Racine County
WISCONSIN

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January 5, 2022

Sheriff Christopher Schmaling
Racine County Sheriff's Office
717 Wisconsin Avenue
Racine, WI 53403

RE: KCSO Investigation into the Death of Malcolm James

Sheriff Schmaling,

I have completed my review of this case to make a determination as to whether or not there my office will file criminal charges against any of the correctional staff who was on duty in the Racine County Jail and involved with Malcolm James at the time of his death on June 1, 2021.

FINDINGS OF FACT

MAY 28, 2021

On May 28, 2021, Malcolm James was arrested by the Racine Police Department (RPD) for 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 and himself. Responding officers transported Mr. James to Ascension Hospital - Racine where he was examined, treated, and released by emergency medical personnel. At the hospital, Mr. James was interviewed by police and stated he intentionally lit his clothes on fire after thinking about a phone conversation between his mother and uncle relating to his uncle wanting to start himself on fire. Mr. James stated this led to negative or bad thoughts. At the hospital, Mr. James did not make suicidal statements or any statements about wanting to harm anyone else. RPD Officers spoke with hospital staff while on scene who advised that Mr. James did not indicate any intention of being suicidal at the hospital. Mr. James was then was transported to the Racine County Jail (RCJ). Once at the RCJ, Mr. James was placed on suicide watch by jail staff. He was supervised and monitored by correction officers every 15 minutes, pursuant to RCJ

policy for someone who may want to harm themselves. Mr. James was provided with a green suicide prevention smock/gown and a green suicide prevention blanket.

MAY 29, 2021

While performing a cell check, on May 29, 2021, at about 5:30 pm (RASO 21-028786), a corrections officer observed that Mr. James was striking his head against the metal mirror on the cell wall and crying. The correctional officer informed a supervisor of the self-harm behavior. The supervisor 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 a lengthy period of time with multiple instructions by correction officers, Mr. James complied. Correctional officers entered the cell while one correctional officer provided cover with a Conducted Energy Weapon (CEW) or TASER. The CEW was not deployed during the encounter. The corrections officers controlled and restrained Mr. James in handcuffs and escorted him from the cell under his own power. Mr. James was placed in an emergency restraint chair (ERC) and the jail nurse examined him. As a result of the examination by the jail nurse, at 9:50pm Mr. James was transported to Ascension Hospital - Racine by Racine County Deputies. He was evaluated, examined, and treated by emergency medical personnel. The physician who treated him reported no serious injury to Mr. James' head. Mr. James was released and transported back to the RCJ by the deputies.

Correctional Officers Present: Mason, Benson, Davalos, Saulys, Gister, Rodriguez, Benson, Davis, Carter, Slater

MAY 30, 2021

On May 30, 2021 at 6:10pm (21-029014), correctional officers were again alerted to Mr. James striking his head against the cell walls. A supervisor ordered correctional officers to make entry and secure Mr. James to stop his self-harm. Prior to entering the cell, Mr. James was given instructions to stop hitting his head on the wall, but he continued to do so. The correctional officers then made entry and asked Mr. James to lay on his stomach on the floor. Mr. James was seated on the floor and did not comply with directions. Correctional officers moved in to secure Mr. James and while he did not cooperate, he did not resist. Mr. James was placed into the ERC and examined

by a jail nurse. Mr. James was monitored by corrections officers every 10 minutes, due to his head injury.

Correctional Officers Present: Sayer, Benson, Koski, Lemmons, Morris, Kach, Saini

May 30, 2021 at 11:15pm (21-029061), Correctional officers entered the padded safety cell and informed Mr. James that they were going to remove him from the ERC. Mr. James then responded with "No." Attempts were made to gain verbal compliance, to no avail. Per RCJ policy, Mr. James was required to be removed from the ERC due to the length of time he had been in the ERC. Mr. James refused a shower, a clean gown, and medical attention. The shoulder restraints from Mr. James were removed and as staff attempted to lean Mr. James forward, Mr. James became non-compliant and leaned back. Multiple attempts and explanations were made to Mr. James by staff in an attempt to gain compliance. James continuously repeated, "No. No." and "Get off of me. Get off of me." Slowly, staff began to start physically forcing Mr. James forward to place him in handcuffs so that they could remove all the restraints from his person. Mr. James was continuously told that staff was not there to hurt him. Mr. James' head was secured and he was leaned forward. Staff then began to remove both hands out of the restraints, secured them into handcuffs, and removed the leg restraints. Staff then assisted Mr. James into a standing position from the ERC and fixed his gown so that it wouldn't fall off. Staff then escorted Mr. James into his cell and assisted him into a sitting position on the cell bunk.

Mr. James was then instructed to lay down on his shoulder and roll onto his stomach. Mr. James then attempted to aggressively stand up off the bunk. Staff then pushed him back into a seated position on the bunk. Mr. James was shouting out, "Get off me yo!" "I'm being sexually harassed!" and "I don't lay down for nobody!". A supervisor ordered staff to re-secure Mr. James to the ERC and decentralized James onto the floor, due to his continued active resistance. A corrections officer was struck on the left side of her face with Mr. James' right elbow.

