OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

August 28, 2020

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

Re: Custodial Death on July 18, 2019
Death of Inmate Shikiira Monae Kelly
District Attorney Investigations Case: S.A. 19-015
Orange County Sheriff's Department Case: 19-027291
Orange County Crime Laboratory Case: FR# 19-49360

Dear Sheriff Barnes,

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 July 18, 2019, custodial death of 37-year-old inmate Shikiira Monae Kelly.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Kelly. 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 July 18, 2019, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Central Women's Jail (CWJ), where Kelly died while in custody after receiving medical treatment. During the course of this investigation, the OCDASAU interviewed fifteen witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), 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 an experienced deputy district attorney for legal review. Deputy district attorneys from the Homicide, 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 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 April 18, 2019, Kelly was released from state prison after being held for approximately nine years pursuant to convictions for violating Penal Code section 245(a)(1), Assault with a Deadly Weapon with Great Bodily Injury and Penal Code section 4502(a), Prisoner in Possession of a Weapon. On April 18-19, 2019 Kelly was temporarily detained in Santa Ana for violating Penal Code section 647(f), Disorderly Conduct - Public Intoxication and she was released on April 19.

On April 20, 2019, Kelly received a mental health evaluation at St. Joseph's Medical Center (SJO) in Orange, at which time she expressed suicidal ideations. Kelly was also evaluated for methamphetamine use and substance-induced psychosis. Ultimately, she declined antipsychotic medication and was cleared for release. Furthermore, a Welfare and Institutions Code 5150 hold for Mental Health Danger (allowing medical staff to take those who pose a danger to themselves into custody) was released.

The next day, on April 21, 2019 Kelly was brought back to SJO by Orange Fire Department after she had reported chest pains. This time, she was evaluated for schizophrenia, psychosis, and amphetamine abuse. After being examined by the SJO Emergency Department Medical Team, Kelly was cleared for release as a malingerer. Yet, despite having refused antipsychotics the day before, Kelly now refused to leave unless she was given medication for mental illness. At approximately 7:00 PM, Kelly was arrested by the Orange Police Department for violating Penal Code section 602.1 (Trespass: Obstruct Business) and Penal Code section 3056 (Parole Violation) when she refused to leave the SJO Medical Center.

At approximately 8:10 PM, during the initial mental health screening at the Orange County Jail, Kelly claimed to have Post Traumatic Stress Disorder (PTSD) and admitted to at least one prior suicide

attempt while being held in state prison. Kelly told the assigned Orange County Health Care (HCA) worked the following: “In 2018 I lost my brother and overdosed on pills. I took a handful of codeine while in prison. I felt drowsy and nauseous.”

Kelly was subsequently booked into CWJ, where she was initially classified as a “Level 2 / Low” inmate. She was prescribed Trileptal (aka: Oxcarbazepine), which is an anticonvulsant / antiepileptic drug, Zoloft (aka: Sertraline), which is an antidepressant / antianxiety drug, and Vistaril (aka: Hydroxyzine), which is an antihistamine for itchiness, anxiety, and nausea.

On April 23, 2019, Kelly was charged in the Orange County Superior Court Central Justice Center – case Number 19CM03450 with violating Penal Code section 602 (Trespass and Refusal to Leave Private Property. On April 25, 2019, Kelly’s Parole Hold was removed by Parole Agent Sung-Han Kim and she remained in custody in lieu of $5,000 bail. On May 10, 2019 at approximately 11:30 AM, Kelly slashed another inmate with a razor while in the holding cell at the Central Justice Center and a crime report for violating Penal Code section 245(a), Assault with a Deadly Weapon, was taken by OCSD. Accordingly, Kelly was re-classified as a “Mental/Assaultive/Pro Per” inmate, and she was accordingly required to wear waist and leg chains for all movement.

On May 15, 2019, Kelly was prescribed Remeron (aka: Mirtazapine) for treatment of depression.

On May 29, 2019, two inmates from Kelly’s dayroom group complained to jail personnel that they did not feel safe around Kelly, as she was openly bragging about having slashed another inmate. Kelly was subsequently re-classified as a “Total Separation” inmate, with leg and waist chains required for all movement.

