City and County of San Francisco **Chief Medical Examiner**

Gavin Newsom
Mayor

PRESS RELEASE

CAUSE OF DEATH DETERMINED IN THE DEATH OF S.F. JAIL INMATE [redacted]

A 31 year old inmate [redacted], being held in San Francisco County Jail on assault and other charges died on September 7, 2009.

After a careful and thorough investigation with the full cooperation of other City agencies, and based on the physical evidence, the cause of Mr. [redacted] death was determined to be Probable Respiratory Arrest During Prone Restraint with Morbid Obesity.

The medical determination of the manner of death is based on the cause and circumstances of the death. In this case, the medical determination of homicide as a manner of death was made when investigation showed that the death most likely resulted from the actions of others. The medical determination of a manner of death of homicide does not relate to, or make any inference, as to any criminal activity or wrongdoing. It is an indication that, absent the actions of others, Mr. [redacted] would not have died at that time.

Amy P. Hart, M.D.

Chief Medical Examiner

9/23/10

CITY AND COUNTY OF SAN FRANCISCO
CHIEF MEDICAL EXAMINER

GAVIN NEWSOM
MAYOR

ORIGINAL

COPY

October 6, 2010

Re: [redacted]
Case #2009-0899

To Whom It May Concern:

It has just come to my attention that the following Chemistry Report for [redacted] (ME Case #2009-0899) was omitted from your copy of the Medical Examiner's report and is the final page in the report on the above case.

Thank you.

Nina Fiore
Executive Assistant

enc

Case# 2009-0899

MEDICAL EXAMINER'S REGISTER

ORIGINAL

CITY AND COUNTY OF SAN FRANCISCO - RECORD OF DEATH

COPY

Name: [redacted]

Alias:

ADDRESS: [redacted] SAN FRANCISCO CA 94115

DATE OF DEATH: 09/07/2009 TIME: 6:33 PM REPORTED BY: LT. CASEY SFSD

DATE OF REPORT 09/07/2009 TIME: 7:24 PM REPORTED PHONE:

PLACE OF DEATH: 6TH FLR. JAIL 850 BRYANT ST. ZIP: 94110

TYPE OF CASE: IN CUSTODY DATE AND TIME OF INCIDENT:

PLACE OF INCIDENT: ZIP:

NEXT OF KIN: DATE NOTIFIED 09/08/2009

BIRTHDATE [redacted] AGE: 31 SS# [redacted] SEX: MALE RACE BLACK

RECEIVED AT MEDICAL EXAMINER: 09/07/2009 TIME: 10:00 PM

RELEASED TO: EVERGREEN FUNERAL DIRECTOR

RELEASED DATE: 10/22/2009 TIME: 00:01

RECEIVED BY: INDIGENT CREMATION CLOTHING RECEIVED: NO

RELEASE SIGNED BY _____ RELATIONSHIP: _____

POUCH: YES RESIDENCE SEALED:NO

PROPERTY LISTING	INITIALS	EVIDENCE LISTING	INITIALS
0 NO PROPERTY	( )	1 PARTIAL HOSPITAL CHAR	( )

VERIFIED BY: akp DATE: 9/9/2009

PUBLIC ADMINISTRATOR: DATE NOTIFIED:

PLACED IN BOX #: _____ RECEIVED AMOUNT: _____ CHECK#: _____

RECEIVED BY: _____ RELATIONSHIP: _____ DATE/TIME: _____

RECEIVED BY: _____ RELATIONSHIP: _____ DATE/TIME: _____

BODY SEARCHED BY: SFSD STAFF AT: SFSD JAIL 6TH FLOOR

PREMISES SEARCHED BY: NOT AT: _____

PREMISES SEALED BY: NOT DATE: _____

EXAMINATION: _____ PERFORMED BY: MELINEK M.D.

EVIDENCE DISPOSITION: _____

INVESTIGATORS: DONALD J. STOCUM #116 TIMOTHY HELLMAN #109

Case#: 2009-0899

MEDICAL EXAMINER / INVESTIGATOR'S REPORT

CITY AND COUNTY OF SAN FRANCISCO - RECORD OF DEATH

NAME: [redacted] [redacted] Date/Time of Death: 09/07/2009 6:33 PM

PLACE OF DEATH 6TH FLR. JAIL 850 BRYANT ST. **Age:** 31 **Sex:** MALE **Ht:** 6' 1" **Wt:** 307 **Race:** BLACK

POLICE NOTIFIED	POLICE STATION NOTIFIED	POLICE OFFICER
YES	SFSD / SFPD	SGT. QUANICO

HOMICIDE NOTIFIED	DATE	TIME	HOMICIDE OFFICER
SFPD	09/07/2009		JOHNSON / JONES

MARITAL STATUS: UNKNOWN

IDENTIFIED BY: SFSD STAFF **AT:** 6TH FLR. JAIL 850 **DATE:** 09/07/2009

FINGERPRINTS TAKEN	PALMPRINTS	PRINTS TAKEN BY	DATE
YES	YES	FATS	09/10/2009

TO SFPD DATE: 09/11/2009 **TO CII DATE:**

SFPD MATCH: yes **SFPD MATCH#:** [redacted] **CII MATCH:** **CII MATCH#:**

TO FBI DATE: **PHOTOS DATE:**

FBI MATCH: **FBI MATCH#:** **TAKEN BY:**

POLICE AT SCENE	AT SCENE OFFICER	POLICE STATION
YES	SGT. QUANICO	SFSD

SFPD CASE#: 090-921-864

AIB or HR NOTIFIED: **AIB DATE:**

AIB OFFICER: **NATURE:**

CASE HISTORY

Mr. [redacted] a thirty one year old male that had been incarcerated in one of this city's jails was witnessed to become unresponsive, and pronounced dead in the presence of jail staff. According to information obtained from Sergent James Quanico, and other San Francisco Sheriffs Office staff, on 9/7/2009 at approximately 1700 hours Mr. [redacted] who was being held in the jail on the sixth floor of 850 Bryant Street was being transferred from the area of the jail called Area 13 where inmates are held that require closer scrutiny as they have been deemed problematic because of psychological issues. Mr. [redacted] had been held in this ward since his arrest in March 2009. It was decided to move him to another area of the jail as he was a large man and was found to be intimidating, and bullying other inmates. Mr. [redacted] was brought to the area of the jail known as K2, and once Mr. [redacted] realized that he was to be placed in this area he reportedly became combative, and began struggling with deputies.

