Special Report

The Death of Kevin Evans

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1. THE DEATH OF KEVIN EVANS

INTRODUCTION AND SUMMARY OF CONCLUSIONS

I. INTRODUCTION

On October˚20, 1999, shortly after six in the evening, in the Lancaster-Palmdale area, a Los Angeles County Sheriff s Deputy stopped Kevin Evans, a homeless, mentally ill 33˚year-old African-American with Cerebral Palsy who had been in and out of the Los Angeles County jails at least four times in recent years for minor offenses.

This time, Mr. Evans was stopped for having taken a shopping cart from a supermarket lot. Two other Deputies soon joined the officer who had stopped Evans. As the Deputies prepared to issue a citation, they discovered that Mr. Evans had an outstanding bench warrant for failure to appear on a 1998 citation for public intoxication. The officers then placed Evans under arrest and held him overnight at the Lancaster Station lock-up. The next day, a judge ordered that Evans be taken to Twin Towers in downtown Los Angeles until October 25, when he was to re-appear in court.

During the evening of October 21, as Mr. Evans was processed over a period of approximately five hours through the Inmate Reception Center (IRC) in downtown Los Angeles, officers found him to be withdrawn and giving inappropriate responses. They observed him mumbling unintelligibly to himself and hallucinating. No one, however, stated that Mr.˚Evans was violent, dangerous, or combative that evening. Nonetheless, he was twice ordered into restraints -- first, into three-point restraints by a jail physician, and next, a couple of hours later, before the first order had been carried out, into four-point restraints by a jail psychiatrist who had never seen him and relayed the order over the phone to a nurse. The second restraint order was assertedly for threatening behavior. But just what that threatening behavior was, if there was any at all, is a

mystery: There is nothing in the LASD records indicating that Evans acted in a threatening way that evening. Even more perplexing, neither of the two doctors who prescribed restraints, nor the nurse who called the psychiatrist on the phone, was interviewed by LASD investigators, much less asked to describe the basis, if any, for their findings and orders.

A few hours later, in the early morning hours of October 22, 1999, on the third floor of the Medical Services Building (MSB) at Twin Towers, Mr. Evans was placed in four-point restraints, a procedure in which an inmate is strapped down as he lies on his back on a low bed. Each leg is secured with a leather strap at the two lower corners of the bed. One arm is secured with a leather strap at the inmate s side; the other arm is secured at an upper corner of the bed. The LASD s internal rules require that restraining an inmate must be performed in the presence of medical personnel, but none were summoned or present when Mr. Evans was strapped down.

After a sandwich he had been clutching was taken from his hand by one of the deputies, Mr. Evans began to kick and struggle. It took approximately eight minutes to strap Mr. Evans down. Nine LASD officers were involved at one point or another in restraining him. Another Deputy recorded the event on a video camera. By the time Mr.˚Evans was strapped to the bed, or within moments thereafter, he was dead.

The Deputy Medical Examiner, Dr. Carpenter, who conducted Mr. Evans's autopsy, concluded that Mr. Evans died from a combination of asphyxiation due to some form of compression against the throat, and the strain against an enlarged and scarred heart. [1] Yet the struggle alone was not enough to have caused his death, even given the

[1] Letter of October 30, 2000 to Captain Frank Merriman from Deputy District Attorney Marcia Daniel, p. 7.

enlarged heart. Indeed, Dr. Carpenter opined that the strain of the struggle alone most likely would not have been enough to cause the heart, even in this weakened condition, to fail, thereby causing Evans's death. [2]

The Medical Examiner s conclusion was supported by two findings from the Evans autopsy. First, the Medical Examiner discovered several dark and distinct bruises on the back of Evans's pharynx, the topmost part of Evans's air passageway. The bruising suggested that pressure was applied to Evans's throat with enough force to cause the back of the pharynx to be pressed against Evans's spinal column — the solid bone structure behind the pharynx. That amount of pressure would have cut off Evans's breathing altogether. The multiple bruises gave rise to an inference that the severe compression occurred more than once; an inference corroborated by Evans's intermittent but repeated gasping and gurgling heard on the videotape. Second, the Medical Examiner also found compression trauma to the muscles covering the front side of Evan s lower trachea, located just above the chest. This trauma also suggests compression of the airways.

Although the Medical Examiner did not specifically state how the trauma to the neck and throat came about, careful review of the videotape demonstrates that it was caused by the actions of two or three deputies. Here are two examples:

- About five seconds after Evans began to struggle with the officers, the videotape shows Deputy W placing his left knee in the vicinity of Evans's throat. After maintaining that position for about 12 seconds, Deputy W used a hopping or slipping motion to switch legs and to forcefully land his right knee in the vicinity of Evans's throat. About 15 seconds later,

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[2] *Id.*

Deputy W can be observed to press his knee even more forcefully down. Two seconds after that, Deputy W uses both hands to pull Evans to him, increasing the pressure exerted by his knee. Immediately thereafter, the videotape picks up the first sounds of Evans's gasping for air. The Coroner s Investigator, upon viewing this section of the video, concluded that Deputy W must indeed have blocked Evans's airway by putting his knee on Evans's throat or upper chest.

- The videotape also shows that at critical moments throughout the entire struggle, Deputy C2 shifted his body weight forward and pressed down on Evans's chest with his hands. That Deputy later conceded to investigators that he was pressing on Evans's diaphragm. He knelt on top of Mr. Evans, with his knees on Evans's thighs up near his groin. The video shows yet another officer, Deputy G, pressing firmly down on Evans's face and throat. In the same shot, Deputy W s hand is also visible pressing against Evans's throat. The shot follows several seconds of gurgling and gasping sounds from Evans. Later, Deputy G spends seven seconds kneeling either on Evans's face or throat. He later told investigators that he had knelt on Evans's cheek.

As the LASD should have known, asphyxiation is the single greatest cause of death in the use of restraints. As reported by the United States General Accounting Office to Congress, [r]estraint . . . can be dangerous to individuals . . . because restraining them can involve physical struggle, pressure on the chest, or other interruptions in breathing. [The Joint Commission on the Accreditation of Healthcare Organizations] reviewed 20

restraint-related deaths and found that in 40 percent the cause of death was asphyxiation, while strangulation, cardiac arrest, or fire caused the remainder. *Mental Health: Improper Restraint or Seclusion Use Places People at Risk*, GAO/HEHS 99-176. A 1998 study by the Hartford, Connecticut newspaper, the *Courant*, reached similar conclusions in a study of 142 cases over 10 years drawn from across the country. The Hartford *Courant*, Oct. 11-15, 1998.

II. SUMMARY OF CONCLUSIONS.

From the moment Mr. Evans was stopped by LASD deputies to the moment he died, the Sheriff s Department had sole custody of Mr. Evans. During this brief time, the LASD committed many errors. Where it had adequate internal policies to prevent these errors, the LASD violated its own policies. To the extent it lacked policies, or the policies it had were inadequate, the LASD acted in a negligent, even perhaps reckless, way. To the extent that the Sheriff s personnel were trained to put someone in restraints, the training fell significantly below reasonable standards in either a correctional or a mental health setting. To the extent that Sheriff s personnel did their jobs correctly, it was not enough. Each single mistake, mishap, or misjudgment along the way, taken alone, may not have foreshadowed death, yet their sum led inexorably to a lethal conclusion.

Even more dispiriting, when called upon to examine the LASD s actions to determine if it had done anything wrong, the internal LASD investigations were careless to the point of slipshod, self-justifying and rationalizing to the point where their credibility vanished, and insensitive and defensive to the point where reason and good judgment flew out the window. Stripped of the rhetoric and obfuscation, the

Department s position boiled down to this: The force employed putting Mr. Evans in restraints was reasonable because the LASD personnel in question did not lose their tempers and did not angrily beat Mr. Evans or knock him around as they might have ten years or so ago; this was no Rodney King.

The LASD s position does not hold water. As soon as the Deputy Medical Examiner let it be known that Mr. Evans had been asphyxiated, the LASD should have acknowledged that the force used to place Mr. Evans in restraints was out of policy, or, at the very least, it should have re-opened or expanded the investigation. Any restraint causing asphyxiation is per se out of policy absent justification for lethal force. Moreover, it was equally clear that California law had been violated: Physical restraints should be utilized ***only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior.*** California Code of Regulations (C.C.R.) ⁄1058. (Emphasis supplied). No less restrictive alternatives were even attempted, even though, as will be shown below, Mr. Evans had not engaged in any violent behavior and had complied, albeit at times grudgingly and with some mouthing off, with all instructions given him.

Evans’s family sued the County. When the $600,000 settlement came before the Board of Supervisors for approval, it came out that there was an LASD videotape of Mr. Evans’s being placed in restraints. Supervisor Molina asked to see it and was sickened by what she saw. Although assured by the LASD that what she witnessed on the tape was a standard, run-of-the-mill restraint, and that it perhaps looked worse to her than it might to others because she was seeing it with an untrained eye, the Supervisor remained

skeptical. Supervisor Molina and the rest of the Board asked us to conduct a special investigation, which we recently concluded.

We collected and gathered all the evidence we could, consistently finding that the Department s assurances that we had been given all the evidence and documentation were hollow˚— the more we persisted and insisted, the more was found. Files and records that we were told did not exist suddenly turned up; files we were told had been copied for us in their entirety turned out to be incomplete; requests we made were ignored; deadlines we attempted to impose were disregarded; phone calls were not returned. We had to go all the way to the Undersheriff himself to break the logjam. For the first time since 1993, when we started monitoring the Department for the Board of Supervisors, we felt that good faith cooperation was not consistently forthcoming. In the end, however, the truth was inescapable and plain˚— Evans died because officers had intermittently cut off this breathing in violation of Department use of force policies, in violation of California law, and in derogation of any reasonable correctional or medical procedure.[3]

Then was it murder? No. We are convinced that none of the LASD personnel acted with specific intent to do Evans in or to harm him for its own sake or with malice.[4]

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[3] At times, the LASD appeared to argue that placing Mr. Evans in restraints was not a use of force but rather a medical procedure. Our medical experts were shocked by the notion: No one with medical training would have compressed Mr. Evans's chest, diaphragm, or throat. The LASD should make clear, if there is any doubt whatsoever, that the application of restraints is a use of force and should be reported as such and reviewed as such. If it is to be done by custody personnel at all — a proposition we question because of the medical risks — it should be performed by individuals given medical training and under medical supervision.

[4] What we witnessed on the videotape was the playing out of a group ethos to incapacitate a combative inmate in response to an order to put Evans in restraints. Whether that order was wise or foolish was not their concern; whether Mr. Evans should have been in jail in the first place was not their place to question. They did what they were told to do in the manner in which they were trained to do it and according to an implicit set of rules: Overcome the resistance the inmate puts up and get him in restraints. Don t act in anger or be gratuitously violent or punishing; we will discipline you for that. But if in the midst of a difficult struggle you

If it was not murder, could the DA nonetheless have charged sworn personnel involved in the restraint with other crimes? Possibly, at least in theory. Then did the DA abuse his discretion by deciding to decline prosecution? No. The DA made a reasonable judgment that to prove a crime, much less prove it beyond a reasonable doubt, was more than this set of facts, however painful and sad, could bear.