After some coordination, staff then assisted Mr. James off the floor and back into the ERC. Mr. James was displaying dead weight tactics during this time. Mr. James' head was secured as staff began to secure the ERC restraints onto his person. Mr. James was still actively resisting during this time. Staff secured the leg restraints, the waist restraint, and the shoulder restraints. Mr. James was then escorted back in the padded safety cell. Once inside the padded safety cell, his shoulder restraints were unsecured so that staff could lean him forward to remove the handcuffs.

Mr. James continued his active resistance, but staff was able to remove the handcuffs and secure both of his arms into the restraints. Medical then arrived to perform an assessment on Mr. James, but he refused the assessment. Medical then checked the restraints and left the cell.

Corrections Officers Present: Lowery, Kach, Morris, Sayer, Koski, Vela, Ramos, Born, Kumm, Arjan, Brands, Gister

MAY 31, 2021

At 5:12am, (21-029061) Mr. James was removed from the ERC and returned to his cell without incident. Mr. James was cooperative. Mr. James refused a shower but accepted a new gown.

At 7:08 pm on May 31, 2021, (21-029253) correction officers again 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. A corrections officer in possession of a CEW warned Mr. James that if he did not comply that he would be shocked, but Mr. James did not comply. The cell door was opened and the CEW was deployed 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, exiting the cell. Mr. James tripped over his 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 Mr. James in handcuffs. Mr. James was then secured in the ERC and his head and upper body were held in a forward position so that officers could remove the handcuffs he was wearing behind his back. At the end of the struggle, the probes were located in Mr. James' finger and arm, and were removed by corrections staff. Once secured, Mr. James was then wheeled into the padded safety cell and an exam by the jail nurse was attempted but refused by Mr. James. He was regularly monitored by corrections officers every 15 minutes, pursuant to RCJ policy.

Correctional Officers Present 5/31/21 at 7:08pm: Brands, Koski, Dismuke, Coutts, Siani, Morris, Mastronardi, Washington, Lowery, Kach, Wegrzyn, Benson, Lass,

Following the May 31, 2021, incident at 7:08pm, correctional officers attempted to remove Mr. James from the ERC every two hours. When they would attempt to remove him, Mr. James

would again become resistive and flail around in the chair. Mr. James would yell, "Get off me", even though there were no officers near him.

JUNE 1, 2021

June 1, 2021, at 9:15pm, Mr. James is seen on facility video, in his cell, striking his head against the wall. Various correctional officers and staff approach the door of his cell and are seen speaking to Mr. James, trying to calm him or distract him to stop him from hurting himself. During this time, members of the Correctional Emergency Response Team (CERT) begin to gather in the dayroom outside Mr. James' cell and prepare for an entry. CO Carter is wearing her body camera and captures what is occurring in the cell after staff becomes aware Mr. James is hitting is head again. Sgt. Brands instructs CO Carter to continue talking to Mr. James.

BWC – CORRECTIONS OFFICER CARTER

CO Carter is wearing her body worn camera at this time. Mr. James is seen with his suicide gown down around his waist and is pacing inside his cell. Mr. James then places a blanket over his head. CO Carter asks him to take the blanket off and talk to her. Mr. James places his head against the wall but does not remove the blanket. Mr. James gets up, walks around, and then sits down resting his head on the wall several times. At 2:45 into the BWC from CO Carter, Mr. James again begins to hit his head against the wall. CO Carter pleads with him to stop but Mr. James gets up and wanders around the cell again. At 3:39, he again starts striking his head against the wall numerous times. CO Carter again pleads with him to stop and calls for Sgt. Brands. At 4:25, Mr. James again strikes his head against the wall.

At 4:50, CO Bowman is outside the cell, asking Mr. James if he remembers her. At 5:46, CO Payne is also outside the cell door. CO Payne asks Mr. James "What is going on?" There is no response from Mr. James. At 6:23, Mr. James begins striking his left shoulder against the wall and at 6:30 he strikes his head against the wall. At 7:00, Mr. James says "Get the fuck up off me bitch. Get the fuck up off me. You're a fucking wack ass bitch. Shit. Get the fuck up off me bitch. I don't give a fuck. Bitch get the fuck up off me, with y'all nasty ass. Shit bitch." Mr. James continues to wander the cell and mumble to himself.

At 15:00, Mr. James sits down on his bunk. At 19:14 Mr. James strikes the back of his head against the wall. At 19:24 Mr. James begins striking his head again six more times, each time hard

enough to be audible on the BWC outside of the cell. At 20:15 Mr. James yells "Man, get the fuck off of me bitch." At 20:48, Mr. James stands back up and then strikes the side of his head against the mirror and then paces the cell before sitting down again at 21:32. Mr. James immediately begins striking his head against the wall seven times quickly, followed by four or five more strikes of his head to the wall. Mr. James then says "Get the fuck off me, I swear to God, get the fuck off me bitch." Mr. James then stands up and walks over to the cell door and bangs his hands on the door three times, hard. Mr. James begins pacing quickly from the door to the back of the cell, banging the door with his hands several times more. He can be heard saying "These bitches man." At 23:30, Mr. James walks to the back of the cell and hits his head against the wall several more times. Mr. James is saying "Get the fuck off me man, get the fuck off me bitch. You fucking dirty ass, black ass. I swear to God You dirty ass mother fucking white cop. Get the fuck off me." Mr. James sits down at 25:04 and says "These mother fuckers are molesting me yo." Mr. James then stands up again.

