November 8, 2021

1. I have been requested by Ms. Patricia J. Hanson, District Attorney of Racine County, WI to provide a report of my opinions regarding the custodial death of Mr. Malcom James, a pre-trial detainee confined in Racine County Jail. Mr. James died on June 1, 2021, after a forced cell extraction in the jail in which several correction officers of the RCSO used varying force options.

2. On June 1, 2021, the Racine County Sheriff's Office contacted the Kenosha County Sheriff's Office to perform the death investigation and detective Jon Hasselbrink was assigned the task and was assisted by detective Ergish. At the RCJ, captain Weidner briefed the detectives and they proceeded with the investigation. Detective Hasselbrink submitted an investigation report of his findings on July 1, 2021 (see report).

   On August 6, 2021, Medical Examiner Jessica Lelinski, MD, submitted her autopsy report and concluded that: the cause of death was asphyxia following a physical struggle and subdual by multiple officers; deceased became unresponsive while strapped in a restraint chair, with hands handcuffed behind his back and spit mask covering his mouth, after multiple officers placed their body weight on his head, posterior neck, and back. Puncture marks were noted consistent with TASER probe sites, two on the upper side of the back and two on the anterior left thigh. Dr. Lelinski noted focal abrasions and contusions on the upper left chest, posterior shoulders, upper extremities including wrists and ankles scalp, and temporalis muscles. A small subdural blood clot and subarachnoid blood overlying the left parietal lobe of the brain. Dr. Lelinski also noted other significant conditions included: hypertensive cardiovascular disease, cardiomegaly (510 grams) and obesity (BMI=41.9 km/m$_2$). The toxicology report showed positive for THC glucuronide and Cotinine (Report of Sara Schreiber).

3. My opinions contained in this report are expressed to reasonable degree of professional certainty. My opinions described are focused on whether a reasonable, trained, and experienced correction officers, such as these involved officers use of force was appropriate given the totality of the circumstances that they encountered. My opinions have been formed from reviewing the following case documents:

   - Kenosha County Sheriff's Department Investigation Report: Case No. 2021-00323025; by Detective Jon Hasselbrink (7/1/21; 246 pages);
   - Racine County Sheriff's Office Rules and Regulations and Policies/Procedures, including:
     - Use of Protective Spit Net: #265300 (9/4/2013);
     - Electronic Control Device: #236.226 C (11/14/13);
     - Training General: #290.000 (7/7/2003);

  - Corrections FTO Program: #298.200 (10/24/12);
  - Padded Cell: #390.310 A (1/23/14);
  - Emergency Restraint Chair (ERC): #390:400 (8/11/2014);
  - Chemical Agents: #236.200B (1/23/2014);
  - Oleoresin Capsicum Spray: #236.225 D (12/05/2013);
  - Use of Force General: #390.100C (9/1/5/2020);
  - Use of Force Jail: #390.300 (11/18/2003);
  - Use of Specialty Chemical Agent Munitions: # 390.600;
  - Emergency Medical Responses—Jail: #585.500 B (11/12/2007);
  - Suicide Prevention: #588.300 (6/1/2016);
- Jail Training Documents: curriculum; training manuals; power points; and training videos;
- Training Records of:
  - Sergeant Justin Brands;
  - Correction Officer Josue Davalos;
  - Correction Officer Cristian Brindis;
  - Correction Officer Michael Saulys;
  - Correction Officer Khadeja Dismuke
  - Correction Officer Jonathan Koski;
  - Correction Officer Justin Gaudes;
  - Correction Officer Adrian Payne;
- WI Law Enforcement Training Standards Board Policies and Procedures;
- TASER Data Port Print Outs (4 pages); Serial #:X00-708528; X00-660480; X00-660509; & X00-710136;
- Autopsy Report of Malcom James by Dr. Jessica Lelinski (8/6/2021);
- Toxicology Reports by Sara J. Schreiber (6/15/2021);
- AED Download of Malcom James;
- Racine County Sheriff's Office Revised Jail Evaluation Training Program (12/2019) and Task Performance Checklist;
- Jail Training Academy 200-hour Standards;
- Correction Officer Orientation, Day 1-5; and
- 7 Thumb Drives of Body Worn Camera Videos of Correction Officer Intervention with Mr. James (#21-29457; #21-28786; #21-029253; #21-29061; #21-20134; #21-2901; #21-28827 & 1 with paper documents)

4. I received my Ph.D. in 1992 from Michigan State University. Since August 2010, I have been employed as a Professor, the Department Head of Sociology, Anthropology, and Criminal Justice, and the Director of the Center of Applied Social Sciences at Valdosta State University, Valdosta, GA. From 2006 to 2010, I served as a Professor and the Director of The School of Law Enforcement and Justice Administration at Western Illinois University, Macomb, IL. I was a Professor and former Chair of the Department of Criminal Justice at East Carolina University, Greenville, NC from 1992 to 2006. Attached hereto is a current copy of my CV and my fee schedule.

5. From 1985 to 1992 I served as the Technical Assistance Coordinator for the Criminal Justice Institute at Ferris State University, Big Rapids, MI. My duties included: research and training for police, corrections, security, and military personnel, locally and nationally and I also instructed academic courses. I was a certified instructor by the Michigan Commission on Law Enforcement Standards (MCOLES) and instructed the state training curriculum in the police academy at Ferris, including the mechanics of arrest, search, and subject control and restraint techniques, responding to persons in crisis and responding to persons with mental disorders, physical fitness, and health and wellness.

6. From 1973 to 1985 I worked for the Michigan Department of Corrections and I was the Unit Manager/cell block manager of a psychiatric/protective custody cell block housing 500 mentally ill prisoners at the State Prison of Southern Michigan, Jackson, MI. I was a correction officer and a probation officer. Further, working for the training division as a certified instructor I provided instruction at all levels of departmental positions and jail officers throughout the state, teaching a variety of courses including: defensive tactics and subject control techniques; the use of restraints; crisis intervention; special response teams; prisoner behaviors; response to the mentally impaired prisoner; suicide awareness, and policy and procedures.

7. I am familiar with correctional standards, practices, policies, use of force training, and subject control techniques underscoring the application of reasonable use of force measures, including the American Correction Associations Standards for Adult Local Detention Facilities; various state administrative rules and regulations for using force in detention centers; United States Marshalls Service Detention Policies; United States Immigration and Customs Enforcement Policies (US Dept. of Homeland Security); the US Dept. of the Interior Bureau of Indian Affairs policies, and the Federal Detention Facility Standards.

8. I have published over 100 manuscripts, including articles, five books, and nine book chapters/monographs. I have authored and have made hundreds of national and international conference and training presentations with a majority use of force related. I have developed and have provided numerous line level and administrative training programs for police, correctional officers, military, and security personnel throughout the United States and internationally (see CV for reference). I have been researching, publishing, speaking at numerous conferences and training seminars to officers and administrators, instructors, death investigators, attorneys, and medical and mental health professionals on various issues of the use of force, officer involved shootings, use of force and human factors, developing policies and procedures on the use of force,

use of force training issues, custodial death investigations, and developing use of force systems. I have analyzed thousands of published Section 1983 United States Supreme Court and lower court decisions on the use of non-deadly and deadly force in law enforcement and corrections, published articles on the liability trends and implications of these decisions, and routinely provide training to officers and administrators on these decisions. I have been certified as a TASER instructor by Axon International (formerly TASER Intl.). I am also a certified law enforcement instructor by the GA POST. I am on the teaching faculty of Americans for Effective Law Enforcement (AELE, Las Vegas, NV) and I regularly present research and speak at the Institute for the Prevention of In-Custody Death (IPICD, Las Vegas, NV) training conference. I am a member of seven professional associations.

