

# REPORT ON USE OF FORCE



## Legal Analysis Surrounding the incident on February 25, 2013, resulting in the Death of Luis Solano

### INTRODUCTION

On February 21, 2013, at approximately 1858 hours, Las Vegas Metropolitan Police Department (LVMPD) Narcotic Detectives arrested Luis Solano (hereinafter "Decedent") at 5825 West Flamingo, building 5, apartment 118, for trafficking in controlled substance: cocaine. At the time of Decedent's arrest, LVMPD Detectives located approximately 975.4 grams of cocaine in Decedent's residence. Detectives also charged Decedent with conspiracy to violate the Uniform Controlled Substance Act under event# 130221-3113. Detectives transported Decedent to the Clark County Detention Center (CCDC) and booked him accordingly on February 22, 2013, at approximately 0121 hours.

Decedent<sup>1</sup> was initially housed in unit 2LMOD at CCDC; however, on February 25, 2013, at approximately 1340 hours, Decedent began disrupting the unit. A psych services nurse responded to the unit and, after evaluating Decedent, determined that he needed to be transferred to unit 2A, the psychiatric module, for further psychiatric review. Decedent was subsequently transferred to unit 2A and housed in unit 2A08U.

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<sup>1</sup> Decedent was 5' 11" tall and weighed 265 lbs at the time of the incident.

On February 25, 2013, at approximately 1340 hours, the inmates housed in unit 2A were allowed to enter the day room for free time. Decedent exited room 8 and started to complain about the water. Corrections officers instructed Decedent to return to his cell several times, but he refused. Decedent then demanded to be let out of the unit, began acting erratically and disrupted the unit. Sgt. Aspiazu, along with Officers Dixon, Grey and Temple, attempted to detain Decedent to prevent him from further disrupting the unit. Sgt. Aspiazu, Officers Dixon, Grey and Temple grabbed Decedent and attempted to handcuff him. Decedent resisted and began to struggle with officers. Officers took Decedent to the ground and he continued resisting the officers' efforts to handcuff him. Officers eventually were able to handcuff Decedent, at which time Sgt. Aspiazu radioed for a restraint chair<sup>2</sup> to be brought to the unit.

Officer Munoz, along with other officers, then arrived in unit 2A. Sgt. Aspiazu and Officer Munoz attempted to place Decedent in the restraint chair and noticed he was unconscious. Sgt. Aspiazu requested a "Code 99," which was a code used by the detention facility for a medical emergency.

Medical personnel responded to unit 2A and began emergency medical procedures which included CPR and the use of an automated external defibrillator (AED). Lieutenant Meyers requested an ambulance, and Las Vegas Fire and Rescue Unit #1 responded to CCDC. Rescue personnel continued CPR efforts and transported Decedent to University Medical Center (UMC).

On March 1, 2013, although Decedent had been previously stable, Decedent's condition markedly worsened and medical staff believed that Decedent was probably going to die. There were discussions between the family and the hospital about organ harvesting. On March 6, 2013, Decedent died at 1502 hours.

The District Attorney's Office has completed its review of the February 25, 2013 incident, resulting in the death of Decedent. It was determined that, based on the evidence currently available and subject to the discovery of any new or additional evidence, the actions of the officers were not criminal in nature. This review was based on all the evidence currently available, including the benefit of a Police Fatality Public Fact-finding Review.

This report explains why criminal charges will not be forthcoming against the officers involved. It is not intended to recount every detail, answer every question or resolve every factual conflict regarding this police encounter. This letter is

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<sup>2</sup> A restraint chair is used to restrain inmates who will not follow commands and who pose a physical threat to themselves and/or corrections officers and other inmates. Because the use of a restraint chair involves the immobilization of an individual by the use of physical restraints, detention center policy requires that the implementation and use of a restraint chair be documented via handheld video camera.

intended solely for the purpose of explaining why, based upon the facts known at this time, the conduct of the officers was not criminal.

This decision, premised upon criminal-law standards, is not meant to limit any administrative action by the LVMPD or to suggest the existence or non-existence of civil actions by any person where less stringent laws and burdens of proof apply.

**I. DESCRIPTION OF SCENE AND VISIBLE EVIDENCE:**

**A. DESCRIPTION OF THE SCENE:**

The scene is located within the Clark County Detention Center, located at 330 South Casino Center Blvd, in unit 2A. Unit 2A is located in the North Tower, on the second floor. Unit 2A is located in the southeast corner of the floor. The unit door faces west and "2A" in white is marked on the outside of the unit door. This unit door is controlled by the main control room located on the 12<sup>th</sup> floor of the facility.

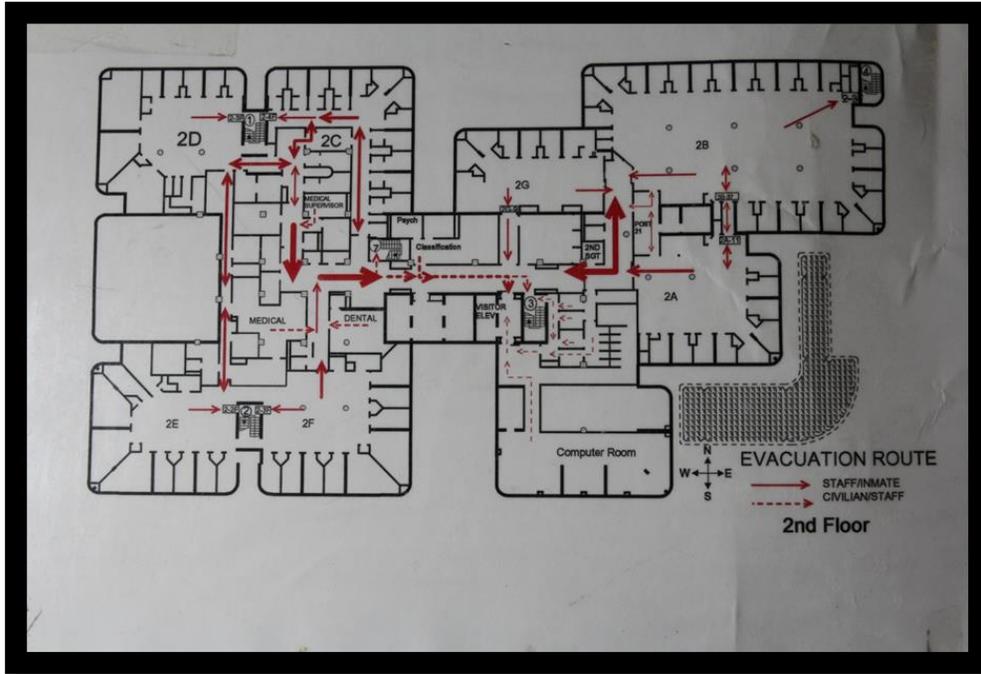
The unit was previously used to house juvenile inmates. Because of this, the main entry door into the unit has frosted glass to prevent other inmates from looking into the unit. Unit 2A has nine cells and is identified by numbers marked in white on the outside of the cells. Cells 1 through 3 are located on the east wall. Cells 4 and 5 are located in the southeast corner. Cells 6 through 9 are located on the south wall. All of the cells have a window which faces into the day room.

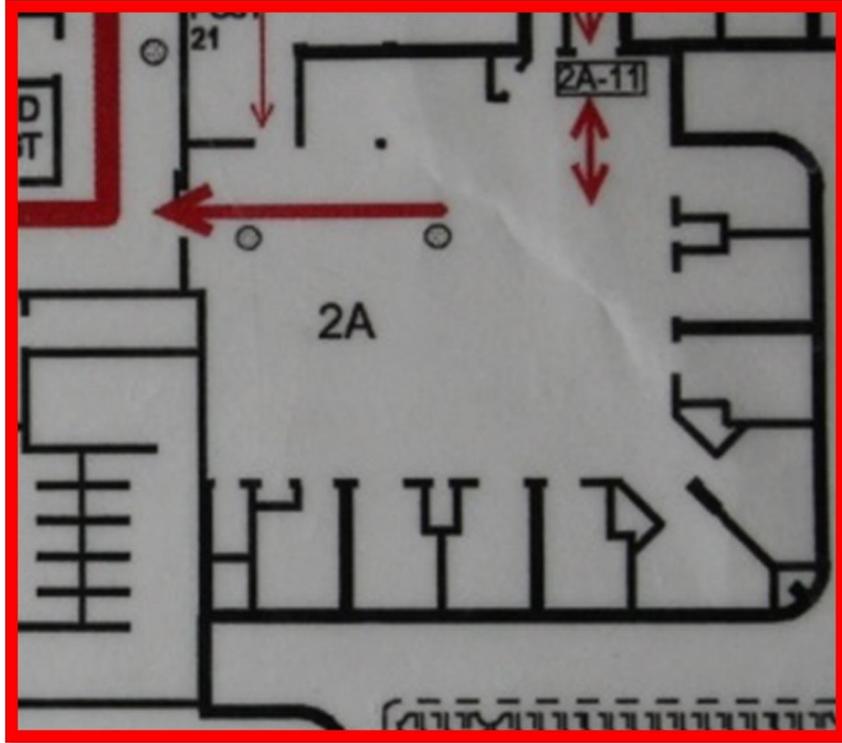
The control room is located in the northwest corner of the unit and is the control room for the cells within units 2A and 2B. **A red line is located outside the cells in unit 2A and red marking the shape of a box is located outside the control room. This box is used by correction personnel as a safety zone when interacting with inmates.** A concrete column is located in the southeast corner of the day room and has "2A" in blue on the west side of the column. The day room has four round tables located in the center of the room, and each table is surrounded by plastic maroon chairs.

Two surveillance cameras are located within the unit. For the purposes of this report, the cameras will be identified as cameras #1 and #2.

Per the Clark County Detention Centers Standard Operation Procedures, when a restraint chair is requested and used, the incident is videotaped using a hand-held camera. The subscriber identity module (SIM) card to the hand-held camera is given to the Administrative Lieutenant and downloaded. A copy of this video was obtained by Detective Merrick. For the purposes of this report, this camera will be identified as camera #3.

# Layout of the 2nd floor





Camera #1 captured the incident between Decedent and the corrections officers. Camera #1 is attached to the ceiling on the west wall and outside the unit's main entry door. Camera #1 faces east into the day room. The field of view covers the north wall and cell doors 1- 7 on the south wall.

Photo of camera #1, affixed outside Unit 2A and faces east.



Camera #2 is attached to the ceiling outside the module's control room and faces west. The camera is protected by a metal housing box. This camera records the west side of the main entry door. Decedent was seen on this camera prior to the incident, and the responding medical and correction personnel were seen entering the unit after the incident.

Photo of camera #2, affixed outside control room and faces west.



**B. AUTOPSY:**

On March 7, 2013, Dr. Telgenhoff performed an autopsy on the body of Decedent under Clark County Coroner Case# 13-2350. Injuries to Decedent noted at autopsy included: abrasions and blisters on the back of the ankles; a small abrasion on right chin; a swollen right hand; and an abrasion on the left wrist.

The results of the toxicology report did not reveal the presence of any illicit drugs. Doctor Telgenhoff opined that Decedent died from complications of positional asphyxia<sup>3</sup> due to police restraint procedures; Doctor Telgenhoff also noted renal failure as a significant condition, as well as the fact that Decedent had documented cardiomegaly (an enlarged heart – Decedent's Heart = 490 grams – normal range = 250-350 grams).

**II. RECORDED WITNESS STATEMENTS AND PERSONS CONTACTED:**

**INMATES HOUSED IN UNIT 2A:**

Detective McCarthy received a roster of the inmates housed in unit 2A. The inmates were contacted and interviewed by Sgt. Darr and Detectives McCarthy, Merrick, Raetz, Gillis, Bunting, and Rogers. A synopsis of each inmate interview follows.

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<sup>3</sup> Positional Asphyxia is defined as a body position that interferes with one's ability to breath.

## **INMATE #1**

On March 1, 2013, at approximately 1640 hours, Detective Rogers contacted and conducted a recorded interview with Inmate #1 at the Clark County Detention Center. Inmate #1 was housed in room 3 of the mental health ward, where he met Decedent. Inmate #1 said that he was in the common area of the unit, when Decedent walked up and initiated a conversation. Inmate #1 described Decedent as "acting friendly, but high strung." Decedent then asked a corrections officer for water, but was told to walk away from the door. Decedent refused to move away and was approached by an unknown corrections officer, who physically tried to move Decedent. Inmate #1 stated that Decedent began resisting, as additional officers arrived and attempted to take Decedent to the ground. A struggle ensued between Decedent and the officers and Decedent was finally taken to the ground.

