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INDEPENDENT MONITOR

Presentation to the City Council Safety, Housing, Education, and Homelessness Committee

March 21, 2018

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Independent Monitor

2017 ANNUAL REPORT

- Key OIM Responsibilities:
  - Conduct **outreach** to community and law enforcement
  - Make recommendations for improving **policy**, **practices, and training**
  - Monitor officer-involved **shooting and in-custody death** investigations
  - Monitor and make recommendations **on Internal Affairs Bureau (“IAB”) investigations and disciplinary findings**
  - Cultivate Denver Police Department (“DPD”) officer/community member dialogue through **mediation**

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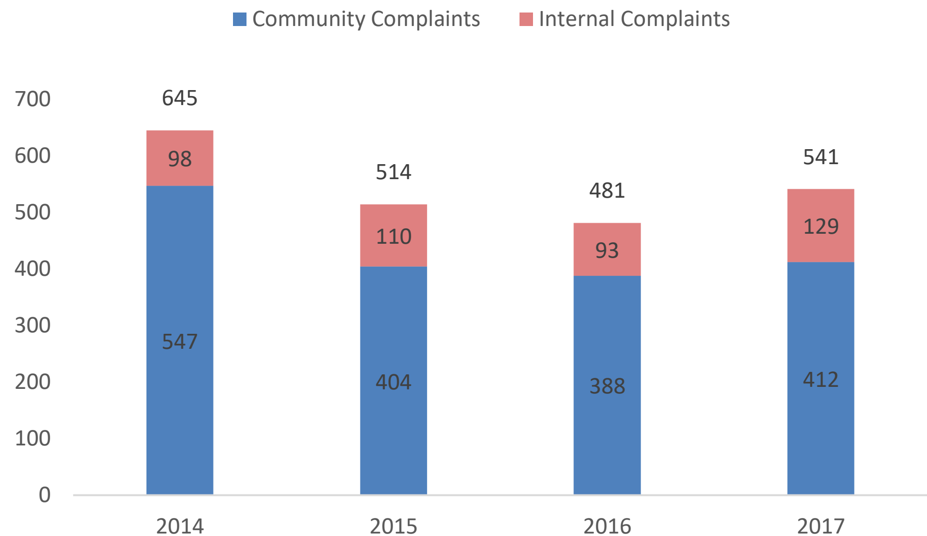
Complaints Against DPD Officers

- 541 complaints recorded in 2017
  - 12% increase from 2016
  - Relatively large increase in complaints with specifications for failing to activate body worn cameras



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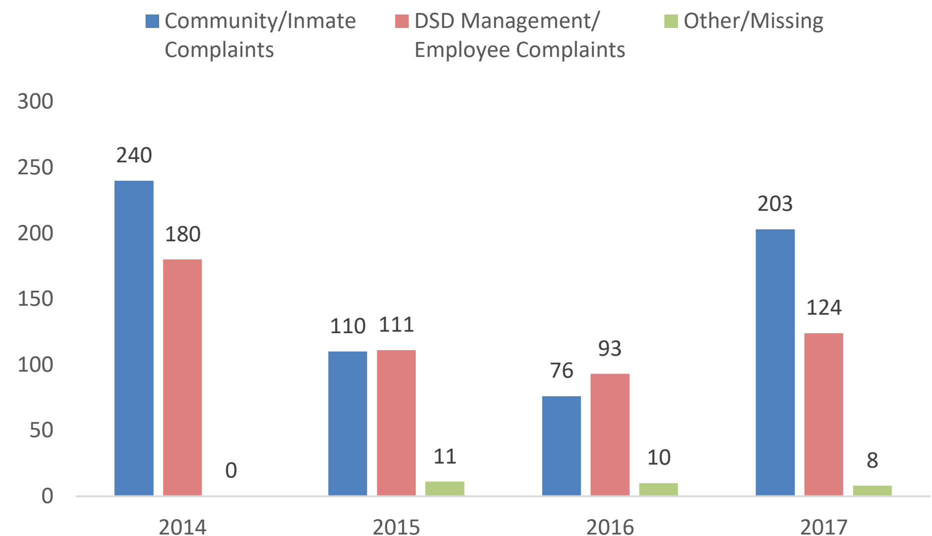
DPD Discipline and Commendations

