October 25, 2016

Michael McIntosh, Adams County Sheriff
Adams County Sheriff’s Office
332 N. 19th Avenue
Brighton, CO 80601

Re: The investigation of the death of David Lee Skelly at the Adams County Detention Facility at 150 N. 19th Avenue, Brighton, Colorado on March 27, 2016.

Dear Sheriff McIntosh:

The investigation and legal analysis into the death of David Lee Skelly while in-custody at the Adams County Detention Facility (ACDF), on March 27, 2016, is complete. Detective Matthew Marquez of the Adams County Sheriff’s Office led the investigation and presented his reports, photos, videos, documents, and materials to the office of the Seventeenth Judicial District Attorney for our review. Based on the evidence presented, Mr. Skelly died of asphyxia due to hanging. The investigation and the evidence also demonstrate that the manner of death was suicide. Therefore, no criminal charges will be filed against anyone in this matter.

STATEMENT OF INVESTIGATION

Events prior to Mr. Skelly’s death:

On February 26, 2016 the Westminster Police Department arrested David Skelly on numerous charges including; identity theft, criminal impersonation, and resisting arrest. Additionally, David Skelly had a warrant out of Ohio for sexual assault, aggravated robbery, and domestic violence. David Skelly had been wanted on those charges for fifteen years and had been previously featured on America’s Most Wanted. David Skelly was booked into the Adams County Detention Facility and housed in the administrative segregation unit because he was considered an “extreme escape risk.”

In addition to the above filed charges Westminster Police Detective DeHerrera was in the process of completing an affidavit requesting a warrant for unrelated Sexual Assault on a Child charges against David Skelly and was preparing to present it when Mr. Skelly hung himself.
On February 28, 2016 medical staff at the detention facility completed the intake screening on David Skelly. During the screening process David Skelly reported he had no current mental health complaints and did not have a history of mental health problems. Additionally, David Skelly reported he had not thought of suicide in the past, did not have a history of suicide attempts, and that he was not presently feeling hopeless or thinking about suicide.

On March 2, 2016 the Classifications Review Board made the decision to move David Skelly to general population. David Skelly was moved to B-Module, cell 218 as he had previously been classified as maximum security.

On March 21, 2016 David Skelly turned in a mental health request form known as a kite. In this kite, David Skelly stated, “Depression-Anxiety-Can’t sleep thinking about too much-seems to be too many problems and all I seem to do is go over them constantly. Can I talk to Suzie in Mental Health?” Due to the kite David Skelly was placed on a list to speak to a Mental Health professional, but had not been seen in reference to the kite prior to his death.

According to medical staff at the detention facility when an inmate submits a request to speak with mental health staff, the inmate is asked if they are having thoughts of hurting themselves so that individuals that indicate they are considering self-harm can be given priority in speaking with a mental health professional. In this instance there was no indication that Mr. Skelly was suicidal.

From March 23, 2016 to the date of his death on March 27, 2016 Mr. Skelly was the sole occupant of cell (B218).

**Mr. Skelly’s death on March 27, 2016:**

Detention Specialist Andrew Titus reported that he was working in the B-Module tower when he heard screaming and pounding on the door to pod two. Detention Specialist Titus saw inmates screaming and pointing to cell B218, Mr. Skelly’s cell. Detention Specialist Titus informed Deputy Holguin that there was a disturbance in pod two.

Deputy Holguin entered pod two and ordered inmates to lock down as he went to cell B218. When he went into the cell Deputy Holguin saw David Skelly with a sheet wrapped around his neck and Mr. Skelly was hanging from the top bunk. Deputy Holguin immediately cut him down and rendered aid to Mr. Skelly. Deputy Kyle Brown administered CPR and Deputy Dustin Naylor gave Mr. Skelly oxygen. The Deputies continued this until medical staff took over resuscitation efforts.

Detectives reviewed the video of the relevant time and areas to show the activity around David Skelly’s cell. The Video review revealed the following:

At 11:50 hours – David Skelly left his cell (B218) and walked down the stairs to attempt to make telephone calls then went back to his cell at 11:58:40 hours.
At 12:00:18 hours – Cell doors in B-Module, pod 2 are closed for the noon to 1500 hour lockdown. Cell B218 closes with David Skelly in his cell by himself.

The required row checks were completed at 12:01:55 hours, 12:29:53 hours, 13:01:35 hours, 13:32:29 hours, 14:05:03 hours, and 14:37:27 hours.

