STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

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M E M O R A N D U M

Warrant Denial Request Memorandum

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FROM: Richard Cunningham
Assistant Attorney General
Criminal Trials & Appeals

RE: **Request for Authority to Deny Criminal Charges and Close File**
Hulon, Anthony Scott
AG 2020-0292982-A

Summary:

On April 11, 2020 prisoner ANTHONY SCOTT HULON, a 54 year old white male, died during a struggle with police officers at the Lansing Police Department detention facility. The Medical Examiner concluded from an autopsy and the reported circumstances surrounding his death that the cause of death was positional asphyxia and that contributory causes included methamphetamine intoxication and hypertensive and atherosclerotic cardiovascular disease. The Medical Examiner classified the manner of death as homicide.

The Michigan State Police conducted a thorough and complete investigation of the incident and submitted the results of that investigation to the Attorney General. That investigation found that HULON was arrested for domestic violence at approximately 5:30 pm on April 10, 2020 and was transported to the Lansing Police detention facility. At the time of his arrest and transport he was acting erratically, and the officers believed him to be under the influence of some

controlled substance. His erratic behavior continued while in custody, and the decision was made to transport him to Sparrow Hospital for evaluation.

While at the hospital Hulon continued to be agitated and constantly in motion. A drug abuse panel ordered by the treating physician found presumptive positives for methamphetamines and ecstasy. But after only a short period of time he was cleared and medically discharged by hospital staff. He was diagnosed as having a Substance Abuse Disorder. The hospital was working under a COVID-19 protocol and saw no basis to keep him any longer. He was then transported back to the Lansing Police lock-up. He displayed agitation and twitching movements as the officers moved him from the emergency room to the police vehicle.

The officers had difficulty in removing him from the police vehicle and placing him in a cell. When they got him into a cell he kept moving about in a manner that made it difficult for the officers to remove his leg restraints and hand cuffs. Hulon kept thrashing about and would not (or could not) follow the officers' commands to get on his knees while they removed his cuffs. Based on his behavior a decision was made to place a belly strap on him to restrict his movements. Hulon did not cooperate with the attempt to put the restraint around him and fell on the floor of the cell as he struggled with the officers. One officer held his legs to stop him from kicking, while two others attempted to put the restraint around his waist. Throughout this time Hulon kept making scream-like noises.

After only a short period of time Hulon suddenly stopped struggling and went limp. The officers finished putting the restraint around him, and then attempted to stand him up against the wall. He was completely non-responsive, and the officers could not find a pulse. The officers then administered CPR and used an AED in an unsuccessful attempt to revive him. An EMT team was called in, but they could not revive him. Hulon was then transported to the hospital where he was pronounced dead.

As part of the investigation the MSP detective obtained the report of the Lansing Police Department officer who made the original arrest, medical records pertaining to both the initial admission for the erratic behavior and the subsequent transport where he was pronounced dead, the autopsy report, a toxicology report, a police report from an officer involved in the struggle, and various videos from stationary cameras at the detention facility, dash-cams and officer body-cams. Of particular note are the videos from the stationary camera in cell 6-2 and the body cam worn by P.O. Trevor Allman. The struggle that led to the death was captured by both cameras.

Also of note is the fact that while there were four officers in the cell with the prisoner at the time of the final struggle, only two of them submitted reports concerning the incident. The four officers have been identified as (1) Police Officer

Trevor Allman, (2) Detention Sgt. Edgar Guerra, (3) Detention Officer Charles Wright, and (4) Detention Officer Gary Warden. Only Allman and Guerra provided reports which addressed the struggle. Warden submitted a report which addressed Hulon's conduct before he went to the hospital, but not the fatal struggle. Wright did not submit any report. The Lansing Police Department did not require Warden or Wright to submit a report on the struggle under Garrity. While Allman was wearing a body cam throughout the incident, department policies do not require the detention officers to similarly wear body cams.

