FINAL REPORT
CASE #0203 SAN JOAQUIN COUNTY JAIL

REASON FOR INVESTIGATION:

The 2003-2004 San Joaquin County Civil Grand Jury (Civil Grand Jury) received several complaints requesting an investigation of the San Joaquin County Jail (County Jail) regarding the death of Mr. Mondez Denmon. The complaints alleged Mr. Denmon died from excessive force by jail staff while in custody. During the investigation the Civil Grand Jury was informed of Merle Scott, another inmate who also died at the County Jail.

This report combines the findings and recommendations of both inquiries. The Civil Grand Jury focused the investigation on the booking and medical units, regarding policies and procedures.

BACKGROUND:

OVERVIEW OF CIVIL AND CRIMINAL GRAND JURIES

Civil Grand Juries are charged with investigating county and local state agencies with respect to policies and procedures. Civil Grand Juries complete their own investigations of these agencies using county counsel and a presiding or assigned judge as advisors. These investigations are conducted in closed sessions. It is the responsibility of the Civil Grand Jury to report findings and recommendations to the public for each case.

Criminal Grand Juries are charged with hearing testimony and reviewing evidence to determine whether a party will be indicted for criminal charges. The testimony and evidence is prepared and presented by the District Attorney's office and includes witnesses and evidence for both the prosecution and the defense. The evidence is normally presented in closed session though a Criminal Grand Jury can hold a public hearing with the support of the District Attorney and the presiding judge. An indictment handed down from a Criminal Grand Jury declares, in their opinion, there is sufficient evidence to conduct a criminal trial, though an indictment is not a conviction.

THE BOOKING UNIT

The booking unit is where arresting officers transfer custody of arrestees to the jail staff. The booking lobby has an open space that allows cooperative and competent detainees to sit comfortably, watch television, access a private restroom, and use

telephones without being restrained. There are holding cells to detain those who may harm themselves, other detainees, or jail staff.

The Pre Booking Officer is the first of the jail staff to have contact with an arrestee and conducts the screening process. The screening requires arrestees to answer questions regarding current medications, drug dependencies and influences, ailments, mental conditions and suicidal tendencies. The officer is required to input the arrestee's response to each question, as given, regardless of what the officer may believe otherwise. The officer then enters observations of the arrestee on a separate form.

Any person in custody who has an injury or illness may be referred to the nurse's station in the booking area. The nurse is responsible for assessing physical ailments and determines if a patient requires further attention from the medical unit within the jail. Those in need of a higher level of medical attention are transferred to the County Hospital.

Any person in custody who has psychiatric needs is examined by a Psychiatric Technician (Psych Tech). The Psych Tech, with the direction of a licensed physician, may administer medication and/or refer a person to an observation cell. Wards needing more psychiatric support than the jail offers are sent to the Mental Health facility.

THE MEDICAL UNIT AND OBSERVATION ROOMS

The medical unit provides limited medical and psychiatric care for inmates. The medical unit, though located within the jail, adheres to the policies and procedures of the County Hospital and the Mental Health Department of San Joaquin County.

The medical unit has several types of cells, one of which is an observation cell. The observation cell is designed for high risk inmates who may cause harm to others. All fixtures in the observation rooms are permanently affixed to the walls or floor to keep inmates from using objects in the cell to harm anyone. The beds in the observation rooms have restraint systems attached. The restraint system has an arrangement of leather straps at each corner to secure the wrists and ankles. The leather belt that wraps the subject's waist is secured to the bed using two additional leather straps located on the sides of the bed. The observation room is outfitted with a steel door and windows constructed of safety glass.

MEDICATIONS USED

Ativan (lorazepam) is an anti-anxiety agent. Ativan is a benzodiazepine and mild tranquilizer, sedative and central nervous system depressant. There are many side effects associated with the use of Ativan including clumsiness, dizziness, drowsiness, agitation, disorientation, abdominal discomfort, and increased incidence of sedation, hallucination and irrational behavior. Additional adverse reactions of the Central Nervous System include anxiety, tremors, stimulation, fatigue, weakness and unsteadiness.
(Reference: Physicians Desk Reference, page 576 and 577)

Haldol (Haloperidol) is an anti-psychotic medication considered effective in the management of manifestations of acute and chronic psychosis, hyperactivity, agitation and mania.

