

BACKGROUND

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

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

The Office of the Independent Monitor (“OIM”) provides independent oversight of the DSD and the DPD through its review of, and recommendations about, internal investigations, disciplinary findings, and policies of those departments. The OIM actively monitored the IAB investigation, was present for every interview, and made nonbinding recommendations throughout in an attempt to ensure a thorough and fair investigation. Relying on its first-hand knowledge of the case, as well as national best practices, on March 19, 2018, the OIM issued a 73-page report, called *The Death of Michael Marshall, an Independent Review*. The report begins with a summary of the incident and the process by which it was internally investigated and reviewed. It then analyzes the investigation, the disciplinary decisions, adjustments made by the DSD in response to this incident, and other changes recommended by the OIM.

KEY FINDINGS

Among the OIM’s key findings:

- The DSD made several necessary policy and training changes after the incident, including reengineering its Use of Force and Use of Restraints Policies, and implementing Crisis Intervention Training for all deputies.
- Pursuant to the Settlement, the DSD and the City will make other improvements that include providing additional mental health services for inmates, and implementing annual trainings for deputies on mental illness and use of force, including de-escalation.

The OIM also made findings about significant deficiencies and concerns. Specifically:

- Although IAB is mandated to conduct thorough and impartial investigations, it mishandled its investigation into the incident by deeming it complete without interviewing the subject deputies, questioning the involved nurses, or obtaining other information necessary to completely and impartially evaluate the use of force that was one of the causes of Mr. Marshall’s death.
- The OIM believes that the disciplinary decisions made by the DOS were flawed for two reasons: first, the DOS should have suspended the on-scene sergeants for their failure to prevent the inappropriate force against Mr. Marshall, which constituted a failure to supervise. Second, the DOS did not apply the most appropriate disciplinary conduct category to the use of inappropriate force by one of the deputies, resulting in a short suspension not commensurate with the seriousness of his misconduct.
- Despite national best practices regarding background checks for law enforcement recruits, a deputy who participated in the use of force against Mr. Marshall was permitted to join the DPD as a police recruit while he was a subject of the criminal investigation into that use of force, and before there had been any internal investigation into the deputy’s conduct.
- The DSD provides training on excited delirium, yet the deputies involved in this incident had little recollection of that training, and generally did not act in accordance with the City’s protocol for handling excited delirium incidents.

- Although a nurse raised concerns about how Mr. Marshall was being restrained, they were not heeded. The DSD currently lacks a clear policy requiring that, when time and circumstances permit, supervisors attempt to resolve conflicting urgent medical and security concerns raised during an incident or providing guidance on how to do so.
- The DOS has not published guidelines for how it will determine when to release evidence of critical incidents, including video. The lack of such guidelines may inadvertently invite public confusion, controversy, and potential litigation, such as the hunger strike and lawsuit demanding the release of the video in this case.
- Finally, almost three years after outside consultants recommended that the DSD develop a protocol for learning from all significant uses of force in Denver's jails, the DSD has yet to fully implement such a process, which we believe is essential to preventing other tragedies like the death of Mr. Marshall in the future.

RECOMMENDATIONS

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

- The OIM recommended that the DSD make changes to the culture of its Internal Affairs Bureau to ensure that serious cases are investigated thoroughly and impartially, as DSD policy requires. This may include but not be limited to placing the management of IAB under civilian control; and
- The OIM recommended that, when misconduct may fall into multiple disciplinary conduct categories, the DOS should, in its disciplinary order, specifically explain why a particular category was chosen.

Regarding training:

- The OIM recommended that the DSD provide additional, regular classroom and situation-based refresher training on identifying persons suffering from excited delirium and how to best respond to such incidents; and
- The OIM recommended that the DSD train supervisors on how to quickly resolve conflicts between urgent medical and security concerns, when time and circumstances permit, by weighing security risks against potential needs for immediate medical intervention in emergency situations.

Regarding policy:

- The OIM recommended that the DSD develop a policy that, when time and circumstances permit, requires supervisors to attempt to resolve urgent medical and security concerns that may be in conflict, and that cannot be resolved by medical staff and deputies alone. The policy should require a supervisor to prepare a report that documents the conflict and its resolution, and to participate in a non-disciplinary debriefing after the incident;
- The OIM recommended that the DOS evaluate its hiring policies and procedures for the DPD and the DSD to ensure that they do not permit potential recruits to be hired while they are under criminal or administrative investigation;
- The OIM recommended that the DOS publish written guidelines regarding the release of evidence of critical incidents, including video. The guidelines should balance the need for prompt public transparency with the need for confidentiality during active investigations, among other factors. The guidelines should explain, to the extent possible, the analytical framework that the DOS will use in evaluating requests for the release of evidence of critical incidents; and
- Finally, the OIM recommended that the DSD immediately prioritize the development and full implementation of a formal protocol for, and an enhanced culture of, analyzing and learning from critical incidents in order to make Denver's jails safer and to prevent other tragedies like the death of Mr. Marshall in the future.

The review presented here is discussed in depth in the OIM's full report, [The Death of Michael Marshall, an Independent Review](#), which can be accessed at <http://denvergov.org/oim>.

Nicholas E. Mitchell, Independent Monitor
 Office of the Independent Monitor
 101 W. Colfax Avenue, 1st floor
 Denver, CO 80202
 Phone: (720) 913 3306
 Fax: (720) 913 3305
<https://denvergov.org/oim>
<https://www.facebook.com/DenverOIM>