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October 3, 2017

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

Re: Custodial Death on February 25, 2017
Death of Inmate Christopher Thomas Hardesty
District Attorney Investigations Case # S.A. 17-005
Orange County Sheriff's Department Case # 17-007548
Orange County Crime Laboratory Case # 17-43317 and 17-43804
Orange County Sheriff's Coroner Case # 17-01044-GE

Dear Sheriff Hutchens,

Please accept this letter detailing the investigation and legal conclusion by the Orange County District Attorney's Office (OCDA) in connection with the above-listed incident involving the custodial death of 45-year-old inmate Christopher Thomas Hardesty on Feb. 25, 2017.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Hardesty. 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 Feb. 25, 2017, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center (OCGMC), where Hardesty died while in custody after receiving medical treatment. During the course of this investigation, the OCDASAU interviewed 14 witnesses, obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), examined 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/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

Hardesty was in poor health and suffered from numerous life-threatening, interrelated, medical conditions. These conditions included: chronic hypertension, cardiovascular disease (severe peripheral vascular disease), congestive heart failure, morbid obesity, obstructive sleep apnea, venous stasis of lower extremities, chronic venous insufficiency, superficial thrombophlebitis, chronic pain syndrome, dyspnea on exertion, left leg cellulitis, hepatomegaly, lower leg edema, and umbilical hernia. On May 2, 2015, after being admitted to a hospital for treatment, Hardesty was informed that he was permanently disabled and that his conditions were so severe that they would likely result in his death. Hardesty also had a history of methamphetamine abuse and was a heavy tobacco smoker.

On April 13, 2016, Hardesty was convicted in Orange County Superior Court case # 13HF1914 and # 15HF0270 of nine felony charges including receiving stolen property and possession for sale of Methamphetamine, Heroin, Suboxone, Adderal, and Alprazolam, with multiple sentencing enhancements. Hardesty was not immediately sentenced, and instead remained out of custody at the request of his attorney. On Feb. 24, 2017, Hardesty was sentenced to three years in Orange County Jail, with a mandatory term of two years in-custody and one year of supervised release. Hardesty was immediately remanded to the custody of the OCSD and transferred to the Jail Intake Release Center (IRC) later in the day. Upon his arrival at the IRC, Hardesty underwent a routine medical screening as part of the booking process. Hardesty was in possession of his medical paperwork outlining his specific medical needs, and he discussed his medical history with OCSD personnel. During the evaluation, Hardesty did not complain of any immediate, life-threatening issues. Hardesty was cleared for booking at approximately 6:10 p.m.

Due to Hardesty's lack of mobility, and use of a machine for sleep apnea, it was determined that Hardesty could not remain at the Central Jail Facility and would need to be housed in a medical observation unit at the Theo Lacy Facility. However, since transfers between jail facilities occur in the morning and in the afternoon, Hardesty was not scheduled to be transferred until the following day, Feb. 25, 2017, at around 10:30 a.m. To accommodate his medical needs, Hardesty was housed alone, in a cell located directly in front of, and a few feet away from, a deputy's work station so that he could be monitored throughout the night as he awaited transfer.

On Feb. 25, 2017, at approximately 6:00 a.m., deputies assigned to shift 1B began their workday at the work station directly across from Hardesty's cell. The deputies were aware of Hardesty's sleep apnea and were aware that he was going to be transferred to the Theo Lacy Facility. As a result, they continually monitored Hardesty while he was inside the cell as they completed their assigned work tasks. During this time, Hardesty was snoring loudly and could be heard by the deputies outside of the cell. Additionally, the deputies observed that Hardesty was constantly shifting around the cell in an apparent attempt to get comfortable. Hardesty switched between sitting upright on the concrete bench inside the cell, and leaning against the wall, to sitting on the ground and leaning with his back against the concrete bench. If Hardesty was found sleeping on his back, the deputies would knock on the glass, tell him to sit up, and direct him to lean against the concrete bench.

At approximately 7:15 a.m., a nurse observed Hardesty sitting on the floor, leaning against the concrete bench inside the cell. Hardesty appeared to be sleeping. The nurse noted that Hardesty was obese and observed Hardesty's abdomen rise and fall while breathing. The nurse noted that Hardesty's color appeared natural. When the nurse knocked on the cell door, Hardesty sat up, moved toward the nurse, and spoke to her. The nurse asked Hardesty if he was okay and he nodded in the affirmative. The nurse informed Hardesty that he was going to his new housing soon and directed him to stay in a seated position. Following, Hardesty returned to the floor, leaned against the bench, closed his eyes, and appeared to go back to sleep.

At approximately 7:45 a.m., another nurse went to Hardesty's cell to provide him with medication. Hardesty was lying on the floor and both the nurse and a deputy called out for him to wake up. Hardesty awakened, appeared lethargic, and took his medication. Hardesty did not complain of any medical issues and did not request any medical assistance. Hardesty was advised to be careful as he sat down to avoid falling.

