DENVER
OFFICE OF THE
INDEPENDENT MONITOR

The Death of Michael Marshall, an Independent Review

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The Office of the Independent Monitor

The Office of the Independent Monitor ("OIM") is charged with working to ensure accountability, effectiveness, and transparency in the Denver Police and Sheriff disciplinary processes. The OIM is responsible for:

- Ensuring that the complaint and commendation processes are accessible to all community members;
- Monitoring investigations into community complaints, internal complaints, and critical incidents involving sworn personnel;
- Making recommendations on findings and discipline;
- Publicly reporting information regarding patterns of complaints, findings, and discipline;
- Making recommendations for improving Police and Sheriff policy, practices, and training;
- Conducting outreach to the Denver community and stakeholders in the disciplinary process; and
- Promoting alternative and innovative means for resolving complaints, such as mediation.

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Acronyms, Abbreviations, and Key Terms

Aspirate	To inhale foreign material into the airways
CIT	Crisis Intervention Training, a training that aims to improve law enforcement responses to people in crisis
COB	Denver Citizen Oversight Board, which consists of seven citizens who assess the effectiveness of the Office of Independent Monitor and make policy recommendations, among other responsibilities
CPR	Cardiopulmonary Resuscitation
CRO	Denver Sheriff Department Conduct Review Office, which reviews and analyzes the facts gathered by the Internal Affairs Bureau and makes disciplinary recommendations
DA	Denver District Attorney
DDC	Denver Sheriff Department Van Cise-Simonet Detention Center or Denver Detention Center (commonly referred to as the "Downtown Detention Center")
Decline	A process by which after a review of the relevant facts regarding a complaint of deputy misconduct, the Denver Sheriff Department Internal Affairs Bureau determines that further investigation and disciplinary action are not warranted, and dismisses the complaint
DHMC	Denver Health Medical Center
Disciplinary Conduct Category	Categories that determine a presumptive range of penalties for deputy misconduct based upon the nature and type of misconduct and its harm/impact on the DSD and the community
DOJ	United States Department of Justice
DOS	Denver Department of Safety, which makes final disciplinary decisions regarding Denver Sheriff Department deputies, among other responsibilities
DPD	Denver Police Department
DRMC	Denver Revised Municipal Code
DSD	Denver Sheriff Department
ED Protocol	City and County of Denver Multi-agency Excited Delirium Protocol
Extubate	To remove a tube from a hollow organ or passageway, often from the airway
IAB	Denver Sheriff Department Internal Affairs Bureau, which conducts administrative investigations into misconduct complaints
IAB Manual	Denver Sheriff Department Internal Affairs and Civil Liabilities Bureau Procedures Manual, which describes complaint investigation procedures, among other things

Inappropriate Force	Any use of force that fails to comply with the Denver Sheriff Department's Use of Force Policy
OIM	Denver Office of the Independent Monitor
OIR Group	External consultants who reviewed the Denver Sheriff Department's use of force and internal affairs operations, and issued findings and recommendations in May 2015
OPN	Orcutt Police Nunchakus, which are used by deputies as restraint devices or impact tools
Positional Asphyxia	A type of asphyxia that occurs when body position prevents adequate gas exchange, such as from upper airway obstruction or a limitation in chest wall expansion
Prone Position	The position of a body that is lying face down
Restraint Chair	Restraint chair used by the Denver Sheriff Department to help control combative, self-destructive, or potentially violent inmates
Restraints Policy	Denver Sheriff Department Use of Restraints Policy, which describes the policies and procedures guiding deputies' use of restraints
Sally Port	A secure entryway connecting rooms or corridors within a correctional facility
SER	Sentinel Event Review, which is a collaborative review of systemic failings, with the goal of understanding their causes, mitigating risk, and preventing the reoccurrence of negative outcomes
Settlement	Settlement of potential claims related to Michael Marshall's death between the City and County of Denver and his family
Specification	The precise rule or policy a deputy accused of misconduct is charged with violating
Spit Hood	Protective hood used by the Denver Sheriff Department when deputies are concerned that an inmate may spit on or bite another person
Use of Force Policy	Denver Sheriff Department policy, which describes the policies and procedures guiding deputies' use of force
X03B	Denver Sheriff Department mental health code that describes inmates with "major mental illness . . . [who] are currently exhibiting major psychiatric symptoms including psychotic symptoms of auditory and other types of hallucinations, paranoia, delusional symptoms, mania, or symptoms consistent with psychotic depressive disorders"

Introduction

On the evening of November 11, 2015, Michael Marshall was in the custody of the Denver Sheriff Department ("DSD") when he began displaying erratic behavior. Deputies isolated him in a jail sally port, and when he attempted to enter an adjacent hallway, they moved him to the floor and put him into restraints. For approximately 13 minutes, deputies used physical force on Mr. Marshall, primarily involving the application of pressure and bodyweight on his body, while he intermittently struggled on the floor. Mr. Marshall ultimately became unconscious, and paramedics transported him to Denver Health Medical Center ("DHMC"), where he was in a comatose state. Nine days later, on November 20, 2015, Mr. Marshall was taken off life support, and died.

On the night of the incident, a criminal investigation was initiated by the Denver Police Department ("DPD"), and the Denver District Attorney ("DA") ultimately declined to file criminal charges against the deputies involved in the incident. After an administrative investigation by the DSD Internal Affairs Bureau ("IAB"), the Department of Safety ("DOS") suspended two deputies for having used inappropriate force, and a captain for having failed to properly supervise the incident. On November 1, 2017, the City and County of Denver and Mr. Marshall's family announced a settlement ("Settlement") of potential claims related to this incident that included a $4.65 million cash payment to Mr. Marshall's estate, coupled with policy and training changes within the DSD.

The Office of the Independent Monitor ("OIM") provides independent oversight of the DPD and the DSD through its review of, and nonbinding recommendations about, internal investigations, disciplinary findings, and policies of those departments.[1] We begin this report with a summary of the incident and the process by which it was administratively investigated and reviewed. We then analyze the investigation, the disciplinary decisions, adjustments made in response to this incident, and other changes that we believe should be made.[2] Among our key findings:

- The DSD made several necessary policy and training changes after the incident, including reengineering its Use of Force and Use of Restraints Policies, and implementing Crisis Intervention Training ("CIT") for all deputies.
- Pursuant to the Settlement, the DSD and the City will make other improvements that include providing additional mental health services for

inmates, and implementing annual trainings for deputies on mental illness and use of force, including de-escalation.

We also make findings about significant deficiencies and concerns. Specifically:

- Although IAB is mandated to conduct thorough and impartial investigations, it mishandled its investigation into the incident by deeming it complete without interviewing the subject deputies, questioning the nurses involved in the incident, 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. While the deputies had been interviewed by the DPD as part of the criminal investigation, those interviews focused on assessing whether there had been criminal conduct, rather than on whether the deputies complied with DSD policy, which falls within IAB's jurisdiction.
- We believe the disciplinary decisions made by the DOS were flawed for two reasons: first, the DOS should have suspended the on-scene sergeants for their failure to prevent the inappropriate force against Mr. Marshall, which constituted a failure to supervise.[3] Second, the DOS did not apply the most appropriate disciplinary conduct category to the use of inappropriate force by one of the deputies, Deputy Garegnani, resulting in a short suspension not commensurate with the seriousness of his misconduct.
- Despite national best practices regarding background checks for law enforcement recruits, a deputy who participated in the use of force against Mr. Marshall was permitted to join the DPD as a police recruit while he was a subject of the criminal investigation into that use of force, and before there had been any internal investigation into the deputy's conduct.
- The DSD provides training on excited delirium, yet the deputies involved in this incident had little recollection of that training, and generally did not act in accordance with the City's protocol for handling excited delirium incidents.
- A nurse expressed concern during the incident about Mr. Marshall's ability to breathe, yet Deputy Garegnani continued to hold Mr. Marshall in the manner she cautioned against, and no supervisor took action to resolve this conflict. The DSD currently lacks a clear policy requiring that, when time and circumstances permit, supervisors attempt to resolve conflicting urgent medical and security concerns raised during an incident or providing guidance on how to do so.

- The DOS has not published guidelines for how it will determine when to release evidence of critical incidents, including video. The lack of such guidelines may have inadvertently invited public confusion, controversy, and potential litigation about the release of the video in this case.
- Finally, almost three years after outside consultants recommended that the DSD develop a protocol for learning from all significant uses of force in Denver's jails, the DSD has yet to fully implement such a process, which we believe is essential to preventing other tragedies like the death of Mr. Marshall in the future.[4]

In light of these findings, the OIM makes eight recommendations to the DSD and DOS. Regarding investigatory and disciplinary practices:

- The OIM recommends 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; and
- The OIM recommends 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.

Regarding training:

- The OIM recommends 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; and
- The OIM recommends 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.

Regarding policy:

- The OIM recommends 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;

- The OIM recommends 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 OIM recommends 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. 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; and
- Finally, the OIM recommends 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.

Why We Publish this Report

Pursuant to Denver's Revised Municipal Code ("DRMC"), the OIM is involved in the investigation and review of all critical incidents involving DSD deputies, including deaths in custody, and publishes reports that discuss the handling of those incidents.[5] Generally, these reports briefly summarize the facts, the process by which each incident was investigated, any disciplinary determinations made, and the OIM's assessments of whether or not those determinations were reasonable.[6] This report provides a much more comprehensive account of the death of Michael Marshall, and its handling by the DSD and DOS, than is customary in OIM reports.[7] We have done this for several reasons.

First, the OIM is required to address issues of concern to the Citizen Oversight Board ("COB") and the community,[8] and members of both groups have repeatedly expressed concerns about the death of Mr. Marshall, and a desire for greater transparency regarding its investigation and review.[9] On April 20, 2017, after the disciplinary decisions were made by the DOS, the OIM announced that it would provide further analysis of the matter in an upcoming report.[10] On November 7, 2017, shortly after the Settlement was presented to the Denver City Council, the COB formally requested that the OIM "prepare a written public report that provides sufficient details regarding the manner in which the death of Mr. Marshall was investigated to allow for greater public understanding of the DSD internal affairs and disciplinary processes and how they worked in the Michael Marshall case."[11] After the Settlement was approved, Councilman Paul Kashmann, the Chairman of the Denver City Council's Safety, Housing, Education & Homelessness Committee, sent a letter to the OIM regarding the incident. In that letter, dated December 15, 2017, Chairman Kashmann asked the OIM to provide insight into, among other things, whether the death was "investigated properly with full transparency," and what lessons may be "learned to prevent this from happening again?"[12]

Second, national standards establish the importance of conducting in-depth, non-disciplinary organizational evaluations to help an agency identify weaknesses that may have contributed to, or are revealed by, critical incidents.[13] When a use of force results in the death of a person in DSD custody, there is heightened need for such an evaluation. Because the DSD has yet to develop a formal process for completing such evaluations, this report attempts to capture some of the lessons that we recommend be learned from the death of Michael Marshall to help the City avoid similar tragedies in the future.

Third, best practices for law enforcement oversight agencies, like the OIM, establish that when monitors detect issues that impact the effectiveness of an agency's internal accountability mechanisms, they must report those problems to the public.[14] Indeed, when monitors "identify systemic issues impacting the integrity, fairness, and effectiveness of internal procedures to identify and deal with" alleged misconduct, they are mandated to "issue uncensored public reports" that include discussion of how those issues can be remedied.[15] We believe that several of the issues discussed in this report impacted the effectiveness of the DSD's internal procedures to identify and address the misconduct in this case. As such, we have attempted through this report to provide transparency about these matters, and suggestions for how they may be remedied.

The Incident

The facts of this case have been described extensively in other documents, and will only be summarized here.[16] Mr. Marshall—a 50-year-old black male who was 5 feet, 4 inches tall, and weighed 112 pounds—was arrested for trespassing and disturbing the peace on November 7, 2015.[17] His bond amount was set at $100, and he was being held at the Van Cise-Simonet Detention Center ("DDC") in downtown Denver.[18] He was housed in a pod for inmates who require special management, including those suffering from mental illness.[19, 20] The DSD had given Mr. Marshall a mental health code of "X03B," which the DSD defines as inmates with "major mental illness … that are currently exhibiting major psychiatric symptoms including psychotic symptoms of auditory and other types of hallucinations, paranoia, delusional symptoms, mania, or symptoms consistent with psychotic depressive disorders."[21] Mr. Marshall had been prescribed psychiatric medication, but on November 9, 2015, he began to refuse that medication.[22]

Mr. Marshall Began Behaving Erratically, and Deputies Isolated Him in a Sally Port

On November 11, 2015, Mr. Marshall was out of his cell on free time when deputies observed him acting extremely erratically; he was without a shirt, carrying a blanket and papers, and aggressively approaching another inmate.[23] At approximately 18:28:27,[24] Deputies David Arellano and Carlos Hernandez, who were working in the pod, put Mr. Marshall into a sally port by himself, and called a nurse to evaluate him.[25] Mr. Marshall dragged the blanket and papers behind him, and he bumped into a cart, knocking several items onto the floor.[26]

Deputy Arellano asked Mr. Marshall to have a seat on a bench in the sally port, and he initially complied.[27] Deputy Bret Garegnani, a corridor patrol officer, was watching Mr. Marshall pacing back and forth in the sally port from a closed circuit video feed in a jail control center.[28] Deputy Garegnani left the control center, and at approximately 18:31:19, he arrived at the sally port and the door opened.[29] Mr. Marshall had by that time again sat down on the bench.[30] Deputy Smajo Civic and Deputy Thanarat Phuvapaisalkij also approached and stood behind Deputy Garegnani, who tried to talk to Mr. Marshall to see if he was okay.[31, 32] Deputy Hernandez approached Mr. Marshall from the other side of the sally port.[33]

Mr. Marshall Attempted to Leave the Sally Port and the Deputies Initiated Physical Contact

At approximately 18:32:50, Mr. Marshall got up and walked toward Deputy Garegnani, who was standing in the sally port doorway.[34] Deputy Garegnani pointed toward the bench, and Mr. Marshall instead tried to pass by Deputy Garegnani into the hallway.[35] Deputy Garegnani placed his left hand on Mr. Marshall to prevent him from leaving,[36] then pushed Mr. Marshall against the sally port wall.[37] Mr. Marshall slid down the wall.[38] Deputy Garegnani grabbed Mr. Marshall by the upper right arm, and swung him toward the bench.[39] Deputies Hernandez, Civic, and Phuvapaisalkij assisted Deputy Garegnani, and at approximately 18:33:00, the deputies took hold of Mr. Marshall and moved him to the floor onto his stomach.[40] The deputies gave multiple verbal commands for Mr. Marshall to "stop fighting," "just relax," and "calm down," and Deputy Garegnani placed a radio call for officer assistance.[41] According to several accounts, Mr. Marshall was not saying anything, but he was occasionally growling or grunting.[42]

On the floor, Mr. Marshall was on his stomach and his head was turning from side to side, while deputies attempted to control his arms and legs.[43] Deputy Garegnani applied pressure to Mr. Marshall's lower back/buttock area with his knee, and used his hand to apply pressure to Mr. Marshall's right shoulder blade.[44] Deputy Civic used Orcutt Police Nunchakus ("OPNs"), a pain compliance device, on Mr. Marshall's left ankle.[45] They were initially ineffective, so Deputy Civic increased the pressure.[46] The OPNs broke.[47] Deputy Hernandez then provided his own OPNs to Deputy Civic, who applied that pair to Mr. Marshall's left ankle.[48] The deputies eventually handcuffed Mr. Marshall and put him in leg irons, at which time Deputy Civic removed the OPNs from Mr. Marshall's ankle.[49] Deputy Civic said that after Mr. Marshall was handcuffed and his legs were shackled, "he was pretty much under control."[50]

Between approximately 18:33:23 and 18:33:38, less than one minute after the deputies took Mr. Marshall to the ground, Deputy Sarah Bautista, and Sergeants Keri Adcock, Tracy Moore, and Michael Newtown arrived at the scene in response to the call for officer assistance.[51] Sergeants Adcock and Moore stood in or near the doorway watching the deputies restrain Mr. Marshall on the floor.[52] At approximately 18:35:27, Captain James Johnson arrived, looked briefly into the sally port a few times, and then stood near the hallway's back wall, where he remained for most of the incident.[53]

Mr. Marshall Lost Consciousness and the Deputies Called a Medical Emergency, but Mr. Marshall Remained in the Prone Position

The video shows that at approximately 18:35:30, the deputies were attempting to get Mr. Marshall up and onto his feet when he became limp and unresponsive.[54] The deputies put him back down and rolled him onto his side.[55] Deputy Garegnani performed a sternum rub and Mr. Marshall did not react.[56] Because the deputies realized that Mr. Marshall had lost consciousness and vomited, they broadcasted a medical emergency over the radio.[57]

Nurse Ashley Allison was working on the fourth floor at the time of that call, and ran to help.[58] Nurse Allison stated that when she arrived, Mr. Marshall "had vomited but … he had an airway."[59] At approximately 18:37:00, the deputies moved Mr. Marshall's limp body along the floor to the center of the sally port, and Mr. Marshall did not struggle against them.[60] Deputy Garegnani explained that "as medical staff was on the way … I pulled [Mr. Marshall] out from underneath the bench so they could have more uh, accessibility to him."[61] On video, Deputy Garegnani can be seen moving the limp body of Mr. Marshall, face-down, to the center of the sally port, where he remained face-down in the prone position for approximately nine minutes.[62]

Mr. Marshall Regained Consciousness and Resumed Struggling

At approximately 18:38:58, the video shows no movement or struggle from Mr. Marshall or the deputies.[63] At approximately 18:39:00, 3 minutes and 30 seconds after Mr. Marshall had gone limp, Deputy Hernandez removed his OPNs from his duty belt and applied them to Mr. Marshall's left ankle.[64] He did so "in order to gain compliance," he said.[65] Mr. Marshall then began struggling again.[66] Deputy Hernandez said that Mr. Marshall was exhibiting very high levels of strength, and he had "never felt anybody that strong before."[67] Other deputies agreed.[68] At that time, Mr. Marshall's legs were bound in leg irons, his hands were handcuffed behind his back, and four deputies were controlling his 112 pound body.[69] Deputy Hernandez maintained pressure on Mr. Marshall's left ankle using his OPNs until approximately 18:41:11, when Deputy Bautista took control of that ankle with her hands.[70] Deputy Hernandez then removed the OPNs from Mr. Marshall's left ankle, and applied them to Mr. Marshall's right ankle until approximately 18:43:20, when he removed the OPNs altogether and replaced them on his duty belt.[71]

Mr. Marshall Vomited and Medical Staff Expressed Concern that He Would Aspirate

Nurse Helen Ajao, who had arrived at the sally port at approximately 18:38:00, was kneeling next to Mr. Marshall when he vomited again.[72] At approximately 18:40:15, 4 minutes and 45 seconds after Mr. Marshall had gone limp, the video shows Nurse Ajao bend down near Mr. Marshall.[73] In her interview with the DPD, Nurse Ajao said she "was very concerned [Mr. Marshall] was going to aspirate," or inhale vomit into his lungs.[74]

At approximately 18:41:19, Nurse Ajao again checked on Mr. Marshall and can be seen on video saying something to Deputy Garegnani, who can be seen responding.[75] In her interview with the DPD, Nurse Ajao said, "when I wiped [the vomit] off I told the Officer that was closest to me—holding his neck and head—I said, 'You need to relax your hand on his neck.'"[76] According to Nurse Ajao, the deputy told her, "Well we have to restrain him he's not being cooperative."[77] She reiterated that she asked the deputy, "Could you please release his neck a little bit? You know, you know that he's throwing up."[78] Instead Nurse Ajao said "his response was, 'Well we have to restrain him.' . . . I felt he was kind of mad at me."[79] When asked during the investigation, Deputy Garegnani, the other deputies, and the other nurses did not recall this exchange.[80] Based on video footage, after Nurse Ajao spoke to Deputy Garegnani, he relieved the pressure on Mr. Marshall long enough to put on gloves, but immediately returned his hands to Mr. Marshall.[81]

Nurse Renee Chavez, who arrived at 18:37:54, also described Deputy Garegnani holding Mr. Marshall down by the head and neck as Mr. Marshall was vomiting.[82] She said that "the officer would just like, hold his head down, you know, so he wouldn't move and . . . I was like, okay, he's vomiting, he's lying on the floor . . . at some point, I'm sure he aspirated . . . ."[83]