Side effects of Haldol can include psychotic behavior, hallucinations, difficulty breathing, increased perspiration and involuntary body movements of extremities and the trunk. Other Central Nervous System adverse effects include insomnia, restlessness, anxiety and increased agitation. (Reference: Physicians Desk Reference, page 2444)

Benadryl is a medication used for allergy symptoms, rhinitis, motion sickness, anti-parkinsonism, nighttime sedation, infant colic and non-productive cough. Central Nervous system adverse reactions include poor coordination, fatigue, anxiety, euphoria, confusion, drowsiness and dizziness. Benadryl can be used to counter some of the side effects of Haldol, specifically throat closing and rigidity in the perimeters. (Reference: Physicians Desk Reference, page 344)

ADMINISTRATIVE SEGREGATION

The Administrative Segregation unit (Ad Seg) houses high risk inmates who pose a threat to other inmates or jail staff. It is the intent of the Ad Seg unit to protect staff and, more commonly, inmates from other inmates. Inmates are locked in one man cells a majority of the time to minimize potentially dangerous situations. Those inmates considered the most dangerous are classified "Level 8" inmates. County Jail policy states that an inmate released from the jail classified as "Level 8" and who is rebooked into the jail, shall re-enter the system as "Level 8." Inmates are evaluated periodically and those who comply with the jail's rules may eventually be downgraded to general population status.

USE OF FORCE

The San Joaquin County Jail's Use of Force Policies and Procedures maintain officers may use force to control an inmate. The levels of force that can be used range from

physical presence and vocal dialogue to use of weapons and deadly force. An officer is afforded the authority to raise the level of force, as dictated by a situation. This does not allow officers to abuse inmates or use excessive force to control an inmate.

THE CRIMINAL GRAND JURY PUBLIC HEARING REGARDING THE DEATH OF MONDEZ DENMON

Mondez Denmon was arrested September 5, 2003 and transferred to the County Jail without conflict with the arresting officer. He was booked into the County Jail and spent the first two hours in the jail's booking lobby without incident.

The pre booking officer later determined Mr. Denmon to be classified a "Level 8" inmate because he was a "Level 8" inmate when he was last discharged from the San Joaquin County Jail.

Mr. Denmon was placed in a holding cell in the booking unit awaiting transfer to the Ad Seg unit. He quickly became aggravated and threatened to fight staff because he did not want to "go back to the hole", a term referring to the Ad Seg unit. Jail and psychiatric staff continuously advised Mr. Denmon to calm down and cooperate. Mr. Denmon would subside only to become aggravated again, yelling and punching the cell door.

Mr. Denmon repeatedly yelled for others to call his family because he feared he would be hurt or killed by jail staff. He also flooded the floor with water, a common tactic used to make the floor slippery for jail staff.

The booking staff pepper sprayed Mr. Denmon forcing him to comply. His eyes were flushed with water and he was transported to the medical unit in a mobile restraint chair. Jail staff secured Mr. Denmon in an observation room placing him in a five point restraint system in the prone position.

Minutes later, Mr. Denmon slipped his wrist from the restraint. He was re-secured by jail staff. A Psych Tech orally administered 15mg of Benadryl and 5mg of Haldol to Mr. Denmon to help calm him. Fifteen minutes later Mr. Denmon again slipped his wrist from the restraint. The Psych Tech then administered 2mg of Ativan. About an hour later, Mr. Denmon again slipped his wrist from the restraint and proceeded to break the waist strap part of the restraint system. Staff responded to re-secure Mr. Denmon. At least 11 jail staff entered the observation cell to re-secure Mr. Denmon against a direct order to stand by from the Duty Sergeant, Judy Doran. The jail staff also ignored a second direct order from the Psych Tech and the Duty Sergeant to place Mr. Denmon on his back. The order to turn Mr. Denmon on his back was given at least three times.