9. I have expertise from training, education, and experience, and possess specialized technical knowledge of: police and correctional use of force standards, policies, procedures, and practices, the use of correctional emergency response teams and responses to subject resistance, subject control techniques, use of force equipment and force options, officer use of force training, and custodial deaths of arrestees, pre-trial detainees, and prisoners. I continue to attend training sessions on varying aspects of the use of force and human factors. Regularly I provide training and consulting services to police and correctional agencies and review and edit use of force training curriculum, policies and procedures, and use of force investigations. I am an advisory board member of the Integrated Use of Force Options Training Organization (Charleston, IL). I have served on the Pressure Point Control Tactics Management, Inc. Advisory Board (PPCT). As board member I have assisted in researching and developing the teaching curriculum and instructing subject control and restraint techniques to thousands of police and correction officers, federal officers, private security personnel, all branches of the military, and instructors nationally and internationally. As a board member I assisted in developing the Inmate Control Instructor Manual and the procedures for conducting cell extractions/insertions of combative prisoners. I have also been a member of the UGA Chancellor's Campus Police Executive Committee.

10. I have served as a consultant and or trainer for the: National Institute of Justice, Michigan Commission on Law Enforcement Standards, Board of Regents University System of GA Campus Police Chiefs, GA Chief's Association, MS Chiefs' Association, Illinois Law Enforcement Training and Standards Board, IL State Police, Topeka, KS PD, Battle Creek, MI PD, MI Sheriff's Association, North Carolina Justice Academy, Federal Law Enforcement Training Center, Integrated Force Options (IFO), Alaska Peace Officers Training Commission, Pennsylvania Law Enforcement Training and Education Commission, State of Florida Police

Training Commission, Florida Department of Corrections**,** State of Wyoming Police Training Commission, American Corrections Association, National Institute of Corrections, Michigan Department of Corrections, Michigan Department of Corrections Jail Division, North Carolina Department of Corrections, Corrections Corporation of America, States Attorney's General Office in 6 states, U.S. Attorney's General Office in Florida, Federal Bureau of Prisons, Australia Government, Hong Kong Correctional Services, other agencies across the United States, and all branches of the military to mention a few (see CV for further reference).

11. Prelude to the June 1, 2021 cell extraction incident

A. May 28-29, 2021

On May 28, 2021 Mr. James was arrested by Racine, Wisconsin police officers (Bodnar, Lauer, and Ropiak) on charges of Recklessly Endangering Safety and Arson. A 911 call made by Mr. James indicated that he was feeling suicidal. Mr. James set his clothes and apartment on fire which endangered other residents of the complex as well as himself (see Racine Police Department video and apartment photos). Responding officers transported Mr. James to the Ascension Hospital where he was examined and treated by emergency medical personnel and then was transported to the Racine County Jail (RCJ) by the officers.

At the RCJ, Mr. James was confined in cell number 9 in Dayroom 2, was placed on suicide watch, and he was supervised and monitored by correction officers on a regular basis. Mr. James was provided with a green suicide mock/gown and a green suicide blanket. While performing a cell check, on May 29, 2021, at about 5:30 pm, correction officer Benson observed that Mr. James was striking his head against the metal mirror on the cell wall and he informed sergeant Rodriguez. Sergeant Rodriquez instructed correction officers to remove Mr. James from the cell in order for the jail nurse to examine him. Officers instructed Mr. James to lay prone on the cell bunk with his hands behind his back and he initially did not comply. After several instructions by correction officers, Mr. James complied, officers entered the cell, and an officer provided cover with a Conducted Energy Weapon (CEW, TASER). The officers controlled and restrained Mr. James in handcuffs, and escorted him from the cell under his own power. Mr. James was placed in the restraint chair and the jail nurse examined him (see videos and officer reports).

Mr. James was transported to the Ascension Hospital by Racine County deputies Plew and Baker and he was examined and treated by emergency medical personnel (see video). Mr. James was released and transported back to the RCJ by the deputies.

B. May 30, 2021

Correction officers observed Mr. James striking his head on the cell wall in cell number 9, on May 30, 2021 at about 6:10 pm. Sergeant Brands was notified and officers instructed Mr. James to stop. Mr. James did not comply and sergeant Brands instructed the officers to enter the cell and remove him. Rather than lay prone on the cell floor, Mr. James sat on the floor, and under cover of an officer with a CEW, the officers entered the cell. Mr. James resisted the officers' efforts to control and restrain him but finally the officers were able to secure him in handcuffs and leg restraints. Mr. James was escorted out of the cell and was placed in the restraint chair. Mr. James was examined by the jail nurse (see video and officer reports).

C. May 31, 2021

On May 31, 2021, at about 12:06 am, correction officers met resistance from Mr. James as they were attempting to remove the restraints from him and secure him in the cell. Mr. James' head was controlled and the officers were able to remove the restraints and he was secured in the cell. However, in the cell, Mr. James initiated resistance by attempting to pull away from the officers. The officers removed him from the cell and secured him in the restraint chair. Mr. James was wheeled into the padded cell, examined by the jail nurse, and monitored. He was later secured in cell number 9 by the officers (see video and officer reports).

At about 7:08 pm on May 31, 2021, correction officers observed Mr. James' striking his head on the cell wall. The officers instructed Mr. James to stop and to go to the cell floor but he refused. Officer Koski pointed the CEW at Mr. James and instructed him to stop, to go the floor, or he would use the CEW. Mr. James did not comply. The cell door was opened and officer Koski deployed the CEW for one, five second discharge. There was not a complete connection of the probes as Mr. James wore the green suicide gown and the blanket. Mr. James yelled and quickly charged the officers, exited the cell, tripped over the blanket, and fell to the floor in the Day Room. On the floor, Mr. James actively resisted the officers' efforts of control and it required eight officers to finally control and restrain him in handcuffs. Mr. James was secured in the restraint chair, wheeled into the padded cell, examined by the jail nurse, and monitored by correction officers (see video and officer reports).

Opinion:

The overarching objective of the jail is to operate the facility by maximizing security and implementing protocols which enhance safety for all detainees as well as the officers who work

there. Based on Mr. James behaviors associated with his 911 call revealing his suicidal ideation, and manifestation of the ideology by setting his clothes on fire and his apartment, and the arrested charges, the most appropriate housing option was to house him in cell #9, an observation cell, to minimize the risk of self-harm. Supervising and monitoring Mr. James on a regular basis allowed the officers to safely confine him to protect him from potential self-harm, to protect other detainees from him, to maintain facility order and security, and to protect facility officers and supervisors, and jail medical care personnel. Further, the officers followed appropriate correctional protocols by ensuring to remove any items that Mr. James could potentially use for self-harm and provided him with a green suicide gown and blanket, consistent with RCJ's policy on suicide prevention (see *Suicide Prevention Policy*, #588.300E, 6/1/2016). The actions performed by the officers followed legitimate detention objectives and practices.

Mr. James' demonstrated ongoing self-injurious behaviors created the need for the officers to use force measures in order to protect him. As I would expect, and as a legitimate detention objective, the correction officers responded to Mr. James on each occasion in order to protect him from himself. As the videos showed, the officers did not ignore nor delay in responding to Mr. James when they observed that he was engaged in harmful behaviors. Prior to entering Mr. James' cell, the officers first engaged in dialog with him and instructed him to stop and lay on the bunk over several minutes so they could enter and control and restrain him. The responding officers used reasonable and proportionate force based on the degree of resistance exhibited by Mr. James. The officers fulfilled their custodial care functions by following accepted force protocols for removing a potentially combative detainee who demonstrated behaviors indicative of a mind-body disconnect.