- Discipline
  - No officers terminated
  - 8 officers retired or resigned pending investigation/discipline
  - 12 officers suspended
- Police/Citizen Mediations
  - 53 completed, a three-year peak
- Commendations
  - 423 awarded to officers

COMPLAINTS AGAINST DENVER SHERIFF DEPARTMENT ("DSD") DEPUTIES

- 335 complaints recorded in 2017
  - 167% increase in complaints by community members and inmates
  - Reflects change in triage and complaint recording policies



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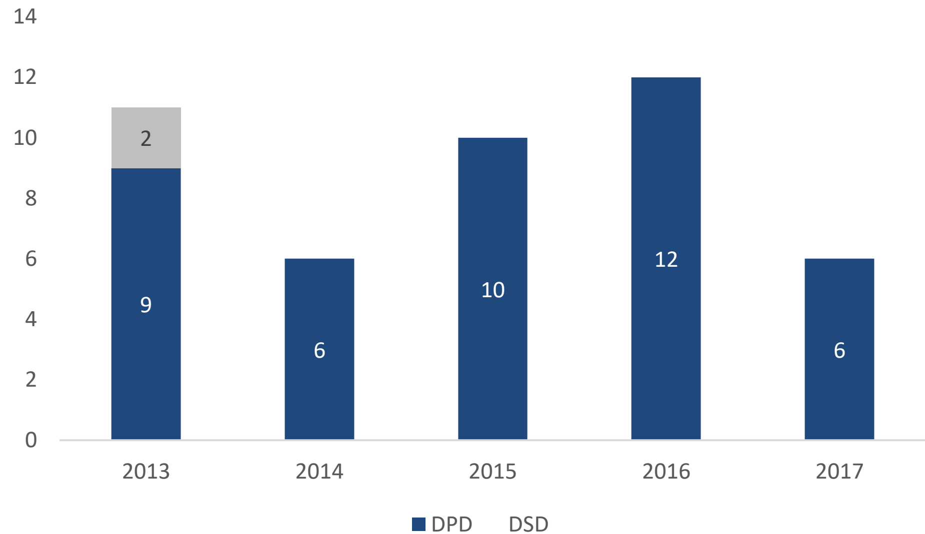
DSD Discipline and Commendations

- Discipline
  - 3 deputies terminated
  - 9 deputies retired or resigned pending investigation/discipline
  - 47 deputies suspended
- Commendations
  - 67 awarded to deputies