Inmate #1 then entered his cell and watched through the door window, while he made handwritten notes of his observations. Inmate #1 said that because of Decedent's large frame, the officers had difficulty putting Decedent's hands behind his back. Inmate #1 described Decedent as being extremely strong and said that Decedent threw the officers around like they were rag dolls.

Inmate #1 said that the "SERT" (Special Emergency Response Team) officer placed his knee on Decedent's neck and yelled over and over, "Stop resisting!" Although Inmate #1's cell door was closed, he said that he could hear Decedent saying, "I can't breathe, I can't breathe." Inmate #1 stated that he observed an unknown officer "rabbit punch" Decedent twice to his right side and once to his jaw in what Inmate #1 thought was an attempt to complete the handcuffing process.

Inmate #1 said that once Decedent was finally handcuffed, the officers turned Decedent over and sat him up. According to Inmate #1, Decedent seemed lifeless at that point. Inmate #1 said that an ammonia capsule was placed under Decedent's nose, but Decedent did not respond. Inmate #1 said that he heard radio traffic, "Code 99 in 2 Adam," and medical personnel responded a short time later. The responding medical personnel started chest compressions and were later relieved by paramedics. Inmate #1 stated that although Decedent was resisting and he was wrong for starting the incident, the officers didn't need to use that much force on him. Inmate #1 also stated the officers did an outstanding job.

## **INMATE #2**

On March 8, 2013, at approximately 1800 hours, Inmate #2 was contacted by Sergeant Darr while he was in-custody at City Jail. Investigative Detectives were told Inmate #2 was housed in unit 2A, room #2 during the incident. Inmate #2 had subsequently been released, arrested for another charge and transported to City Jail. Inmate #2 refused to be interviewed and stated that he did not remember the incident.

### **INMATE #3**

On Friday, March 1, 2013, at approximately 1650 hours, Detective McCarthy contacted and conducted a recorded interview with Inmate #3 at the Clark County Detention Center. Inmate #3 was housed in unit 2A, in room 2 of the mental health ward. Inmate #3 said that Decedent was transferred to the unit two hours prior to the incident. Inmate #3 stated that Decedent was housed in room 8. Inmate #3 said that he observed Decedent pounding on his door and requesting assistance for something, but Inmate #3 did not know what that something was.

At approximately 1330 hours, the inmates were let out for free time. Inmate #3 saw Decedent acting excitedly and was the first inmate to enter the day room. Inmate #3 said he left his cell for a short time and then returned back to his cell. Inmate #3 stated he saw through his cell window the officers on the ground with Decedent. Inmate #3 stated that Officer Temple was on Decedent's left side and Officer Grey was to the rear of Decedent. Inmate #3 stated that a Sergeant was present, along with Officer Dixon. Inmate #3 refused to provide any further information about the incident without a lawyer present. The process of the investigation was explained to Inmate #3 several times, but Inmate #3 refused to provide any further information.

### **INMATE #4**

On March 1, 2013, at approximately 1632 hours, Detective Merrick obtained a statement from Inmate #4 while at the Clark County Detention Center. During the interview, Inmate #4 said he was being housed in unit 2A in cell 3. At approximately 1330 hours, Inmate #4 said that they were allowed to enter the dayroom for free time. Inmate #4 said that a person, who he identified as Decedent, told everyone to sit down and he would get them some water. Decedent approached the guards and demanded water. The correction officers told Decedent to sit down multiple times.

When Decedent did not comply with the officers' demands, Inmate #4 said that four corrections officers "jumped him from behind." Inmate #4 said one of the corrections officers was dressed in "greens." Inmate #4 said the officers then tackled Decedent to the ground. Inmate #4 said that the "SERT" Officer put his knee on Decedent's back and applied a choke hold while the other correction officers were trying to handcuff Decedent.

Inmate #4 said that he heard Decedent yell, "I can't breathe." Inmate #4 then heard Decedent's "last breath" at which time all the inmates were put back in the cells. Inmate #4 said he then went into cell #4 and continued to look through his cell window. Inmate #4 said that he saw corrections officers trying to revive Decedent with "smelling salts," but they did not have any success. Inmate #4 said that medical attendants then arrived and performed "CPR" on Decedent until Las Vegas Fire department medics arrived and transported Decedent. Inmate #4 said Decedent was initially resisting the corrections officers.

## **INMATE #5**

On March 1, 2013, at approximately 1642 hours, Detective Raetz conducted a recorded interview with Inmate #5 on the second floor interview rooms at the Clark County Detention Center. Inmate #5 stated he was housed in cell 4 of unit 2A with a male, not Decedent, he called V-loc. Inmate #5 did not know V-loc's actual name. Inmate #5 stated that during free time on Monday the 25th of February, he heard a commotion and saw correction officers restraining another inmate. Inmate #5 stated he did not come out of his cell when this happened. Inmate #5 stated that the corrections officers held Decedent down on the floor, but did not punch or kick him.

## **INMATE #6**

On March 1, 2013, at approximately 1647 hours, Detective Merrick obtained a recorded statement from Inmate #6 while at the Clark County Detention Center. Inmate #6 relayed that on February 25, 2013, he was being housed in unit 2A in cell 4. At approximately 1300 hours, the inmates were allowed to enter the dayroom for free time. Inmate #6 said the person, who he identified as Decedent, was asking everyone if they needed water. Inmate #6 said that Decedent then asked the corrections officers for water.

Inmate #6 said that four corrections officers, one dressed in a green uniform, came out into the dayroom and wrestled Decedent to the ground. Inmate #6 then heard Decedent say, "I can't breathe," two times while the correction officers were on top of him. Inmate #6 stated that Decedent was resisting and the corrections officers were trying to put Decedent into handcuffs. Once Decedent was in handcuffs, the corrections officers called a medical emergency. Inmate #6 said medical personnel took Decedent out of the unit on a stretcher.

## **INMATE #7**

On March 1, 2013, at approximately 1656 hours, Detective Merrick obtained a recorded statement from Inmate #7. Inmate #7 said that on February 25, 2013, he was housed at the Clark County Detention Center in unit 2A, cell 5. In the afternoon, Inmate #7 said the inmates were allowed to enter the dayroom. Inmate #7 was at the control room asking for request forms when the correction officer asked Decedent to **step out of the red square and quit knocking on the control room window.** Inmate #7 said Decedent was moving in a funny way and Inmate #7 knew the next thing that was going to happen was that the corrections officer was going to put Decedent's hands behind his back. Inmate #7 said that Decedent was combative, and he saw four corrections officers trying to place Decedent into custody.

Inmate #7 said that he heard Decedent say, "I can't breathe, get off me." Inmate #7 was told to go back to his cell at which time he heard the medical personnel say, "I got a pulse."

#### **INMATE #8**

On March 1, 2013, at approximately 1703 hours, Detective Raetz conducted a recorded interview with Inmate #8 in one of the second floor interview rooms at the Clark County Detention Center. Inmate #8 stated he was housed in cell 5 of unit 2A with Inmate #7.

On Monday, February 25, 2013, Inmate #8 said the corrections officers had released the inmates from their cells for free time in the common room. Inmate #8 said that Decedent started giving the other inmates orders telling some where to go and others to stay where they were. Decedent asked Inmate #8 where the water was. Inmate #8 showed Decedent where to find the sink in the common area. Inmate #8 said that Decedent got "rude" with a corrections officer. The officers told everyone to go back into their cells because they were going to take Decedent to 2C (the isolation module).

The corrections officers ordered Decedent to put his hands behind his back, but Decedent refused. Inmate #8 said the officers attempted to handcuff Decedent, but he resisted. The corrections officers took Decedent to the floor. Other officers and medical staff came in a short time later and performed CPR on Decedent.

Inmate #8 said he did not see any of the corrections officers kick or punch Decedent. Inmate #8 also stated that in his opinion the corrections officers treated all of the inmates fairly. Inmate #8 further said that if Decedent would have complied with the corrections officers' orders, they would have taken him to 2C and nothing else would have happened.

#### **INMATE #9**

On March 1, 2013, at approximately 1711 hours, Detective Merrick obtained a recorded statement from Inmate #9. Inmate #9 said that on February 25, 2013, Inmate #9 was being housed at the Clark County Detention Center in unit 2A, cell 6. Inmate #9 said he was let out into the dayroom with the other inmates in 2A. Inmate #9 said the person he identified as Decedent was asking for water. Inmate #9 said he saw four corrections officers take Decedent to the ground and try to put handcuffs on him. Inmate #9 said that he heard the officers tell Decedent to relax. Inmate #9 said Decedent was resisting and there were four corrections officers who tried to put him into handcuffs. Inmate #9 said that he heard someone say, "He is playing possum." Inmate #9 said that he was told to go back to his cell and he saw a female with a hand-held video recorder recording the incident. Inmate #9 said they put Decedent on a stretcher and removed him from the unit.

## **INMATE #10**

On March 1, 2013, at approximately 1719 hours, Detective Merrick obtained a recorded statement from Inmate #10. Inmate #10 said that on February 25, 2013, he was being housed at Clark County Detention Center in unit 2A, cell 6. Inmate #10 said that Decedent was being housed in the same unit.

Inmate #10 said that he did not leave his cell but heard yelling and looked out the window and saw several corrections officers pinning Decedent to the ground.

## **INMATE #11**

On March 1, 2013, at approximately 1733 hours, Detective Raetz conducted a recorded interview with Inmate #11 in one of the second floor interview rooms at the Clark County Detention Center. Inmate #11 stated that he was housed in cell 7 of unit 2A with an inmate he did not know by name; however, he was not present during the incident because he had been to court the morning of Monday, February 25, 2013. A check of jail records showed that Inmate #11 had not been in court that morning. Detective Raetz confronted Inmate #11 with the fact that he had not been to court, and Inmate #11 stated he had a visitation with someone about court, but could not remember who the visit was with. Corrections Officer C. Pizan, P# 13864, sat in during the recorded interview.

Inmate #11 maintained he had a visitation which lasted approximately 30 minutes. Inmate #11 said that he was coming back to the housing module when the corrections officer who was escorting him held him up outside of the unit. Inmate #11 said that he saw medical personnel wheeling a person out on a gurney. He could not tell who the person was.

Detective Raetz requested jail personnel check the visitation records of Inmate #11 after the interview was completed. They were able to confirm he did have a legal visitation at 1304 hours, on February 25, 2013.

## **INMATE #12**

On March 1, 2013, at approximately 1726 hours, Detective McCarthy contacted and conducted a recorded interview with Inmate #12 at the Clark County Detention Center. Inmate #12 was housed in Unit 2A, room 7. Inmate #12 identified a photo of Decedent and stated he was in room 9, which was later determined to be room 8. Inmate #12 said that at approximately 1330 hours, the inmates were let out into the day room for free time. Decedent was saying, "I need some water, look at the water." Decedent was telling other inmates to sit down and continued talking about the water. Inmate #12 stated Decedent may have been cursing at the officers. The officers went to grab Decedent's hands and Decedent pulled his hands back away from the officers. The officers then began to struggle with Decedent. Inmate #12 said that one of the officers jumped on Decedent's back in an attempt to get

Decedent to the ground, but was unsuccessful. Inmate #12 said that Decedent told the officers to get off of him. The officers told Decedent to put his hands behind his back, but Decedent refused.

Inmate #12 stated that during the struggle with the officers, Decedent tripped over one of the officer's legs and fell to the ground face down. Inmate #12 said that Decedent still would not give the officers his hands. The officers told Decedent to give them his hands again. Inmate #12 stated that he observed an officer on each side of Decedent and another officer trying to get handcuffs on him. The officers told Decedent to stop resisting several times. One of the officers managed to get one of Decedent's hands handcuffed.

Inmate #12 stated that Officer Temple got up and unlocked the cell doors so the inmates could go back to their rooms. Inmate #12 said that he went back into his room, which was located to the south of where Decedent was lying. Inmate #12 said that he continued to watch the incident from his room. Inmate #12 stated that Officer Temple returned and assisted the other officers in handcuffing Decedent. Inmate #12 observed Officer Temple "jab" Decedent in the abdomen and face, at which time Decedent gave the officers his other hand to be handcuffed.