At approximately 9:50 a.m., OCSD Deputies Steven Ledesma and Juan Ochoa attempted to wake Hardesty when they noticed that Hardesty's snoring sounded irregular and choppy. They began knocking on the glass in the cell door and entered the cell when Hardesty did not respond. Deputy Ochoa pushed Hardesty three times on his left shoulder, but Hardesty did not awaken. Instead, Hardesty rolled to his side, and continued to sleep. The Deputies noticed that Hardesty's breathing appeared to improve once he rolled over onto his side and, even though Hardesty continued to snore, they did not otherwise observe anything abnormal. As a result, the deputies left the cell and returned to their work station.

At approximately 10:00 a.m., Deputy Daniel Gerlach noticed Hardesty was no longer snoring and observed Hardesty lying motionless, on his back, with arms at his sides and his mouth open. Hardesty's tongue protruded slightly from his lips. Deputy Gerlach immediately entered the cell, along with Deputies Richard Paniagua and Ochoa. Working together, they turned Hardesty on his left side and attempted to wake him with sternum rubs. Hardesty was unresponsive. When Deputy Paniagua was unable to locate a pulse, Deputy Ochoa began cardiopulmonary resuscitation (CPR) and an emergency "man down" call was sent over the radio to summon medical staff and additional deputies. While awaiting additional assistance, Deputy Ledesma retrieved an airway mask and provided the mask to Deputy Paniagua, who tried to perform rescue breathing. However, Deputy Paniagua could not successfully use the mask due to the confined space of the cell and Hardesty's overweight condition.

At approximately 10:03 a.m., two Registered Nurses responded to the radio call for medical assistance. When they arrived they observed Hardesty inside the cell and a deputy performing CPR compressions. The nurses directed the deputies to call for paramedics, and Deputy Gerlach made the request via his radio. Working together, the deputies slid Hardesty out of the cell to make it easier to render medical aid. Automated External Defibrillator (AED) pads were affixed to Hardesty's chest and an Ambu bag, with an oxygen line, was used to provide oxygen to Hardesty. Due to Hardesty's size, the nurses had difficulty keeping his airway open. A third nurse arrived to assist and attempted to start an intravenous line (IV) in one of Hardesty's arms. However, she could not locate a vein to access for the IV. During this time, the AED analyzed Hardesty's heart condition on three separate occasions. Each time the AED completed an analysis, a shock was not advised, and CPR continued. The deputies worked as a team to perform CPR and took turns delivering chest compressions until Orange County Fire Authority (OCFA) paramedics arrived.

At approximately 10:06 a.m., the Orange County Fire Authority (OCFA) received a call for service at the OCJ IRC. Paramedics were dispatched and took over medical assistance to Hardesty upon their arrival at approximately 10:12 a.m. They noted that Hardesty's heart was in an asystole condition and that he had no vital signs. An intraosseous line was established in Hardesty's left tibia and Hardesty was given five, one milligram, doses of epinephrine at three to five minute intervals. Hardesty's heart showed electrical activity, but was not pumping blood. During this time, CPR efforts were continuous.

At approximately 10:31 a.m., Hardesty was placed in an ambulance and transported to the OCGMC. The ambulance arrived at approximately 10:42 a.m. Lifesaving medical treatment continued at the hospital and Hardesty was connected to a variety of medical equipment within the emergency room. Testing and observation by OCGMC medical staff revealed that Hardesty's

heart was in agonal rhythm, and a glide scope was utilized to confirm Hardesty's tracheal tube was properly positioned and ventilating. Hardesty received additional injections of epinephrine at three to five minute intervals, per hospital protocols, but there was never any change in Hardesty's condition. At approximately 10:50 a.m., Hardesty was pronounced deceased by the attending physician.

AUTOPSY

On March 1, 2017, independent Forensic Pathologist Dr. Scott A. Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Hardesty. Dr. Luzi's preliminary examination revealed that Hardesty had a heart attack in two separate areas of the heart, and also suffered a rupture at the top of the heart. Dr. Luzi determined that Hardesty's heart attack began a day or so before he was taken into custody. However, Dr. Luzi was unable to determine if Hardesty's heart rupture resulted from the heart attack or CPR efforts. After toxicology, microscopic slide, and tissue sample examination, Dr. Luzi noted that Hardesty suffered from acute methamphetamine intoxication and ultimately concluded Hardesty's death was the result of natural causes, myocardial infarction due to hypertensive heart disease.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Hardesty's postmortem blood and brain tissue collected during the autopsy, and analyzed by the OCCL, yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Oxazepam	Postmortem Blood	0.203 ± 0.012 mg/L
Acetaminophen (Free)	Postmortem Blood	5.47 ± 0.63 mg/L
Amphetamine	Postmortem Blood	0.0642 ± 0.0040 mg/L
Amphetamine	Brain	0.366 ± 0.023 mg/kg
Methamphetamine	Postmortem Blood	0.505 ± 0.033mg/L
Methamphetamine	Brain	2.53 ± 0.17 mg/kg
Metoprolol	Postmortem Blood	Detected
Dicyclomine	Postmortem Blood	Detected