2017 Officer-Involved Shootings

- Six officer-involved shootings
  - Decrease from 2016



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2017 Outreach Achievements

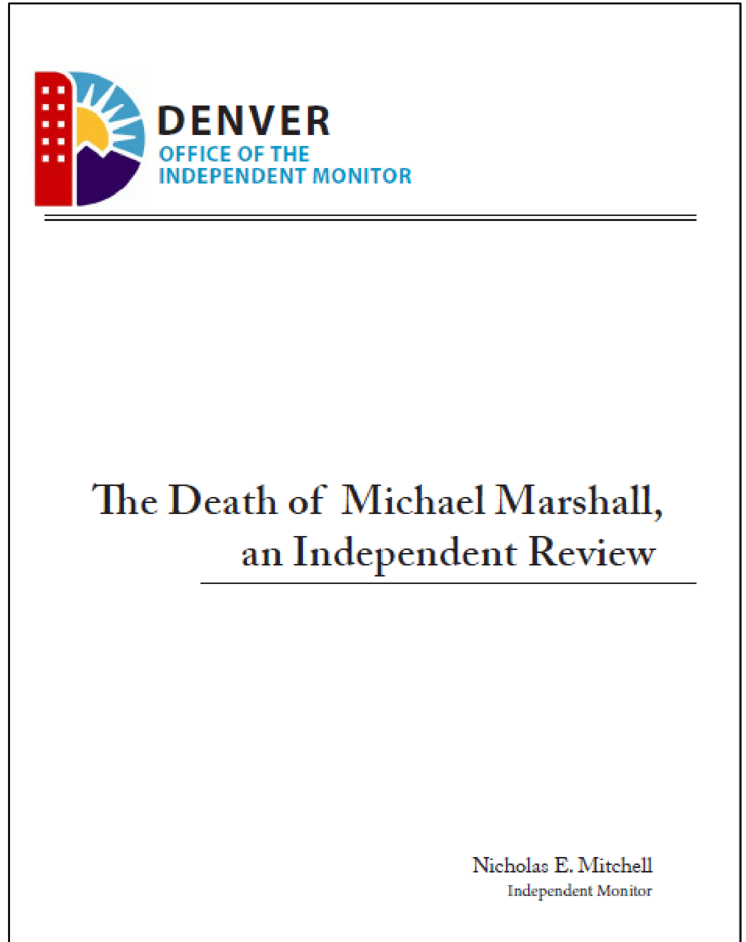
- Outreach events
  - 165 presentations or events with groups in the community
  - 87 law enforcement events
- Youth Outreach Program
  - 12 youth-officer forums held in 2017, reaching 474 youth and 30 DPD officers
  - 90 officers trained in adolescent development and de-escalation strategies

THE DEATH OF MICHAEL MARSHALL, AN INDEPENDENT REVIEW

- On November 11, 2015, DSD deputies used force on Mr. Marshall, which resulted in a medical emergency and his eventual death
- After a criminal investigation, no charges were filed
- DSD IAB conducted an internal investigation, which the OIM actively monitored
- The Department of Safety ("DOS") ultimately imposed short suspensions on:
  - Two deputies for the use of inappropriate force (10 and 16 days)
  - A captain for failing to supervise (10 days)
- The City and Mr. Marshall's family reached a settlement that included a $4.65 million payment

The Death of Michael Marshall, an Independent Review

- On March 19, 2018, the OIM released a report providing an independent review of the incident, investigation, and discipline decisions
- 73 pages, citations to factual record and national standards
- 8 recommendations for change
- The goal: to help the DSD learn from Mr. Marshall's death to prevent future incidents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The Death of Michael Marshall,
an Independent Review

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Incident Summary

- Mr. Marshall was being held at the Van Cise-Simonet Detention Center ("DDC") on a $100 bond
- He was assigned a mental health code for inmates with "major mental illness"
- He began behaving erratically and attempted to enter a jail hallway without permission
- Deputies restrained Mr. Marshall on the ground in the prone position in handcuffs and leg irons while he intermittently struggled

Incident Summary

- Mr. Marshall vomited, lost consciousness, then regained it
- Medical staff expressed concern that Mr. Marshall would aspirate, but he was restrained prone on the ground for almost five more minutes
- Deputies eventually moved Mr. Marshall to a restraint chair and he again lost consciousness, his heart stopping
- Deputies performed CPR for approximately 19 minutes
- Mr. Marshall was transported to Denver Health where he was comatose for nine days before he was extubated and died

INCIDENT SUMMARY

- The medical examiner found that Mr. Marshall died from, among other things:

> complications of positional asphyxia to include aspiration pneumonia due to physical restraint by law enforcement . . . .[1]

[1] Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 3 (Jan. 7, 2016).

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The DSD Made Several Positive Changes After the Incident

- Following Mr. Marshall’s death, the DSD:
  - Invested in department-wide Crisis Intervention Training
    - All sworn staff receive 40 hours of training
  - Reengineered its Use of Force Policy
    - Includes more restrictive use of force standard
    - Emphasizes de-escalation
  - Improved its Use of Restraints Policy
    - Guidance for spit hood use during medical emergencies

The DSD Made Several Positive Changes After the Incident

- The settlement with Mr. Marshall's family requires the DSD and the City to:
  - Make significant improvements to mental health services
    - Additional full-time mental health professionals
    - Annual in-service training related to mental illness and use of force
    - Require deputies to contact mental health professionals when issues are detected
  - Enact policies to allow family members to visit inmates who have suffered a serious injury or illness at a Denver jail