On June 17, 2019, Kelly cursed at jail staff during medical call. This incident was documented in a Jail Incident Report (OCSD Case #20190617-1956). Kelly was given ten days in Disciplinary Isolation (DISO), ranging from the date of July 5, 2019 to July 14, 2019. In the days following her eventual release back into the general population, Kelly would proceed to complain about being unjustly put “in the hole” to family as well as fellow inmates.

On July 14, 2019, the attending HCA Mental Health Clinician met with Kelly in DISO. Kelly told her, “I need to get out of here, I am going through so much. My mom died. I can’t take this anymore.” However, she denied suicidal ideations. Kelly was subsequently prescribed Olanzapine (aka: Zyprexa), an antipsychotic medication. On July 15, 2019, Kelly was transferred from DISO to CWJ’s Module I, Tank 10, Cell 4, where she was housed by herself. Module I was monitored by four security cameras without audio. However, only one camera monitored the upper tier where Cell 4 was located. This camera had a view of the walkway outside Cell 4, but no view into the interior of the cell. That same day, Kelly’s trespassing case was scheduled for a jury trial in Courtroom C5. A hearing was held, and the case was transferred to the Community Court Building 1 (CCB1). Another hearing was held in CCB1, at which time Kelly’s jury trial was continued to July 18, 2019. A Discharge Plan was requested from the HCA by the Orange County Collaborative Court. Collaborative or “problem solving” courts are specialized courts which track and address underlying issues such as mental health. Participants in the Collaborative Court must have a diagnosis of schizophrenia, bipolar disorder, major depressive disorder, and/or drug and alcohol abuse issues.

On July 16, 2019, Kelly’s Assault with a Deadly Weapon case was submitted to the OCDA electronically for filing consideration. That same day, Kelly borrowed a razor from inmate Jane Doe who was held next to her in Module I, Tank 10, Cell 3. Kelly told Jane Doe that she wanted the razor to “shave her sides.” Later, Jane Doe heard Kelly tearing up a bedsheet, but took no special notice.

Jane Doe explained that inmates frequently tear bedsheets and use the torn sheets as “strings” to pass items from cell to cell. Jane Doe claims that she spoke with Kelly “a lot.” She said that Kelly was unhappy with being held in the single cells, expressing frustration with being locked up by herself. Kelly often spoke of an unnamed friend who was on suicide watch, but she never intimated that she herself was suicidal.

Kelly had similar interactions with other fellow inmates. For instance, another neighbor in Module I, inmate Jane Doe 1, also loaned Kelly a razor for the purpose of cutting sheets only a few days before Jane Doe did the same. Jane Doe 1 never saw what Kelly did with the sheet that she cut. As was the case in her interactions with Jane Doe, Kelly expressed discontent with her overall situation, mentioning that her mother had recently passed away, but never going so far as to indicate that she was suicidal.

In addition, several of Kelly’s interactions with other inmates are suggestive of Kelly’s underlying mental illness. Jane Doe 1 recalls one incident where Kelly acted strangely, pretending to use the inmate phone despite the fact that she was not speaking to anybody. Similarly, inmate Jane Doe 2 recounted an episode where she was with Kelly in the break room when Kelly began speaking out loud to people who were not there. Despite these unnerving occurrences, neither Jane Doe 1 nor Jane Doe 2 ever perceived anything to suggest that Kelly might hurt herself.

On July 17, 2019, at 3:26 PM, Kelly spoke to several family members on the recorded jail telephone line for approximately 38 minutes, including her father, her sister, and her son. She told them that she was looking forward to seeing them again, and that she hoped to be released from custody as soon as July 19, 2019. However, during the phone call, Kelly’s son expressed doubts that she would ever be released, let alone anytime soon, in light of her violent criminal history and repeated parole violations. At one point, her son told her “I’m going to be a grown man by the time [you] get out.” In similar fashion, Kelly’s father lamented that “all my people, my kids are dying on me. And the ones ain’t dying are staying in jail all their life... you won’t get them years back.”

Moreover, during the phone call, Kelly briefly alluded to her criminal history with a hint of regret when speaking to her son, who recently had a minor incident with shoplifting. Dismayed that he was following in her footsteps when he told her about almost being arrested, Kelly admonished her son, incredulously asking, “Do you want to be a jailbird like your momma?” In particular, Kelly took issue with the fact that he indicated that he was willing to physically fight security guards over a $3 shoplifting incident, as she scolded him, repeating the phrase “you better stop.” Nevertheless, at the end of the call, Kelly reassured her family that she was “keeping her spirits up,” and she promised to call them again on July 19th.