According to Corporal Wong, the supervising officer involved in the transfer, five deputies began the process of subduing the inmate, and he was placed in shackles, and cuffs, and eventually brought under control. Because of the disturbance it was decided to place Mr. [redacted] in what is referred to as a safety cell where the prisoners are closely monitored, and the room is padded for the protection of the inmate. Mr. [redacted] was able to get to his feet, and walk from the K2 area of the jail to the safety cell area. Once they entered the safety cell Mr. [redacted] again began to struggle, and deputies were again forced to take him to the floor, and remove his shackles, and

Case#: 2009-0899

MEDICAL EXAMINER / INVESTIGATOR'S REPORT

CITY AND COUNTY OF SAN FRANCISCO - RECORD OF DEATH

cuffs, and as protocol states they would remove his clothing.
The deputies reportedly had him in a prone position, and had removed said cuffs, and shackles, and were in the process of removing his clothes when he suddenly went limp. He was rolled over to a recovery position on his side, and he was heard to gasp twice, he then presented with what was described as seizure like activity, and then became unresponsive. Paramedics were summoned, and when they arrived on scene they took over resuscitation efforts started by the jail medical staff. Despite aggressive advanced cardiac life support measures Mr. [redacted] was pronounced dead at 1833 hours, 9/7/2009. This office was contacted at 1924 hours, same date.
When this investigator arrived at the scene, along with Dr. Judy Melinek, Assistant Medical Examiner along with officials from both the investigative staff of the Sheriffs department, and San Francisco Police department Homicide detail Mr. [redacted] was noted to be lying supine on the floor of the safety cell clad in jail issued clothing with his sweatshirt cut. There were no obvious signs of external trauma noted. Rigor mortis was slight, and lividity had began presenting according to his position. Mr. [redacted] axillary temperature was taken and measured 92.5 degrees. Mr. [redacted] was placed in a pouch which was then sealed, and his hands were bagged according to this office's protocol, and he was transported to the Office of the Chief Medical Examiner for further examination, and testing. Mr. [redacted] [redacted] was contacted, and informed this investigator that [redacted] had no known physical ailments, but had been diagnosed with Schizophrenic manic depression at the age of seventeen, and required medications to help with his mental well being. San Francisco General Hospital was contacted, and relayed a history of Schizoaffective disorder/Bipolar disorder with psychiatric admission, and 5150 hold after he tried to enucleate himself in March 2009.

INVESTIGATOR: DONALD J. STOCUM #116 TIMOTHY HELLMAN #109

Case#: 2009-0699 Status: CLOSED

Name: [redacted] alias:

Police Notified: YES

Police_Office:	SFSD / SFPD	Police_At_Scene:	YES
Police_Officer:	SGT. QUANICO	Officer:	SGT. QUANICO
		Station:	SFSD
Homicide_Office:	SFPD	SFPD_Case#:	090-921-864
Homicide Officer:	JOHNSON / JONE	AIB_or_HR_Notified:	
Notification Date:	09/07/2009	Date:	
Notification Time:		AIB_Officer:	
		Nature:	

Fingerprints_Taken:	YES	Palmprints_Taken:	YES		
Taken_By:	FATS				
Taken Date:	09/10/2009				
To_SFPD_Date:	09/11/2009	Match:	ye	Match#:	[redacted]
To_CII_Date:		Match:		Match#:	
To_FBI_Date:		Match:		Match#:	
Photos_Date:		Taken_By:			

Case#: 2009-0699 Status: CLOSED

Name: [redacted] alias:

Date: 09/09/2009

Time: 8:04

Contact_Person: Mother

Contact_Phone:

Comments:

Introduced myself and said I would be performing an autopsy. She has already contacted a lawyer named Gerry Green and will want a second autopsy. I explained to her that I would be starting my examination today and that it probably won't be complete for a few days, possibly into next week. I also explained that during an autopsy some specimens may need to be taken from the body for a period of time for additional examination (for example, the brain), but that they could be returned.

Investigator: JUDY MELINEK, MD #107

Date: 09/10/2009

Time: 8:31

Contact_Person: [redacted]

Contact_Phone:

Comments:

[redacted] had his last court date last Thursday and the judge and the attorney were going to help him and were very impressed because he had been taking his medication. He had called her and he was very happy because they were going to help him with an application for a program in the jail. He has no medical history of seizures, strokes or heart disease. He does have a history of high blood pressure, which she believes is due to his weight. He had been out of jail for a little over a year before he was incarcerated in March, but he didn't he see any doctor except for his psychiatric medications. He gets his medications at the Tenderloin psychiatric clinic. She thinks it was a Dr. John Remington - Tenderloin outpatient clinic. 134 Golden Gate Ave. 673-5700 x2013. No family history of sudden death or seizures.

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 Status: CLOSED

Name: [redacted] alias:

Date: 09/14/2009
Time: 10:40
Contact_Person: DR. JOHN REMINGTON
Contact_Phone: [redacted]

Comments:

PSYCH RECORDS REQUESTED FROM [redacted] BY INVESTIGATOR CHARLES CECIL VIA FAX ON 09/10/09. FAXED RECORDS RECEIVED ON 09/14/09 AND GIVEN TO DR. JUDY MELINEK AT 1115 HRS, SAME DATE.

Investigator: DAVID LE NOUE #123

Date: 09/14/2009
Time: 11:12
Contact_Person: [redacted]
Contact_Phone:

Comments:

Told her that I have completed my evaluation with the body and that the funeral home can pick his body up today. I also told her that I retained the brain fixed in formalin for additional study, if necessary. I explained that the cause of death will be pending additional testing (histology, toxicology) as well as additional police investigation.

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 Status: CLOSED

Name: [redacted] alias:

Date: 09/17/2009
Time: 8:17
Contact_Person: David Posey, MD
Contact_Phone: [redacted]

Comments:

Discussed the autopsy, including some basic gross findings: what organs were retained and what was returned to body. Explained in general technique and approach to in-custody cases: including length and breadth of police and medical examiner investigation, photography and dissection technique.

Investigator: JUDY MELINEK, MD #107

Date: 09/25/2009
Time: 16:00
Contact_Person: [redacted]
Contact_Phone:

Comments:

Discussed status of case

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 Status: CLOSED

Name: [redacted] alias:

Date: 10/20/2009
Time: 2:00
Contact_Person: Diane Knoles DA
Contact_Phone:

Comments:

Discussed case and physical findings. She will help arrange getting me transcripts of witness interviews.

Investigator: JUDY MELINEK, MD #107

Date: 10/21/2009
Time: 10:09
Contact_Person: Dr. Estes
Contact_Phone: 201-4674.

Comments:

Jail medical director covering in Dr. Goldenson's absence. Left message Re: getting AED printout for cardiac rhythm on arrest.

He reported that the AED card went to the chief medical officer for the fire department Carl Spore 558-3645.

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 **Status:** CLOSED

Name: [redacted] **alias:**

Date: 02/12/2010
Time: 12:54
Contact_Person: [redacted]
Contact_Phone:

Comments:

I spoke to her regarding the status of the case. She asked about why the date of death was 9/7/09 when he died 3/16/09. I confirmed the date of death with her as 9/7/09 by re-reading to her the Investigator's case summary, the date on the police report, and I also read her the on-line article in sfgate.com, which is where she said she remembered the date was actually 3/16. She was tearful and sad and I told her I would prioritize her report to the best of my ability.

Investigator: JUDY MELINEK, MD #107

Date: 03/19/2010
Time: 9:04
Contact_Person: Kevin Jones SFPD
Contact_Phone:

Comments:

Left message requesting Sheriff's Department records on this case.

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 Status: CLOSED

Name: [redacted] alias:

Date: 04/12/2010
Time: 8:30
Contact_Person: Dr. Goldenson
Contact_Phone:

Comments:

Jail Medical Director: I told him that the records I received did not contain the MAR - records of what medications were given and when in the last week before the death. He said that he would get that to me.