OIM Findings

- IAB is charged with investigating allegations of misconduct against DSD deputies
- According to DSD policy and national standards, investigations should:
  - Be “thorough, complete and impartial”
  - Provide sufficient information that a reviewer need not resort to “surmise, prejudice, or assumption”
  - Be conducted “in an objective manner and no effort will be made to slant any investigation for either the benefit or detriment of the subject officer(s)”

DSD IAB Mishandled its Investigation

- The OIM actively monitored IAB's investigation, was present for every interview, and made recommendations throughout
- Approximately one month after starting its investigation, IAB submitted it as completed
- At that time, IAB had not interviewed any of the deputies involved in the use of force or the nurses who responded to the medical emergency call
- The DPD had interviewed these individuals, but the interviews appropriately focused on whether there had been criminal conduct, not on potential violations of DSD policy

DSD IAB Mishandled its Investigation

- The OIM made detailed recommendations to IAB and others higher up regarding the investigation
- IAB subsequently interviewed the involved deputies, then attempted to “decline” the case for any further investigation, review, or disciplinary action
- Per DSD policy, IAB can decline cases only if it is clear that no rules or regulations were violated

DSD IAB Mishandled its Investigation

- IAB's draft decline letter asserted that the "complaint against the Denver Sheriff Department has been investigated thoroughly," and the "outcome of this investigation was made after careful consideration of all the evidence, statements, and circumstances surrounding this incident."
- It concluded that the "deputies and supervisors in this incident performed within the policies and procedures set forth by the Denver Sheriff Department. The minimum amount of force was utilized to control inmate Marshall as he appeared to be in an excited delirium state."

DSD IAB Mishandled its Investigation

- The attempted decline happened after IAB had substantial evidence of potential misconduct, including:
  – The medical examiner's conclusions about the cause of death
  – Video showing a deputy applying pressure to Mr. Marshall for an extended period of time after he had gone limp and was restrained in handcuffs and leg irons
  – The nurse's statement that a deputy refused to relieve some of the pressure on Mr. Marshall after he was asked to do so
- Had the decline been permitted, there would have been no disciplinary review

OIM RECOMMENDATION 1

The OIM recommended that the DSD make changes to the culture of its Internal Affairs Bureau to ensure that serious cases are investigated thoroughly and impartially, as DSD policy requires. This may include but not be limited to placing the management of IAB under civilian control.

The DOS Should Have Suspended the On-Scene Sergeants for Their Failure to Supervise

- Three sergeants and a captain responded to the scene and primarily watched from the corridor hallway throughout
- The DOS suspended a captain for his failure to supervise, but not the three sergeants closest to the incident
- DSD policy requires sergeants to "ensure safe and proper use of force"
- None of the sergeants took action to prevent the use of inappropriate force or even asked questions to understand why the deputies were continuing to restrain Mr. Marshall in the prone position

FINDINGS AND DISCIPLINE FOR A DEPUTY

- One of the deputies:
  - Applied "pressure to various vital, sensitive areas of inmate Marshall's body, on and off, for approximately 11 minutes after inmate Marshall was heavily restrained, in the prone position, and had already gone unconscious and vomited."
  - That he "continued to apply pressure, despite Inmate Marshall gasping for air and continuing to vomit to the extent that it came out of his nose and pooled by his mouth."
  - And he "applied pressure in the above manner despite receiving instructions from medical personnel to release pressure . . . ."
- The DOS suspended him for 16 days

THE DISCIPLINE WAS NOT COMMENSURATE WITH THE SERIOUSNESS OF THE MISCONDUCT

- The DSD Discipline Handbook requires the DOS to assign misconduct to one of six disciplinary conduct categories (A-F) based on the seriousness of the misconduct
- The penalties associated with the categories range from written reprimand (A) to dismissal (F)
- Inappropriate force can be assigned to categories D-F
- The DOS found that the deputy used inappropriate force, assigned the misconduct to a Category D, the lowest available, before imposing a 16-day suspension

