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February 6, 2015

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

Re: Custodial Death on May 20, 2013
Death of Inmate Jason James Holliday
District Attorney Investigations Case # SA 13-010
Orange County Sheriff's Department Case # 13-094462 and 13-095304
Orange County Crime Laboratory Case # FR 13-47047 and 13-47097

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 May 20, 2013, custodial death of inmate Jason James Holliday.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Holliday. 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 May 21, 2013, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Western Medical Center Santa Ana (WMCSA), where Holliday died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 18 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 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 or Gang Units review 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 his or her supervisor, and this Assistant District Attorney eventually will review and approve any legal conclusions and resulting memoranda. 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 the evening of May 16, 2013, Holliday was arrested pursuant to an outstanding bench warrant for public intoxication. He was taken to the Orange County Jail Intake Release Center (OCJIRC) and given a medical evaluation. Holliday's vital signs were stable and he did not complain of any pain. According to the on-duty registered nurse, Holliday was HIV positive, but he had not taken any HIV medication for approximately one year. In addition, Holliday was an alcoholic, consuming a fifth of vodka per day. Holliday also had a history of seizures as a result of alcohol withdrawal.

After the initial medical assessment, Holliday was seen by the on-duty physician who placed him on the following alcohol withdrawal protocol:

- A low bunk/low tier for five days
- A regular diet
- Vital signs checked twice a day for two days, then daily for two days
- Multiple vitamins
- Maalox
- Serax taper for seven days

On May 17, 2013, at approximately 4:30 a.m., the on-duty OCSD registered nurse checked Holliday while he was still in the OCJIRC booking loop. Holliday's vital signs were stable and he was alert. He complained of nausea and some vomiting, but he was not experiencing tremors, hallucinations, headaches, pain, agitation, or anxiety. The following day, Holliday was transported to Theo Lacy Jail (TLJ) and housed in G Barracks East, F Cube, Bunk 16. That afternoon, a correctional medical services licensed vocational nurse went to the G Barracks to dispense medication to inmates. After all the medications were dispensed, the nurse noted that Holliday was the only inmate that had not received his medication. Minutes later, an inmate assisted Holliday to the nurse location. According to the nurse, Holliday tried to speak to her during their encounter but his speech was "gibberish, like babbling." The nurse did not observe any injuries on Holliday. Due to Holliday's strange behavior, the nurse alerted a correctional medical services senior registered nurse, who in turn requested that Holliday be sent to the medical unit for further evaluation.

At approximately 2:00 p.m., Holliday arrived, unassisted, at the medical unit. Holliday's vital signs were normal, but he complained of pain in his right eye. Moreover, Holliday appeared extremely confused and unaware of his surroundings. Holliday was able to recite his name, but could not tell the Senior Nurse the date, their current location, or the name of the president of the United States. The senior nurse further described Holliday as having audio and visual hallucinations. Holliday spoke to the walls and chairs, and his answers to questions were nonsensical. The senior nurse believed that Holliday was displaying classic symptoms of alcohol detoxification and she concluded that Holliday needed a level of care that was unavailable at the jail, and proceeded to contact the on-call physician for Orange County Correctional Medical Services to

discuss the situation. The on-call physician agreed with the senior nurse's assessment of Holliday, and directed that Holliday should be transported to a hospital emergency room. The senior nurse contacted an ambulance and had Holliday transported to Western Medical Center Anaheim (WMCA).

At approximately 2:32 p.m., Pacific Ambulance personnel arrived at TLJ and transported Holliday to the WMCA Emergency Room (ER). Holliday was confused and disoriented while en route to the hospital, but he was not in distress. Upon arrival at the ER, Holliday was transferred to the OCSD jail ward of the hospital.

On May 19, 2013, at approximately 9:30 a.m., WMCA on-duty physician assistant evaluated Holliday and noted that Holliday was "agitated, incoherent, lethargic," and unable to respond to questions. The physician assistant placed Holliday on an "alcohol protocol," which consisted of multivitamin fluids, administered intravenously, and an antianxiety medication, Librium, administered orally. Holliday also was referred to a psychologist for substance abuse and potential psychosis.

At approximately 8:40 p.m., Holliday's condition declined significantly and he was unresponsive. Medical staff initiated a "Code Blue" medical emergency, indicating that a patient is near death. Holliday was intubated and transferred to the WMCA Intensive Care Unit (ICU). Holliday was administered Keppra and saline, intravenously, for seizures. A Computed Axial Tomography (CAT) scan was completed on Holliday and revealed small areas of bleeding in the right frontal lobe and left temporal lobe of his brain. The medical staff concluded that Holliday had suffered a stroke.