Inmate #12 said that he heard Decedent say, "I can't breathe" one time. Inmate #12 said that two of the officers had Decedent's feet crossed at the ankles and held toward his buttocks. Inmate #12 observed one officer who was dressed in a green uniform, who was later identified as Sgt. Aspiazu, kneeling down next to Decedent. Inmate #12 said that Sgt. Aspiazu had one knee on the right side of Decedent's abdomen. Inmate #12 believed the officers called for a code red and other officers arrived inside the unit. Inmate #12 said that when the officers attempted to get Decedent into the restraint chair, he was unconscious. Medical personnel then arrived and began CPR until Decedent was transported by medical personnel from the unit.

### **INMATE #13**

On March 1, 2013, at approximately 1735 hours, Detective Rogers contacted and conducted a taped interview with Inmate #13 at the Clark County Detention Center. Inmate #13 was housed in the mental health ward and had recently become cellmates with Decedent. Inmate #13 stated that as soon as he met Decedent he knew "there was going to be a problem." Inmate #13 said that Decedent acted very jittery and was not normal. Inmate #13 said that Decedent slept on the floor rather than on the upper bunk and kept pushing the emergency button in their cell.

Inmate #13 said that while he was trying to sleep, he heard Decedent causing a commotion in the common area of the unit. Inmate #13 said that he looked out the door window and saw several corrections officers trying to put Decedent's arms behind his back as Decedent struggled with them. Inmate #13 stated that Decedent

was resisting the corrections officers while the officers attempted to handcuff Decedent. Inmate #13 stated that the officers did not use any excessive force.

#### **INMATE #14**

On March 11, 2013, at approximately 0918 hours, Detectives McCarthy and Merrick obtained a recorded statement from Inmate #14 at his residence. During the interview, Inmate #14 said that he was in custody at the CCDC on February 25, 2013, and was housed in unit 2A, cell 9. Inmate #14 said that module 2A is the psychiatric module for CCDC. Detectives showed Inmate #14 a photo of Decedent, and he identified him as the person involved in the incident with the correction officers.

Inmate #14 said that Decedent came over to him during free time and Decedent put his hands on Inmate #14. Inmate #14 said he told one of the corrections officers that if Decedent kept putting his hands on him, they were going to have a problem. A corrections officer told Decedent three times to quit touching people. Inmate #14 said that three or four "SERT" officers came into the module and wrestled Decedent to the ground. When they did, Inmate #14 said that Decedent hit his head on the floor. One officer pulled Decedent's arm behind him and bent his wrist putting him into a wristlock. Inmate #14 said that two of the officers put their knees on Decedent's back and Inmate #14 heard Decedent say, "I can't breathe," twice. The officers kept telling Decedent to quit resisting.

Inmate #14 said that in his opinion, Decedent was not resisting because both of his hands were behind his back. Decedent was just asking for air. Inmate #14 said that "some big wig" came into the module and made all the inmates go lay face down on their bunks. Inmate #14 was at first looking out his cell window and he saw medical staff working on Decedent, including using the "shocker things" which never shocked Decedent. According to Inmate #14, the other inmates had to remain on their stomachs for 45 to 50 minutes and were not allowed to look out their cell windows.

Inmate #14 also stated he had to walk around blood on the floor all night to get water because he had no running water in his cell. Detectives reviewed the surveillance video and there was no evidence of the presence of blood on the floor. Inmate #14 also said there was no running water in his cell for the five days he was in-custody at CCDC.

#### **INMATE #15**

On March 11, 2013, at approximately 1200 hours, Inmate #15 was interviewed by Detectives McCarthy and Merrick at High Desert State Prison. Investigative Detectives were told that Inmate #15 was housed in unit 2A at the time of the incident and had since been transferred to High Desert State Prison. During the interview, Inmate #15 was unable to identify Decedent and did not recall the

incident. It was later determined that Inmate #15 was transferred prior to the incident.

### **INMATE #16**

On March 1, 2013, at approximately 1730 hours, Detective Merrick obtained a recorded statement from Inmate #16 with the assistance of Spanish translator Corrections Officer H. Rodriguez P#7629. During the interview, Reyes stated he did not remember the incident or Decedent.

### **NAPHCARE MEDICAL PERSONNEL AT CCDC INTERVIEWS:**

#### **MEDICAL PROVIDER #1**

On March 4, 2013, at approximately 0952 hours, Detective Bunting obtained a recorded statement from Medical Provider #1 at CCDC. Medical Provider #1 is the Medical Director for CCDC and has overseen all medical care provided at the facility for the last three years. Per Medical Provider #1, Decedent's medical record revealed that he was first seen at screening in booking on February 22, 2013. At that time, Decedent stated that he suffered from anxiety and was taking Xanax 2mg by mouth twice a day, as well as Zantac as needed. Decedent's blood pressure at screening was 165/105 with a heart rate of 111 (both of which were well above normal). A follow up blood pressure was 130/85 with a heart rate of 99. Medical Provider #1 explained that a normal blood pressure runs between 100/60 to 140/90 and a normal heart rate ranges from 72-100. Medical Provider #1 also stated Zantac and Xanax would have been prescribed to Decedent, if needed, upon request.

Medical Provider #1 stated that on February 25, 2013, at approximately 1300-1400 hours, he heard a "Code 99" (medical emergency) called out over the intercom system in unit 2A while he was on the ninth floor. Medical Provider #1 said that he responded to module 2A and found Decedent lying supine on the floor and CPR being administered by medical personnel. Medical Provider #1 said that he asked what had occurred and heard various unknown corrections officers report that Decedent was resistant and that he struggled with officers and fell to the ground.

Medical staff reported they started two IV's, one in each arm, and that Decedent had received a dose of Epinephrine. Medical Provider #1 observed that Decedent had no pulse, his eyes were fixed and dilated and that the AED (automated external defibrillator) reported he was in asystole (absent heart rhythm). The fire department arrived to transport Decedent and, while transferring custody, Medical Provider #1 was able to obtain a radial and a carotid pulse. Medical Provider #1 stayed with Decedent until the fire department personnel departed with Decedent to UMC. According to Medical Provider #1, Decedent weighed 250 pounds, was 5'5" and was considered morbidly obese. Medical Provider #1 did not observe any injuries on Decedent.

## **MEDICAL PROVIDER #2**

On March 4, 2013, at approximately 1031 hours, Detective Gillis, along with Sergeant Darr, conducted a recorded interview with Medical Provider #2. During the interview, Medical Provider #2 said that at the time of the incident he was conducting his routine follow-up with psych inmates near unit 2A. Medical Provider #2 said that escort Officer Dixon contacted Medical Provider #2 to request a psych evaluation on an inmate.

Medical Provider #2 stated he was outside the module, but could see an inmate inside the module who appeared restless. Medical Provider #2 later identified the inmate as Decedent and described Decedent's actions as erratic walking and not calm. Medical Provider #2 further noted that Decedent had his mouth open and appeared to be saying something that Medical Provider #2 could not hear. Medical Provider #2 said that he moved into the control center for the module and obtained Decedent's name to see if he was an existing patient. Medical Provider #2 then exited the command center in order to run Decedent's name in the computer system.

While typing in the name, Medical Provider #2 stated he heard a noise. When Medical Provider #2 turned around, he could see that correction officers were struggling with the Decedent. Medical Provider #2 stated that from his vantage point he could only see the upper half of the struggle through the window. Medical Provider #2 could tell the correction officers were having a hard time with Decedent and he remembered thinking, "Where is their back up?" Medical Provider #2 stated that he could not find Decedent in the computer system as an existing patient.

Medical Provider #2 believed he saw four officers struggling with Decedent before additional corrections officers arrived. Prior to the "crash cart" arrival, Medical Provider #2 stated that he saw a sergeant holding the inmate on his side. Medical Provider #2 further stated, after additional officers arrived, he entered the unit just a few seconds prior to the arrival of the crash cart. Medical Provider #2 looked at Decedent and could see that he was somewhat gray, but could not ascertain if he was breathing. Medical Provider #2 stated he did not observe any corrections officers hit or kick Decedent during the struggle.

While Medical Provider #2 was in the module, he said that he observed a sergeant in a green uniform holding the inmate who had his hands cuffed behind his back. Medical Provider #2 said that the sergeant was holding Decedent, by supporting him on his side by his upper body. Medical Provider #2 stated he did not remember what was being said and did not administer any emergency aid since other medical personnel had arrived with the crash cart.

## **MEDICAL PROVIDER #3**

On March 4, 2013, at approximately 1023 hours, Detective Raetz conducted a recorded interview with Medical Provider #3 on the second floor medical office at the Clark County Detention Center. Medical Provider #3 stated she was working in screening and intake in the first floor booking area when a "Code 99" was called in housing module 2A. Medical Provider #3 said she responded to 2A immediately and saw two male nurses working on an inmate when she arrived. Medical Provider #3 said she checked the subject's wrist and neck for a pulse, but did not find one. Medical Provider #3 said that Decedent was not breathing and **his face was beginning to change color**. Medical Provider #3 instructed the corrections sergeant to call 911 and to remove the handcuffs from Decedent. Medical Provider #3 said that Medical Provider #9 attached an electronic defibrillator to Decedent, but that it never administered a shock. Medical Provider #3 said that CPR was continued until the AMR ambulance crew arrived. Medical Provider #3 said that during this interval, Medical Provider #6 was able to locate a pulse in Decedent's femoral artery which was confirmed by AMR's monitor. Decedent was then transported to UMC. Medical Provider #3 said that she did not know Decedent's name. The corrections sergeant told her afterwards Decedent had been combative when they took him into custody, and he was found to be unconscious when they attempted to put him into a restraint chair.

#### **MEDICAL PROVIDER #4**

On March 1, 2013, at approximately 1608 hours, Detective Bunting obtained a recorded statement from Health Services Administrator Medical Provider #4 at the Clark County Detention Center (CCDC). Medical Provider #4 stated that she had worked at CCDC for four-and-a-half years and that she oversaw the operations of both the acute and chronic health care services at CCDC. Medical Provider #4 said that on February 25, 2013, there were eight other medical personnel who responded to the "Code 99" (medical emergency) regarding Decedent.

At approximately 1350-1355 hours, Medical Provider #4 said that she heard a "Code 99" (medical emergency) reported in 2A (Mental Health Module) over the intercom. Medical Provider #4 said she did not hear any follow up traffic in reference to the call and responded to module 2A to investigate approximately two minutes later. Upon her arrival, Medical Provider #4 said that she found Charge Nurse, Medical Provider #9, and Medical Provider #5 assessing Decedent's airway, his breathing and his circulation. According to Medical Provider #4, Medical Provider #3 entered the module just behind her. Medical Provider #4 observed Decedent lying unconscious on his back. Medical Provider #9 asked Medical Provider #4 to grab the AED from the crash cart and she, along with Medical Provider #5, applied the pads to Decedent's chest. Medical Provider #11 then arrived and started an IV in Decedent's left arm, while Medical Provider #4 started an IV in his right arm. Medical Provider #4 observed Medical Provider #5, Medical Provider #11 and Medical Provider #9 administering CPR

on Decedent. Medical Provider #4 said that the fire department then arrived and transported Decedent to UMC Hospital.

While transferring care to the fire department, Medical Provider #4 said that Medical Provider #1 and Medical Provider #9 observed that Decedent had a “rhythm” and a femoral pulse. Medical Provider #4 also recalled that Decedent had received oxygen through an “Ambu Bag,” as well as a dose of Epinephrine. Medical Provider #4 observed no signs of trauma to Decedent other than a small amount of blood on the left corner of his mouth. Medical Provider #4 said that she did not hear any comments from corrections officers or other inmates as to what had happened to Decedent.

#### **MEDICAL PROVIDER #5**

On March 4, 2013, at approximately 1019 hours, Detective Merrick obtained a recorded statement from Medical Provider #5. During the statement with Medical Provider #5, he said that he had been employed by Naphcare Medical Services as a Medical Assistant for the past seven years. On February 25, 2013, Medical Provider #5 said that at approximately 1348 hours he heard radio traffic calling “Code 99” in module 2A. Medical Provider #5 said that he responded to module 2A, which is about 100 feet from the medical facility. Medical Provider #5 said that he told Medical Provider #12 about the medical emergency and they both responded to 2A with a “crash cart.”