Recommendation:

I was assigned to review the results of the MSP investigation and then determine whether the evidence would support any criminal charges. I carefully reviewed all the documentary evidence and watched each and every one of the many videos provided to me. I gave particular attention to the question as to whether any officer used excessive force or acted in any manner that was not reasonable under the circumstances.

Based on my review of the evidence in light of the applicable law, I conclude that there is insufficient evidence to justify any criminal charges. I thus recommend that criminal charges be denied and that our file be closed without further action.

Discussion of the Evidence:

Police Reports and Videos

Discussion of the incident and its prelude best begins by noting that I found no relevant inconsistencies or contradictions between the reports prepared by the numerous officers and the videos captured by the several cameras and body-cams. I simply have no basis to believe, or even suspect, that any officer was being less than truthful in describing the facts and circumstances surrounding the arrest, detention, transport, or struggle. However, I am concerned about the fact that two detention officers involved in the struggle did not submit a report on the incident and were not required to do so by the police department under Garrity.

At approximately 12:50 pm on Friday, April 10, 2020, Lansing Police Officers Benjamin Perry, Tara Brandman, Christopher Clew and Lindsey Howley were dispatched to [redacted] Ave., Lansing on a domestic violence run. Upon arrival at the scene, PO Perry contacted [redacted], who stated he had been assaulted by his roommate, Anthony Hulon. [redacted]'s left eye was visibly swollen and bruised. He appeared to have a cut below the eye, with dried blood on his face. PO Perry recorded his observations and actions in a police report.

[redacted] stated that he was just sitting on the couch while Hulon kept walking around the house and being a general nuisance. When Hulon walked into the living room [redacted] smiled at him, which seemed to upset Hulon. [redacted] said that Hulon then walked over to the couch and punched him several times while he was still on the couch. Hulon then confronted a female who was with [redacted] (body-cam videos and soundtracks establish this was [redacted]'s sister) but did not assault her. Hulon then came back and punched him several more times. [redacted] said that Hulon then went upstairs to his room.

The Lansing Fire Department responded to the scene and transported [redacted] to the hospital. Once he had left the scene, officers made contact with Hulon to hear his side of the story. PO Perry then questioned him about the incident and recorded his responses in the report.

Hulon stated that [redacted] had been bugging and annoying him all day. He said he told [redacted] to leave him alone, but [redacted] confronted him. [redacted] then stood up from the couch and the two of them started pushing each other, back and forth. Hulon stated that he never punched [redacted], and that they only pushed each other. Hulon stated that when the pushing stopped [redacted] picked up an object and motioned like he was going to throw it at Hulon. He said that at that point he turned and ran upstairs to his room. Hulon stated that he could not explain how [redacted] got the bruises or the cut below his eye.

While there is nothing in P.O. Perry's report as to Hulon's demeanor during the investigation of this incident, his body-cam (Axon Body 2 X81341778) recorded his interaction with the suspect. The video clearly establishes that Hulon was extremely agitated and constantly moving his body. Throughout the time that the officers were at the scene Hulon never stood still. His constant motion is also seen on the videos of the body-cams worn by PO Brandman (Axon Body 2 X81344921) and PO Howley (Axon Body 2 X81335158). While Hulon was not aggressive or uncooperative, his conduct during the investigation and subsequent arrest would cause a reasonable person to suspect he might be under the influence of some type of substance.

Upon his arrest, Hulon was transported to the Lansing P.D. detention center, and was booked at approximately 1:55 pm. The entire booking process was captured on videos by cameras at different locations within the detention facility. The videos show that even though he was restrained in handcuffs he continued to move his body as much as he could, and he continued to demonstrate agitation. He is also heard complaining about the handcuffs being too tight. Notwithstanding the visual evidence of extreme agitation, the Lansing Police Department booking report (Booking Number 9915) indicates that he was not under the influence of alcohol or drugs.

After being booked in, Hulon was placed in cell 6-2 and the handcuffs were removed. While in that cell he displayed conduct that led a police officer to conclude that he was under the influence of methamphetamine. He was transferred to cell 6-3 at about 2:33 pm. In his report Detention Officer Gary Warden stated that while Hulon was escorted to the cell without incident, he shortly thereafter displayed erratic behavior. DO Warden stated that Hulon began taking his clothes off and was pacing the floor of the cell and yelling. DO Warden reports that when such behavior continued for about eight hours, the shift supervisor notified dispatch to have the Lansing Fire Department transport Hulon to a hospital for evaluation.