But were crimes committed by others? Yes. One nurse deliberately falsified the medical records to make it appear that Evans was alive when another nurse had come in to Evans's room, shortly after the restraints were applied, to give him a shot of a sedative. But Evans's heart had stopped pumping; the tranquilizer simply pooled in Evans's arm, giving lie to the nurse s story. Did the DA take appropriate action on this falsification? Yes.

Was the internal investigation by the LASD s Homicide Bureau full, fair, thorough, and complete? No. Did Internal Affairs do its job in a responsible way? No. Internal Affairs did not conduct a separate, complete, and independent investigation as it should have, either at the time Mr. Evans died or later, after the Deputy Medical Examiner had concluded that Mr. Evans had died by asphyxiation.[5] Were the medical decisions by the doctors that led Evans to be put in restraints reasonable? No.

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mistakenly use more force than in retrospect may strictly have been necessary, or if in the heat of the moment you apply that force in a dangerous way — say by cutting off an inmate s breathing — the organization will back you up. As a Homicide investigator put it, I know many people have reviewed that videotape many times and have seen other things. But, you know, what we saw was a very controlled thing. This was not a brawl. This was not a free-for-all like you d see back when I was in Custody . . . . They had the guy, he resisted, they immobilized him. It all looked very controlled to us. . . . No one was losing their head on that tape. It was all very controlled.

[5] It is mandatory that Internal Affairs roll to the scene of any death following an altercation with any Department member. Here, a mandatory roll-out was called for. Evans died following a struggle with Department members who were trying to put him in restraints; clearly a death following an altercation. The LASD attempted to excuse IA s failure to roll on the grounds that the initial conclusion by the Homicide investigators on the scene was that Evans died of

Should supervisory personnel who permitted the restraint to go forward in the absence of medical personnel be disciplined? Yes. Did the supervisors know, or should they have known, that the pressures being applied to Evans's head, neck, throat, diaphragm, and chest were putting his life at risk? Yes.

As for the sergeant in charge and the deputies who got on top of Evans or otherwise applied pressure to his chest, neck, and throat, and thereby intermittently cut off his breathing, did they know or consciously realize that Evans was dying? No, we do not believe they did. Each was acting in the heat of the moment; each was responding ad hoc. Should they have known? Yes. A reasonable person in the position of each of these deputies, even in the absence of specific training or teaching, should have known from life experience, if not from general instruction at the Academy, that it is dangerous to apply substantial pressure to someone s neck, throat, chest, and diaphragm. They were negligent to ignore Evans's gasping and gurgling, and to continue interrupting his breathing.

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natural causes and not at the hands of another. The excuse is both facile and transparently wrong. Every human being ultimately dies of natural causes — the heart stops beating; the brain stops functioning. It is *how* the death came about that is important. Here, force, including lethal force, was applied to put Evans in restraints, and he died. Whether the force proximately caused the death is the question ultimately to be answered. Here, the investigators simply assumed it was not the case, apparently because Evans had a weak heart. But even if Evans had an abnormally weak heart and had died when a person with a normal heart would have survived, he still would have died at the hands of another because the force was a but for cause of the death. The questions then would be whether the LASD knew or should have known of the weak heart prior to the application of force and whether the amount of force employed was justified in any event. Because the videotape clearly discloses that lethal force was employed, the Homicide Bureau should have conducted a fuller investigation, and IA clearly should have done so as well. But even if it did not at the time Evans died, Internal Affairs should have opened a full investigation at a later time when the Deputy Medical Examiner s report came out and it was clear that Mr. Evans had been asphyxiated. This is one of the rare instances in the several years we have monitored the LASD that Internal Affairs has failed so completely.

There were three supervisors present for most of the restraint — a sergeant from MSB, a sergeant from IRC, and a senior deputy. They were there to make sure what happened here should never have occurred. Although they were acting in good faith and without an intention to see Mr. Evans suffer harm, they were nonetheless negligent in two respects. First, none of them should have allowed the restraint to go forward until medical personnel arrived on the scene so that they could monitor Mr. Evans's condition at all times. Second, at least one of the supervisors, probably the sergeant from MSB, should not have participated actively in the struggle to restrain Mr. Evans. Although the sergeant's desire to help her fellow officers is understandable, she had a duty to act purely as a supervisor. Her task was to monitor Mr. Evans, to maintain an unimpeded line of sight, and to supervise and instruct from a position where she could see everything that was happening.[6]

Should some of the deputies be disciplined? Yes, in a way that sends a clear and fair message that each bears a personal responsibility to preserve a life entrusted to his or her care and that each had a personal duty to have intervened to stop the others when Mr. Evans was struggling for breath. But that s not all that should be done. They should watch the videotape in the presence of an expert so that they come to understand, if they

[6] The sergeant from MSB, Sergeant H, called us and volunteered to come in and speak with us about the incident. She answered all of our questions fully and truthfully, and we found her credible and trustworthy and believe she was trying to do the right thing during the Evans restraint. She trusted us enough to volunteer to talk. We commend her forthrightness. We also commend her willingness to learn from and deal constructively with this incident. She chose not to put the incident behind her, but rather had the courage to confront it. In doing so, she earned our respect. In addition, by coming forward and speaking with us, she was able to put her own role in the incident in a clearer light. She was able to point out things to us in the videotape and put the incident in context for us. Her suggestions and recommendations for improvement of the process were correct and coincided with our own.

have not already, that they needlessly took a life. Each act or failure to act that contributed to the death should be pointed out and explained.

Does the responsibility stop with the sergeants and supervisors? By no means. Although not involved in the specific circumstances of Mr. Evans's death, LASD executives, at each level of command, from the Captains of IRC and Twin Towers to the Commander to the Chief and on up, had general duties and responsibilities concerning the administration of the jails that should have been performed and would have prevented the tragedy that occurred. In the jails, there are many things that have been left undone, some for many years.

The Sheriff s Department has been on repeated notice from the Board of Supervisors, from the Department of Justice, from the Department of Health Services, from us, from the newspapers, from the ACLU, from inmates, from doctors, from psychologists, from nurses, from consultants, from experts, from lawyers, from judges who have been complaining openly for years that the Sheriff s Department ignored their orders for medical treatment of inmates, from lawsuits, from hefty settlements, and from present and former Sheriff s executives that health care to inmates, particularly mentally ill inmates, was substandard if not illegal; scandalous if not outrageous.

We turn now to a detailed discussion of certain critical events and seriously flawed decisions that were made during the course of Mr. Evans's arrest and detention. Thereafter, we set forth the flaws and deficiencies in the LASD s internal investigation. Finally, we offer our recommendations.

ANALYSIS

I. THE LASD S COURSE OF CONDUCT CONCERNING EVANS CONTAINED MANY FLAWS.

A. There was an Inadequate Basis to Conclude that Evans Constituted a Danger.

October 20, 1999
6:10 pm. Palmdale Deputy Greg Schell stopped Kevin Evans, who was pushing a shopping cart. Deputy Cox and his trainee responded to the scene and prepared to cite Evans for stealing the cart. Evans was cooperative and sat uncuffed in the back of the radio car while Deputy Schell prepared a citation and ran a warrant check. Deputy Schell discovered an outstanding bench warrant for Evans's failure to appear in court on a 1998 citation for public intoxication (being under the influence of a controlled substance).[7] Deputy Schell then placed Mr. Evans under arrest and began driving back to the station. As he drove to the station, Deputy Schell realized that he had forgotten to handcuff Evans. He called for back-up, on a non-emergency basis, and then, when back-up

[7] The 1998 arrest was based upon the suspicion that Evans was under the influence of cocaine. To our knowledge based upon LASD records, he was not tested for cocaine in his system. Although the deputy who made the 1998 arrest may have observed physiological signs and behavior consistent with cocaine, those same signs and behavior were also consistent with Mr. Evans's physical and psychological disabilities. The line between schizophrenia and drug-induced psychosis is not one that a lay person is equipped to make, and there are instances in which a given suspect will present a dual diagnosis: he will both be mentally ill and using an illegal substance. For these reasons, there is a compelling need to divert these individuals, as described at greater length in the section of this chapter dealing with prevention of similar incidents in the future.

We also want to underscore that after Mr. Evans died in October 1999, the Medical Examiner s blood toxicology report revealed no traces of cocaine or any other illegal substances in Mr. Evans s bloodstream.

arrived, he handcuffed Evans without incident.[8] None of the involved officers reported that they had to use any force on Evans or that he had acted in a belligerent manner.

6:45 pm. At the Lancaster Station where Evans was taken, Deputy Schell did not report that Mr. Evans was mentally unstable or that he appeared to be under the influence of drugs or alcohol. The station jailer completed a Jailer s Assessment of Evans, finding no apparent mental or medical problems. Without stating any reasons, he classified Evans as aggressive as contrasted to passive or assaultive on the Station Jail Prisoner Classification Questionnaire. No one in any subsequent investigation asked the jailer what his basis was for the classification and what Evans did, if anything, that led the jailer to label Evans aggressive. Nor could we find any written guidelines explaining the basis for the jailer to choose among the categories. The jailer did not believe, however, that there was any reason to segregate Mr. Evans. Evans was then housed in a minimum security cell, and there were no reports of any problems with his behavior.

October 21, 1999

6 -7 am. A Lancaster Station deputy opened the cell to call the prisoners out for court appearances. He noticed Evans standing near the sliding door leading out of the holding area and told him to step back. Evans replied, I ll do what I want, fool. Other prisoners laughed and told the deputy that Evans was not all there. The deputy ignored Evans comment, and Evans stepped back into the cell. Evans was thereafter transported to the Antelope Valley Court without any incident noted.

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[8] In calling for back-up, Deputy Schell was merely following good police practice. The decision to call for back-up in these circumstances is not evidence that he considered himself to be in danger. Indeed, Deputy Schell did not tell Homicide investigators or anyone else that he considered Evans to be dangerous. He also indicated on his arrest questionnaire that he did not consider Evans as a threat.

Later that morning. The Courthouse lock-up deputy, Deputy B, reported that upon first seeing Evans, he seemed a little slow mentally and physically but nonetheless seemed to get along fine in the [lock-up] in the morning. [9]

That afternoon. Mr. Evans, chained to four other inmates, was taken to his arraignment before Superior Court Judge Randolph Rogers. During the hearing, Mr. Evans began to act strangely. As the judge began to address him, Evans slowly bent over. Finding him very odd at this point, and unsure of what Evans intended, Deputy B called for backup, albeit on a non-emergency basis. The bailiff in the courtroom at the time, Deputy T, in a later interview, thought the call for back-up was premature: He stated that he did not think there was a need to get back-up because Evans was controllable and became cooperative. When two back-up officers arrived, Mr. Evans turned around, stared for a moment at the rear wall of the courtroom, and told the judge that he might as well be talking to the wall. Evans then began mumbling to himself. Nothing further occurred. The judge ordered Mr. Evans to be kept at Twin Towers in downtown Los Angeles. According to Deputy B, the chain of four inmates quietly left the courtroom.