When Medical Provider #5 arrived at module 2A, he saw Decedent lying on the ground and Medical Provider #9 providing medical aid to him. Medical Provider #5 said that Decedent had his hands cuffed at the time. Medical Provider #9 attempted to wake the patient with smelling salts with no success. The corrections officers then took the handcuffs off Decedent and Medical Provider #9 started chest compressions. Medical Provider #5 said that he grabbed the “ambu bag” and started breathing for Decedent. Other medical staff arrived and started an IV on Decedent. Medical Provider #5 said that medical personnel also hooked up the AED machine to Decedent; however, the AED never shocked him. Medical Provider #5 said that he relieved Medical Provider #9 and continued chest compressions on Decedent. Medical Provider #5 estimated that Las Vegas Fire Rescue transported the patient between 1410 and 1415 hours. Medical Provider #5 said that he saw a corrections officer was recording the incident.

#### **MEDICAL PROVIDER #6**

On March 4, 2013, at approximately 0948 hours, Detective McCarthy conducted a taped statement with Medical Provider #6 at the Clark County Detention Center. Medical Provider #6 said that she had been employed by Naphcare Medical Services as an Assistant Health Administrator and Nurse for eleven years and had worked at CCDC for one year. Medical Provider #6 said her office was located on the second floor and down the hallway from unit 2A. Medical Provider #6 said that when she arrived in unit 2A an assistant called the “Code 99.” Medical Provider #6 said that

she saw Decedent lying on the floor. Medical Provider #6 said that Decedent's skin was purple and that he didn't appear to be breathing. Medical Provider #6 stated that the AED was already attached and CPR was in progress. Medical Provider #6 said that the AED machine was advising "no shock, continue with CPR." Medical Provider #6 explained this reading meant the heart did not have a "shockable" rhythm or that the subject was in "asystole."

Medical Provider #6 stated that the infirmary charge nurse and the north tower charge nurse were on scene, as well as the booking provider and other nurses who were CPR certified. Medical Provider #6 stated that she assessed the situation and became the recorder for the incident.

Medical Provider #6 said that she was told that Decedent was getting aggressive or agitated and the officers were attempting to put him in the restraint chair when he became unresponsive.

Medical Provider #6 said that medics from the Las Vegas Fire Department (LVFD) arrived on scene, placed Decedent on a transport gurney and connected him to a LVFD heart monitor. Once hooked to the LVFD monitor, Medical Provider #6 stated that Decedent showed a rhythm on the heart monitor. Medical Provider #6 said that she also checked Decedent and found a femoral pulse. Medical Provider #6 said that Decedent was then transported from CCDC to the hospital. Medical Provider #6 was seen and heard on camera #3 (hand-held camera) finding the femoral pulse.

#### **MEDICAL PROVIDER #7**

On March 4, 2013, at approximately 0949 hours, Detective Raetz conducted a recorded interview with Medical Provider #7 on the second floor medical office at the Clark County Detention Center. Medical Provider #7 stated she was working in the second floor medical administration offices on Monday, February 25, 2013, when someone came in and notified the supervisor of a medical emergency in housing module 2A. Medical Provider #7 said that she followed the individual to 2A since it was just down the hallway from the medical offices. Medical Provider #7 said that she observed a male subject on his back on the floor with his head toward the doorway. Medical Provider #7 said that she went directly to the subject's head and took over the operation of the "ambu bag." Medical Provider #7 said that the electronic defibrillator was already hooked up to Decedent. Medical Provider #7 said that others assisted in CPR until the ambulance crew arrived and that Decedent never regained consciousness.

#### **MEDICAL PROVIDER #8**

On March 4, 2013, at approximately 1012 hours, Sergeant Darr interviewed Medical Provider #8. Medical Provider #8 said that at the time of the incident he was returning from his lunch break and was exiting onto the second floor. Medical Provider #8 said that he saw several medical personnel inside unit 2A. Medical Provider #8 said that someone asked him to get a laptop. Medical Provider #8 retrieved the laptop, entered the unit and observed medical personnel working on Decedent. Medical Provider #8 said that he assisted by holding an IV bag which had already been connected to Decedent. Medical Provider #8 said that he held the bag until Decedent was transported to the hospital.

### **MEDICAL PROVIDER #9**

On March 4, 2013, at approximately 0952 hours, Detective Gillis, along with Sergeant Darr, conducted a recorded interview with Medical Provider #9. According to Medical Provider #9, he worked as a charge nurse at the Clark County Detention Center in 2-North Medical. At the time of the incident, Medical Provider #9 said that he saw several corrections officers in a hallway at approximately 1348 hours. Medical Provider #9 said that he heard Sergeant Neville calling him and that he also heard an emergency medical code over the intercom.

When Medical Provider #9 walked into the module 2A, he said that he observed an unresponsive male (Decedent) lying on his right side on the floor with his hands cuffed behind his back. Medical Provider #9 said that he also observed three corrections officers near a restraint chair. **Medical Provider #9 stated that he could see Decedent was breathing at that time.** Medical Provider #9 said that he performed a sternum rub while administering an ammonia inhalant, but Decedent did not respond. Medical Provider #9 said that he then noticed Decedent had "agonal" breathing, was gasping for air and began turning purple. Medical Provider #9 said that he checked for a pulse, but did not locate one. Medical Provider #9 further stated that Medical Provider #3 confirmed there was no heartbeat and Decedent was immediately placed flat on his back on a cardiac board. Medical Provider #9 said that Decedent's handcuffs were removed, CPR was immediately started and AED pads were placed on Decedent's chest.

According to Medical Provider #9, the AED evaluated Decedent four times and advised no shock was needed. The AED directed Medical Provider #9 to continue CPR. Medical Provider #9 stated that he continued to perform chest compressions and switched out with Medical Provider #5 a few times. Medical Provider #9 also said that he administered Epinephrine to Decedent's right antecubital vein and continued CPR after the first evaluation by the AED. Medical Provider #9 said that Medical Provider #6 administered a second vial of Epinephrine, after the second IV was established. Medical Provider #9 stated he continued CPR until the arrival of paramedics, who took over the patient care. Medical Provider #9 said that the new medical personnel were able to locate a femoral pulse after which they discontinued CPR. Medical Provider #9 said that he did not observe any injuries to Decedent.

### **MEDICAL PROVIDER #10**

On March 4, 2013, at approximately 1009 hours, Detective Raetz conducted a recorded interview with Medical Provider #10 on the second floor medical office at the Clark County Detention Center. Medical Provider #10 stated she was on the fifth floor distributing medication when she heard a "Code 99" called out over a corrections officer's radio. The "Code 99" was not cleared after a few minutes so Medical Provider #10 responded to housing module 2A on the second floor. Medical Provider #10 said that she observed medical staff performing CPR on Decedent when she arrived. Medical Provider #10 said that she retrieved a computer from the second floor medical offices and looked up Decedent's medical records to identify what medications he was taking. Medical Provider #10 said that she did not remember the subject's name at the time of the interview, but that she had looked up the name she was told at the time.

Medical Provider #10 said that the ambulance crew arrived two to three minutes later and they loaded Decedent onto a gurney. Medical Provider #10 said that the medical personnel were able to locate a pulse in the subject's femoral artery and that the monitor from the ambulance confirmed that a pulse was present.

### **MEDICAL PROVIDER #11**

On March 4, 2013, at approximately 1013 hours, Detective McCarthy contacted and conducted a taped interview with Medical Provider #11 at the Clark County Detention Center. Medical Provider #11 said that he was employed as a nurse with Naphcare and worked at CCDC. Medical Provider #11 said that on the incident day, he was working in pre-booking when he heard a "Code 99" called in unit 2A. Medical Provider #11 said that he responded to unit 2A and saw other medical personnel performing CPR on Decedent. Medical Provider #11 said that he started an IV and took over chest compressions until firefighter paramedics arrived. Medical Provider #11 said that he and firefighter paramedics continued CPR by taking turns until Decedent had a pulse. Decedent was then transported to the Hospital. Medical Provider #11 said that he did not know what happened and only overheard that Decedent was involved in a fight with officers or another inmate.

### **MEDICAL PROVIDER #12**

On March 4, 2013, at approximately 1016 hours, Detective Gillis conducted a recorded interview with Medical Provider #12. According to Medical Provider #12, he was at his desk when he heard the emergency medical code. Medical Provider #12 said that he responded, along with another health professional, to module 2A. When Medical Provider #12 arrived, he noticed a nurse was already there and that Decedent was on the ground with his hands handcuffed and corrections officers around him. Medical Provider #12 said he assisted in attempting to locate a pulse and then assisted with CPR. Medical Provider #12 stated that Decedent's handcuffs were removed prior to starting CPR and that an AED was applied. Medical Provider

#12 further stated he assisted with bagging Decedent and rotated compressions with the other health professionals.

Medical Provider #12 said that they continued CPR until they got a pulse and the Fire Department arrived. Medical Provider #12 further stated that he did not observe any injuries to inmate Decedent.

### **MEDICAL PROVIDER #13**

On March 6, 2013, Detectives McCarthy and Merrick contacted Medical Provider #13 at her residence. Medical Provider #13 is employed by Naphcare as a psych nurse. Medical Provider #13 said that she has been a nurse since 1979 and works part time at CCDC. Medical Provider #13 said that she was called to Unit 2L to evaluate Decedent on February 25, 2013. When she arrived in the unit Decedent was handcuffed and seated in a chair. The officers working in the unit told Medical Provider #13 that Decedent would not sit still nor would he lay down. Decedent was described as getting up and down on his bed and the officers were having a difficult time with him. Medical Provider #13 asked Decedent why he was getting up and down. Medical Provider #13 said that Decedent did not understand why she was there or why the officers were there. Medical Provider #13 said that Decedent's behavior was "bizarre." Medical Provider #13 recommended that Decedent be put in the psychiatric evaluation unit, located in unit 2A for further evaluation.

### **CORRECTIONS OFFICER/SERGEANTS RECORDED INTERVIEWS:**

#### **Officer Gabriel Munoz P# 7137 - Relieved Involved Officers**

On March 4, 2013, at approximately 1326 hours, Detectives Merrick and McCarthy obtained a recorded statement from Correction Officer G. Munoz P#7137. The statement was obtained after Officer Munoz was afforded the protections of the *Garrity*<sup>4</sup> decision. During the statement, Officer Munoz stated that he was in his office on the second floor of CCDC when he heard Sgt. Aspiazu request a restraint chair over the radio. Officer Munoz said that he could tell that an incident had occurred because Sgt. Aspiazu was out of breath on the radio. Officer Munoz said that he responded to module 2A with other corrections officers. When Officer Munoz arrived, he said that the outer slider door was closed to module 2A. He pushed the button and Control opened the sliding door to the module.

Officer Munoz said that he was the first one to arrive and he saw Sgt. Aspiazu, Officers Dixon and Gray restraining Decedent with Officer Temple standing behind them. Decedent was handcuffed on the ground and the officers were breathing heavily. Sgt. Aspiazu asked Officer Munoz to relieve him and Officer Munoz relieved

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<sup>4</sup> *Garrity v. State of New Jersey*, 385 U.S. 493, 87 S. Ct. 616 (1967)(The United States Supreme Court held that the statement of a police officer that is compelled as a condition of his employment cannot be used against that officer for any purpose in a criminal matter).

Sgt. Aspiazu. When Officer Munoz took control of Decedent's arm, Sgt. Aspiazu told him to be careful because Decedent was strong.

Officer Munoz said that the restraint chair arrived and the plan was to roll Decedent towards Officer Munoz and to sit him up into the restraint chair. When the officers tried to sit Decedent up, Officer Munoz looked at him and noticed he was unconscious. Officer Munoz said that he told Sgt. Aspiazu that "he is out, he is out." Officer Munoz then placed Decedent on his side and Officer Munoz told Officer Kapp to perform a "sternum rub."<sup>5</sup> Decedent did not respond so Officer Munoz told Officer Kapp to "do it again." Sgt. Aspiazu then called a "Code 99" over the radio. Medical responded from across the hall and took control of Decedent. The officers took the handcuffs off Decedent and the medical personnel started medical intervention.

Officer Munoz said that he told Officer Bioko to start a script (major incident log), so they would know who was on scene and what time the Code 99 was called. Officer Munoz also said he told Officer Bioko what to write down and what times to write down. Officer Munoz said that medical was performing CPR on Decedent and had him hooked up to the AED. Officer Munoz said that Sgt. Aspiazu called for medical to respond to CCDC, Code 3 and a few minutes later Officer Munoz started to perform chest compressions.

Officer Munoz said that medical staff relieved him from performing chest compressions when LVFD arrived at the module. Officer Munoz said that medical staff then briefed LVFD and LVFD hooked Decedent up to their machine and found a pulse. Officer Munoz said that LVFD placed Decedent on a gurney and that a female nurse also found a pulse before LVFD transported the inmate from the module.

