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Daryl Green, Chief

INTERNAL BOARD OF REVIEW

At the direction of Lansing Police Chief Daryl Green, an Internal Board of Review convened in accordance with Lansing Police Department (LPD) procedure 200.08 Internal Board of Review to review the in-custody death of Anthony Hulon that occurred on 04/11/20.

The Internal Board of Review was comprised of Captain Rodney Anderson, Captain Ellery Sosebee, Captain Robert Backus, Captain Katie Diehl, Lieutenant Nathan Osborn, Lieutenant Jeromy Churchill, Sergeant Josh Traviglia, Sergeant Cedric Ford, and Detective Ellen Larson.

Incident Summary

On 4/11/20 in accordance with LPD Procedure 300.24 Outside Investigation, LPD contacted the Michigan State Police (MSP) to initiate an outside agency investigation regarding the in-custody death of Anthony Hulon that occurred at the LPD Detention facility. LPD fully cooperated with the Michigan State Police's independent investigation and a detailed criminal review by the Michigan Attorney General's Office regarding the incident. The Attorney General's Office advised they declined criminal charges on the Lansing police and detention officers involved. Chief Daryl Green announced in a press release on 4/9/21 that the next step would be an internal review to examine the officers' actions, department's procedures, equipment, and training systems regarding this incident.

The following is an overview of what occurred: On 4/10/20, at approximately 1:34 pm the decedent, Anthony Hulon, was arrested for Domestic Violence. Hulon was transported to the City of Lansing Detention facility and lodged. According to LPD Detention personnel, Hulon was acting erratically and Detention staff believed he was under the influence of a controlled substance. On 4/10/20, at approximately 10:00 pm, LFD transported Hulon to Sparrow Hospital for medical evaluation. On 4/11/20, at approximately 12:50 am, Hulon was cleared by Sparrow Hospital and was transported back to the Detention Unit. Hulon returned to Detention at approximately 01:00 am. Hulon was not following officer's commands and moving around in a resistive manner as they were bringing him back into the Detention facility. While officers and Detention Staff were attempting to place soft restraints on Hulon he fell unconscious. LPD personnel performed CPR and used an AED on Hulon. Hulon was transported to Sparrow by LFD and was pronounced dead at approximately 02:15 am.

Board Responsibilities

The responsibilities of the board, and purpose of this report, was to objectively identify areas for improvement from every aspect of the incident. The board reviewed LPD's current practices including the Administration's response to the incident. In addition, the board considered recommendations for additional training, tactics, equipment, and policy or procedure updates.

Records Reviewed

The Internal Board of Review included the review of the following:

1. All associated LPD police and internal reports
2. Incident Timeline
3. IC911 CAD and audio files
4. MSP Report
5. Attorney General's Office decision
   The below link is a video of which Attorney General Nessel explains her findings.
   https://www.youtube.com/watch?v=DE73pUgBfU0
6. Medical documents
7. Sparrow Hospital discharge summary
8. Applicable photographs and videos
9. Cell Check Log
10. Body Worn Camera and Fleet videos associated with the incident.
11. External video posted to social media sites regarding the incident.
12. Training Records for LPD personnel involved
13. Law Suit Information
14. LPD Press Release: Update – Inmate Death Investigation 04.09.2021
15. Related Policy and Procedures (Listed below)

    300.24 – Outside Investigation
    500.02 – Arrest Management
    500.04 – Detention of Adults and Juveniles
    500.09 – Strip/Body Cavity Search
    500.11 – Religious Head Coverings
    600.07 – Response to Resistance
    600.50 – Sudden Custody Death Syndrome
    600.57 – DNA Sample Collection
    700.26 – Restraint Procedure
    700.28 – Cell Checks
    700.29 – Detainee Medical Evaluation
    700.27 – Digital Video Recording
    700.32 – Detainee Care Medication/Intoxication
    700.34 – Bonding
    700.35 – Detainee Release
    700.37 – Detainee Property
    700.38 – Cell Assignment Transfer
    700.39 – Detainee Booking and Processing
    700.41 – Detention Officer Responsibilities
    700.44 – Suicide Awareness

700.46 – Detainees with Disabilities
700.47 – Inmate Detainer
700.51 – Detainee Food
700.53 – Use of Detainee Telephone System

Board Findings

- LPD personnel have limited medical related training.
- There was 8 hours of time from when Hulon was lodged at LPD Detention and transported to the hospital.
- All officers and detention staff involved rendered medical attention for Hulon based on his observed behavior while he was in custody.
- At the hospital Hulon displayed behavior consistent with some form of delirium; This behavior continued after the hospital medically cleared him to return to LPD Detention.
- While at the hospital officers made appropriate attempts to de-escalate their interaction with Hulon who physically resisted as officers were getting him inside the patrol car to be transported back to Detention.
- Hulon's medical discharge documents showed presumptive for detection of drugs and he advised medical staff he had used methamphetamine.
- Hulon was still uncooperative when he was returned to the LPD Detention.
- Hulon's behavior required multiple LPD personnel to place him in the isolation cell.
- When it was observed Hulon was unconscious LPD personnel coordinated as a team and rendered appropriate life saving measures once they were aware of his condition.
- Patrick Hansma, DO determined the manner of death for Hulon to be "homicide." Homicide as a "manner of death" is a medical term of art used by medical examiners;
    - It is not the same as the legal term "homicide" used by prosecutors, judges, and criminal jury instructions.
    - Autopsy reports announce a manner of death that falls into one of several limited categories: accident, suicide, homicide, natural or undetermined.
    - Deaths are reported in the medical profession as having been caused by "homicide" when they result from a voluntary act by one person against another that causes physical harm.
    - The medical term does not address the actors' intent, or issues of legal justification or mitigation, all of which are critical in determining criminal culpability.
- The Forensic Postmortem Examination determined Hulon's cause of death was positional asphyxia; It also showed that Hulon had the following contributory conditions: Acute methamphetamine intoxication, hypertensive and atherosclerotic cardiovascular disease.
- During the booking process Hulon indicated he was experiencing shortness of breath when asked COVID screening protocol questions. Difficulty breathing wasn't documented in the booking folder.
- There was no information in the booking report regarding use of drugs although it was mentioned by the dispatcher and recorded in the computer aided dispatch (CAD) report. Additionally, there were no medical concerns noted in the booking report.