Mr. Denmon struggled yelling "Get off! I can't breathe!" while Officer Fuhrer stomped on his back. To this, Judy Doran replied "If you can talk, you can breathe." Officer Fuhrer yelled at Mr. Denmon, "I'm going to (explicative) kill you!" Chaos ensued and though Mr. Denmon was still secured by both ankles and his left wrist, he was punched multiple times in the head and his back stomped repeatedly before expiring a short time later. The medical examiner determined Mr. Denmon died of traumatic positional asphyxiation.

OUTCOME OF CRIMINAL GRAND JURY PUBLIC HEARING

Four staff members of the County Jail were placed on paid administrative leave and faced indictments.

Correctional Officer Greg Fuhrer was indicted for felony assault under the color of authority.

Deputy Officer Bruce Thrasher was indicted for misdemeanor battery. Bruce Thrasher retired shortly after the night Mr. Denmon died.

Duty Sergeant Judy Doran and Correctional Officer Michael Griggs were not indicted.

On April 28, 2004, criminal charges against Officer Greg Fuhrer and retired Officer Bruce Thrasher were dismissed by San Joaquin County Superior Court Judge Richard Guiliani.

DEATH OF INMATE MERLE SCOTT

Merle Scott was arrested on October 8, 2003 for possession of a controlled substance and possession of drug paraphernalia. The Civil Grand Jury reviewed evidence that Mr. Scott was in possession of heroin and had a hypodermic needle sticking out of his arm when he encountered a Stockton Police officer. Additional information was given to the Civil Grand Jury stating Mr. Scott informed the arresting officer he would "kick hard" when he detoxifies. Mr. Scott used the term "kick hard" to describe the withdrawal symptoms commonly associated with the detoxification process including dehydration, cramping, loss of appetite, vomiting and diarrhea. Mr. Scott was transported to the county jail where he was booked, processed and then housed in a general housing unit.

Mr. Scott refused to exit his cell the following day due to his detoxifying condition. Jail staff convinced Mr. Scott to leave his second floor cell, under his own power. Mr. Scott fell down the stairs. He was transported to the medical unit for treatment of wounds from the fall and to aide with detoxification. Mr. Scott died hours later in the

medical unit. The medical examiner determined the cause of death to be methamphetamine toxicity and chronic obstructive pulmonary disease.

Merle Scott used heroin for over 20 years. Mr. Scott also had Multiple Resistant Staphylococcus Aureus (MRSA), a bacterial disease that discourages wounds from healing. The bacteria itself is resistant to normal antibiotic treatment. The medical unit was aware Mr. Scott had MRSA from a previous sentence at the County Jail. County Jail records show that Merle Scott was arrested numerous times for drug charges. He underwent detoxification for heroin use at the jail's medical unit.

METHOD OF INVESTIGATION:

The Civil Grand Jury was present at the public hearing the Criminal Grand Jury conducted regarding the death of Mondez Denmon and used the evidence the District Attorney's office presented. Evidence included testimony from expert witnesses, the medical examiner, and jail, medical, and psychiatric staff. The majority of the witnesses from the Criminal Grand Jury's hearing were present at the jail the night Mr. Denmon died.

The Civil Grand Jury heard testimony from Duty Sergeant Judy Doran, on duty the night Mr. Denmon died.

Other testimony was given by jail, psychiatric, and medical staff with experience and knowledge of their respective polices and procedures.

The Civil Grand Jury reviewed the booking of Merle Scott. We also reviewed Mr. Scott's prior jail record, including criminal charges, screening process, and medical log.

As part of the normal duty of the Civil Grand Jury, we toured the County Jail to gain an overview of the operation. We returned several times and focused observations and questioning on the booking and medical units. We interviewed senior management and line duty staff regarding cell extractions, use of force, restraint systems, housing units, and training for staff members. The Civil Grand Jury witnessed detainees being screened by Pre Booking Officers on several occasions.