6-1-21 BWC Carter.mp4

BWC – CORRECTIONS OFFICER PAYNE

At 21:00 minutes into what will become the primary BWC to record this incident, held by CO Payne, the CERT is ready and takes over efforts to secure Mr. James to protect him from further hurting himself. There are five members of the CERT: CO Davalos, CO Gaudes, CO Saulys, CO Koski and CO Brindis. *(See attached Diagram of Positions)* Multiple verbal commands are tried to gain compliance before entry is actually made. CO Davalos is heard giving orders for Mr. James to lay on his bunk. Mr. James does not comply and oleoresin capsicum (OC Spray) is sprayed into the cell at 22:05 to incapacitate Mr. James and allow staff to secure him for a move back to the ERC. Mr. James sits on his bunk and is coughing from the OC Spray but does not comply. CO Davalos again orders Mr. James to lay down on his bunk with his hands behind his back so they can take him for a decontamination shower to remove the OC Spray and medical attention. Mr. James again does not comply.

At 23:40 the cell door is unlocked and CERT enters the cell. Using padded shields, two COs pin Mr. James into the corner of the cell while ordering him to lay down. Mr. James is reaching over the top of the shields and is hitting the COs on the tops of their helmets. Mr. James continues to fight and CO Gaudes deploys his CEW at 9:59:03pm. The CEW units record the exact

time that the device is used. Mr. James can be heard screaming as the prongs strike. The CEW does not give the CERT any more control as Mr. James continues to struggle. A second CEW is deployed by CO Gaudes at 9:59:15pm but the struggling continues. A third CEW is deployed by CO Gaudes at 9:59:29pm and following this deployment, CERT seems to have Mr. James on the floor of the cell, but there continues to be a struggle. Members of the CERT are being thrown back by Mr. James while they try to gain compliance. There is a fourth and CEW deployment at 10:00pm by CO Saulys and Mr. James once again screams. The struggle on the floor continues and Mr. James can be seen throwing officers back off him and continuing to try to stand up despite the presence of five officers in the cell with him. At 10:03:28pm, CO Koski deploys his CEW once for five seconds and then again for two seconds.

In subsequent interviews of the CERT members, it is learned that during the eight minute struggle, Mr. James struck, bit and kicked the CERT members. Mr. James was able to throw the five men around the cell and stand up with all of them on him. Mr. James was unaffected by OC Spray, pulled out CEW prongs from his own skin, and was not subdued by 27 seconds of CEW shock.

It is not until 31:45 in the BWC video of CO Payne that Mr. James' hands and feet are secured in the cell. At that time staff raises his upper body onto the bunk to put on a spit mask to prevent more biting or spitting, and insure that Mr. James' hands and feet are secure. The CERT calls him secure at 34:35 in the video. At 35:05, Mr. James has been brought to his feet and is quiet and compliant. He is breathing heavier than at rest, but freely. Mr. James walks on his own out of his cell, through the day room and to the intake area where staff assists him in sitting in the ERC. His feet and waist are secured to the chair but Mr. James continues some resistive efforts with his head that is being held by a CERT member for his safety and the safety of the officers.

By 39:45, Mr. James has been wheeled into the shower area to decontaminate him of the OC Spray. Mr. James refuses a shower on two occasions, so CO Davalos wets a towel to at least wipe Mr. James' face of the spray. The spit mask is removed for this. The wiping of Mr. James face stings and he cries out negatively. CO Davalos continuously talks to Mr. James, explaining to him why he is wiping and drying his face and that it will make him feel better. Mr. James appears to be trying to bite the officer holding his head. Once his face has been wiped and dried twice, a clean mask is returned to his face. By 44:00 the group all leaves the shower room with Mr. James still in the ERC, headed for the padded safety room.

At 44:40, there is a realization that Mr. James cannot be fully secured in the ERC because he has two CEW prongs in his back. Mr. James has been sitting against the back of the ERC without objection to the prongs up until that point. Someone calls for medical to come over the remove the prongs. It is explained to Mr. James that the prongs need to be removed so they do not hurt him or cause further injury.

At 44:04, Mr. James is leaned forward in the ERC for the nurse to remove the prongs from the CEW. CO Koski is holding Mr. James head forward, CO Davalos is holding his right shoulder and CO Saulys is holding his left shoulder. The nurse and CO Gaudes make attempts to remove the prongs at 47:44. Mr. James pushes himself back up in the ERC and is sitting on the CEW prongs again. During these three minutes, Mr. James is pushing up, moving back and forth and grabbing at CO Brindis' hands as he tries to secure him. Mr. James is talking, saying "Get off of me." At 47:45, both of Mr. James' hands can be seen and are secured behind him in handcuffs.

While sitting back, he can more clearly be heard saying "Get off of me." CO Davalos kneels down and is talking to Mr. James, telling him his name, that the staff is there to help him and that it will hurt for a little while but then feel better once the CEW prongs are removed. Mr. James responds to CO Davalos and says "Bro" and CO Davalos responds with his name and says he is not Mr. James' "Bro" but he is trying to help him out. Mr. James is breathing heavily but he is breathing and talking to staff. Sgt. Brands then comes into the area and explains to Mr. James that he is again going to try to pull out the prongs.

