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Interim Director

Office of Accountability and Transparency

Monitoring Report
Incident OAT23-003

On February 2, 2023, the Phoenix Police Department responded to a call of alleged trespassing near 2300 West McLellan Boulevard. After being detained, the Involved Civilian suffered a medical emergency and died at a local hospital the next day.

This report contains OAT's review and conclusions about the administrative investigation completed by the Department following the incident and provides recommendations to improve future investigations.

July 31, 2024

STATUTORY HISTORY AND AUTHORITY

The City of Phoenix created the Office of Accountability and Transparency (OAT) in 2021 to perform independent civilian oversight of the Phoenix Police Department (Department). OAT reviews Department administrative investigations of critical incidents involving sworn personnel and provides community members a way to freely communicate complaints, commendations, and concerns about officers and the Department without fear of retaliation. Phoenix City Code (P.C.C.) §§ 20-6 and 20-7 give OAT the authority to review Department administrative investigations.[1]

Specifically, P.C.C. § 20-6, requires OAT to review administrative investigations of:

- officer-involved shootings;
- deaths in-custody;
- any duty-related incidents resulting in serious bodily injury;
- incidents in which Department personnel are under investigation for or charged with offenses against persons under Arizona law; and
- incidents in which a Phoenix police officer is under investigation for any misdemeanor or local law violation where use of force or threatened use of force is an element in the crime.[2]

Phoenix City Code § 20-7, gives OAT discretionary authority to review:

- Department administrative investigations of any incidents that result in a Department administrative investigation in which OAT believes it is in the City's best interest for OAT to be involved, and
- Department administrative investigations when requested to do so by the City Manager.[3]

[1] P.C.C. Chapter 20 can be found here.
[2] P.C.C. Sec. 20-6.
[3] P.C.C. Sec. 20-7.

EXECUTIVE SUMMARY

On February 2, 2023, Department officers responded to a trespassing call near the 2300 block of West McLellan Boulevard. Officers contacted the suspect (the Involved Civilian) and placed him into custody. Shortly after being handcuffed, the Involved Civilian began giving incoherent responses and having difficulty sitting upright. Fire responded and transported the Involved Civilian to the hospital, where he died the next day.

Exercising its discretionary authority, OAT sent the Police Chief and the City Manager a Monitoring Notice on October 23, 2023. The Department's in-custody death (ICD) investigation showed that the Involved Officers' conduct did not lead to the Involved Civilian's death or constitute any policy violations. OAT concurs with the Department's conclusion and finds the investigation was thorough and complete.

FACTUAL AND PROCEDURAL HISTORY[4]

- February 2, 2023 – Incident
- October 23, 2023 – OAT sent the Department a Monitoring Notice[5]
- January 17, 2024 – OAT received initial disclosures from Department
- July 21, 2023 – Department concluded its administrative investigation
- July 31, 2024 – OAT released Monitoring Report

I. Incident

On February 2, 2023, Department officers responded to a trespassing call near 2300 West McLellan Boulevard. The Involved Civilian was standing at the front of a house as Involved Officer A approached with their weapon drawn. The Involved Civilian moved toward the driveway with his hands in the air and knelt on the

[4] See Appendix A (p. 8) for a detailed list of the information and materials OAT received from PSB and through the public records request process.

[5] OAT learned of this incident after inquiring about the Department's ICD case numbering. Through this inquiry, OAT realized that the Department had not notified OAT of this ICD when it occurred in February and subsequently filed its monitoring notice.

ground. Involved Officer A commanded the Involved Civilian to place his hands on his head and not move. Involved Officer B commanded the Involved Civilian to lay on his stomach. The Involved Civilian complied with the officers' commands. The Involved Officers handcuffed the Involved Civilian with his hands behind his back while he was lying face down.

After he was handcuffed, the Involved Officers moved the civilian to a seated position on the curb. The Involved Civilian then closed his eyes and began struggling to stay upright. The Involved Officers questioned the Involved Civilian as to why he was going through backyards, but his responses were incoherent. The Involved Officers prompted the Involved Civilian to wake up, open his eyes, and sit up straight, but he continued to struggle to stay upright, despite officers' efforts to keep him sitting up.

The Phoenix Fire Department arrived, and the Involved Officers re-cuffed the Involved Civilian with his hands in front of his body instead of behind his back. The Phoenix Fire Department provided medical care until an ambulance arrived to transport the Involved Civilian to the hospital.

The Involved Civilian died at the hospital the next day. The Maricopa County Medical Examiner's Office determined that the death was accidental due to multiple drug toxicity.[6]

II. The Police Department's Investigation

The Department's Professional Standards Bureau (PSB) conducted an administrative investigation of the incident. The investigation began as an in-custody death investigation, but PSB later determined that the incident was not an in-custody death. The Department's investigation included a review of the Involved

[6] Maricopa County Office of the Medical Examiner. Report #2023-01228 (Mar. 9, 2023).

Officers' body-worn camera footage, interviews with hospital staff, and incident reports.