In my opinion, the correction officers and sergeants took reasonable force measures to protect Mr. James as I would expect on each of the identified occasions. In each incident, the officers performed their duties under the supervision of a sergeant, the incidents were video-recorded, the nurse was summoned and examined Mr. James (many in which he refused), and the incident was documented in writing. The officers' actions were guided by RCJ policies, training completed, and their correctional experience. I did not observe any evidence where a correction officer failed to adequately supervise and monitor Mr. James, used excessive, inappropriate, or punitive force measures, or denied him access to appropriate medical care. In my opinion, the video evidence and the interviews of the involved officers provide supporting evidence in their collective totality, which underscore the behaviors of Mr. James and the appropriate responses of the involved officers.

12. RCJ Policies

As I would expect, prior to the incident, RCJ administrators had developed and implemented various use of force policies which guided the correction officers in determining when to use force, the justification for using a given force option, and the procedures for using force. RCJ correction officers are authorized to employ force measures and force equipment pursuant with the following policies: Use of Force (#390.100C) and Use of Force-Jail (#390.300); Chemical Agents (#236.200B); Use of Specialty Chemical Agent Munitions (#390.600); Electronic Control Device (#236.226 C); Emergency Restraint Chair (#390.400); and the Use of Protective Spit Net (#265.300).

Opinion

I have reviewed these policies. In my opinion, they appropriately guide the officers in the reasonable use of force based on the circumstances the officer encounters and to accomplish the correctional objective of control as quickly as possible. These policies combined with officer training assist in guiding correction officers in the practices of supervising, interacting, monitoring, and responding to detainees, including responding to violent detainees and using appropriate force as warranted. Use of Force policy number 390.300 directs correction officers to use force in compliance with Wisconsin Administrative Code DOC 350.14 (Use of Force), with Wisconsin's Principles of Subject Control (POSC), Wisconsin's Defensive And Arrest Tactics (DAAT), and stipulates that the subject's behavior and level of response dictate the level of force used by officers. Force measures consistent with POSC include the use of: the first responder philosophy; officer (s) presence; dialog; empty-hand control techniques; intermediate weapons; deadly force; and various types of restraints. The policy directs officers to use the amount of force reasonably necessary to achieve the objectives for which force is used and corporal punishment of inmates is prohibited.

13. June 1, 2021—Cell Extraction Incident (see videos)

A. Use of Force

When examining an allegation of excessive force, the totality of circumstances of the situation must be examined within the framework of four general incident components including: (1) nature of the facts and circumstances; (2) the circumstance environment; (3) the actions or inactions, including threat posed by the detainee; and (4) the perception and response of the involved officer (s). In the training that I provide to correction officers, administrators, use of

force instructors, and investigators, I emphasize that the review of the incident and an officer's response must be performed in accordance with the objective reasonableness standard and the criteria outlined in the United States Supreme Court's decision in *Kingsley v. Hendrickson* (2015) including: the need to use force; the need to preserve internal order and discipline; the severity of the security problem; the relationship between the need and the amount of force applied; whether the detainee was actively resisting; whether the detainee posed and immediate threat to the safety of the officer (s) or others; the extent of injury sustained by the detainee; and efforts made by the officer to limit the use of force. Such an assessment recognizes that officers must frequently make a decision to use a level of force under tense, uncertain, and rapidly evolving circumstances confronting the officer (s). The use of force assessment must also include all of the facts and circumstances of each case on its merits, based upon the perception of the officer (s) at the moment force was required.

Correction officers do not always get to script their response to a given situation. Correction officers are taught and, in the training that I provide them, they are instructed that their decision to respond with any level of force must be predicated on the resistive behaviors, and actions/inactions, demonstrated by a particular person. Officers may use force: in self-defense; in defense of another; to prevent a crime; to protect property; to maintain control, to prevent an escape; to gain compliance to an officer's instructions; to ensure the security of the facility; and to prevent a person from self-harm. Frequently making a decision about using a degree of force must be made in a split second and there is no luxury of time for the officer to "wait and see" what a resisting detainee "may or may not do."

As correction officers supervised and monitored Mr. James' behaviors, his self-inflicted behaviors, violence and active resistance, and his demonstrated combativeness, correction officers would form the perception to constantly be on high alert and to be situational aware of their safety and the safety of medical personnel who provided medical care for him. Mr. James continued his self-injurious behaviors over the course of three days, created a volatile security management risk to the operations of the jail requiring the officers to use various force measures in order to control him, protect him from himself and to provide care, to protect the officers and medical personnel while performing their custodial tasks, and to maintain facility security.

B. Mr. James' Behaviors: 9:15 pm to 9: 54 pm

A correction officer working in a jail or prison, including the RCJ officers, are not taught to diagnose or psychoanalyze any detainee's/prisoner's mental health or medical condition. Rather,

correction officers are taught to respond to and interact with a detainee based on observed and exhibited behaviors and communications (or lack of communication) of the detainee.

At about 9:15 pm, correction officer Carter observed Mr. James wearing the suicide gown smock with the suicide blanket draped over his head standing and striking his head against the cell wall (see video). She instructed Mr. James several times to stop and over a few minutes he stopped, but resumed striking his head on the wall, would sit down, paced back and forth in the cell, and struck the cell door with his hand. Mr. James repeated this cycle over several minutes. Officer Carter advised sergeant Rodriquez, she responded to the cell, instructed to him to stop, but he did not comply and continued to strike the cell door with his hand and struck his head into the cell wall (see Carter video).

Mr. James stood 6'3" and weighed 335 pounds with a BMI of 41.9kg. Involved correction officers of the June 1, 2021 incident interviewed by the investigators collectively described Mr. James' behaviors in the cell as: self-injurious; non-compliant and non-responsive to repeated instructions and commands of the officers and the sergeants. Mr. James further increased his self-injurious behaviors by repeatedly hitting his head on the cell wall, yelling incoherently, pacing back and forth in the cell, repeatedly striking the cell door, and failed to comply with officer Carter, Payne, and sergeant Rodriquez's instructions to stop. Mr. James continued to periodically strike the wall with his head and shoulder (with blanket over his head), and struck the door window several times with his hand, as he yelled: "get the fuck off of me, get off of me bitch, and the MFer's are molesting me."

Opinion

During this time, and as I would expect, correction officers Carter, Bowman and Payne continued to speak with Mr. James, instructing him to stop hitting his head on the wall, and requesting that he talk to them but Mr. James was noncompliant (see Payne video). Mr. James was non-compliant with the officer's repeated instructions and presented a safety risk for himself, the officers, and he created a security risk in the jail. In my opinion, Mr. James clearly needed to be controlled and needed to be re-located for his safety, examined by medical personnel, and controlled for the security of the facility. It would be contrary to correctional practices and to the facility security for a correction officer to allow a detainee, who presents a risk to security and a risk of self-harm to allow him to continue to harm himself.

C. Assembling Correction Officers

As correction officers spoke to Mr. James in cell #9, sergeant Brands was notified and he assembled corrections officers to respond to the cell. After the May 31, 2021 incident, sergeant Brands decided that if Mr. James required physical intervention again, he would assemble the Correction Emergency Response Team (CERT).