Mr. Evans went back to the Courthouse lock-up and was placed in a holding cell. According to Deputy B, inmates in the holding cell asked that Mr. Evans be removed from their cell because he was acting so odd. Deputy H saw Evans being relocated to another cell because he was causing problems in the cell. Deputy H stated that Evans did not have any problems with the Deputies and did not cause any problems with

[9] There is a conflict in the record regarding whether Evans, an African-American, was first put in a cell in the Courthouse lock-up that housed some white supremacists. One deputy stated that Evans was moved from the cell when another Deputy realized that it contained white power inmates. Another deputy suggested that Evans was diverted to another cell before he was put in with the white power inmates.

deputies in the lock-up. Deputy A also was present. In a report to his supervisor, Deputy A said that a male black inmate from inside the cell asked A to please get Evans out of the cell because he was talking crazy. I immediately placed Evans in the sally port of cell #3 and closed the gate behind him . . . . Approximately 5-10 minutes later, I . . . told Evans to come out because I was moving him. . . . I directed him down the hall towards cell #7 where other deputies were to receive him. He complied with no incident.

Deputy L also had contact with Mr. Evans. In his report to his supervisor, L reported that Evans was having some words with another inmate. L pulled Evans out to ascertain what the problem was. L was unable to get any information from him. When I attempted to put him back into the holding cell, he shrugged his shoulders and stated I don t want you to touch me. But I ll let you put me in. The Homicide interviewer gave a somewhat different report of Deputy L s interaction with Evans. He reported that Deputy L had told him that when Deputy L was escorting Evans to another cell, he placed his hand on Evans's arm. Evans shrugged his shoulders and pulled away stating, Don t touch me! Evans appeared to be agitated but did not cause additional problems, according to Deputy L.

Deputy B, however, interpreted Evans's gesture as hostile. She thought Evans had thrown up his arms, saying, Don t touch me! At that point, Deputy B wrote a Keep Away card on him for everyone s information and protection.

Deputy B attempted to justify doing so stating, Inmate Evan exhibited an aggressive demeanor toward deputies. The arresting deputy called for a Code 3 back-up to cuff him. Evans backtalked the judge and seems to be 918. He almost swung at a

lock-up deputy. He can not get along with other inmates either. Recommend leg and waist [chains] when transporting to court. Some of Deputy B s characterizations, perhaps, are judgment calls; others, however, are exaggerations. One asserted fact was clearly in error: The arresting deputy had not called for a Code 3 back-up (i.e., that the back-up officers come on an emergency basis with lights flashing and sirens sounding).

In light of the event as described by others, it is hard not to find some exaggeration in Deputy B s statement that Evans almost swung at a deputy. The statement apparently refers to Evans's reaction when Deputy L earlier had touched Evans's arm and Evans had either shrugged his shoulders or threw his hands up. Neither Deputy L nor any other Deputy witness claimed that Evans swung at Deputy L, and Deputy B does not say so in her written memorandum to the Homicide investigator. In any event, almost swung is markedly different from swung and seems to be a make-weight characterization.

As strange as it may seem given the importance of Deputy B s observations and recommendations on the Keep Away card, it does not appear that investigators ever interviewed Deputy B in person or asked her to explain her decision to fill out the card. She was never asked to reconcile her account of Evans's conduct with the accounts of other deputies who said that Evans was not a problem. Nor did Homicide or Internal Affairs question why she decided to fill out a Keep Away card when it had not occurred to any of the other deputies who dealt more directly with Evans to do so. It is important to note both the inaccuracy regarding the Code 3 and the relatively sparse justification for the Keep Away card. The Keep Away card will have a profound impact on how others perceived and later dealt with Evans.

Later in the Afternoon. Later, Deputy A placed a waist chain and handcuffs on Evans, who behaved calmly during this procedure. He then began walking with other inmates to the bus destined for Twin Towers. Deputy B saw that Mr. Evans was acting strangely and bent over at the waist. Deputy C also noticed and told Deputy B that she thought Evans was suffering from Multiple Sclerosis. Deputies A and L thought (correctly it turns out) that Evans had Cerebral Palsy. When Evans was about 20 feet from the bus, he stopped abruptly. Deputies C and M ordered him to keep moving, and Evans began repeating, Don t touch me and I don t have a case. He spoke unintelligibly and then talked to Deputy M, who had responded to the scene, saying he would not get on the bus because the court did not have a case against him. At that point, Deputy Q walked over and asked Evans to get on the bus. He agreed and boarded the bus without further incident. There are no reports in the record indicating that Evans engaged in any disruptive behavior while he rode the bus to the Inmate Reception Center at Twin Towers.

B. Evans was erroneously ordered into restraints.

That evening.
7:35 pm. Evans arrived in downtown Los Angeles at the LA County Jail s Inmate Reception Center (IRC.) Watch Sergeant H2 reviewed Deputy B s Keep Away card and classified Evans as D dangerous. [10]

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[10] The classification of Evans as dangerous appeared to be based solely on Deputy B s Keep Away card. If, as we believe, Deputy B s classification was not based on adequate or accurate evidence, the error is compounded by Watch Sergeant H2 s classification of Evans as dangerous. The Custody Division Manual states that the dangerous classification is appropriate for inmates who have physically assaulted other inmates or who have resisted officers. May also be used for inmates who, for any reason, may become dangerous. The circumstances must be considered. No one interviewed the IRC employee who decided that Evans should be classified as dangerous. Moreover, the last sentence of the Custody Division policy is open-ended: It is hard to see how anyone s discretion is meaningfully bounded by a phrase like inmates who *for*

It is at this point that the failure of the LA County jail to have computerized records about inmates began to have tragic consequences. Had the Watch Sergeant or anyone else who saw Evans earlier had access to or had reviewed the Department s records on Evans's previous stays at the jail, such as his visits in 1998, they would have learned that Evans's peculiar affect (*e.g.*, hallucination, mumbling to himself, failing to respond to external stimuli) had never resulted in him trying to injure himself or others. Nor had he ever tried to escape. Although Evans occasionally backtalked some of the people he encountered, Evans had otherwise behaved himself.

Moreover, and more crucially, the LASD personnel who dealt with Evans during this arrest and incarceration would have known from the very beginning that medical personnel in the LASD had previously diagnosed Evans during his prior incarcerations as having Spastic Cerebral Palsy, which produces extraordinary body rigidity (spasticity) and abnormally tight muscle tone (hypertonia).° For example, in August 1998, °the LASD noted in its records that it knew at that time that Evans's condition was so severe that he had once undergone surgery to release his hamstring muscles, which had locked up on him.° This previously-acquired information would have gone a long way toward explaining why Evans had, on October 21, 1999, behaved so bizarrely by bending deeply at the waist while in court and later when he stood in the bus line.° There is every reason to believe that Evans had done so at least in part because he was suffering from severe muscle tension.° Had his previous history of compliance and his medical condition

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any reason *may* become dangerous. It could apply, in theory at least, to any person at any time. Clearly, the definition needs tightening so that the jailer must articulate a basis for the conclusion that someone has the potential to be dangerous.

been known, noted, and taken into account when Evans was classified at IRC, he likely would not have been classified as dangerous. His odd behavior and bizarre manner would have been clearly linked to his mental and physical diseases, and the behavior which Deputy B, had misinterpreted as aggressive or dangerous would have been more accurately evaluated in light of his disabilities.[11]

7:35 - 9 pm. There is no record that Mr. Evans caused any problems or was disruptive.

9:00 pm. Mr. Evans was questioned as his name was entered into the IRC database. The interviewer noted that Evans knew that he was in jail but did not know when or where he was first incarcerated. Mr. Evans denied mental illness and said that the interviewer was asking dumb questions. Evans denied substance abuse or being on medication. The interviewer noted that Evans appeared to be responding to internal stimuli and requested that he be moved to the psych line at IRC for evaluation by medical staff and either a psychologist or psychiatrist.

9:12 pm. A physician, Dr. S, examined Evans and diagnosed him as a 33 year-old with Cerebral Palsy. He jotted down on the medical chart that Mr. Evans was Withdrawn with inappropriate responses. Tottering gait. IMPRESSION: Chronic Cerebral Palsy. He ordered tests to rule out drug-induced psychosis. He also sent Evans to the Psych. line. And finally, Dr. S. ordered that Mr. Evans be placed in 3- point restraints. He did not state any basis for the order.

Again, it is tragic that prior medical and custody records about Mr. Evans were not available on-line. It would have been easy to see that Mr. Evans indeed had Cerebral

[11] The LASD claims that an inmate s medical records are, or will soon be, available through the Jail Hospital Information System (JHIS). We have not seen rules mandating that such records, if they in fact exist, be available and consulted during classification at IRC.

Palsy, indeed had been mentally ill, but had never needed to be put in restraints and otherwise generally behaved himself during prior stays in the jail. It is puzzling why Dr. S s suspicion of Cerebral Palsy was not passed on to the custody staff that evening so that they knew, prior to dealing further with Mr. Evans, that he was disabled with the disease. As will be seen later, the officer s failure to ascribe his stiffness and rigidity to Cerebral Palsy may have led them to mistakenly conclude that he was resisting them or under the influence of powerful narcotics, such as PCP.[12]

Dr. S. was never interviewed by the LASD or questioned about the restraint order. If, as we suspect, the order was given because of the classifications made by Deputy B and Watch Sergeant H2, then Dr. S. compounded the prior errors by ordering restraints without having independently established that the legal criteria for restraints had been met.

If Dr. S had done so, he might have decided to attempt less restrictive measures, inasmuch as there was no apparent reason to conclude that they would not have sufficed. It is important to note that the law mandates less restrictive alternatives. 15 C.C.R. ⁄1058. The law permits the restraint of an individual only in narrow circumstances, and then *only* when less restrictive means of control would not be effective. The administrative convenience and efficiency of restraints are not lawful grounds for placing an inmate in leather restraints.

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[12] In her conversation with us, Sergeant H was clearly troubled that no one had bothered to inform the Restraint Team that Mr. Evans had Cerebral Palsy. She quickly realized the implications of the disease and said that had she known of his condition, she would have sought guidance from a lieutenant or other senior officer before proceeding. She pointed out that medical staff does not routinely share information about inmates that would impact how the inmate is handled. They never tell you anything about the patients you have to strap. All you hear is, Lookout, this guy s nuts. Indeed, she suggested that medical staff affirmatively tries to keep custody staff away from medical records and charts.