#### **Officer Gregory Kapp P# 8858 - Relieved Involved Officers**

On March 4, 2013, at approximately 1355 hours, Detectives McCarthy and Merrick conducted a recorded interview with Officer Kapp P#8858 at the Clark County Detention Center. The statement was obtained after Officer Kapp was afforded the protections of the *Garrity* decision.

Officer Kapp stated that he was on the second floor in the South Tower when he heard, over the radio, a request by Sgt. Aspiazu for a restraint chair, video camera and movement officers to report to unit 2A. Officer Kapp said he responded to unit 2A and when the module door opened, he saw Officers Temple and Dixon

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<sup>5</sup> When assessing a patient who is not alert and does not respond to verbal stimuli, a painful stimulus may be applied to the body. The sternal rub is the most common stimulus practiced out in the field, in fact the most common painful stimulus applied to a patient in the prehospital setting is the sternal rub. To perform the procedure, the sternum is rubbed vigorously with the knuckles of a closed fist to create pain. This technique is often performed for only a few seconds while watching for a reaction from the patient. If there is no response within a few seconds of stimulation, one would assume that the patient is unresponsive and the brain's integrity is compromised.

restraining Decedent who was lying face down in the day room. Sgt. Aspiazu had his knee on Decedent's back holding Decedent down, Officer Temple was on Decedent's right side and Officer Dixon was holding Decedent's legs. Officer Kapp said he did not remember seeing Officer Gray.

Officer Kapp said that Sgt. Aspiazu told him that they had to fight with Decedent and at one point they had lifted him up. Officer Kapp said that he took Officer Temple's position and grabbed Decedent's wrist. Decedent was already handcuffed. Officer Munoz replaced Sgt. Aspiazu's position and Officer Redmond replaced Officer Dixon's position.

Officer Kapp said that the restraint chair arrived and Sgt. Aspiazu requested Decedent be placed in the restraint chair. Officer Kapp said that when he went to move Decedent, he realized that Decedent was limp and appeared grayish-bluish in color. Sgt. Aspiazu called a "Code 99" over his radio. Officer Kapp said that medical personnel arrived and determined Decedent had no pulse and was not breathing. Decedent's handcuffs were then removed and he was placed on his back. Officer Kapp said that medical personnel started CPR and continued it until Las Vegas Fire medics arrived and transported Decedent.

**Officer Kapp is seen on the left side of the photo performing a sternum rub on Decedent's chest prior to medical personnel arriving.**



### **Officer Barry Redmond P# 7980 - Relieved Involved Officers**

On March 4, 2013, at approximately 1410 hours, Detectives McCarthy and Merrick conducted a recorded interview with Officer Redmond P# 7980 at CCDC. The statement was obtained after Officer Redmond was afforded the protections of the *Garrity* decision.

Officer Redmond stated he heard over the radio a request for a restraint chair in unit 2A. Officer Redmond explained that when a restraint chair is requested it's an emergency situation. Officer Redmond said that he immediately responded to unit 2A and when the module door opened into the day room he saw Sgt. Aspiazu and other officers detaining Decedent on the floor. Officer Redmond said that he saw Decedent was handcuffed with two pairs of handcuffs which were linked together. Officer Redmond stated Decedent was still struggling so he grabbed Decedent's feet to keep Decedent from kicking. Decedent attempted to kick Officer Redmond off of him soon after Redmond grabbed his feet. Officer Redmond said that the restraint chair arrived and Sergeant Trotter brought the hand-held camera.

Officer Redmond stated that medical personnel arrived a short time later and Decedent was unresponsive so the medical personnel started CPR. Officer Redmond said that he took the hand held camera from Sergeant Trotter and continued to videotape the situation until Decedent was loaded into the ambulance by Las Vegas Fire medics to be transported to UMC.

### **Sergeant Vashon Trotter P# 7972 - Had Hand Held Recorder**

On March 4, 2013, at approximately 1252 hours, Detectives McCarthy and Merrick obtained a recorded statement from Sergeant V. Trotter, P#7972. The statement was obtained after Sgt. Trotter was afforded the protections of the *Garrity* decision.

On February 25<sup>th</sup>, 2013, Sgt. Trotter was working as a corrections sergeant on the 5<sup>th</sup> floor of the Detention Center. At approximately 1348 hours, a call went out over the radio system requesting a restraint chair in module 2A. Sgt. Trotter said that she grabbed a restraint chair and a hand-held video recorder and responded to module 2A. When Sgt. Trotter arrived at 2A, she said that she activated the hand-held video recorder and started recording the incident. Sgt. Trotter said she saw four officers engaged with Decedent on the floor of the dayroom. Sgt. Trotter observed that each officer had control of one of Decedent's limbs. Sgt. Trotter said that Officer Dixon was getting up off the floor while Sgt. Aspiazu was holding Decedent's left arm. Sgt. Trotter said that Sgt. Aspiazu said, "Cuff him" and someone else said, "He is out." Sgt. Trotter said that Sgt. Aspiazu then called a "Code 99" over the radio system. Sgt. Trotter said that she also heard someone say, "Give him a sternum rub" and, "Is he playing possum?"

Sgt. Trotter said that medical personnel responded very quickly because they were located on the same floor, just down the hall. Sgt. Trotter said that Officer Munoz started chest compressions and was relieved by medical staff. While Sgt. Trotter was recording, she said she was giving instructions to the officers to go with medical to the hospital. Sgt. Trotter then gave the video recorder to Officer Redman and continued to give instructions to other officers.

#### **Officer Jim Batu P# 13616**

On March 4, 2013, at approximately 1430 hours, Detectives McCarthy and Merrick conducted a recorded interview with Officer Jim Batu P#13616 at the Clark County Detention Center. The statement was obtained after Officer Batu was afforded the protections of the *Garrity* decision.

Officer Batu stated that he was on the 5<sup>th</sup> floor talking with Sergeant Trotter when he heard a commotion on the radio. Officer Batu said that the radio traffic continued, but it was unclear what was happening. Officer Batu said that he heard unit 2ABG but could not understand what was being relayed on the radio. Sergeant Trotter instructed him to grab the restraint chair as she grabbed the video camera (Camera #3). Officer Batu said that Sgt. Trotter and he responded to unit 2A. Officer Batu said that he left the restraint chair outside the unit because he saw that one was already in place inside the unit. When Officer Batu entered the unit, he said he saw that Decedent was on the floor and he appeared to be passed out. Officer Batu observed that Decedent was not handcuffed. Officer Batu said he remembered seeing Officers Temple, Munoz, and Sgt. Aspiazu near Decedent. A "Code 99" was called and medical personnel arrived and began CPR. Officer Batu stated he was then assigned to another post and he left the unit.

#### **Officer Jeanette Miranda P# 8351**

On March 4, 2013, at approximately 1500 hours, Detectives McCarthy and Merrick conducted a recorded interview with Officer Miranda P# 8351 at the Clark County Detention Center. The statement was obtained after Officer Miranda was afforded the protections of the *Garrity* decision.

Officer Miranda said that she was working as a movement officer when she heard a request for a restraint chair to respond to unit 2A. A short time later, Officer Miranda heard "Code 99" called in unit 2A. By the time Officer Miranda got to unit 2A, medical personnel had already responded and were performing CPR.

#### **Officer Ted Ragone P# 5926**

On March 4<sup>th</sup>, 2013, at approximately 1340 hours, Detectives Rogers and Bunting contacted and conducted a taped interview with Corrections Officer Ted Ragone P# 5926 at the Clark County Detention Center. The statement was obtained after Officer Ragone was afforded the protections of the *Garrity* decision.

On the incident day, Officer Ragone was working at his desk as a classifications officer. Officer Ragone said that he was apprised of an incident at 2A and he responded to the module with other corrections officers from his office. Upon his arrival, Officer Ragone said that he saw SERT Sgt. Aspiazu, as well as uniform corrections officers Dixon, and Temple trying to restrain a prone male inmate (Decedent) on the floor. Officer Ragone stated he never witnessed any officers using excessive force. Sgt. Aspiazu called a "Code 99" over the radio, as another unknown officer requested the "restraint chair."

Sgt. Aspiazu later told Officer Ragone that Decedent was acting erratically and was not complying with commands. Officer Ragone said that he was told that Decedent refused to be locked down in his cell and tried to enter their office. Officer Ragone also said that Sgt. Aspiazu told him that Decedent was ordered to put his hands behind his back, but he refused and a struggle ensued. Sgt. Aspiazu also commented that Decedent was extremely strong.

Since Decedent had already been handcuffed, he was moved to a sitting position. Officer Ragone heard Decedent make a snoring sound although he seemed to be unconscious. Officer Ragone said that medical personnel assigned to the detention center responded and initiated life-saving measures. Fire department paramedics later arrived and took over medical intervention and subsequently transported Decedent to the hospital.

#### **Officer Matthew Catalano P# 8230**

On March 4, 2013, at approximately 1305 hours, Detectives Rogers and Bunting contacted and conducted a taped interview with Corrections Officer Matthew Catalano P# 8230 at the Clark County Detention Center. The statement was obtained after Officer Catalano was afforded the protections of the *Garrity* decision.

On the incident day, Officer Catalano was also working at his desk as a classifications officer. Officer Catalano said that he was apprised of an incident in 2A and he responded to the module along with other corrections officers from his office. Upon his arrival, Officer Catalano said that he saw SERT Sgt. Aspiazu, as well as uniform Corrections Officers Gray, Dixon, and Temple, trying to restrain Decedent on the floor. Officer Catalano said that the officers he saw were attempting to place two sets of handcuffs on Decedent, who struggled with them the entire time. Officer Catalano said that he wasn't sure what each officer was doing at the time, but he did not believe any officer was using excessive force. Officer Catalano then began looking for an unknown officer's set of missing keys when medical personnel arrived. Officer Catalano left the module prior to the arrival of paramedics.

#### **Sergeant Trevor Neville P# 7141**

On March 4, 2013, at approximately 1349 hours, Detectives Raetz and Gillis conducted a recorded interview with Corrections Sgt. T. Neville P# 7141. The statement was obtained after Sgt. Neville was afforded the protections of the *Garrity* decision.

Sgt. Neville stated that he was in the Classification/Intelligence Offices on the second floor of CCDC when he was notified by one of the Gang Intelligence Officers of an issue in housing module 2A where the “psych” inmates were housed. Sgt. Neville said that he responded to 2A with Officers Munoz, Ragone and Catalano. Sgt. Neville said that he saw corrections officers on the floor of the day room (common area) with Decedent when he arrived in 2A. Sgt. Neville said that the other inmates were in their individual cells; however, Sgt. Neville heard the shower running and went into the shower area to secure an inmate for safety purposes. Sgt. Neville said that he helped put the inmate from the shower into his cell and returned to the day room where Sgt. Aspiazu, Officers Dixon and Temple were still restraining the inmate on the floor. Sgt. Neville said that Decedent was wearing two sets of handcuffs because of his large build. Sgt. Neville said that he did not remember what positions the officers were in around Decedent; however, he did state they were all positioned according to how the department had taught them in situations like this. Sgt. Neville said that he also heard the officers warning other officers taking their places around Decedent to be careful because Decedent was very strong and still struggling.

Sgt. Neville stated that he saw the officers attempt to sit Decedent up and observed that Decedent was unconscious. Sgt. Neville told them to call a “Code 99.” Sgt. Neville said that medical staff arrived within one minute and he saw Sgt. Aspiazu perform a sternum rub on Decedent in an attempt to wake him. Decedent did not respond. Sgt. Neville said that Medical Provider #9 broke an ammonia capsule and waved it under Decedent’s nose, but this did not revive him. Sgt. Neville said that Medical Provider #9 then began to perform CPR.

Sgt. Neville said that he did not see anyone hit or kick Decedent, nor did he see any injuries on him other than “a little” blood on his lower lip when they sat him up.

#### **Officer Alexander Gonzalez P# 6188**

Detectives Raetz and Gillis conducted a recorded interview with Corrections Officer A. Gonzalez, P# 6188, at approximately 1303 hours on Monday, March 04, 2013. The statement was obtained after Officer Gonzalez was afforded the protections of the *Garrity* decision.