After Nurse Ajao's conversation with Deputy Garegnani, she relayed her concern about potential aspiration to Monica Bisgard, the Charge Nurse.[84] According to Nurse Ajao, "I got up and went to the Charge Nurse. I told the Charge Nurse, 'Monica, you need to tell them to release him a little bit, because he's throwing up. He's going to aspirate.' And Monica said, 'I know.'"[85] Nurse Ajao said that she further told Charge Nurse Bisgard that "I'm afraid he's aspirate [sic]. He's throwing up," because "he was not only throwing up from his mouth; it was coming from his nose."[86] Charge Nurse Bisgard recalled "Nurse Ajao coming out of the Sally Port and telling me she was concerned that Mr. Marshall might aspirate because he was vomiting, and she asked if they could move his face away from the vomit."[87] Video footage corroborates that a discussion occurred at approximately 18:42:10.[88]

After speaking with Nurse Ajao in the hallway, Charge Nurse Bisgard entered the sally port.[89] Charge Nurse Bisgard instructed Nurse Allison to assess Mr. Marshall's lung sounds, and said that Mr. Marshall needed to be put into a chair.[90] According to Nurse Allison, "at that point in time I told everybody to make sure they got off his back . . . ."[91] Nurse Allison said that she heard what sounded like a bronchial spasm, or what she described as tightness or an asthma attack.[92] She then told the deputies to hold Mr. Marshall by his extremities and they all complied.[93] Deputy Garegnani heard and initially acknowledged Nurse Allison's instructions to relieve pressure from Mr. Marshall's shoulder and back area.[94] He then, however, returned his hands to those areas and continued to restrain Mr. Marshall in the manner that had been specifically advised against by the nurses.[95]

Nurse Allison said, "I told the officers hey, we need to get him up—I need ta [sic] listen to his lungs better… so, I can listen to the front."[96] According to the deputies, when they tried to release pressure from Mr. Marshall, he continued to struggle.[97] The deputies believed that they could not get Mr. Marshall off the floor by putting him into a wheelchair because they would not be able to properly restrain him.[98] A restraint chair was therefore requested.[99]

At approximately 18:45:11, Deputy Arellano brought a protective hood ("spit hood") to Deputy Garegnani, who placed it over Mr. Marshall's head with the help of another deputy.[100] Deputy Garegnani said that he put the spit hood on Mr. Marshall because Mr. Marshall had thrown up and he wanted to prevent the vomit from getting on the deputies.[101]

The Deputies Put Mr. Marshall into a Restraint Chair, and He Again Became Unconscious

At approximately 18:45:48, a restraint chair arrived at the doorway of the sally port.[102] The deputies restrained Mr. Marshall on the sally port floor until approximately 18:46:11, 10 minutes and 41 seconds after he had first gone limp, when they picked him up to put him into the restraint chair.[103, 104] As the deputies strapped Mr. Marshall into the chair, video footage shows that his head lolled forward as if he was again possibly unconscious.[105] At approximately 18:49:10, Nurse Allison began to check on him.[106] She listened to his heart and heard two and a half heartbeats.[107] Then she heard his heart stop.[108]

At 18:50:52, Nurse Allison took the spit hood off of Mr. Marshall, and Nurse Ajao placed ammonia under his nose to attempt to revive him.[109] Nurse Allison checked Mr. Marshall's pupils for dilation, and she gave the order to remove Mr. Marshall from the restraint chair and start cardiopulmonary resuscitation ("CPR").[110] At approximately 18:51:12, the deputies began to unstrap Mr. Marshall from the

restraint chair, approximately 4 minutes and 30 seconds after his head had lolled forward in the restraint chair.[111] Deputy Garegnani and Deputy Hernandez performed chest compressions for approximately 16 and 3 minutes, respectively, and Mr. Marshall was periodically turned onto his side throughout CPR because he continued to vomit.[112] Paramedics then arrived on scene and transported Mr. Marshall to DHMC.[113]

Mr. Marshall's Death, and its Causes

Mr. Marshall was in a comatose state for nine days.[114] He was extubated on November 20, 2015, and he died shortly thereafter.[115] On November 21, 2015, an autopsy was performed by Dr. Meredith Frank, an Assistant Medical Examiner with the Office of the Medical Examiner for the City and County of Denver.[116] According to Dr. Frank, Mr. Marshall "died as a result of complications of positional asphyxia to include aspiration pneumonia due to physical restraint by law enforcement due to agitation during acute psychotic episode."[117] Positional asphyxia occurs when a person is positioned in a way that restricts or cuts off their air supply.[118] Dr. Frank also noted that "hypertensive and atherosclerotic cardiovascular disease and chronic obstructive pulmonary disease/emphysema contributed to his death."[119]

In her report, Dr. Frank noted that Mr. Marshall "vomited during a state of agitation and while being restrained in a prone position. During the episode he suffered cardiopulmonary arrest, and he subsequently developed pneumonia with bacteremia suggestive of aspiration."[120] Dr. Frank also stated that "[d]uring restraint he was witnessed to vomit after which bronchospasm/rales were noted."[121] Mr. Marshall "subsequently became unresponsive and suffered cardiopulmonary arrest," and there was "emesis [vomit] in [Mr. Marshall's] airway during resuscitation attempt."[122] The report stated that because Mr. Marshall "collapsed unresponsive and suffered cardiopulmonary arrest during an event which involved the actions of another individual(s), the manner of death is homicide."[123]

After the release of the autopsy report, a senior member of the DA's Office interviewed Dr. Frank "in order to gain a complete understanding of the Autopsy Report and medical opinions about issues in this case."[124] The DA summarized the interview in his letter reviewing Mr. Marshall's death.[125] According to the DA, Dr. Frank would have testified in court that it was probable, but not certain, that aspiration contributed to Mr. Marshall's collapse.[126] She would have testified that she would not have expected Mr. Marshall to have difficulty breathing simply because he was held in a prone restraint position by deputies, and that it was a reasonable possibility that Mr. Marshall's heart was not functioning properly prior

to any physical contact with the deputies.[127] She could not have testified with any degree of certainty when Mr. Marshall's heart began to malfunction.[128] She also could not testify with certainty what triggered Mr. Marshall's heart failure during the incident.[129] It was her opinion that it is likely that Mr. Marshall's physical exertion against the deputies coupled with his weakened heart and lung health were major factors in causing his heart to fail during the incident.[130]

Supervisor Actions During the Use of Force

Three sergeants and one captain responded to the scene and primarily watched from the corridor hallway throughout the incident. Sergeants Adcock, Moore, and Newtown, and Captain Johnson all arrived before approximately 18:35:30, when Mr. Marshall fell unconscious the first time.[131] According to multiple deputies, none of the supervisors ever gave them any specific direction or instructions regarding the use of force.[132]

Sergeant Adcock arrived at approximately 18:33:23 and she stood in the hallway corridor and watched the incident unfold.[133] On the video, she did not appear to ask the deputies any questions about Mr. Marshall's condition, or the force being used on him.[134] Indeed, during her IAB interview, Sergeant Adcock said she was unaware that Mr. Marshall had vomited during the use of force.[135] Sergeant Adcock said that she never gave any instructions for the deputies to stop using force on Mr. Marshall.[136]

Sergeant Adcock explained in her interview that supervisors should make sure that deputies are not "stepping over medical lines when they're not medical," and regarding this incident, she said "I don't think anybody did."[137] Sergeant Adcock was specifically asked whether she remembered Nurse Ajao expressing any concerns about Mr. Marshall's wellbeing, and she said no.[138] Sergeant Adcock was asked whether it would have been appropriate for the deputies to put a spit hood on an inmate who had thrown up, and she said no.[139] She said that a spit hood would not have been appropriate in that situation because an inmate could swallow or choke on his or her own vomit.[140]

Sergeant Moore stated that after Mr. Marshall began to vomit, Sergeant Adcock called a medical emergency.[141] Sergeant Moore said that, at that time, she did not give deputies any direction because it looked like everyone was doing what they were supposed to do.[142] Sergeant Moore never heard the nurses say "a word about anything like [aspirating]."[143] She also said that she did not hear any of the nurses give any direction about taking any pressure off of Mr. Marshall's back.[144] The first time that Mr. Marshall went limp, Sergeant Moore believed that he was passively

resisting, not unconscious.[145] When asked about the moment the deputies picked Mr. Marshall up to put him in the restraint chair, Sergeant Moore again said that Mr. Marshall was passively resisting.[146] At that time, Mr. Marshall's face was obscured by a spit hood.[147] Although Sergeant Moore was aware that Mr. Marshall had vomited, she said the spit hood was appropriate.[148]

Sergeant Newtown said that the deputies had everything under control during the incident, and noted that "if I'm on tape, you're going to see me kind of back away and wait for everything."[149] He stated that he "wasn't totally in earshot," so he did not hear whether the nurses raised concerns about Mr. Marshall aspirating.[150] Sergeant Newtown said he "didn't see anything unusual, so it just seemed like a very routine, as much as use of force is routine . . . ."[151] Sergeant Newtown stated that putting a spit hood on Mr. Marshall was appropriate even though he had vomited, because "the last thing [deputies] want" is for an inmate who is vomiting to "clear his mouth even unintentionally and to get it on us."[152]

Throughout the incident, Captain Johnson positioned himself near the hallway wall opposite the incident.[153] He approached the entrance to the sally port three times during the incident, but never entered.[154] Sergeants Adcock and Moore stood near the door to the sally port and interacted with the deputies and nurses during the use of force.[155] Sergeant Newtown looked into the sally port when he first arrived, but then stood away from the incident, only getting involved again when the restraint chair arrived.[156]

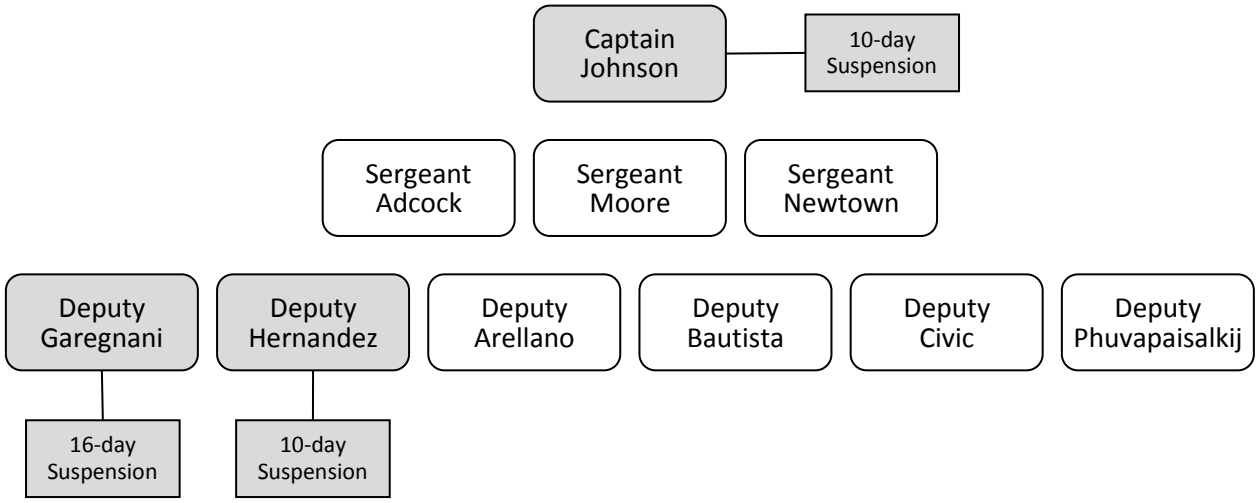
Procedural History

OIM staff were promptly informed about this use of force, and immediately responded to DSD IAB, then to DPD headquarters, to review available evidence and monitor interviews. The DPD and DA's Office initiated a criminal investigation that night, and approximately two months later, on January 21, 2016, the DA's Office announced that it would not pursue criminal charges against any of the involved deputies.[157] After the DA's Office announced its decision, the case was forwarded to DSD IAB, which is tasked with conducting administrative investigations to determine whether deputies complied with DSD Policy.[158] The OIM actively monitored IAB's handling of the matter, was present for every interview, and made recommendations throughout that were intended to ensure the completeness of the investigation.[159]

The DSD IAB investigation became active on January 27, 2016, and on August 4, 2016, the case was sent to the DSD Conduct Review Office ("CRO") for review of whether the deputies adhered to policy.[160] The CRO prepared its analyses and recommendations, and the OIM subsequently made its own disciplinary recommendations to the CRO.[161] Between February 13 and 15, 2017, there were meetings between OIM, CRO, DOS, and DSD representatives to discuss potential findings for the involved deputies and supervisors. Between March 21, 2017 and April 4, 2017, contemplation of discipline meetings were held for the sworn staff members who were charged with specifications of alleged misconduct in the case.[162]

On April 19, 2017, the DOS released its disciplinary orders, suspending two deputies and the captain for their conduct during the incident. Deputy Garegnani was suspended for 16 days and ordered to take remedial use-of-force training.[163] He was found to have used inappropriate force by applying pressure to vital, sensitive areas on Mr. Marshall for approximately 11 minutes after Mr. Marshall had gone unconscious and vomited while in the prone position, despite receiving instructions from medical personnel to release pressure from Mr. Marshall's back, shoulder, and neck areas.[164] Deputy Hernandez was suspended for 10 days for failing to use the least amount of force to achieve a legitimate detention function, and using unnecessary force when he applied OPNs to Mr. Marshall's ankle after Mr. Marshall was restrained.[165] Deputy Hernandez was also ordered to take remedial use-of-force training.[166] Captain Johnson was suspended for 10 days for neglecting his supervisory duties.[167] The DOS found that Captain Johnson demonstrated a "lackadaisical approach" and "passive management of the situation," and stood at a distance, at the far wall through the majority of the incident.[168] No discipline was imposed against any of the other supervisors or deputies.

Figure 1: Sworn DSD Personnel Primarily Involved in the Incident and Discipline Imposed by the DOS[169]



OIM Analysis

The OIM is required to address policy issues in the DSD and to issue public reports that, among other things, make "recommendations regarding the sufficiency of investigations and the appropriateness of disciplinary actions, if any, and changes to policies, rules, and training."[170, 171] To fulfill these mandates, in this section, we first comment on policy changes already made in response to this incident. We then analyze the internal investigation into the death of Mr. Marshall and the disciplinary decisions made by the DOS. We end by addressing several additional policy and training changes that we recommend be implemented. We note that these sections represent the OIM's analysis and conclusions. Others may analyze the facts differently or draw different conclusions from them, and reviewers should examine the evidence for themselves to make their own determinations.

The DSD Made Several Positive Changes After the Death of Michael Marshall

The DSD Proactively Invested in Department-Wide Crisis Intervention Training

The death of Mr. Marshall prompted the DSD to provide additional training to deputies on techniques and approaches for managing inmates suffering from mental illness. In July 2016, the DSD said it would spend over $1 million to send each of its nearly 700 deputies through a 40-hour CIT program.[172] CIT is a training model that aims to improve law enforcement responses to people in crisis.[173] CIT programs generally provide 40 hours of intensive instruction that includes verbal de-escalation skills and scenario-based trainings, with the goal of giving participants additional tools to do their jobs safely and effectively.[174] According to the DSD, 100% of its staff hired prior to 2016 are CIT-trained,[175] and DSD policy now requires all new uniformed staff to complete CIT training within the first year of their employment.[176] The OIM attended portions of the DSD's CIT training, found it to be extremely valuable, and we have personally observed a number of DSD staff members demonstrate excellent de-escalation and crisis intervention skills. We commend the DSD for this investment in training, which we expect will enhance deputy and inmate safety in the future.

The DSD Reengineered its Use of Force Policy

In June 2016, the DSD publicly announced a revised draft Use of Force Policy that significantly changed the standards for when force may or may not be used by DSD deputies.[177] The new policy contains significant improvements, including the adoption of a "reasonable and necessary" use of force standard that is more

restrictive than the one provided by state and federal law.[178] It also requires deputies to attempt to de-escalate potential confrontations through voluntary compliance, when time and circumstances permit,[179] and revises the system for reporting use of force incidents.[180] All sworn staff have been given a 10-hour training on the new standards.[181]

In addition, the new Use of Force Policy aligns with the U.S. Department of Justice ("DOJ") guidelines suggesting that departments establish protocols intended to minimize the risks of positional asphyxia.[182] Notably, the new policy advises deputies that after an inmate has been restrained and has stopped resisting, they should be turned onto their side or allowed to sit up as soon as possible.[183] The policy also specifies that although an individual may be able to speak, they may still be having trouble breathing.[184] Thus, if an inmate states they are having trouble breathing, deputies must treat them as if they are, in fact, having trouble breathing, and seek immediate medical assistance once the inmate is restrained.[185] While the policy did not go into effect until October 2017, we commend the DSD for its adoption.[186]

The DSD Improved its Use of Restraints Policy

The DSD's Use of Restraints Policy ("Restraints Policy") provides guidance on when and how deputies should use restraints on inmates.[187] At the time of the incident involving Mr. Marshall, the Restraints Policy did not articulate when spit hoods were permitted or prohibited and, instead, stated generally that "restraints will be applied and maintained in a safe, secure, humane and least restrictive manner."[188] In fact, the Restraints Policy made no specific mention of spit hoods at all.[189]

After Mr. Marshall's death, the DSD adopted a new Restraints Policy that now establishes that, "a protective hood may be used on any inmate who spits on or bites another person, attempts to spit on or attempts to bite another person, or who has a history of spitting or biting during escort or transport."[190] It also includes new instructions in case of a medical emergency, during which:

> staff shall ensure that the hood is removed immediately . . . . If an inmate vomits while wearing a protective hood, the protective hood shall be immediately removed and discarded and medical attention sought immediately. A protective hood shall also be immediately removed when a medical issue such as bleeding from the mouth or respiratory distress is observed, and medical treatment shall immediately be sought. Inmates that have been placed in a

> protective hood should be continually monitored and shall not be left unattended until the protective hood is removed. The on-duty supervisor must approve the use of the protective hood.[191]

We believe this change to be consistent with national standards,[192] and commend the DSD on these aspects of its new Restraints Policy.

The Settlement with Mr. Marshall's Family Requires the DSD and the City to Make Significant Improvements in Mental Health Services

In the Settlement between the Estate of Mr. Marshall and the City and County of Denver, the City made numerous non-monetary commitments to better address the needs of inmates suffering from mental health issues.[193] Specifically, the City will fund one additional full-time mental health professional to provide mental health services 24 hours a day, 7 days a week in each of the two jails.[194] The DSD will also require all deputies to go through annual in-service trainings related to mental illness, use of force, and de-escalation.[195] The DSD will also revise its mental health policies to require deputies to contact medical and mental health professionals as soon as possible when mental health issues are detected.[196] Additionally, the DSD will develop a protocol for communication between DSD staff and medical providers regarding inmates having mental health issues.[197] Finally, the DSD will enact policies to allow immediate family members to visit an inmate who has suffered a serious injury or illness at a Denver jail.[198] We commend Mr. Marshall's family, the City, and the DSD, for agreeing to these changes, which we hope will enhance the DSD's ability to address mental health issues, and prevent similar tragedies in the future.

The IAB Investigation and Disciplinary Decisions Were Flawed

Notwithstanding the positive changes discussed above, the OIM has serious concerns about IAB's investigation of the case, the disciplinary decisions made by the DOS, and additional areas of DSD policy or training that we recommend be revised.

The Internal Affairs Bureau Mishandled its Investigation into this Incident

> One of the most important issues that a disciplinary system for any law enforcement agency must address is the use of force. Due to the myriad consequences that can flow from such an incident, no issue is likely to impact the public's relationship with, and respect for, the Department more than the inappropriate use of force. Consequently, all law enforcement agencies must be vigilant in ensuring that . . . allegations of inappropriate force are thoroughly and objectively investigated; and that, when the evidence points to a use of inappropriate force, disciplinary penalties commensurate with the seriousness of the misconduct are imposed.
>
> *Denver Sheriff Department Discipline Handbook: Conduct Principles and Disciplinary Guidelines* (effective Nov. 12, 2013).[199]

IAB is charged with investigating allegations of misconduct against DSD deputies.[200] Under DSD policy, every IAB investigation must be "thorough, complete and impartial," and both IAB procedures and national best practices establish minimum standards for investigative thoroughness and impartiality.[201] To be considered thorough, investigations must reveal all relevant facts necessary for the resolution of the allegations.[202] They must provide sufficient information that a reviewer need not resort to "surmise, prejudice, or assumption."[203] Further, IAB investigations shall 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)."[204] They should not "favor any particular interest, affect any particular outcome, or shield any relevant facts from disclosure."[205]

After the conclusion of the DA's criminal investigation, on January 27, 2016, IAB began its investigation that was mandated to find the facts necessary to determine whether or not any deputies violated policy during the incident.[206] IAB received the DPD's investigative file, and between February 2 and February 18, 2016,

interviewed 13 witness deputies and security specialists.[207, 208] From February 18 to February 22, 2016, IAB interviewed Sergeants Adcock, Newtown, Moore, and Captain Johnson.[209, 210] All of these interviews were monitored in real time by the OIM.

