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May 21, 2012

Sheriff-Coroner Sandra Hutchens
Orange County Sheriff's Department
550 North Flower Street
Santa Ana, CA 92703

Re: Custodial Death on August 13, 2010
Death of Inmate Taylor Lang Hart
District Attorney Investigations Case # SA 10-020
Orange County Sheriff's Department DR # 10-150259 / JI-8-13-10-0025
Orange County Crime Laboratory Case # FR 10-49920

Dear Sheriff Hutchens,

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 Aug. 13, 2010, custodial death of inmate Taylor Lang Hart.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Hart. 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) deputy or any other person under the supervision of the OCSD.

On Aug. 13, 2010, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Intake Release Center (IRC) of the Orange County Jail (OCJ) after Hart died while in custody. The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and 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. 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 and evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the Orange County Crime Lab 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 or Gang Units review fatal, officer-involved shootings and custodial death cases and determine whether criminal charges are appropriate. Prosecutors assigned to the Special Prosecutions Unit review the non-fatal officer-involved shooting cases for possible criminal filings. Throughout the review process, the assigned prosecutor will be in consultation with his or her supervisor, and this Assistant District Attorney will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors, their supervisors and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

Hart had a criminal history which began in 2010. He also had a history of mental health issues. According to his mother, Hart had been diagnosed as being bi-polar schizophrenic. She reported that his bi-polar symptoms were mixed with "manic and depression episodes, with psychotic features if he's been using any kind of drugs." Hart's mother had been informed by OCSD personnel that Hart had recently admitted to using illegal drugs during a previous arrest.

Since September 2009, Hart's mother estimated that Hart had been hospitalized for mental health evaluations, per Welfare and Institutions Code section 5150, six or seven times. Hart had also been prescribed three types of medications for his mental condition.

On Aug. 7, 2010, at approximately 2:16 p.m., an OCSD deputy arrested Hart for stealing clothes from a Nordstrom department store located at the Shops at Mission Viejo. Hart struck a Loss Prevention Officer in the face while attempting to leave the area.

At approximately 5:35 p.m., Hart was treated at Mission Hospital, in Mission Viejo, by Doctor Richard Kozak for abrasions and dehydration, and then released to OCSD deputies.

At approximately 7:22 p.m., Hart was booked into the OCSD IRC, located at 550 North Flower Street, Santa Ana. Hart was booked and classified as an "expedite booking."

During the Intake Screening and Triage Procedure it was noted by the Booking Officer, Deputy Richard Clark, that Hart had been "[t]aken to Mission Hospital for heart rate. Cleared by Dr. KOLZAK Mission Hospital." During the Triage screening, Hart was administered the standard Medical/Mental Questionnaire. He reported no known allergies, and no "mental problems." He responded to questions, "[h]ave you ever tried to harm yourself or take your own life?" and, "[a]re you currently thinking of harming yourself now?" with answers of, "No." His Triage Disposition referred him to Mental Health and with respect to Work Status he was designated for a Follow-up/Recheck on Aug. 15, 2010.

During the initial mental health screening which occurred at 7:11 p.m. on Aug. 7, 2010, it was documented that Hart was not currently on medication. It was further reported that the inmate was "requesting to start medications for bipolar." Hart was referred to Correctional Mental Health (CMH).

Hart was subsequently housed in Module L, Section 18, Cell 13. Module L, the Men's Medical Observation Unit (MOU), houses inmates with mental health issues. Mental health personnel have a designated work station within Module L. There are six sectors within Module L, which are visible from the deputies designated guard station. Module L, Sector 18 contains single inmate cells. Due to the mental health condition of the inmates housed there, they are not permitted to have physical contact with other inmates within the sector or to enter another inmate's cell.

When Hart was first assigned to Module L, he was reported by one of the jail deputies to have been aggressive towards staff.

Mental Health personnel make a determination as to status for inmates housed in Module L. "safety gown" status entails an inmate being provided with a one-piece jail-issued jumpsuit and a mattress pad. They are given no other bedding materials. Inmates so designated are also subject to being restricted from exiting their cell except to attend court or for medical treatment.

Hart's initial CMH classification occurred at 11:30 p.m. on Aug. 7, 2010, when he was given CMH restrictions which included being placed in a safety gown and being placed on psychiatric observation, along with additional restrictions prohibiting dayroom, roof, education classes, church, and visit privileges.