Corrections Officer Gonzalez stated that he was in the Classification/Intelligence Office on the second floor of CCDC when he heard a broadcast of a struggle with an inmate in housing module 2A on the same floor. Officer Gonzalez said that he could not remember if the broadcast came over the radio or the intercom system. Officer Gonzalez said that he responded to 2A with Corrections Officers Gabe Munoz, Ted Ragone, and Matthew Catalano. Upon arrival, Officer Gonzales said that he saw

Corrections Sgt. Aspiazu and Corrections Officers Temple and Dixon struggling to restrain a large Hispanic male (Decedent) on the floor of the common area of the module. Officer Gonzalez said that Sgt. Aspiazu was kneeling near Decedent's head issuing commands and telling him to comply and that officers Temple and Dixon were trying to control Decedent's arms. Officer Gonzalez said that Officer Dixon stood up when everyone came in and was unsteady on his feet as he did so. Officer Gonzalez described Dixon as being "woozy."

Officer Gonzalez said that he heard the shower running so he went to the shower to secure whatever inmate was in there for safety reasons. The inmate in the shower was assigned to cell 1, so Gonzalez escorted him to his cell. Officer Gonzalez said that he learned that Officer Dixon had lost his jail keys during the struggle. Officer Gonzalez and another Corrections Officer then searched the inmate and cell 1 for the keys. Officer Gonzales said that he later learned the keys had been picked up by another officer.

Officer Gonzalez said that he left the module when medical staff and other corrections officers arrived. Officer Gonzalez said that he did not see Dixon, Temple or Aspiazu hit or kick Decedent, nor did he see any injuries on Decedent.

### **Sergeant Michael Murphy P# 4449**

On March 18, 2013, at approximately 1214 hours, Detectives McCarthy and Merrick obtained a recorded statement from Sergeant M. Murphy P#4449.

On February 25, 2013, Sgt. Murphy said that Sgt. Aspiazu called over the radio for assistance. Sgt. Murphy said he felt by the tone of Sgt. Aspiazu's voice it was an emergency. Sgt. Murphy recalled that most of the free officers at CCDC responded to module 2A.

Sgt. Murphy said that when he arrived at module 2A, from the 9<sup>th</sup> floor, he saw Decedent lying on the floor in handcuffs and he was not responding to verbal commands. Someone called "Code 99" at that time and medical personnel responded to the module. Sgt. Murphy said that medical personnel assessed the situation and officers removed the handcuffs from Decedent. Sgt. Murphy said that medical personnel then started and continued CPR until Decedent was transported by the Las Vegas City Fire Department. Sergeant Murphy said that he then directed his attention to arranging to have corrections officers ride to the hospital with Decedent.

### **Sergeant Kimberly Brodeur P# 6665**

On March 26, 2013, at approximately 1300 hours, Detectives McCarthy and Gillis obtained a recorded statement from Sergeant K. Brodeur P#6665. The statement was obtained after Sgt. Brodeur was afforded the protections of the *Garrity* decision.

On February 25, 2013, Sgt. Brodeur said that she was on the third floor of the North Tower when she heard Sgt. Aspiazu call over the radio for a restraint chair. Shortly thereafter, Sgt. Aspiazu called a "Code 99." Sgt. Brodeur said that she responded to unit 2A and upon arrival she observed medical staff from within the jail attending to Decedent. Sgt. Brodeur said that she saw Officer Temple stand up from the floor and described Officer Temple as being "stressed" and that his demeanor appeared different. Sgt. Brodeur said that she learned that Decedent was attempting to go into the 2A control room and that he was agitated. During the ensuing struggle with officers, Decedent apparently lifted Sgt. Aspiazu up and Decedent was then taken to the ground. Sgt. Brodeur said that she observed Sgt. Trotter videotaping the incident with a hand-held video camera (Camera #3). Sgt. Brodeur said that LVFD arrived and Decedent was transported to the hospital. Sgt. Brodeur said that she then coordinated efforts to have correction personnel sent to the hospital with Decedent.

#### **Sergeant Robert Burleson P# 8115**

On March 4, 2013, at approximately 1444 hours, Detectives Gillis and Raetz along with Lieutenant Faulis P#4764, conducted a recorded interview with Sergeant Burleson P# 8115. The statement was obtained after Sgt. Burleson was afforded the protections of the *Garrity* decision.

According to Sgt. Burleson, while in the Booking Sergeant's Office, he heard a call on the radio for assistance. Sgt. Burleson said that he responded along with Sgt. Williams and Officer Redmond. While responding, Sgt. Williams said that he grabbed a restraint chair by 2 North medical and then went to module 2A.

Sgt. Burleson said that when he entered 2A, he saw that Sgt. Aspiazu and a couple of other officers had Decedent down on the ground. Sgt. Burleson said that he also saw several additional officers responding to the area and Sergeant Williams push the restraint chair up near the officers and Decedent.

Sgt. Burleson said that Sgt. Murphy informed him that there was a set of keys missing, so Sgt. Burleson left the immediate vicinity to deal with the missing keys because he thought the situation with Decedent was under control. Sgt. Burleson said that he assisted with the inmate who was in the shower, as well as a strip search of that inmate because they were looking for the missing keys.

Sgt. Burleson said that another officer located the keys on the ground and recovered them. Sgt. Burleson said that he heard officers asking for the chair and then heard a call for an emergency medical response. Sgt. Burleson said that he saw medical

personnel respond and start CPR. Sgt. Burleson stated LVFD personnel also responded and transported Decedent.

**Sergeant Nick Mowery, P# 5917**

On March 4, 2013, Detectives Raetz and Gillis spoke with Corrections Sergeant N. Mowery, P# 5917. The statement was obtained after Sgt. Mowery was afforded the protections of the *Garrity* decision.

Sgt. Mowery stated that he arrived in housing module 2A after medical staff had already arrived and the initial corrections officers and sergeant involved had been removed from the scene.

**Sergeant Mario Rodriguez, P# 5751**

On Monday, March 4, 2013, Detectives Raetz and Gillis spoke with Corrections Sergeant M. Rodriguez, P# 5751. The statement was obtained after Sgt. Rodriguez was afforded the protections of the *Garrity* decision.

Sgt. Rodriguez stated that he arrived in housing module 2A after medical staff had already arrived and the hand-held video camera was already in use.

**Officer Anthony Bioko, P# 9070**

On March 4, 2013, approximately 1410 hours, Detectives Bunting and Rogers interviewed Corrections Officer Anthony Bioko P#9070 at CCDC. PPA Representative Scott Nicholas P#6676 was present during the interview. After speaking with Officer Bioko, it was determined a recorded interview was not necessary, because he arrived after medical personnel began intervention. Officer Bioko recorded a log of those individuals who responded to unit 2A and was not present during the initial incident.

**Officer Jacob Williams, P# 9422**

On March 4, 2013, approximately 1439 hours, Detectives Bunting and Rogers interviewed Corrections Officer Jacob Williams P# 9422 at CCDC. The statement was obtained after Officer Williams was afforded the protections of the *Garrity* decision.

Officer Williams stated that on February 25, 2013, he was assigned as a movement officer and was to respond to calls for service and transport inmates along with other miscellaneous duties. While performing his duties in the south tower on the 5<sup>th</sup> floor, Officer Williams said that he heard radio traffic requesting that two movement officers respond to module 2A in north tower.

Upon his arrival, Officer Williams said he observed that both doors to the module were open and a heavy set, Asian/Pacific Islander male inmate (Decedent) was being rolled over onto his left shoulder by Sgt. Aspiazu and other unknown officers. Officer Williams said that he did not observe any injuries on Decedent, except a "little" blood in his mouth. Officer Williams said that he never observed any officers using excessive force. Officer Williams did say that he heard that Decedent was non-compliant and was fighting with the officers.

Officer Williams said that he was in the module for approximately two minutes when he was asked to escort AMR to their location. Officer Williams said that he observed medical personnel respond and shake Decedent, as well as place a stethoscope on him.

Officer Williams said that he observed Sgts. : Aspiazu, Rodriguez, Burleson, Mowery, Officers Kapp, Gray, Dixon, Miranda, Temple and Munoz all inside the module, but couldn't recall when they arrived. Officer Williams said that he overheard officers state that Decedent was not following instructions, but couldn't recall who made these statements.

#### **Sergeant Steven Williams Jr. P# 7127**

On March 4, 2013, at approximately 1327 hours, Detectives Gillis and Raetz, along with Lieutenant John Faulis Jr. P# 4764, conducted a recorded interview with Corrections Sergeant Williams P# 7127. The statement was obtained after Sgt. Williams was afforded the protections of the *Garrity* decision.

According to Sgt. Williams, he was working in the booking area as a booking sergeant, when he heard a commotion on the radio, which sounded like a struggle. Sgt. Williams said that he looked at his radio display and saw that the last unit that transmitted was (21N) 21 North. Sgt. Williams said that he grabbed two corrections officers who were also working in booking and headed toward stairwell seven. While in the stairwell, Sgt. Williams said that he heard on the radio Sgt. Aspiazu ask for a restraint chair along with backup officers. Sgt. Williams said that he exited the stairwell on level two where he grabbed a restraint chair and pushed it into 2A.

Sgt. Williams said that when he entered 2A, he observed Decedent on the ground already in handcuffs. Sgt. Williams said that Sgt. Aspiazu, Officers Gray, Temple and Dixon were with Decedent. Sgt. Williams said that he also observed Officer Munoz and Sgts. Neville and Long in the Module. Sgt. Williams noted that Decedent was on his stomach, by rooms 1 and 2, with his head facing toward the doors of 2A.

Sgt. Williams stated that Decedent was still actively moving and struggling with Sgt. Aspiazu and that Sgt. Aspiazu and another officer had their knees across the shoulder blades of Decedent as corrections officers are trained to do. Sgt. Williams stated that he could hear Sgt. Aspiazu yelling, "Stop resisting."

Sgt. Williams stated that he then saw other officers, who had just arrived, start rotating out Sgt. Aspiazu, as well as the other officers who had been in the struggle. Sgt. Williams told Sgt. Aspiazu to rotate Redmond out with the officer who was currently on Decedent's legs. The decision was made to place Decedent into the restraint chair. Sgt. Williams said that Sgt. Aspiazu began to give Decedent verbal commands on how they were going to pick him up. As officers attempted to raise Decedent up, rolling him on his side, they noticed he was limp. Sgt. Williams said that Decedent was then placed back onto the floor and Sgt. Williams believed Sgt. Aspiazu attempted to perform a sternum rub on Decedent. When Decedent did not respond, a "Ccode 99" was called.

Sgt. Williams stated that he told Sgt. Aspiazu to call for an ambulance and to have Officer Jacob Williams meet the ambulance in the transfer/release area. Sgt. Williams further stated he had Officers Dixon, Temple and Gray go to the Sergeant's Office and told them he would meet them to talk in a few minutes.

Sgt. Williams said that when medical arrived and determined they needed to begin CPR, Decedent was taken out of handcuffs. Sgt. Williams stated that at no time did he see any corrections officer strike or kick Decedent. Sgt. Williams further stated that he did not observe any injuries to Decedent. Sgt. Williams said that his focus then moved to locating a set of jail keys, which had been misplaced during the incident. Sgt. Williams said that the keys subsequently were located and he then went back to caring for the officers who had been injured during the incident with Decedent.

### **Sergeant Gary Long P# 5909**

On March 4, 2013, at approximately 1409 hours, Detectives Gillis and Raetz along with Lieutenant Faulis P#4764, conducted a recorded interview with Corrections Sergeant Gary Long P#5909. The statement was obtained after Sgt. Long was afforded the protections of the *Garrity* decision.

According to Sgt. Long, he was in the Sergeant's office when he heard a radio call from Sgt. Aspiazu, asking for movement officers along with an inmate restraint chair and camera to be brought to his location. Sgt. Long stated that he could tell by Sgt. Aspiazu's voice that something was going on because there was a sense of urgency. Sgt. Long stated that he got up and ran to module 2A where he saw Decedent laying on the floor face down, in what he described as the felony prone position. Sgt. Long further described Decedent as having his legs crossed, ankles up toward his buttocks and restrained in what he believed were two sets of handcuffs. Sgt. Long noted that Officers Dixon and Gray were on Decedent's legs and Officer Temple was on one shoulder area with Sgt. Aspiazu bent over with a hand on Decedent.

Sgt. Long noted several additional officers were arriving and it appeared to him Decedent was still moving his legs. Sgt. Long said that Decedent was not verbal, but

was moving as Sgt. Aspiazu began to assess him. Sgt. Long said that arriving officers then began to relieve the officers currently restraining Decedent on the floor.