At 49:20, Mr. James is pushed forward again with the same three correctional officers holding him in the same three places. As he is moved forward, the handcuff on his left wrist is now open and only hooked on below the wrist. Mr. James is holding the back of the ERC with his left hand. At 49:36, Mr. James lets go of the chair and the handcuff falls down, drawing the attention of Sgt. Brands. Mr. James left hand is now free and Sgt. Brands quickly grabs it to secure it. CO Dismuke comes into the frame and grabs Mr. James' hand to hold it back. Mr. James then squeezes CO Dismuke's hand to the point that it hurts her, and she tells him to stop. Mr. James' left hand is secured in the handcuff and then his right hand comes free. An extra set of cuffs is added and the cuffs are all doubled locked. During this time, Mr. James is moving around and pushing himself up. Mr. James cannot be heard saying anything and at least two COs have their heads right next to him holding him forward. Mr. James, in the State's opinion, is last seen moving at 51:00.

Sgt. Brands removes the first prong at 51:43 and CO Koski removes the second at 52:16. Sgt. Brands at 52:26, says to check on Mr. James and see if he is ok. The COs holding Mr. James push him back up and his head tips over to the right. He now appears to be unresponsive. Staff calls for the nurse, Nurse Kristiansen, to respond and she walks over and begins an examination of Mr. James at 52:57.

At 53:05 Nurse Kristiansen breaks open an ammonia capsule and holds it with both hands over Mr. James mouth and nose. She reaches under the spit mask and puts a hand on Mr. James neck and tells the COs that he is swallowing. Sgt. Brands then asks her to examine the injuries to Mr. James back from the prongs. At 53:29 she again puts the ammonium capsule under Mr. James' nose for approximately 20 seconds. Then she touches his chest and neck again and appears to stand there looking at Mr. James. At 54:12 Sgt. Brands suggest that Nurse Kristiansen put something on him to check oxygen and she begins to look for a pulse oximeter to put on his finger. CO Dismuke begins to look for Mr. James' finger. CO Dismuke puts the oximeter on and there is no reading. Nurse Kristiansen tries again with no reading and asks if he is handcuffed. She tries a third time with no reading and then at 56:22 says they need to call 911.

At 56:32 CO Koski suggests using the AED and Nurse Kristiansen says she does not know where they are located. CO Koski leaves to get the AED kept in intake. CO Koski suggests a sternum rub and she and Nurse Kristiansen begin to shake Mr. James and rub his chest. At 57:05, Nurse Kristiansen notes that Mr. James had been making noises. 57:15 CO Koski returns with the AED and Nurse Kristiansen says they will need to lay him down on the floor. Corrections officers begin the process of removing the handcuffs and moving Mr. James to the floor. Nurse Kristiansen applies the AED pads and at 1:00:44, the unit says that no shock required. At 1:01:50, rescue arrives and takes over care. CPR is started by rescue.

Nurse Kristiansen is later interviewed and advised that earlier in her shift, she had responded to Mr. James' cell to a call that he was nonresponsive. She found him lying on his bunk, breathing and moving, but not responding or answering questions. She used ammonia salts at that time and Mr. James was holding his breath to avoid the smell. She determined at that time that he was fine and left the cell. When the correctional officers called her over that he was unresponsive in the ERC, she believed Mr. James had passed out so she used ammonia salts again and then tried the pulse oximeter. When she could not get a reading, she claimed to check his pulse on his neck and did not feel one. That was when she told a Sargent nearby to call 911.

The State, in reviewing the BWC from CO Payne, believes that there are 5 instances of agonal breathing from Mr. James after he is unresponsive, found at 53:20, 53:55, 54:02, 54:28, 54:44 in the BWC from CO Payne.

Correctional Officers Present 6/1/21 at 9:15pm: Brands, Davalos, Brindis, Koski, Gaudes, Dismuke, Payne, Saulys

6-1-21 Payne BWC.mp4

Throughout the various videos of Mr. James from May 28, 2021 - June 1, 2021, all of the corrections staff who has contact with Mr. James uses verbal tactics to try and calm him down. Efforts are made to soothe and relax him in response to his obvious strife. Staff are expressing concern for his wellbeing and possible injuries he is causing himself. There are no occurrences of negative, angry, or accusatory language directed at Mr. James. There is no intentionally abusive behavior or intentionally abusive words used with Mr. James.

July 3, 2021

At autopsy was conducted at the Milwaukee County Medical Examiner's office. The cause of death was ruled asphyxia, due to the examining pathologist's review of the video recovered in the case. No signs of asphyxia were noted, such as petechial hemorrhages or congestion of the face and neck. In speaking with the pathologist in this case, the State learned that it is not unusual for there to be no physical signs of asphyxia. She advised that asphyxia is a diagnosis of exclusion when nothing else is seen, or a diagnosis of the circumstances surrounding a death. In this case, the videos that the pathologist reviewed from the incident recorded the circumstances surrounding Mr. James' death. Also noted at autopsy was significant obesity, hypertensive cardiovascular disease and an enlarged heart. Mr. James was 75 inches tall and weighs 335 pounds.

Mr. James did show evidence of blunt force injuries (abrasions & bruises) indicative of the struggles he had with the correctional officers, puncture wounds from the CEW strikes, and a small blood clot on the left side of his head consistent with the injury Mr. James was taken to the hospital for on May 29, 2021. The pathologist opined that none of these injuries were the cause of Mr. James' death.

