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October 11, 2016

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

Re: Custodial Death on Nov. 18, 2015
Death of Inmate Michael Gale Coffey
District Attorney Investigations Case #SA 15-021
Orange County Sheriff's Department Case #15-258642
Orange County Crime Laboratory Case #15-58416

Dear Sheriff Hutchens,

This letter details the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion regarding the Nov. 18, 2015, custodial death of 55-year-old inmate Michael Gale Coffey.

OVERVIEW

This letter contains the description of the investigative methodology employed by the OCDA, 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 Nov. 18, 2015, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Orange County Men's Central Jail to investigate Coffey's death. During the course of this investigation, the OCDASAU interviewed twelve (12) witnesses, obtained and reviewed reports from the Orange County Fire Authority (OCFA), Orange County Crime Laboratory (OCCL), OCSD, incident scene photographs, and other relevant materials.

The OCDA conducted an independent and thorough investigation into 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 any 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, 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 Sept. 1, 2015, Coffey was being treated for complaints of "tiredness and shortness of breath" by the emergency room staff at the Western Anaheim Medical Center, located at 3033 West Orange Avenue in the City of Anaheim. Coffey received a full medical exam and no medical related issues were discovered. When Coffey was told that the examination did not reveal anything medically wrong with him and that he was being discharged from the hospital, he became very upset, stating that he needed medication. When no medications were prescribed, Coffey threatened Jane Doe 1, by pointing his finger directly at her saying, "Then what if I come back here and shoot up this hospital, all the doctors, nurses and you." Anaheim Police Officer Mark Gell, who was at the hospital on an unrelated investigation, was notified by hospital staff about Coffey's threats. Officer Gell interviewed the victims and witnesses involved in the threat and subsequently arrested Coffey for making criminal threats after he was discharged at 4:57 p.m. Coffey was initially booked at the Anaheim Detention Facility.

On Sept. 2, 2015, at approximately 8:16 a.m., Coffey was transferred from the Anaheim Detention Facility and booked into the OCSD Men's Central Jail Intake Release Center (IRC) in Santa Ana. At the time of his booking, Coffey completed the preliminary medical and psychological screening and the OCSD documents associated to Coffey's booking was marked "medical" and "mental." Coffey had self-reported that he was suffering from neck and back problems, anxiety, and a hernia.

On Sept. 14, 2015, Coffey was convicted of misdemeanor criminal threats and was sentenced to 180 days in the Orange County Jail and three years of informal probation. Coffey's scheduled release date was Nov. 28, 2015.

While incarcerated, Coffey submitted several Inmate Health Message Slips for both medical and mental health related issues, including: chronic pain, constipation, dizziness, numbness in his extremities, sleep apnea, depression, and anxiety. Coffey was routinely seen by the jail nurses, doctors, and psychiatrists, was prescribed several medications, but for reasons unknown, often refused to take the prescribed medications provided to him by the jail's medical staff.

On Nov. 4, 2015, at the request of the jail classification unit and a registered nurse (RN), Jane Doe 2, Coffey was moved to Module O, Ward C. This is a medical ward for observation, and it allows the use of a continuous positive airway pressure (CPAP) machine for sleep apnea treatment. On several occasions, Coffey was observed sleeping in his cell not using the CPAP machine.

On Nov. 5, 2015, Coffey submitted an inmate message slip complaining that he was "depressed", "suicidal", and "anxious" and wanted to see a doctor, marking the message slip "emergency today." The doctor, John Doe 1, the attending physician, examined Coffey; however, Coffey refused to speak and answer John Doe 1's questions.

On Nov. 16, 2015, while confined in Ward C, Coffey attempted to asphyxiate himself with a CPAP cord. After his attempted suicide, Coffey was moved to Module L, which is a high risk mental health module where the use of a CPAP machine is prohibited and, every hour, the jail deputies complete routine visual health and welfare checks on each inmate in the module.