Distinct movement can be seen in cell window of B218 between 13:08:50 hours and 13:38:41 hours. Possible movement can be seen in cell window at 14:36:50 hours but difficult to tell for sure because of the video quality.

At 15:00:10 hours – Cell doors in B-2 open, ending noon to 1500 hours lockdown. Most of the inmates come out of their cells and go into the day space.

At 15:07:48 hours – Inmate Russel Tucker walked past cell B218 while walking toward cell B217. Russel Tucker appears to notice something in cell B218 and alerts other inmates in the pod.

At 15:08:28 hours – Deputy Holguin enters the pod and goes to cell B218. Additional Deputies arrive to assist.

At 15:10:35 hours – ACDF nursing staff begin to arrive to provide medical attention.

At 15:16 hours – EMS arrive and provide additional medical attention to David Skelly.

On March 27, 2016 at 15:25 hours David Skelly was pronounced deceased by Doctor Sarin from Platte Valley Medical Center.

18:02 hours – David Skelly’s body removed from the pod by Investigator Hoover with Adams County Coroner’s Office.

**Investigation after Mr. Skelly’s death:**

A review of the Phone calls showed that David Skelly completed fifteen phone calls while in the facility and left no indication that he was suicidal.

Interviews with other inmates revealed that David Skelly did not talk about suicide to other inmates other than in a single conversation with his former cellmate. In that conversation they talked about what would happen if they ended up getting lengthy prison sentences and discussed whether a person would go to hell if they committed suicide.

A note was found in David Skelly’s cell, and it was titled “good-bye letter” and was dated Easter Sunday. The note contained statements to several different people talking about memories with them. Also, found in David Skelly’s cell was a large cross drawn in pencil on the south wall.
of the cell. It had Bible scriptures written in it, but it is unknown if it was there before Skelly was housed in that cell.

An autopsy was performed on the body of David Lee Skelly on March 28, 2016. The autopsy was performed by Dr. Michael Arnal, a board certified forensic pathologist. The Dr. Arnal later prepared an autopsy report, and listed the cause and manner of Mr. Skelly’s death as *asphyxia due to hanging*.

**Legal Analysis**

Criminal liability is established in Colorado when it is proven beyond a reasonable doubt that someone has committed all of the elements of an offense defined by Colorado statutes, and it is proven beyond a reasonable doubt that the offense was committed without any statutorily recognized justification or excuse.

The lowest level of criminal culpability for causing the death of an individual is criminally negligent homicide. “Any person who causes the death of another person by conduct amounting to criminal negligence commits criminally negligent homicide,” C.R.S. 18-3-106. The other crimes for causing the death of a person – reckless manslaughter, second degree murder, and first degree murder – require a higher culpable mental state. To commit them, a person must act recklessly, knowingly, or intentionally. In analyzing the case, we must first determine whether any one acted with criminal negligence and caused Mr. Skelly’s death.

Pursuant to C.R.S. 18-1-501 (3), “A person acts with criminal negligence when, through a gross deviation from the standard of care that a reasonable person would exercise, he fails to perceive a substantial or unjustifiable risk that a result will occur or that a circumstance exists.”

Mr. Skelly was appropriately screened for physical and mental health issues when he entered the Adams County Detention Facility. He indicated that he had no prior or current mental health issues and was not suicidal. When he was found hanging from the top bunk by the use of a sheet, the jail staff and EMS administered appropriate medical treatment to Mr. Skelly.

In summary, a review of the materials presented does not disclose any abuse, mistreatment, or maltreatment that rises to a level of criminal culpability. There is not sufficient evidence to prove that anyone caused the death of David Skelly by conduct amounting to criminal negligence. The video and physical evidence obtained indicate that Mr. Skelly’s death was caused by hanging, and that it was self-inflicted. There is no evidence to support the filing of criminal charges for the death of David Lee Skelly. The evidence demonstrates that on March 27, 2016, Mr. Skelly took a jail issued sheet and hung himself from the top bunk in his cell while he was alone.
Conclusion

On March 27, 2016, Mr. David Lee Skelly was in the Adams County Detention Facility awaiting prosecution on numerous charges. He also had warrants for serious felony charges to include sexual assault and aggravated robbery out of another state. All of the evidence indicates that Mr. Skelly died as a result of suicide and there is no indication that the detention personnel contributed to his death.

If you have any questions pertaining to this report or findings and conclusions, please contact me.

Very truly yours,

Trevor Moritzky
Chief Trial District Attorney
17th Judicial District Attorney’s Office