Established procedures utilized by the CMH staff at the OCJ require that a doctor order the removal of "safety gown" status for mental health inmates. The criteria for the doctor's determination to remove "safety gown" status is based upon the patient's responses to evaluation questions asked by the doctor at the time of evaluation, along with consideration of any prescribed medications being administered.

On Aug. 8, 2010, at 10:15 a.m., inmate Hart was cleared for regular housing by CMH Doctor Ebtesam Khaled. Thereafter, Hart was no longer on "safety gown" or psychiatric observation status and the dayroom and other restrictions were lifted.

In the first couple of days following his incarceration, Hart was reported to be verbally aggressive towards a nurse.

On Aug. 9, 2010, at approximately 5:00 a.m., Correctional Medical Services (CMS) staff attempted to take Hart's vital signs. Hart refused to cooperate and his vital signs were not taken.

On Aug. 9, 2010, at approximately 4:00 p.m., Registered Nurse (RN) Angelito Mora went to Hart's cell in order to assess him because he was due to be released to regular housing. RN Mora reported that, according to Hart's medical chart, he had been removed from "safety gown" and observation status earlier in the day, yet RN Mora observed that Hart was still wearing a safety gown. As RN Mora assessed Hart, he noticed him hallucinating and responding to internal stimulation as if he was hearing voices in his head. Hart was pacing in his cell and talking to himself. RN Mora reported that Hart told him "that he wasn't doing very well" and that he also said, "if I'm not on medication, I may hurt others." Hart did not make any statement to RN Mora that he wanted to hurt himself. After assessing Hart, RN Mora took steps to put him back on "safety gown" and observation status.

At 4:45 p.m., CMH Dr. Tuong Nguyen, in response to RN Mora's observations, gave a verbal order placing Hart back on "safety gown" status, to include psychiatric observation status along with the other associated restrictions previously described.

At approximately 8:30 p.m., Hart was prescribed and administered Seroquel and Zyprexa as mood stabilizers, upon the order of Dr. Khaled.

On Aug. 10, 2010, at 6:30 p.m., Hart was observed by mental health specialist Brian Kunst to be standing on his chair within his cell. He was then seen stepping over to his bunk, laying down, covering himself with his safety gown, and going to sleep.

On Aug. 11, 2010, at 3:00 p.m., Hart's status was changed by Dr. Khaled. The "safety gown" requirement was discontinued. He remained on psychiatric observation status. This "Observation" status allowed Hart to be issued full jail clothing, bedding for the mattress, and a towel. He still was not allowed to exit his cell, except to attend court or for medical treatment, and he had no jail privileges.

On Aug. 12, 2010, at approximately 10:00 a.m., Hart was prescribed Depakote and Seroquel as mood stabilizers, by Dr. Nguyen.

Licensed Vocational Nurse (LVN) Robinson Panaligan provided Hart his prescribed psychotropic medications on Aug. 10 and Aug. 12, 2010, between 9:00 and 9:30 p.m. While doing so, he observed Hart to be alert and attentive. LVN Panaligan reported that Hart made no complaints and "did not indicate any suicidal tendencies."

Later, on Aug. 12, 2010, sometime between 9:50 and 11:00 p.m., mental health specialist Kunst was in Sector 18 contacting another inmate when he noticed Hart in his cell waving at him to get his attention. Kunst made contact with Hart through the cell glass window, at which time Hart asked him, "when breakfast was going to be served?" Kunst answered Hart. That was the last contact Kunst had with Hart, however, during the brief contact, Hart appeared to be in good spirits, showing no signs of depression.

At approximately 11:10 p.m., OCSD Deputy Matthew Cheeks conducted a Module Safety Check and reported to OCSD Deputy Bernard Hamill that there was nothing unusual. Deputy Hamill documented that safety check.

From the period beginning with Hart's incarceration in Module L on Aug. 7, 2010, through Aug.12, 2010, the medical orders records document a daily chart review in accordance with established procedure.

On Aug. 13, 2010, at approximately 12:07 a.m., OCSD Deputy Erik Roy assisted Deputy Cheeks with escorting an inmate who was housed in Sector 18, Cell 15, which was the cell next to Hart's. According to Deputy Roy, while he was in the dayroom waiting for the inmate to get from his cell to the sector door, he looked into the other cells within Sector 18 to see if anything was out of the ordinary. Deputy Roy did not observe anything out of the ordinary. The sector door where he and Deputy Cheeks waited for the inmate was adjacent to Hart's cell.