The Civil Grand Jury reviewed policies and procedures including the following:

- Use of five point restraint systems
- Use of force
- Cell extractions
- Use of pepper spray

- Pre booking screening
- Various cell types and uses
- Monitoring of inmates
- Training for line staff
- Administering of medication

FINDINGS:

The Civil Grand Jury finds the following:

1. Mr. Denmon posed no immediate threat to himself or others while restrained by both ankles and one wrist and locked in an observation room in a secured unit at the County Jail.
2. Jail staff used excessive force to re-secure Mr. Denmon when he expired at the County Jail.
3. Though Mr. Denmon verbally threatened to fight staff, was uncooperative, and was a large and strong man, he never attempted to strike anyone at the jail.
4. Sergeant Doran ordered Line Duty staff to stand by to wait for an assessment from a Psych Tech. The Line Duty staff ignored the direct order to stand by.
5. Line Duty staff entered the observation room without direction to re-secure Mr. Denmon.
6. An excessive number of officers entered the observation room to re-secure Mr. Denmon. Credible testimony was given stating no more than four people are needed to re-secure any person, including a man as large and strong as Mr. Denmon.
7. Line Duty staff failed to follow repeated orders from medical personnel, a Psych Tech, and the Duty Sergeant to turn Mr. Denmon on his back.
8. Jail, medical, and psychiatric staff at the County Jail have testified it is highly unusual for detainees to break the waist belt of the five point restraint system.
9. The San Joaquin County Mental Health Department uses the same five-point restraint system. Experienced members of San Joaquin County Mental Health staff stated detainees break the waist belt of the five point restraint system regularly.
10. The leather straps of the five point restraint system used to secure Mr. Denmon were old and pliable compared to new straps which are very rigid.
11. No written procedures regarding maintenance and replacement of leather restrains were made available to the Civil Grand Jury.
12. Though not yet implemented, the County Jail is creating Critical Emergency Response Teams (CERT). The teams will be deployed for riots, cell extractions and other emergencies.

13. Disconnect between arresting officers and Pre Booking Officers allows arrestees who are intoxicated and/or have medical conditions to be processed without the appropriate screening.
14. Pre Booking Officers, at times, rush through the screening process. Pre Booking Officers do not consistently enter responses from detainees during the screening process. Pre Booking Officers do not always note their observations.
15. Merle Scott's current and previous charges were not considered when he was screened in the Booking Unit. Proper screening could have placed Mr. Scott in the medical unit to assist with the detoxifying process.
16. Because Mr. Merle Scott had MRSA and a visible open wound, he should have been placed in medical isolation.
17. The jail's security staff (deputy sheriffs, transportation officers and other correctional officers) are expected to observe inmates for physical and mental conditions with minimal training.
18. There is insufficient training for newly appointed duty sergeants.

RECOMMENDATIONS:

The Civil Grand Jury recommends the following:

1. The County Jail create a policy limiting the number of staff members allowed in a cell for an extraction and for security purposes.
2. Pre Booking Officers be trained more extensively to evaluate an arrestee's physical and mental condition.
3. A written policy be created to ensure proper maintenance and replacement of leather restraint systems.
4. Alternative materials of restraint systems other than leather be considered.
5. Alternative positions of body placement during the restraining period be considered (for example, inclined bed and seated position).
6. Expand the pre booking screening to include questions regarding infection of communicable diseases.
7. Incorporate prior charges, medical records, and jail staff notes into prebooking screening.
8. Implement a transitional period to train newly promoted Duty Sergeants with experienced Duty Sergeants.

RESPONSE REQUIRED:

Pursuant to Section &Sect;933.05 of the Penal Code:

The San Joaquin County Board of Supervisors and the San Joaquin County Sheriff shall report to the Presiding Judge of the San Joaquin Superior Court, in writing and within 90 days of publication of this report, with a response as follows:

As to each finding in the report a response indicating one of the following:

a. The respondent agrees with the finding.
b. The respondent disagrees with the finding, with an explanation of the reasons therefore.

As to each recommendation, a response indicating one of the following:

a. The recommendation has been implemented, with a summary of the action taken.
b. The recommendation has not yet been implemented, but will be with a time frame for implementation.
c. The recommendation requires further analysis, with an explanation of the scope of the analysis and a time frame not to exceed (6) six months.
d. The recommendation will not be implemented, with an explanation therefore.