On February 25, 2016, IAB submitted the case to the OIM as a completed investigation.[211] At that time, IAB had not interviewed any of the deputies involved in the use of force, Deputy Arellano (who was present but did not use force), or the nurses who responded to the medical emergency call.[212] These people had been interviewed by the DPD during its criminal investigation, but those interviews appropriately focused on whether there had been criminal conduct during the incident, not on determining whether or not DSD policy had been followed, which falls under IAB's jurisdiction.[213] Thus, the deputies had not been asked questions sufficient to determine whether they handled Mr. Marshall's mental illness appropriately under DSD policy, whether they reacted properly to Mr. Marshall's medical emergency, or whether they held Mr. Marshall in a prone position for an unreasonably long period under DSD policy. They had not been asked to address whether continuing to use force on Mr. Marshall after he had lost consciousness and vomited was consistent with DSD policy. Nor did the DPD interviews of the deputies focus on whether the supervisors took any action during the incident to prevent inappropriate force, as DSD policy requires.

Additionally, critical evidence for the administrative investigation was either not used during the DPD interviews or only subsequently became available to DSD IAB. To thoroughly investigate whether or not DSD policy had been followed, IAB should have asked the deputies and nurses about this evidence before deeming the investigation complete. For example, video footage was not used during the nurses' DPD interviews, thus they were not asked to explain their actions, or the actions of the deputies, as they appeared on video.[214] In addition, the autopsy report had not been completed at the time of the DPD interviews, thus neither the nurses nor subject deputies had been asked questions about the medical examiner's finding that the death was a homicide that resulted, in part, from "complications of positional asphyxia … due to physical restraint by law enforcement."[215] Thus, when IAB submitted this investigation as complete, it had failed to gather "all relevant facts necessary" for the resolution of the allegations.[216]

On March 4, 2016, the OIM made detailed written recommendations to IAB regarding its investigation.[217] Thereafter, from March 24 to April 4, 2016, IAB interviewed Deputies Garegnani, Civic, Hernandez, Phuvapaisalkij, Bautista, and Arellano, in interviews that were monitored by the OIM.[218] IAB also contacted

legal counsel for the nurses to schedule interviews with the nursing staff.[219] On May 6, 2016, Mr. Marshall's estate served a Notice of Claim expressing intent to file suit against the City and County of Denver and other defendants.[220] In light of the threatened litigation, on May 23, 2016, legal counsel for the nurses informed IAB that the nurses would no longer consent to be interviewed.[221, 222]

IAB's Attempt to Decline the Case

On June 1, 2016, IAB attempted to decline the case for any further investigation, review, or disciplinary action.[223, 224] IAB provided a decline letter to the OIM, which asserted IAB's conclusions about the case.[225] According to the letter, "DSD IAB has reviewed the complaint and after careful consideration of the facts, this case is declined for further action."[226] The letter stated 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."[227] 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."[228] By this decline letter, IAB attempted to summarily close the case with neither discipline imposed nor even any review by the disciplinary decision-makers in the DSD or DOS.

Under DSD policy, IAB may decline a case when "after careful review . . . [IAB and the OIM] agree that the incident has not violated any rules and regulations."[229] On June 17, 2016, the OIM again made detailed written recommendations to IAB regarding the investigation. Thereafter, IAB again reached out to counsel for the nurses, and on July 27, 2016, IAB informed the OIM that the nurses had responded to additional questions that had been posed.[230, 231] That same day, on July 27, 2016, IAB again sent the case to the OIM as completed, with the June 1, 2016 proposed decline letter still included with the case.[232] The OIM believed, at that time, that the investigation was sufficient to allow the CRO to review it in order to make disciplinary determinations. On August 4, 2016, the OIM made additional written recommendations to IAB.[233] Subsequently, IAB sent the case to the CRO for disciplinary review.[234]

IAB's Attempt to Close the Case Was Improper for Several Reasons

IAB's attempt to close its incomplete investigation on various dates conflicted with DSD policy and national standards for investigative thoroughness and impartiality.[235] This is troubling for at least two reasons. First, at the time IAB initially declared the investigation to be complete, on February 25, 2016, crucial evidence had not yet been gathered.[236] This included asking the deputies to explain, in detail, the pressure they put on Mr. Marshall's head, neck, and back, whether they were concerned about potential positional asphyxia, and whether they believed Mr. Marshall was suffering from excited delirium.[237] The deputies also had not been asked about the direction, if any, provided by on-scene supervisors.[238] It was concerning that IAB declared its investigation complete without this key evidence.[239]

Yet, even more troubling is that by the time IAB attempted to summarily close the case as a decline, it *had* substantial evidence of potential misconduct that clearly necessitated a review for potential discipline by the CRO.[240] IAB was aware of the medical examiner's conclusion that Mr. Marshall had died of, among other things, complications from positional asphyxia due to physical restraint in a prone position.[241] IAB had the video showing Deputy Garegnani applying pressure to Mr. Marshall's body for an extended period of time after he had already gone limp and vomited while being restrained in handcuffs, leg irons, and by body weight.[242] IAB also knew about Nurse Ajao's statement that she asked Deputy Garegnani to relieve some of the pressure and that he refused, as well as evidence that Captain Johnson and other supervisors failed to intervene to prevent the use of inappropriate force.[243, 244] IAB attempted to decline the case despite this obviously concerning evidence.

In 2014, the City and County of Denver hired two outside consulting firms to perform a "top to bottom" review of the DSD.[245] One of those firms, the OIR Group, was specifically retained to analyze IAB and make recommendations for improvement.[246] In its final report, the OIR Group stressed the importance of comprehensive IAB investigations, calling them "a key function of any law enforcement agency. Credibility inside the agency – and with the public – depends on it."[247] The importance of that work was further emphasized by the OIR Group:

> It is essential that a law enforcement agency critically review and evaluate each force incident in order to determine whether the use of force complies with Departmental expectations as set out by policy and reinforced in training . . . . This requires a commitment to comprehensive fact-gathering and dispassionate review.[248]

The OIR Group found, at that time, "significant shortcomings in the way the Sheriff Department investigates and reviews most force incidents," and the City has since been involved in a comprehensive reform effort.[249] As part of that reform, on October 20, 2017, the DSD adopted a much-improved revision of its Internal Affairs and Civil Liabilities Procedures ("IAB Manual"). We commend the DSD for making this important change.

Yet, to be effective, we believe that the new IAB Manual should be accompanied by changes to IAB's internal culture and its management structure.[250] The attempts by IAB to cut short its investigation into Mr. Marshall's death—the only death in custody following a use of force during the prior five years—raised troubling questions about IAB's willingness to conduct a thorough and impartial investigation of this serious case, as DSD policy required.[251] Therefore:

OIM Recommendation 1: The OIM recommends 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.

IAB Performance Excelled Under Civilian Management

In September 2014, following a series of written analyses of systemic problems within the DSD, a civilian was appointed Interim Director of IAB.[252] That Interim Director, Grayson Robinson, made significant enhancements to IAB that resulted in improvements to the quality and timeliness of IAB's investigations.[253] The OIM noted the improvements to IAB's performance in its 2014 Annual Report.[254] The changes were also noted by the OIR Group, and include:

- A greatly reduced backlog of IAB investigations;[255]
- The hiring of civilian senior investigators with extensive law enforcement investigatory experience;[256] and
- The standardization of investigative case books and other quality control measures for investigations.[257]

The OIR Group also noted the benefit of hiring IAB staff from outside of the DSD's sworn staff to help insulate them from internal pressures.[258] Mr. Robinson resigned from the DSD in 2015, at which time IAB was placed back under sworn management, although a number of talented civilian investigators remained. In light of the positive results of civilian management in 2014, and given the serious issues identified in this report, the DSD should consider making a structural change to permanently place IAB under civilian control.

The Disciplinary Decisions in this Case Were Flawed in Several Ways

The OIM was concerned by the disciplinary decisions in this case for several reasons.

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

The DOS suspended one supervisor, Captain Johnson, for his Failure to Supervise, but did not discipline the three sergeants who were closest to the incident and who also failed to sufficiently supervise to prevent the use of inappropriate force against Mr. Marshall.[259, 260] In the disciplinary order issued to Captain Johnson, the DOS emphasized the particular supervisory duties that he failed to properly discharge.[261] For example, Captain Johnson was "responsible for, among other things, ensuring the safety and security of the inmates in the DDC, and being alerted to and addressing current or potential issues affecting the same. Captain Johnson was also responsible for responding to and managing critical incidents, including overseeing and ensuring proper actions by subordinate sergeants and deputies."[262] Further, Captain Johnson "failed to effectively act as a supervisor to actively manage the critical incident, including making informed, sound decisions and providing guidance and direction to responding staff."[263]

While these findings were made about Captain Johnson alone, many of them also applied to Sergeants Adcock, Moore, and Newtown. Under DSD policy, sergeants must, "fulfill all obligations, duties and responsibilities of their rank."[264] The obligations, duties, and responsibilities of sergeants include "ensur[ing] safe and proper use of force, restraints, and response to alarms."[265] Of particular relevance to this case, it is the responsibility of all DSD supervisors, including sergeants, to ensure that deputies adhere to the DSD's Use of Force Policy, which prohibits the use of inappropriate force.[266] The presence of the captain on scene did not absolve the sergeants of these duties.[267]

Mr. Marshall was on the ground in the prone position for over 10 minutes after his medical emergency, and none of the sergeants took any action to prevent the use of inappropriate force against him.[268] Further, nothing in the sergeants' or deputies' interviews suggests that the sergeants even asked the questions necessary to understand why the deputies were restraining him in that position, or whether it was safe to continue to do so.[269]

The DOS emphasized Captain Johnson's lack of communication with the deputies, finding, for example, that "had Captain Johnson sufficiently interacted with the deputies in a more active way, including asking question [sic] of them, or better

observed the scene, he would have known that inmate Marshall had vomited and gone unconscious prior to his arrival."[270] Yet, the deputies were unanimous that they also did not receive any guidance from the sergeants about how best to restrain Mr. Marshall after his medical emergency.[271] Indeed, Deputy Garegnani stated that none of the supervisors, including the sergeants, gave him any guidance whatsoever about the use of force on Mr. Marshall.[272] According to Deputy Garegnani, no supervisor asked why Mr. Marshall was continuing to struggle, exhibiting very high levels of strength, or any questions related to Mr. Marshall's possible medical or mental health conditions.[273] Had any of the supervisors asked these questions, they could have determined that Mr. Marshall should be taken out of the prone position as soon as possible. Instead, the deputies continued to use force for approximately 10 minutes and 41 seconds after Mr. Marshall first went limp, while all of the supervisors, including the sergeants, largely stood in the hallway, failing to take action.[274]

Further, the DOS's decision not to discipline the sergeants for their failure to supervise may have compromised the disciplinary case against Captain Johnson, who appealed his suspension to a Career Service Board Hearing Officer—and won.[275] In a November 6, 2017 order, the Hearing Officer overturned Captain Johnson's suspension and implied that the decision was based, in part, on this inconsistency.[276] While we strongly disagree with the Hearing Officer's decision to overturn Captain Johnson's suspension, we believe that it was inconsistent for the DOS to suspend only Captain Johnson for his failure to supervise, but not the sergeants who also failed to supervise during the incident.

The Role of DSD Sergeants Remains a Critical Concern

In 2014, the OIM was asked by a member of Denver's City Council to provide input and findings into the possible causes of certain high-profile incidents of DSD deputy misconduct.[277] In a 15-page letter sent in response, the OIM shared eight findings that included a need to address deficiencies in the DSD use of force database, the deputy rounds tracker system, and the early intervention system, among others.[278] The OIM's first finding concerned the need to address the role of sergeants in the DSD.[279] The OIM noted that effective supervision by sergeants is necessary "to deter deputy misconduct," in that sergeants are uniquely positioned to identify deputies who may be engaging in problematic behavior and take corrective action.[280] However, numerous jail personnel indicated that sergeants were often absent from housing pods or otherwise disengaged from actively supervising the deputies under their command.[281] The OIM made four specific recommendations for how the DSD should address these supervisory gaps.[282]

The DSD has since made a number of strides in this area, including updating its staffing model and forming a Staffing and Performance Optimization Committee that meets quarterly.[283] Yet we believe that this case, in which the sergeants did not act to prevent the use of inappropriate force and were not held accountable for it, reflects that this issue requires continuing attention from DSD and DOS leadership as they seek to reform the DSD.

The Discipline Imposed on Deputy Garegnani Was Not Commensurate with the Seriousness of His Misconduct[284]

The DOS found that Deputy Garegnani used inappropriate force and suspended him for 16 days, which is near the bottom of the range of possible penalties for inappropriate force.[285] We believe that this discipline was not commensurate with the seriousness of Deputy Garegnani's misconduct, and the disciplinary order did not sufficiently explain how the DOS arrived at that penalty.

According to the Discipline Handbook, to determine a disciplinary penalty, the DOS must assign the misconduct to one of six disciplinary conduct categories.[286] These categories, A–F, range "from the least serious to most serious."[287] By rule, some types of misconduct may only be assigned to a single category, while other types can be assigned to multiple categories.[288] When misconduct can be assigned to multiple categories, to determine the best fit, the DOS must review their definitions and other factors, including the deputy's motivation for the misconduct, as well as its "harm/impact on the Department and community."[289] The penalties associated with the categories range from the least serious (Category A–reprimand) to most serious (Category F–dismissal). Thus, the DOS's determination of conduct category plays a critical role in establishing the penalty for an act of misconduct.[290]

Inappropriate force can be assigned to three categories: D, E, and F, which carry presumptive penalties of 10-day suspension, 30-day suspension, and dismissal, respectively.[291] There is no default category for inappropriate force violations. Instead, the Discipline Handbook makes clear that "[a]ny reviewer must look to all the facts and circumstances of the particular use of inappropriate force to determine which conduct category (D, E or F) is most appropriate."[292] In this case, the DOS assigned Deputy Garegnani's inappropriate force to Disciplinary Conduct Category D, the lowest available, and aggravated the penalty to a 16-day suspension.[293] The disciplinary order did not explain why Category D was assigned, nor why Categories E and F were not assigned.[294] Instead, the disciplinary order simply concluded that Deputy Garegnani's conduct was "substantially contrary to the guiding principles of the department or . . . substantially interfere[d] with its mission, operations, or professional image, or . . . involve[d] a demonstrable serious risk to Deputy Sheriff, employee, or public safety."[295] Yet, this was merely a recitation of language taken from the definition of Category D, rather than an explanation of why that category was chosen.[296]

Discipline Categories E or F Were More Appropriate for Deputy Garegnani's Misconduct

The Discipline Handbook establishes that inappropriate force is among the most serious kinds of misconduct that DSD deputies can engage in.[297] "Because of the

trust placed in them and the enormity of the discretion and authority granted to them, deputy sheriffs must understand that the community has every right to expect and demand the highest level of accountability from the Department and from individual deputies."[298] Indeed, the Discipline Handbook mandates that "when the evidence points to a use of inappropriate force, disciplinary penalties commensurate with the seriousness of the misconduct [will be] imposed."[299]

Based on our analysis, several factors weighed in favor of assigning Category E or F to Deputy Garegnani's misconduct. First, one of the essential values of the DSD, and one of the most important duties of deputy sheriffs, is safeguarding the wellbeing of the inmates in the DSD's custody.[300] Deputies "hold a 'position of trust' . . . [and] are given enormous discretion in carrying out their duties—discretion which also carries tremendous responsibility. Deputy Sheriffs are given the responsibility to provide for the care of persons held in the custody of the City and County of Denver . . . ."[301] Notwithstanding these duties, Deputy Garegnani did not heed signs that Mr. Marshall was in danger during the use of force. Mr. Marshall went unconscious and began vomiting, clear signs of medical distress.[302] Medical staff were properly notified and instructed Deputy Garegnani to relieve pressure during the continuing restraint—yet Deputy Garegnani failed to comply.[303] Indeed, although Deputy Garegnani did not recall these instructions when interviewed after the incident,[304] the DOS found that he 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 . . . . Deputy Garegnani 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 . . . . Furthermore, Deputy Garegnani applied pressure in the above manner despite receiving instructions from medical personnel to release pressure . . . .[305]

In fact, the DOS found that when Nurse Ajao asked Deputy Garegnani to release pressure on Mr. Marshall's neck, Deputy Garegnani "failed to do so."[306] Additionally, "Deputy Garegnani heard and initially acknowledged Nurse Allison's instructions to relieve pressure from inmate Marshall's shoulder and back area; however the evidence shows that Deputy Garegnani returned his hands to those areas and continued to restrain inmate Marshall in the manner that had specifically been advised against by medical personnel."[307]

Deputies are sometimes called upon to make split-second decisions to use force in fast-moving situations.[308] In such circumstances, policy generally counsels against second-guessing decisions that may have appeared reasonable in the moment they were made.[309] No such considerations are in play here. In this case, the DOS found that Deputy Garegnani was instructed to relieve pressure from Mr. Marshall, and he had ample time to heed those instructions.[310] Mr. Marshall was in arm and leg restraints and deputies were controlling all of his appendages during this period, reducing the threat, if any, that he may have posed.[311] Yet, while the minutes ticked by, Deputy Garegnani continued to use force in the very manner counseled against.[312]

Second, the gravity of the harm created also weighed in favor of a higher conduct category.[313] After the inappropriate force, Mr. Marshall fell into a coma.[314] He remained in the coma for nine days, after which he was extubated and died.[315] According to the autopsy report, "complications of positional asphyxia to include aspiration pneumonia due to physical restraint by law enforcement" was one of the official causes of his death.[316, 317] We believe the seriousness of the harm resulting from the inappropriate force necessitated a higher conduct category.

Finally, the very terms of Categories D, E, and F suggest that Categories E or F were more appropriate for Deputy Garegnani's misconduct.[318] When assessing a penalty for inappropriate force, the DOS must assess the harm that it created.[319] To facilitate that analysis, the definitions of the conduct categories discuss the harm or potential harm created.[320] The definitions of Categories E and F discuss misconduct that ***harmed*** public safety.[321] But the definition of Category D discusses misconduct that merely created a ***serious risk*** to deputy sheriff, employee or public safety.[322]

Table 1: Definitions of Disciplinary Conduct Categories that Apply to Inappropriate Force Violations[323]

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

According to the DOS's own findings, Deputy Garegnani used inappropriate force, deliberately disregarded medical advice to remove pressure from Mr. Marshall's body, and Mr. Marshall died thereafter.[324] By themselves, we believe these facts are sufficient to demonstrate that Deputy Garegnani's inappropriate force created more than a ***serious risk*** to Mr. Marshall's safety, the language of Category D, and that it instead caused him actual harm (Categories E or F). Thus, Categories E or F would have been more appropriate for Deputy Garegnani's inappropriate force. Had they been applied, the presumptive disciplinary penalties would have been a 30-day suspension or dismissal, respectively.

The Disciplinary Order Did Not Sufficiently Explain Why Category D Was Assigned for a 16-Day Suspension

As explained above, the disciplinary order did not explain why Category D was chosen, which we believe created public confusion. The Denver Career Service Board and its hearing officers have noted the perils of such decision-making in prior cases. For example, in *Ford v. Department of Safety*, the Career Service Board found that:

> any act of inappropriate force could 'properly' be determined to fit into almost any Matrix category. The [DOS] need only say the appropriate magic words, that is, recite the wording defining the matrix category, opine that the inappropriate force fits into that category, and ride on the coattails of the discretion afforded her to mete out a ten-day suspension, a thirty-day suspension, or even a discharge.[325]

In the days after Deputy Garegnani's disciplinary decision was issued, several news articles were published expressing confusion about why this serious case, which ended with Mr. Marshall's death, resulted in a penalty for Deputy Garegnani near the bottom of the available penalty range.[326] In addition, on August 28, 2017, Denver's Citizen Oversight Board sent a letter to the DOS expressing its concerns about the disciplinary decisions.[327] The Discipline Handbook generally requires the DOS to explain the reasons for its findings when it imposes discipline.[328] Although the Discipline Handbook does not specifically require explanation of the choice of conduct category, in the future, we recommend that the DOS provide such an explanation to enhance transparency and understanding for both deputies and the public, particularly in serious cases.[329]

OIM Recommendation 2: The OIM recommends 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.