EXPERTS RETAINED BY THE STATE

In order to be certain that review of this case was accurate and to be most fair to the parties involved, the State retained two experts to examine the same materials and provide guidance as to two important issues. First, were the correctional officers who were handling Mr. James on June 1, 2021, acting properly, according to known standards of training, at the time of his death. Second, because asphyxia is a diagnosis of exclusion, was there a medical doctor who has done research in the area of respiratory physiology and asphyxia with live subjects that would be of assistance in understanding the cause of death.

Dr. Darrell Ross – Use of Force

As to the first question, the State hired Dr. Darrell Ross. Dr. Ross is an expert in the area of use of force in both law enforcement and correctional settings. His curriculum vitae is extensive and in choosing to hire Dr. Ross, the State found his education, work history and publications make him a leader in his field.

Dr. Ross' report analyzed the days and the incidents leading up to when Mr. James died on June 1, 2021. Between May 28, 2021 and May 31, 2021, he found no fault with the overall objective of the RCJ to operate the facility by maximizing security and implementing protocols to keep inmates and staff safe. Mr. James was given extra attention and monitoring commensurate with his state of mind. The use of force by correction officers and staff in that time frame was appropriate and reasonable to protect Mr. James. Dr. Ross did not observe and excessive or punitive force and access to appropriate medical care was always given.

In reviewing the incidents beginning at 9:15pm on June 1, 2021, Dr. Ross separated events into several periods of time, depending on what was occurring. To each of the periods of time, he applied the standards for care and use of force for correctional settings that are widely known and accepted nationally. Further, Federal case law tells us that:

> review of a use of force 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). This includes: 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. *Dr. Ross report at Page 9.*

Between 9:15 and 9:54pm, Mr. James was engaging in repeated self-harm. This was not the first time that staff had seen this behavior by Mr. James. CO Carter, CO Bowman and CO Payne, stood by with CO Carter's BWC. Various staff attempted to interact with Mr. James to get him to stop harming himself. It was clear that Mr. James needed to be controlled, relocated for his safety and seen by medical staff. Further it would have been inappropriate and cruel to have left Mr. James alone and not tried to intervene. During this time, correctional officers were gathering outside of Mr. James cell to form a CERT. Based on the three days prior and the escalation of Mr. James' conduct when staff tried to intervene for his safety, Sgt. Brands called for the CERT members to insure entry and removal of Mr. James from his cell could be done without further injury to anyone. Dr. Ross opined that there were no problems with how staff handled Mr. James in this time frame. The State agrees and notes that none of these actions led to Mr. James' death.

Once the CERT is assembled at 9:56pm, CO Davalos attempts to gain compliance rom Mr. James by spraying OC Spray into the cell. OC Spray is classified as an intermediate weapon--- a less lethal force option. Dr. Ross tells us that the objective of the use of OC Spray 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. Cleaning up after the spray and time allow the effects to dissipate so it is temporary. Unfortunately here, the OC Spray was not at all effective for Mr. James. Dr. Ross opined that there were no problems with how staff handled Mr. James in this time frame and the State agrees this use of force was appropriate. None of these actions led to Mr. James death.

From 9:58 – 10:09pm, the CERT was in the cell with Mr. James. This time frame in the cell was a significantly violent and aggravated incident. The CERT 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 CERT and Mr. James and allow them to move him either onto the bed or to the floor in order to control and restrain

him. Mr. James vigorously fought through the shields, reached over them and struck the CERT members, and failed to follow the officers repeated instructions to stop and comply. The officers escalated their force response in response to Mr. James' escalated assaultive behaviors of striking them. When CO Gaudes discharged his CEW, rather than comply, Mr. James pulled the lead wires out and began kicking at the CERT members, and attempted to bite them. CO Saulys reported that Mr. James did indeed bite him and it resulted in a scratch. The CEW was used a total of six times and none had any effect on Mr. James to gain compliance from him. Dr. Ross notes that the CEW provides an appropriate force option which can bring a violent person under control quickly, shortening the confrontation time span, allowing the correctional officers to control and restrain the person in a timely fashion. The longer this fight continued, the more likely it was that one, if not all of the CERT, and Mr. James would be injured. Dr. Ross opined that the use of the CEW was appropriate and was only in response to Mr. James' aggressive and assaultive behaviors. The State agrees and none of these actions led to Mr. James death.

From 10:09pm until 10:20pm, Mr. James was in the ERC, a spit mask was put on his head, and he was taken to the showers for decontamination of the OC Spray. Dr. Ross reveals that 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. More importantly, spit masks are relatively safe. Dr. Ross cites research on the use of spit masks that has been performed to determine whether the spit mask can cause a clinically significant impact on breathing. *Lutz, et al. (2019)* The study measured the heart rates, blood pressure, and ventilation of 15 subjects wearing the spit mask for thirty minutes. Measurements were taken at intervals of 5, 10, and 15 minutes. The findings showed that there were no significant clinical differences in breathing from the baseline of the individuals at each time. *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. Dr. Ross felt the use of the spit mask was appropriate and Dr. Lelinski did not feel that the spit mask contributed to Mr. James death. The State agrees that the spit mask did not lead to Mr. James death.

