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September 28, 2015

Sheriff Sandra Hutchens
Orange County Sheriff's Department
320 N. Flower Street, Suite 108
Santa Ana, CA 92703

Re: Custodial Death on Dec. 5, 2014
Death of Amani McCoy
District Attorney Investigations Case # SA 14-019
Orange County Sheriff's Department Case # 14-232896
Orange County Crime Laboratory Case # 14-55907

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 Dec. 5, 2014, custodial related death of 28-year-old Amani 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) deputy or any other person under the supervision of OCSD.

On Dec. 5, 2014, OCSD investigators responded to West Anaheim Medical Center (WAMC), where McCoy was treated, and to the Community Living Solutions Board and Care home for Developmentally Disabled Adults, where earlier in the evening OCSD deputies found McCoy unresponsive. On Dec. 5, 2014, McCoy was pronounced dead at WAMC after failed efforts to resuscitate him. On Dec. 10, 2014, OCDA Special Assignment Unit (OCDASAU) Investigators met with OCSD investigators regarding the custodial related death of McCoy. Over the following months, 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 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 and evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the Orange County Crime Lab (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. Deputy District Attorneys 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

On Dec. 5, 2014, at approximately 6:57 p.m., McCoy was pronounced deceased at WAMC after OCSD deputies found him unresponsive at residence at a board and care facility for developmentally disabled adults in the City of Stanton.

Background and Events Leading up to McCoy's Death

McCoy had a long and documented history of mental illness, including previous diagnoses of moderate mental retardation, hyperactivity, intermittent explosive disorder, and schizoaffective disorder. McCoy had a history of aggression and violence towards his caretakers and fellow residents at the board and care facility where he resided. In 2009, McCoy was placed under the conservatorship of a Public Guardian, pursuant to Welfare and Institutions Code (WIC) section 5350. This conservatorship was renewed until it terminated in 2011.

Since 2011, McCoy has been hospitalized on several instances for psychiatric evaluation pursuant to WIC section 5150. This occurred especially frequently in the days leading up to his death. On Nov. 20, 2014, OCSD deputies were dispatched to the board and care facility where McCoy resided regarding his aggressive behavior. Staff members pinned McCoy down until an ambulance could take him to a hospital for a voluntary mental health evaluation.

On Dec. 3, 2014, OCSD deputies were again dispatched to the board and care facility regarding McCoy causing a disturbance and damaging another resident's property. Another resident pinned McCoy down until the deputies arrived. Deputies found McCoy to be unresponsive and requested Orange County Fire Authority (OCFA) Paramedics. Paramedics medically cleared McCoy, noting that all his vital signs were normal. McCoy was then transported to Western Medical Center, Anaheim, for a voluntary mental health evaluation.

The next day, on Dec. 4, 2014, at approximately 1:30 p.m., McCoy was released from the hospital and returned to the board and care facility by ambulance. Upon returning to the board and care facility, McCoy immediately became violent. The ambulance crew requested a second ambulance in an attempt to control him. When both ambulance crews were unable to control him, one of McCoy's caretakers called 911, and OCSD deputies were dispatched to the scene. The deputies then requested OCFA Paramedics, who medically cleared McCoy, noting that all his vital signs were normal, before transporting McCoy to La Palma Intercommunity Hospital for voluntary mental health evaluation. Later that day, McCoy was again released from the hospital and returned by ambulance to the board and care facility.

On the evening of Dec. 4, 2014, OCSD deputies again responded to a 911 call at the board and care facility. Upon arrival, Deputy Jesus Maldonado observed McCoy chasing and throwing objects at one of his caregivers. The caregivers stated that McCoy was acting combative and refusing to take his prescribed medications. Deputy Maldonado requested OCFA Paramedics. Upon arrival, the paramedics medically cleared and released McCoy. McCoy was then transported to WAMC for a mandatory mental health evaluation, pursuant to WIC section 5150. While hospitalized, McCoy received divalproex, chlorpromazine, olanzapine, lamotrigine, and benztropine.

On Dec. 5, 2014, McCoy was again released from the hospital and returned to the board and care facility by ambulance. At approximately 5:00 p.m., McCoy arrived at the board and care facility. One of his caretakers attempted to administer his prescribed evening medication, as directed by the hospital staff. McCoy at first refused to take the medication, but ultimately agreed, and received haloperidol, chlorpromazine, and benztropine-mesylate. Shortly thereafter, the caretakers observed McCoy and another resident engaged in an altercation. McCoy assaulted the other resident by striking him in the head with his hands, followed by McCoy chasing the resident into the house. Two caregivers and the resident detained McCoy by pinning him down on the ground with his hands behind his back as another caregiver called 911.

Events on the Evening of Dec. 5, 2014

At approximately 5:54 p.m. on Dec. 5, 2014, OCSD Deputies James Wicks and Moni Faour were dispatched to the board and care facility. Upon dispatch, Deputy Wicks was told that McCoy had just been released from a 5150 hold, and that he should inquire about the facility's license, since the facility was having repeated difficulties in handling its clients. Prior to approaching the facility, Deputy Wicks activated his mobile, audio and video (MAV) recording device, which captured an audio recording of the event.