We note that on November 3, 2017, a Career Service Hearing Officer overturned the discipline imposed on Deputy Garegnani after an evidentiary hearing.[330] The Hearing Officer who made that decision made factual findings that were contrary to those made by the DOS, and based on those findings determined that no discipline should have been imposed at all.[331] We understand that our analysis—that the discipline imposed on Deputy Garegnani was insufficient—is incongruous with the Hearing Officer's ruling. Two points help to explain this. First, the Hearing Officer's ruling has been appealed to the full Career Service Board, which could overturn the decision, and it may not yet represent the final ruling about this case.[332] Second, the Hearing Officer did not assume the DOS's factual findings were true, and in fact, made contrary findings that led to his ruling to overturn the discipline.[333] In this section, we assumed the DOS's factual findings to be true in order to assess whether the DOS applied the correct disciplinary category in light of those findings.

Additional Areas of DSD or DOS Policy, Practices, or Training That Require Revision

A Subject Deputy Should Not Have Been Permitted to Join the DPD Prior to the Conclusion of the Criminal and Administrative Investigations into the Use of Force on Mr. Marshall

Between November 11, 2015 and January 21, 2016, the Denver DA's Office was conducting a criminal investigation into "the physical force exerted against Mr. Marshall by the deputy sheriffs."[334] Deputy Thanarat Phuvapaisalkij played a significant role in the use of force involving Mr. Marshall.[335] He was standing behind Deputy Garegnani when the incident began, and was positioned at Mr. Marshall's head and left shoulder when Mr. Marshall was on the floor, opposite Deputy Garegnani.[336] By Deputy Phuvapaisalkij's own account, he used a gooseneck control hold on Mr. Marshall,[337] held him down by pushing on his left shoulder,[338] and controlled Mr. Marshall's head at various times during the incident.[339] Deputy Phuvapaisalkij also said that he "basically told the nurses that we can't put [Mr. Marshall] in a wheelchair, we need a restraint chair,"[340] which resulted in Mr. Marshall remaining on the floor in the prone position until the restraint chair arrived.[341]

On January 21, 2016, the Denver DA declined to criminally charge the involved deputies, including Deputy Phuvapaisalkij, with crimes related to this incident.[342] Yet, on December 3, 2015—just over three weeks after the incident, and seven weeks before the DA's criminal investigation ended—Deputy Phuvapaisalkij received a conditional offer of employment as a DPD police officer.[343, 344] On December 15, 2015, he received a final job offer, and on December 28, 2015—approximately three-and-a-half weeks before the DA had criminally cleared him—he began as a recruit officer in the Denver Police Academy.[345, 346]

National standards dictate that law enforcement agencies must complete thorough pre-employment investigations of all police hires who have prior experience in law enforcement, including a review of their histories of using force.[347] Given those standards, when a potential recruit is under criminal investigation for a use of force resulting in death, we believe they should not be permitted to join a new agency until that criminal investigation has been completed and they have been cleared of criminal conduct. In this case, a background investigation had been conducted of Deputy Phuvapaisalkij before the incident involving Mr. Marshall.[348] Nonetheless, after the incident, Deputy Phuvapaisalkij was permitted to proceed through the hiring process even though he had, by that time, become a subject of a criminal investigation.

In addition, when Deputy Phuvapaisalkij began as a recruit DPD officer, the IAB investigation to determine whether or not he had complied with the DSD's use of force and other policies had not even begun. Had such a review been completed, resulting in a determination that he violated the DSD's use of force policy, as it ultimately did for several others in this case, he could have been disciplined up to and including dismissal.[349] Instead, no such internal investigation was completed, the DOS made no disciplinary findings regarding his conduct, and there is no official finding regarding the allegations against him to this day.[350]

Working in partnership with Denver's Civil Service Commission, the DOS diligently screens applicants for the DPD. Indeed, in this case, a background check was completed of Deputy Phuvapaisalkij before the use of force involving Mr. Marshall. Yet, after the use of force, his hiring went forward, even though he was then under criminal investigation. We believe that this should not have happened. Therefore:

OIM Recommendation 3: The OIM recommends 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 DOJ defines excited delirium as a physical condition characterized by "extreme agitation, bizarre and/or violent behavior, imperviousness to pain, exceptional strength and endurance, inappropriate nudity, extreme paranoia, and/or incoherent shouting."[351] Best practices establish that the failure to recognize excited delirium, and engaging in a prolonged use of force with individuals experiencing excited delirium can significantly increase their likelihood of sudden death.[352, 353, 354]

To guide first responders on potential excited delirium incidents, the City and County of Denver has a Multi-Agency Excited Delirium Protocol ("the ED Protocol") to which the DSD is a party.[355] The purpose of the ED Protocol is to "create consistent, citywide procedures for responding to incidents involving actual or potential excited delirium," and to have "Denver Sheriff deput[ies] . . . recognize the physiological and behavioral indicators associated with excited delirium."[356] The ED Protocol states that excited delirium is "a medical emergency in which a person develops extreme agitation, aggressiveness, overheating and exceptional strength that cannot be managed by routine physical or medical techniques."[357] Persons suffering from excited delirium "lose their mental capacity to stop resisting and are truly out of control," and may suffer sudden death.[358]

Table 2: Indications of Excited Delirium Included in the DSD Training Bulletin[359]

Indication
Confusion and disorientation
Violent behavior
Incoherent speech, grunting and groaning
Partially clothed or naked
Striking out at objects made of glass
Escalated violent behavior when restrained
Continued struggle despite restraint
Appearance of "superhuman" strength and not cognizant of painful stimuli

The Office of the Medical Examiner did not make an official finding that excited delirium was a cause of Mr. Marshall's death. Yet, we believe that Mr. Marshall exhibited indications of excited delirium during the incident.[360] For example, he was acting erratically and aggressively approached another inmate.[361] Mr. Marshall had several trays and rapidly crammed food into his mouth with his hands.[362] He mumbled to himself, and when he was told to clean up, he continued to make a mess.[363] In fact, Mr. Marshall never said anything at all to the deputies, but he instead grunted or growled.[364] He was not wearing a shirt, and he carried a blanket wrapped up with trash.[365] The deputies stated that Mr. Marshall never complied with any of their commands to stop struggling.[366] They repeatedly called Mr. Marshall's actions out of the ordinary,[367] and said that he exhibited extraordinary strength.[368]

Yet, the deputies did not generally recognize the potential indications of excited delirium during the incident. In fact, the possibility that Mr. Marshall was suffering from excited delirium did not cross Deputy Civic's mind during the incident.[369] Deputy Garegnani did not believe that Mr. Marshall was suffering from excited delirium at the start of the incident,[370] and the first time he thought of it was much later, as the deputies waited for the restraint chair.[371] Deputy Hernandez never believed that Mr. Marshall was in a state of excited delirium.[372]

According to the DSD, deputies receive training on excited delirium.[373] Yet, the deputies in this case had, at best, a minimal recollection of the ED Protocol and its associated training. Deputy Garegnani believed that he had received an in-service class on excited delirium, and remembered that some indicators might include profuse sweating, super human strength, loud screaming, and incoherent

speaking.[374] Deputy Hernandez also thought that he had taken a brief course on excited delirium while he was at the training academy.[375] He recalled that potential indicators included body temperature and strength.[376] Deputy Civic also remembered attending a class on excited delirium during the academy.[377] He said that deputies were instructed to talk to inmates and de-escalate the situation as much as possible, and to try to use the least amount of force.[378] Deputy Phuvapaisalkij also recalled a classroom training,[379] but did not recall much about it.[380] Deputy Bautista also said that excited delirium was possibly taught at an in-service or class, but she did not really remember.[381]

Although the deputies did not generally recall its specifics, the ED Protocol actually cautions against some of the very practices used in this case. It requires first responders, including deputies, to attempt to minimize the exertions of a person who is suffering from excited delirium and contain them until EMS arrives.[382] "If the subject cannot be contained or calmed down and the decision to take the subject into custody is made . . . [p]hysical force needs to be fast and overwhelming" and "[t]he struggle needs to end as soon as possible."[383] Further, the ED Protocol specifically cautions that "[t]he longer the struggle lasts, the more intensely the subject will fight back and the worse his medical risk will become."[384]

In addition, on November 2, 2015, nine days before the incident, all DSD deputies were emailed a training bulletin related to excited delirium and sudden in-custody death.[385] The bulletin warned that sudden in-custody deaths have been attributed to excited delirium and positional asphyxia.[386] It listed signs to aid deputies in recognizing excited delirium, including unusual agitation, aggression toward inanimate objects, partial disrobement, violently resisting restraint, and a diminished sense of pain.[387] The bulletin further instructed deputies that a person experiencing excited delirium must be quickly restrained because a prolonged struggle could increase their likelihood of sudden death.[388] Furthermore, once that person has been restrained, they should be immediately placed in a recovery position, such as lying on their side.[389] Deputies also should not put weight on a subject's back for a prolonged period, because it could add stress to the respiratory muscles and inhibit movement of the diaphragm and rib cage.[390] Lastly, deputies were instructed to monitor a subject suffering from excited delirium to make sure that their airway is unobstructed, that there is airflow to the lungs, and that the subject has a pulse and a heartbeat.[391]

The deputies did not generally follow these recommended techniques, nor did the supervisors ensure their compliance. The incident was not handled quickly, the use of force was not ended as soon as possible, Mr. Marshall was not moved to a

recovery position on his side once restrained, and he was instead left in a prone position, face-down for a prolonged period of time.[392] And the deputies did not monitor Mr. Marshall's airflow, breathing, or circulation after the spit hood, which obscured his face, was applied.[393] Indeed, they could not see Mr. Marshall's mouth and nose, or whether his breathing was inhibited, and may have not been able to determine whether he was conscious because his face was obscured.[394]

We commend the DSD for providing training on excited delirium and distributing the updated bulletin on November 2, 2015. Yet, we believe that the deputies' limited recollection demonstrates that additional training on excited delirium is needed. Therefore:

OIM Recommendation 4: The OIM recommends 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 Urgent Medical and Security Concerns That Are in Conflict

According to Nurse Ajao, she asked Deputy Garegnani to release pressure from Mr. Marshall's neck because Mr. Marshall was vomiting, and she feared that he could aspirate.[395] Nurse Ajao was unable to get Deputy Garegnani to release pressure from Mr. Marshall's neck.[396] Although Deputy Garegnani did not recall this,[397] the video shows Nurse Ajao speaking to Deputy Garegnani twice, and he does not appear to change the position of his hands after those interactions, except to put on gloves.[398] Nurse Ajao is partially corroborated by Charge Nurse Bisgard, who remembered Nurse Ajao raising concerns about aspiration, and Nurse Chavez, who remembered that Mr. Marshall was "vomiting" and that Deputy Garegnani continued to hold him down.[399] Nurse Allison, on the other hand, remembered asking the deputies to remove their hands from Mr. Marshall's back, and she believed that they did so.[400]

Deputies are in charge of jail security, and have the difficult and important role of ensuring the safety of staff and inmates.[401] As such, it is appropriate that deputies are empowered to control the jail environment, to decide when force is to be used, and if so, how much.[402] Yet, medical staff also have an essential function. They are to ensure the health of those in DSD custody, which is essential to the DSD's mission.[403, 404] Sometimes there may be unavoidable conflict between urgent security and medical concerns, and we believe that this case highlights the importance of having a clear policy that explains how any such conflicts are to be resolved. When medical personnel believe that an inmate or staff member is in immediate danger

and are unable to resolve their concerns with deputies, we believe that, if time and circumstances permit, staff should be required to notify a DSD supervisor. The supervisor should be responsible for assessing the situation as quickly as possible and, if time and circumstances permit, deciding how the conflict will be resolved. We believe that the supervisor should also be required to prepare a report that includes, at a minimum: the medical and security concerns that were raised, the supervisor's assessments of those concerns, and the decisions made by the supervisor to resolve the conflict. In addition, following such an incident, we believe that a non-disciplinary debriefing should occur that includes, at minimum, the facility's physician, the watch commander, and the supervisor who handled the situation.

To facilitate this process, the DSD should develop and require a training for supervisors that specifically addresses this issue, using actual critical incidents—including the Michael Marshall case—as learning tools. The training should focus on preparing supervisors to make sound, split-second decisions that weigh the security risks posed by the inmates against the potential need for immediate medical intervention in emergency situations.

OIM Recommendation 5: The OIM recommends 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 recommends 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 of Critical Incidents

The DOS does not have published guidelines regarding the release of video of critical incidents, as law enforcement agencies in some other cities do.[405] We believe that the lack of published guidelines may have created unnecessary confusion or controversy about when the video of this incident would be released. Mr. Marshall's family sought to review the video shortly after Mr. Marshall's death, and that request was initially denied.[406] An online news site, the *Colorado Independent*, subsequently filed a request for the video and other records under the Colorado Criminal Justice Records Act. This request was also initially denied, as "contrary to the public interest to release records related to the incident before completion of the current investigations."[407] The *Colorado Independent* then filed a lawsuit alleging that this denial violated state law.[408]

In January 2016, a coalition of clergy and community members, and members of Mr. Marshall's family, demanded that the City release the video and the names of the deputies involved, among other things.[409] The coalition announced its intention to protest until its demands were met, and specifically, to stage a hunger strike until the video was released.[410] The hunger strike began on January 11, 2016, and lasted for almost two weeks.[411] On January 18, Mr. Marshall's niece, speaking at a protest, said:

> I'm losing my voice, losing my weight, and I'm tired. There is no reason for us to sit here mourning him, requesting and begging the release of tapes we should already have. We want to know what happened to Michael [Marshall].[412]

The Marshall family, and the public, were ultimately told that the video would be released once everyone who needed to be interviewed for the criminal investigation had been interviewed.[413] On January 21, 2016, the Denver District Attorney released its decision letter, which signaled the end of the criminal investigation, and on the following day, more than 13 hours of video footage from inside the jail were released.[414]

To build trust with the community, national standards recommend that departments should release relevant evidence as soon as possible after potentially controversial incidents like deaths-in-custody.[415, 416] In order to facilitate realistic public expectations, national best practices have recommended that law enforcement agencies publish written policies that provide guidelines for the request and release of such evidence.[417] Agencies have addressed this in a variety of

ways, with some publishing policies that require video to be released within 72 hours,[418] within 5 to 10 days,[419] or no later than 60 calendar days after a critical incident.[420] Most policies include exceptions that allow video to be withheld if release will compromise an ongoing investigation.[421]

Yet, such policies need not include per se rules for when evidence will be withheld or released.[422] They can instead explain, in more general terms, how requests for such evidence will be evaluated, and how the decisions regarding release will be made on a case-by-case basis.[423] We believe that if such guidelines were adopted by the DOS and made available to the public, they could help avoid the public confusion, controversy, and potential litigation associated with the video in this case from recurring. Therefore:

OIM Recommendation 7: The OIM recommends 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, and an Enhanced Culture of, Analyzing and Learning from Critical Incidents in Denver's Jails

Lastly, we believe that the DSD should develop a formal protocol for, and an enhanced culture of, learning from critical incidents, and other sentinel events, that occur in Denver's jails. We were troubled that after Mr. Marshall's death, some in the DSD appeared to minimize potential issues with the incident instead of seeing it as an opportunity to learn. This included the attempt by IAB to decline the matter without a full investigation and to close it without a disciplinary review. It also included the nomination, submitted by a DSD sergeant nearly a month-and-a-half before the criminal investigation had concluded, of Deputy Garegnani for the DSD's Life Saving Award for this incident—even though Mr. Marshall, in fact, had died.[424]

In 2011, the National Institute of Justice began developing an approach to learning from systemic issues that lead to negative outcomes in the criminal justice system, a process known as Sentinel Event Review ("SER").[425] SERs have been used in the medical profession to examine unexpected patient deaths, medication errors, wrong-patient surgeries, "near misses," and similar incidents to learn from their root causes.[426] Recently, SERs have been applied in criminal justice,[427] and they

have become an emerging best practice for law enforcement agencies.[428] SERs can provide a "forward-leaning mechanism . . . [to] learn from error and make systemwide improvements that go beyond disciplining rulebreakers and render similar errors less likely in the future."[429] Model SERs generally consist of multiple steps, including: gathering multi-disciplinary teams, identifying contributing factors and root causes, developing corrective action plans, creating reports to share lessons learned, and measuring the successes of any corrective actions taken.[430]

In its 2015 review of the use of force and internal affairs operations in the DSD, the OIR Group found that DSD needed to "dramatically alter the way it investigates and reviews force incidents."[431] It recommended that the DSD design "protocols whereby a Force Review committee reviews significant force incidents" and "develop a written action plan for each force incident reviewed and ensure an effective feedback loop to present the results."[432] In addition, it recommended that the DSD commit to "examine force incidents to determine whether there were issues of supervision, policy, or training that it should address."[433] We understand that Division Chief Gary Wilson was recently appointed and has begun implementing this recommendation. We believe that the urgency of acting on it is demonstrated by testimony given in a disciplinary appeal in the Michael Marshall case by a former DSD trainer who, until recently, taught other deputies and recruits when and how to use force:

Q:	Based on your review of the video, and I know you didn't read statements, do you believe all – that the actions of the deputies were within policy and procedure?
Trainer:	Yes, sir.
Q:	Were they consistent with your - the training that you provide?
Trainer:	Yes, sir.
Q:	Did you have any concerns whatsoever about the actions of Deputy Garegnani and Deputy Hernandez?
Trainer:	No, I actually thought they did a pretty well job [*sic*]. I think I even stated that in my – that it was well done.
Q:	Ok, so this was, in your view, not a shaky or questionable use of force?
Trainer:	No.

Q:	Do you see where it says… 'yeah, actually I'd love to have the video just for training, just to show.' Do you see that? [*Referencing another transcript*]
Trainer:	Yes, sir.
Q:	Did you make that statement?
Trainer:	I did.
Q:	Why did you want the video for training?
Trainer:	Uh, just to show exactly how force can be ugly but it's still – if you do it right – and it looks good it's – you know – it was like – done the way we want it done.[434]

Law enforcement trainers should incorporate lessons learned from critical incidents into the instruction they provide to other officers.[435] In this case, a man died needlessly, cutting short his life and causing tremendous pain to his family and community. This resulted in many hard working DSD deputies, and the DSD as a whole, to be subjected to scrutiny and suspicion. And Denver taxpayers spent more than $4.65 million of public funds in settlement of the claims—money that could have been put to other, more productive uses. These facts alone should demonstrate how faulty was the former trainer's conclusion that the force was "done the way we want it done."

Yet, the former trainer was not alone in his belief that the incident was appropriately handled, and this report does not intend to single him out. Throughout the investigation and review of the case, we spoke with many in the DSD who expressed similar views. And it is those reflexive conclusions—that the incident was well handled, the force was appropriate, and minimal changes to policy and training, if any, are needed—that we believe the DSD must learn from. The DSD needs to develop a formal process for learning from critical incidents in order to make Denver's jails safer for both deputies and inmates, and to help prevent other tragedies like the death of Michael Marshall from happening in our city in the future.

OIM Recommendation 8: The OIM recommends 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.

The Death of Michael Marshall, an Independent Review, OIM Recommendations:

■ Recommendation 1: The OIM recommends 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.

■ Recommendation 2: The OIM recommends 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.

■ Recommendation 3: The OIM recommends 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.

■ Recommendation 4: The OIM recommends 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.

■ Recommendation 5: The OIM recommends 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.

■ Recommendation 6: The OIM recommends 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.

■ Recommendation 7: The OIM recommends 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.

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Endnotes

[1] Denver Revised Municipal Code Art. XVIII § 2-371(b).

[2] Throughout this report, the OIM asserts its conclusions based on its analysis of the incident. These conclusions do not represent the conclusions of any other person or entity. This includes the City and County of Denver and any of its other agencies or officials.

[3] Throughout this report, we refer to the force used in the incident as "inappropriate force" because the DOS found the force used by two of the deputies to be inappropriate. DOS Disciplinary Determination for Deputy Bret Garegnani, at 17 (Apr. 19, 2017); DOS Disciplinary Determination for Deputy Carlos Hernandez, at 17 (Apr. 19, 2017).

[4] Independent Monitor Mitchell was a co-chair of the DSD's Use of Force and Internal Affairs Action Team, which, among other things, developed draft policies associated with this Use of Force review process before providing them to the DSD for review and implementation in 2016.

[5] Denver Revised Municipal Code Art. XVIII §§ 2-371(b), 2-373(a)(2), 2-375(c).