Custody officials have many options available to them when it appears that an inmate poses a danger of injury. One option is a Safety Cell (15 C.C.R. ⁄ 1055), a padded area in which the inmate can be secluded from others and prevented from using objects or hard surfaces to injure himself.[13] An array of additional alternatives was quickly put forward by the experts we consulted, ranging from simple counseling to leaving Mr. Evans in the wheelchair and putting him in a room where he could be observed and monitored.

9:35 - 10:59 pm. Mr. Evans spent this time sitting on a bench at the IRC nurses' station without incident.

C. There was no Apparent Basis for Upping the Restraint Order to Four-Points.

11:00 pm. Nurse A arrived for his shift and noticed Evans sitting on the bench next to the nurse s station mumbling unintelligibly to himself. IRC Nurse Cr telephoned on-call Psychiatrist Dr. M. at his home. The doctor ordered 4-point restraints for threatening behavior and a psych evaluation in the morning. [14]

11:20 pm. Evans was still sitting on the bench. Nurse A wrote on Mr. Evans s medical chart that Evans was actively hallucinating. Bizarre behavior noted. Nurse A did not

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[13] Tellingly, there are no safety cells at MSB. By failing to have alternatives like safety cells available, the LASD has thoughtlessly, if not negligently, restricted the availability of reasonable, less force-intensive options.

[14] Neither Dr. M. nor Nurse Cr was ever interviewed by the LASD. Dr. M did, however, participate in the death review. Even so, there is no explanation given for the conclusion concerning threatening behavior. There is no basis given for upping the restraints from three to four points. Dr. M. never saw Mr. Evans and there is no evidence that immediate authorization for restraints was necessary due to an emergency situation. Dr. M. apparently did not ask, or was not informed, that Evans had been sitting calmly for nearly 1 _ hours and had been acting calmly since his arrival at IRC approximately four hours previously. Nor, apparently, did Dr. M. attempt to consult records about prior times Mr. Evans was incarcerated at the LA County Jail. He would have learned that although Mr. Evans was equally mentally ill on those occasions, there never was need for restraints and that he behaved reasonably.

try to describe the bizarre behavior he said he observed. Nor did he write that Evans was disruptive or combative.

11:21 pm to 12:20 am on October 22, 1999. Evans spent this hour sitting on the bench near the nurses's station without incident.[15]

D. The LASD s Manner of Restraining Evans Led to his Death.

October 22, 1999.
12:25 am. Beginning at approximately 12:25 am, Evans was transported in a wheelchair from IRC to the third floor of the nearby Medical Services Building (MSB). He was accompanied by four IRC officers and two nurses. At this point, videotape coverage began. Senior Deputy B2 pushed Evans's wheelchair across the parking lot separating IRC and MSB. Evans was quiet and motionless. No one else was close to the wheelchair.

Shortly thereafter, B2 wheeled Evans into the elevator for a short trip to the third floor of MSB. The camera pulled in for a close up of Evans, who was calm, quiet, and unemotional; seemingly inattentive. His eyes were downcast. He occasionally looked at a plastic-wrapped sandwich in his hand.[16] His right wrist was handcuffed to a waistchain.

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[15] At this point, Evans had been at IRC for five hours. No one had noted that he acted disruptive, combative, dangerous, or violent. Indeed, at no time since his arrest had he acted in a dangerous manner. It is critical, therefore, that to this point *he has never been directly observed by any qualified medical personnel to be dangerous and no medical personnel had any stated factual basis whatsoever for ordering restraints.*

There should clearly be a rule that a restraint order has to be reviewed and renewed by a mental health professional if more than an hour elapses between the giving of the order and the actual placement in restraints. The inmate may very well have calmed down, thereby eliminating any reason for restraints. Apparently, sending calm inmates to be restrained is not an infrequent occurrence. We were told by a restraint team member, They ve sent us calm people to put in points [before]. I wonder, What are we doing this for? But we just do what we are told.

[16] We were informed that it was contrary to policy to permit Evans to leave IRC with a sandwich. Everything is supposed to be taken away from the inmate prior to being transported to MSB.

His left arm was unrestrained and rested across his legs. Neither B2 nor any others in the escort team spoke to Evans.

Approximately 12:32 am. B2 wheeled Evans out of the elevator and down the hallway behind two nurses, neither of whom turned to observe Evans. Evans was wheeled easily down the hallway to Room 23 to be restrained. The MSB restraint team awaited him. There were four deputies: Deputies O, G, W, and C2. Room 23 is approximately nine feet wide by 13 feet deep. Next to its glass door is a safety glass window measuring roughly three feet by three feet. As Evans neared the doorway, the camera showed Deputy G holding a set of thick leather straps.

12:27 — 12:34 am.*[During this time period, we will measure time by the videotape counter and will indicate elapsed time in brackets]* Evans was able to see that he was to be strapped down. As the wheelchair was backed into Room 23, various officers discussed among themselves whether the order was for three-point or four-point restraints. [1:48] Evans remained quiet. Deputy G placed his right hand on Evans's left arm and asked, Are you all right? Can you stand up? We need you to stand up. [1:58] Evans shied away from Deputy G and moved the sandwich away from him. Deputy G then placed both hands on Evans's left arm and began to raise him from the wheelchair. Evans mumbled words that sound like, Why you gotta tie me up for, man? Deputy G did not answer the question but stated, We need you to stand up. [2:01] . At this point, Deputy C2, who stood directly behind Evans, pushed Evans up out of his seat. Evans pitched forward slightly and regained his balance. He hunched slightly forward, but otherwise did not react. [2:02].

Deputies G, C2, and W gently walked Evans backwards and pushed him down on the bed. [2:13] Deputy W slowly grabbed Evans's shirt and he and Deputy C2 gently slid Evans up toward the head of the bed. [2:16] Evans did not react except to look behind himself so that his head did not hit the frame at the top of the bed. He then put his head flat on the mattress. [2:19] Officer W maintained a firm grip on Evans's left wrist. Evans did not attempt to pull away. He focused his attention on the sandwich in his left hand. [2:20] Deputy O grasped Evans's right ankle and began reaching for the first leather strap. Deputy G lightly gripped Evans's right shoulder. Evans did not resist or otherwise respond to any of these actions. Deputy C2 moved from the head of the bed toward the foot to hold onto Evans's left foot. Just as Deputy C2 was about to complete his move, Deputy G reached over and, without speaking to or looking at Evans, snatched the sandwich out of Evans's left hand. [2:22].

Evans responded by jerking his arms and legs and kicking his left leg rightward, narrowly missing Deputy O s head with his slippered foot. [2:23] Deputy W maintained his firm grip on Evans's left wrist, and C2 raced around W to prevent Evans from trying to kick O. [2:24] C2 grasped Evans's left leg in both arms. He then climbed on the bed, landing his right knee on Evans's upper thigh or groin as he tried to pin Evans's left leg to the bed. O gripped Evans's right ankle with her left hand, while her right hand continued holding the leather straps. She and C2 pinned Evans's left leg to the bed. Deputy G pushed Evans's right arm, still handcuffed to the waistchain, down to the bed. [2:26-2:28]

Almost simultaneously, other officers entered the room. [2:26-2:27] The first three officers to assist were members of the IRC Escort Team: Sergeant E, Senior

Deputy B2, and Deputy S. None of them seemed particularly familiar or experienced with restraint techniques.

For the next few moments, there was confusion. Restraint Team Sergeant H was not yet in the room because she was donning latex gloves. No one coordinated the use of force. Instead, the officers improvised. B2 moved left to help O restrain Evans's right leg. Sergeant E and Deputy S remained in the right foreground, focusing on Evans's left leg. Deputy G remained on the upper left side of the bed (Evans's upper right) and appeared to be pushing with both hands on Evans's head, neck, or right shoulder. C2 remained straddled across Evans's upper legs and pushed down on the center of Evans's chest with both arms. (He later told Homicide he had been pushing on Evans's diaphragm area.) W remained on the upper right side of the bed (Evans's upper left) and appeared to be using both hands to hold down Evans's left arm. [2:28-2:29]

A few seconds later, MSB Senior Deputy C3 entered the room and positioned himself on the right side of the bed (Evans's left) to pin down Evans's right arm and hand. [2:29-2:31] Shortly after C3 entered, either C2 or C3 calmly but firmly commanded, Relax. Relax. [2:33] Another officer ordered, Let s get those legs strapped first. [2:35]

The camera then slowly moved to the left to reveal the positions the officers had taken. C2 remained kneeling on Evans's thighs, leaning heavily on Evans's chest. W remained on the right side of the bed (Evans's left), bent over Evans's shoulder area. G remained on the left side of the bed near Evans's head. W put his left knee on the bed, possibly on top of Evans's left upper arm or chest. [2:27] Next, W changed legs, and

slipped or hopped to place his right knee onto Evans. The point of contact is obscured, but W s knee landed in the vicinity of Evans's head, neck, and shoulder. [2:39]

After this maneuver, Evans seemed momentarily subdued and was completely pinned down by the four Restraint Team Deputies. W knelt in the area of Evans's face, neck, and left shoulder; the exact point of contact remaining obscured. W shifted his weight to press his knee down more firmly on Evans. [2:54] C2 remained on top of Evans, leaning heavily on his chest; his right leg has pinned down Evans's left leg. O, partially off-camera, pinned down Evans's right leg. G remained on the upper left side of the bed, pressing down on Evans's upper right arm or shoulder.

Evans, however, continued to wriggle his torso and legs, prompting the commands, Relax, relax, from one of the officers. [2:54] Other officers reentered the room to provide assistance. W next pulled Evans's body toward himself, thereby increasing pressure from his knee down further in Evans's face-neck-shoulder area. [2:56] W s knee may have at least partially obstructing Evans's airway, because the maneuver caused Evans to gasp and grunt several times. At least one of the gasps clearly sounded like a strained effort to inhale. [2:57-3:02] S took hold of Evans's upper left arm, but Evans continued to struggle. He shook himself and let out a loud grunt. [3:08] A male officer said, Relax. [2:57-2:58] Evans grunted again and said, Get off. C2 then brought his left knee toward Evans's upper left thigh or groin. [3:12]

Next, Deputy W moved off the bed and stood bent over by Evans's left shoulder. C2 s right knee remained on Evans's upper right thigh or groin. [3:23-3:27] W then slowly lowered his left knee on the upper right side of the bed (Evans's upper left). The point of contact is obscured, but W s knee was clearly in the area of Evans's upper chest,

shoulder, and neck. Almost simultaneously, Evans made a loud hacking or gurgling noise. [3:38] An officer responded, Calm down. Stop fighting. C2 returned his left knee to Evans's lower right thigh. [3:41-3:43]

The camera then pulled back, lost focus briefly, and then displayed the entire room. [3:48] Deputy G remained positioned on the upper left side of the bed (Evans's upper right) with both hands firmly pressing down on Evans's head-neck-shoulder area. Directly opposite was W, his head almost touching G s. W appeared to be applying the same maneuver to the opposite side of Evans's body. [3:50] In the right foreground, to W s left, Senior B2 held Evans's left leg. Sergeant H was also in the foreground, to B2 s left. She also attended to Evans's left leg. [3:52] C2 maintained his position on top of Evans and continued to lean on Evans's chest. C2 s position appeared to prevent H from seeing Evans's head. [3:53] To H s left, evidently holding Evans's right leg down, was Sergeant E. Kneeling to his left was Deputy O, fastening the first leather strap to Evans's right ankle. Above her, and behind Deputy G, is Deputy S, who appeared to be pinning Evans's right arm down. G remained by Evans's upper torso and head. [3:53-3:56]

Deputy O next fully secured the first strap and moved to the right to work on Evans's left leg. Evans had become sufficiently calm to allow C2 to take both of his hands off Evans's chest and toss a leather strap to the floor. At the same time, Sergeant E released Evans's right leg, which was now strapped into place. Deputy O knelt down to work on Evans's left leg. After a moment, W released Evans and walked around the head of the bed to the left side (Evans's right). [4:08-4:14] Evans appeared to be completely under control; there was no sign of struggle.