III. Investigative Sufficiency

Under P.C.C. § 20-10, OAT is tasked with reviewing any Department administrative investigation that it reviews to ensure that it is thorough and complete.[7]

The Department concluded that the Involved Officers did not engage in misconduct or violate any policies during the incident and that their interactions with the Involved Civilian did not contribute to his death. The Department reached its conclusions based on the officers' body-worn camera footage, the Maricopa County Medical Examiner's report, and interviews with hospital staff.

After reviewing the Department's investigation, OAT concurs with the Department's conclusions and finds that the investigation was thorough and complete. Recommendations for future ICD investigations follow.

1. Articulate and Document Application of Criteria for Determining Whether a Death Occurred In-Custody and Resulted from Officer Conduct

Department policy defines an in-custody death as one that occurs while the individual's freedom to leave was restricted by the responding officer(s) in the field or in a temporary holding facility.[8] Neither the operations order nor any Department manual defines "freedom to leave"—a status that can be ambiguous in some situations, such as when police have to call for medical assistance and then follow medical transport to the hospital.

[7] OAT's thorough and complete sufficiency determinations include a review and assessment of: allegations made; evidence obtained, reviewed, and analyzed; quality and extent of subject and witness interviews; investigative report clarity and objectivity; and the investigative process taken.

[8] Phoenix Police Department. (Rev. Nov. 2020). *Operations Orders 1.3.18.*

Additionally, the policy does not provide any criteria for determining whether the Involved Officer's conduct while the individual was not free to leave led or contributed to the death.

Therefore, OAT recommends that the Department establish formal criteria for evaluating deaths that occur during or immediately following police contact. These criteria should include clear parameters for determining whether a) the death occurred "in custody," and b) the officers' conduct led to or contributed to the death. As with other decision-making processes at the Department, clearly articulated criteria would promote consistency across investigations. By providing a detailed explanation of how the ICD investigation considered and addressed the articulated parameters and criteria, the Department would increase transparency for supervisors reviewing the investigation and the public.

2. **Maintain ICD Designation for all Investigations**

Under the Department's current practice, some ICD investigations are redesignated as inquiries (INQ) following the initial information gathering and resulting Departmental findings discussed above. OAT asked the Department what criteria it uses when deciding whether to redesignate an incident originally investigated as an ICD to an INQ and learned that the Department does not have any such criteria. Instead, this decision appears to be at the discretion of Department leadership, who base their decision on a variety of factors relevant to ICD investigations (e.g. the involved officers' conduct, the amount of physical contact between the decedent and the officers, the length of time between the death and last contact with officers, the cause of death, etc.), but this process and the relevant criteria are neither articulated nor documented.

Consequently, some cases initially classified as an ICD are left with the ICD designation while others are converted to an INQ, despite the

circumstances of the deaths being factually similar. Maintaining the ICD investigation designation, even if the Department ultimately concludes that the death did not occur in-custody or as the result of police contact or officer conduct, will increase transparency of the Department's internal investigative process by allowing for internal and external review of the number and quality of ICD investigations conducted.

Inquiries typically involve a less rigorous investigation and review than a PSB investigation. Completing a full, robust investigation of any death that occurs close in time to or because of police contact conveys the seriousness of a death investigation—an important aspect of accountability for family members of the deceased and the public.

CONCLUSION

OAT respectfully submits the above report and recommendations in compliance with P.C.C. §§ 20-6 and 20-7 and requests a response from the Police Chief within 30-days, by August 30, 2024.

APPENDIX A

INVESTIGATIVE MATERIALS LIST

Items	PPD Date	Date to OAT
PSB Investigative Documents		
Administrative Inquiry Report	February 3, 2023	January 17, 2024
Medical Examiner Report	March 9, 2023	January 17, 2024
BWC Videos		
Officer A	February 2, 2023	January 17, 2024
Officer B	February 2, 2023	January 17, 2024
Other Items/Evidence		
Homicide Interview with Nurse	Undated	January 17, 2024
Items OAT Obtained Via Public Disclosure Request		
	Date Requested	**Date Provided**
Incident Report	May 29, 2024	June 18, 2024

APPENDIX B

MONITORING CASE DETAILS:

Monitoring Report Date:	July 31, 2024
OAT Monitoring Case #:	23-003
Monitoring Case Classification:	Mandatory-Converted to Discretionary
Police Incident Report #:	2023-00000168032
Incident Date & Time:	February 2, 2023, 7:02 p.m.
Location:	2300 W McLellan Blvd, Phoenix, AZ
OAT Monitoring Notice Sent:	October 23, 2023
Department Administrative Case #:	INQ23-0106
Department-Issued Findings:	Within Policy -No CIRB
Date of Administrative Finding:	July 21, 2023
Officer(s) Involved:	(2) Involved Officers
Officer(s) Injury Level(s):	None
Civilian(s) Involved:	(1) Involved Civilian
Civilian(s) Injury Level(s):	Deceased
Complainant(s):	(1) Involved Civilian