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June 17, 2016

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

Re: Custodial Death on July 12, 2015
Death of Inmate Antoinette Jo McCoy
District Attorney Investigations Case #SA 15-014
Orange County Sheriff's Department Case #15-145391
Orange County Crime Laboratory Case # FR15-50883

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 July 12, 2015, custodial death of 51-year-old inmate, Antoinette Jo McCoy.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of McCoy. 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 July 12, 2015, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Woman's Central Jail, where McCoy died while in custody. During the course of this investigation, the OCDASAU interviewed 17 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 a veteran deputy district attorney for legal review. Deputy district attorneys from the Homicide, Gangs and TARGET, and Special Prosecution 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

On Friday, July 10, 2015, at approximately 8:30 a.m., McCoy was transported from the Los Angeles County Jail to the OCSD Women's Central Jail (OCSD Women's Jail) in reference to an outstanding Orange County Probation bench warrant. At 11:09 a.m., McCoy was booked into the Intake Release Center. Upon McCoy's arrival to the facility, she complained of needing a wheelchair to move around and also complained of having a burning sensation in her stomach. An Orange County Health Care Agency (OCHCA) Registered Nurse (RN) assessed her during the booking process. At approximately 7:34 p.m., McCoy was assigned to a single-person cell (Cell 1), located in the Isolation Wing. McCoy was housed in Cell 1 because it was an Americans with Disabilities Act (ADA) compliant cell, due to McCoy needing assistance moving and walking.

At approximately 8:00 p.m., OCSD Deputy Michelle Sitton made contact with McCoy in her cell. McCoy advised Deputy Sitton that she needed a wheelchair to move around and still had a burning sensation in her stomach. Deputy Sitton notified the jail medical staff and a nurse evaluated McCoy by taking her vital signs and documenting her request to see a doctor. McCoy told the medical staff that her hip was out and one leg was shorter than the other. McCoy was placed on the next available appointment to be seen by a doctor, who was not on duty at that time. The nurse did not find McCoy to have a high fever nor any other health problem that needed immediate medical attention.

On Saturday, July 11, 2015, at approximately 9:00 a.m., an OCHCA Licensed Vocational Nurse (LVN) contacted McCoy in her cell in order to provide McCoy her prescribed medication. McCoy stood up from her bed and walked up to the cell door and took possession of her medication, which was handed to her through a hatch located on the cell door. McCoy complained to the LVN about pain in her hip. The LVN knew about McCoy's medical history, which included a recent hip surgery. McCoy walked over to the sink in her cell to obtain water to take with her medication. The LVN was reminded by McCoy that she needed to be given her 200mg of Zoloft. At 3:00 p.m., Deputy Molly Mussig went to McCoy's cell after McCoy used the cell intercom to call the deputies in the control booth. McCoy complained that her left hip was hurting and she was in pain. Deputy Mussig spoke with McCoy and an RN about McCoy's complaints. McCoy was told she was scheduled to see the doctor the next day for the pain she was experiencing. No further action was taken and McCoy was left in her cell.

On July 12, 2015, at approximately 4:00 a.m., OCSD Deputy Lisa Dolan made contact with McCoy who was standing inside of her cell. This contact occurred when Deputy Dolan and an RN made their rounds throughout the first floor of the housing unit to distribute medication to the inmates who required medication. Deputy Dolan approached McCoy's cell and found her standing inside of her single person cell, next to the cell door. McCoy was standing with her walker and as she approached, McCoy complained of discomfort while making negative comments in general. The RN gave McCoy her medication. McCoy did not indicate she needed to see a doctor or go to the hospital. Deputy Dolan closed the cell door and continued on through the housing unit to distribute the medication to other inmates.

At approximately 4:40 a.m., Deputy Dolan returned to McCoy's cell to distribute the day's breakfast meal. McCoy stood up from her bed and received her tray of food. McCoy took her tray of food and placed the tray on the floor. Dolan noticed the dinner tray, from the previous meal, on the cell floor. During this time McCoy did not complain of any pain or make any comments. Deputy Dolan continued distributing breakfast to other inmates and she did not have any further interaction with McCoy. Deputy Dolan continued her cell checks for the remainder of her shift, until approximately 6:00 a.m. During those times she saw McCoy using the toilet and later resting on her bed. McCoy never formally requested through her to see a doctor or to be seen by medical staff. Deputy Dolan was told at the beginning of her shift that McCoy had made a request to a deputy the day before, July 11, 2015, to see a doctor.