Information was received by fax on 04/13/2010.

Investigator: JUDY MELINEK, MD #107

Date: 05/03/2010
Time: 16:02
Contact_Person: Diane Knoles
Contact_Phone:

Comments:

Received additional interviews and memorandums including confidential memo summary from Investigator Matt Irvine and transcript of interview with former Lt. John Casey. Meeting scheduled for 5/12/10.

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 Status: CLOSED

Name: [redacted] alias:

Date: 07/28/2010
Time: 12:05
Contact_Person: [redacted]
Contact_Phone:

Comments:

Met with [redacted] and [redacted], along with ADA Diane Knoles and Kathleen McCarthy (DA investigator) at my office. I asked nurse [redacted] what she witnessed and she described that she heard moaning or murmuring coming from the safety cell. She described that her office is across the hall and she was concerned, so she went to see what was going on. She walked down the hall and passed by the cell, past the supervising Deputy who was standing in the hall. She glanced into the cell and she saw the officers "hovering" over Mr. [redacted] His head was close to the corner of the cell and there was one officer kneeling at or near his right shoulder. Another officer was at the right waist and two or three were to the left of his body. Several were kneeling or leaning. She did not notice the configuration of Mr. [redacted] legs and did not see the arms lifted up behind the back in a "flagpole" configuration, as Deputy Wong had described. She said she only glanced in for a split second and did not see what parts of the officers were touching what parts of Mr. [redacted] body, nor did she see whether they were placing any weight on him. She did not see weight being placed at his back or neck. She reiterated that this was just a fleeting glance. She did not notice gurgling or other signs of respiratory compromise. The moaning was going on for "quite some time," enough for her to be concerned, but she couldn't further quantify the amount of time. After she crossed back toward her office, she passed the cell a second time but did not look in. The moaning had stopped so she thought things were better. I asked if she ever had concerns about the restraint techniques used in the jail or had seen procedures that she would be concerned would lead to respiratory compromise, and she said "No." She was concerned sometimes about "rough handling" during safety cell placement, but had not seen pressure applied to the backs of the neck or torso in the past on other inmates.

I discussed the case with Diane Knoles and requested a copy of the Sheriff's restraint procedures, per Dr. Hart.

Investigator: JUDY MELINEK, MD #107

Date: 07/28/2010
Time: 16:11
Contact_Person: [redacted]
Contact_Phone: 07/28/10

Comments:

Discussed status of case.

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 Status: CLOSED

Name: [redacted] alias:

Date: 08/25/2010
Time: 9:52
Contact_Person: ADA Knoles,Lt. Flewellen #1098
Contact_Phone: 554-2380

Comments:

Called Diane Knoles, ADA, who requested a copy of the safety cell guidelines and use of force guidelines as well. Then called Sheriff Lt. Flewellen to request that he fax her the same material he sent me.

I also asked Lt. Flewellen about a reconstruction of events. He said he seemed to recall that this was reviewed with Sheriff's legal counsel, but he would check and get back to me.

I noted that in the use of force policy (Page 5) that "manual restraint" is "according to the methods taught in the department training courses." I asked if there was a training manual or written instruction and Lt. Flewellen reported that he had spoken to the Sheriff's trainer (Deputy Crittle) and was told that they don't have anything in writing regarding manual restraint techniques that they could give me. In lieu of that, I asked to speak to Deputy Crittle about manual restraint training and he said he would call and see if that could be arranged.

He called back and left a voicemail which I received at 14:18 referring me to Fraya Horne, Sheriff's Assistant Legal Counsel at 415-554-4334. I called her and left a message regarding my requests for a reconstruction and for training materials.

Investigator: JUDY MELINEK, MD #107

Date: 08/26/2010
Time: 12:00
Contact_Person: Fraya Horne
Contact_Phone: 415-554-4334

Comments:

She is legal counsel to the Sheriff Department. I asked her if a reconstruction would be possible using the officers involved and her concern was that after one year it would be difficult to accurately reconstruct the events, positions or motions of the Deputies, and this would be misleading to my investigation. I asked about interviewing someone who trains the officers so that I could understand what the correct manual restraint procedures were and she said a taped interview with a trainer could be arranged. She would contact Lt. Flewellen to set it up.

Investigator: JUDY MELINEK, MD #107

Case#: 2009-0899 [redacted] Status: CLOSED

Name: [redacted] alias:

Date: 09/03/2010

Time: 15:35

Contact_Person: Freya Horne

Contact_Phone:

Comments:

Met at 25 Van Ness, Investigative Services Division for Sheriff's Department with Freya Horne (Sheriff's legal counsel), Matt Irvine (DA Investigator), Amy Hart, MD (Chief, OCME), Dian Knoles (Assistant DA), Robert Lynch (SFPD Homicide) to interview Lt. John Garcia, identified to me by Freya Horne as a trainer for the San Francisco Country Sheriff's Department. The following is not verbatim and the meeting was recorded. Questions were restricted to general training methods and not about this specific incident, since Lt. Garcia was not present and was not a witness to the events preceeding the death of [redacted]

I asked where officers can be exerting pressure on the inmate during placement in a "Figure 4" and he said typically there is one officer on each arm, one exerting pressure on the torso at the upper shoulder blades and one or two at the legs. He instructs the trainees to use their hands, but depending on the degree of resistance and their own level of exhaustion, they may be exterting pressure with their legs or even their whole body (laying across the back). During this time they should be talking to the inmate and giving him/her instructions. With regard to supervision, this is done by the supervisor, though the person at the inmate's head may be the one who can monitor the breathing best. In general, he said that it may be appropriate to put pressure on the back and shoulders, especially if the inmate is thrashing around. Monitoring breathing is done by everyone involved, and as soon as the person gets quiet they should ask if they are OK. I asked if obesity as a contributing factor is taught in prone restraint and he said that instruction is given not to leave the inmate prone for a prolonged period of time and to get a medical team to evaluate nearby. He later mentioned that a proper Figure 4 hold is sometimes difficult to accomplish on a larger person because of the size of their thighs.

With regard to neck flexion, he reported that this may be used in a cell extraction to keep an inmate from biting or spitting by putting pressure on the back of the head or neck, or even by a hair-pull. This can also be done when they are being "walked backwards" down a hall, and that the head is generally held down by the back of the neck. This is used to prevent spitting and biting, to control the inmate and also to prevent them from agitating other inmates by talking or yelling to them. If the inmate complaints of having difficulty breathing, the officers should "let up and notify medical."

When people are restraining the inmate, it may be appropriate to place the knee on the back or even the officer's entire body on the inmate's back. He usually trains officers to put pressure between the shoulder blades. There is no limitation to the amount of time that this is done for, only to continue in response to how combative the inmate is, and to use the minimal force necessary to achieve restraint. The knee may even be placed behind the neck. No timeframe is advised, but in general they try to "get in and out as fast as possible." He was unfamiliar with the term "flagpole" with regard to raising the arms backwards on a restrained individual, but he did say that lifting the arms up may be done to lift the inmate up or to control him/her by creating a "modified bar arm," and controlling flexion of the arm by locking the wrist and elbow. It may also be used as a pain compliance technique to put stress on the shoulder.