Training and Equipment Recommendations

- Additional training should be provided to all LPD officers and detention officers focused on broadening awareness and mitigation of health risks an arrested person may be experiencing.

- Provide more verbal de-escalation training for the Detention Unit Workgroup annually; Training provided should be scenario based and encompass interaction with combative detainees, medical emergencies, application of restraints, confirming and documenting the medical status of arrested persons, CPR, AED use, and Sudden Custody Death Syndrome (SCDS). Training provided should also focus on ensuring documentation of all "Prisoner Assessment" information as explained in LPD Procedure 700.29 Detainee Medical Evaluation/Treatment.
- LPD's police social worker should be included in leadership and training meetings for the Detention Workgroup to enhance the awareness of staff regarding interacting with and managing inmates.
- LPD should partner with the Lansing Fire Department (LFD) to have a Detention Command Officer trained to be an in-house AED trainer for the Detention Workgroup. LPD's AED Trainer could then offer continuous AED refresher content throughout the year and serve a liaison between LPD Detention, LPD Training Unit, and LFD regarding equipment use and training.
- Provide Emergency Medical Technician (EMT) training to Detentions Officers with one year or more experience.
- Additional training in regards to positional asphyxia and excited delirium. Involve LFD and local hospital professionals in training and review of medical related detention procedures.
- Some aspects for the Detention video system should be upgraded as better quality equipment would help to improve safety and mitigate risk.
- Some of LPD's equipment has not been updated in over 20 years. LPD Detention Unit, Training Unit, and Administration should jointly evaluate alternatives available as means to increase safety and help to mitigate risk.
- Detention Command should be sent to Drug Recognition Expert (DRE) training to enhance their ability to evaluate circumstances where arrestees are or may be under the influence of drugs.

Policy and Procedure Recommendations

- All related procedures will continuously be reviewed and updated as part of LPD's new Michigan Association of Chiefs of Police (MACP) accreditation process that began in August 2020. This process focuses on best practices for law enforcement identified by the Michigan Law Enforcement Accreditation Commission.
- Maintenance Check Logs for all department AED equipment should be standardized to help enhance management of this equipment.
- Officers should ask prescreening medical questions regarding injury, any medical concerns, use of drugs or alcohol post arrest prior to transporting a prisoner to LPD Detention and relay this information and direct observations regarding prisoner welfare to Detention staff during the booking process.
- Establish guidelines regarding circumstances that may require an officer's name being withheld from the media for a period of time.
- Implement a standard medical clearance appeal protocol to help guide decision making of officers and detention officers.
- Officers should be required to confirm on body worn camera that medical staff have exhausted all means of treatment and report this to Patrol and Detention Command for consideration.
- Update procedures regarding hospital utilization; McLaren Hospital has a contract with CMH where they have a therapist on duty. Explore the possibility of mental health issues being directed there prior lodging at Detention.

- Update procedures with clarification when officer and detention officers should consider a referral for detainees who continue to display violent behavior, appear to be mentally disabled or suicidal, or who display unusual or bizarre behavior (PAR Rehab, Social Worker, CMH, Hospital).
- Establish a response process to all complaints where breathing difficulties are expressed that show acknowledgement, assessment and response when appropriate.
- Enhance cell check methods and specific intervals required when certain medical or other safety concerns have been observed and/or documented.
- A review of LPD Procedure 600.50 Sudden Death Syndrome should be revisited as part of every Detention Unit Annual Training Day.
- Involve Lansing Fire Department and ER Medical Personnel in review of procedures that include medical related content.
- Establish a protocol involving LPD Command for persons who require medical care and clearance before they can be transported by an officer to LPD Detention.
- 700.29 Detainee Medical Treatment – Evaluation should be updated to be applicable to officers and detention officers so that it is not exclusive to Detention Staff.
- When officers are trying to gain control of a combative detainee who is at the hospital for treatment they should consider the most effective and safest approach based on the totality of circumstances. Officers must document their decision making process in a report in accordance with LPD Procedure 600.07 Response to Resistance.
- All detainee transported to the hospital for treatment from Detention will be placed in belly chain restraints.

Conclusion

LPD is committed to continuously growing and improving. This Internal Board of Review is aware that officers and detention officers have to make complex decisions based on their knowledge, skills and resources they have, at the time, when interacting with agitated individuals. During this review process board members observed how well LPD personnel did. The board's consensus was some things need to be improved but there were a lot of things done very well. With that being said, it cannot be emphasized enough that officers and detention officers must diligently seek to differentiate between behavior and other observations that warrant medical care in all types of incidents. All LPD personnel involved in this incident conducted themselves professionally and with compassion for the decedent, Anthony Hulon who was clearly in crisis.

The Internal Board of Review concurred that several deficiencies in preparedness, communication, and cooperation were identified that were not in line with the mission and goals of the LPD. It is the board's intent that with the recommendations provided in this report action plans will be developed to implement improvements to help LPD be better equipped to handle similar situations in the future and better serve the community and LPD personnel.

06/11/2021