At approximately 12:25 a.m., Orange County CMS Mental Health Care LVN Florin Maracine, who was at the nurse's station of Module "L", observed within Sector 18, Cell 13, that Hart was lying on the cell bunk, nude, with a bed sheet or toilet paper wrapped around his neck and his left arm dangling off of the bed. LVN Maracine requested Module "L" OCSD deputies to turn on the full complement of lights to illuminate Sector 18's dayroom and cells, and to respond for assistance.

Deputy Hamill used the cell's intercom system to attempt to verbally communicate with Hart; however, Hart did not respond. Deputy Hammill electronically opened Hart's cell door to allow access for LVN Maracine and the responding deputies.

Once the lights were turned on, LVN Maracine and Deputies Cheeks and Roy responded to Cell 13 and observed Hart lying on his bunk, nude with a bed sheet ligature around his neck. Deputies Cheeks and Roy immediately opened the

cell door and entered Cell 13 in an attempt to wake Hart. Hart did not respond to the deputies and LVN Maracine did not see Hart breathing. LVN Maracine asked his partner, RN Mora, to retrieve the "man-down" bag, which contained advanced life saving apparatus.

Hart had a wet bed sheet wrapped twice around his neck with a single hitch knot tied to the left of the front of the neck. The sheet ends were under his left side and back. The bed sheet was not affixed to any object or part of Hart's body. The wetness of the sheet caused the knot to hold tight.

RN Mora immediately returned with the "man-down" bag and LVN Maracine removed the Automated External Defibrillator (AED) machine, attached the enclosed pads to Hart's chest area, and activated the machine. CMS medical staff responded and arrived right after LVN Maracine attached the AED pads to Hart. The AED did not advise to defibrillate or start cardiopulmonary resuscitation (CPR). Hart was cold to the touch and had no signs of life. CMS medical staff took over advanced life saving measures. CMS RN Darron Durgin advised not to begin CPR, due to rigor mortis and lividity being present. RN Durgin stated that Hart was deceased.

LVN Maracine did not remove the ligature from Hart's neck because he understood that OCSD personnel were the only ones authorized to do so. After lifesaving attempts were made, LVN Maracine was told by OCSD Deputy Apryl Soapes to leave the ligature on Hart, because Hart and the area were now considered a crime scene.

Deputy Hammill requested Santa Ana Fire Department (SAFD) Paramedics to respond to the jail for a possible suicide.

At approximately 12:32 a.m., SAFD Engine 5 and Santa Ana Medic Unit (SAM) 5 were dispatched to a possible suicide at the OCSD Central Jail Complex. Engine 5 and SAM 5 responded to OCSD Central Jail Complex – IRC.

At approximately 12:37 a.m., Engine 5 and SAM 5 arrived at the OCSD Central Jail Complex and were escorted by OCSD personnel to the module and cell involved.

SAFD personnel observed Hart lying on the cell's bunk with his feet toward the cell door and a sheet tied around his neck. Hart's left arm was draped over the side of the bunk with signs of rigor mortis in the left extremities. According to SAFD personnel, Hart appeared to be deceased. Examination of Hart revealed he had rigor mortis and lividity in the head, neck, back and left extremities; no rise and fall of the chest, lungs were absent, a heartbeat was absent and the cardiac monitor indicated he was asystole (absent heartbeat).

At approximately 12:47 a.m., given there were obvious signs of death and no life saving measures performed prior to SAFD's arrival, Hart was pronounced dead.

Procedures of the OCSD Safety Check Log include the following:

a. The Safety Checks will be conducted from inside the housing locations, to provide best visual observation.
b. "Safety Checks" should include direct, visual observation to provide for the health and welfare of inmates. (Title 15)
c. Safety Checks should be conducted **AT A MINIMUM** once every 60 minutes. More frequent checks are encouraged.
d. Safety Checks shall be conducted at random times within the required time period.
e. Exact times of the checks are to be recorded on the Safety Check Log.
f. If a safety check is not completed within the required time period (60 minutes), the area Sergeant will be notified as soon as possible. An entry will be made on the Safety Check Log describing the circumstances which caused the check to be delayed and which sergeant was notified.