A separate report was prepared by Sgt. Billy Windom. This LPD supervisor reported that he began his shift around 5:30 pm on April 10 and was informed that Hulon was being held for an assault on his roommate and that he was placed in isolation in cell 6-2 due to exhibiting signs of narcotic intoxication. Inmate Booking Report 9915 indicates that while Hulon was originally placed in cell 6-2, he was transferred to cell 6-3 at about 2:33 pm, before Windom began his shift. Thus, Windom's report was in error in this regard. However, that error is inconsequential.

Sgt. Windom reported that Hulon was jerking and moving about in a manner consistent with someone on narcotics. He described such actions as "tweaking." But notwithstanding his agitation, Hulon was able to communicate with detention staff and to understand instructions and follow directions.

However, Sgt. Windom further reports that as the evening progressed Hulon began showing more serious symptoms. He took off his clothes and began pulling at his genitals. He put his clothing in the toilet but removed them when instructed to do so. Throughout the evening he continued to bang on the cell door and yell incoherently. When detention staff advised him that the prisoner began to sweat, Sgt. Windom decided to have him transported to the hospital for a medical evaluation.

There is a camera located in cell 6-3, which was recording the entire time that Hulon was held there. Review of the many hours of video establishes that Hulon remained extremely agitated and constantly in motion throughout the time he was in this cell. He removed clothing, writhed around on the floor, and continually yelled and made incoherent noises. The video clearly supports the observations reported by P.O. Worden and Sgt. Windom.

At approximately 9:45 pm on April 10, 2020, PO Rickey Spratt was dispatched to the Lansing PD lock-up for a medical assist. He waited in his vehicle outside the building while the Lansing Fire Department EMT arrived and went into the location. After only several minutes they brought Hulon out, handcuffed to a cot. PO Spratt then accompanied the EMT to Sparrow Hospital. Hulon was taken to ER

room #36, where he was secured to the bed. PO Spratt submitted a report on his involvement in the matter.

PO Spratt indicates in his report that he was told prior to leaving the detention facility that Hulon had possibly ingested an unknown illicit substance prior to arrest and needed to be medically cleared before returning to the jail. Once he got to the hospital and was secured to the bed Hulon failed to remain calm. He sat upright in the bed and moved around as much as his restraints allowed. PO Spratt noted that during the time he was at the hospital Hulon never got out of the bed and never left the room. After about 2 ½ hours, PO Spratt was relieved by PO Trevor Allman. He left the hospital at about 12:20 am on April 11.

PO Trevor Allman was dispatched to Sparrow Hospital to relieve PO Spratt and stay with Hulon while he received treatment. PO Allman was told only that the prisoner was receiving medical treatment and did not then know what the medical condition was. When he arrived at the hospital PO Spratt was sitting with Hulon. PO Allman observed that Hulon's hands and ankles were cuffed to the bed, but he was moving erratically, throwing his hands up and down and thrusting his body. PO Spratt advised PO Allman that Hulon had been acting in that manner the entire evening, but he had been cooperative.

PO Allman then engaged Hulon in conversation. Referencing his behavior, he asked Hulon what kind of narcotic he had taken. Hulon replied that he took meth on Thursday (April 9), and then took a nap. Hulon reported that when he awoke he couldn't stop moving. Following this conversation PO Allman sat guard by the door.

At the time he was brought into the hospital, Hulon was wearing just T-shirt and underpants. A nurse asked for PO Allman's assistance in placing blue hospital pants on him. PO Allman took the leg cuffs off and told Hulon not to kick his feet. Notwithstanding this directive, the prisoner continued kicking and made it very difficult for the officer and the nurse to get the pants on him.