On July 18, 2019, at approximately 3:53 AM, Kelly was awakened by OCSD Deputy Jory Crandall and the attending HCA Registered Nurse (RN) during routine medication distribution. Deputy Crandall told Kelly that she had been awakened early to receive medication because she had a court appearance scheduled for later that day. However, Kelly argued that she did not have court until the following day. Kelly’s confusion regarding her court appearance was consistent with her telephone call from the day prior, in which she told her family that she had court scheduled for July 19. Other Module I inmates overheard this discussion between Kelly and Deputy Crandall. Although several neighboring inmates heard Kelly moving around in her cell following the encounter, none of them believed that Kelly would hurt herself. Shortly thereafter, Deputy Crandall and the RN left the upper tier of the cell block, and no one else was seen on the jail surveillance recording in the area of Cell 4.

An hour later, at approximately 4:54 AM on July 18, 2019, shortly after Module I's lights were turned on, OCSD Deputy Susan Orellano was conducting Module Book Count when she passed by Cell 4, at which time she discovered Kelly hanging by the neck. Kelly had a ligature made from a strip of bedsheet constricting her neck, tied to the ventilation duct in the wall in the back of her cell. Her feet were on her bunk with her torso suspended above the bunk. Deputy Orellano immediately called for assistance on the radio.

Additional deputies promptly answered Deputy Orellano's call for assistance. Kelly was cut down and cardio-pulmonary resuscitation (CPR) was initiated. Medical staff and paramedics were summoned. An automated external defibrillator (AED) was deployed, but no shock was advised, so CPR continued. An RN recalled to OCSD investigators that the AED evaluated Kelly "approximately four or five times," and that each time, the AED advised no shock and to continue CPR.

At approximately 5:12 AM, less than twenty minutes after Deputy Orellano originally radioed for help, Orange County Fire Authority (OCFA) paramedics arrived in Module I and took over the administration of emergency treatment. At 5:16 AM, Kelly was pronounced dead by the paramedics.

Deputy Crandall reported that she was the last deputy to speak with Kelly prior to her death. Deputy Crandall states that she had no prior interactions with Kelly. After Kelly expressed confusion regarding her court date, Deputy Crandall stated that she would double-check the jail's court schedule. Deputy Crandall describes Kelly's demeanor as "irritated." Before leaving, Deputy Crandall ensured that Kelly had taken her medication. Around 4:50 AM, Deputy Crandall was alerted via radio to an attempted suicide, and she rushed to Module I. Once there, Deputy Crandall saw Kelly hanging from an air vent. By the time Deputy Crandall returned with a safety knife to cut her down, Kelly had already been removed and placed on her bunk, where she was receiving chest compressions. Deputy Crandall was given a mobile recording device to document the incident. The device recorded the attempts of jail staff and paramedics attempting to provide life-saving emergency treatment. At no point did Deputy Crandall personally administer CPR, as there were other deputies already doing so before they were eventually relieved by the paramedics several minutes later. After Kelly was pronounced dead, Deputy Crandall was told to secure the scene and stop recording.

Deputy Orellano stated that when the incident occurred, she was conducting a Module Book Count (i.e. verifying the presence and identities of inmates) in Module I, and that as she patrolled Tank 10, she encountered Kelly hanging from a strip of bedsheet in Cell 4. Deputy Orellano immediately yelled out Kelly's name, but she was unresponsive. Deputy Orellano radioed for help with an attempted suicide, and other deputies arrived promptly. Deputy Orellano ran to the panel to unlock the cell, and her colleagues rushed inside to cut Kelly down. Deputy Orellano returned to help with the administration of emergency medical care. Deputy Orellano was unable to find a pulse and found Kelly's skin cold to the touch. Deputy Orellano administered the first round of chest compressions while medical professionals rushed to the scene. Once help arrived, Deputy Orellano allowed them to take over. Within minutes, Kelly was pronounced dead. Deputy Orellano had only seen Kelly once before, on the day preceding her death, and described her as seeming fine, smiling and acting friendly to the prison staff.

