Independent Monitor Releases Report Regarding the Death of Michael Marshall

Denver, Colorado – (March 19, 2018) Today, the Office of the Independent Monitor (“OIM”) released a report entitled The Death of Michael Marshall, an Independent Review. On November 11, 2015, Michael Marshall, a mentally ill man, was being held in the custody of the Denver Sheriff Department (“DSD”) on a $100 bond. When Mr. Marshall attempted to enter a jail hallway without permission, deputies used force to restrain him while he intermittently struggled on the floor. Mr. Marshall eventually lost consciousness and deputies tried to resuscitate him with CPR. He died nine days later, and his cause of death was determined to be, among other things, positional asphyxia due to restraint by law enforcement. Following the incident, an internal investigation was conducted by DSD’s Internal Affairs Bureau (“IAB”), which resulted in short suspensions being imposed on two deputies and a captain. In 2017, the City and County of Denver (“City”) settled potential civil claims related to this incident with a $4.65 million payment to Mr. Marshall’s family, and an agreement to make certain policy and training changes in the DSD.

The OIM is made up of attorneys, investigators, and criminologists who provide oversight of the DSD. OIM staff responded to this incident immediately after it happened, and monitored the IAB investigation. The report analyzes the incident, IAB investigation, and disciplinary decisions, and makes several key findings:

• The City and the DSD made commendable improvements after Mr. Marshall’s death, including re-engineering the DSD’s Use of Force and Use of Restraints Policies, and committing to providing additional mental health services for inmates.

• IAB is mandated to conduct thorough and impartial investigations. Yet it attempted to summarily close its investigation, finding no violations of policy, without interviewing the subject deputies, questioning the involved nurses, or obtaining other information necessary to completely and impartially evaluate the use of force that was one of the causes of Mr. Marshall’s death. The OIM had to intervene on multiple occasions to ensure an investigation that complied with the minimum investigative standards contained in DSD policy.

• Despite national best practices regarding background checks for law enforcement recruits, the Department of Safety (“DOS”) permitted an involved deputy to join the Denver Police Department as a police recruit while he was a subject of the criminal investigation into the use of force against Mr. Marshall, and before there had been any internal investigation into his conduct. There is no official finding regarding the allegations against him to this day.

• Finally, almost three years after outside consultants recommended that the DSD develop a formal protocol for analyzing all significant uses of force in Denver’s jails in order to learn from them and to prevent their recurrence, the DSD has to yet to fully implement such a process.

The report includes eight actionable recommendations to the DSD and DOS to address these and other findings discussed in the report. “This incident was a tragedy for Mr. Marshall, his family, and for the public,” said Independent Monitor Nicholas E. Mitchell. “As a city, we have an obligation to learn from it, and I hope that the DSD and DOS use this report to make quick and effective changes to prevent future tragedies in our jails.” The full report can be found on the OIM’s website.

###