On Nov. 17, 2015, at approximately 9:00 p.m., while they were administering medications to the inmates in Module L, a licensed vocational nurse, Jane Doe 3, and OCSD Deputy Guadalupe Ortiz attempted to dispense cardiac and mental health

medications to Coffey, which he refused. At approximately 10:00 p.m., OCSD Deputy Ronald Eccles escorted an RN, Jane Doe 4, to dispense medications to additional inmates in Module L. Jane Doe 4, with knowledge that Coffey refused his medication earlier, attempted again to give Coffey his medication but again Coffey refused. At the time, Coffey was lying on his mattress on the cell floor and he appeared to be alert and responsive. Coffey did not appear to be having any medical related issues or need any medical assistance. Each hour throughout the remainder of the night Deputy Eccles and Deputy Ortiz continued their routine visual check on Coffey. During each visual check, there was no physical contact or communication between Coffey and the deputies because Coffey appeared to be sleeping.

On Nov. 18, 2015, at approximately 3:45 a.m., Jane Doe 4 conducted a routine check on the inmates in Module L, and observed Coffey in his cell. Jane Doe 4 specifically observed the rise and fall of Coffey's torso indicating he was breathing. At approximately 4:25 a.m., while distributing food in Module L, Deputies Eccles and Ortiz arrived at Coffey's cell and knocked on the cell door announcing it was time for breakfast, but there was no response. Deputy Eccles immediately unlocked the cell door, entered Coffey's cell, and attempted to wake him up. Coffey did not respond. Deputy Eccles then checked for a pulse and yelled out that Coffey was unresponsive. The jail nurses, who were within feet of Coffey's cell, immediately began cardiopulmonary resuscitation (CPR) on Coffey and placed automated external defibrillator (AED) pads on him. At approximately 4:43 a.m., OCFA Engine #75 arrived at the jail and connected Coffey to the OCFA's Zoll heart monitor. Coffey was not responsive and he was pronounced dead at 4:48 a.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Small package of crackers from Coffey's pants pocket
- Black socks
- White underwear
- Two white tee-shirts
- Yellow jail shirt
- Two yellow jail pants

AUTOPSY

On Nov. 21, 2015, independent Forensic Pathologist Scott Luzi from Clinical and Forensic Pathology Services conducted an autopsy on the body of Coffey. Dr. Luzi found no significant injuries or trauma, but noted that Coffey had an enlarged heart consistent with hypertension and a history of chronic sleep apnea. Dr. Luzi stated that the cause of death was consistent with natural causes.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Michael Gale Coffey's postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Orphenadrine	Postmortem Blood	0.289 ± 0.054 mg/L
Valproic Acid	Postmortem Blood	Detected
Nordiazepam	Postmortem Blood	Detected
Benzodiazepines	Postmortem Blood	Presumptive Positive

BACKGROUND INFORMATION

Coffey had a State of California Criminal History record, dating back to 1980, which revealed arrests for: battery, assault to commit rape, robbery, disorderly conduct – under the influence of drugs, grand theft, malicious mischief/vandalism, grand theft, disorderly conduct – begging, disorderly conduct – prostitution, threaten crime with intent to terrorize, violation of probation.

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/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 in the present 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 Coffey 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). Coffey received timely medical attention during his incarceration. Specifically, Coffey was seen by doctors when requested, and was given medication when appropriate. However, Coffey refused to take the medication prescribed on several occasions and also attempted to commit suicide. As a result, Coffey was moved to another module where, every hour, the jail deputies are required to complete routine visual health and welfare checks on each inmate. Deputies Eccles and Ortiz conducted those inspections regularly throughout their shift, noting that the ward was "all secure". When Coffey was found unresponsive, CPR was immediately administered and OCFA paramedics were called to respond. Despite the continued application of life-saving measures, the OCFA paramedics and nurses were not able to resuscitate Coffey. Dr. Luzi conducted an extensive examination of Coffey and determined that the cause of death was consistent with natural causes. 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. There is no evidence in this case of any criminal conduct by any OCSD personnel or any individual under the supervision of the OCSD.

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 Coffey died as a result of natural causes.

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

Respectfully submitted,

David Porter
Senior Deputy District Attorney
TARGET/Gangs Unit

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