The Safety Check Logs for the Central Jail IRC, Mod L, for Aug. 12, 2010, and Aug. 13, 2010, document the requisite checks were made.

A search of descendent Hart's cell by Coroner Investigator Kelly Ralph revealed the absence of a suicide note or any other evidence of suicidal intent.

AUTOPSY

On Aug. 13, 2010, at 9:14 a.m, an autopsy was conducted with Riverside County Chief Pathologist, Dr. Joseph Cohen, performing a post-mortem examination of Hart at the Orange County Sheriff-Coroner Forensic Science Center.

During the autopsy, Dr. Cohen's visual examination of Hart revealed:

a. No trauma to the neck bone structure (no fractures)
b. No bruising to neck muscles
c. Petechial hemorrhaging in his eyes.

After completing the autopsy, Dr. Cohen concluded the preliminary cause of death was self-strangulation.

Following Coroner's Review, the cause of death was determined to be "**Asphyxia**" due to "**Cloth ligature around death**" and the manner of death was determined to be "**Suicide**."

EVIDENCE ANALYSIS

Toxicological examination of Hart's post-mortem blood detected Quetiapine Metabolite, Quetiapine and Tetrahydrocannabinol Carboxy-Acid.

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, it 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;
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.

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

There is no evidence of express or implied malice on the part of any OCSD deputy or any inmates or other individuals under the supervision of 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 OCSD owed Hart a duty of care, the evidence does not support a finding that this duty was breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

OCSD personnel complied with applicable procedures and protocol, including hourly welfare checks, medical screening, and daily chart reviews. Hart remained under mental health observation and was administered medication upon doctors' orders for his bi-polar condition.

In order to rule out negligence, there are two relevant areas of inquiry;
1) The determination as to the removal of inmate Hart from "safety gown" status; and
2) Compliance with proper observation procedures.

The removal from "safety gown" status is the mechanism which provided Hart with bedding materials, to include sheets, which were the instrument of his suicide. On the second day of his incarceration, upon a properly documented review, Dr. Khaled cleared Hart for Regular Housing, which involved discontinuation of all of his CMH restrictions. This was before any medications were prescribed. Despite this initial removal from all restrictions, the record clearly indicates that the observation never ceased. Although Hart had been verbally aggressive towards jail staff and non-cooperative, there was no indication that he exhibited any evidence of harming himself.

It was because of the continued observations, notwithstanding his initial removal from "safety gown" status, that his bizarre behavior (including hallucinations and apparent responses to internal stimuli) was observed in the early evening hours of Aug. 9, 2010. Here, the jail Mental Health personnel went beyond their required duty of care. These observations resulted in inmate Hart being returned to "safety gown" status with all the associated CMH restrictions. It was at this time that he was administered mood stabilizing psychotropic medications.

From that time forward, with the monitored administration of prescription medications, continued observations revealed inmate Hart to be alert, attentive, without complaint, and with no indication of suicidal tendencies.

When Dr. Khaled discontinued the "safety gown" status on Aug. 11, 2010, there was no indication that, since the inception of medication, inmate Hart had displayed any adverse behavior. Dr. Khaled continued him in CMH status with psychiatric observation and out-of-cell restrictions. Based on all the attendant facts of the case, this decision was completely reasonable, prudent, and in full compliance with established operating procedures. It should be noted that at no time whatsoever did Hart display any indications that he posed a threat to himself.

Close review of the records reveals no deficiency in compliance with observation requirements by either sworn jail personnel or CMH staff.

Having followed this protocol, there was no reason to believe Hart posed a danger to himself or was intending to harm himself. Accordingly, there is no evidence of any breach in the duty of care owed to inmate Hart. Without a breach or failure to perform a duty there can be no negligence, much less criminal negligence.

Furthermore, there was no evidence of foul play on the part of any person who came into contact with Hart prior to his death. Hart's death was due to his own decision to end his life.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA and pursuant to applicable legal principles, 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 OCSD. Evidence shows that Hart died as a result of suicidal asphyxiation by cloth ligature.

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

Respectfully Submitted,

Jim Mendelson
Senior Deputy District Attorney
Homicide Unit

Read and Approved,

Dan Wagner
Assistant District Attorney,
Supervisor Homicide Unit