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. The process for using the ERC is a lengthy one and great care and concern must be taken to insure an inmate's safety. There are ten requirements that must be met in order to safely use the restraint chair, but when done properly, the restraint chair is an effective tool to immobilize a combative/dangerous detainee, enhance the protection of the detainee from further self-initiated harm, provide a safe and closely supervised period of time for the detainee to calm down, provide protection to correction officers who supervise and interact with the detainee, and protect medical personnel who provide medical attention to the detainee. Dr. Ross did not observe any misuse of the ERC in the BWC recorded by CO Payne in this time frame. The State agrees and nothing about the use of the ERC between 10:09pm and 10:20pm lead to Mr. James' death.

The most critical time frame to this analysis is when the staff are trying to remove the CEW prongs from Mr. James' back. 10:20pm – 10:37pm. Staff appropriately knew that Mr. James had two CEW prongs in his back and that they could not use the ERC without causing him pain and discomfort as the ERC did its job to calm Mr. James down. To work on removing the CEW Prongs, the staff flexed Mr. James forward in the ERC in order to remove the probes. The "Flex Forward" techniques are taught in the Principals of Subject Control (POSC) program authorized by the Wisconsin Department of Justice Law Enforcement Standards Board, and were applied to control Mr. James in the restraint chair. CO Koski controlled Mr. James' head by placing the palm of one hand over the other, in a V-shape, and applied downward pressure on the back of Mr. James' neck. This technique is known as the "Push/Pull Decentralization Technique." Other corrections officers used downward pressure to control Mr. James' shoulders and arms, as Mr. James resisted against them.

Dr. Ross opines that these physical tactics were necessary to have access to Mr. James' back to see and remove the prongs, and the State agrees. The method is proscribed and trained to corrections officers all over the State and country. There was no evidence in the video that any one

officer acted with malice or anger towards Mr. James. All were verbalizing calming language and concern for Mr. James, asking him to calm down and relax. Dr. Ross opines that the corrections officers in this case did not do anything impermissible by correctional standards in flexing Mr. James forward and holding him forward. 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. The correctional 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 State in understanding Dr. Ross and the principals of POSC training cannot see any conduct that conflicts with these standards.

The question of whether these techniques caused the death of Mr. James is the heart of the decision that needs to be made here. A causal relationship would be necessary for the State to prosecute any of the staff who handled Mr. James in the ERC while the CEW prongs were being removed. *(See attached Report of Dr. Ross)*

Dr. Jessica Lelinski – Medical Doctor/Pathologist Opinion as to Cause of Death

At autopsy, Dr. Lelinski described the cause of death as being asphyxia. In speaking with Dr. Lelinski, the State learned that there were no obvious signs of asphyxia. Dr. Lelinski advised that she based her diagnosis on the videos and reports that she reviewed in conjunction with her autopsy. The materials were provided to her at her request. Dr. Lelinski is a pathologist, not a researcher or pulmonary practitioner. During the process of reviewing this case, the State became aware that studies have been conducted researching the ERC, the "Flex Forward" position in the ERC, and pulmonary function. It was following this meeting and discussion that the State decided to seek additional specific opinions as to pulmonary function under the circumstances of this case, as it related to the cause of death for Mr. James with experts that were familiar with the ERC and its impact on pulmonary function. *(See attached Autopsy Report from Dr. Lelinski)*

Dr. Tom Neuman – M.D. Opinion as to Cause of Death

Dr. Tom Neuman is one of the physicians who conducted the research that the State referenced above regarding he "Flex Forward" position, the ERC and effects on pulmonary function. Dr. Neuman agreed to review this case after having been retained by the State. Dr. Neuman prepared a report that is attached to this decision, along with three published articles regarding his findings in this area, published long before he was retained for this case. For the reasons he outlines in his report, Dr. Neuman does not agree that asphyxia was the cause of death for Mr. James. Dr. Neuman, based on his research, is of the opinion that Mr. James was not bent forward and lacking oxygen long enough for him to have died of asphyxia. Dr. Neuman further says that based upon published data on ventilation needs, one could assess a person's ventilatory needs in this type of situation. Given any reasonable estimate of Mr. James' oxygen consumption during this incident, his ventilatory ability was more than sufficient to meet this need. Dr. Neuman goes on to say that without the ability to quantitatively assess the effects of ventilatory loading and the oxygen requirements in any given situation, any comments about asphyxia, difficulty breathing, or restricted breathing must be viewed as unproven. Finally, Dr. Neuman believes that Mr. James suffered from more significant heart disease than Dr. Lelinski attributed to her findings at autopsy that would have put him at risk for a sudden cardiac death, and is of the opinion that a cardiac incident was the cause of death. *(See attached Report of Dr. Tom Neuman and Articles)*

Dr. Darrell Ross, Opinion as to Cause of Death

Dr. Ross also does not believe that Mr. James died of asphyxiation while in the restraint chair because he disagrees that the officers used their entire body weight on his head, neck, and back. In his opinion, the officers used appropriate and trained control techniques and used proportionate force in response to Mr. James' resistance against their control efforts. As evidence, he cites the fact that Mr. James was breathing in the chair, actively resisted by lifting up in the chair, vigorously grabbed CO Dismuke's hands, and was yelling at the correctional officers just moments before going limp. Additionally, Dr. Ross also opines that these behaviors and Mr. James active resistance to the correctional officers would not have placed a reasonably trained and experienced correctional officer on alert that Mr. James was in distress or at an immediate risk of sudden death. The staff at the RCJ had used the same techniques to secure Mr. James in the chair previously in a hip-flexed position, without an adverse outcome.