[6] *See*, *e.g.*, OIM, *2017 Semiannual Report*, at 31-40.

[7] This report also does not anonymize the deputies and nurses involved in the incident the way that the OIM's Annual and Semiannual reports do. Under Denver Revised Municipal Code § 2-375(b), the OIM's reports are required to "present information in statistical and summary form, without identifying specific persons except to the extent that incidents involving specific persons have otherwise been made public by the City and County of Denver." In this case, the deputies and nurses have been identified in the Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall (Jan. 21, 2016), the DOS Disciplinary Determinations for Deputies Bret Garegnani, Carlos Hernandez, and Captain James Johnson (Apr. 19, 2017), and the public Career Service Hearings of Captain James Johnson (Aug. 28-29, 2017), and Deputies Bret Garegnani and Carlos Hernandez (Sept. 18-19, 2017).

[8] Denver Revised Municipal Code Art. XVIII §§ 2-371(b), 2-375(c).

[9] *See, e.g.*, Letter from the Citizen Oversight Board to Executive Director of Safety Stephanie Y. O'Malley (Apr. 28, 2017) (on file with author); Letter from City Councilmember Paul Kashmann to Independent Monitor Nicholas E. Mitchell (Dec. 15, 2017) (on file with author).

[10] Michael Roberts, *Longer Suspension for Sexy Text than for Killing Michael Marshall,* Westword (Apr. 20, 2017).

[11] E-mail from COB Chair Katina Banks to Independent Monitor Nicholas E. Mitchell (Nov. 7, 2017) (on file with author).

[12] Letter from City Councilmember Paul Kashmann to Independent Monitor Nicholas E. Mitchell (Dec. 15, 2017) (on file with author).

[13] *See* National Institute of Justice, *Mending Justice: Sentinel Event Reviews* (2014); *see also* President's Task Force on 21st Century Policing, *Final Report of the President's Task Force on 21st Century Policing*, at 22 (2015).

[14] *See, e.g.*, Police Assessment Resource Center, *National Guidelines for Police Monitors*, at 16-17, 77-78 (2008).

[15] Police Assessment Resource Center, *National Guidelines for Police Monitors*, at 16-17 (2008).

[16] *See, e.g.*, Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall (Jan. 21, 2016); DOS Disciplinary Determination for Deputy Bret Garegnani (Apr. 19, 2017); DOS Disciplinary Determination for Deputy Carlos Hernandez (Apr. 19, 2017); DOS Disciplinary Determination for Captain James Johnson (Apr. 19, 2017).

[17] Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 5 (Jan. 7, 2016); Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 1 (Jan. 21, 2016); *People v. Marshall*, Case No. 15GS016208, County Court Mittimus (County Court, Denver, CO, Nov. 12, 2015); DSD Internal Affairs Database ("IAPro").

[18] Mr. Marshall was charged with violating Denver Revised Municipal Code § 38-115(a) – Trespass, and 38-89(a) – Disturbance of the Peace. *See People v. Marshall*, Case No. 15GS016208, County Court Mittimus (County Court, Denver, CO, Nov. 12, 2015).

[19] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 1 (Jan. 21, 2016).

[20] *See* DSD Classification/Housing Post Order § XXI(5) (effective Jan. 7, 2014).

[21] *See* DSD Classification/Housing Post Order § XXI(5) (effective Jan. 7, 2014).

[22] DOS Disciplinary Determination for Deputy Bret Garegnani, at 5 n. 2 (Apr. 19, 2017).

[23] DOS Disciplinary Determination for Deputy Bret Garegnani, at 5-6 (Apr. 19, 2017).

[24] Unless otherwise indicated, the time stamps in this summary refer to the sally port video. All times are approximate.

[25] DOS Disciplinary Determination for Deputy Bret Garegnani, at 5 (Apr. 19, 2017).

[26] DOS Disciplinary Determination for Deputy Bret Garegnani, at 5-6 (Apr. 19, 2017).

[27] DOS Disciplinary Determination for Deputy Bret Garegnani, at 5 (Apr. 19, 2017); Deputy David Arellano DPD Interview Transcript, lines 240-42 (Nov. 12, 2015).

[28] DOS Disciplinary Determination for Deputy Bret Garegnani, at 6 (Apr. 19, 2017).

[29] Deputy Garegnani's arrival can be seen on the Hallway Video. *See also* DOS Disciplinary Determination for Deputy Bret Garegnani, at 6 (Apr. 19, 2017).

[30] DOS Disciplinary Determination for Deputy Bret Garegnani, at 6 (Apr. 19, 2017).

[31] Deputy Bret Garegnani DPD Interview Transcript, lines 226-27 (Nov. 12, 2015). Deputy Civic arrived at 18:31:35 on the Hallway Video. Deputy Phuvapaisalkij arrived at 18:32:45 on the Hallway Video.

[32] During the administrative investigation, Deputy Phuvapaisalkij resigned from the DSD and was hired as a Denver Police Officer recruit. For ease, he will be referred to as Deputy Phuvapaisalkij throughout this report, although he is now employed by the DPD, not the DSD.

[33] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017); Pod 4D has a hallway that connects the main hallway corridor on one end to the officer's desk on the other, called the sally port. On either side of the officer's desk is an entrance to the northern half of the pod and southern half of the pod where the inmates' cells are. Most of the events of this incident took place in the hallway sally port in pod 4D. Deputy Hernandez approached at 18:32:00 on the Sally Port Video.

[34] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); 18:32:50 on the Sally Port Video.

[35] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); 18:32:53 on the Sally Port Video.

[36] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); 18:32:53 on the Sally Port Video.

[37] 18:32:53 on the Sally Port Video.

[38] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); DOS Disciplinary Determination for Deputy Bret Garegnani, at 6 (Apr. 19, 2017); 18:32:53 on the Sally Port Video.

[39] 18:32:56 on the Sally Port Video.

[40] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017).

[41] DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[42] *See*, *e.g.*, Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 194-95 (Nov. 12, 2015); Nurse Ashley Allison DPD Interview Transcript, lines 779-790 (Nov. 23, 2015).

[43] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017).

[44] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017).

[45] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017).

[46] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017).

[47] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017).

[48] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017); Deputy Carlos Hernandez DPD Interview Transcript, lines 1173-77 (Nov. 12, 2015); Deputy Smajo Civic DPD Interview Transcript, lines 635-58, 664-68 (Nov. 12, 2015).

[49] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017); 18:35:24 on the Sally Port Video.

[50] Deputy Smajo Civic DPD Interview Transcript, lines 679-82, 702-05 (Nov. 12, 2015).

[51] 18:33:23 to 18:33:38 on the Hallway Video; *see also* Sergeant Keri Adcock DSD Interview Transcript, lines 75-82 (Feb. 18, 2016).

[52] *See, e.g.*, 18:34:20 on the Hallway Video.

[53] *See, generally*, 18:35:27 to 18:52:05 on the Hallway Video (Captain Johnson appears to look into the sally port at approximately 18:35:51, 18:36:02, and 18:36:30).

[54] 18:35:30 on the Sally Port Video; *see also* DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[55] DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[56] DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[57] DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017); Deputy Bret Garegnani DPD Interview Transcript, lines 246-47 (Nov. 12, 2015) ("it appeared to me that he . . . went unconscious or was not responsive . . . all of a sudden."); Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 3 (Jan. 21, 2016).

[58] Nurse Ashley Allison DPD Interview Transcript, lines 110-112 , 133-34 (Nov. 23, 2015) (Nurse Allison arrived at the sally port entrance at 18:36:42 in the hallway video).

[59] Nurse Ashley Allison DPD Interview Transcript, lines 145-46 (Nov. 23, 2015).

[60] 18:37:00 on the Sally Port Video.

[61] Deputy Bret Garegnani DPD Interview Transcript, lines 639-41 (Nov. 12, 2015).

[62] We based this determination on our review of the Sally Port Video from 18:36:59 to 18:46:11. The deputies can be seen moving Mr. Marshall face-down at approximately 18:36:59, and he remained face-down in the middle of the sally port until approximately 18:46:11. Deputy Garegnani confirmed that he moved Mr. Marshall from under the bench to the middle of the sally port so the deputies and nursing staff could have access to him. Deputy Bret Garegnani DPD Interview Transcript, lines 639-41 (Nov. 12, 2015); *see also* DOS Disciplinary Determination for Deputy Bret Garegnani, at 10 (Apr. 19, 2017) (Renee Chavez "stated that inmate Marshall was face down the entire time, until he was later placed in the restraint chair.").

[63] 18:38:58 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[64] 18:39:00 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[65] Deputy Carlos Hernandez DPD Interview Transcript, lines 256-58, 1088-89 (Nov. 12, 2015).

[66] DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[67] Deputy Carlos Hernandez DPD Interview Transcript, lines 240-43 (Nov. 12, 2015).

[68] Deputy Smajo Civic DPD Interview Transcript, lines 548-49, 615-17 (Nov. 12, 2015); Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 187-90 (Nov. 12, 2015).

[69] 18:39:00 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 (Apr. 19, 2017); Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 5 (Jan. 7, 2016).

[70] 18:41:11 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[71] DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[72] 18:38:00 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 10 (Apr. 19, 2017).

[73] 18:40:15 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 10 (Apr. 19, 2017).

[74] DOS Disciplinary Determination for Deputy Bret Garegnani, at 10 (Apr. 19, 2017); Nurse Helen Ajao DPD Interview Transcript, lines 538-53 (Dec. 1, 2015).

[75] 18:41:19 to 18:41:28 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 11 (Apr. 19, 2017).

[76] Nurse Helen Ajao DPD Interview Transcript, lines 581-83 (Dec. 1, 2015).

[77] Nurse Helen Ajao DPD Interview Transcript, lines 600-01 (Dec. 1, 2015).

[78] DOS Disciplinary Determination for Deputy Bret Garegnani, at 11 (Apr. 19, 2017); Nurse Helen Ajao DPD Interview Transcript, lines 606-07 (Dec. 1, 2015).

[79] DOS Disciplinary Determination for Deputy Bret Garegnani, at 11 (Apr. 19, 2017); Nurse Helen Ajao DPD Interview Transcript, lines 611-12 (Dec. 1, 2015).

[80] *See, e.g.*, Deputy Bret Garegnani DPD Interview Transcript, lines 453-73 (Dec. 17, 2015); Deputy Bret Garegnani DSD Interview Transcript, lines 244-52 (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 221-37 (Mar. 31, 2016); Deputy Carlos Hernandez DPD Interview Transcript, lines 234-57 (Dec. 17, 2015); Nurse Ashley Allison Written Responses, at 1; Charge Nurse Monica Bisgard Written Responses, at 1.

[81] 18:41:33 to 18:41:42 on the Sally Port Video.

[82] Nurse Renee Chavez DPD Interview Transcript, lines 215-19, 240-47, 279-83 (Dec. 1, 2015); DOS Disciplinary Determination for Deputy Bret Garegnani, at 10 (Apr. 19, 2017); 18:37:54 on the Hallway Video.

[83] Nurse Renee Chavez DPD Interview Transcript, lines 215-19 (Dec. 1, 2015).

[84] DOS Disciplinary Determination for Deputy Bret Garegnani, at 9, 11 (Apr. 19, 2017).

[85] Nurse Helen Ajao DPD Interview Transcript, lines 620-23 (Dec. 1, 2015).

[86] Nurse Helen Ajao DPD Interview Transcript, lines 633-35 (Dec. 1, 2015).

[87] Nurse Monica Bisgard, Written Responses, at 2.

[88] 18:42:10 on the Hallway Video.

[89] 18:42:21 on the Sally Port Video.

[90] Nurse Monica Bisgard DPD Interview Transcript, lines 538-39 (Nov. 23, 2015).

[91] Nurse Ashley Allison DPD Interview Transcript, lines 885-86 (Nov. 23, 2015).

[92] Nurse Ashley Allison DPD Interview Transcript, lines 902-14 (Nov. 23, 2015).

[93] Nurse Allison stated that the deputies were holding Mr. Marshall by his back and she knew there was pressure on it. She also stated that she did not know if there was excessive pressure, and that she did not think there was. She stated that Mr. Marshall did not have any red marks on his back from deputies putting pressure on him. She said that before she instructed deputies to remove their hands from Mr. Marshall's back, so she could evaluate him with a stethoscope, there was pressure on his back, but she did not believe the pressure interfered with his ability to breathe. Nurse Ashley Allison DPD Interview Transcript, lines 937-40, 1412-13, 1417-32 (Nov. 23, 2015).

[94] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[95] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[96] Nurse Ashley Allison DPD Interview Transcript, lines 944-45 (Nov. 23, 2015).

[97] Deputy Garegnani DPD Interview Transcript, lines 427-51 (Dec. 17, 2015); Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 956-68 (Nov. 12, 2015); Deputy Smajo Civic DPD Interview Transcript, lines 252-56 (Nov. 12, 2015); Deputy Carlos Hernandez DPD Interview Transcript, lines 252-60 (Nov. 12, 2015).

[98] Deputy Bret Garegnani DPD Interview Transcript, lines 898-900 (Nov. 12, 2015); Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 952-61 (Nov. 12, 2015).

[99] Sergeant Michael Newtown DSD Interview Transcript, lines 139-40 (Feb. 18, 2016).

[100] 18:45:54 on the Sally Port Video; DOS Disciplinary Determination for Deputy Bret Garegnani, at 11 (Apr. 19, 2017).

[101] DOS Disciplinary Determination for Deputy Bret Garegnani, 11 (Apr. 19, 2017); Deputy Bret Garegnani DPD Interview Transcript, lines 505-12 (Dec. 17, 2015).

[102] 18:45:48 on the Hallway Video.

[103] 18:46:11 on the Sally Port Video. Mr. Marshall went limp at 18:35:30 on the Sally Port Video; *see also* DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017).

[104] After the deputies put Mr. Marshall into the restraint chair, the remainder of the events take place on the Hallway Video.

[105] 18:46:38 on the Hallway Video.

[106] 18:49:10 on the Hallway Video.

[107] Nurse Ashley Allison DPD Interview Transcript, lines 1025-27 (Nov. 23, 2015).

[108] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 5 (Jan. 21, 2016).

[109] 18:50:52 on the Hallway Video; Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 5 (Jan. 21, 2016); *see also* Nurse Helen Ajao DPD Interview Transcript, line 877 (Dec. 1, 2015).

[110] 18:51:04 on the Hallway Video; Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 5 (Jan. 21, 2016).

[111] 18:51:12 on the Hallway Video.

[112] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 5 (Jan. 21, 2016); DOS Disciplinary Determination for Deputy Bret Garegnani, at 12, 16 (Apr. 19, 2017); DOS Disciplinary Determination for Deputy Carlos Hernandez, at 13 (Apr. 19, 2017).

[113] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 5 (Jan. 21, 2016).

[114] DOS Disciplinary Determination for Deputy Bret Garegnani, at 13 (Apr. 19, 2017).

[115] Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 4 (Jan. 7, 2016).

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

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

[118] *See, e.g.*, U.S. DOJ, *Positional Asphyxia–Sudden Death* (June 1995); Segen's Medical Dictionary, *Positional Asphyxia* (2011) ("A form of asphyxia which occurs when body position prevents adequate gas exchange, such as from upper airway obstruction or a limitation in chest wall expansion, e.g., due to steering wheel compression.").

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

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

[121] Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 1 (Jan. 7, 2016). Oxford English Dictionary, *Rale* ("An abnormal rattling sound heard when examining unhealthy lungs with a stethoscope.").

[122] Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 1 (Jan. 7, 2016). Mosby's Medical Dictionary, 9th Edition, (2009) *Emesis* ("Vomit").

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

[124] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 6 (Jan. 21, 2016).

[125] *See* Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 6-7 (Jan. 21, 2016).

[126] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 6 (Jan. 21, 2016).

[127] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 6-7 (Jan. 21, 2016).

[128] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 7 (Jan. 21, 2016).

[129] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 7 (Jan. 21, 2016).

[130] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 7 (Jan. 21, 2016).

[131] Sergeants Adcock and Newtown arrived at 18:33:23 on the Hallway Video and Sergeant Moore arrived at 18:33:33 on the Hallway Video. Captain Johnson arrived at 18:35:27 on the Hallway Video. Mr. Marshall went limp at 18:35:30 on the Sally Port Video.

[132] *See, e.g.*, Deputy Bret Garegnani DSD Interview Transcript, lines 473-79 (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 324-90 (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript, lines 342-57 (Mar. 31, 2016).

[133] 18:33:23 on the Hallway Video.

[134] *See, generally*, 18:33:23 to 18:45:53 on the Hallway Video.

[135] Sergeant Keri Adcock DSD Interview Transcript, lines 193-201 (Feb. 18, 2016).

[136] Sergeant Keri Adcock DSD Interview Transcript, lines 567-73 (Feb. 18, 2016).

[137] Sergeant Keri Adcock DSD Interview Transcript, lines 688-89, 720-23 (Feb. 18, 2016).

[138] Sergeant Keri Adcock DSD Interview Transcript, lines 1020-28 (Feb. 18, 2016).

[139] Sergeant Keri Adcock DSD Interview Transcript, lines 1071-77 (Feb. 18, 2016).

[140] Sergeant Keri Adcock DSD Interview Transcript, lines 1078-80 (Feb. 18, 2016).

[141] Sergeant Tracy Moore DSD Interview Transcript, lines 359-72 (Feb. 22, 2016).

[142] Sergeant Tracy Moore DSD Interview Transcript, lines 431-35 (Feb. 22, 2016).

[143] Sergeant Tracy Moore DSD Interview Transcript, lines 467-70 (Feb. 22, 2016).

[144] Sergeant Tracy Moore DSD Interview Transcript, lines 471-74 (Feb. 22, 2016).

[145] Sergeant Tracy Moore DSD Interview Transcript, lines 148-56 (Feb. 22, 2016).

[146] Sergeant Tracy Moore DSD Interview Transcript, lines 937-42 (Feb. 22, 2016).

[147] *See, e.g.*, 18:49:04 on the Hallway Video.

[148] Sergeant Tracy Moore DSD Interview Transcript, lines 919-21 (Feb. 22, 2016).

[149] Sergeant Michael Newtown DSD Interview Transcript, lines 308-11 (Feb. 18, 2016).

[150] Sergeant Michael Newtown DSD Interview Transcript, lines 469-72 (Feb. 18, 2016).

[151] Sergeant Michael Newtown DSD Interview Transcript, lines 554-56 (Feb. 18, 2016).

[152] Sergeant Michael Newtown DSD Interview Transcript, lines 805-16 (Feb. 18, 2016).

[153] *See, generally*, 18:35:27 to 18:52:05 on the Hallway Video.

[154] *See, e.g.*, 18:36:00, 18:36:30 on the Hallway Video.

[155] *See, e.g.*, 18:34:19, 18:35:08, 18:35:42, 18:35:53, 18:36:12, 18:36:31, 18:36:43, 18:38:54, 18:41:26 on the Hallway Video.

[156] *See* 18:33:26, 18:47:15 on the Hallway Video.

[157] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall (Jan. 21, 2016).

[158] DSD Internal Affairs and Civil Liabilities Bureau Procedures § 101.0 (revised May 2013); DSD IAB uploaded the DPD Homicide Book to IAPro on January 27, 2016.

[159] E-mail from Independent Monitor Nicholas E. Mitchell to DSD IAB then-Sergeant Jamison Brown (Jan. 21, 2015) (on file with author); *see also* E-mail from Independent Monitor Nicholas E. Mitchell to DSD IAB Major Jodi Blair (Mar. 4, 2016) (on file with author); *see also* E-mail from Nicholas E. Mitchell to Executive Director of Safety Stephanie Y. O'Malley, et al. (June 17, 2016) (on file with author).

[160] According to IAPro, the status of the case was changed to "active" on January 27, 2016 (screenshot on file with author). *See also* IAPro routing from DSD IAB then-Manager Armando Saldate to DSD CRO then-Captain Stephanie McManus (Aug. 4, 2016) (screenshot on file with author). DSD Conduct Review Office Procedures § 101.0 (revised Nov. 25, 2013).

[161] IAPro routing from DSD CRO then-Captain Stephanie McManus to Senior Deputy Monitor Gregg Crittenden (Aug. 29, 2016) (screenshot on file with author); IAPro routing from DSD CRO then-Captain Stephanie McManus to Senior Deputy Monitor Gregg Crittenden (Aug. 30, 2016) (screenshot on file with author); IAPro routing from DSD CRO then-Captain Stephanie McManus to Senior Deputy Monitor Gregg Crittenden (Sept. 7, 2016) (screenshot on file with author); IAPro routing from DSD CRO then-Captain Stephanie McManus to Senior Deputy Monitor Gregg Crittenden (Oct. 31, 2016) (screenshot on file with author); IAPro routing from Independent Monitor Nicholas E. Mitchell to DSD CRO then-Captain Stephanie McManus (Nov. 4, 2016) (screenshot on file with author); *see also* E-mail from Independent Monitor Nicholas E. Mitchell to DSD CRO then-Captain Stephanie McManus (Nov. 4, 2016) (on file with author).