The Discipline Was Not Commensurate with the Seriousness of the Misconduct

- Several factors weighed in favor of assigning Category E or F:
  - The deputy failed to comply with instructions from medical staff to release pressure from Mr. Marshall
  - The seriousness of the harm resulting from the deputy's use of inappropriate force, Mr. Marshall's death
  - The definitions of Categories E and F discuss misconduct that ***harmed*** public safety, but Category D discusses misconduct that merely created a ***serious risk*** to public safety

Definitions of Disciplinary Conduct Categories (D-F)

Conduct Category	Definition
Category F	Any violation of law, rule or policy which: ***foreseeably results in death or serious bodily injury***; or constitutes a willful and wanton disregard of department guiding principles; or involves any act which demonstrates a serious lack of the integrity, ethics or character related to a deputy sheriff's fitness to hold his or her position; or involves egregious misconduct substantially contrary to the standards of conduct reasonably expected of one whose sworn duty is to uphold the law; or involves any conduct which constitutes the failure to adhere to any condition of employment required by contract or mandated by law.
Category E	Conduct that involves the serious abuse or misuse of authority, unethical behavior, or an act that ***results in an actual serious and adverse impact on deputy sheriff, employee or public safety***, or to the professionalism of the department.
Category D	Conduct that is substantially contrary to the guiding principles of the department or that substantially interferes with its mission, operations or professional image, or that involves a demonstrable ***serious risk to deputy sheriff, employee or public safety***.

Conduct Category Applied to the Use of Inappropriate Force Against Michael Marshall

The Disciplinary Order Did Not Sufficiently Explain Why Category D Was Assigned

- The disciplinary order simply recited language taken from the definition of Category D, rather than explain why Category D was chosen
- We believe that the lack of explanation of why these suspensions were shorter than others in less serious cases may have created public confusion

OIM RECOMMENDATION 2

The OIM recommended that, when misconduct may fall into multiple disciplinary conduct categories, the DOS should, in its disciplinary order, specifically explain why a particular category was chosen.

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A Subject Deputy was Permitted to Join the DPD Prior to the Conclusion of the Investigations

- National standards recommend pre-employment investigations of all police hires with prior law enforcement experience
- Another deputy played a significant role in the use of force involving Mr. Marshall. He:
  - Used a gooseneck control hold on Mr. Marshall
  - Held Mr. Marshall down by pushing on his left shoulder
  - Controlled Mr. Marshall's head
  - Said that he "basically told the nurses that we can't put [Mr. Marshall] in a wheelchair, we need a restraint chair," which resulted in Mr. Marshall remaining on the floor in the prone position until the restraint chair arrived

A Subject Deputy was Permitted to Join the DPD Prior to the Conclusion of the Investigations

- This deputy was hired by the DPD while under criminal investigation
- The DOS permitted him to begin as a recruit officer in the Denver Police Academy three-and-a-half weeks before the District Attorney's Office announced its decision not to pursue criminal charges against him
- At that time, the DSD IAB investigation had not yet begun, and no disciplinary findings regarding his conduct have been made to this day

OIM RECOMMENDATION 3

The OIM recommended that the DOS evaluate its hiring policies and procedures for the DPD and the DSD to ensure that they do not permit potential recruits to be hired while they are under criminal or administrative investigation.

THE DSD SHOULD PROVIDE ADDITIONAL TRAINING TO DEPUTIES ON EXCITED DELIRIUM

- The U.S. Department of Justice defines excited delirium as a physical condition in which a person may exhibit "extreme agitation, bizarre and/or violent behavior, imperviousness to pain, exceptional strength and endurance, inappropriate nudity, extreme paranoia, and/or incoherent shouting"
- National standards establish that the failure to recognize symptoms of excited delirium, and engaging in a prolonged use of force can significantly increase the likelihood of sudden death
- The DSD is party to the City and County of Denver's Multi-Agency Excited Delirium Protocol