Opinion

In my opinion, the correction officers attempted to talk to Mr. James and dissuade him from continuing his self-injurious behaviors and when he would not respond or comply, it became necessary to activate correction officers to remove him from the cell for his own protection. Sergeant Brands was advised of the situation and instructed several correction officers to assemble and put on their protective gear including: chest protector, arm protection, knee guards, a helmet, and a gas mask. Officer Davalos was the only CERT member working on shift and he requested that officers Brindis, Saulys, Koski, and Gaudes assist as they had previous experience performing cell extractions. The officers were briefed of the situation and Sergeant Brands acquired authorization from Lieutenant Luther to use the OC Vapor known as the "Cell Buster."

In my opinion, the video from the May 31, 2021 cell extraction incident clearly showed that Mr. James behaviors escalated, he became more combative, increased his danger and threat level to the officers as he aggressively charged them as they were attempting to enter the cell, fought through one discharge of the CEW, and required eight officers to control and restrain him. Based on the escalating nature of Mr. James' behaviors on June 1st, it was appropriate for sergeant Brands to require correction officers to suit up in their protective gear prior to intervening with Mr. James for his safety as well as the responding officers' safety. As evidenced by the May 31st and the June 1st incidents, performing a cell extraction of a violent and combative detainee can be unpredictable and one of the most dangerous tasks asked of a correction officer. Correction officers do not have to jeopardize their own of safety when intervening with a violent detainee and requiring they wear protective gear prior to entering the cell and intervening with Mr. James was prudent.

D. Correction officers at Cell # 9: 9:56 to 9:58 pm

At about 9:56 pm, the video of officer Payne showed sergeant Brands and the officers standing outside Mr. James' cell door (#9) and Brands supervised the officers. Sergeant Brands instructed Mr. James to stop hitting his head, to comply with the instructions, and to lay down on the bunk.

Officer Davalos also gave Mr. James several instructions to lay down on the bunk and warned him that force would be used. Mr. James stood up and did not comply with the repeated instructions. Officer Davalos waited for Mr. James to comply and when he refused, he discharged one short burst of the OC spray into the cell. Approximately a minute and half later, Mr. James was instructed again to lay down on the bunk but he did not comply.

Opinion

In my opinion, sergeant Brands and officer Davalos followed appropriate crisis intervention procedures and intervention and disturbance resolution options, by instructing Mr. James to stop and to cooperate with them. The officers followed appropriate correctional measures and accepted practices prior to entering the cell. First, the actions taken in regard to Mr. James were video recorded. Second, prior to assembling the officers, numerous officers and sergeant Rodriquez used verbal dialogue and repeated instructions over a reasonable period of time in order to gain Mr. James' cooperation. Third, only after Mr. James repeated non-compliance did sergeant Brands assemble the officers to respond and briefed them. Fourth, at the cell door, Mr. James was again given an opportunity to comply but he refused. Fifth, the assembled officers stood at the cell door under the direction of sergeant Brands and demonstrated a show of force with the presence of the staged officers. These actions taken by the officers, as evidenced on the video were consistent with RCJ's *Use of Force—Jail Policy* (#390.300) and the *Use of Force—Sworn Policy* (#390.100 C).

Sixth, officer Davalos advised Mr. James that force would be used if he did not comply. Seventh, officer Davalos gave Mr. James time to comply with the advisement. Eighth, only when Mr. James did not comply did Davalos discharge a short burst of the OC Vapor Spray, which had been authorized by Lieutenant Luther. Ninth, sergeant Brands gave Mr. James time to comply before opening the cell door allowing the officers to enter.

By deploying the OC spray officer Davalos demonstrated his comprehension of using a force measure and tempering the use of force aligned with RCJ's policies entitled: *Use of Specialty Chemical Agent Munitions* (#390.600) and *Oleoresin Capsicum Spray* (#236.225 D). The spray is classified as an intermediate weapon--- a less lethal force option. The objective of the use of OC or any aerosol is to safely resolve a threatening confrontation and prevents the need to use physical force measures which may result in a prolonged struggle in the cell. In my opinion, the use of the spray was appropriately used and used as it was designed. However, the spray appeared

to have minimal effect with Mr. James and required the officers to enter the cell and physically remove him.

E. Officers in Cell #9: 9:58 pm to 10:09 pm

Sergeant Brands opened the cell door at about 9:58 pm and the officers entered the cell. Using padded shields, officer Brandis entered the cell first followed by officers Saulys, Gaudes, Koski, and Davalos. In the cell the officers pinned Mr. James against the back left corner wall and Mr. James was combative and aggressively fought the officers. During the struggle Mr. James reached over the pads and struck officers Brindis and Saulys in the head and the officers adjusted the pads.

During their interviews with investigators, the correction officers described Mr. James' behaviors in the cell as: he did not comply after the use of the OC Vapor; he actively and aggressively resisted the officers' efforts of control; struck the officers; attempted to bite the officers; kicked at the officers; Mr. James was strong and the strongest man "I" ever saw and it was scary; he was the most resistive person encountered; he pulled and/or ripped the CEW probes out; he did not comply after the use of the CEW and it was ineffective on him; he tossed us around in the cell; he was able to push all of us around and resisted the entire time; he did not fatigue and kept on going; on a previous incident it took eight officers to control him; and it was difficult to secure him in handcuffs and leg restraints as his wrists and ankles were big. Officer Saulys reported that he felt Mr. James' teeth on his right hand and it resulted in a scratch (Investigation Report, Pg. 115/246).

Mr. James aggressively fought through the pads and officer Gaudes yelled TASER several times and discharged it in the Probe Mode for one, five second cycle, at about 9:59:03 (see TASER Data printout). Mr. James pulled the probes out and he continued to fight the officers by kicking and attempting to bite officer Koski and Davalos. Officer Brandis instructed Mr. James not to bite staff and he struck Mr. James in the head with a closed fist twice. Officer Gaudes deployed the CEW two more times one for five second discharge at 9:59:15 and a third discharge for five seconds at about 9:59:29 (see TASER Data printout).

Mr. James slid to the floor as he continued to fight the officers and he attempted to stand up. Officer Saulys was close to Mr. James and discharged the CEW probes into the back of Mr. James due to his aggressive resistance and concern for the other officers at about 10:00 pm, for one, five second application. Mr. James was unaffected by the CEW and continued to fight and actively resisted the officers' efforts of control (see TASER Data printout).

Officer Koski deployed his CEW using the Probe Mode, discharging it twice, once for five seconds at about 10:03:28 and a second discharge for two seconds at about 10:03:04 pm (see TASER Data printout). The CEW appeared to have minimal effect and Mr. James continued to actively and aggressively resist and fight against the officers and failed to comply with their commands to stop resisting.

Opinion

In my opinion, sergeant Brands and the responding officers followed acceptable correctional cell extraction protocols and tactics when Mr. James refused to comply with the officers' instructions to stop harming himself just as they had performed on previous incidents with him. As evidenced on the videos of past intervention incidents with Mr. James, in this incident as well, the officers acted professionally, under control, and used reasonable and proportionate force in response to the active resistance and safety risk manifested by Mr. James.

First, the officers further tempered their use of force measures when they entered the cell by using padded shields, rather than using plastic riot shields commonly used by some facilities. The padded shields would serve to protect the officers and Mr. James and allow them to move him either onto the bed or to the floor in order to control and restrain him. However, Mr. James vigorously fought through the shields, reached over them and struck the officers, and failed to follow the officers repeated instructions to stop and comply. Second, the officers escalated their force response appropriately and only in response to Mr. James' escalated assaultive behaviors of striking them when officer Gaudes discharged the Conducted Energy Weapon in the Probe Mode (CEW; TASER). Rather than comply, Mr. James pulled the lead wires out and began kicking at the officers, and attempted to bite them. Officer Saulys reported that Mr. James did indeed bite him and it resulted in a scratch.