At approximately 5:30 a.m., during scheduled cell checks, McCoy complained to Deputy Sitton that her stomach was burning. Deputy Sitton notified the medical staff, comprised of an LVN and an RN, of McCoy's complaint and the medical staff requested that McCoy fill out a "pink" slip and then to submit it to the jail staff. Inmates use "pink" slips to request to be seen by a doctor. Deputy Sitton handed the pink slip to McCoy and informed her to fill it out. When Deputy Sitton handed McCoy the pink slip, McCoy was laying on her bed, face up. Deputy Sitton noted that there was a dinner tray from the night before and a breakfast tray from that morning sitting on the floor. Deputy Sitton noted food, including peas and carrots, were spilled on the floor. Deputy Sitton felt McCoy's cell floor needed to be cleaned because she did not want McCoy to slip and fall on the spilled food when McCoy got out of bed. Deputy Sitton stood by while the cell floor was cleaned by other inmates who were assigned to do clean up work. McCoy did not make any statements to Deputy Sitton during this time, and that was the last time Deputy Sitton had contact with McCoy.

Inmates Jane Doe 1, Jane Doe 2, Jane Doe 3, Jane Doe 4, and Jane Doe 5 all share a cell near McCoy's, while Jane Doe 6 and Jane Doe 7 are housed separately in other nearby cells. At some point during the night or early morning hours, Jane Doe 1 said she heard someone crying and pleading to be taken to the hospital from the direction of McCoy's cell. Jane Doe 2 indicated that around 9:00 p.m., she heard screaming that she described as "complaining," "craziness," and an inmate "giving a hard time." Jane Doe 5 said that she heard deputies in the hallway having difficulty with an inmate screaming in her cell. Jane Doe 6 said she heard whining and complaining all night, but did not know who made the noise and didn't see anything from McCoy's cell. Later, Jane Doe 1 and Jane Doe 2 both said they looked through their cell window and saw deputies tell the woman she would not go to the hospital. The deputy identified by Jane Doe 1 did not begin work until 6:00 a.m. that morning, while Jane Doe #2 could not identify any deputy. Jane Doe 3, Jane Doe 4, and Jane Doe 6 indicated that they didn't hear anything that night.

At approximately 6:26 a.m., OCSD Deputy Sherry Martins performed a visual cell check of McCoy's cell and observed that McCoy was lying atop her bunk and being very loud. At approximately 7:00 a.m., Deputy Martins performed another cell check and observed McCoy was quiet during that check. At approximately 8:13 a.m., OCSD Deputy Amie Giusiana conducted a safety check of McCoy. During the check, Deputy Giusiana observed McCoy asleep, face down on her bed with her hands up by her face, as if she were using them as a pillow, and a blanket pulled up around her shoulder area. Deputy Giusiana had a hard time seeing McCoy due to the position of the blanket, but didn't believe there was anything out of the ordinary with McCoy during the check.

At approximately 8:47 a.m., OCSD Deputy Amber Corwin made a couple of her scheduled cell checks. All of the inmates housed in the area were secure and no problems noted. Deputy Corwin did not have verbal contact with McCoy at this time. Deputy Corwin looked into McCoy's cell through the glass window on the cell door and did not observe anything unusual. Deputy Corwin was unable to recall the specific details of McCoy's position or activity when she looked in on McCoy. At approximately 9:19 a.m., Deputy Corwin and an LVN went to distribute medication to the inmates housed in the medical ward of the jail. The LVN went to McCoy's cell in order to provide her prescribed medication, which consisted of 200mg of Zoloft and 600mg of Ibuprofen. Deputy Corwin opened the hatch and called out to McCoy to come and get her medication. McCoy, who was lying face down on her bed, did not respond. The LVN assumed, due to the complaint of McCoy's hip pain the previous day, McCoy was slow to get out of bed. Deputy Corwin called Deputy Sherry Martins, who was close by, to come and assist with McCoy, who was unresponsive inside her cell.

Deputy Martins looked for McCoy's torso to rise and fall indicating that she was breathing; however, Deputy Martins could not see McCoy's torso moving. The LVN told the deputies to turn McCoy over to see her face. As soon as McCoy was turned over the LVN noticed McCoy's face was wet around her mouth and hair that was lying next to her face. The LVN noted McCoy as having Coffee Grounds Emesis (vomit that looks like coffee grounds) leak out of her mouth as she was turned over. The LVN checked McCoy's pulse from the carotid artery (neck) and radial (wrist) and no pulse was present. Deputy Corwin exited the cell to locate additional help and summon medical staff. Deputy Giusiana, Deputy Mussig, and two RNs responded to assist with the medical aid. One of the RNs arrived with the first aid kit, which contained oxygen, automated external defibrillator (AED), IV fluid, and other medical supplies.