Upon arrival at 6:04 p.m., Deputy Wicks observed McCoy lying face down on the floor directly inside the front door, being restrained by Caregiver 1 and Caregiver 2. Deputy Wicks was unable to see McCoy's face at that time, as McCoy was facing away from the front door and was blocked by Caregiver 1 and Caregiver 2 as they restrained him. Deputy Faour arrived approximately one minute after Deputy Wicks. Deputy Wicks asked Caregiver 3 to provide a copy of the facility's license for his review, since the facility had been frequently having difficulty managing McCoy.

About two minutes after Deputy Wicks arrived, Caregivers 1 and 2 asked Deputy Wicks to place McCoy in handcuffs. Deputy Wicks attempted to communicate with McCoy, calling him by his first name several times, asking him to look at him; however, McCoy was unresponsive. Deputy Wicks then asked whether McCoy was breathing. One of the caregivers responded "yes." Deputy Wicks had difficulty handcuffing McCoy because of McCoy's large body size and the tight space in the entryway where McCoy was lying. After handcuffing one of McCoy's wrists, Deputy Wicks asked McCoy to give him his other wrist and move his body over, but McCoy remained unresponsive. Deputy Wicks later stated in an interview that McCoy "appeared to be sleeping." Deputy Faour also stated when interviewed that McCoy appeared to be "heavily sedated." Deputy Wicks spoke briefly on the telephone with the facility's owner regarding the facility's license, then requested paramedics at 6:08 p.m. Deputy Wicks continued his conversation with the facility's owner for about another minute.

At 6:10 p.m., Deputies Wicks and Faour rolled McCoy onto his side in an effort to improve McCoy's air intake. Deputy Wicks continued to attempt to verbally communicate with McCoy, but McCoy remained unresponsive. Seconds later, one of the caregivers said, "As long as he's breathing." At which time Deputy Wicks responded, "Is he?" The caregiver then asked, "Does he have a pulse?" And Caregiver 3 then stated that she had given McCoy medication. Deputy Wicks asked what kind of medication, and Caregiver 3 replied, "Sedation, which made him drowsy." Deputy Wicks then asked Caregiver 3 to spell McCoy's name and provide his date of birth for his investigation, and Deputy Wicks took a photo of the facility's license, which was mounted on the wall.

At 6:13 p.m., one of the caregivers asked Deputy Wicks if McCoy was okay, and Deputy Wicks responded, "I don't know." Deputy Wicks then stated that he did not feel a pulse. Deputy Wicks continued to call out to McCoy by his first name, but McCoy remained unresponsive. Deputy Wicks then removed McCoy's handcuffs, checked again for a pulse, looked for a rise in McCoy's chest, and determined that McCoy was not breathing and had no pulse. Deputy Wicks began Cardiopulmonary Resuscitation (CPR) on McCoy by administering chest compressions.

At 6:17 p.m., OCFA Engine 46 arrived, and Deputy Faour directed the paramedics to McCoy's location. The paramedics moved McCoy to a more accessible location in the house and checked McCoy's vital signs. After determining that McCoy had no pulse and was not breathing, the paramedics began providing lifesaving medical intervention.

At 6:22 p.m., the paramedics inserted an endotracheal tube into McCoy's airway and initiated an intravenous line into McCoy's arm, and began to administer saline solution and five separate dosages of epinephrine. The paramedics performed CPR and administered ventilations using a bag and valve mask. As the paramedics performed CPR, they placed heart monitor and defibrillator pads onto McCoy. Caregiver 3 handed McCoy's prescription medications to the paramedics, including the three which she had administered immediately prior to this incident.

At approximately 6:38 p.m., an ambulance transported McCoy to WAMC and arrived at approximately 6:41 p.m.

Upon arrival, McCoy was unconscious, not breathing, and unable to sustain a pulse. Paramedics continued performing CPR. The attending physician directed his staff to begin cardiac life support protocols and intervention on McCoy. After several minutes of advanced cardiac care, McCoy was still unable to sustain a pulse without advanced medical intervention. Due to McCoy's age, the attending physician continued advanced lifesaving intervention longer than normal; however, McCoy remained unresponsive, unable to breathe or sustain a pulse, and never regained consciousness.

At 6:57 p.m., the attending physician pronounced McCoy deceased and all efforts to revive him were terminated. When interviewed by OCDASAU investigators, the attending physician noted that he saw no evidence of trauma, bruising, or compression to McCoy's body.

AUTOPSY

On Dec. 8, 2014, Dr. Etoi Davenport, a pathologist with the Orange County Sheriff-Coroner's Office, conducted a postmortem examination of McCoy. Dr. Davenport noted slight abrasions on McCoy's forehead and chin, but found no signs of trauma that could be attributable to McCoy's death. After further analysis of microscopic samples and toxicology, Dr. Davenport determined McCoy's death was "natural," and was caused by "hemorrhagic lymphocytic encephalitis; meningitis and bronchopneumonitis with tracheitis."