[162] Contemplation of discipline meetings were held for Deputy Smajo Civic, March 21, 2017, Deputy Bret Garegnani, March 22, 2017, Deputy Carlos Hernandez, March 23, 2017, Sergeant Keri Adcock, March 31, 2017, Sergeant Michael Newtown, March 31, 2017, Captain James

Johnson, March 31, 2017, and Sergeant Tracy Moore, April 4, 2017. No contemplation of discipline meeting was held for Deputy David Arellano. *See also* Contemplation of Discipline Letter, Deputy Smajo Civic (Mar. 7, 2017); Contemplation of Discipline Letter, Deputy Bret Garegnani (Mar. 7, 2017); Contemplation of Discipline Letter, Deputy Carlos Hernandez (Mar. 7, 2017); Contemplation of Discipline Letter, Sergeant Keri Adcock (Mar. 7, 2017); Contemplation of Discipline Letter, Sergeant Michael Newtown (Mar. 7, 2017); Contemplation of Discipline Letter, Captain James Johnson (Mar. 7, 2017); Contemplation of Discipline Letter, Sergeant Tracy Moore (Mar. 7, 2017).

[163] DOS Disciplinary Determination for Deputy Bret Garegnani, at 1 (Apr. 19, 2017).

[164] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[165] DOS Disciplinary Determination for Deputy Carlos Hernandez, at 15-16 (Apr. 19, 2017).

[166] DOS Disciplinary Determination for Deputy Carlos Hernandez, at 1 (Apr. 19, 2017).

[167] DOS Disciplinary Determination for Captain James Johnson, at 17 (Apr. 19, 2017).

[168] DOS Disciplinary Determination for Captain James Johnson, at 15-16 (Apr. 19, 2017).

[169] The three suspensions presented in this figure are currently under appeal.

[170] Denver Revised Municipal Code Art. XVIII § 2-371(b).

[171] Denver Revised Municipal Code Art. XVIII § 2-375(a), (c).

[172] Denver Department of Safety News Release (Apr. 19, 2017), https://www.denvergov.org/content/denvergov/en/department-of-safety/news/2017/review-of-the-in-custody-death-of-michael-marshall-concludes.html; DSD Training Academy Procedure Manual § 2021.00 (effective Oct. 31, 2016); DSD, *2016 Annual Report*, at 5; Noelle Phillips, *Denver Sheriff's Department is Spending $1 Million to Train Every Deputy in Crisis Intervention,* The Denver Post (July 19, 2016).

[173] National Alliance on Mental Illness, *What is CIT?* (accessed Apr. 28, 2017) https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT.

[174] National Alliance on Mental Illness, *What Does CIT Training Include?* (accessed Feb. 16, 2018) https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT.

[175] DSD, *2016 Annual Report*, at 5.

[176] DSD Training Academy Procedure Manual § 2021.00 (effective Oct. 31, 2016).

[177] This revision was drafted by a Use of Force and Internal Affairs Action Group, which was co-chaired by former Manager of Safety Alvin LaCabe and Independent Monitor Nicholas E. Mitchell. *See* Noelle Phillips, *Denver Sheriff Overhauls Use-of-Force Policy, Requires "Verbal Judo" to Avoid Conflict*, The Denver Post (June 16, 2016).

[178] DSD Department Order 5011.1N §§ 4(a), 13(c) (effective Oct. 5, 2017). *See also* DSD Department Order 5011.1M § 5(A) (effective Jan. 27, 2014) (citing C.R.S. §§ 18-1-703, 18-1-707); *Graham v. Connor*, 490 U.S. 386 (1989).

[179] DSD Department Order 5011.1N § 5(A) (effective Oct. 5, 2017).

[180] DSD Department Order 5011.1N § 17 (effective Oct. 5, 2017).

[181] OIM, *2016 Annual Report*, at 3.

[182] Consent Decree, *U.S. v. the City of Ferguson*, 16-cv-000180 § 147(c) (E.D. Mo. Apr. 19, 2016).

[183] DSD Department Order 5011.1N § 12(E) (effective Oct. 5, 2017).

[184] DSD Department Order 5011.1N § 12(F) (effective Oct. 5, 2017).

[185] DSD Department Order 5011.1N § 12(F) (effective Oct. 5, 2017).

[186] There were numerous changes made to the New Use of Force Policy between its public release in June 2016 and its eventual adoption in October 2017.

[187] DSD Department Order 5013.1H (effective Dec. 22, 2017).

[188] DSD Department Order 5013.1F § 2 (effective May 14, 2015).

[189] DSD Department Order 5013.1F (effective May 14, 2015).

[190] DSD Department Order 5013.1H § 5(a), (c) (effective Dec. 22, 2017).

[191] DSD Department Order 5013.1h § 5(b)-(d) (effective Dec. 22, 2017).

[192] S*ee, e.g.*, U.S. DOJ, *Collaborative Reform Initiative: An Assessment of the Salinas Police Department* § 306.5 (2016).

[193] Full and Final Release and Settlement Agreement, Estate of Michael Marshall and City and County of Denver (Oct. 13, 2017); Noelle Phillips, *Denver Agrees to Pay $4.6 Million Settlement to Family of Inmate Killed in 2015 by Sheriff's Deputies*, The Denver Post (Nov. 1, 2017).

[194] Full and Final Settlement Agreement, Estate of Michael Marshall and the City and County of Denver § 3(a) (Oct. 13, 2017).

[195] Full and Final Settlement Agreement, Estate of Michael Marshall and the City and County of Denver § 3(b)-(c) (Oct. 13, 2017).

[196] Full and Final Settlement Agreement, Estate of Michael Marshall and the City and County of Denver § 3(f) (Oct. 13, 2017).

[197] Full and Final Settlement Agreement, Estate of Michael Marshall and the City and County of Denver § 3(d) (Oct. 13, 2017).

[198] Full and Final Settlement Agreement, Estate of Michael Marshall and the City and County of Denver § 3(e) (Oct. 13, 2017).

[199] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix C at 9 (effective Nov. 12, 2013).

[200]DSD Internal Affairs and Civil Liabilities Bureau Procedures, at 4, 6 (revised May 2013). Some complaints alleging misconduct against DSD deputies will be investigated by the DPD (for example, those alleging law violations).

[201] DSD Internal Affairs and Civil Liabilities Bureau Procedures, at 4 (revised May 2013). *See also* DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 8.1 (effective Nov. 12, 2013) ("[T]he integrity of the internal investigation process is essential to the fair administration of discipline." "No system of discipline can be effective without investigations that can be considered unbiased and trustworthy by members of the Department as well as the general public."); U.S. DOJ Office of Community Oriented Police Services, *Standards and Guidelines for Internal Affairs: Recommendations from a Community of Practice* § 3.1 (2008).

[202] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 8.3 (effective Nov. 12, 2013).

[203] U.S. DOJ Office of Community Oriented Police Services, *Standards and Guidelines for Internal Affairs: Recommendations from a Community of Practice* § 3.1 (2008).

[204] DSD Internal Affairs and Civil Liabilities Bureau Procedures § 104.0 (revised May 2013).

[205] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 8.3 (effective Nov. 12, 2013).

[206] The case was opened in IAPro on November 11, 2015. The case was immediately suspended, and its status was changed to active on January 27, 2016 (screenshots on file with author).

[207] Security Specialists are DSD employees that are not Deputy Sheriffs. Security Specialists provide technical and administrative support to Deputy Sheriffs by maintaining security. They are responsible for, among other things, monitoring, opening, and closing doors, sally ports, and vestibules, and allowing authorized movement of inmates, staff, citizens, and professional visitors to the jails. They control and operate the elevators, and monitor and observe the jails and courthouse via video surveillance. They communicate and coordinate with deputies throughout the facility during normal hours and during emergencies. *See* DSD Security Specialist Information Booklet (available at www.denvergov.org) (on file with author); DSD Post Order 7635.1B § 2 (A)(2); DSD Post Order 2142.1B.

[208] *See* Deputy Darryn Brown DSD Interview Transcript (Feb. 10, 2016); Deputy Tyson Hicks DSD Interview Transcript (Feb. 10, 2016); Deputy Geoffrey Johnson DSD Interview Transcript (Feb. 3, 2016); Deputy Brian Kelly DSD Interview Transcript (Feb. 2, 2016); Deputy Roger Kline DSD Interview Transcript (Feb. 3, 2016); Security Specialist LaTasha McKenzie DSD Interview Transcript (Feb. 2, 2016); Sergeant Robert Petrie DSD Interview Transcript (Feb. 10, 2016); Deputy Davis Phillips DSD Interview Transcript (Feb. 16, 2016); Deputy David Sewitsky DSD Interview Transcript (Feb. 18, 2016); Security Specialist Alexandra Uehling DSD Interview Transcript (Feb. 3, 2016); Deputy Wayne Wilmot DSD Interview Transcript (Feb. 10, 2016); Captain Jeffery Wood DSD Interview Transcript (Feb. 18, 2016); Deputy Eishi Yamaguchi DSD Interview Transcript (Feb. 3, 2016).

[209] All DSD sworn staff that report to the Sheriff may be referred to as "deputies" regardless of rank, unless otherwise noted.

[210] *See* Sergeant Keri Adcock DSD Interview Transcript (Feb. 18, 2016); Sergeant Michael Newtown DSD Interview Transcript (Feb. 18, 2016); Sergeant Tracy Moore DSD Interview Transcript (Feb. 22, 2016); Captain James Johnson DSD Interview Transcript (Feb. 18, 2016).

[211] E-mail from DSD IAB Major Jodi Blair to Independent Monitor Nicholas E. Mitchell (Feb. 25, 2016) (on file with author).

[212] *See* Deputy David Arellano DSD Interview Transcript (Mar. 31, 2016); Deputy Sarah Bautista DSD Interview Transcript (Apr. 4, 2016); Deputy Smajo Civic DSD Interview Transcript (Mar. 24, 2016); Deputy Bret Garegnani DSD Interview Transcript (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript (Mar. 31, 2016). The nurses were never interviewed in person by DSD IAB, and DSD IAB informed the OIM that the nurses' written statements were provided on July 27, 2016.

[213] *See* Deputy David Arellano DPD Interview Transcript (Nov. 12, 2015); Deputy Sarah Bautista DPD Interview Transcript (Nov. 12, 2015); Deputy Smajo Civic DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Deputy Bret Garegnani DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Deputy Carlos Hernandez DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Deputy Thanarat Phuvapaislkij DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Nurse Helen Ajao DPD Interview Transcript (Dec. 1, 2015); Nurse Ashley Allison DPD Interview Transcript (Nov. 23, 2015); Nurse Monica Bisgard DPD Interview Transcript (Nov. 23, 2015); Nurse Renee Chavez DPD Interview Transcript (Dec. 1, 2015).

[214] *See* Nurse Helen Ajao DPD Interview Transcript (Dec. 1, 2015); Nurse Ashley Allison DPD Interview Transcript (Nov. 23, 2015); Nurse Monica Bisgard DPD Interview Transcript (Nov. 23, 2015); Nurse Renee Chavez DPD Interview Transcript (Dec. 1, 2015).

[215] Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 3 (Jan. 7, 2016). *See also* Deputy David Arellano DPD Interview Transcript (Nov. 12, 2015); Deputy Sarah Bautista DPD Interview Transcript (Nov. 12, 2015); Deputy Smajo Civic DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Deputy Bret Garegnani DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Deputy Carlos Hernandez DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Deputy Thanarat Phuvapaislkij DPD Interview Transcripts (Nov. 12, 2015 and Dec. 17, 2015); Nurse Helen Ajao DPD Interview Transcript (Dec. 1, 2015); Nurse Ashley Allison DPD Interview Transcript (Nov. 23, 2015); Nurse Monica Bisgard DPD Interview Transcript (Nov. 23, 2015); Nurse Renee Chavez DPD Interview Transcript (Dec. 1, 2015).

[216] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 8.3 (effective Nov. 12, 2013).

[217] Letter from Executive Director of Safety Stephanie Y. O'Malley to Marshall Family, et al. (Mar. 16, 2016) (on file with author) ("As previously noted, the Office of the Independent Monitor (OIM) is actively monitoring the administrative review of the case and recently made recommendations to the Sheriff Department to take additional steps to ensure the investigation is thorough and complete. The Sheriff Department is reviewing the OIM's recommendations and determining what additional resources and time may be necessary in meeting the recommendations."); Letter from Executive Director of Safety Stephanie Y. O'Malley to Marshall Family, et al. (Apr. 1, 2016) (on file with author) ("In my last correspondence I noted that the Office of the Independent Monitor (OIM) recommended that the Sheriff Department Internal Affairs Bureau (IAB) take additional steps to ensure the investigation is thorough and complete. Since then, the Sheriff Department's IAB met with the OIM to discuss the recommendation and additional steps. Currently, additional interviews were scheduled with each of the use of force subject officers, five of which have been completed to date."); *see also* E-mail from Independent Monitor Nicholas E. Mitchell to DSD IAB Major Jodi Blair (Mar. 4, 2016) (on file with author).

[218] *See* Deputy David Arellano DSD Interview Transcript (Mar. 31, 2016); Deputy Sarah Bautista DSD Interview Transcript (Apr. 4, 2016); Deputy Smajo Civic DSD Interview Transcript (Mar. 24, 2016); Deputy Bret Garegnani DSD Interview Transcript (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript (Mar. 31, 2016).

[219] E-mail from DSD IAB then-Manager Armando Saldate to OIM Deputy Monitors Kevin Strom and Denis McCormick, et al. (Apr. 7, 2016) (on file with author).

[220] Notice of Legal Claims of the Estate of Michael Lee Marshall, from Mari Newman to Mayor Michael B. Hancock, et al. (May 6, 2016).

[221] E-mail from DSD Major Jodi Blair to Deputy Monitor Kevin Strom and Independent Monitor Nicholas E. Mitchell (May 24, 2016) (on file with author).

[222] The nurses did not have a right to flatly refuse to be interviewed by IAB. The Operating Agreement between DSD and DHMC, which employs the nurses, states that "[i]f the City or [DHMC] are defending a pending or threatened claim, the Sheriff Internal Affairs Investigators shall be allowed to interview nurses or other [DHMC] personnel who work at the [Correctional Care Medical Facility] by submitting written questions to [DHMC]. [DHMC] shall have the nurses answer the written questions in their own words with the assistance of legal counsel." Fiscal Year 2016 Amendment to the Amended and Restated Operating Agreement Between the City and County of Denver and Denver Health and Hospital Authority, Appendix A § A-6(1.7)(b) (Nov. 5, 2015).

[223] At the time, IAB and Civil Liabilities Bureau Procedures defined a decline as: "after careful review of both the complaint statement and all incident reports, the Internal Affairs and Civil Liabilities Bureau command staff and the Office of the Independent Monitor concur that the incident has not violated any rules and regulations." DSD Internal Affairs and Civil Liabilities Bureau Procedures § 903.0 (revised May 2013).

[224] Although IAB submitted this case as a completed investigation on February 25, 2016, IAB did not propose a decline at that time. Therefore, we have treated IAB's submission of the case to the OIM on June 1, 2016 as the first attempted decline by IAB. *See* IAPro routing from then-Sergeant Jamison Brown to Deputy Monitor Kevin Strom (June 1, 2016) (on file with author).

[225] That letter was subsequently produced to Deputies Garegnani and Hernandez during their disciplinary appeals, and it was Exhibit F in that appeal. Further, in the disciplinary order issued to Deputy Bret Garegnani, the Hearing Officer noted that "the agency's own IAB . . . declined this case for further action. [Exh. F]." Decision Reversing Suspensions, *Carlos Hernandez and Bret Garegnani v. Dep't of Safety, Denver Sheriff Dep't*, Hearing Officer, Career Service Board, City and County of Denver, Appeal No. A025-17 and A026-17, 11 (Nov. 3, 2017).

[226] Letter to file regarding Michael Marshall Case No. S2015-0263 (uploaded June 1, 2016) (on file with author).

[227] Letter to file regarding Michael Marshall Case No. S2015-0263 (uploaded June 1, 2016) (on file with author).

[228] Letter to file regarding Michael Marshall Case No. S2015-0263 (uploaded June 1, 2016) (on file with author). This letter was admitted as Appellant's Exhibit F during the Career Service Hearings of Deputies Bret Garegnani and Carlos Hernandez on September 18-19, 2017.

[229] DSD Internal Affairs and Civil Liabilities Bureau Procedures § 903.0 (revised May 2013).

[230] Letter from Executive Director of Safety Stephanie Y. O'Malley to Marshall Family, et al. (June 29, 2016) (on file with author) ("The administrative review of Mr. Marshall's death is nearing conclusion; however, some follow up with witnesses continues to take place to support a thorough and complete investigation."); E-mail from Independent Monitor Nicholas E. Mitchell to Executive Director of Safety Stephanie Y. O'Malley, Sheriff Patrick Firman, DSD IAB Major Jodi Blair, and DSD IAB then-Manager Armando Saldate (June 17, 2016) (on file with author).

[231] IAPro routing from DSD IAB then-Sergeant Jamison Brown to Deputy Monitor Kevin Strom (July 27, 2016) (screenshot on file with author); E-mail from DSD IAB then-Sergeant Jamison Brown to Deputy Monitor Kevin Strom (July 27, 2016) (on file with author).

[232] E-mail from DSD IAB then-Sergeant Jamison Brown to Deputy Monitor Kevin Strom (July 27, 2017) (on file with author); IAPro routing from DSD IAB then-Sergeant Jamison Brown to Deputy Monitor Kevin Strom (July 27, 2017) (screenshot on file with author).

[233] E-mail from Independent Monitor Nicholas E. Mitchell to DSD IAB Major Jodi Blair and DSD IAB then-Manager Armando Saldate (Aug. 4, 2016) (on file with author).

[234] E-mail from Independent Monitor Nicholas E. Mitchell to DSD IAB Major Jodi Blair and DSD IAB then-Manager Armando Saldate (Aug. 4, 2016) (on file with author); IAPro routing from DSD IAB then-Manager Armando Saldate to DSD CRO then-Captain Stephanie McManus (Aug. 4, 2016) (screenshot on file with author).

[235] DSD Internal Affairs and Civil Liabilities Bureau Procedures § 104 (revised May 2013); *See also* DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 8.1 (effective Nov. 12, 2013) ("[T]he integrity of the internal investigation process is essential to the fair administration of discipline." "No system of discipline can be effective without investigations that can be considered unbiased and trustworthy by members of the Department as well as the general public."); U.S. DOJ Office of Community Oriented Police Services, *Standards and Guidelines for Internal Affairs: Recommendations from a Community of Practice* § 3.1 (2008).

[236] *See, e.g.*, Deputy David Arellano DSD Interview Transcript (Mar. 31, 2016); Deputy Sarah Bautista DSD Interview Transcript (Apr. 4, 2016); Deputy Smajo Civic DSD Interview Transcript (Mar. 24, 2016); Deputy Bret Garegnani DSD Interview Transcript (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript (Mar. 31, 2016). The nurses were never interviewed in person by DSD IAB, and DSD IAB informed the OIM that the nurses' written statements were provided on July 27, 2016.

[237] *See* E-mail from Independent Monitor Nicholas E. Mitchell to DSD IAB Major Jodi Blair (Mar. 4, 2016) (on file with author).

[238] *See* E-mail from Independent Monitor Nicholas E. Mitchell to DSD IAB Major Jodi Blair (Mar. 4, 2016) (on file with author).

[239] It also appeared to conflict with guidance provided by the OIR Group, which emphasized the importance of IAB being able to conduct thorough investigations prior to sending them for review by the OIM ("IA staff should be catching the basic types of deficiencies identified by the OIM prior to the case being released for review. This would result in in greater efficiency and free up the OIM to review the investigations' more subtle issues"). OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 67 (May 2015).

[240] *See, generally*, Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 3 (Jan. 7, 2016); Sally Port and Hallway Videos 18:35:30-18:46:11.

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

[242] *See, generally,* 18:35:30-18:46:11 on the Sally Port and Hallway Videos (uploaded to IAPro on Jan. 27, 2016).

