

## Sacramento County District Attorney's Office

ANNE MARIE SCHUBERT District Attorney Stephen J. Grippi Chief Deputy

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Captain Jim Ortega, Commander Sacramento County Sheriff's Department Correctional Services Unit 651 I Street Sacramento, CA 95814

Re: In-Custody Death – Michael Lee Rachel SSD Report No. 15-82918 Date of Incident: April 6, 2015

Dear Captain Ortega:

The above case was referred to this office for review of the circumstances surrounding the April 6, 2015, death of inmate Michael Rachel while in the Sacramento County Main Jail.

On April 6, 2015, at 11:06 a.m., Sacramento County Sheriff's Deputies Ralph Garcia and Lindsey Lamb responded to 9350 Jackson Road regarding a male subject reportedly hiding in a trash bin and bleeding from his stomach. Upon arrival, they contacted Michael Rachel, who identified himself as John Clarence Gibson. Rachel had superficial scratches on his wrists, hands, and stomach. Deputy Lamb noted that Rachel had objective signs of intoxication, including bloodshot and watery eyes, slurred speech, unsteady gait, and an odor of alcoholic beverage on his breath. Rachel admitted to deputies that he drank a "fifth of vodka" earlier in the day. Rachel claimed that the scratches on his body occurred as a result of falling. Deputy Lamb determined that Rachel was unable to care for himself or others due to his inebriated state and arrested him for public intoxication in violation of Penal Code section 647(f). The deputies departed the scene with Rachel at around noon and arrived at the jail approximately fifteen minutes later. At 12:55 p.m., Rachel was cleared by jail nursing staff and was booked into custody.

During the initial jail intake, Rachel continued to state his name was John Gibson. He appeared angry and refused to speak to deputies. However, Rachel was coherent, followed all directions and did not appear to be intoxicated at that point. An individual arrested by law enforcement for public intoxication will generally remain at the jail for at least 4 hours, even if they do not appear intoxicated at the jail. This is the minimum time it takes to complete the booking process, place the individual in a holding tank, and then move the individual into the release tank. Deputy Jesse Brucker searched and escorted Rachel to a holding cell. Rachel was stable on his feet, had a steady gait, and was placed into the cell with numerous other inmates without incident at approximately 1:01 p.m.

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Deputy Christopher Mrozinski responded to the holding cell at approximately 2:55 p.m. Other inmates were agitated and complained that Rachel defecated on himself. As a result, Deputy Mrozinski escorted Rachel to a different cell. Another inmate, Shawn Spillane, was already inside the cell, sleeping on a bench.

At approximately 3:39 p.m., after hearing someone kick the cell door, Deputy Brucker responded to the holding cell. Spillane was now awake and complained that Rachel was urinating and defecating throughout the cell. Deputy Brucker relocated Spillane to a different cell and then spoke to Rachel. Rachel stated, "I felt like I had to poop. I'm okay, sometimes I just felt like this. I'm not sick, I don't have any mental problems. I'm fine." Rachel was calm, coherent, able to answer questions, and did not have objective signs of intoxication.

Deputies walked by and looked inside through the holding cell window at approximately 5:02 and 5:31 p.m. Rachel was observed sitting on the floor leaning on the bench.

Deputy Brucker went to check on Rachel at approximately 5:33 p.m. He opened the cell door and observed Rachel still sitting on the floor leaning over the bench. Rachel's skin was gray and he was not breathing. Deputy Brucker pulled Rachel away from the bench and noticed he had vomited. Deputy Mrozinski arrived and immediately requested medical assistance. The deputies pulled Rachel out of the cell into the corridor. Rachel did not have a pulse, so Deputy Brucker immediately began cardiopulmonary resuscitation (CPR). Other deputies and medical personnel arrived to assist with treatment. As they performed chest compressions, Deputy Brucker observed a clear foamy liquid come from Rachel's mouth. Fire department medics arrived at approximately 5:38 p.m. and resumed treatment. Rachel was pronounced deceased at 5:53 p.m.

The entire incident was captured on jail surveillance video. A subsequent review of the video recordings showed that during his time in the initial holding cell, Rachel went to the water fountain multiple times and consumed a significant amount of water. Video of Rachel after he was moved to a different cell showed that Rachel pulled his pants down and repeatedly walked to the fountain to consume copious amounts of water for several minutes at a time. As a result, Rachel vomited several times while also urinating and defecating on the floor. After Deputy Brucker left following his moving of inmate Spillane, the video showed Rachel pull up his pants and repeat his routine of drinking large amounts of water from the fountain. At one point, he vomited and started to lose his balance. Rachel eventually sat down on the floor and leaned on the bench at approximately 4:51 p.m.

Forensic Pathologist Brian Nagao, M.D., for the Sacramento County Coroner's Office conducted an autopsy and concluded that the cause of Rachel's death was undetermined. He noted the following: vitreous electrolytes demonstrating decreased sodium and normal chloride, mild cerebral edema without herniation, and 1425 milliliters of watery gastrointestinal contents. Dr. Nagao also determined that Rachel suffered from hypertensive heart disease and myocardial tunneling of the coronary arteries. There were no drugs or alcohol detected in his system. Trauma was limited to cutaneous injuries. Dr. Nagao noted that Rachel had a psychiatric diagnosis of schizoaffective disorder, bipolar type, as well as a clinical diagnosis of asthma. There is no credible evidence to support a finding that any of the deputies intentionally tried to harm Rachel. Moreover, it does not appear that the deputies acted in a criminally negligent manner. Under California law, more than ordinary negligence is required to support a charge of involuntary manslaughter. Evidence must prove that the person acted in an aggravated, culpable, gross or reckless manner, a manner so imprudent as to be incompatible with a proper regard for human life, or in other words, a disregard of human life, or an indifference to consequences of the act. (*Somers v. Superior Court* (1973) 32 Cal.App.3d 961, 968-969.) Further, the evidence must prove that the consequence of the negligent act could reasonably have been foreseen, and it must appear that the death or danger to human life was not the result of inattention, mistaken judgment or misadventure, but the natural and probable result of an aggravated, reckless, or grossly negligent act. (*People v. Villalobos* (1962) 208 Cal.App.2d 321, 326-328; *People v. Rodriguez* (1960) 186 Cal.App.2d 433, 437-441.)

The deputies did not act in an aggravated, culpable, gross, or reckless manner. Although Rachel was initially angry and quiet, deputies noticed that he was coherent and was not exhibiting signs of intoxication after he was formally booked at the jail. In fact, he followed all of the deputies' directions, was steady on his feet, and entered into the first cell without incident. Deputies and other inmates in the cell did not notice anything unusual about Rachel other than he defecated on himself, which resulted in his relocation to another cell. Later, when deputies confronted him about urinating and defecating in the second cell, Rachel calmly answered their questions. He did not complain or exhibit any troubling signs which required an examination by medical personnel.

The deputies regularly checked on Rachel to ensure he was okay in the cell. Upon realizing that Rachel vomited and had no pulse, the deputies immediately called for medical assistance and performed CPR until paramedics arrived. The officers demonstrated a proper regard for human life, as indicated in the jail surveillance video.

No evidence of criminal misconduct or criminal negligence is presented or suggested in any of the supporting reports. The District Attorney's Office will not take any further action in this matter.

cc: Rick Braziel, Office of the Inspector General Lieutenant Lisa Gayman