Over 10˚seconds passed as O worked on Evans's left ankle. Evans then made more throaty, gasping sounds. [4:26-4:30] At this point, B2 and C3 leaned back from Evans's left side, affording a brief glimpse of G s hands. G s left hand appeared to push Evans's face to the left. His right hand appeared firmly pressed against Evans's throat. [4:28] As G maintained this hold on Evans's throat, Evans lets out his loudest gasp yet; sounding as if Evans's airway was partially constricted. [4:29-4:30]

Sergeant H interpreted Evans's throaty sounds to mean that Evans was preparing to spit. She asked if any of the deputies had a spit bag. [4:30] Deputy G replied, Probably just get us a sheet. [4:34] H responded, A sheet? Nurse, could you get us a sheet? C2 pulled a spit bag out of his right rear pocket and handed it to G and W. [4:36-4:37] H then told the off-camera nurse to Forget it. [4:45] [17] By the time, C2 had handed the spit bag to G. Evans had become quiet. Deputy C2 briefly took one hand off Evans's chest so that he could wipe his own face. Deputy G s left hand held the top portion of the spit bag firmly over Evans's forehead. Deputy G s right hand pressed the bottom of the mesh bag over Evans's throat. Deputy G appeared to be exerting some pressure to Evans's throat. At the same time, Deputy W s right hand also held the bottom of the spit bag in place. His hand was either on Evans's chin or the uppermost portion of this throat. Deputy W appeared to apply less pressure than G. Sergeant H appeared to be in a position to see Deputies G and W but did not comment on the pressure being applied to Evans's throat. [4:47-4:48]

[17] We asked Sergeant H if a nurse was actually present or in the area when she had called out for the sheet. Sergeant H said no, but that the nurses's room was nearby and within shouting distance. Sergeant H was critical of the nursing staff and their reluctance to attend, much less attempt to oversee, the placing of inmates in restraints.

Deputy C2 then shifted his weight and pressed harder on the lower center of Evans's chest, near his solar plexus or diaphragm. [4:50] Deputy O finished securing Evans's left leg [5:10] and moved to the head of the bed, where she retrieved a leather strap from the floor and began working on Evans's left arm. At the same time, H moved to the left foot of the bed (by Evans's right foot). A male officer told someone to start working on this hand here. Sergeant H added, One hand at a time. ˚[5:12-5:20]

Although at this point Evans's left ankle was strapped to the bed, and his left leg pinned to the mattress by Deputy C3 s right leg, Sergeant H returned to Evans's left ankle and held on to it with both hands. Rather than move to Evans's head to check on his condition, Sergeant H fixed her gaze on the officers efforts to strap down Evans's left wrist. She remained in this position for nearly 40 seconds. [5:28-6:05]

Evans resisted C3 s and B2 s efforts to slide his left arm into position for Deputy O. [5:20-5:23] The officers nonetheless quickly moved the arm into place and Deputy O, now kneeling, began to strap Evans's left wrist down. Deputy G is visible as well, continuing to hold the spit bag down with noticeable pressure.

The officers next briefly discussed which of Evans's arms was to be strapped by Evans's waist. They decided that because Evans's left arm was already pinned down by his waist, the right arm would be secured in a higher position. [5:47] Evans remained under control. Deputy G removed his left hand from Evans's head to check his wristwatch briefly. [5:47] C3 then asked the officers to slide Evans's body a few inches toward the head of the bed. The officers accomplished this with no visible resistance from Evans. [6:04] After roughly 15˚seconds, Deputy O fully secured Evans's left wrist. [6:20] At this point, Evans's two legs and left arm were fully secured by leather

restraints. Evans's right arm remained handcuffed to his waist chain. Evans did not attempt to move his legs or left arm. His head and right arm were at this point obscured from view by Deputy C2, who continued kneeling on top of Evans's legs with both hands pressing against Evans's chest. O and W walked around the head of the bed to work on Evans's right arm. Senior Deputy C3 can be heard saying to someone, Nah, he s fine. He s not getting out of there. [6:23]

The camera then panned to the middle of the room. [6:26] Deputy C2 continued to lean heavily on Evans's chest. C3 stood on the right (Evans's left) and appeared to be holding Evans's left hand or fingers in a compliance hold. Evans showed no reaction to this hold, which was probably painful. [6:27] Evans's fingers appeared to be completely still for the next several minutes. Deputy G remained in the same position, firmly pressing the spit bag over Evans's face. Deputy S, on G s left, firmly holds Evans's right arm down.

Deputy O then moved over to Evans's right shoulder. [6:27-6:33] Deputy G moved over to the right side of the bed (Evans's left) while maintaining his hold on Evans, pressing down firmly with both hands. Although Evans did not appear to be struggling, G slowly raised his left leg and planted his left knee near Evans's head or throat. (He would later tell Homicide investigators that he had planted his shin on Evans's cheek.) [6:33] No one commented on G s maneuver. Evans did not appear to react to G s knee.

At this point, Sergeant H was positioned at the left foot of the bed, by Evans's secured right ankle. She was not standing in a place where it was possible to check on Evans's condition and did not comment on Deputy G s knee placement. [6:35][18]

Next, Senior Deputy C3 asked which officer had a handcuff key so he could uncuff Evans's right hand from the waist chain. C2 raised his right hand from Evans's chest to reach into his right breast pocket. C2 then returned his hand to Evans's chest. Evans remained quiet and motionless. [6:38]

C3 then asked B2, who had moved over to Evans's right foot, to bust these [the waistchains] out. [6:42] Deputy W responded by walking past the head of the bed (and past the kneeling G) to where C3 was positioned. [6:45] Deputy W attempted to unlock the waist chains. This effort failed, and he returned to the left side of the bed (Evans's right), between Deputies S and O. [6:46-7:22] During this time, Evans remained silent and apparently motionless.

The officers then engaged in some banter to relieve stress [6:58-7:07] which was interrupted by another throaty sound from Evans. [7:09] Sergeant H responded by moving along the left side of the bed (Evans's right) up to Evans's head, where she was in a position to see where G s knee was located. (This marked the first time since the struggle began that Sergeant H appeared to check on Evans's condition.) [7:14] B2, on the right side of the bed (Evans's left) likewise moved up to G s head to take a look. He moved calmly and slowly, his hands in his front pants pockets. [7:25] Neither H nor B2 said anything, although they appeared to be intently studying Evans's face. Meanwhile,

[18] As we noted before, Sergeant H permitted herself to become too involved in the restraint procedure itself. Her instincts, however, were correct: She said that if she had seen a deputy s knee on anyone s face, Hell yes, I would have told him to remove it.

the deputies were having a difficult time figuring out how to remove Evans's waistchain. Although Evans appeared to have stopped moving, Deputy C2 remained on top of him, pressing down on his chest. Evans then moved slightly, causing the officer to press down harder. A male officer told Evans, Relax. [7:43] [19]

B2 next slowly bent down by Evans's head, appearing to place one or both hands near the top of Evans's head. To his left was G, who continued to kneel on Evans's face or throat. They remained in this position for several seconds. Evans was not moving or making a sound. [7:45-7:50] At this point, there was a long silence as H studied Evans's face. [7:52-8:06] C3 broke the silence by asking B2 if he had gloves on yet. [8:07]

The camera now clearly showed C2 s knees resting on Evans's thighs with C2 continuing to press down on Evans's chest. [8:07] Two barely audible sighs escaped from Evans. [8:15-8:17] C3 asked an unidentified officer to start on Evans's waistchain. [8:20] Efforts to this end continued on the left side of the bed, where Deputies S, W, and O were standing. Evans grunted again but did not move. [8:28] For the next several moments, the deputies figured out how to remove Evans's waistchain. C2, still atop Evans, assisted with his right hand, his left hand continuing to press down on the center of Evans's chest. [8:29-8:58] He then returned his right hand to Evans's chest. [8:59] Senior Deputy B2 then disengaged from Evans's head and moved toward the foot of the bed, past C3, who maintained a firm compliance hold on Evans's left hand. [8:52] Evans's fingers had remained motionless for several minutes. The officers then were able

[19] Sergeant H noted that there are no rules about when it is improper to straddle an inmate: Sometimes you have to get on top of them just to keep them under control. Rules? Just common sense. I don t want to see [the Restraint Team deputies] get their knees on a guy s neck, but you know there s nothing written on it.

to remove the waistchain. [8:54] Evans's right hand had been secured sometime earlier, off camera.

Thus, Evans was at this point held down by four-point restraints. Nonetheless, G remained kneeling on Evans's face or neck. Sergeant H bent down, perhaps to examine Evans's face through the mesh of the spit bag. [8:57] She said nothing to G about the placement of his knee. C2 remained on top of Evans, pushing down on his chest. H did not remark about this either.

Senior Deputy C3 then calmly ordered, Everyone except G and C2, out. [8:59] G s knee came off Evans face-neck area briefly, returned, and then came off again. [9:02-9:05] Sergeant H also left the room at this point. [9:07-9:11] Next, C3 ordered, C2, out. [9:11] C2 hopped off Evans's body, landing both feet on the floor. To do so, C2 had to briefly place his full body weight on Evans's chest. [9:12-9:13] The maneuver drew no comment from C3 or G, the only two officers remaining. Deputy C2 later told Homicide investigators that when he climbed off of Evans, he noticed that Evans had urinated on himself.

C3 continued to maintain his compliance hold on Evans s fingers, and G continued pressing the spit bag over Evans's face. [9:14-9:17] As G released his grip, the camera showed that most of Evans's head appeared to be covered with a sheet. (The camera had not captured when or how the sheet came to be placed over Evans's head.) G then spent over 20˚seconds reaching under the sheet, apparently so that he could remove Evans's spit bag. [9:19-9:41] Eventually, C3 had to assist G in this effort, and it appeared as if it was difficult to remove the spitbag, possibly because the sheet covering Evans's face, which in turn was covered by the spitbag, was tight and difficult to

maneuver under. [9:39-9:41] Sergeant H suggested that another reason it took so much time was that the spitbag s rear handling snaps may have become knotted or tangled. C3 tossed the spit bag and G returned the sheet over Evans's head, obscuring Evans's face from view. (Sergeant H later told Homicide that she subsequently had to remove the sheet from Evans's face in order to check on his condition.) [9:42] Deputy G then placed his hands on each side of Evans's throat, evidently checking for a carotid pulse. At the same time, C3 extended his right hand to the left side of left of Evans's throat, also as if to check for a pulse. [9:44] At this point, G and C3 were alone with Evans. Evans, now in plain, unobstructed view of the camera, was quiet and motionless.