[243] Nurse Helen Ajao DPD Interview Transcript, lines 581-612 (Dec. 1, 2015) (uploaded to IAPro on Jan. 26, 2016).

[244] *See, e.g.*, Deputy Bret Garegnani DSD Interview Transcript, lines 473-79 (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 324-90 (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript, lines 342-57 (Mar. 31, 2016).

[245] DSD, *DSD Reform Effort: Phase One Status Report*, at 17 (Oct. 31, 2014), https://www.denvergov.org/content/dam/denvergov/Portals/728/documents/DSD/FINAL%20Denver%20Sheriff%20Department%20Reform%20Effort%2010-31-14.pdf; *Mayor Hancock Sets New Leadership and Top-to-Bottom Review of Sheriff Department* (July 21, 2014), https://www.denvergov.org/content/denvergov/en/mayors-office/newsroom/2014/mayor-hancock-sets-new-leadership-and-top-to-bottom-review-of-sh.html.

[246] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 2, 5 (May 2015).

[247] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 47 (May 2015).

[248] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 11-12, (May 2015).

[249] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 2 (May 2015); *See* Denver Sheriff Top-to-Bottom Reform Overview, https://www.denvergov.org/content/denvergov/en/mayors-office/programs-initiatives/sheriff-department-reform.html.

[250] *See, e.g.*, OIM, *2013 Semiannual Report*, at 16-20 (recommending that "IAB's policies and procedures be clarified to make certain that all allegations of misconduct that are relayed to IAB are entered into IAPro and communicated to the OIM, without fail"); Letter from Independent Monitor Nicholas E. Mitchell to City Councilmember Paul D. Lopez, at 14-15 (Sept. 10, 2014) (on file with author) (identifying the OIM's "concern that it has taken too long for investigations into alleged deputy misconduct to be completed" and noting that solutions "likely involve dedicating additional resources to DSD Internal Affairs, taking steps to restructure the unit, and making significant investments in investigator training"); OIM, *2015 Annual Report*, at 59 (noting that "a prior IAB commander had marked a large number of inmate complaints as requiring formal investigation (in internal tracking documents), presumably due to their level of seriousness, but many of these complaints were never entered into IAPro (the DSD's complaints tracking database) and/or reviewed by the OIM"); OIM, *2016 Annual Report*, at 41 (announcing "a review of the DSD's grievance and complaint handling processes" following a decrease in recorded complaints at a time of "rising jail populations in both DSD jails").

[251] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 8.1 (effective Nov. 12, 2013).

[252] Elizabeth Hernandez, *Grayson Robinson to Lead Denver Sheriff Department's Internal Affairs,* The Denver Post (Sept. 22, 2014); OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 48 (May 2015).

[253] OIM, *2014 Annual Report*, at 74, 84.

[254] OIM, *2014 Annual Report*, at 74, 84.

[255] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 48 (May 2015).

[256] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 51 (May 2015).

[257] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 66 (May 2015).

[258] OIR Group, *Report on the Use of Force & Internal Affairs Operations in Denver Sheriff Department*, at 83 (May 2015).

[259] DOS Disciplinary Determination for Captain James Johnson, at 17 (Apr. 19, 2017); Letter from DSD CRO then-Captain Stephanie McManus to Sergeant Keri Adcock (Apr. 19, 2017) (on file with author); Letter from DSD CRO then-Captain Stephanie McManus to Sergeant Tracy Moore (Apr. 19, 2017) (on file with author); Letter from DSD CRO then-Captain Stephanie McManus to Sergeant Michael Newtown (Apr. 19, 2017) (on file with author).

[260] Under the DSD Discipline Handbook, RR-1100.8 – Failure to Supervise states that "Supervisors are required to fulfill all obligations, duties and responsibilities of their rank." It carries a presumptive penalty ranging from a written reprimand to possible termination. DSD Disciplinary Handbook: Conduct Principles and Disciplinary Guidelines, Appendix E, Appendix F at 25 (effective Nov. 12, 2013).

[261] DOS Disciplinary Determination for Captain James Johnson, at 15 (Apr. 19, 2017).

[262] DOS Disciplinary Determination for Captain James Johnson, at 15 (Apr. 19, 2017).

[263] DOS Disciplinary Determination for Captain James Johnson, at 15 (Apr. 19, 2017).

[264] DSD Disciplinary Handbook: Conduct Principles and Disciplinary Guidelines, Appendix F at 25 (effective Nov. 12, 2013).

[265] DSD Performance Enhancement Plan, Denver Sheriff – Sergeant, at 1 (effective May 23, 2016).

[266] DSD Department Order 5011.1M § 14 (C) (effective Jan. 27, 2014); DSD Performance Enhancement Plan, Denver Sheriff – Sergeant, at 1 (effective May 23, 2016).

[267] *See, generally*, DSD Trans-Divisional Order 1.00.5024 – Sergeant (effective Oct. 20, 2017); DSD Performance Enhancement Program Plan – Deputy Sheriff – Sergeant (effective May 23, 2016); DSD Employee Manual, at 21 (2016); DSD Post Order 1.00.5025 – Watch Commander (effective Oct. 20, 2017).

[268] *See, e.g.*, 18:35:30-18:46:11 on the Sally Port and Hallway Videos; Deputy Bret Garegnani DSD Interview Transcript, lines 473-79 (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 324-90 (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript, lines 342-57 (Mar. 31, 2016); Sergeant Keri Adcock DSD Interview Transcript, lines 567-73 (Feb. 18, 2016); Sergeant Tracy Moore DSD Interview Transcript, lines 431-35 (Feb. 22, 2016); Sergeant Michael Newtown DSD Interview Transcript, lines 308-11 (Feb. 18, 2016).

[269] Deputy Bret Garegnani DSD Interview Transcript, lines 473-79 (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 324-90 (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript, lines 342-57 (Mar. 31, 2016); Sergeant Keri Adcock DSD

Interview Transcript (Feb. 18, 2016); Sergeant Tracy Moore DSD Interview Transcript (Feb. 22, 2016); Sergeant Michael Newtown DSD Interview Transcript (Feb. 18, 2016).

[270] DOS Disciplinary Determination for Captain James Johnson, at 15-16 (Apr. 19, 2017).

[271] *See, e.g.*, Deputy Bret Garegnani DSD Interview Transcript, lines 473-79 (Mar. 31, 2016); Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 324-90 (Mar. 31, 2016); Deputy Carlos Hernandez DSD Interview Transcript, lines 342-57 (Mar. 31, 2016).

[272] Deputy Bret Garegnani DSD Interview Transcript, lines 473-91 (Mar. 31, 2016).

[273] Deputy Bret Garegnani DSD Interview Transcript, lines 473-91 (Mar. 31, 2016).

[274] *See, generally,* 18:35:30-18:46:11 on the Sally Port and Hallway Videos.

[275] Decision Reversing 10-day Suspension, *Johnson v. Dep't of Safety, Denver Sheriff's Dep't*, Career Service Board, Appeal No. A024-17, at 6-7 (Nov. 6, 2017). The City has appealed that ruling to the full Career Service Board.

[276] The Hearing Officer stated "[The discipline against Captain Johnson] presumes Johnson was tasked with a responsibility to be involved in a hands-on manner. The evidence, above, indicates it is the on-scene sergeants who had that responsibility and that Johnson fulfilled his obligation to observe whether the sergeants were properly monitoring their charges. As was stated above, [the DOS] had no issue with the conduct of any of the sergeants." *See* Decision Reversing 10-day Suspension, *Johnson v. Dep't of Safety, Denver Sheriff's Dep't*, Career Service Board, Appeal No. A024-17, at 7 (Nov. 6, 2017).

[277] E-mail from City Councilmember Paul D. Lopez to Independent Monitor Nicholas E. Mitchell (Sept. 2, 2014) (on file with author); Letter from Independent Monitor Nicholas E. Mitchell to City Councilmember Paul D. Lopez, at 1 (Sept. 10, 2014) (on file with author).

[278] Letter from Independent Monitor Nicholas E. Mitchell to City Councilmember Paul D. Lopez (Sept. 10, 2014) (on file with author).

[279] Letter from Independent Monitor Nicholas E. Mitchell to City Councilmember Paul D. Lopez, at 4-6 (Sept. 10, 2014) (on file with author).

[280] Letter from Independent Monitor Nicholas E. Mitchell to City Councilmember Paul D. Lopez, at 3-6 (Sept. 10, 2014) (on file with author).

[281] Letter from Independent Monitor Nicholas E. Mitchell to City Councilmember Paul D. Lopez, at 4-5 (Sept. 10, 2014) (on file with author).

[282] Letter from Independent Monitor Nicholas E. Mitchell to City Councilmember Paul D. Lopez, at 6 (Sept. 10, 2014) (on file with author).

[283] Denver Office of the Auditor, *Follow-up Report: Denver Sheriff Department Jail Operations*, at 2 (Dec. 2016).

[284] The OIM is required by ordinance to include in its reports analyses of the "appropriateness of disciplinary actions, if any" and provides this analysis pursuant to the D.R.M.C. *See* Denver Revised Municipal Code § 2-375(a).

[285] DOS Disciplinary Determination for Deputy Bret Garegnani, at 17 (Apr. 19, 2017); DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix E (effective Nov. 12, 2013).

[286] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines §§ 13.0, 14.0 (effective Nov. 12, 2013).

[287] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 13.1 (effective Nov. 12, 2013).

[288] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 14.1 (effective Nov. 12, 2013).

[289] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 13.1, Appendix C at 10 (effective Nov. 12, 2013).

[290] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix E (effective Nov. 12, 2013).

[291] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix E (effective Nov. 12, 2013).

[292] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix C at 11 (effective Nov. 12, 2013).

[293] DOS Disciplinary Determination for Deputy Bret Garegnani, at 17 (Apr. 19, 2017).

[294] DOS Disciplinary Determination for Deputy Bret Garegnani, at 16 (Apr. 19, 2017).

[295] DOS Disciplinary Determination for Deputy Bret Garegnani, at 16 (Apr. 19, 2017) (quoting the definition of Conduct Category D, DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 13.1.4 (effective Nov. 12, 2013)) (emphasis added).

[296] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 13.1.4 (effective Nov. 12, 2013).

[297] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix C at 9 (effective Nov. 12, 2013) ("One of the most important issues that a disciplinary system for any law enforcement agency must address is the use of force. Due to the myriad consequences that can flow from such an incident, no issue is likely to impact the public's relationship with, and respect for, the Department more than the inappropriate use of force.").

[298] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 1.3 (effective Nov. 12, 2013).

[299] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix C at 9 (effective Nov. 12, 2013).

[300] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 1.2 (effective Nov. 12, 2013).

[301] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 1.2 (effective Nov. 12, 2013).

[302] DOS Disciplinary Determination for Deputy Bret Garegnani, at 8 (Apr. 19, 2017); *see also* Deputy Bret Garegnani DPD Interview Transcript, lines 246-47 (Nov. 12, 2015) ("it appeared to me that he . . . went unconscious or was not responsive . . . all of a sudden."); Nurse Ashley Allison DPD Interview Transcript, lines 145-46 (Nov. 23, 2015).

[303] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[304] Deputy Bret Garegnani DPD Interview Transcript, lines 453-57 (Dec. 17, 2015).

[305] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[306] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[307] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[308] DSD Department Order 5011.1M § 4 (effective Jan. 27, 2014).

[309] *See, e.g.*, Baltimore Police Department Manual Policy 1115, at 4 ("Reasonableness must be judged from the perspective of a reasonable officer on the scene, rather than with the benefit of hindsight."); Seattle Police Department Manual § 8.000(4) ("The reasonableness of a particular use of force is based on the totality of circumstances known by the officer at the time of the use of force and weighs the actions of the officer against the rights of the subject, in light of the circumstances surrounding the event. It must be judged from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight.").

[310] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017); 18:41:19-18:46:11 on the Sally Port and Hallway Videos.

[311] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7, 15 (Apr. 19, 2017).

[312] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[313] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 15.1.4 (effective Nov. 12, 2013).

[314] DOS Disciplinary Determination for Deputy Bret Garegnani, at 7, 15 (Apr. 19, 2017); Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 5 (Jan. 21, 2016).

[315] Office of the Medical Examiner, *Autopsy Report, Michael Marshall*, at 5 (Jan. 7, 2016); *see also* Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 5 (Jan. 21, 2016).

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

[317] We note that there were other causes of death. Indeed, in a follow up interview with the Denver DA's Office, the Assistant Medical Examiner who performed the autopsy qualified her opinion about Mr. Marshall's death in several ways. She noted, for example, that she would not have expected Mr. Marshall to have had difficulty breathing because he was held in a prone position by deputies, among other findings. Yet, while his death may have been caused by a number of factors, the DOS's findings make clear that Deputy Garegnani's inappropriate force impacted Mr. Marshall's ability to breathe, and, at the very least, caused demonstrable serious risk to his safety. *See* Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 6-7 (Jan. 21, 2016); DOS Disciplinary Determination for Deputy Bret Garegnani, at 15 (Apr. 19, 2017).

[318] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines §§ 13.1.4-13.1.6 (effective Nov. 12, 2013).

[319] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 15.1.4 (effective Nov. 12, 2013).

[320] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines §§ 13.1.4-13.1.6 (effective Nov. 12, 2013).

[321] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines §§ 13.1.5-13.1.6 (effective Nov. 12, 2013).

[322] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 13.1.4 (effective Nov. 12, 2013).

[323] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines §§ 13.1.4-13.1.6 (effective Nov. 12, 2013) (emphasis added).

[324] DOS Disciplinary Determination for Deputy Bret Garegnani, at 15-16 (Apr. 19, 2017).

[325] Decision and Order, *Ford v. Department of Safety, Denver Sheriff Dep't*, Career Service Board, Appeal No. 48-14A, at 7-8 (Dec. 17, 2015). *See also* Decision Modifying Two-Level Demotion with Attendant Loss of Pay to a 30-Day Suspension, *Wilson v. Dep't of Safety, Denver Sheriff's Dep't*, Career Service Board, Appeal No. A038-17, at 14 (Dec. 17, 2015) (holding that the description of the offense in the disciplinary order "merely restates the matrix, and fails to explain the basis for extraordinary aggravation, as required.").

[326] Michael Roberts, *Longer Suspension for Sexy Texts than for Killing Michael Marshall,* Westword (Apr. 20, 2017); Jesse Paul, *Two Denver Deputies, Sheriff's Watch Commander Suspended in Jail Death of Michael Marshall*, The Denver Post (Apr. 19, 2017).

[327] Letter from the Citizen Oversight Board to Executive Director of Safety Stephanie Y. O'Malley (Apr. 28, 2017) (on file with author).

[328] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 10.17 (effective Nov. 12, 2013).

[329] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines § 15.0 (effective Nov. 12, 2013).

[330] Decision Reversing Suspensions, *Carlos Hernandez and Bret Garegnani v. Dep't of Safety, Denver Sheriff's Dep't*, Career Service Board, City and County of Denver, Appeal No. A025-17 and A026-17 (Nov. 3, 2017).

[331] Decision Reversing Suspensions, *Carlos Hernandez and Bret Garegnani v. Dep't of Safety, Denver Sheriff's Dep't*, Career Service Board, City and County of Denver, Appeal No. A025-17 and A026-17, at 7, 11 (Nov. 3, 2017).

[332] We note that these decisions may be reversed by the Career Service Board only under limited enumerated grounds. For example, the Career Service Board may reverse if the Hearing Officer erroneously interpreted any applicable legal authority, or if the decisions were not supported by the evidence, and were clearly erroneous. *See* City and County of Denver Career Service Rules, Rule 21, § 21-21 (revised Feb. 21, 2017).

[333] Decision Reversing Suspensions, *Carlos Hernandez and Bret Garegnani v. Dep't of Safety, Denver Sheriff's Dep't*, Career Service Board, City and County of Denver, Appeal No. A025-17 and A026-17, at 7, 11 (Nov. 3, 2017).

[334] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 8 (Jan. 21, 2016).

[335] Under Denver Revised Municipal Code § 2-375(b), the OIM's reports are required to "present information in statistical and summary form, without identifying specific persons except to the extent that incidents involving specific persons have otherwise been made public by the City and County of Denver." In this case, Deputy Phuvapaisalkij was neither criminally charged nor disciplined in connection with this incident, but his identity was made public by the City and County of Denver. *See*, *e.g.*, Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall (Jan. 21, 2016), and the DOS Disciplinary Determinations for Deputies Bret Garegnani, Carlos Hernandez, and Captain James Johnson (Apr. 19, 2017). Therefore, neither he nor the other deputies who were not criminally charged or disciplined have been made anonymous in this report.

[336] Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 159-67, 187-97, 596-97, 1440-41 (Nov. 12, 2015).

[337] Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 167-82 (Nov. 12, 2015). A gooseneck hold is a pain-compliance hold performed by using one or two hands to push the subject's hand toward the inside of the wrist. *See* United States Department of Army, *The Military Police Handbook*, B58-B60 (1975).

[338] Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 723-58 (Nov. 12, 2015).

[339] Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 879-96 (Nov. 12, 2015).

[340] Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 967-68 (Nov. 12, 2015).

[341] Multiple people, including Deputy Phuvapaisalkij, said that they made the decision that Mr. Marshall could not be properly restrained in a wheelchair, and that they had to wait for the restraint chair. *See* Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 959-968; (Nov. 12, 2015); Deputy Bret Garegnani DPD Interview Transcript, lines 907-09 (Nov. 12, 2015); Deputy Smajo Civic DPD Interview Transcript, lines 762-74 (Nov. 12, 2015); *see also* DOS Disciplinary Determination for Deputy Bret Garegnani, at 10 (Apr. 19, 2017).

[342] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall (Jan. 21, 2016).

[343] E-mail to Independent Monitor Nicholas E. Mitchell (Nov. 7, 2017) (on file with author).

[344] The Executive Director of Safety is responsible for making conditional job offers based on a review of eligible candidates provided by the DPD following initial testing and screening. *See* Denver Police Recruiting webpage, https://www.denverpolicerecruit.com/hiring-process (accessed Jan. 22, 2018); Denver Civil Service Commission Rule 3 § 1 (B)(4).

[345] E-mail to Independent Monitor Nicholas E. Mitchell (Nov. 7, 2017) (on file with author).

[346] Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 21-31 (Mar. 31, 2016).

[347] Settlement Agreement, *U.S. v. City of Albuquerque*, 14-CV-1025 § 239 (D.N.M. Nov. 14, 2014).

[348] The Background Investigation Report is dated October 21, 2015. *See* Background Investigation Report, Thanarat Phuvapaisalkij (Oct. 21, 2015) (on file with author).

[349] DSD Discipline Handbook: Conduct Principles and Disciplinary Guidelines, Appendix C at 11, Appendix E (effective Nov. 12, 2013).

[350] According to IAPro, Deputy Phuvapaisalkij was added as a subject to the case on November 23, 2015. Four specifications of potential misconduct were added for Deputy Phuvapaisalkij on January

27, 2016. As of January 22, 2018, none of the four specifications have been resolved. (Screenshot on file with author). *See also* DOS Disciplinary Determination for Deputy Bret Garegnani, at 7 n. 5 ("Deputy Phuvapaisalkij is no longer a member of the Denver Sheriff Department and, therefore, his conduct was not analyzed pursuant to this administrative determination.") (Apr. 19, 2017).

[351] Agreement between The United States of America and Jerry L. Demings, in his official capacity as Orange County Sheriff § 14 (2010).

[352] We note that there is no evidence in the case file of an official diagnosis of excited delirium.

[353] Brian Roach, M.D., Kelsey Echols, M.D., and Aaron Burnett, M.D., *Excited Delirium and the Dual Response: Preventing In-Custody Deaths*, Law Enforcement Bulletin (FBI Training Division), available at https://leb.fbi.gov/articles/featured-articles/excited-delirium-and-the-dual-response-preventing-in-custody-deaths (July 8, 2014).

[354] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions § 3 (Sept. 9, 2009) (distributed to "DSD Badged" listserv on Nov. 2, 2015).

[355] City and County of Denver Multi-Agency Excited Delirium Protocol.

[356] City and County of Denver Multi-Agency Excited Delirium Protocol § I.

[357] City and County of Denver Multi-Agency Excited Delirium Protocol § II.

[358] City and County of Denver Multi-Agency Excited Delirium Protocol § II.

[359] Keith Wesley, MD, *Excited Delirium Strikes Without Warning,* Journal of Emergency Medical Services (Feb. 2011) (the e-mail was sent to the "DSD Badged" listserv on Nov. 2, 2015).