With regard to the guidelines given for safety cell placement, he confirmed that training is consistent with the manual and that safety cells are to be used when a person is a danger to themselves or to others.

He confirmed that if an inmate is not talking or vocalizing, this is considered concerning. I asked if the concept of "air hunger" is taught and I defined that by describing that a person might be struggling more violently if they are asphyxiating because they cannot get enough oxygen, and he said he had not heard that term before. He said he would want to incorporate that in the training.

He stated that the medical division is "usually waiting at the safety cell for you" and tha they need to evaluate every person placed in the safety cell. They are automatically notified when a safety cell placement is occuring.

Investigator: JUDY MELINEK, MD #107

CITY AND COUNTY OF SAN FRANCISCO
Office of the Chief Medical Examiner
Medical Division

Case No. 2009-0899

Name [redacted] Date & Time of Necropsy: **September 10, 2009 09:25 Hours**

Age: **31** Height: **6′ 1″** Weight: **307 lbs.**

PRELIMINARY EXAMINATION: The body is received in a yellow plastic pouch sealed with Medical Examiner's seal # 52629, and is identified by a Medical Examiner's label affixed to the outside of the pouch, which is transferred to the left great toe. An orange jail identification bracelet on the right wrist is inscribed [redacted] SF# [redacted]." When first viewed, the decedent is clad in a "4X" sized orange T-shirt with some black stains on the front, which is bunched upward exposing the abdomen; orange pants, rolled at the cuffs and pulled slightly down exposing the underwear; and orange brief underpants. Received separately on September 15, 2009 are two black sneakers, two orange socks and a cut orange sweatshirt. The pants have a clear fluid stain at the groin and black gray stains (some patterned) at the left thigh and shin. The clothing is retained as evidence.

Radiography is performed on September 9, 2009. The external examination and autopsy are begun on September 10, 2009. The skin along the posterior back is reflected and the subcutaneous injuries are photographed on September 11, 2009 and the ribs are dissected by separating them at the intercostal muscles for examination of occult fractures on September 14, 2009.

EXTERNAL EXAMINATION: The body is of a well developed, well nourished, morbidly obese (Body Mass Index = 40.5 lbs/in^2) adult Black man, whose appearance is consistent with the reported age of 31 years. The body is cold (refrigerated). Rigor mortis is marked and symmetric. Unfixed purple livor mortis is minimally evident over the posterior surfaces of the body, and the head and neck above the clavicles, except in areas exposed to pressure.

The face is unremarkable without visible injury but with slight bloody fluid about the right face, at the mouth. The head is atraumatic, symmetric, and normocephalic. The scalp is intact and atraumatic. The scalp hair is black, curly and measures approximately 1 inch in length over the crown. The eyelids are atraumatic, intact, and unremarkable. The irides are brown. The pupil on the right measures 0.5 cm and the one on the left is obscured by corneal clouding and mottling. Upon aspiration of vitreous humor, left right vitreous humor is clear but the left is opaque and scarce. The sclerae and conjunctivae are markedly congested. No petechial hemorrhages are identified on the palpebral conjunctivae, bulbar conjunctivae, facial skin or oral mucosa. The nose and ears are not unusual except for one pierce mark in the left earlobe. The decedent wears a 1/4 inch black mustache and stubble at the beard. The frenula are intact. The teeth are natural and in good condition.

The neck is unremarkable. The trachea is palpable and midline. The thorax is well developed and symmetrical with an increased anterior-posterior diameter. The abdomen is protuberant with lateral abdominal and axillary striae. [redacted]

[redacted]. The upper and lower extremities are well developed and symmetrical, without absence of digits. There is no clubbing or edema.

EVIDENCE OF MEDICAL THERAPY: Evidence of acute medical therapy includes an endotracheal tube (secured with positioner and strap); defibrillator pads on the chest and left abdomen; electrocardiogram patches on the shirt and back left hand; 3 needle puncture marks and associated ecchymosis at the left antecubital fossa; needle puncture marks and associated ecchymoses at the back right hand, back lower left arm and volar left forearm. A single lumen intravenous catheter is at the back right hand, connected to a 1 liter bag of saline, of which approximately 500 cc have been infused, and a full bag of Dopamine inscribed "800 mcg/mL 200 mg total." A faint needle puncture mark is at the right great toe. Injuries associated with resuscitation include a 4 by 2 cm hemorrhage at the left back of the tongue extending to the pyriform recess and submucosal paratracheal and laryngeal hemorrhage (consistent with intubation injury).

IDENTIFYING MARKS AND SCARS: A 1/2 inch horizontal linear faint well-healed scar is on the inner lower lip at the midline. A monochromatic professional tattoo inscribed [redacted] is on the upper left chest. A monochromatic professional tattoo of a football player with flames is on the upper outer left arm. A monochromatic professional tattoo inscribed possibly [redacted]" is on the upper back. A 3 inch horizontal linear well-healed scar is on the right antecubital fossa. A 1-1/2 inch area of punctate well-healed scars is on the right elbow. Below it, in a line overlying a subcutaneous vein (consistent with "track marks") are a 5/8 inch triangular well-healed scar of the back lower right arm; a 1/2 inch and a 3/8 inch oval well-healed scar of the mid-back lower right arm and wrist, respectively. A 3-1/2 inch horizontal linear well-healed scar is on the mid-volar lower right arm. Multiple (at least 4) overlapping horizontal linear well-healed scars ranging in size from 1-1/2 to 2-1/2 inches are on the volar right wrist. A 3/4 inch vertical linear well-healed scar is on the back right hand, at the web between the index finger and thumb. A 4 inch horizontal linear well-healed scar is on the volar lower left arm. Multiple (at least 4) overlapping horizontal linear well-healed scars ranging in size from 1-1/2 to 3 inches are on the volar left wrist. Multiple faint linear well-healed scars are on the back left hand. A faint aggregate of well-healed scars ranging in size from 1/4 to 1/2 inch each is on the right knee. A 1-1/2 inch oval well-healed scar is on the pretibial lower right leg. A 2 inch curvilinear well-healed scar is on the upper pretibial lower left leg. A 1-1/2 inch irregular well-healed scar is on the mid left shin (pretibial lower left leg). Additional identifying marks and scars are not readily identified.

EVIDENCE OF INJURY: There is blunt trauma of the neck, torso and extremities. These injuries are described by body region. The directions are stated with reference to the standard anatomical planes with the body measured in the horizontal position.

Blunt trauma of neck: A 3/8 inch brown abrasion is on the right neck, behind the ear. No other injuries are evident on external examination.

Upon reflection of the skin, there is a 5 by 1.5 cm vertically-oriented deep muscle contusion in the left occipital attachment of the trapezius. A 1 cm area of possible congestion versus hemorrhage is at the C2 vertebral spinous process. A 4 by 1 cm area of subcutaneous hemorrhage (contusion) involves the outer belly of the left upper sternocleidomastoid muscle.