The LVN asked deputies Martins and Giusiana to place McCoy on the floor of the cell. McCoy was warm to the touch and her body and clothing were wet and smelled of urine. Deputies Martins and Giusiana began performing chest compressions on McCoy. Deputy Giusiana cut off McCoy's shirt with a pair of scissors as Mussig started chest compressions. The LVN began providing positive pressure ventilation by utilizing the bag valve mask (Ambu bag) on McCoy. Deputy Giusiana relieved Deputy Mussig in providing compressions and then an RN took over performing compressions. One of the RNs applied the defibrillator pads to McCoy's chest and started the AED. The AED advised to stay away as the AED analyzed the heart rhythm. The AED advised no shock was needed and to continue CPR. This meant the heart was not in a shockable rhythm. The AED went through two or three analyzing periods and advised no shock was needed. The LVN used the Ambu bag with oxygen to assist McCoy's breathing.

At approximately 9:25 a.m., Orange County Fire Authority (OCFA) Engine #75 was dispatched to the OCSD Women's Jail regarding an unconscious female. OCFA Engine #75 arrived less than five minutes after the initial dispatch. An OCFA paramedic arrived at the cell and observed two people doing cardiopulmonary resuscitation (CPR). One person was doing chest compressions, a second person was using an Ambu bag on McCoy, and there was also an AED connected. The AED instructed to stop CPR; it analyzed McCoy's cardiac rhythm, and advised not to shock. Staff continued CPR while McCoy was placed on a ZOLL heart monitor with defibrillator pads carried by the paramedics so her heart rhythm could be checked. A responding paramedic began assessing McCoy, checking her pupils, skin color, making sure her jaw and limbs were moving, and checking for pooling and obvious signs of death. The responding paramedic found several indicators of obvious death, including the heart monitor showing McCoy's heart in asystole, her pupils were fixed and dilated, her skin was cool and pale, her lips were turning blue, and there was rigor in her jaw. No additional medical aid or medications were administered to McCoy. At approximately 9:32 a.m., the responding paramedic pronounced McCoy deceased based on the lack of breathing, cardiac activity, and obvious signs of death.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Three AED pads
- Heart Blood (During Autopsy)

AUTOPSY

On July 18, 2015, independent Forensic Pathologist Dr. Scott Luzi of United Forensic conducted an autopsy on the body of McCoy. The forensic pathologist conducted an extensive examination of McCoy's body and found no significant injuries or trauma. The forensic pathologist located an internal hemorrhage, the result of a tear in the aorta in McCoy's lower back. Dr. Luzi concluded that this tear was related to the brittleness of a plaque in her aorta, a pre-existing condition, which subsequently fractured and ruptured the aorta causing McCoy to bleed internally, causing her death. Dr. Luzi noted that the diagnosis, however, is not usually considered in an initial assessment and might have been missed, unless an abdominal CT was performed to identify blood in the retroperitoneum. McCoy also suffered from heart and liver disease.

EVIDENCE ANALYSIS

Toxicological Examination

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

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Amphetamine	Postmortem Blood	0.469 ± 0.033 mg/L
Nortriptyline	Postmortem Blood	0.59 ± 0.11 mg/L
Sertraline	Postmortem Blood	1.17 ± 0.15 mg/L
Hydroxyzine	Postmortem Blood	0.588 ± 0.092 mg/L
Phenytoin	Postmortem Blood	Detected
Hydroxyzine Metabolite	Postmortem Blood	Detected
Norsertaline	Postmortem Blood	Detected

BACKGROUND INFORMATION

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

- Under the Influence of Control Substance
- Possession of Control Substance
- Possession of Control Substance Paraphernalia
- Disorderly Conduct/Prostitution
- Vehicle Theft/Take Vehicle without Owner Consent
- Violation of Parole
- Loiter/Intent Prostitution
- Assault on Custodial Officer
- Disturbing the Peace/Fight/Noise
- Willful Cruelty to Child
- Driving Under the Influence
- Driving without a License
- Evading Peace Officer
- Receive Stolen Property
- Exhibit Deadly Weapon/Not Firearm
- Obstruct/Resist Public Officer
- Threaten Crime with Intent to Terrorize
- Trespass/Closed Land
- Trespass/Occupy Property without Consent
- Possess Stolen Vehicle
- Bring Control Substance into Prison
- Hit and Run/Property Damage
- Petty Theft

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:

> "[T]he 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 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/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 McCoy a duty of care, the evidence does not support a finding that this duty was in any way criminally breached – either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter). There were no signs or indications that McCoy needed immediate medical attention prior to her death. McCoy's complaints were directed to medical professionals, who assessed her and determined that she did not need additional care at that specific time. McCoy received prompt and thorough medical treatment for the symptoms she presented while in jail by at least five different medical professionals and was determined to have died due to pre-existing medical conditions.

Thus, there is no evidence whatsoever to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty. McCoy's tragic death was due to natural pre-existing medical conditions.

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 McCoy died from an internal hemorrhage due a tear in her aorta located in her lower back which was the result of pre-existing medical conditions.

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

Respectfully submitted,

Janine L. Madera
Senior Deputy District Attorney
Gangs and TARGET Unit

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