The CEW is a less-lethal force option and is designed to be used in two different modes. In the Probe mode, an officer can deploy the CEW from a safe distance through an Air Cartridge mechanism which projects two probes connected to lead wires. The probes attach to the person and carry electrical impulses which cause neuromuscular incapacitation (NMI) causing involuntary stimulation of the sensory nerves and motor nerves. The probe mode of application is not dependent upon pain and is effective on persons who may have a high tolerance of pain. Immediate submission by momentarily disrupting the nervous and muscular system occurs. A normal discharge of the CEW is for five seconds, but can last longer if the officer continues to pull on the trigger. Many agencies have installed the automatic power performance magazine

(APPM) which assists in containing a trigger pull to five seconds. A probe spread from about 9 to 12 inches is recommended and allows for a higher degree of effectiveness of the CEW. The wider the spread between the probes, the more peripheral motor neurons are effected by the electric fields, and therefore the greater the incapacitation. Officers are instructed to deploy the CEW and assess the situation prior to applying additional discharges if feasible.

Alternatively, the CEW may be used in a "Drive-Stun" mode by pushing the front of the weapon into the skin to function as a higher charge stun gun. The Dive Stun mode is applicable for application in close quarter circumstances and generally used as a pain compliance device when confronting a combative person. With the fixed electrodes only 4 cm (centimeters) or 1.6 inches apart — and the lack of skin penetration — the current flow is primarily through the dermis between the electrodes and there is no significant penetration beyond the fat layer. Since there is insufficient depth of current flow to capture muscles, the drive-stun mode serves only as a compliance technique. To make an analogy to medicine, drive-stun is like rubbing an antibiotic on the skin compared to the probe mode which is like an injection. The modes of application have significantly different effects. Expected impact of the CEW exposure can result in local skin irritation or minor contact burns.

In my opinion the officers demonstrated their comprehension of the force principle of escalation and de-escalation and appropriately applied the CEW. The principle guides an officer to gauge the level of resistance and aggression of a detainee and as the detainee escalates the level of resistance as Mr. James did in this incident (aggressively resisting the officers, striking, kicking, and biting), the officer is justified in escalating the force option in proportion to the need and the level of resistance encountered. Using the CEW in the quickly evolving, threatening, and close cell environment was highly appropriate under the circumstances. Only the Probe Mode was used by the officers.

Each time the CEW is discharged (a trigger pull) it is recorded and it can be downloaded. After the incident, investigators secured the CEWs used in the cell by officers Gaudes, Koski and Saulys, downloaded their applications, and described the discharges in the investigation report. Officer Gaudes discharged the CEW three times, each for a five second application, in intervals of 12 to 14 seconds between each discharge. The CEW had minimal effect, Mr. James pulled the lead wires out, and he continued to aggressively resist the officers. Officers observing Mr. James pull out the lead wires would form the impression that his pain tolerance was extremely high, would place them on high alert for concern of their own personal safety, and underscore their

perception that he was exhibiting strong symptoms of a body and mind disconnect, enhancing the urgency to control him and to protect themselves.

Mr. James continued to aggressively fight against the officers. Officer Saulys discharged the CEW once for five seconds. The officers continued to instruct Mr. James to stop, comply, and not to bite staff but Mr. James continue to fight the officers. In response to Mr. James biting and aggressively fighting the officers, officer Brandis instructed Mr. James not to bite staff and struck him in the head with a closed fist. Officer Koski discharged the CEW for two applications: one for five seconds and a second discharge about 12 seconds later for a two-second application. These applications had minimal effect and Mr. James continued to resist and fight the officers.

The officers discharged three separate CEWs, with 6 deployments for a total of about 27 seconds. The discharges were applied over various intervals spanning about 4 minutes. Although two probes were lodged in Mr. James' back, the CEW had limited effect as the connections of the lead wires became dislodged, disrupting the current flow as Mr. James actively resisted and struggled against the officers.

In my opinion the application of each CEW discharge and the strike to Mr. James' head was appropriate under the circumstances, was not disproportionate to the resistance encountered, and only used for control purposes, in self-defense, and defense of other officers in the cell. Mr. James' would not comply with the officers' instructions, escalated his resistance to aggressively fighting the officers, biting at least one officer, striking them, and kicking at them. Under the violent confrontation the officers faced, it would not be unreasonable for them to form the perception that their own personal safety was in immediate jeopardy, and the longer Mr. James fought with them, the higher the likelihood that one if not all of them could be seriously injured. RCJ's Use of Force policy authorizes the officers to use force to accomplish the objective of controlling a detainee for the purposes of changing the detainee's location (amongst others) and to accomplish the objective as quickly as possible, as appropriate. In this incident the officers were attempting to accomplish this legitimate objective and met assaultive resistance from Mr. James.

Further, each discharge of the CEW was appropriate and only applied in response to Mr. James aggressive and assaultive behaviors. The officers used the CEW in compliance with RCJ's *Electronic Control Device Policy* (#236.226 C). The confined space of the cell and Mr. James actively moving and resisting would not allow the officers to fully observe what another officer was doing. The immediate attention of each officer would be focused on the aggressive behaviors

by Mr. James from their position in the cell and their proximity to struggling with Mr. James. The officers would form the perception to use force based on the immediate and active resistance of Mr. James and his non-compliance to their instructions. Using the CEW in response to the type of assaultive resistance Mr. James offered was appropriate and was the preferred force option to use under the circumstances. As shown on the videos of previous incidents with Mr. James, the CEW was used by an officer as a device for cover, to protect the other officers from being assaulted or injured from Mr. James. The CEW was only used on one incident (May 31, 2021), and it was used when Mr. James aggressively charged the officers, which presented an immediate threat to them. The CEW provides an appropriate force option which can bring a violent person under control quickly, which shortens the confrontation time span, allowing the officers to control and restrain the person in a timely fashion. The officers were following this force and control objective but due to the combative nature of Mr. James's active resistance, the lead wires became dislodged and the applications had minimal effect.

F. Mr. James was secured in the restraint chair and decontaminated: 10:10 pm to 10:19: pm

The officers were able to control and restrain Mr. James in two-sets of handcuffs and leg restraints and they placed a spit mask over his head. The officers stood Mr. James up, placed the green suicide blanket over him, and escorted him under his own power from the cell at about 10:09 pm to the officer's station. The officers secured Mr. James in the restraint chair which was set up at the officers' station (see video).

Opinion

Correction officers at the RCJ had a legitimate interest in maintaining jail security and internal order, and protecting a detainee from self-harm. Responding to a detainee who exhibited self-harm, continued to ignore instructions to stop, and used appropriate force to control and restrain the detainee is rationally related to a legitimate correctional objective of protecting the detainee and preserving jail security.

Given Mr. James' self-injurious behaviors and his assaultive resistance behaviors against the five responding officers (as evidenced from the video), in my opinion, it was prudent to place and secure him the restraint chair. RCJ administrators had developed and implemented the *Emergency Restraint Chair* (ERC) *Policy* (#390.400) and it guided the officers' decision in using it. The use of the ERC is supported by the RCJ's Use of Force policy (described earlier) and WI Statute #66.0511 (2). The ERC procedure directs the officers to use the restraint chair to control inmates who are in danger of causing physical harm to themselves or others, or destruction of County

property, when other control techniques are not effective. Further, the ERC procedure directs that: a supervisor will oversee the officers' use the restraint chair; it is to be used only as a temporary measure to restore the safe and orderly running of the RCJ; is not to be used as punishment; officers will notify medical staff of its application; and stipulates supervision and monitoring requirements of detainees in the restraint chair (ERC Procedures, 2-9; and ERC Application). The ERC policy and its application aligns with legitimate detention practices.