When investigators examined Kelly's cell, they found the remnants of bedsheets hanging from the air vent. In addition, one of the sheets still on Kelly's bed was missing long strips of fabric which appeared to match the torn sheets used to create a ligature. There were papers and photos present, but no suicide notes or journal entries expressing depression, anxiety, or suicidal thoughts were discovered.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Fabric from Vent
- Fabric Strip from Bunk
- White T-Shirt, Fabric Cord, Sheet from Bunk
- Light Grey Nightgown
- White Underpants and Sanitary Pad
- White Underpants and Sports Bra from Bunk
- Sheet Covering Mattress

AUTOPSY

On July 24, 2019, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Kelly. During examination, medical pads were found on Kelly's chest and back, left over from her emergency medical treatment. Her fingernails were short, clean, and intact. There was a furrow across her neck, extending toward the hairline on both sides of her head, with an upward angle below each of her ears. There were no other injuries nor any sign of a struggle.

Dr. Luzi concluded that the preliminary cause of death was ligature hanging consistent with suicide, pending toxicology and microscopic tests. On April 16, 2020, after the test results were received, Dr. Luzi formally concluded that the cause of death was ligature hanging, and that the manner of death was suicide.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Kelly's postmortem blood was collected for testing. The following results and interpretations were documented:

Drug	Postmortem Blood	Peripheral Blood	Liver	Stomach
1-(4-chlorobenzhydryl) – piperazine	Detected			
Caffeine	Detected			
Hydroxyzine	0.654 ± 0.061 mg/L	0.175 ± 0.017 mg/L	1.77 ± 0.17 mg/kg	<2.8 mg
Mirtazapine	Detected			
N-desmethylmirtazapine	Detected			
Norsertraline	Detected			
Olanzapine	Detected			
Oxcarbazepine	Detected			
Sertraline	0.71 ± 0.10 mg/L	0.156 ± 0.023 mg/L		

BACKGROUND INFORMATION

Kelly had a State of California Criminal History record which revealed arrests dating back to 2000 for the following violations:

- Attempted Murder
- Prisoner in Possession of a Weapon
- Assault with a Deadly Weapon
- Auto Theft
- Contempt of Court
- Trespassing
- Disorderly Conduct / Lodging without Consent
- Drunk in Public
- 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 he/she acted he/she knew his/her act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

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

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

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

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

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

> "The most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable 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/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

There is no evidence whatsoever in this case 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 Kelly a duty of care due to her status as an inmate, the evidence does not support a finding that this duty was in any way breached, either intentionally or through criminal negligence. Rather, the evidence reveals that OCSD personnel consistently exercised reasonable care – Kelly was isolated for her own safety and for the safety of others after she attacked someone with a razor and boasted about it, she was given her prescribed antipsychotic medication to deal with her severe psychological issues twice daily, and emergency medical attention was summoned as soon as she was discovered on the morning of July 18. Although OCSD personnel conducted their duties in a diligent manner, they were not able to prevent Kelly from taking her own life.

In the days preceding her death, Kelly expressed no suicidal ideations to OCSD staff or other inmates. In her conversations with fellow inmates, Kelly merely expressed discontent with her current situation, but she did not indicate that she was suicidal. Likewise, in her phone conversations

with family, Kelly even expressed hope that she would be released on July 19, a single day after her eventual suicide. The closest indication of Kelly's dejected mental state at the time was in her conversation with her son regarding the possibility of him following in her footsteps by ending up in prison. Moreover, in her tense interaction with Deputy Crandall and the RN on the morning of her death, Kelly was irritated and argumentative, but not noticeably depressed nor suicidal. In fact, Deputy Crandall believed that she had ultimately "seemed satisfied" with the resolution of their conversation after Deputy Crandall told Kelly that she would double-check her court date.

There is ample evidence supporting a conclusion that Kelly suffered from severe and debilitating mental illness, as well as evidence showing that jail staff were generally aware that she posed some degree of risk to herself and others. However, for the OCDA to file criminal charges relating to her death, we must be able to prove beyond any reasonable doubt criminal culpability, including causation, as described above. The OCDA is not able to meet this burden of proof based on all of the available evidence. Altogether, there is insufficient evidence to support a finding beyond a reasonable doubt that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty, with such failure causing Kelly's death. Instead, the evidence demonstrates that OCSD staff acted reasonably in fulfilling their duties, and that Kelly's death was a self-inflicted tragedy attributable to mental illness.

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 Kelly. The evidence shows that Kelly died as a result of suicide by hanging and that the death was a natural one.

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

Respectfully submitted,

ELISABETH HATCHER
Senior Deputy District Attorney
Homicide Unit

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

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