STANDARD OF REVIEW

The question before the State is whether or not anyone employed by the RCJ, or a contract employee of the RCJ, should be held *criminally* responsible for the death of Malcolm James and whether that can be proven *beyond a reasonable doubt*. The question of civil liability carries a lesser burden that a criminal case and will not be considered in this decision. Nothing determined here should have any bearing on those questions. To begin, one must determine which Wisconsin Criminal Statutes, if any, apply in this case. To narrow that field of choices, we must first examine the three different types of criminal responsibility: Intentional Crimes, Reckless Crimes, and Negligent Crimes.

"Criminally intentional" conduct here means that the State would have to prove that the correctional officers and nurse had the mental purpose to kill Mr. James and that they were aware that his or her conduct was practically certain to cause that result. [sec. 939.23(3)&(4)] Intentional crimes would be 1st Degree Intentional Homicide, or any form of Battery. The State's review of the materials does not show any intentional behavior to harm or injure Mr. James by anyone who was employed by the RCJ. The opposite is true. Staff and correctional officers tried over and over again to calm Mr. James, to deescalate his feelings and anxiety in order to protect him from himself.

"Criminally reckless conduct" means the conduct created a risk of death or great bodily harm; and the risk of death or great bodily harm was unreasonable and substantial; and the defendant was aware that his/her conduct created the unreasonable and substantial risk of death or great bodily harm. [sec. 939.24] There was no evidence in any of the materials that employees of the RCJ recklessly created a situation of substantial risk of death to Mr. James. The CERT members in particular were using well established practices and techniques to provide for the care and safety of Mr. James while he was in the custody of the county. None of the correctional officers was using their own methods, outside of their training, to gain control of Mr. James. Improvised methods might have been reckless, but none were present here. The use of force was always a reaction to the conduct of Mr. James and escalated with his behavior, not the correctional officers. The State did not observe any reckless behavior that was unreasonable or substantial under the circumstances.

Under the circumstances of the situation under review here, there was also no evidence that the correctional officers *knew* they were creating a risk of death to Mr. James. He ERC had been used multiple times with Mr. James in the days leading up to his death without incident. The ERC had been a tool that had successfully worked on multiple occasions to calm Mr. James and interrupt his self-harm. At the moment the correctional officers became aware that Mr. James needed medical intervention, it was requested by the correctional officers. No one continued their conduct after they became aware that Mr. James was not well

"Criminal negligence" means the conduct created a risk of death or great bodily harm; and the risk of death or great bodily harm was unreasonable and substantial; and the defendant *should have been aware* that his/her conduct created the unreasonable and substantial risk of death or great bodily harm. Based on the prior use of the ERC with Mr. James and the fact that the members of the CERT were aware of its prior use with Mr. James, it would be impossible to prove beyond a reasonable doubt that the CERT should have been aware that the use of the ERC would be dangerous to Mr. James. Again, had the CERT gone outside their training or the protocols that are accepted and used in correctional settings nationally, the argument that the conduct here was criminally negligent might be stronger, but there is no evidence of that. Given what had just occurred in removing Mr. James from his cell and the first attempts to remove the prongs from his back where Mr. James continued to resist, it is difficult to say that the correctional officers should have known there was any risk of great bodily harm or death to Mr. James.

The correctional officers were not trained medical experts. They were not made aware that there was any respiratory distress from Mr. James that caused them to react differently to the situation. Mr. James' words, "Get off of me", were the same words he had been using for days, whether there was staff near him or not. Until two minutes before he was unresponsive, he was continuing to resist their efforts to render medical assistance for the prongs. Nothing about the way Mr. James acted or spoke was different than how he had responded to the staff in the days prior to his death. The correctional officers could not have known if Mr. James was having trouble breathing because of his position. The correctional officers could also not have known of Mr. James' heart disease and what impact that might have had on the situation.

From the time of Mr. James' last movement, until staff noticed he was unresponsive, was less than two minutes. This time frame creates a difference of opinion between two medical doctors as to what the cause of death may have been for Mr. James. One doctor says asphyxia

based on no other cause of death and a review of the circumstances, in this case video. One doctor says asphyxia is impossible in such a short window to have caused death and that Mr. James had to have suffered a cardiac arrest. The existence of these two expert opinions creates a reasonable doubt as to whether or not the correctional officers should have known there was any risk of great bodily harm or death to Mr. James.

These three levels of criminal responsibility, intentional, reckless and negligent, cover all of the possible criminal homicide charges. Under the circumstances of this case, the State cannot meet its burden of proof on any of these charges. There is one additional charge that needs to be considered by the State, as Mr. James was an inmate at the time of his death and was to be given a certain level of care. Wisconsin Statute sec. 940.29, Abuse of Residents of Penal Facilities.