The restraint chair serves as a viable and effective piece of restraint equipment designed to safely control a combative detainee. The objective of using the restraint chair is to minimize injuries to a detainee. The restraint chair is used to: immobilize a combative/dangerous detainee; enhances the protection of the detainee from further self-initiated harm; provides a safe and closely supervised period of time for the detainee to calm down; it provides protection to correction officers who supervise and interact with the detainee; protects medical personnel who provide medial attention to the detainee; and reduces the likelihood that an agitated detainee from inciting other detainees to insubordination, violence, or misconduct.

Generally, and depending on the individual variables associated with each incident and the individual detainee's condition and level of resistance, the following ten procedures are applied. First, the placement of the detainee in the restraint chair is authorized and supervised by a sergeant and is video recorded. Second, throughout the process, officers will provide continued instructions to the detainee. Third, the detainee is seated in the chair by at least four officers. Fourth, the officers will use various empty-hand control techniques. One officer will stand behind the back of the chair and cradle and control the head and jaw of the detainee with both hands which protects other officers from the detainee from rocking in the chair, from suddenly moving forward and using his head to strike an officer who is securing the lap belt and ankle straps (standing in front of the chair), and from biting attending officers. Other officers will stand on opposite sides of the chair, control the arms and shoulders of the detainee, and secure the chair's shoulder straps over the shoulders of the detainee and the ankle straps are secured. Fifth, depending on the resistance of the detainee and the circumstances, the handcuffs and legs restraints will be removed. In order to remove the handcuffs from behind the detainee, the detainee is bent/flexed forward in the chair to remove the handcuffs from behind the back. This procedure is standard to remove the handcuffs of a detainee in the restraint chair. As this is accomplished, an officer will control the head of the detainee, while other officers control the detainee's shoulders and arms.

Sixth, as needed, a spit mask may be placed over the head of the detainee to protect officers from being spit on or bitten. Seventh, the detainee will be moved in the restraint chair to another cell or area, to be examined by medical personnel. Medical personnel will also check the tightness of the straps and periodically also monitor the condition of the detainee. Eighth, depending on whether pepper spray was used, the detainee will be offered a decontamination shower or at a minimum, an officer will clean the face of the detainee. Ninth, the detainee will be monitored by correction officers while in the restraint chair on a regular basis, offered water, and allowed to be removed and walk around escorted by officers and/or for restroom breaks. Tenth, once it has been determined that it is medically safe to do so, safe for the detainee, and to ensure jail security would not be jeopardized, the officers will remove the detainee from the restraint chair and re-locate him to a cell for continued observation.

The involved officers were questioned as to their knowledge about securing a detainee in the restraint chair and the use of the spit mask by investigators. The responses of the officers demonstrated their comprehension of the restraint chair policy, the rationale for using the restraint chair, explained the process for securing the detainee in the restraint chair, described the application and use of control measures used for securing the detainee in the chair, the rationale for bending/flexing a detainee forward and control measures used to remove the hand and leg restraints of the detainee (see Koski, pg. 105/226; Brands interview, pg. 226/246; Gaudes interview, pg. 239/246), moving the detainee to be showered for decontamination, contacting medical personnel for examination, and monitoring the detainee while in the restraint chair.

From my review of the video, I found that the officers followed these procedures appropriately and followed the ERC policy as I would expect. Sergeants Brands and Rodriquez oversaw securing Mr. James in the restraint chair and it was recorded. The officers instructed Mr. James not to resist, to comply with the instructions, and to calm down while they secured him with the restraint chair straps. As the officers accomplished the restraining process, they controlled Mr. James head and shoulders through empty hand control techniques as described previously. The officers maintained the green suicide smock on Mr. James as they secured him in the restraint chair. These are trained techniques and were reasonably and appropriately applied by the officers and they were not disproportionately applied.

Moreover, the officers appropriately applied the spit mask consistent with RCJ's policy on *Use of the Protective Spit Net* (#265300). The policy authorizes the officers to use the spit net to eliminate an officer being spit on and eliminating the transmission of communicable diseases. In

my opinion the officers used the net for its intended purpose and protected them from Mr. James spitting on them. It is not uncommon for a detainee to spit on the attending officers, particularly after the use of OC. Correction officers are not required to endure being spit on by Mr. James and applying the spit mask was appropriate. Even though the RCJ Spit Net policy does not permit the net to be used to prevent an officer from being bitten, it is not contrary to reasonable detention practices to use the net for that purpose as well.

OC spray is a safe non-deadly force measure and symptoms resolve quickly with time, air, and water. The officers appropriately followed the decontamination procedures of the *OC Spray Policy* (236.225 D). Item number 6 of the policy directs the officers to provide "aftercare" decontamination for detainees exposed to OC. As I would expect, and at the direction of sergeant Brands, the officers wheeled Mr. James in the restraint chair to the changing room to perform a decontamination shower, at about 10:13 pm. Mr. James refused a shower twice. The officers removed the spit mask and officer Davalos cleaned Mr. James' face with a wet towel. During the decontamination process, Mr. James responded to the stinging sensation of the OC by yelling, "get the fuck off of me," moved his head, and officer Davalos spoke calmly to Mr. James. During the process Mr. James resisted the officers and he attempted to the bite them. The officers instructed him not to resist or bite them and also offered him a drink of water but he verbally refused the water. Prior to exiting the change room, the officers placed a new spit mask over Mr. James' head (see Payne video). There was no evidence that he experienced any problems with ventilation and Mr. James spoke to the officers while in the restraint chair.

From the video evidence of the incident, it is undisputed that Mr. James clearly needed to be controlled, restrained for his own protection, and he required medical examination. The restraint chair provided the best, preferred, and safest method for correction officers to provide custodial care, security, and safety for Mr. James. As well, the restraint chair provided the safest method for medical personnel to examine and provide medical attention as needed for Mr. James. In my opinion, the officers use of the authorized force measures, equipment, restraints, the OC, and the spit mask were used only in response to the need and risk presented by Mr. James, and were consistent with the respective RCJ policy. The officers used appropriate force and none of the measures were used punitively or disproportionately to the aggressive resistance displayed by Mr. James.

14. Removing the Probes: 10:20 pm to 10:37 pm

The officers wheeled Mr. James out of the changing room in the restraint chair and requested that the nurse examine him at about 10:20 pm. Officers Davalos, Brindis, Gaudes, Koski, and Saulys surrounded Mr. James in the restraint chair.

During the process officers observed that two CEW probes were lodged in Mr. James' back. The shoulder straps were removed, and at about 10:22 pm, the officers flexed Mr. James forward in the restraint chair and nurse Kristiansen attempted to remove the probes but was unsuccessful (see video). Officer Koski was positioned in front of Mr. James and controlled Mr. James' head while two other officers held Mr. James's shoulders. Mr. James moved about in the restraint chair and yelled at the officers several times to "get the fuck off," and the officers instructed him not to resist. They explained to Mr. James that the probes needed to removed. At about 10:24 pm the officers sat Mr. James up and back in the restraint chair for about 1½ minutes.