EVIDENCE ANALYSIS

Toxicological Examination

An examination of McCoy's postmortem blood, peripheral blood, liver tissues and stomach contents detected the presence of the following drugs:

Drug	Matrix	Results & interpretations
Olanzapine	Postmortem Blood	0.125 + 0.019 mg/L
Chlorpromazine	Postmortem Blood	0.273 + 0.029 mg/L
Benztropine	Postmortem Blood	0.198 + 0.020 mg/L
Lamotrigine	Postmortem Blood	10.9 + 0.3 mg/L
Valproic Acid	Postmortem Blood	Detected
Benztropine	Peripheral Blood	0.128 + 0.013 mg/L (Peripheral blood) 2.96 + 0.30 mg/kg (Liver)
Haloperidol	Peripheral Blood	<0.050 mg/L (Peripheral Blood) 0.60 + 0.11 mg/kg (Liver)
Haloperidol	Postmortem Blood	<0.050 mg/L (Blood)

BACKGROUND INFORMATION

McCoy had a State of California Criminal History Record that revealed arrests for assault, battery, and trespass.

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 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 that 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;
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 *Girardo v. California Department of Corrections and Rehabilitation* (2008) 168 Cal.App.4th231,251, the court established that there is a "special relationship" between custodian and inmate:

> "The most important consideration in establishing duty is foreseeability. It is manifestly foreseeable that 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 of express or implied malice on the part of any OCSD deputy or any 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 Amani McCoy 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).

The facts of this case do not indicate that either Deputy Wicks or Deputy Faour knew or had reason to know that McCoy needed prompt medical attention until after Deputy Wicks had requested paramedics. Under California Government Code section 845.6, a duty exists when a public employee knows or has reason to know that the person in custody is in need of immediate medical care. Deputies Wicks and Faour initially saw McCoy pinned to the ground by his caretakers, who then asked Deputy Wicks to place McCoy in handcuffs. Upon dispatch, the deputies knew McCoy had been acting aggressively, so seeing him pinned to the ground was consistent with their initial expectations as well as all the available information. Further, when Deputy Wicks asked whether McCoy was breathing, one of the caregivers responded "yes." Deputy Wicks observed that McCoy "appeared to be sleeping," while Deputy Faour thought McCoy appeared to be "heavily sedated." As such, the deputies neither knew, nor had any reason to know, that McCoy needed immediate medical care. When Deputy Wicks asked again if McCoy was breathing, a caretaker told the deputies that she had given him a sedation medication. At 6:08 p.m., Deputy Wicks requested paramedics, even though it was not clear at that time that McCoy needed immediate medical care.

The deputies' duty of care to Amani McCoy only existed once they knew or had reason to know that he needed medical care. Thus, it was not until Deputy Wicks determined that he could not feel a pulse that the deputies had a duty to act as far as requesting medical care. Deputy Wicks continued to call out McCoy's name to try to elicit a response, and then removed McCoy's handcuffs and administered CPR. Since Deputy Wicks called for paramedics before he knew McCoy needed immediate care, and administered CPR after he knew McCoy needed immediate care, his actions were reasonable. Similarly, Deputy Faour went outside to direct the paramedics to the scene, facilitating the prompt provision of medical care. Therefore, neither of these deputies breached their duty to aid McCoy. On the contrary, from all the available evidence it is clear that they both acted appropriately and reasonably.

The facts also do not demonstrate the causal relationship necessary for a homicide, since it is not established by the evidence that the deputies could have prevented McCoy's death if they had acted any differently. An act causes death when death is the direct, natural, and probable consequence of the act **and the death would not have happened without the act**. The Coroner's Office determined that McCoy's death was caused by "hemorrhagic lymphocytic encephalitis; meningitis and bronchopneumonitis with tracheitis."

In an interview with OCDA investigators, McCoy's attending physician at WAMC stated that McCoy arrived in "full arrest," and that he exhibited no response to the hospital's lifesaving protocol. Further, McCoy was unresponsive the entire time that Deputies Wicks and Faour were at the board and care facility, and McCoy was unresponsive at least for several minutes before the deputies realized he needed medical care, and possibly even longer. Because the facts do not show that McCoy's death could have been prevented if the deputies had acted differently, the evidence therefore does not establish the type of causation necessary for anybody to reasonably conclude that McCoy's death was a murder or an involuntary manslaughter.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA and pursuant to the applicable legal principles, it is our legal opinion that the evidence does not support a finding of criminal culpability on the part of any OCSD personnel or any individual under the supervision of OCSD. The evidence shows that McCoy died of natural causes resulting from hemorrhagic lymphocytic encephalitis, meningitis and bronchopneumonitis with tracheitis.

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

Respectfully Submitted,

Cliff Bodley

Cliff Bodley
Deputy District Attorney
TARGETS/Gangs Unit

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