Blunt trauma of torso: Upon reflection of the skin, a 1 cm contusion is on the left sterno-clavicular joint. A 15 by 6 cm area of deep muscular hemorrhage is oriented vertically along the posterior paraspinous musculature of C5 through T3. The underlying bone is intact. A 2 cm subcutaneous contusion is on the left scapular spine. A 1 by 0.5 cm contusion is at the left lower back. A 2 cm contusion is on the paraspinous muscles to the left of the L1 spinous process. A 14 by 4 cm aggregate of ovoid contusions measuring from 3 by 0.5 cm, to 2 cm to 1 cm are on the lower right back and flank, above the buttock, to the sacral area.

Blunt trauma of extremities:
Right arm: A 1/2 inch red contusion is on the inner back right wrist. A 1 inch red contusion is on the back right hand, slightly below the wrist, and at the base of the thumb. A 1/2 inch red contusion is on the back right hand, overlying the metacarpal of the small finger. A 1/8 inch red abrasion is on the base of the ring finger nail.

Left arm: A 1-1/2 inch area of ovoid contusions (consistent with "finger pad contusions") is on the inner upper left arm, near the axilla. A 1-1/4 inch red contusion is on the back left wrist. Upon reflection of the skin there is a 4 by 1 cm diagonally-oriented contusion extending from the back left wrist to the inner lower left arm. Two 1/6 inch punctate red abrasions are at the inner left index finger tip.

Right leg: Two 1/2 inch red contusion with faint punctate red abrasions are on the pretibial lower right leg, below the knee and at the right knee. A 1-1/2 inch horizontally-oriented red abraded contusion is on the front outer right ankle. Upon reflection of the skin, a 9 by 9 cm area of mottled hemorrhage is on the back right thigh. A 10 by 5 cm contusion is on the right knee. A 2.5 cm contusion is on the outer back right calf and a 17 by 2 cm horizontally-oriented contusion is on the back lower right leg, slightly above the ankle.

Left leg: A 3/4 inch red contusion with a 1-1/2 inch horizontally-oriented red abrasion are on the left ankle. A 3/4 inch hyperpigmented ridge is vertically-oriented below the left great toenail (possible remote subungual contusion). Upon reflection of the skin, a 2.5 by 1 cm contusion is on the upper back left thigh. A 2.5 by 1.5 cm contusion is on the outer left knee. A 5 by 2 cm red contusion is on the left knee and extends vertically to the pretibial lower left leg, below the knee. A 1 cm round red contusion is on the outer left calf and below it there is a 4 by 3 cm oval contusion. Three 1.5 cm round contusions are on the front and outer lower left leg (shin). A 12 by 2 cm red contusion is diagonally-oriented along the back lower left leg. An 8 by 2 cm horizontal linear red contusion is on the left ankle.
Post-Mortem Injuries:

Upon re-examination of the body on September 14, 2009 a 1/16 inch punctate abrasion is noted on the inner lower lip and a 1/8 inch curvilinear abrasion is on the left chin. They have no associated vital reaction (consistent with post-mortem injury sustained when the body was previously placed face-down on the table).

The injuries above, having been described once, will not be repeated.

INTERNAL EXAMINATION: The body is opened in the usual manner with a Y-shaped incision. No adhesions or abnormal collections of fluid are in any of the body cavities. All body organs are in normal and anatomic position. The serous surfaces are smooth and glistening. The subcutaneous fat measures approximately 2-1/4 inches in maximum thickness at the level of the umbilicus. There is diffuse visceral congestion.

HEAD AND CENTRAL NERVOUS SYSTEM: Reflection of the scalp shows the usual scattered reflection petechiae. The calvarium is intact. The brain weighs 1,360 grams. The dura mater and falx cerebri are unremarkable and the leptomeninges are thin and delicate. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels are free of abnormality.

Sections through the cerebral hemispheres reveal no lesions within the cortex, subcortical white matter or deep parenchyma of either hemisphere. The cerebral ventricles are of normal caliber. Sections through the brainstem and cerebellum are unremarkable. The first portion of the spinal cord, viewed through the foramen magnum, is unremarkable.

The spinal cord is removed by the anterior approach, with technical difficulty, due to body habitus. The spinal cord is preserved in formalin for subsequent neuropathologic examination.

NECK: The neck is dissected after the thoracoabdominal and cranial contents are removed. Examination of the soft tissues of the neck, including large vessels and strap muscles, reveals no additional abnormalities. The superficial and deep muscles of the neck are firm, red-brown, intact, and otherwise unremarkable. The hyoid bone and larynx are intact. The tongue is normal.

CARDIOVASCULAR SYSTEM: The heart weighs 490 grams. The epicardial surfaces are smooth, glistening, and unremarkable. The coronary arteries arise normally and follow the distribution of a right dominant pattern with no significant atherosclerosis. The chambers demonstrate some right ventricular dilatation and slight biventricular hypertrophy. The valves bear the usual size/position relationship, are morphologically normal and are unremarkable. The valves are free of vegetations. The measurements of the heart valves are as follows: tricuspid valve 15.1 cm, pulmonic valve 7.5 cm, mitral valve 11.6 cm, and aortic valve 6.2 cm. The myocardium is dark red-brown, flaccid, and unremarkable. The atrial and

ventricular septa are intact and the septum and free walls are free of muscular bulges. There is no focal or regional fibrosis, erythema, pallor or softening. The left ventricle measures 1.5 cm and the right ventricle measures 0.5 cm in thickness as measured 1 cm below the respective atrioventricular valve annulus. The interventricular septum measures 1.0 cm in thickness. The aorta and its major branches arise normally and follow the usual course with no significant atherosclerosis. The orifices of the major aortic vascular branches are patent. The vena cava and its major tributaries return to the heart in the usual distribution and are unremarkable.

RESPIRATORY SYSTEM: The right and left lungs weigh 500 and 570 grams, respectively. The upper and lower airways are patent and the mucosal surfaces are smooth, yellow-tan, and unremarkable. The pleural surfaces are smooth, glistening, and unremarkable. The pulmonary parenchyma is congested and the cut surfaces exude moderate amounts of blood and frothy fluid. There are no masses, hemorrhages, consolidations, obstructions or destructive emphysema. The pulmonary arteries are normally developed and patent. There is no saddle embolus on *in situ* examination of the pulmonary trunk.

HEPATOBILIARY SYSTEM: The liver weighs 2480 grams, appears enlarged, and restricts the relatively small right pleural cavity. The hepatic capsule is intact, smooth and glistening, covering red-brown parenchyma. The gallbladder contains approximately 25 ml of dark green viscid bile without stones. The extrahepatic biliary tree appears to be patent.

HEMATOPOIETIC SYSTEM: The spleen weighs 210 grams and has a smooth intact capsule covering red-purple, moderately firm parenchyma. The splenic white pulp is grossly unremarkable. The regional lymph nodes appear normal. The bone marrow (rib) is red-purple. A 60 gram thymus identified in the anterior mediastinum, is pink, soft, normally lobulated and infiltrated with fat.

ENDOCRINE SYSTEM: The pituitary gland is intact, normally developed, and is unremarkable without laceration, hemorrhage, or mass lesion. The thyroid gland is symmetric and unremarkable with a firm, red-brown, granular parenchyma and no cyst, hemorrhage, fibrosis, or mass lesion. The adrenal glands are normally situated and have soft, yellow cortices and soft, grey-brown medullae. The pancreas has a soft, tan parenchyma with a normal lobular architecture and no saponification, pseudocyst, neoplasm, fibrosis, hemorrhage, or mineralization.