BACKGROUND INFORMATION

Hardesty had a State of California Criminal History record that began in 1990 and revealed arrests for the following violations:

- Possession of a narcotic controlled substance, and possession of a controlled substance without prescription
- Possession of a controlled substance for sale
- Being under the influence of a controlled substance
- Possession of stolen property
- Planting/cultivating marijuana
- Possession of a dangerous weapon
- Possession of a hypodermic needle, and possession of a firearm by a felon
- Probation and parole violation

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 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 they act 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 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 Hardesty 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).

Hardesty suffered from numerous life-threatening, pre-existing, medical conditions at the time he was placed in OCSD's custody, including chronic hypertension, cardiovascular disease, and congestive heart failure. During booking, Hardesty underwent, and successfully completed, a medical screening process where medical personnel reviewed his medical history and interviewed Hardesty to determine if he had any immediate medical concerns. At the time of booking, Hardesty did not complain of any immediate health issues; he did not request, nor was he denied, any medical treatment. However, after reviewing Hardesty's medical history, OCSD personnel made special accommodations to ensure that Hardesty received appropriate medical care while incarcerated.

Hardesty was scheduled to be transferred to a medical observation unit the morning following his arrival at the OCJ IRC. During the night preceding the transfer, OCSD staff took special precautions to ensure that Hardesty was safe and monitored. Hardesty was placed in a cell, by himself, to accommodate both his body size and lack of mobility. Additionally, the cell was located directly across, and just several feet away, from a deputy's work station. The deputies that worked at the station were made aware of Hardesty's medical conditions and they were informed that Hardesty suffered from sleep apnea. The proximity of the workstation to the cell allowed deputies to frequently monitor Hardesty's condition, and the deputies periodically checked on Hardesty throughout the night. When they found him sleeping on his back, they woke him up and instructed him to lie on his side. When they detected a change in his breathing, or the sound of his snoring, they entered the cell to evaluate his condition further.

Hardesty's condition deteriorated dramatically and unexpectedly during the 10-minute window between the time when Deputies Ledesma and Ochoa checked on Hardesty's condition, and the time when Deputy Gerlach observed Hardesty motionless on the cell floor. Hardesty was still breathing and moving when Deputies Ledesma and Ochoa entered the cell at 9:50 a.m. While Hardesty did not awaken when they pushed on his shoulder, Hardesty rolled to his side and continued to sleep. Hardesty's breathing appeared to improve, and he continued snoring. There was no indication, apparent or otherwise, that Hardesty would soon suffer full cardiac arrest.

Deputies immediately entered Hardesty's cell to assess his condition when they observed him motionless on the floor. They began CPR without delay when they determined Hardesty did not have a pulse, and quickly summoned nurses, and paramedics, to their location to provide additional medical assistance. Working together, OCSD medical personnel, deputies, and OCFA paramedics employed lifesaving measures continuously, and without interruption, as they awaited the arrival of an ambulance to transfer Hardesty to the hospital. An AED was utilized to monitor the condition of Hardesty's heart, and an Ambu bag, with an oxygen line, was utilized to support his breathing. Efforts to save Hardesty's life began at the first indication of medical distress and only terminated at the direction of a medical doctor after Hardesty had been transferred to the hospital.

There is also no evidence in this case to support criminal negligence on the part of anyone connected with the OCSD. Criminal negligence is established when a person 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. There is no evidence that any OCSD personnel or anyone under their supervision acted in a reckless manner.

OCSD personnel took active steps to make sure that Hardesty's medical needs were met during his time in custody. Hardesty received special housing accommodations and was continuously monitored during the brief period of time between his arrival at OCJ and his scheduled transfer the following day. The deputies charged with his care were made aware of his medical conditions and immediately took action when they observed Hardesty engaging in concerning behavior, like sleeping on his back, or when they detected an abnormality in his breathing or appearance. There was no indication that Hardesty had suffered, or was suffering, from a heart attack or that cardiac arrest was imminent. Further, OCSD personnel did not do anything, intentionally or negligently, to exacerbate Hardesty's condition at any time.

The facts are consistent with the Coroner's conclusion that Hardesty died from natural causes. All available records support the conclusion that the OCSD met its legal duty with the appropriate standard of care. Thus, there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD was criminally negligent or failed to perform a legal duty owed to Hardesty.

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 personnel or any individual under the supervision of the OCSD. The evidence shows that Hardesty died as a result of natural causes.

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

Respectfully submitted,

JEFFREY KIRK
Deputy District Attorney
Special Prosecutions Unit

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