Sgt. Long described the officers who were relieved as being expended from the struggle; they were replaced one at a time. As the officers involved in the struggle would stand up, Sgt. Long noted a few of them almost fell over from exhaustion. Sgt. Long said that he had to help Officer Dixon to keep him from falling onto the floor, and that he had to help Officer Dixon walk over to the wall. Sgt. Long said that as he was assisting Officer Gray, who was wobbly after being relieved, the video camera arrived.

Sgt. Long stated that Sgt. Aspiazu directed officers to reposition Decedent and to roll him over to his buttock so he could be placed into the inmate restraint chair. As officers attempted to sit Decedent up, Sgt. Long heard what he described as air coming out of Decedent as a “snore type” noise. Sgt. Long said that Decedent was immediately evaluated and they determined Decedent was not breathing. Sgt. Long said that an emergency code was called for medical to respond.

Sgt. Long noted that the medical staff station was only about 150 feet down the hall on the second floor. Sgt. Long said that Decedent was placed supine onto his back and his handcuffs were removed. Sgt. Long estimated that the medical staff arrived in seconds and that they placed an AED (Automatic External Defibrillator) on Decedent and started CPR. Sgt. Long said that he believed Sgt. Aspiazu called for an ambulance and that jail medical rendered assistance until LVFD arrived to transport Decedent. After LVFD transported Decedent, Sgt. Long assisted with locating misplaced jail keys.

### **III. FOLLOW-UP INVESTIGATION:**

#### **A. PREVIOUS INCIDENTS AT CCDC INVOLVING DECEDENT**

- **LVMPD Detention Services Division Incident Details Report authored by Correction Officer Tarver P#12837.**

The date and time of the report was February 25, 2013, at 0121 hours. The incident report detailed that Decedent was told he would receive a 24 hour lockdown for talking after he was briefed and instructed to stop talking during lights out. Per the report, Decedent acknowledged this instruction without further incident. This documentation occurred while Decedent was housed in Unit 2L.

- **LVMPD Detection Services Division Incident Details Report authored by Correction Officer Dye P#13598.**

The date and time of the report was February 25, 2013, at 1010 hours. The incident report stated that Decedent refused to follow the directions given to him by Officer

Dye. Decedent was disturbing the module and was moved from his bunk in unit 2L to the multi-purpose room for not following instructions. Decedent was asked by Officer Dye to come to the officer's desk, and Decedent approached him in an "aggressive manner" and crossed control lines on the unit's floor. Officer Dye handcuffed Decedent, notified psych services and psych services nurse responded to the unit. After the psych nurse evaluated Decedent, she determined that Decedent needed to be transferred from his current unit to one where he would receive a psychological review. Decedent was then transferred to Unit 2A.

## **B. INCIDENT OF FEBRUARY 26, 2013, AT CCDC INVOLVING DECEDENT**

Sergeant Aspiazu, and Officers Temple, Dixon and Gray did not provide any statements about the incident to investigators following the events of February 26, 2013. Sgt. Aspiazu did, however, author a division incident details report about the February 26, 2013, incident prior to Decedent's death and before the ensuing investigation took place. That report is detailed below.

- **LVMPD Detention Services Division Incident Details Report authored by Corrections Sergeant Aspiazu P# 7117.**

The date and time of the report was February 26, 2013, at 0726 hours, and had log #405401. The details of the report, according to Sgt. Aspiazu, stated that Sgt. Aspiazu was called by Officer Temple to come into unit 2A because there was an inmate in the module acting erratically and he would not go back to his room.

Sgt. Aspiazu stated that he entered the module and saw Decedent at the door pacing back and forth and pointing at the sally port door. Sgt. Aspiazu said that he opened the module door, and Decedent attempted to enter the module office. Sgt. Aspiazu said he instructed Decedent to step back from the door, which he did. Sgt. Aspiazu said that Decedent said, "Let me out, I need to talk to you about the water right now." Sgt. Aspiazu said that he told Decedent to go to his room and they would talk about it and Decedent refused. Sgt. Aspiazu said that Decedent yelled, "Let me out of this fucking door" pointing at the sally port door. Sgt. Aspiazu said he told Decedent he couldn't do that, to just go to his room and Sgt. Aspiazu would talk to him. Decedent said, "Fuck that! I'm not going anywhere!"

At this point, Sgt. Aspiazu said that he stepped toward Decedent's right arm and instructed him to put his hands behind his back. Sgt. Aspiazu said that he reached for Decedent's right hand to place him in handcuffs, but Decedent pulled away. Sgt. Aspiazu said that he and Officer Temple then attempted to get Decedent into handcuffs with officers Temple, Grey, and Dixon attempting to control Decedent's arms and upper torso. During this altercation, officers were giving Decedent verbal commands to get on the ground, but he refused. Sgt. Aspiazu said that Decedent kept walking towards him as Sgt. Aspiazu was walking backwards while holding on to Decedent's shirt and giving him verbal commands to get on the ground.

Sgt. Aspiazu said that one of the officers was able to grab Decedent's legs and they were able to get Decedent to the ground. Once on the ground, Sgt. Aspiazu said that he placed his right knee on Decedent's left shoulder while the other officers controlled Decedent's legs and tried to handcuff him. Sgt. Aspiazu said that Decedent would not give his legs up and rolled his body from side to side. Sgt. Aspiazu said that he continued to give verbal commands to Decedent to stop resisting and to give Sgt. Aspiazu his hands for handcuffing. Sgt. Aspiazu said that Decedent was able to lift Sgt. Aspiazu off of Decedent at one point. Sgt. Aspiazu said that he then repositioned his knee on Decedent's right shoulder.

Sgt. Aspiazu said that Officer Temple was able to get a handcuff on Decedent's right hand, but then Decedent pulled it out of Officer Temple's grasp. Sgt. Aspiazu said that he saw Decedent's arm come forward with the handcuff attached. Sgt. Aspiazu said that Officer Temple finally was able to control Decedent's right arm and Officer Dixon was able to control Decedent's left arm and get him handcuffed.

Sgt. Aspiazu stated that he then called for movement officers to respond to 2A. In addition, Sgt. Aspiazu said that he also requested that a restraint chair and camera be brought to 2A. Sgt. Aspiazu stated that Decedent was still cursing and yelling at them to get off of him. Sgt. Aspiazu said he attempted to lift off of Decedent's left shoulder, but Decedent again started to roll his body around and resisted their efforts to keep him under control, so Sgt. Aspiazu said he again placed his right knee back on Decedent's left shoulder. Sgt. Aspiazu said that responding officers then arrived and Sgt. Aspiazu had Officer Dixon and Officer Temple replaced with those officers. Sgt. Aspiazu said that Decedent was still conscious at this time. Sgt. Aspiazu said, however, that when Officer Munoz and Officer Kapp turned Decedent over to assist him to his feet, Officer Munoz and Sgt. Aspiazu saw that Decedent was unconscious. Sgt. Aspiazu said he called a "Code 99" on the radio.

Sgt. Aspiazu said that medical arrived and began to administer CPR. Sgt. Aspiazu said that medical requested an ambulance and when LVFD arrived and Decedent was transported to UMC.

### **ANALYSIS OF THE AUTOMATED EXTERNAL DEFIBRILLATOR (AED)**

Investigators recovered the Automated External Defibrillator (AED), which was used by the medical staff on the day of the incident. The automated external defibrillator (AED) was manufactured by Phillips Medical Systems in Seattle, Washington. Once recovered, Phillips Medical Systems analyzed and tested the AED and downloaded the data from the device pertaining to the incident involving Decedent. The AED was found to be in good working order; however, it was noted that there was a time stamp difference between the AED and the cameras which recorded the incident.

Phillips Medical Systems provided the following explanations to questions asked during the investigation:

- **Why does the downloaded patient report have a time-stamp that is one hour off from the correct time?**

“The FRx AED device does not have a Real Time Clock circuitry which keeps track of the correct time. Instead, the AED device keeps track of the elapsed time from the time of the patient-use event. This time is accurate as long as the battery is not removed from the AED device.

There are two possible reasons why the patient report has a time stamp that is one hour off from the correct time:

1. If the AED battery was not removed from the device after a patient-use event, and the data was downloaded from the device using Data Management software from a computer, the AED, device uses the time from the computer, along with the elapsed time in the AED, to note the appropriate time stamp for the event on patient report. If the computer has the incorrect time stamp, the resulting patient report will also have the incorrect time.
2. If the AED battery was removed from the AED device after the patient-use event, then during the data download process, The Data Management software will ask the user to manually enter the correct data and time of the event, the resulting patient report will have the incorrect data and time.”

- **How long is the patient data stored in the AED device?**

“As long as the battery is installed in the AED device, the AED will store patient data information for 30 days. After 30 days, the patient information is automatically erased to ensure that adequate memory space is available for other patient-use.”

- **How can you determine if the AED was operational at the time of the incident?**

“The FRx AED device automatically runs a daily self-test which checks for the viability and proper operations of the AED device, the battery, and the AED pads. If at any time the self-test fails, the AED device will chirp or beep to alert the user that the self-test failed and that service is required for the AED device and/or its accessories. An audible message explaining the failure can be heard if the user presses the “I” button on the front of the unit while the device is beeping. A flashing green light on the front of the unit also indicates that the AED device passed the most recent self-test.

If the device is not chirping or beeping and the front green light is blinking, then this indicates that the AED device is fully operational and passed all its recent self-tests. A standard Preventive Maintenance procedure is not required because the AED will run its own self-tests to ensure that the device and its accessories are fully operational at all times.

The facility AED coordinator will only have to ensure that the AED pads and battery are replaced as needed. The AED pads have a working life of 2 years. The AED battery has a working life of 4 years.”

The data downloaded from the AED showed that throughout the incident, Decedent maintained an electrical heart tracing. In fact, the AED continued to record Decedent’s electrical heart activity from the moment the device was connected to Decedent, to the point where it was removed just prior to his transport to the hospital. The AED recorded activity from approximately 12:51:51 hours to 12:57:13 hours. During that time interval, the AED showed that the Decedent appeared to be in a regular sinus rhythm. At no time did the AED record that Decedent was in asystole (no heart rhythm).

#### **IV. VIDEO RECORD OF INCIDENT**

On March 1, 2013, Detective Merrick contacted Lt. Ryan Yanagzhara, who was the acting Administrative Lieutenant at CCDC and obtained a copy of the surveillance video from unit 2A, as well as a copy of the video from a hand-held camera used on the date of the incident.

#### **SURVEILLANCE VIDEO TIMELINE FROM AFFIXED CAMERA #1 IN UNIT 2A:**

1:40:34	Movement seen near cell# 8
1:40:47	Decedent walking north across the dayroom
1:40:51	Decedent walking towards the 2A control room
1:41:02	Decedent walking south across the day room
1:41:04	Decedent stops and points back toward 2A control room with right hand
1:41:05	Decedent walks toward 2A control room pointing with his left hand
1:41:11	Decedent walking across day room pointing with right hand
1:41:19	Decedent walks to cell #7

1:41:29 Pacing near cells 8-9 pointing with right arm  
1:41:42 Decedent pointing with his right hand towards inmates near  
cells #1-2  
1:41:44 Decedent pointing toward control room with his left hand  
1:41:51 Decedent is raising both arms up and down, other inmates  
attention or on him  
1:42:05 Decedent walking at a fast pace towards 2A control room  
1:42:15 Decedent pointing to the south across dayroom  
1:42:19 Decedent is next to 2A control room and has left arm up  
1:42:40 Decedent walking away from 2A control room  
1:42:52 Decedent walking back toward the dayroom, arms up  
1:42:59 Decedent walking back towards 2A control room, right arm up  
1:43:00 Decedent is near the 2A control room on the left of the screen  
1:43:35 Decedent is seen left corner of the screen by 2A control room  
arm up

**BEGINNING OF OFFICERS CONTACT**

- 1:43:56 Decedent walking backwards away from officers
- 1:43:57 Decedent pulls left hand away from officers
- 1:43:58 Officers grab Decedent
- 1:44:01 Decedent and officers move to the left of the screen
- 1:44:05 Decedent and officers move to the right and are struggling, the back of Decedent's shirt is up
- 1:44:11 Decedent struggling with officers, all still standing



- 1:44:21 Decedent and officers go to the ground behind a dayroom table on east end of the room



- 1:44:25 View of the officers heads from behind the table
- 1:44:47 Movements are seen from Sergeant Aspiazu