On May 20, 2013, at approximately 1:33 a.m., Pacific Ambulance was dispatched to WMCA to transport Holliday to WMCSA for advanced care. At approximately 2:15 a.m., when the Pacific Ambulance personnel arrived at the WMCA ICU, they found Holliday unresponsive, hypotensive, and his pupils were unequal. Holliday remained on a ventilator and continued to receive Propofol and saline, intravenously, during transport, but he never regained consciousness.

At approximately 3:03 a.m., Holliday arrived at WMCSA. He was taken to the ICU and his care was relinquished to hospital personnel. At approximately 7:00 a.m., the on-duty WMCSA registered nurse evaluated Holliday and she noted that Holliday was in "poor condition" and unreactive to light stimuli. The on-duty physician inserted an intracranial bolt in Holliday's head to monitor the pressure in his skull, and Holliday was also administered the following medications intravenously:

- Multivitamin bag for electrolytes
- Morphine
- Propofol drip
- 3% Sodium
- Neosynephrine
- Normal saline
- Zosyn
- Albumin
- Keppra
- Valproic acid

At approximately 12:00 p.m., WMCSA medical staff re-evaluated Holliday and transported him to the hospital's ER. A CAT scan was completed on Holliday and the results revealed bleeding in his brain. At approximately 12:13 p.m., Holliday's condition continued to deteriorate, and Holliday's sister requested that medical staff discontinue advanced life-support measures. Holliday was a terminal patient with a current Do-Not-Resuscitate Order. Therefore, the medical staff removed the following medical equipment attached to Holliday's body:

- Ventilator
- Endotracheal and esophageal tubes
- Intracranial bolt
- All medications (except Morphine)

At approximately 4:37 p.m., Holliday's heart rate stopped, he was not breathing, and his pupils were fixed and dilated. The WMCSA attending physician pronounced Holliday deceased.

AUTOPSY

On May 23, 2013, at approximately 1:10 p.m., a postmortem examination of Holliday was conducted by Doctor Joseph Cohen, a forensic pathologist on contract with the Orange County Sheriff-Coroner's Office. Following the autopsy, Doctor Cohen determined that Holliday's death was the result of complications of chronic human immunodeficiency viral infection.

In addition, Doctor Jeremy Deisch, a neuropathologist, determined that Holliday's brain showed signs that were consistent with early state (World Health Organization Grade 1) lymphomatoid granulomatosis.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Lorazepam	Postmortem Blood	Detected
Morphine (Free)	Postmortem Blood	0.31 mg/L
Valproic Acid, Propofol, Levetiracetam	Postmortem Blood	Detected
Oxazepam	Antermortem Blood	Detected

BACKGROUND INFORMATION

Holliday had a State of California Criminal History record that was considered in this review process.

THE LAW

Homicide is the killing of one human being by another. Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. To prove that a person is guilty of murder, the following must be proven:

a. The person committed an act that caused the death of another person;
b. When the person acted he/she had a state of mind called malice aforethought; and
c. He/she killed without lawful excuse or justification.

There are two kinds of malice aforethought, express malice and implied malice. Express malice is when the person unlawfully intended to kill. Implied malice requires that a person intentionally committed an act, the natural and probable consequences of the act were dangerous to human life, at the time the person acted he/she knew the 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.' 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 section 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

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

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

Based on the entirety of all available facts, it is clear that 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 Holliday 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).

Holliday suffered from HIV. He also had a long history of alcohol abuse, and he was given medication to treat his withdrawal symptoms during the booking process. Initially, Holliday complained only of nausea, but within 48 hours of his incarceration, Holliday became disoriented and unable to answer basic questions. Correctional medical services personnel evaluated Holliday promptly and concluded that he needed additional care at an outside facility. Holliday was transported to a hospital where it was determined that he had suffered a stroke. Ongoing tests revealed bleeding in his brain, and his condition continued to deteriorate. Finally, Holliday did not have any signs of injury or trauma to his body inconsistent with those sustained from standard life-saving measures, and he did not make any statements regarding being injured or assaulted while incarcerated in the OCJ or TLJ.

Thus, there is no evidence to support a finding that any OCSD personnel or any individual acting under the supervision of the OCSD failed to perform a legal duty. No crime was committed against Holliday causing his death.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that Holliday died as a result of complications from a chronic human immunodeficiency viral infection.

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

Respectfully submitted,

Rahul Gupta
Senior Deputy District Attorney
Gangs Unit

Read and Approved by **Ebrahim Baytieh**
Assistant District Attorney
Head of Court – Special Prosecutions Unit