A female voice near the door to Room˚23 and close to the camera was then heard to say something like, Unh. [9:46] It is unclear what prompted this sound, or what it denoted. The exclamation was immediately followed by H s order, Somebody want to get a nurse in here? [9:48] Roughly a second later, a female voice quietly exclaimed, Wow. H turned away from Evans's room to face the officers in the hallway. She ordered in a calm, but commanding tone, Kill the video. Kill the video. [9:52] [20] The video footage almost immediately stopped [9:54]. The tape stops at approximately 12:34˚am.

Sergeant H s order to turn off the video camera was not intended to do so, but it nonetheless substantially impeded the LASD s investigation of what happened in the

[20] Some persons hearing the kill the video comment suggested that Sergeant H at that point knew Mr. Evans was dead and wanted to stop the cameras. Even before we interviewed her, we were convinced that was not the case. She was following then-standard procedure both by shutting off the camera and calling a nurse to check on the inmate. The standard procedures needed to be changed. Less than 24˚hours after Evans s death, the LASD modified its policy to require that the camera should stay on at least until medical personnel have confirmed that the inmate is in stable condition. And, as stated before, medical personnel should be in attendance during the entire restraint procedure.

critical minutes after Evans had been restrained. Ordering the camera off proved particularly unfortunate because the witness accounts of those first crucial minutes vary dramatically, at least two witnesses were later proven to have lied about their actions, and others also appear to have fabricated at least some portion of their testimony. We will therefore set forth next what we believe to be the most likely sequence of events.

E. There Was a Failure to Attempt Timely Resuscitation

Approximately 12:34 am. Sometime after giving the order to kill the video, Sergeant H went back into Evans's room. H told Homicide investigators that she removed the sheet from Evans's head and saw that Evans's eyes were staring straight ahead. She said she checked his carotid and could not detect a pulse, although she also claimed at another point that Evans's neck was still warm and his chest was moving up and down. Finding no pulse, H claimed she called for Nurses C and D to examine Evans, because he did not look good. In her interview with us, Sergeant H again emphasized how the fixed, blank stare caused her to realize that Mr.˚Evans was in trouble.

At about 12:30 am., while the restraints were being applied, the supervisor on duty, Nurse C, telephoned the only MSB physician on duty, Dr. M2. Nurse C told Dr. M2 that Evans was highly agitated and requested authority to give him a sedative. Dr. M2 authorized her to administer two milligrams of Ativan every six hours. Nurse C then asked Nurse D to accompany her to Room 23 and give the shot to Evans.

Approximately 12:35 am. By the time they arrived, Evans had already been restrained and the room was empty. Without checking Evans's condition, Nurse D administered the shot of Ativan. We know that by this point Evans's heart had already stopped beating, because the Medical Examiner found no detectable traces of Ativan in Evans's bloodstream.

D noticed that Evans did not flinch when he received the shot. She then shook him and found no response. Seeing that his eyes were open, Nurse D exited the room and asked for a flashlight.

Approximately 12:36- 12:40 am. Seeing that Evans made no response to the flashlight to his eyes, she exclaimed, My God, his pupils are dilated. D then left the room to find a blood pressure cuff. She returned with the cuff, checked Evans's blood pressure, and found no reading. Deputies G, W, and C2 asked Nurse D if she wanted them to contact paramedics. Nurse D ignored them.

Approximately 12:41 am. Dr. M2 was called to render assistance.

Approximately 12:42 am. At Deputy C3 s request, Twin Towers Control called the paramedics. Why the paramedics had to be called is also somewhat of a mystery: One would expect that all personnel in MSB, both custody and medical personnel alike, would be trained in CPR.

Approximately 12:45 am. Dr. M2 arrived and, seeing that no one was performing CPR, he began chest compressions and asked Nurse C to call Dr. Hill, who, unlike Dr. M2, had Emergency Room experience.

Crucial moments were thereby lost in which it might have been possible to save Mr. Evans's life. Even more disturbing, however, is that CPR was not performed in the critical minutes that followed discovery that Mr. Evans was not responding. The record is in conflict about what happened, and the LASD s internal investigation did not clear it up. It appears likely that the crash cart with the CPR equipment was not fully stocked when brought to Evans's room. There is a suggestion in the record that the personnel present were reluctant to perform CPR on Evans because the crash cart was missing a

mouthpiece.[21] Regardless of whether the personnel had a legitimate reason not to perform mouth-to-mouth resuscitation, there is no reason why chest compressions were not commenced, and the American Heart Association has noted that chest compressions, even without mouth-to-mouth, saves lives. It is undisputed (and we re-confirmed the fact with the LASD) that none of the sworn personnel present performed CPR.

Approximately 12:50 am. Dr. Hill arrived from IRC. The paramedics arrived nearly simultaneously and commenced CPR.

12:55 am. Evans was pronounced dead.

II. THE INVESTIGATION OF EVANS'S DEATH WAS SERIOUSLY FLAWED.

We found the investigation by the LASD s Homicide and Internal Affairs Bureaus deficient in many respects. First, investigators failed to interview many witnesses who had dealt with Evans from the time he was arrested until the time he was pronounced dead.

[21] Deputy W told Homicide, I don t understand why, why they [the nurses] didn t start [CPR] earlier, why the nurses didn t start earlier, I know when they wheeled the crash cart out they were not prepared, they didn t have a breathing mask with the little apparatus, the breathing apparatus for CPR . . .and so I, I waited, I didn t want to . . . endanger myself so we re waiting for the mask and still nothing was there, the crash cart wasn t prepared, I saw the nurses come in and their saying, Oh, we need saline, Oh we don t have saline on this crash cart, just the crash cart was a complete mess . . . "˚ Transcript at 10:17-28.

A. Failure to Interview

Homicide and Internal Affairs failed to interview:

- Three of the four deputies who had first encountered Evans the evening of October 20, when he was spotted with the stolen shopping cart;[22]
- The station jailer who made the initial assessment of Evans's behavior in custody;
- The station watch sergeant who had approved the arresting officer s and jailer s assessment of Evans at the time of booking;
- Any of the prisoners housed with Evans in the station jail cell;
- Deputy S2, who had witnessed a verbal outburst from Evans as prisoners were being called out of their cells for court;
- Any of the prisoners housed with Evans in the courthouse holding cell, particularly those who had complained about Evans's behavior;
- The judge who had witnessed Evans's courtroom behavior and ordered transported to Twin Towers;
- Any of the prisoners who accompanied Evans on the trip from the courthouse to Twin Towers;
- Deputy B, the courthouse officer who had written up a Keep Away card warning IRC to isolate Evans from others;
- The IRC Sergeant who decided upon the basis of Deputy B s Keep Away card, to classify Evans as a dangerous inmate;

[22] In addition, investigators failed to conduct a formal, tape-recorded interview of the fourth officer, Deputy Schell, who had arrested Evans and drove him to the station. Instead, one investigator merely telephoned this deputy and interviewed him for several minutes.

- The individual(s) in IRC who first conducted a mental screening of Evans at 9:00˚p.m. the evening of October 21;
- Dr. S, who first examined Evans and recommended that he be placed in three-point restraints;
- The social worker who had briefly interviewed Evans within hours of his death;
- Two nurses involved in communicating the decision to restrain Evans to MSB;
- Nurse Cr, who telephoned the on-call psychiatrist, Dr. M, to report on Evans's behavior at 11:00 p.m.;
- Dr. M, who, upon receiving a call to his home from Nurse Cr, ordered that Evans's restraint be modified from three-point to four-point restraints;
- The unidentified male lab worker seen in the videotape to be peering into Room˚23 after Evans had been restrained to the bed; and
- The individual paramedics who had arrived at the scene in order to assist in resuscitation efforts.

Perhaps more significantly, investigators neglected to interview Deputy B2, who pushed Evans's wheelchair over to the Medical Services Building and subsequently assisted the Restraint Team in subduing Evans. Deputy B2 was allowed to go home after the incident without providing a statement to anyone, and investigators did not call him back for an interview. This investigative failure was particularly troubling given that videotape of the incident plainly shows that Deputy B2 not only used force on Evans, but

also actually bent over Evans's head at one point to check on his condition. In this respect, Deputy B2 was a key witness.

We discussed this issue with the Department on many occasions and received many conflicting stories. Initially we were told that investigators decided not to interview Deputy B2 because he was too peripheral. Later, those same individuals told us that Internal Affairs had in fact interviewed Deputy B2. When we then asked for the interview tape, the Department admitted over a week later that no one had interviewed Deputy B2 after all. Still later, one of the key investigators told us that the investigative team had not interviewed Deputy B2 because he was assigned to the Inmate Reception Center and thus was not part of the group from the Medical Services Building that was under investigation. When we then pointed out that Homicide investigators had interviewed all of the other officers at the scene, including those assigned to IRC, the investigator offered a different explanation. He stated that Deputy B2 was not a high priority witness because [H]e he was not one of the officers applying any significant force to Evans. But this excuse likewise failed to hold water because Homicide and Internal Affairs had interviewed other personnel who had witnessed the restraint but had never touched Evans. Finally, the investigator stated that someone was supposed to get around to interviewing Deputy B2, but evidently neglected to do so. As we stated earlier, the Department s failure to interview Deputy B2 was inexcusable.

B. Failure to Analyze.

Second, department investigators did not at all scrutinize any of the decisions that lead up to the actual restraint procedure. They did not question:

- whether Deputy B was accurate when she stated on Evans's Keep Away card that the arresting officer had requested a Code-3 backup (she was not);
- °whether IRC had sufficient information to classify Evans as a dangerous inmate (it did not);
- whether Dr. S. had good cause to order Evans into three-point restraints (he did not);
- whether Dr. M had good cause to increase the order to four-point restraints without ever examining Evans (he did not); and
- whether, given that Evans had sat quietly at the IRC nurses's station for over an hour after Dr. M. had given his restraint order, it would have been appropriate to reassess the need for restraints (it was).

Instead, the investigators many of whom are highly-regarded for leaving no stone unturned when it comes to investigating street crimes never considered these critical issues or, worse, assumed that the decisions of the health care personnel were not subject to further scrutiny. For example, we were surprised to hear one investigator tell us matter-of-factly, I mean, someone, a doctor or someone says that this guy needed to be in three-point or four-point restraints you have to take that at face value.