GASTROINTESTINAL SYSTEM: The esophagus is lined by gray-white smooth mucosa. The gastric mucosa is arranged in the usual rugal folds, and the lumen contains approximately 350 ml of green fluid with white granular material (possibly egg). There are no pill fragments or foreign bodies identified. The small and large bowels are unremarkable. The appendix is unremarkable. The colon contains soft stool.

GENITOURINARY SYSTEM: The right and left kidneys weigh 220 and 210 grams, respectively. The renal capsules are smooth, thin, semitransparent, and strip with ease from the underlying, smooth, red-brown, firm, cortical surfaces. The cortices are of normal thickness and well-delineated from the medullary pyramids. The calyces, pelves, and ureters are unremarkable. The urinary bladder contains no urine; the mucosa is gray-tan and smooth. The bilaterally descended testes are unremarkable. The prostate is unremarkable.

MUSCULOSKELETAL SYSTEM: The skeleton is well developed and without deformity or osteoporosis. The vertebrae, clavicles, sternum, ribs, and pelvis are without fracture. The supporting musculature and soft tissues are not unusual. The firm, red-brown muscles are well hydrated and free of focal lesions. The cervical spinal column is stable on internal palpation.

Name: [redacted] Date & Time of Necropsy: **September 10, 2009 09:25 Hours**

DIAGNOSES:

I. PRONE RESTRAINT.
   A. BLUNT FORCE TRAUMA OF NECK, TORSO AND EXTREMITIES CONSISTENT WITH ALTERCATION AND PRONE RESTRAINT WITH COMPRESSION OF NECK AND BACK.
      1. ACUTE HEMORRHAGE, DEEP MUSCLE AND SOFT TISSUE OF LEFT NECK, UPPER BACK, C2 SPINOUS PROCESS AND LEFT ANKLE.
      2. INSUFFICIENT VITAL INTERNAL ORGAN INJURY TO ACCOUNT FOR DEATH.
      3. SUDDEN CARDIORESPIRATORY ARREST.
         a. STATUS POST INTUBATION WITH PARATRACHEAL AND LARYNGEAL SUBMUCOSAL HEMORRHAGE.
         b. VISCERAL CONGESTION WITH PASSIVE CONGESTION, LIVER AND SPLEEN.

II. MORBID OBESITY (BODY MASS INDEX = 40.5 LBS/IN^2).
   A. HYPERTENSIVE CARDIOVASCULAR DISEASE:
      1. 490 GRAM HEART WITH SLIGHT BIVENTRICULAR HYPERTROPHY (RIGHT 0.5 CM, LEFT 1.5 CM) AND RIGHT VENTRICULAR DILATATION.
   B. HEPATOMEGALY, 2480 GRAM, WITH RESTRICTION OF RIGHT PLEURAL CAVITY SIZE IN SUPINE POSITION.
      1. SLIGHT HEPATIC STEATOSIS.
   C. ABDOMINAL PANNUS, 2-1/4 INCHES SUBCUTANEOUS FAT.

III. SCHIZOPHRENIA/BIPOLAR DISORDER (CLINICAL HISTORY).
   A. AGITATION WITHOUT EVIDENCE OF PSYCHOSIS, HALLUCINATION, OR HYPERTHERMIA (CLINICAL HISTORY).
   B. RISPERIDONE AND VALPROIC ACID THERAPY (CLINICAL).
      1. RISPERIDONE, 9-HYDROXYRISPERIDONE AND VALPROIC ACID DETECTED – SEE TOXICOLOGY REPORT.
   C. STATUS POST REMOTE SUICIDE ATTEMPTS (CLINICAL HISTORY).
      1. HORIZONTAL SCARS ON VOLAR UPPER EXTREMITIES.
      2. STATUS POST REMOTE ATTEMPTED ENUCLEATION (CLINICAL HISTORY)
         a. LEFT EYE RUPTURE, REMOTE, WITH SUBSEQUENT OPACIFICATION.

IV. NON-SPECIFIC SINGLE INTRAMYOCARDIAL FOCAL LYMPHOID INFILTRATE, NOT DIAGNOSTIC FOR MYOCARDITIS.

Case No. 2009-0899

Name: [redacted] Date & Time of Necropsy: **September 10, 2009 09:25 Hours**

Spec. to Pathology: Portions of all major organs, the entire spinal cord, brain with dura, heart and the neck block are fixed in formalin and retained.

Spec. to Histology:

1. Heart.
2. Lungs.
3. Liver, kidney, spleen, adrenal, pancreas.
4. Brain.
5. Heart: SA nodal area.
6. Heart: AV nodal area.
7. Left neck.
8. Deep back muscle.
9. C2 spinous process soft tissue.
10. Left ankle.
11. – 12. Spinal cord.

Spec. to Toxicology: Peripheral blood, central (heart, right ventricle) blood, bile, brain, gastric contents, liver, muscle, vitreous humor.

Radiographs: Digital radiographs of the head, neck, chest and abdomen are taken by Judy Melinek, MD, Assistant Medical Examiner, San Francisco Medical Examiner's Office. Radiographs demonstrate no discernible fractures or projectiles.

Physician(s) Present: V.J. Azar, M.D., E.G. Moffatt, M.D., J. J. Smith, M.D.

Forensic Tech(s): J. Wedrychowski, A. Fuentes, J. Vergara.

Photographer: Judy Melinek, M.D., Assistant Medical Examiner, San Francisco Medical Examiner's Office.

Evidence: Blood spot on filter paper for DNA, Medical Examiner's seal, clothing, hand bags.

Judy Melinek, M.D.
Assistant Medical Examiner

A.P. Hart, M.D.
V.J. Azar, M.D.
J.J. Smith, M.D.
E.G. Moffatt, M.D.
J. Melinek, M.D.
jm 5/7/10

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF THE CHIEF MEDICAL EXAMINER
Medical Division

Name: [redacted] Case No: **2009-0899**

NEUROPATHOLOGIC EXAMINATION

The specimen is the spinal cord (with dura) of an adult.

Spinal cord with dura from upper cervical to cauda equina levels measures 38 cm and shows traction and saw artifact (non-hemorrhagic vertical disruptions) at the proximal end. There is no epidural, subdural or subarachnoid hemorrhage or other external abnormality. Transverse sections of the cord at 1.5 cm intervals are unremarkable.

MICROSCOPIC DESCRIPTION

Tissue or Organ x # of fragments and/or levels (slide ID)

HEART x 33 (1, 1 recut A-C, 5, 5 recut A-C, 6, 6 recut A-C, 13-16): Normal myocardium with a single focal lymphocytic aggregate associated without myocyte necrosis. Unremarkable coronary arteries. Single colony of bacterial cocci with nucleated squamous cells at periphery of section without inflammatory reaction consistent with post-mortem artifact. SA nodal region has small lymphoid aggregate in fat and fibrous tissue, without myocyte proximity or damage. AV nodal region (slide 6) has foci of extravasated red cells without myocytolysis, contraction-band necrosis, edema or inflammation. Other sections show extravasated red cells at edges of section (consistent with section artifact). *Slides also reviewed with Philip Ursell, M.D., UCSF Pathology, who concurs with the diagnosis.*

LUNG x 3 (2): Passive congestion and focal red cell extravasation into airspaces but no specific pathologic changes.