At about 10:26 pm sergeant Brand responded and informed Mr. James that "it will hurt but the Probes needs to be removed." The officers flexed Mr. James forward at the waist and instructed him not to resist. Officer Koski controlled Mr. James' head while officers Saulys and Davalos controlled his shoulders on either side and pressed against Mr. James as he resisted in the restraint chair by lifting himself up and yelled at the officers. Just prior to removing the probes, sergeant Brands observed that the handcuff on Mr. James' left wrist was lose and he was assisted in securing it by officer Dismuke. During the process of resecuring Mr. James' wrist, he tightly squeezed Dismuke's hand, vigorously moved in the chair, he was instructed to stop, and she was able to free her hand. The officers were able to secure Mr. James's left wrist in the handcuff. At about 10:27 pm, sergeant Brands removed the probes from Mr. James' back and the officers relaxed their control of Mr. James, and they sat him back up in the restraint chair.

Opinion

In my opinion it was appropriate to remove the probes from the back of Mr. James. As with other incidents of using the restraint chair and using it with Mr. James, he would be secured in the chair for a period of time and monitored by medical personnel and the officers in order for him to calm down. Mr. James would not be completely secured in the restraint chair until the probes were removed. Further, leaving the probes in Mr. James' back for a long period of time (several hours) would be painful, contrary to correctional practices, and contrary to legitimate correctional objectives. Leaving the probes in Mr. James' could be construed as deliberately indifferent and punitive to the medical needs of Mr. James. It was necessary to remove the probes in a timely

manner and having the nurse attend to Mr. James first and then later sergeant Brands remove the probes was appropriate.

The officers used appropriate empty-hand control as they flexed Mr. James forward in order to remove the probes. The techniques are taught in the DAAT program and were applied to control Mr. James in the restraint chair (see DAAT/POSC curriculum approved by WI DOJ Law Enforcement Standards Board; Training Video). As seen on the Payne video and as officer Koski explained to investigators, he controlled Mr. James's head by placing the palm of one hand over the other (in V-shape) and applied downward pressure on the back of Mr. James' neck (nape). This technique is known as the "Push/Pull Decentralization Technique." I am familiar with this technique having instructed it to thousands of officers and instructors in the Pressure Point Control Tactics System (PPCT). Generally, it can be applied in close quarters when a subject has attacked an officer. The attacked officer would deflect a subject's advancement and re-direct the subject to the ground by applying moderate pushing pressure with the officer's palms of both hands to back of the neck of the subject downward to decentralize the subject. It can also be used to stabilize the nape of the neck of the subject by the officer to facilitate control and restraint of the subject.

In this incident, officer Koski applied the technique with pressure to the back of the neck (nape) of Mr. James with both of the palms of his hands to keep him flexed forward in order to allow the nurse and later for sergeant Brands to remove the probes from the back. Flexing Mr. James forward and controlling the head with the technique was appropriate and did not compromise Mr. James' ability to ventilate. Other officers used downward pressure to control Mr. James' shoulders and arms, and Mr. James resisted against the officers. These actions were only used to keep Mr. James flexed forward so that the probes could safely be removed.

Mr. James was in a flexed position for a short duration. Mr. James was flexed forward for about two minutes while the nurse attempted to remove the probes. During this time Mr. James yelled several times at the officers and moved around in the chair. The officers reported to the investigators that Mr. James resisted by trying to lift up out of the chair. Combined with his yelling and the active resistance and movement in the chair, Mr. James' actions would not demonstrate symptoms of ventilation difficulty and alert the officers that he was in respiratory distress.

When the nurse could not remove the probes, the officers sat Mr. James up and placed him back in the chair for about 1½ minutes. During this time Mr. James yelled at the officers and again

struggled in the chair. There was no evidence that Mr. James was exhibiting ventilation difficulties and the officers instructed Mr. James to relax.

Sergeant Brands responded, Mr. James was flexed forward, and Brands worked to remove the probes. Brands observed that a handcuff was unsecured and officer Dismuke responded and assisted Brands. Mr. James resisted in the chair, lifted himself up, yelled, and strongly squeezed Dismuke's hand. Dismuke instructed Mr. James to stop, she freed her hand, and she and Brands secured the free hand of Mr. James in handcuffs. Mr. James' hand was not secure, he began to resist and it was appropriate for sergeant Brands to secure the wrist in the handcuff prior to removing the probes. There was no evidence that Mr. James was exhibiting ventilation difficulties at this time. In less than two minutes, sergeant Brands was able to remove the probes. At about 10:27 pm Mr. James became limp and the officers requested the nurse examine him.

The medical examiner concluded that Mr. James died of asphyxiation while in the restraint chair, while wearing the spit mask, as the officers used their body weight on his head, neck, and back. In my opinion, the officers used appropriate and trained control techniques and used proportionate force in response to Mr. James' resistance against their control efforts. Mr. James was breathing in the chair, actively resisted by lifting up in the chair, vigorously grabbing officer Dismuke's hands, and yelling at the officers just moments before going limp. These behaviors and active resistance would not place a reasonably trained and experienced correction officer on alert that Mr. James was at an immediate risk of sudden death. In my opinion, the officers used appropriate and trained techniques while controlling Mr. James for the expressed purpose of removing the probes which was necessary and they followed appropriate and legitimate correction practices.

The actions of the officers did not cause nor contribute to the death of Mr. James. In this incident, the officers followed the RCJ ERC policy and applied the same techniques to secure Mr. James in the chair which did not result in any adverse outcome as they had done with him on previous restraint chair incidents (see videos). In those incidents, the officers also placed him in hip-flexed, forward position to remove the handcuffs for a period of time, which is standard procedure, and none of those incidents resulted in an adverse outcome. There is no evidence in the documents that I reviewed or observed from viewing the videos, that showed that the officers placed excessive weight on Mr. James, including the June 1st incident, which would compromise ventilation.

The restraint chair is a safe device to use to restrain a combative detainee. The medical research on the restraint chair reveals that it poses little to no medical risk and is a safe and appropriate device for use with violent individuals (Castillo, et al., 2015). Vilke, et al. (2009) found that with 10 respondents after exercise and placed in the restraint chair for 30 minutes, there were no significant changes in pulmonary function and there was no evidence of hypoxemia or hypercapnia. Childers et al., (2021) evaluated the ventilatory effects of subjects in the prolonged hip-flex/head down restraint position. Findings of 15 subjects who exercised from 8 to 10 minutes were placed in the restraint chair after with hands handcuffed behind their backs for five minutes, resulted in a small decrease in ventilation but it was not a clinically significant change which would support that such positioning would lead to asphyxia over a five-minute time period. These findings are consistent with other studies performed on restraining subjects with weight applied to the back which found no clinically significant ventilatory or hemodynamic compromise and concluded that other factors are more likely the cause of sudden death in subjects in prone positions (Michalewicz et al., 2007; Chan et al., 1998; Chan et al., 2004; Kroll et al., 2018; Savaser, et al., 2013).