[360] We were not alone in that view. In fact, upon watching the video, the DSD use of force trainer who reviewed the case almost immediately identified Mr. Marshall's behavior as possibly indicative of excited delirium. *See* Deputy Eishi Yamaguchi DSD IAB Interview Transcript, at 5 (Feb. 3, 2016).

[361] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); Deputy Carlos Hernandez DPD Interview Transcript, lines 194-97 (Nov. 12, 2015).

[362] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 n. 2 (Jan. 21, 2016).

[363] DOS Disciplinary Determination for Deputy Bret Garegnani, at 5 n. 1 (Apr. 19, 2017).

[364] *See, e.g.*, Deputy Carlos Hernandez DPD Interview Transcript, lines 1398-1420 (Nov. 12, 2015); Nurse Ashley Allison DPD Interview Transcript, lines 779-90 (Nov. 23, 2015); Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 192-200 (Nov. 12, 2015); Deputy David Arellano DPD Interview Transcript, lines 414-20 (Nov. 12, 2015); Deputy Sarah Bautista DPD Interview Transcript, lines 967-74 (Nov. 12, 2015).

[365] Decision Statement from District Attorney Mitchell R. Morrissey Regarding the Death of Michael Marshall, at 2 (Jan. 21, 2016); Deputy Carlos Hernandez DPD Interview Transcript, lines 188-89 (Nov. 12, 2015).

[366] *See, e.g.*, Deputy Bret Garegnani DPD Interview Transcript, lines 437-56 (Nov. 12, 2015); Deputy Carlos Hernandez DPD Interview Transcript, lines 239-49 (Nov. 12, 2015); Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 171-77 (Nov. 12, 2015).

[367] *See, e.g.*, Deputy Smajo Civic DPD Interview Transcript, lines 445-47 (Nov. 12, 2015); Deputy Bret Garegnani DPD Interview Transcript, lines 214-16 (Nov. 12, 2015); Deputy Carlos Hernandez DPD Interview Transcript, lines 186-90 (Nov. 12, 2015).

[368] *See, e.g.*, Deputy Smajo Civic DPD Interview Transcript, lines 615-17 (Nov. 12, 2015); Deputy Carlos Hernandez DPD Interview Transcript, lines 242-43 (Nov. 12, 2015); Deputy Thanarat Phuvapaisalkij DPD Interview Transcript, lines 188-90 (Nov. 12, 2015).

[369] Deputy Smajo Civic DSD Interview Transcript, lines 612-16 (Mar. 24, 2016).

[370] Deputy Bret Garegnani DSD Interview Transcript, lines 88-90 (Mar. 31, 2016).

[371] Deputy Bret Garegnani DSD Interview Transcript, lines 91-97 (Mar. 31, 2016).

[372] Deputy Carlos Hernandez DSD Interview Transcript, lines 158-63 (Mar. 31, 2016).

[373] E-mail from DSD Deputy Larry Brown to Independent Monitor Nicholas E. Mitchell (Nov. 7, 2016) (on file with author) (attachments include DSD Lesson Plan for Excited Delirium Course, DSD Video, and PowerPoint presentation entitled "What is Excited Delirium?").

[374] Deputy Bret Garegnani DSD Interview Transcript, lines 65-74 (Mar. 31, 2016).

[375] Deputy Carlos Hernandez DSD Interview Transcript, lines 139-44 (Mar. 31, 2016).

[376] Deputy Carlos Hernandez DSD Interview Transcript, lines 147-49 (Mar. 31, 2016).

[377] Deputy Smajo Civic DSD Interview Transcript, lines 512-19 (Mar. 24, 2016).

[378] Deputy Smajo Civic DSD Interview Transcript, lines 539-48 (Mar. 24, 2016).

[379] Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 55-64 (Mar. 31, 2016).

[380] Deputy Thanarat Phuvapaisalkij DSD Interview Transcript, lines 65-67 (Mar. 31, 2016).

[381] Deputy Sarah Bautista DSD Interview Transcript, lines 55-71 (Apr. 4, 2016).

[382] City and County of Denver Multi-Agency Excited Delirium Protocol § II(8).

[383] City and County of Denver Multi-Agency Excited Delirium Protocol § II(9).

[384] City and County of Denver Multi-Agency Excited Delirium Protocol § II(9).

[385] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions (Sept. 9, 2009) (the e-mail was sent to the "DSD Badged" listserv on Nov. 2, 2015).

[386] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions, at 1 (Sept. 9, 2009).

[387] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions, at 1 (Sept. 9, 2009).

[388] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions, at 2 (Sept. 9, 2009).

[389] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions, at 2 (Sept. 9, 2009).

[390] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions, at 2 (Sept. 9, 2009).

[391] Orange County Sheriff's Department Jail Compliance & Training Team, In-Custody Death Precautions, at 2 (Sept. 9, 2009).

[392] *See, generally*, 18:35:30-18:46:11 on the Sally Port Video.

[393] *See*, 18:45:11-18:50:52 on the Sally Port and Hallway Videos.

[394] *See, e.g.*, 18:49:04 on the Hallway Video.

[395] Nurse Helen Ajao DPD Interview Transcript, lines 528-44, 581-96, 606-07 (Dec. 1, 2015).

[396] Nurse Helen Ajao DPD Interview Transcript, lines 598-612 (Dec. 1, 2015).

[397] Deputy Bret Garegnani DSD Interview Transcript, lines 244-57, 517-25 (Mar. 31, 2016).

[398] *See* 18:40:15 and 18:41:19 on the Sally Port Video.

[399] Nurse Monica Bisgard, Written Responses, at 2; Nurse Renee Chavez DPD Interview Transcript, lines 211-16, 343-47 (Dec. 1, 2015); DOS Disciplinary Determination for Deputy Bret Garegnani, at 10 (Apr. 19, 2017).

[400] Nurse Ashley Allison DPD Interview Transcript, lines 937-40 (Nov. 23, 2015).

[401] DSD Employee Manual, at 6 (2014).

[402] DSD Department Order 5011.1M (effective Jan. 27, 2014).

[403] DSD Department Order 6001.M § 2 (effective Sept. 3, 2014); Denver Health Policy NCCHC J-B-02 – Patient Safety, at 1.

[404] The DSD's mission is "to provide safe and secure custody for those placed in our care and to perform all of our duties in a manner that is responsive to the needs of our diverse community." *See* DSD Employee Manual, at 1 (2014).

[405] *See, e.g.*, Seattle Police Department Manual § 1.115.6 – Media Release: Officer Involved Shooting, available at https://www.seattle.gov/police-manual/title-1---department-administration/1115---media-release-officer-involved-shooting; Video Release Policy for the City of Chicago §§ III-IV, available at https://www.cityofchicago.org/content/dam/city/depts/cpd/Policies/VideoReleasePolicyfortheCityofChicago.pdf.

[406] Lance Hernandez, *Family Attorney Demands to See Video of Fatal Confrontation with Michael Marshall, Denver Deputies,* thedenverchannel.com (Nov. 24, 2015).

[407] Susan Greene, *Hancock Administration's "Transparency" About Michael Marshall's Death is Hard to See,* The Colorado Independent (Nov. 24, 2015).

[408] *The Colorado Independent v. Mary Dulacki*, Denver District Court, Case No. 2016CV30197 (filed Jan. 20, 2016).

[409] Laura Bond, *Colorado Independent Sues Denver: Release the Michael Marshall Tapes,* The Colorado Independent (Jan. 20, 2016).

[410] Laura Bond, *Colorado Independent Sues Denver: Release the Michael Marshall Tapes,* The Colorado Independent (Jan. 20, 2016).

[411] Laura Bond, *Colorado Independent Sues Denver: Release the Michael Marshall Tapes,* The Colorado Independent (Jan. 20, 2016).

[412] Laura Bond, *Colorado Independent Sues Denver: Release the Michael Marshall Tapes,* The Colorado Independent (Jan. 20, 2016).

[413] *A Pledge from Mayor Hancock on Denver Jail Video of Michael Marshall's Death*, The Denver Post (Jan. 18, 2016).

[414] Noelle Phillips, *Denver Releases Key Video in Michael Marshall Jail Death Review,* The Denver Post (Jan. 22, 2016).

[415] U.S. DOJ, Community Oriented Policing Services, and Vera Institute of Justice, *Police Perspectives, Building Trust in a Diverse Nation: How to Increase Cultural Understanding*, at 31 (2016).

[416] President's Task Force on 21st Century Policing, *Final Report of the President's Task Force on 21st Century Policing*, at 22 (2015).

[417] *See, e.g*, President's Task Force on 21st Century Policing, *Final Report of the President's Task Force on 21st Century Policing*, at 22 (2015). The DOJ also recommends that law enforcement policies generally be posted online and otherwise made publicly available. *See United States v. City of New Orleans*, 12-CV-01924 § 428 (E.D. La., Jan. 11, 2013); *see also* President's Task Force on 21st Century Policing, *Final Report of the President's Task Force on 21st Century Policing*, at 13 (2015).

[418] Seattle Police Department Manual § 1.115.6 – Media Release: Officer Involved Shooting, available at https://www.seattle.gov/police-manual/title-1---department-administration/1115---media-release-officer-involved-shooting.

[419] Las Vegas Metropolitan Police Department Body Worn Camera Recordings Policy, at 2-5, available at https://www.lvmpd.com/en-us/Pages/BodyCameraVideo.aspx.

[420] Video Release Policy for the City of Chicago §§ III-IV, available at https://www.cityofchicago.org/content/dam/city/depts/cpd/Policies/VideoReleasePolicyfortheCityofChicago.pdf.

[421] While each policy provides general guidelines for releasing video, each also contains exemptions to those guidelines. For example, Las Vegas's policy states that "BWC recordings that are evidence in an ongoing investigation, judicial or administrative proceeding, are not public records until either the matter is concluded, or, in the case of a criminal proceeding, the evidence is submitted in a public forum." Chicago's policy allows government agencies, such as the State's Attorney and law enforcement agencies, to request that the release of video be delayed.

[422] *See Charity Krantz v. Denver Dep't of Safety*, 14-CV-34756 (Denver Dist. Ct. April 30, 2015) (holding that a blanket policy of denying every request for records contained in an IAB file until the final conclusion of the administrative review process was inconsistent with the Colorado Criminal Justice Records Act); C.R.S. § 24-72-304; *Harris v. Denver Post Corp.,* 123 P.3d 1166 (Colo. 2005).

[423] Any policy should be crafted in consultation with Denver's District Attorney's Office, which is an essential stakeholder regarding evidence that may be relevant to ongoing criminal investigations.

[424] Letter from a DSD Sergeant to Sheriff Patrick Firman (Dec. 8, 2015) (on file with author) ("It is with great pleasure as a supervisor on the Denver Sheriff Department that I recommend Deputy Sheriff Bret Garegnani for the Denver Sheriff Departments 'Life Saving Award' [sic]." According to the nomination, it was because of Deputy Garegnani's initiation of CPR on Mr. Marshall that "[Mr. Marshall] regained a heart rhythm and . . . remained alive for a number of days to allow for family members to visit with their loved one before he finally succumbed to his ailment and passed away . . . Deputy Garegnani is ultimately responsible for prolonging the life of Michael Marshall

which allowed for those valuable moments that the Marshall family ultimately had with Michael and will be forever grateful to Deputy Garegnani.)."

[425] James Doyle, *Learning from Error in the Criminal Justice System: Sentinel Event Reviews, National Institute of Justice, Mending Justice: Sentinel Event Reviews* (2013); Nancy Ritter, *Testing a Concept and Beyond: Can the Criminal Justice System Adopt a Nonblaming Practice?* (2011). In the medical field sentinel events can be catastrophic mistakes, including wrong patient surgeries, medication errors, and unexpected patient deaths.

[426] National Institute of Justice, *Mending Justice: Sentinel Event Reviews*, at 3 (2014).

[427] National Institute of Justice, *Mending Justice: Sentinel Event Reviews*, at 3 (2014). Examples of the application of SER in criminal justice include Leah Pope and Ayesha Delany-Brumsey, *Creating a Culture of Safety: Sentinel Events Reviews for Suicide and Self-Harm in Correctional Facilities*, Vera Institute of Justice (2017). In addition, the NIJ has made several grant awards in recent years to fund research on sentinel events in the criminal justice system. *See* https://external.ojp.usdoj.gov/selector/title?solicitationTitle=NIJ%20FY%2015%20Research%20on%20Sentinel%20Events%20and%20Criminal%20Justice%20System%20Errors&po=NIJ; https://external.ojp.usdoj.gov/selector/awardDetail?awardNumber=2015-R2-CX-K041&fiscalYear=2015&applicationNumber=2015-90390-MI-DN&programOffice=NIJ&po=NIJ.

[428] President's Task Force on 21st Century Policing, *Final Report of the President's Task Force on 21st Century Policing*, at 22 (2015).

[429]National Institute of Justice, *Mending Justice: Sentinel Event Reviews*, at 1 (2014).

[430] Leah Pope and Ayesha Delany-Brumsey, *Creating a Culture of Safety: Sentinel Events Reviews for Suicide and Self-Harm in Correctional Facilities*, Vera Institute of Justice (2017).

[431] OIR Group, Rep*ort on the Use of Force & Internal Affairs Operations in the Denver Sheriff Department*, at 7 (2015).

[432] OIR Group, *Report on the Use of Force & Internal Affairs Operations in the Denver Sheriff Department*, at 21 (2015).

[433] OIR Group, *Report on the Use of Force & Internal Affairs Operations in the Denver Sheriff Department*, at 21 (2015).

[434] Testimony of Deputy Eishi Yamaguchi, *Carlos Hernandez and Bret Garegnani v. Dep't of Safety, Denver Sheriff Dep't*, Career Service Board, City and County of Denver, Appeal No. A025-17 and A026-17 (Sept. 19, 2017).

[435] Police Executive Research Forum, *Review of Use of Force in the Albuquerque Police Department*, at 80 (June 23, 2011).

Appendix A
Department of Safety Response

Jess Vigil
Deputy Director of the Department of Safety

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Nick Mitchell
Independent Monitor
Denver, Colorado

Date: March 12, 2018

Dear Nick:

As you have requested, this is the revised comments/responses to the Marshall Report. Thank you for allowing the Executive Director of the Department of Safety to provide comment.

MARSHALL REPORT

- Neither the IAB investigation or the disciplinary decisions that followed were mishandled. While DSD IAB mistakenly believed it could rely upon the investigation conducted by DSD and did not need to conduct any additional investigation into the deputies' conduct, we disagree with this representation. Further, your report cites a procedural history that perhaps frustrated you. The investigation in the Marshall case is not unique in that regard. In fact, the process is set up to seek your input. There are times when there are disagreements with how investigations are proceeding. The process recognizes this, and avenues are available to you to raise your concerns. You did just that in this investigation and ultimately you certified the investigation as "thorough and complete." You allege that the investigation was flawed. Yet certifying the investigation as "thorough and complete" belies that claim. Moreover, you don't cite any instances or provide any examples where any evidence was unavailable or lost because of the procedural posture you found frustrating. To claim that the investigation was "flawed" without record support does not make it so.

- Recommendation 1 of your report recommends changes to "the culture of its Internal Affairs Bureau to better insure that serious cases are investigated impartially and without bias as DSD Policy requires." In fact, cases are investigated impartially and without bias. The DOS is committed to making sure that the process is thorough, fair and completely free of bias. Further, DSD, as you know, is open to examining and evaluating the benefits of civilianization. However, nothing in the Marshall investigation demonstrates bias or partiality, nor is there a "culture" of

bias or impartiality in DSD's IAB process. We do agree that after a criminal investigation into an incident has been completed, IAB should conduct its own investigation and not merely rely upon information obtained by the investigating law enforcement agency.

- Contrary to your assertions, the disciplinary decisions in this case were not flawed. The DOS reviewed the conduct of all deputies involved in the incident and imposed only those penalties that it believed, in good faith, were supported by the evidence and could withstand the scrutiny of appellate review. Unlike others involved in the disciplinary process, the DOS is the ultimate decisionmaker and must defend disciplinary actions taken when appeals by deputies are filed. As you know, the discipline you characterize as "not commensurate with the seriousness of the misconduct" was overturned by the CSA hearing officer. DOS was simply not willing to impose disciplinary action that was unsupported by the evidence and that would not stand on appeal. To do otherwise compromises the integrity of the process.

- You find fault in one of the DOS Disciplinary Letters because "the disciplinary order did not explain why Category D was assigned, nor why Category E and F were not assigned." Under the Disciplinary Matrix, every inappropriate use of force is a Conduct Category D, unless, after consideration of several factors, which are set forth in the code, a good faith determination is made that the misconduct should be assigned a higher conduct category. Where a decision is made that the misconduct is a Conduct Category D rule violation, there is no need to present in the order or letter why Conduct Categories E or F were not selected. To do so would be an unnecessary and time-consuming exercise. Finally, why DOS decided that the misconduct was of a Conduct Category D nature can be deciphered from a fair reading of the disciplinary letter.

- DOS Response to **OIM Recommendation 2**: The DOS followed the Matrix, as it does in each case where disciplinary action is taken. That inappropriate force of a Conduct Category D was used by the disciplined deputies is adequately explained in the disciplinary letter. The OIM position on what discipline it believes should have been imposed was not only "incongruous with the Hearing Officer's ruling", as you suggest in this report, but it also was devoid of any record support. To say that the hearing officer's ruling "could [be] overturn[ed]" by the Career Service Board indicates a complete lack of appreciation of the legal standard that governs appeals from hearing officer decisions. The Career Service Board is bound by hearing officer findings and determinations unless they lack record support.

- As the individual named in your report was neither charged criminally nor was the subject of disciplinary action for policy violations, it is not appropriate to name him and thus, DOS would ask that you redact his name where it appears in this report.

- DOS Response to **Recommendation 3**: The DOS has in place adequate safeguards to ensure that hiring decisions are made after a complete vetting of candidates. Hiring

decisions are made after careful consideration of all relevant information. Decisions to hire candidates with prior law enforcement experience are subject to pre-employment investigations, which include a review of disciplinary histories. Nevertheless, DOS will re-examine its hiring process to ensure that a candidate who has pending criminal or administrative matters not be considered for final placement until pending matters are resolved.

- DOS Response to **OIM Recommendation 4**: The evidence in the case did not support a finding that Mr. Marshall was suffering from excited delirium. Further, the fact that the deputies indicated that they could not recall their training with respect to excited delirium does not mean that DSD has failed to adequately train its officers with respect to excited delirium and the applicable protocol. Nevertheless, DOS agrees that providing training on a more regular basis, as determined appropriate by DSD, may be helpful for all DSD sworn personnel.

- DOS Response to **OIM Recommendation 5 & 6:** DOS agrees that adequate communication between deputies and medical staff is essential, which is why DSD agreed, as part of the settlement in this case to work with Denver Health and provide in-service training on the need for deputies to work with medical providers, to the extent reasonably possible, by coordinating efforts to ensure compliance with medical directives during mental health emergency situations. This will include supervisors. The DSD also agreed to develop a protocol to ensure better communication regarding inmates experiencing mental illness between correctional care medical staff and DSD staff. As written, however, your additional recommendation to set forth a specific protocol for "resolving urgent medical and security concerns that may be in conflict" does not appear to be feasible, as situations are constantly changing, and deputies and supervisors need to be able to make split second decisions concerning safety. We believe the settlement agreement more than adequately addresses any communication concerns between Denver Health and DSD sworn personnel.

- DOS Response to **OIM Recommendation 7**: Whenever criminal justice records are sought, DOS is required to consider the factors set forth in Harris v. Denver Post, 123 P.3d 116 (Colo. 2005). Those factors include:

  (a) the privacy interests of individuals, if any, who may be impacted by a decision to allow disclosure of the record;
  (b) the agency's interest in keeping confidential information confidential;
  (c) the agency's interest in the integrity of on-going investigations;
  (d) the public purpose to be served in allowing disclosure of the record; and
  (e) any other pertinent considerations relevant to the circumstances of the particular records request, including whether disclosure would be contrary to the public interest.

  This requires is a "case by case" review. To have the policy the OIM appears to be

suggesting in this report abdicates our responsibility under Harris. These factors are applicable to the release of video of critical incidents. Since Colorado law specifically provides what the considerations should be, DOS does not have a separate written policy.

- DOS Response to **OIM Recommendation 8**: DOS is open to considering the development of a "formal protocol" to identify learning opportunities from critical incidents. This is an area which has been an ongoing discussion to determine the logistics of such implementation.

Sincerely,

Jess Vigil
Deputy Director of Safety*+

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