LIVER x 1 (3): Normal hepatic parenchyma with slight macrovesicular steatosis and passive congestion.

KIDNEY x 1 (3): Normal glomerular and tubular architecture. No specific pathologic changes.

SPLEEN x 1 (3): Normal splenic parenchyma with passive congestion and no specific pathologic changes.

ADRENAL x 1 (3): Normal adrenal cortex and medullary architecture and cytology with no specific pathologic changes.

PANCREAS x 1 (3): Marked autolysis.

BRAIN x 2 (4): Sections of cerebellum and hippocampus are unremarkable without specific pathologic changes.

MUSCLE AND FIBROUS TISSUE, LEFT NECK x 1 (7): Acute hemorrhage.

MUSCLE AND FIBROUS TISSUE, DEEP MUSCLE, UPPER BACK x 1 (8): Acute hemorrhage.

MUSCLE AND FIBROUS TISSUE, C2 SPINOUS PROCESS x 1 (9): Acute hemorrhage.

MUSCLE AND FIBROUS TISSUE, LEFT ANKLE x 1 (10): Acute hemorrhage.

SPINAL CORD x 8 (11-12): No specific pathologic changes.

MICROSCOPIC DIAGNOSES:

I. NON-SPECIFIC SINGLE INTRAMYOCARDIAL FOCAL LYMPHOID INFILTRATE, NOT DIAGNOSTIC FOR MYOCARDITIS.[1]
II. SLIGHT HEPATIC STEATOSIS.
III. PASSIVE CONGESTION, LIVER AND SPLEEN.
IV. ACUTE HEMORRHAGE, DEEP MUSCLE AND SOFT TISSUE OF LEFT NECK, UPPER BACK, C2 SPINOUS PROCESS AND LEFT ANKLE.

CAUSE OF DEATH: **PROBABLE RESPIRATORY ARREST DURING PRONE RESTRAINT WITH MORBID OBESITY.**

OTHER CONDITIONS: **HYPERTENSIVE CARDIOVASCULAR DISEASE, SCHIZOAFFECTIVE/BIPOLAR DISORDER.**

MANNER: **HOMICIDE.**

OPINION:

This 31 year old man had been incarcerated at the city jail since his arrest on March 9, 2009 for battery with great bodily injury and forcibly resisting arrest. He was initially in Tank 13, Post 11, when on 9/7/2009 he loudly complained about an officer (Deputy Smith) turning off the televisions. He then started yelling that his back hurt and that he needed medical attention. One inmate [redacted] reported that Mr. [redacted] had "a hard time breathing," and that he was screaming for a doctor. Mr. [redacted] also claimed to he suicidal, but followed up that he was "just kidding." Inmates reported that during this time he appeared healthy, in no apparent distress and had previously been seen exercising regularly. He was not noted by his fellow inmates to be sweating. Officers determined that based on his behavior he appeared agitated and initiated transfer to K tank (also known as Administrative Segregation, or "AdSeg"). He was initially informed that he was going to "main line," and cooperated with collecting his belongings. Two officers (Deputy Guitron and Gutierrez) went to transfer him out of this holding area and restrained his hands behind his back with two sets of handcuffs, because of his girth.

Upon transfer to K2, Mr. [redacted] was initially walking on his own accord, but when he realized that he was at "K tank" and not at "main line," he refused to enter the cell. Four to five officers (Guitron, Gutierrez, White, Lomba, and possibly Song, with Senior Deputy Wong supervising) brought him to the ground in a prone position and shackled his legs. He was brought to his feet and either carried or walked backwards over to the safety cell area, while one officer (first Song, then White) reportedly flexed Mr. [redacted] head downwards. On the way there, deputies reported that he dropped to a kneeling or sitting position and claimed that he was tired, but appeared to deputies to be in no acute distress. This was interpreted as passive resistance, so he was lifted, placed in the cell, where deputies (Guitron, Gutierrez, Macksoud, Lomba, White, with Wong supervising) placed him prone on the floor, positioned his legs in a figure 4 hold, and lifted his arms behind his back in a "flagpole" position (per Supervising Deputy Wong). It was approximately at this time he was heard to be moaning by nursing staff ([redacted]). The deputies were in the process of removing his cuffs and clothing when he became unresponsive.

When nursing staff were alerted approximately 2 or 3 minutes later, the nurses reported that he was pulseless and apneic. Nursing staff noted that his position was prone, with his head at the corner of the room, against the rear wall. He was placed by deputies and [redacted] on his right side ("recovery position"). He was then placed supine, cardiopulmonary resuscitation was started and an Automatic External Defibrillator (AED) was placed. According to the nursing staff it reported "no shock," although the electronic data indicating the electrocardiographic rhythm could not be subsequently obtained from this machine. According to the San Francisco Fire Department Patient Care Report, Sheriff's Deputies reported that the patient started "breathing wrong" during restraint and upon release from all restraining devices "a pulse was present at that time." On arrival of the paramedics, the patient was "apneic, pulseless" and his initial rhythm was "asystole" on the monitor. He was pronounced dead on 9/7/2009 at 18:33. Body temperature measured by the Office of Chief Medical Examiner Investigator Donald Stocum was 92.5 degrees Fahrenheit at approximately 22:00 hours (3-1/2 hours after death).

Review of medical records from the Tenderloin Outpatient Clinic and San Francisco General Hospital reveal a psychiatric history of schizoaffective/bipolar disorder with his first hospitalization in 1995 at the age of 17 for depression and a suicide attempt using Tylenol. He had other suicide attempts, with the most recent attempt occurred in the hospital and involved attempted enucleation with left globe rupture in March of 2009.

Review of medical records from jail from 1/10/1997 to 9/7/2009 indicate that he was consistently given his psychiatric medications from mid-August to the date of death. He was administered 500 mg of Divalproex (Valproic acid) on 9/7/2009 at 07:24 and at 16:41; and 3 mg Risperidone on 9/6/2009 at 19:52. At his last group therapy session on 9/3/2009 he "attended group and participated actively and appropriately." On 9/5 and 9/7 he refused to wear his eye patch and declined wound care treatment. On 9/7/2009 at 18:20 there was a clinic note indicating that "Senior Deputy Wong knocked on the door of the medication room

saying that he thought this patient had stopped breathing during placement into the safety cell" and that on arrival to the cell, [redacted] found the inmate prone, apneic and unresponsive and was turned onto his right side. The note also documents that use of the AED reported "No shock advised."

Review of EMS run-sheet and interviews with paramedics indicate that the decedent was close to the wall upon their arrival and was moved closer to the entrance for resuscitation. A blanket was placed behind his shoulders to facilitate intubation, which was difficult, but successful following multiple attempts. Patient was in asystole on initial presentation to the paramedics.

