygen saturation had decreased to the 60s. The treating physician explained that, with Fang's rapidly worsening respiratory failure and poor prognosis, his death would be imminent without intubation. Fang reiterated that he did not want intubation and wanted to die peacefully. The doctor then explained the benefits of comfort care, but Fang refused comfort care. Fang was willing to accept some medication to make him more comfortable. Based on the doctor's extensive interactions with Fang during the course of his treatment, the doctor and a psychiatrist concluded that Fang possessed sufficient mental capacity to make these medical decisions.

By refusing comfort care, Fang limited the amount of morphine the medical staff could provide him. On January 19, 2021, the medical staff provided Fang with a limited morphine drip. Fang's oxygen saturation persisted in the 60s as he continued to receive oxygen through the BiPAP on January 19th and 20th. The medical staff again tried to obtain next of kin information without success.

On January 20, 2021, Fang was transferred back to the hospital floor as his death was imminent and he continued to receive supportive care. On January 21, 2021, around 8:45 a.m.,

Fang's oxygen alarm went off. Fang's heart monitor also showed that his heart had stopped. Due to the Do Not Resuscitate order, the medical staff took no further action. Fang was pronounced deceased at 8:50 a.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- A sample of Fang's postmortem blood
- Heart blood standard
- Forty-three (43) color digital photographs of the autopsy
- Forty (40) color digital photographs of the hospital scene and Fang's body
- Eighteen (18) post embalming photographs
- Audio Recording of a nurse practitioner employed at Providence St. Joseph Hospital

AUTOPSY

On January 28, 2021, Dr. Scott Luzi, an independent Forensic Pathologist, conducted an autopsy on the body of Ahle Fang. There were no significant signs of trauma to the body. He opined that an abrasion on the bridge of Fang's nose may have been caused by prolonged use of oxygen facemasks during his course of treatment at Providence St. Joseph Hospital. He also noted that Fang's lungs were "heavy", which was consistent with COVID-19. In his report, Dr. Luzi listed a number of natural diseases and pre-existing conditions, including cerebral edema, pulmonary consolidation, cardiomegaly, mild coronary atherosclerosis, mild peripheral atherosclerosis, and nephrosclerosis. Dr. Luzi concluded that Fang's cause of death was diffuse alveolar damage due to novel coronavirus (COVID-19) infection. The manner of death was determined to be natural.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Ethanol/Volatiles	Postmortem Blood	Not Detected
Amphetamine and Related	Postmortem Blood	Negative
Barbiturates	Postmortem Blood	Negative
Methamphetamine and Related	Postmortem Blood	Negative
Cannabinoids	Postmortem Blood	Negative
Lorazepam	Postmortem Blood	0.0190 ± 0.0017 mg/L
Lorazepam-glucuronide	Postmortem Blood	Detected

Acetaminophen (Free)	Postmortem Blood	2.02 ± 0.19 mg/L
Morphine (Free)	Postmortem Blood	0.147 ± 0.016 mg/L

BACKGROUND INFORMATION

According to Fang's State of California Criminal History record, he was arrested in January 2007 for possessing drug paraphernalia, he was arrested in March 2010 for criminal threats and for brandishing a weapon, and he was arrested on August 15, 2017, for 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 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 acted he 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 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 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 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.

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

This is not a case involving express or implied malice. Rather, the only issue is whether there was a murder or involuntary manslaughter for failure to perform a legal duty that caused Fang's death. Due to Fang's incarceration, OCSD owed him a duty of care. The evidence shows that OCSD and those individuals acting under OCSD's supervision fulfilled that duty by providing him appropriate and adequate medical care. Fang's death resulted from health challenges caused by COVID-19.

OCSD offered Fang opportunities to test for COVID-19 on December 19, and December 22, 2020, but Mr. Fang declined. On December 30, 2020, after complaining of a dry cough, Fang was given a COVID-19 test that night and was determined to be positive for COVID-19. In the subsequent days, the medical staff at the Orange County Jail continued to monitor Fang's symptoms, which consisted primarily of a cough. Fang was otherwise not in distress, so no additional medical intervention was required.

At 10:50 p.m. on January 5th, Fang's symptoms worsened. His blood pressure was high, his oxygen saturation level had fallen to 90, and he reported feeling weak. The medical staff attended to him and administered an Albuterol inhaler, which improved his condition. They also provided him with an Albuterol inhaler for self-medication. The following morning, the medical staff re-examined Fang who reported that he had used the Albuterol inhaler and it had

helped his breathing. However, because Fang's oxygen saturation levels continued to fluctuate within the 90s, the medical staff decided to send Fang to the emergency room for further evaluation. These actions further demonstrate that OCSD and those acting under OCSD's supervision fulfilled their duties.

When Fang arrived at Providence St. Joseph Hospital, the hospital staff provided appropriate medical care. In particular, the hospital staff increased the medical interventions as Fang's condition progressively worsened. However, Fang, who had a history of refusing or declining medical treatment, limited their treatment options. For example, Fang, in August 2019, stopped taking his psychiatric medication for schizophrenia. While in the hospital, Fang removed his non-rebreather mask and his BiPAP. Fang refused to submit to blood work or take anticoagulant medication. Fang elected to have "do not intubate" and "do not resuscitate" orders and opted out of receiving comfort care. Despite the warnings from the hospital staff, Fang chose a course of treatment that would inevitably lead to his death.

There is no indication that OCSD failed to fulfill their legal duty of care to Fang. He was continually provided appropriate medical care by OCSD and the medical providers. For those reasons, there is no evidence to support a finding that any OCSD personnel or any individual under OCSD's supervision failed to perform a legal duty that resulted in Fang's death.

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 that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Fang.

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

Respectfully submitted,

CYRIL YU
Senior Deputy District Attorney, Gang Unit

Read and Reviewed by **BARBARA K. KIM**
Assistant District Attorney, Special Prosecutions Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney, Felony Operations IV

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