Moreover, it is common for a combative detainee restrained in the restraint chair to spit on the restraining officers. In response correction officers will commonly place a spit mask over the head of the detainee to reduce the risk of being spit on and to prevent the risk of the transference of communicable diseases. Research on the use of spit masks has been performed to determine whether it can cause a clinically significant impact on breathing. Lutz, et al. (2019) measured the heart rates, blood pressure, and ventilation of 15 subjects wearing the spit mask for 30 minutes. Measurements were taken at intervals of 5, 10, and 15 minutes. The findings showed that there were no significant clinically differences from the baseline of the individuals in the three measures. Marigold et al. (2019) performed a similar study and measured the changes in respiratory and circulatory parameters of respondents wearing a spit mask for 30 minutes. The findings showed no significant clinical differences from the baseline of the individuals in heart rates, blood pressure, oxygen saturation, and respiratory rates. Kroll, et al. (2021) studied the pneumatic impedance of spit masks and other masks. Using a digital anemometer (airflow meter), airflow pressure was distributed in spit masks, N95 surgical mask, other surgical masks, dust masks, and bug masks. The findings showed that the spit mask had nearly zero resistance airflow, allowed for maximum airflow, and was 100 times better for airflow than the other masks studied. All of the findings of these three studies do not support the hypothesis that spit masks would contribute to a sudden arrest related death or death in-custody.

Simply flexing Mr. James forward for a short duration in the restraint chair would not cause asphyxia. There is no documented evidence reviewed in this case which shows the amount of pressure or weight the officers placed against Mr. James as they controlled him as he actively resisted and struggled against their control techniques. The consensus findings of the reputable published scientific research examining weight on subjects restrained prone do not support an increased risk of ventilation compromise or an adverse impact on cardiac output (Vilke, 2020). In my opinion, based on the review of the case documents and videos, while Mr. James was placed in the restraint chair with a spit mask on, Mr. James was yelling, resisting and actively moving in the restraint chair, demonstrating he was moving air in and out of his lungs. A person cannot talk if they cannot move air across the vocal cords, so Mr. James was clearly moving air. Mr. James was actively moving until he became suddenly unresponsive, which is more consistent with cardiac arrest, and not asphyxiation. The control techniques used by the officers were trained techniques used in conjunction with the restraint chair, which have been applied in numerous incidents without adverse outcomes, hence placing Mr. James in the restraint chair and using the techniques did not cause or contribute to the death of Mr. James. It was noted that Mr. James had hypertensive cardiovascular disease, cardiomegaly (510 grams). Mr. James' extensive struggle against the officers, after repeated instructions to stop, combined with his significantly abnormal heart more likely than not led to his sudden death.

15. The officers provided Mr. James with access to medical attention: 10:27-10:37 pm

Once Mr. James was observed to go limp, officer Dismuke checked for a pulse in Mr. James' neck but did not detect one and she performed a sternum rub. The nurse, who was standing close by responded to the officers' request, checked Mr. James' pulse and did not find one at about 10:27 pm, and she took over. The nurse placed an ammonia tab under Mr. James' nose and stated that he was swallowing and breathing. Officer Koski requested that the nurse use the pulse ox, she did but was unable to get a good reading. The nurse advised sergeant Rodriquez to radio for emergency medical services (EMS).

At about 10:31 pm, officer Koski retrieved the AED as the nurse was not sure where it was located. The officers removed the handcuffs from Mr. James, removed him from the restraint chair, and placed him on a mattress on the floor at about 10:35 pm. The AED pads were placed on Mr. James' chest, and it advised "not to shock." At about 10:36 pm EMS responded, began treating Mr. James, and performed CPR at about 10:37 pm (see Payne video). EMS personnel

continued CPR but could not revive Mr. James and he was pronounced deceased at about 11:59 pm (see investigation report, pg. 78/246).

Opinion

In my opinion, once the officers observed that Mr. James was unresponsive, they did not delay or deny him with access to medical care, and they did not fail to render access to aid. The officers followed RCJ's *Emergency Medical Responses—Jail Policy* (#585.500B) as they summoned the jail nurse to attend to Mr. James. The officers did not just stand idly by but rather they checked Mr. James' vital signs, performed a sternum rub, and requested the nurse respond who was within about 20 feet of the restraint chair. The officers also requested that the nurse use the pulse oximeter to check for respirations, called EMS when requested, retrieved the AED, and removed Mr. James from the restraint chair and placed him on a mattress they retrieved at the request of the jail nurse. EMS responded to Mr. James within 5 to 6 minutes of being requested. In my opinion the officers responded appropriately, as I would expect, and relying on professional trained medical personnel would be appropriate.

16. The officers acted appropriately pursuant to their training

Consistent with the United States Supreme Court's decision in *City of Canton v. Harris*, 489 U.S. 378 (1989), RCJ officers had received appropriate training commensurate with their custodial duties. From a review of the training records of the involved officers in this incident I noted that they all completed the basic correction officer training academy and the field training officer training (FTO) program prior to the incident. Further, the officers completed additional in-service training including: jail policy and procedures; CEW training; defensive and arrest tactics (DAAT); CPR; First Aid; and mental health training, to mention a few. Moreover, during their interviews with investigators the officers described the training they had completed prior to the incident.

Opinion

In my opinion the correction officers and sergeants were guided by RCJ's policies, practices, and their training when they interacted with Mr. James. Overall, the training records assessed illustrate that the officers and sergeants were adequately prepared with operational policies and commensurate training in order for them to perform their job tasks. I reviewed the use of force and defensive tactics curriculum and videos presented to correction officers. In my opinion, the training appropriately and adequately addressed the specific subject matter. I have also reviewed

the FTO program. The FTO program appropriately provides guidance and direction to the training officer as he/she supervises the new correction officer.

As the videos documented, the officers' followed the RCJ's use of force policies, they followed their training consistent with POSC, the First Responder Philosophy, subject control techniques taught in the DAAT system, and in only accordance with the resistance displayed by Mr. James. In my opinion, such actions displayed by the officers comport with legitimate detention objectives and accepted detention practices.

17. Conclusion

I conclude that within the collective totality of the circumstances confronted by the officers during their supervision contacts with Mr. James, the officers acted appropriately, within their training, consistent with RCJ's policies, and within the scope of accepted detention practices. Through Mr. James' threatening, self-injurious, and dangerous behaviors, he created the need for the officers and sergeants to provide him with close supervision throughout his confinement. Combined with the need to provide ongoing security and order within the facility and in order to provide adequate custodial care for Mr. James, the officers appropriately implemented the RCJ's policies and practices, and they provided appropriate custodial care for him.

Further, correction officers and sergeants were appropriately prepared through the RCJ's policies, practices, training, and experience to respond to the violent, dangerous, and threatening behaviors of Mr. James. On each occasion where use of force measures were required, Mr. James created the need for the application of the use of force. The officers followed their training and experience by using instructions, the presence of multiple officers, and used time as a tactic in an effort to gain voluntary compliance from Mr. James. Only when Mr. James refused to comply did the officers resort to using any force measure.

The officers used force measures to: protect Mr. James from his own self-injurious behaviors; to restore order and security of the facility; and to relocate to him to another cell in order to maintain facility security and to provide medical attention for him. The use of force and tactics used by officers were taken in good faith as directed by RCJ's policies and not only used to control the self-injurious actions of Mr. James, but were also applied to protect their own personal safety as they intervened with Mr. James. While the officers are charged with providing adequate precautions in the jail to all detainees, they are not required to jeopardize their own personal safety in fulfilling their charge.

The use of force responses applied by the officers showed significant restraint and comprehension of their knowledge of using verbal de-escalation techniques and using force measures appropriately as acquired through their training, experience, and as guided by the RCJ's policies. Such actions were taken in good faith within the circumstances the officers faced and comport with accepted and legitimate detention practices. In my opinion, the officers did not act outside the scope of the law, they did not misuse their authority, nor did they use force measures with the intent of harming Mr. James or sadistically for the purpose of causing harm. The officers did not act with any criminal intent or criminal recklessness or intentional disregard for the application of using force measures.

Respectfully submitted by: *Darrell L. Ross, Ph.D.* November 8, 2021

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