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November 6, 2018

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

Re: Custodial Death on January 21, 2018
Death of Inmate Tony Douglas Rudd
District Attorney Investigations Case # 18-003
Orange County Sheriff's Department Case # 18-002697
Orange County Crime Laboratory Case # 18-41262

Dear Sheriff Hutchens,

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 Jan. 21, 2018, custodial death of 46-year-old inmate Tony Douglas Rudd.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Rudd. 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 Jan. 22, 2018 OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Global Medical Center Santa Ana (OCGMC) where Tony Douglas Rudd died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 15 witnesses, 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 a veteran 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 Felony Operations II Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On Tuesday May 16, 2017, Rudd was booked into the Orange County Jail (OCJ) by the Fullerton Police Department for inflicting corporal injury on cohabitant, identity theft, transportation of a controlled substance, possession of a controlled substance for sale, possession of a controlled substance, and fraud.

Due to Rudd requiring routine medical treatment and observation, he was housed at the Central Men's Jail, Module "O," where he received care for his pre-existing conditions. Rudd suffered from Depression, Diabetes, Hepatitis B, Traumatic Brain Injury and Obstructive Sleep Apnea. Rudd used a Continuous Positive Airway Pressure (CPAP) machine while he slept as part of his sleep apnea treatment. Rudd also had a history of abusing cocaine, benzodiazepines and opiates. Rudd often utilized the "Inmate Heath Message Slip" to notify jail staff of medical issues and concerns. These issues were promptly addressed.

On Friday, Jan. 19, 2018, an inmate informed medical staff at an observation window that Rudd's breathing seemed unusual. The Registered Nurse (RN) and Orange County Sherriff Deputy on staff approached Rudd's bunk and attempted to arouse Rudd, but Rudd did not respond. The RN removed Rudd's CPAP machine and took Rudd's blood pressure and noticed it was very low. A call to 911 was made and additional OCJ medical personnel responded to Rudd's bedside to provide additional medical aid. The medical aid provided included Cardio Pulmonary Resuscitation (CPR) and ventilation with an Ambu bag. During medical aid Rudd continued to be unresponsive and vomited. Rudd was placed on his side while the RN retrieved a hand held V-Vac suction device. The RN placed the suction end of the V-Vac inside Rudd's mouth and began suctioning out the vomit.

The Orange County Fire Authority (OCFA) arrived on scene and assisted in providing medical aid to Rudd. Rudd was transported by ambulance to the OCGMC when paramedics attempted to intubate Rudd during transport they discovered a red plastic cap, consistent in size and color with the cap of the V-Vac machine used at OCJ, inside Rudd's mouth and removed it with forceps. Rudd was successfully intubated during transport to OCGMC.

Upon arriving at OCGMC, Rudd's medical care was relinquished to emergency room staff. Rudd's blood pressure was low and emergency room staff administered dopamine to stabilize his blood pressure. Rudd was placed on a ventilator and transferred from the emergency room department to the Critical Care Unit (CCU). Rudd never regained consciousness and his health deteriorated over the next few days. On Sunday, Jan. 21, 2018 at 4:03 pm an OCGMC physician examined Rudd and pronounced him brain dead. Rudd remained attached to life support equipment, pending the arrival of Rudd's family member. Rudd subsequently was pronounced dead.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Hand held suction device
- Red plastic cap to hand held suction device
- Clear plastic fragment found inside Rudd's pharynx

AUTOPSY

On January 24, 2018, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Rudd. Dr. Luzi examined Rudd's body and found no major injuries or trauma. Dr. Luzi found minor injuries which included an 8.5 x 6 cm contusion on the right arm, a 6 cm linear abrasion along the right elbow, and a .5 cm abrasion on the dorsum of the right foot. Dr. Luzi's final autopsy diagnosis includes the following natural and pre-existing conditions: cerebral edema, pulmonary congestion and edema, cardiomegaly, moderate coronary atherosclerosis, mild peripheral atherosclerosis, hepatic steatosis, nephrosclerosis, colonic mucosal erythema, and Hepatitis B. The autopsy of Rudd revealed a clear plastic fragment measuring 2.5x1.2 cm rectangular adherent to the pharynx just below the epiglottis. Toxicology screen was positive for benzodiazepine and opiates. Dr. Luzi concluded that Rudd died as a result of choking due to vomitus aspiration, with heroin intoxication and sleep apnia as other noted conditions. Dr. Luzi concluded that the manner of death was accidental.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Tony Douglas Rudd's postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Drug/Type Meperidine	Postmortem Blood	0.127 + 0.016 mg/L
Drug/Type Normeperidine	Postmortem Blood	0.174 + 0.28 mg/L
Drug/Type Lorazepam	Postmortem Blood	0.458 + 0.030 mg/L
Drug/Type Lidocaine	Postmortem Blood	Detected
Drug/Type Sertraline	Postmortem Blood	Detected

BACKGROUND INFORMATION

Tony Douglas Rudd had a State of California Criminal History record that revealed arrest for the following violations:

- Domestic Violence Battery
- Inflict Corporal Injury to Spouse/Cohabitant
- Possession of a Controlled Substance
- Possession of a Controlled Substance for Sale
- Transportation of Drug Paraphernalia
- Solicitation of Prostitution

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 deliberate 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.' It is manifestly foreseeable than an inmate may be at risk of harm…. Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows

> "A public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he/she acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he/she acts is so different from how an ordinarily careful person would act in the same situation that his/her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

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 Rudd 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). Upon entrance into the OCJ on May 16, 2017, and throughout the eight months he was housed at OCJ, Rudd received appropriate care and assistance for his preexisting medical conditions, in the medical section of the jail, Module "O." Furthermore, there is no evidence to prove beyond a reasonable doubt that the red plastic cap that came from the V-Vac machine found in Rudd's mouth was a cause of his death. Similarly, there is no evidence to prove beyond a reasonable doubt that the clear plastic fragment found during the autopsy adherent to the pharynx of Rudd, just below the epiglottis, was a cause of Rudd's death. In reaching these conclusions, the OCDA is not addressing the appropriateness of the manner of some of the life saving techniques employed by OCSD personnel in attempting to save Rudd's life. Rather,

the OCDA is solely analyzing the available evidence regarding the conduct of the OCSD personnel from the stand point of a criminal investigation and the ability to prove criminal negligence. Clearly, the evidence does not support a finding beyond a reasonable doubt of criminal negligence on the part of any OCSD personnel in connection with their attempts to save Rudd's life.

Between May 18, 2017 and Jan. 18, 2018, Rudd submitted numerous "Inmate Health Message Slips" to OCJ and medical staff responded promptly to each request and administered medical care responsive to his complaints. As soon as medical staff at OCJ were alerted by another inmate of Rudd's irregular breathing they responded with immediate medical attention and provided medical aid until paramedics arrived to transport Rudd to the hospital.

Thus, there is no 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 owed to Rudd.

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 beyond a reasonable doubt of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD in connection with the death of inmate Rudd.

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

Respectfully submitted,

MICHAEL PEVNEY
Deputy District Attorney
Special Prosecutions Unit

Read and approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney
Felony Operations II