Review of San Francisco Police Department and Sheriff's Department interviews and narratives with officers and witnesses revealed that Mr. [redacted] was generally fit and had been exercising that morning (Deputy Gutierrez, [redacted]). Inmates reported that upon transfer to K tank his head was bent down [redacted] and that when he was taken to the ground outside of K tank, other inmates witnessed the officers using their knees to put pressure on Mr. [redacted] back [redacted], [redacted], [redacted] [redacted] and legs [redacted]. Several inmates reported that Mr. [redacted] said he could not breathe either during or after the take-down at K-tank ([redacted], [redacted], [redacted] [redacted]). Some inmates reported seeing blood either on his face or on the floor [redacted]). All officers, however, deny any pressure being applied to Mr. [redacted]' back. Deputy Guitron and Lomba both note that they felt a pulse at Mr. [redacted] left wrist after he became unresponsive. It is unclear from the Deputy's interviews whether he was still breathing at that time (after he became unresponsive but was in "recovery position"), but Deputy Maksoud stated that his breathing was "different" and "shallow" prior to being rolled over; Deputy Lomba said he shook his head and coughed twice; and Deputy Wong noted that his chest was moving.

At autopsy, Mr. [redacted] was morbidly obese with a height of 6 feet 1 inch and a weight of 307 pounds. The calculated Body Mass Index was at 40.5 lbs/in^2. There were elongate deep soft-tissue and intramuscular hemorrhages on the left neck and upper back. There was congestion of the face, passive congestion of the spleen and liver but no petechial hemorrhages, hyoid or laryngeal fractures. Submucosal injuries at the larynx and pyriform recess were consistent with injury from a difficult intubation. Hemorrhages at the wrists and lower legs were consistent with injuries from wrist and leg shackles. His heart was mildly enlarged for a man of his height and weight and had biventricular hypertrophy and right ventricular dilatation. Multiple microscopic sections were not diagnostic for specific pathology that would explain a sudden cardiac death. There was no evidence of myocardial infarction (heart attack). The liver was enlarged at autopsy and impinged on the right pleural cavity. On microscopy, it had slight fatty change (steatosis), commonly seen in obesity.

He toxicology report documented the presence of risperidone (an anti-psychotic medication), its metabolite and valproic acid (a drug used as a mood stabilizer), consistent with his reported therapy. Vitreous electrolytes were unremarkable for the post-mortem state.

Although the deceased had a history of schizophrenia and exhibited some agitation prior to his death, it would be inappropriate to ascribe this death to excited delirium syndrome because of the absence of psychosis, hallucinations, undressing, hyperthermia, violent behavior, imperviousness to pain, and the other typical symptoms that define this syndrome. While a sudden cardiac arrhythmia precipitated by the physiologic stress of the struggle in the absence of respiratory compromise cannot be completely ruled out, the factors that favor an asphyxial component to this death are: the morbid obesity of the deceased with subsequent restriction in chest excursion by prone restraint, and his self-reported breathing problems with neck flexion; the injuries to the upper back and neck indicating that there was pressure exerted at these locations; and officers' statements that his unconsciousness preceded the loss of a pulse, suggesting a primary respiratory arrest with a secondary cardiac arrest. The components of this case that suggest a sudden cardiac arrest are the deceased's reported complaints of back pain and possible shortness of breath prior to engagement by police officers, the slight cardiac enlargement and the relatively short time interval (reportedly two to three minutes) between conscious prone restraint, unconsciousness with attendant repositioning, and cardiac arrest.

The manner of death, homicide, indicates that the volitional actions of others caused or contributed to this death. Were it not for the physiologic stresses imposed by the struggle and restraint, there is no reasonable medical certainty that Mr. [redacted] would have died at the moment he did. According to "A Guide for Manner of Death Classification," the National Association of Medical Examiners suggests that "Deaths due to positional restraint induced by law enforcement personnel or to choke holds or other measures to subdue may be classified as Homicide."[2]

REFERENCES:

1. Aretz, T.H. et al. Myocarditis: A histopathologic definition and classification. *The American Journal of Cardiovascular Pathology* 1986; 1 (1): 3-14

2. "A Guide For Manner of Death Classification" First Edition. February 2002 National Association of Medical Examiners ® Randy Hanzlick, MD, John C. Hunsaker III, MD, JD; Gregory J. Davis, MD.

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City and County
of
San Francisco

Office of the Chief
Medical Examiner

FORENSIC LABORATORY DIVISION

TOXICOLOGY REPORT

Name: [redacted] **Date of Submission:** 09/11/2009 **M. E.:** JM
Case No: 2009-0899T **Date of Report:** 11/03/2009

ANALYTICAL RESULTS:

SPECIMEN TYPE	COMPOUND	RESULT	UNITS
Blood (Peripheral)	Risperidone[1]	2	ng/mL
Blood (Peripheral)	9-Hydroxyrisperidone[1]	10	ng/mL
Blood (Peripheral)	Valproic Acid[1]	16	mg/L
Blood (Central)	9-Hydroxyrisperidone[1]	2	ng/mL
Blood (Central)	Valproic Acid[1]	15	mg/L

COMMENTS
[1]Confirmation/Quantitation performed by NMS Labs, Willow Grove PA.
Report prepared by CMW

Ann Marie Gordon, M.S.
Manager & Supervising Forensic Toxicologist

ANALYTICAL PROTOCOL:
Specimens submitted were subjected to Analytical Panels A, B, C, Risperidone and Valproic Acid. Analytical Panel A detects and quantifies ethanol, methanol, isopropanol and acetone and may also detect other volatile compounds which would require additional analyses their confirmation and/or quantitation. Analytical Panel B detects, confirms and/or quantifies Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Fentanyl, Methadone, Phencyclidine (PCP), Opiates/Opioids, Propoxyphene and Tricyclic Antidepressants. Analytical Panel C detects, confirms and/or quantifies over one hundred drugs and metabolites. Analytical Panel Risperidone and Valproic Acid detects and quantifies Risperidone, 9-Hydroxyrisperidone, and Valproic Acid. Please contact the Forensic Laboratory Division if you have questions regarding specific substances.

City and County
of
San Francisco

Office of the Chief
Medical Examiner

FORENSIC LABORATORY DIVISION

CHEMISTRY REPORT

Name: [redacted] **Date of Submission:** 09/11/2009 **M. E.:** JM
Case No: 2009-0899T **Date of Report:** 09/08/2010

ANALYTICAL RESULTS:

SPECIMEN TYPE	COMPOUND	RESULT	UNITS
Vitreous Humor (Right Eye)	Sodium	140	mmol/L
Vitreous Humor (Right Eye)	Potassium	19.4	mmol/L
Vitreous Humor (Right Eye)	Chloride	122	mmol/L
Vitreous Humor (Right Eye)	Glucose	42	mg/dL
Vitreous Humor (Right Eye)	Urea Nitrogen	12	mg/dL
Vitreous Humor (Right Eye)	Creatinine	1.1	mg/dL
Vitreous Humor (Right Eye)	Ketones	None Detected	

COMMENTS
Report prepared by CMW.

Nikolas P. Lemos, Ph.D., FRSC
Director & Chief Forensic Toxicologist

ANALYTICAL PROTOCOL:
Specimen received were subjected to Analytical Panel E. Analytical Panel E detects and quantifies sodium, potassium, chloride, glucose, urea nitrogen, creatinine and ketones.