Abuse of residents of penal facilities, as defined in sec. 940.29 of the Criminal Code of Wisconsin, is committed by one in charge of or employed in a penal or correctional institution or other place of confinement who knowingly abuses, neglects, or ill-treats a person confined in or a resident of that institution or place, or who knowingly permits another person to do so. The phrase "abuse, neglect, or ill-treat" means any act or failure to act which causes unreasonable suffering, misery, or physical harm to a resident. *(See attached WI Jury Instruction)* For the reasons outlined above, the State cannot find that any of the correctional officers knowingly abused, neglected or ill-treated Mr. James. The conduct of the correctional officers was intended to help Mr. James, and was done in an effort to minimize harm and pain.

The State additionally considered whether or not the failure of the correctional officers to act more quickly to the change in Mr. James' status might violate sec. 940.29. As soon as the prongs were removed from Mr. James back, Sgt. Brands called for medical staff, Nurse Kristiansen, to come over and review the injuries to Mr. James' back from the prongs. Once the correctional 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 correctional officers summoned the jail nurse to attend to Mr. James. The correctional 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 correctional 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. Under these circumstances and in Dr.

Ross' my opinion the correctional officers responded appropriately. It was reasonable for them to defer to, and rely on, the registered nurse who was present, for her guidance once they were aware that an emergency existed.

The State also questioned whether or not Nurse Kristiansen, who is also responsible for the welfare of inmates under sec. 940.29, may have failed to act causing unreasonable suffering, misery, or physical harm to Mr. James. Two questions apply to Nurse Kristiansen: 1). Did she fail to act when Mr. James was bent forward in the ERC and; 2). Did she fail to respond to Mr. James unresponsive condition appropriately. Nurse Kristiansen certainly did not appear to react to the situation with the kind of urgency and concern that one would expect from a registered nurse, in particular a nurse who is a specialized nurse in a correctional setting.

As to the first question, the State cannot hold Nurse Kristiansen to a different standard than what the State requires for correctional officers. The ERC and the flex-forward technique are both approved methods with which to handle an inmate who is crisis and self-harming. Nurse Kristiansen could not have known of the harm that came to Mr. James by either asphyxiation or cardiac arrest at the point in time when she observed the correctional officers all around Mr. James in the chair.

As to the second question, Nurse Kristiansen did not check for vitals, begin or ask that emergency resuscitation efforts be attempted, had to be prompted to use the pulse oximeter, and was unaware of where the closest AED was to her medical station in the intake area. In order to prove the charge, the State would have to prove beyond a reasonable doubt that Nurse Kristiansen's failure to act caused unreasonable suffering, misery, or physical harm to Mr. James. If the State was certain on the cause of death as asphyxia, perhaps restoring an airway for Mr. James more quickly would have impacted the outcome. If Mr. James died from a cardiac arrest that stopped his heart, there was likely nothing Nurse Kristiansen could have done to save Mr. James. Given that these differences of opinion could both be reasonable conclusions, the culpability of Nurse Kristiansen cannot be proven beyond a reasonable doubt.

SUMMARY

After review of all of the video evidence and a comparison of the opinions of three experts in this case, the State has reached the conclusion that there are no charges that could be filed in the

death of Malcolm James that can be proven beyond a reasonable doubt. Based in this conclusion, no criminal charges will be filed in this case.

Sincerely,

Patricia J. Hanson
Racine County District Attorney

DIAGRAM OF CO POSITIONS

CO Koski

CO Saulys ↑ CO Davalos

Mr. James
Head Forward

CO Gaudes CO Brindis

Sgt. Brands

CO Dismuke

CO Payne w/ BWC

1270 ABUSE OF RESIDENTS OF PENAL FACILITIES — § 940.29

Statutory Definition of the Crime

Abuse of residents of penal facilities, as defined in § 940.29 of the Criminal Code of Wisconsin, is committed by one in charge of or employed in a penal or correctional institution or other place of confinement who abuses, neglects, or ill-treats a person confined in or a resident of that institution or place, or who knowingly permits another person to do so.

State's Burden of Proof

Before you may find the defendant guilty of this offense, the State must prove by evidence which satisfies you beyond a reasonable doubt that the following four elements were present.

Elements of the Crime That the State Must Prove

1. The defendant was (in charge of) (employed in) a facility.

2. (Name of victim) was (a resident of) (confined in) a facility.

3. The facility was a [(penal) (correctional) institution] [place of confinement].

   IF A STATUTE IDENTIFIES THE NATURE OF THE FACILITY, ADD THE FOLLOWING.

   [(Name of facility) is a (penal) (correctional) institution.]

4. The defendant (did knowingly) (knowingly permitted another person to) abuse, neglect, or ill-treat (name of victim) .

   The phrase "abuse, neglect, or ill-treat" means any act or failure to act which causes unreasonable suffering, misery, or physical harm to a resident.

[Reasonable conduct necessary for treatment or maintenance of order and discipline in the facility and deprivation incidental to confinement reasonably required by a sentence or commitment are not abuse, neglect, or ill treatment.]

Deciding About Knowledge

You cannot look into a person's mind to find out knowledge. Knowledge must be found, if found at all, from the defendant's acts, words, ands statements, if any, and from all the facts and circumstances in this case bearing upon knowledge.

Jury's Decision

If you are satisfied beyond a reasonable doubt that all four elements of this offense have been proved, you should find the defendant guilty.

If you are not so satisfied, you must find the defendant not guilty.