THE DSD SHOULD PROVIDE ADDITIONAL TRAINING TO DEPUTIES ON EXCITED DELIRIUM

- There was no official finding of excited delirium in this case. Yet, Mr. Marshall demonstrated indications of excited delirium during the incident. He:
  - Aggressively approached another inmate
  - Had stripped off his shirt
  - Never complied with commands to stop struggling
  - Exhibited extraordinary strength
  - Grunted and growled
- The deputies had minimal recollection of any excited delirium training and did not generally recognize the potential indications or act in accordance with the protocol

OIM RECOMMENDATION 4

The OIM recommended that the DSD provide additional, regular classroom and situation-based refresher training on identifying persons suffering from excited delirium and how to best respond to such incidents.

The DSD Should Establish a Policy for Resolving Conflicting Medical and Security Concerns

- Deputies are in charge of jail security, but medical staff are to ensure the health of those in custody
- The DOS found that:
  - Medical staff instructed a deputy to release pressure from Mr. Marshall's neck because Mr. Marshall was vomiting, and medical staff feared that he could aspirate
  - The deputy responded that "we have to restrain him, he's not being cooperative" and continued to apply pressure to Mr. Marshall in the very manner counseled against
- No supervisor attempted to resolve this conflict, and Mr. Marshall remained in the prone position

OIM Recommendation 5

The OIM recommended that the DSD develop a policy that, when time and circumstances permit, requires supervisors to attempt to resolve urgent medical and security concerns that may be in conflict, and that cannot be resolved by medical staff and deputies alone. The policy should require a supervisor to prepare a report that documents the conflict and its resolution, and to participate in a non-disciplinary debriefing after the incident.

OIM RECOMMENDATION 6

The OIM recommended that the DSD train supervisors on how to quickly resolve conflicts between urgent medical and security concerns, when time and circumstances permit, by weighing security risks against potential needs for immediate medical intervention in emergency situations.

The DOS Should Publish Written Guidelines Regarding the Release of Video

- National standards recommend that departments:
  - Release relevant evidence as soon as possible after potentially controversial incidents like deaths-in-custody
  - Publish written policies that provide guidelines for the request and release of such evidence
- Mr. Marshall's family sought to review video of the incident shortly after Mr. Marshall's death. An online news site filed a request for the records
- Both requests were initially denied, the news site filed a lawsuit, and a hunger strike was organized
- The video was eventually released after the criminal investigation ended
- The DOS does not currently have a published policy

OIM Recommendation 7

The OIM recommended that the DOS publish written guidelines regarding the release of evidence of critical incidents, including video. The guidelines should balance the need for prompt public transparency with the need for confidentiality during active investigations, among other factors. Recognizing that every critical incident is unique, the guidelines should explain, to the extent possible, the analytical framework that the DOS will use in evaluating requests for the release of evidence of critical incidents.

The DSD Should Develop a Formal Protocol for Learning from Critical Incidents

- After Mr. Marshall's death, some in the DSD appeared to minimize potential issues with the incident:
  - IAB attempted to decline the matter without a disciplinary review
  - A sergeant nominated a deputy for a Life Saving Award even though Mr. Marshall, in fact, had died
  - A former DSD trainer stated that he would like to have the video for training purposes because the use of force was "done the way we want it done"

The DSD Should Develop a Formal Protocol for Learning from Critical Incidents

- The National Institute of Justice has developed an approach to learning from systemic issues in the criminal justice system
- In 2015, the OIR Group recommended the DSD create a committee to review significant force incidents to identify supervision, policy, or training issues
- The DSD has not yet fully implemented such a system, though Chief Wilson was recently appointed to implement it
- This incident demonstrates the urgency of the DSD acting on this 2015 recommendation

OIM Recommendation 8

The OIM recommended that the DSD develop a formal protocol for, and an enhanced culture of, analyzing and learning from critical incidents in Denver's jails. This should include but not be limited to immediately prioritizing the development and full implementation of the force review protocol previously recommended by the OIR Group in 2015.

QUESTIONS?

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