C. Failure to use Available Evidence.

Third, although the videotape of the incident plainly showed three officers using highly questionable force and restraint techniques, Department investigators failed to use this evidence to their advantage when they interviewed the officers at the scene. For example, although the videotape clearly showed Deputy W thrusting his knee onto what

appears to be Evans's throat, investigators did not ask Deputy W to account for this unusual maneuver. Indeed, investigators did not ask about this high-risk use of force in *any* of their interviews.

By failing to adequately utilize the videotaped evidence at their fingertips, Department investigators hamstrung their own ability to cross-examine the officers effectively. Accordingly, the Department never learned the answer to many critical questions such as:

- Why, when Sergeant H thought that Evans was going to spit, did she and other officers ask a nurse for a sheet instead of a spit mask, particularly when particularly when the Department has *never* authorized the use of sheets to restrain inmates?
- What did Deputy B2 see when he bent over to peer at Evans's face just as the last leather restraint was being strapped into place?
- Why did Deputies G and W press their hands firmly against Evans's throat? Did they learn this technique from the Department? [23]
- Why did Deputy C2 continue to press both hands firmly against Evans's diaphragm for several minutes *after* other officers had subdued Evans's arms and legs? Did he learn this technique from the Department?
- Why, after Evans had been fully restrained, did Deputy C2 press down heavily on Evans's chest one final time so that he could hop off the bed? Did the Department teach him this dismounting technique as well?

[23] The answer appears to be that no special training was provided. As Sergeant H told us, They don t provide us any special training about what to do whey they fight. You just rely upon your general training on how to take someone down . . . . You just take them down as best you can, with the minimal amount of force.

- Why did Deputy G, after placing a spit mask over Evans's face, later decide to place a sheet over Evans's face? Who told Deputy G that he could use a sheet in the first place?
- Why, given the fact that the spit mask was not torn or otherwise damaged, did Deputy G remove it after Evans was fully restrained and then slide the sheet back over Evans's face?[24]

Instead, the investigators sailed quickly through their interviews, spending roughly 10 minutes to question each officer, including those who had used force on Evans. The following exchange illustrates the superficial nature of the questioning:

> Investigator: O.K. Did you see anyone punch this inmate?
>
> Sergeant H: No, absolutely not.
>
> Investigator: Did you see anyone kick this inmate?
>
> Sergeant H: Absolutely not.
>
> Investigator. Did anyone do anything, uh, that was out of the ordinary as far as restraining is concerned?
>
> Sergeant H: At . No.

A competent, inquisitive investigator would have used his knowledge of the videotape footage to ask more specific questions at this point:

- Did you see anyone kneeling on Evans?
- Did you see any force applied to his face, throat, or chest?
- If you did see such force, did you consider it to be out of the ordinary? Why or why not?

- Did you say anything to the officer(s) when you saw such force being applied? If so, what did the officer(s) say or do in response?

Given that these Homicide investigators surely knew enough to ask such obvious questions, we wonder whether they simply had already determined that since Evans had not been struck gratuitously or in anger, there was no need to conduct an in-depth thorough investigation. Indeed, having heard many other tape-recorded police interviews, we were left with the distinct impression that most, if not of all of the investigators were simply going through the motions.

D. Failure to Intensify or Re-Open Investigation.

Fourth, although the Coroner s office had reported that asphyxiation had played a role in Evans's death, this critical fact did not spur the Department to intensify or re-open its investigation. For example, when the Deputy Medical Examiner (DME) who had performed the autopsy told investigators that he did not know how Evans had been asphyxiated, investigators failed to take the next logical steps: (i) Sitting down with the DME and carefully reviewing the videotape with him, or (ii) conduct their own investigation of the videotape and witnesses to determine, as our medical consultants did, that Evans was asphyxiated because of the actions of sworn personnel.

E. Failure to Re-Interview Witnesses

Fifth, the news that Evans had been asphyxiated should have prompted investigators to re-interview each of the officers present during the restraint procedure. Specifically, they should have sat down with each officer and gone through the videotape

[24] Sergeant H acknowledged that she could not think of a reason, under these circumstances, why it would be appropriate to replace the spitbag with a sheet.

frame by frame. One of the investigators informed us that the investigative team did not even consider taking this step.

These investigative failures are particularly disturbing given that the videotape clearly showed (i) that Deputies G and W used force that likely caused Evans's throat trauma; (ii)˚that Deputies, G, W, and C2 used force and restraint techniques that likely cut off or restricted Evans's breathing; and (iii) that Evans was gasping for air when such force was applied.

III. RECOMMENDATIONS FOR AVOIDING FUTURE EVANS CASES.

Our recommendations fall into two categories. The first includes steps that the LASD should take immediately to remedy the problems that led to Mr. Evans's death the systemic failures at each stage of the proceedings. The second set of recommendations are steps the County should consider so that the tragic circumstances that led to Mr. Evans's death do not get triggered in the first place.

A. Recommendations for Reform of LASD procedures.

1. Immediately Implement the Recommendations we made in June 2000 in our Twelfth Semiannual Report.

Our semiannual reports have highlighted for many years the failings of the LASD in the provision of medical and mental health services. We have repeatedly made several recommendations. These recommendations have largely been ignored. We strongly recommend immediate implementation of them on a tight time schedule ordered by this Board. The most important of them are:

a. Immediate licensure as a Correctional Treatment Center for the Medical Services Building (MSB) at Twin Towers.

Although preliminary steps in this direction have been taken, the process must be speeded up on a tight timetable.

b. Immediate independent Title 15 inspection and immediate response thereto to bring medical and mental health services into compliance, and implementation of adequate mechanisms for external monitoring and oversight to be in place. If the ACLU can no longer effectively monitor, replace that organization with another independent organization that can do so.

c. Seek immediate IMQ accreditation of all out-patient facilities in the Los Angeles County Jail system as the minimum jail health care services delivery standard.

d. Transfer the provision of emergency, inpatient and outpatient specialty visits to MSB under a contract with a university hospital, be it UCLA or USC.

e. Contract immediately with USC for the provision of services at IRC pursuant to a plan devised years ago by Chief Moorehead and Lieutenant Moak.

f. Contract out all or part of the remainder of medical and mental health services to USC or UCLA.

g. Immediately computerize all medical and jail records relating to inmates.

2. The LASD should revise its Station Jail Prisoner Classification Questionnaire and Overhaul its Procedures for Dealing with Mentally or Physically Ill Individuals.

It should give specific guidance and direction to the jailer concerning how and why a particular individual should be classified. The categories of passive and compliant, aggressive demeanor, and assaultive behavior should be abolished. Instead, the questionnaire should ask whether any *specific* behavior has been observed by the arresting officer or the jailer that gives rise to a concern that the individual poses anything greater than a minimum security risk or poses any cognizable risk of danger to himself or others. If so, then the specific factual basis must be specified in detail and the individual housed and classified appropriately.

- If the basis for the specification, or the observed behavior, consists of possible mental illness, strange or odd behavior, or possible drug-induced psychosis, the arrestee must be evaluated within one hour by a medical professional on call or on site at each station. Such medical professional for these purposes shall include a psychiatrist, a psychologist, or any other licensed mental health practitioner certified as capable of recognizing and classifying mental disease. It may also include sworn personnel who are specially trained and certified by a psychiatrist as capable of recognizing and classifying mental disease. If the individual is determined to be suffering from mental impairment, whether organic or drug-induced, he or she shall be specially housed and handled with the goal of stabilizing the individual and protecting him from any risk of danger to himself or others

until such time as the individual is released, arraigned, or transported to IRC. He shall be classified as Ill.

3. Any individual so classified as Ill, or any individual ordered by any court to be put in psychiatric observation, given a mental evaluation, or given medical attention of any kind, should be specially so classified and specially accompanied and given special expedited processing at IRC so that he or she is in the psych or medical line and actually sees a mental health or medical professional within no more than one hour of arrival at IRC.

For these purposes, a medical professional means an MD and a mental health professional means a psychiatrist or licensed psychologist certified as capable of recognizing and classifying mental disease. Each such inmate must be evaluated in person by the mental health professional.

4. The Inmate Special Handling Request (the Keep Away card) shall be revised to include a special handling classification of Ill. Such classification shall override any other classification and shall invoke the procedures specified in (2) above.

5. All inmates so classified shall be mandatorily assigned to a paid or volunteer independent patient advocate detailed to IRC to assist in the timely, efficient, and proper processing of mentally and physically ill inmates.

6. **New policies regarding restraints should be adopted.**[25] **Our recommendations in that regard are:**

   a. **The use of three- and four-point restraints is abolished for all purposes except emergencies involving unanticipated severely aggressive or destructive behavior posing an immediate threat to the physical safety of the inmate or others and only when alternative methods would clearly be ineffective or have failed. Under no circumstances shall restraints be used as a disciplinary measure or as a convenience for custody or medical staff.**[26] Alternative measures should include verbal de-escalation, communication using non-threatening body language and tone of voice, more frequent observation, environmental change (including safety cells and quiet surroundings), orientation of the inmate to his or her surroundings and what is taking place, verbal calming

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[25] Our recommendations are influenced by, and, in some instances, the words or phrases or concepts are taken verbatim or in paraphrase from the following sources: Breggin, Peter, M.D., *Principles for the Elimination of Restraint,* prepared for the Joint Commission on Accreditation of Health Care Organizations (April 1999); Commonwealth of Massachusetts, Department of Correction, Health Services Division, 103 DOC 650, Regulations for Mental Health Services, (April 1999); Louisiana State University Health Services Center at Shreveport, Policies and Procedures re Restraints, Policy No. 5.15 (December, 2000); National Institute of Health (NIH) Clinical Center Nursing Department, *SOP: Management of the Patient in Restraints*, (January 2000).