1:45:03

Officer Dixon removes handcuffs from his duty belt



1:46:00

An Officer stands up and walks toward the 2A control room



1:46:02

Officer Dixon stands up

1:46:03

Officer Dixon goes back down

1:46:15

The remaining inmates are let back into the cells

1:46:33

Officer Temple returns back to Decedent

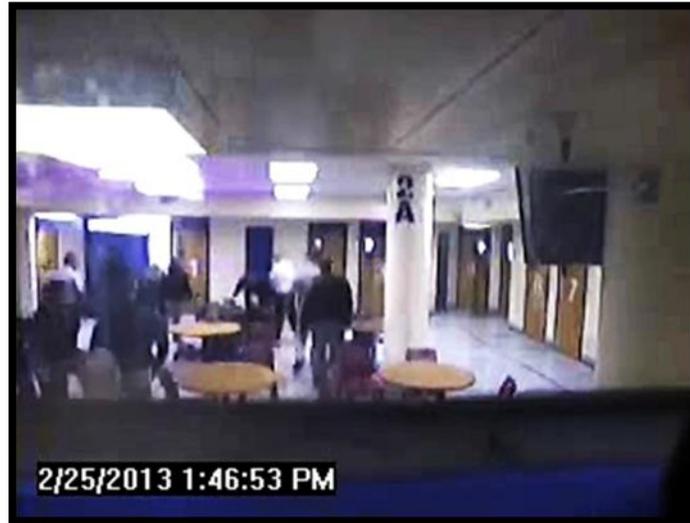
1:46:37

Officer Temple goes back to ground

1:46:44

Officer Munoz enters the Module

1:46:53 Several DSD personnel enter the Module



1:46:58 The DSD restraint chair is brought into the Module  
1:47:07 Arriving DSD Personnel move the dayroom tables clearing the day room  
1:47:08 Sergeant Trotter is seen to the left of the screen with the hand held camera  
1:47:22 Sergeant Trotter standing to the left of screen holding hand held camera  
1:47:41 Involved officers standing up as they are relieved

**END OF CONTACT WITH OFFICERS**

1:47:46 Officers attempting to set Decedent up  
1:47:50 Decedent is placed back to the ground  
1:48:56 CCDC Medical crash cart arrives  
2:00:00 Las Vegas Fire Rescue unit #1, EMT Paramedics arrive  
2:05:00 Fire Department transports Decedent from 2A  
2:15:59 The surveillance video ends

**Total time Decedent struggles with officers until officers are seen standing up is approximately: 3 mins, 45 seconds.**

**SURVEILLANCE VIDEO TIMELINE FROM AFFIXED CAMERA #2 IN UNIT 2A:**

- 1:29:58 The video starts
- 1:42:06 Decedent enters camera view
- 1:42:08 Decedent points at the 2A module door



- 1:42:25 Decedent pacing back and forth in front of module door
- 1:42:31 Decedent walking toward module door
- 1:42:40 Decedent is seen on the video
- 1:43:01 Decedent is pointing at the module door
- 1:43:05 Decedent pointing toward day room with his right hand
- 1:43:22 Decedent attention toward the control room
- 1:43:24 Right arm is up in the air, appears to be talking to someone in control room
- 1:43:31 Decedent is pointing at the other inmates



- 1:43:38 Decedent walking toward control room
- 1:43:53 Decedent and other officers
- 1:43:56 Officer Temple
- 1:46:04 A black object slides across the floor toward the module door
- 1:46:25 Officer Temple picks the black object up



- 1:46:42 Module door opens and Officer Munoz and other officers enter



1:47:00

Sergeant Trotter enters with the hand held video camera



1:48:22

Medical personnel arrives



1:48:52 Medical crash cart arrives



2:00:02 Las Vegas Fire Department arrives

2:05:00 Las Vegas Fire Department transports Decedent out of the Module

2:15:59 Video ends

**SURVEILLANCE VIDEO TIMELINE FROM HANDHELD CAMERA #3 IN UNIT 2A:**

The time Decedent was seen struggling with officers until Sergeant Trotter arrived with Camera#3 (hand-held) was approximately: 3 mins, 6 seconds. This camera was not time stamped. Below are images captured by Camera 3 when it was entering unit 2A.



Officer Kapp (left), Sgt. Aspiazu (middle) Officer Temple (right)



Officer Kapp (left), Sgt. Aspiazu (right) Officer Dixon (middle), Officer Grey (rear)



Officer Grey (left), Officer Kapp (right) Sgt. Aspiazu (in green BDU)

## **VII. VIOLATIONS OF DETENTION CENTER POLICIES AND PROCEDURES BY DECEDENT**

Upon entry into CCDC, inmates are able to view an orientation video in order to learn the rules and policies of the facility. Inmates are also provided access to the CCDC Inmate Handbook which details the rules and regulations of detention services. In addition, more information regarding the rules is available on bulletin boards in the booking cells and in the housing units.

The provided information, in part, explains the rules that the inmates are required to follow, as well as the disciplinary procedures that will occur for various violations of those rules. The disciplinary violations fall into three categories: level one; level

two; and level three violations. As the level number increases for the various violations, so too does the severity of the violations.

The CCDC Inmate Handbook specifically states that there is a red line on the floor and that inmates must not cross that line without permission. In addition, the inmates are instructed that when they are moving from location to location within the facility that they are to walk to the right side of the red line in the hallways with their right shoulder near the wall.

These restrictive measures are important for the protection of the officers and the inmates and are necessary to maintain order within the facility. It should be noted that inmates in the detention center far outnumber the corrections officers and, therefore, maintaining defined areas where the inmates can and cannot go, without permission, is vital to the facility's safe operation.

In the instant case, Decedent violated a number of the rules. Specifically: level one rule #126, "found in a red line/blue carpet area of the housing unit;" level two rule #202, (NRS 199.280) "refusing to obey a direct order by staff; #233, "disrupting the module/court;" level three rule #318, (NRS 200.471; NRS 200.481) "assault/battery on staff; and #320, disrupting the safe and orderly operation of the facility/court . According to the evidence, Decedent moved into restricted areas of the facility without permission, engaged in disruptive behavior, failed to comply with orders given by the corrections staff and actively resisted officers when they attempted to get him under control.

#### **VIII. PRE-INCIDENT FACTORS WHICH MAY HAVE CONTRIBUTED TO DECEDENT'S BEHAVIOR**

According to Decedent's NaphCare medical records from CCDC, Decedent had been taking the prescription drug Xanax at a dose of 2 mg, twice a day, off and on, for the prior five year period. When Decedent first arrived at CCDC, it did not appear from his records that the NaphCare medical personnel initially gave or prescribed him any Xanax. The NaphCare records further revealed that Decedent provided his prior Xanax history and use to the medical staff on more than one occasion.

In addition, on February 23, 2013, Decedent submitted a Medical/Dental/Psychiatric Request to CCDC staff with the following request: "I have anxiety I'm trying to get some pills for that please! Thank U!" Naphcare medical staff made the following reply to Decedent: "[t]his facility dos not provide medication for anxiety. Try to exercise 45 minutes daily before dinner, and read the attached sheet for help with anxiety." There is no indication that Decedent ever received any Xanax, or equivalent, at any time prior to the incident. In fact, the autopsy report indicated that there was not a detectable level of Xanax or other benzodiazepine in Decedent's system at the time of his death.

The District Attorney's office is not charged with determining whether or not the lack of providing Xanax or an equivalent benzodiazepine to Decedent contributed in any way to his behavior and/or subsequent death at the time of the incident. The purpose of this Use of Force Report is solely to determine if the officers' actions, which may have contributed to the death of Decedent, were criminal or were either justified or excusable. The District Attorney is simply providing the foregoing information to give as complete a picture as possible pertaining to the events which led to the incident involving Decedent.

It should be noted that there is no evidence that the officers involved had any prior knowledge of any potential medication issue with Decedent.

### **VIII. SUMMARY**

After a review of all the physical evidence and witness statements, Detective McCarthy concluded the following:

Based on statements from responding witness officers, medical personnel, and the inmates housed in Unit 2A and after reviewing the surveillance video from cameras #1, #2, and #3 several times, the following conclusions were made:

Sgt. Aspiazu, and Correction Officers Temple, Dixon and Grey attempted to restrain Decedent because Decedent was acting in disruptive manner. Decedent resisted the officers, and during the struggle Decedent and the officers went to the ground. Decedent was eventually handcuffed; however, Decedent became unconscious during the struggle to gain control over Decedent. Medical personnel arrived and provided medical care. Decedent was transported to the hospital where he later died.

Most of the statements corroborate the corrections officers multiple attempts at handcuffing Decedent due to his disruptive behavior and Decedent's non-compliance with police commands (supported by witness officers and inmate witness interviews).

Upon completion of the investigation, it appears Sgt. Aspiazu, Officers Dixon, Temple and Grey used the minimal amount of force required in the performance of their duties and promptly provided emergency medical assistance when inmate Decedent was found to be in distress.

### **LEGAL ANALYSIS**

The District Attorney's Office is tasked with assessing the conduct of officers involved in any killing which occurred during the course of their duties. That assessment includes determining whether any criminality on the part of the officers existed at the time of the killing. As this case has been deemed a homicide by the

coroner, the actions of these officers will be analyzed under the State's jurisprudence pertaining to homicides.

In Nevada, there are a variety of statutes that define the various types of justifiable homicide (NRS §200.120 – Justifiable homicide defined; NRS §200.140 – Justifiable homicide by a public officer; NRS §200.160 – Additional cases of justifiable homicide). There is also a statute that defines excusable homicide by misadventure (NRS 200.180 – Excusable homicide by misadventure).

### **A. Justifiable Homicide by a Public Officer**

“Homicide is justifiable when committed by a public officer ... [w]hen necessary to overcome actual resistance to the execution of the legal process, mandate or order of a court or officer, or in the discharge of a legal duty; [and w]hen necessary: In retaking and escaped or rescued prisoner who has been committed, arrested for, or convicted of a felony; [or] In attempting, by lawful ways or means, to apprehend or arrest a person. . . .” NRS §200.140(2)(3). NRS §200.140 has been interpreted as limiting a police officer's use of deadly force to situations when the officer has probable cause to believe that the suspect poses a threat of serious physical harm to either the officer or another. *See* 85-11 Op. Atty. Gen 37, 47 (1985)

In this case, the officers who subdued Decedent had probable cause to believe that Decedent posed a threat of serious physical harm either to themselves or other persons. Decedent, while ignoring commands to get down on the ground and to submit to handcuffing, actively fought the officers and refused to comply. In fact, at one point during the struggle, Decedent broke his arm free from officers with a handcuff partially attached. This potential weapon heightened the danger to the officers and posed a significant risk to them necessitating that they exert sufficient force to control the actions and movement of Decedent. These circumstances created probable cause in the officers' minds that the Decedent posed a threat of serious physical harm to the officers and others. In light of all of the evidence reviewed to date, the State would be unable to prove that the actions of the officers were in fact *unjustified* “in the discharge of a legal duty.”

### **B. Excusable Homicide by Misadventure**

“Excusable homicide by misadventure occurs when: (a) A person is doing a lawful act, without any intention of killing, yet unfortunately kills another. . . or [a]n officer punishing a criminal happens to occasion death, which acts of correction are lawful. . . .” NRS 200.180.

In the instant case, the officers who subdued Decedent were engaged in a lawful act, the control of an inmate who was causing a disruption in the corrections facility and was creating a potentially dangerous situation for the officers and other inmates. Also, a review of the evidence in this case did not indicate that the officers used

excessive force in their attempts to obtain control over Decedent.

Furthermore, although the circumstances of Decedent's death show that he died as a result of lawful contact between the officers and Decedent, there was no evidence that the officers involved had the intention to cause harm to or kill Decedent. Because the State would be unable to prove that the actions of the officers were anything other than possibly misadventure, there is no basis to charge any of the officers related to Decedent's death.

## **CONCLUSION**

Based on the review of the available materials and application of Nevada law to the known facts and circumstances, it has been determined that the actions of law enforcement involved in the efforts to take the Decedent into custody were reasonable and legally justified. The law in Nevada clearly states that homicides which are justifiable or excusable are not punishable. (NRS §200.190). A homicide which is determined to be justifiable *shall* be "fully acquitted and discharged." (NRS §200.190).

As there is no factual or legal basis upon which to charge the officers, and unless new circumstances come to light which contradict the factual foundation upon which this decision is made, no charges will be forthcoming.

DATED: February 28, 2014

STEVEN B. WOLFSON  
District Attorney

By  
MICHAEL V. STAUDAHER  
Chief Deputy District Attorney