[26] The LASD uses restraints far too often. As one staff member from custody put it, On weekends we can have 4 to 5 restraints a night. I mean its restraint-o-rama around here. You get tired struggling with these guys.˚.˚.˚. They ve also sent the wrong guy to restrain. That s happened before, too. Regarding the practice of psychiatrists to prescribe restraints over the phone, the same individual noted, They always do it over the phone. That s standard.

techniques, and if, absolutely necessary, handcuffing or other low-level force options.[27] To avoid the use of restraints, to create a positive environment, and to maintain a high standard of ethics, all sworn and civilian personnel must aim at eliminating behavior towards inmates that is calculated to humiliate or encouraging disrespect. Breggin, supra.

b. **Any order for restraints must be preceded by a face-to-face assessment of the patient by a mental health professional specifically trained in the use of restraints and alternatives thereto. Adequate medical and psychiatric personnel shall be present and available 24 hours a day, seven days a week.** The psychiatrist or physician may not order restraints unless, after personally observing and examining the patient, he or she is clinically satisfied that: (i)˚the use of restraints is *immediately* necessary to prevent the patient from placing himself or others in *imminent* danger of unanticipated severely aggressive or destructive behavior, and (ii)˚all reasonable alternatives have failed or would clearly be ineffective. Furthermore, the mental health professional must

[27] Quoted passage from Louisiana State University Hospital, supra.

specifically state in writing the factual basis for this conclusion.

c. An initial restraint order by any psychiatrist or physician should be valid only for one hour. If more than an hour has transpired before the order has been carried out to completion, a new face-to-face assessment as set forth in (b) above must be performed. Once the inmate is restrained, the restraint order shall be valid only for the next four hours. Any new restraint orders must be preceded by a new face-to-face assessment as set forth in (b). All inmates in restraints must be observed by medical personnel at 15 minute intervals or more frequently if medically advisable.

d. The placement of any individual in restraints shall occur only under the direct command and personal supervision of a physician. All sworn personnel performing restraint procedures shall be under the command of the physician for the duration of the restraint procedure. The physician shall monitor the physical condition of the inmate at all times.[28] Prior to leaving the presence of a restrained inmate, the physician must examine the inmate and affirm that he or

[28] Sergeant H put it this common sense way, What you need is medical personnel standing at the head of the bed to monitor from the diaphragm up. If they see something that might be a problem, they have to pipe up and get it under control.

she is in a stable condition. There shall be staffing by DMH mental health personnel at MSB 24 hours a day, seven days a week.[29]

e. All personnel performing a restraint procedure shall be specifically trained in best medical practice for accomplishing the restraint and must be certified as competent to perform restraint according to best medical practice by a psychiatrist or medical expert in such. Such training must include the ability to determine if the inmate is undergoing breathing difficulties or loss of consciousness. In this regard, staff shall be alert to issues of obesity, alcohol and drug use, or psychotic behavior. In no instance shall any personnel performing a restraint perform any maneuver or take any action whatsoever that risks asphyxiation. Even if an inmate struggles or resists or is combative, no person may apply pressure or weight to an inmate's face, throat, neck, chest, diaphragm, or abdomen.

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[29] Custody staff who work in MSB spoke in the harshest terms about DMH s shortcomings. Noting the absence of mental health workers at MSB, one noted, You won t find nobody from DMH here after 8 pm. That s been a problem for years. Another complaint dealt with the unwillingness of DMH personnel to pitch in: See, there will be times when I got a guy who s threatening to kill himself — cut himself all up, what have you. And the DMH people tell me in this pissy ass voice, That s not my client, and turn their back. So it s up to me to handle him — me and some young, young, deputies. . . . I m telling you this has been going on for years.

7. **The LASD s videotaping procedures should be revised to require:**

   a. Where feasible, videotaping of the face-to-face assessment by the psychiatrist or physician specifically trained in the use of restraints and alternatives thereto.

   b. In all instances, the videotaping must begin immediately after the restraint order has been given and be on continuously until the inmate has been fully secured, evaluated by the physician, and declared to be medically stabilized.

   c. In addition to a hand-held video camera, each room in which an inmate is restrained shall be equipped with an overhead camera providing an unobstructed view of the inmate at all times during the restraint procedure. The videotaping shall continue thereafter until the inmate is released from restraints and leaves the room.

8. **CPR Training.** All personnel working in any capacity in Custody, sworn or not, shall be specifically trained in CPR and shall be required immediately to perform CPR in all instances in which CPR is indicated. All personnel working in any capacity in Custody, sworn or not, shall be provided with a breathing mask or device that will permit mouth-to-mouth resuscitation to be performed safely. All personnel working in any capacity in

Custody, sworn or not, shall be trained or re-trained within the next six months in control techniques with specific reference to avoiding positional or other asphyxia and the application of weight to an individual s face, throat, neck, chest, diaphragm, or abdomen.

B. Long Term Recommendations.

We believe that the long term solution is a diversion program that permits mentally-ill individuals detained by the police to be independently assessed as to their mental status and diverted from the criminal justice system into treatment if appropriate. The analogy is Drug Court. The County s current Mental Health Court is likely the place to start.

An article in the December 1999 edition of ***Psychiatric Services*** magazine succinctly describes a jail diversion program for the mentally-ill:[30]

> Jail diversion generally refers to specific programs that screen detainees in contact with the criminal justice system for the presence of mental disorder; they employ mental health professionals to evaluate the detainees and negotiate with prosecutors, defense attorneys, community-based mental health providers, and the courts to develop community-based mental health dispositions for mentally ill detainees. The mental health disposition is sought as an alternative to prosecution, as a condition of reduction in charges, or as satisfaction for the charges, for example, as a condition of probation. Once such a disposition is decided on, the diversion programs links the client to community-based mental health services.

The National GAINS Center for People with co-occurring Disorders in the Justice System published a fact paper in the Summer of 2000 that describes one apparently successful diversion program in Seattle that dealt with mentally ill individuals who also engaged in substance abuse: Many offenders — both youth and adult — whose

[30] Steadman, et al., ***Psychiatric Services***, December 1999 Vol. 50 No. 12 p.1620.

misdemeanor offenses are related more to the symptoms of mental illness and substance use than to truly criminal behavior are poorly served in a criminal justice system that offers little in the way of structured treatment. *Id.*

The paper concluded that the Seattle program **demonstrates when there is political will, creative vision, and invested people, significant progress can be made in creating integrated systems of care to divert individuals with co-occurring mental health and substance use disorders from the criminal justice system.** ***Furthermore, these experiences demonstrate that the infusion of large amounts of new money is not the key.*** **Rather, it is a matter of joint planning, pooling resources, and more effectively managing existing resources toward new goals.** *Id.* (Emphasis supplied).

Whether or not the County goes forward with such a diversion program, the LASD must create a Crisis Intervention Team. It is by no means rare that law enforcement must deal with mentally-ill individuals.[31]

> The results from a national survey of major police departments in the United States (those serving populations of 100,000 or more), estimated that approximately seven percent of police contacts involve people with mental illness. Similarly, information coming directly from people with mental illness suggests that being arrested is virtually a normative occurrence. In a study that surveyed members of the Oregon chapter of the Alliance for the Mentally Ill, more than half the respondents reported that their mentally ill family member had been arrested at least once, and on the average it was more than three times. Borum, Randy, *Improving High Risk Encounters Between People with Mental Illness and the Police,* The Journal of the American Academy of Psychiatry and the Law, Vol. 28, No. 3 (2000).

[31] We want to acknowledge helpful conversations and suggestions from individuals on the Los Angeles County Mental Health Commission, the Los Angeles County Task Force on the Incarcerated Mentally Ill, including the Minority Report of Ron Schraiber (April 1993); LAMP and its benefits coordinator, Gerald Minsk.

In Seattle, the crisis intervention team was a group of more than 100 volunteers from the existing ranks of the police force agreed to receive 40 hours of specialized training on dealing with persons with mental illness, drug/alcohol problems, and developmental disabilities. Training . . . offered officers new skills to recognize different types of illnesses and to intervene to de-escalate potentially dangerous situations without using for or making arrests. [These] officers are now regularly dispatched to calls involving persons with mental illness with a primary goal being jail diversion. National Gains Center, *supra*. The Memphis, Tennessee Police Department s Crisis Intervention Team is often cited as a model program.

IV. CONCLUSION

From time to time, we all run into people like Kevin Evans: poor, black, homeless, probably unkempt, talking aloud to themselves or to imaginary persons, perhaps on drugs, or drunk, or simply acting odd. They may suffer from Cerebral Palsy, they may have undiagnosed heart conditions, or other serious disease. Shop owners do not want them in or around their stores because they might pilfer or simply intimidate customers. They become too much for even well-intentioned relatives and friends to handle. They carry their few possessions in shopping carts and roam the streets. They go through the revolving doors of jails, in and out, in and out, time and again. The unluckiest of these unlucky people, like the diminutive Margaret Mitchell with her screwdriver, may get shot dead by the police or, like Kevin Evans, be asphyxiated as he is being placed in restraints.

They become the problem of the police or the LASD because of the trivial misdemeanors or other, more serious offenses they commit. But many of them do not really belong in jail.

It is instructive to focus on organizational dynamics as well as individual responsibility in analyzing Kevin Evans's death. We tend as lawyers to think in terms of individual responsibility. Our initial mind set is to look at an incident like Kevin Evans's death in terms of individual legal rights and responsibilities; duties to act and breaches of duties; categories like negligence or recklessness or intentional misconduct or malice aforethought. Our responses arise from a notion that what happened to Mr. Evans was unjust or unfair; a wrong that needs to be righted. We look at the individual actors the deputy who classified Evans as dangerous; the doctor who ordered him in restraints in the first instance; the psychiatrist who upped the restraints to four-points. We focus on whether they made mistakes or failed to act when they should have. We expect each individual s acts to reflect societal norms about how reasonable people should act.

But in focusing on *individual* responsibility, we lose sight that organizations like the LASD — indeed any large bureaucratic organization, public or private — are simply not as capable of acting as intelligently, flexibly, and rationally as we expect an individual to act. Perhaps we mistakenly anthropomorphize organizations. Since they are composed of people, we expect the organization as a whole to act like an individual person would. When an organization does something that seems mindless and senseless, we respond as if an individual did something mindless and senseless. We forget that an organization itself is not a conscious entity and does not have the complex and often conflicting

impulses and goals of an individual. Like a huge, lumbering animal, a large organization can only accomplish a relatively simple, straightforward mission or carry out well-defined rules. Individuals caught up in work in such an organization consciously or unconsciously further that simple mission, and individual decision making or action that might frustrate or complicate the mission is suppressed. In order therefore to minimize error, as in a hospital or laboratory, there are elaborate and meticulous rules governing all aspects of the operation. Licensure, certification, and accreditation are necessary to create the rules and establish minimum standards.

In terms of the LASD, we must keep in mind that most of the sworn personnel who work there think of the LA County Jail as merely a jail — not a mental hospital; not a homeless shelter; not a drug treatment facility. A jail. What s its mission? To house people who have been arrested for crimes, are serving sentences of less than a year, or who have been convicted and are on the way to state prison. People who do not want to be there; people under great stress; people with pent-up rage; people who have poor impulse control; people who are, on occasion, dangerous. They must be processed, fed, housed, taken to and from court. There is a constant stream of inmates in and out. It is not an easy inventory to track. The time for processing is short; inmates cannot be left hanging around unattended. It is hard to render individual attention to each inmate or make nuanced decisions about a given person s potential for danger.

But the LA County Jail, in the final analysis, is in reality more than just a jail. Sheriff Baca has called it the largest mental health facility in the state, and in a sense he is right. It must be recognized more generally that the institution is more than just a correctional facility. It does and must provide medical and mental health care. It must

therefore do so in a responsible way. It can no longer evade or avoid licensure and accreditation. But that is not the entire answer.

Our recommendations for change are calculated to make it harder for the LASD to fail to treat the Kevin Evanses of this world in a more humane, nuanced, careful, and intelligent way. But we are not so na ve as to believe that this is an easy or straightforward thing to do. That is why, when all is said and done, the Kevin Evanses of this world should be diverted before they even reach the jails and be put into treatment facilities or shelters.