The nurse advised PO Allman that Hulon was being medically discharged from the hospital. After checking with Sgt. Windom, the officer informed hospital staff that he would transport the prisoner back to the LPD lock-up. Being concerned about the erratic behavior exhibited by Hulon, the officer requested back-up for the transport. PO Katelynn De'Jeelare Miller and PO Davis responded to the hospital in response to this request.

Standing at the side of the bed, PO Allman told Hulon that they were taking him back to the detention facility. He was still thrashing about on the bed, and the officer told him to try to stand up so he could take the handcuffs off the bed rail. Hulon sat up for a moment, but then laid back down. The nurse and PO Davis then assisted PO Allman in removing the handcuffs from the bed and getting Hulon up.

PO Davis then handcuffed Hulon behind his back, using two interlaced pair of handcuffs so his arms would not be drawn back so far.

Because of Hulon's erratic behavior the officers decided to utilize a wheelchair to get him to the patrol car. PO Allman held Hulon's left arm while he was getting into the wheelchair. The prisoner sat in the wheelchair, but immediately became very upset. He cursed at the officers, and then began complaining about his ankle. PO Allman folded the leg rest down so that Hulon could place his foot on it and did not observe anything that could be causing the prisoner pain.

As the officers were wheeling Hulon out of the hospital the prisoner kept arching his back and several times almost fell out of the chair. Once they reached the vehicle the officers had Hulon stand up and get into the backseat of the patrol car. As soon as he sat in the car he yelled something about his hand and stood back up. PO Davis and PO Miller then assisted him in getting back into the vehicle, while PO Allman shined a flashlight into the vehicle.

Both PO Miller and PO Davis submitted police reports that agree on all materials matters with this portion of the report by PO Allman.

At approximately 12:55 am on Saturday, April 11, 2020 PO Allman left Sparrow Hospital and transported Hulon back to the LPD lock-up. The ride took only about three minutes. When they arrived at the facility Detention Officer Worden was waiting for them with a wheelchair. PO Allman got out of the car and helped Hulon get out of the back seat. The officer then attempted to help the prisoner into the wheelchair, but it rolled backward as he was getting out of it. Hulon was successfully placed in the wheelchair with the assistance of the officer. As he was being wheeled into the building with a degree of difficulty, Hulon almost fell out of the chair several times.

As the officers proceeded toward the elevator bay they encountered a step that the wheelchair could not navigate. At that point PO Allman decided that it would be easier to walk Hulon into the building. PO Allman kept his arm under Hulon's arm, near his arm pit, while holding his other arm. As they entered the building PO Allman walked Hulon directly to a holding cell.

When they reached cell 6-2 the officers placed Hulon so that he could stand in a corner of the cell. There were at this time four officers in the cell with the prisoner. Those four officers are identified as PO Allman, Detention Sgt. Edgar Guerra, Detention Officer Charles Wright, and Detention Officer Gary Warden. As the detention officers were taking the ankle cuffs off the prisoner, PO Allman was holding his arm. Hulon then began twisting and jerking his body and was yelling and trying to pull away from the office. PO Allman noted in his report that he could

barely hold Hulon because of his strength. Hulon then yelled that something hurt real bad. PO Allman assumed that he was talking about the handcuffs, so he told the prisoner to hold still because they were taking them off.

An officer then told Hulon to get on his knees so that the cuffs could be removed and the officers could safely exit the cell. PO Allman explained in his report that this was common procedure when they had an uncooperative inmate. Hulon failed to comply and continued to twist his body and to attempt to pull away from the officer. During this struggle Hulon and PO Allman ended up on the floor of the holding cell.

When they fell to the floor Hulon was no longer wearing the ankle chains. He fell on his stomach and was in a prone position. He kept moving his body erratically and was kicking his legs. PO Allman then placed his hands and knee on Hulon's legs to prevent the officers from being kicked. In his report PO Allman noted that he had great difficulty holding the prisoner's legs, indicating it was like Hulon had super strength. As PO Allman was holding his legs, Hulon stated that he could not breathe. But the prisoner continued to struggle. When Hulon continued to twist his body and kick his legs, the officers decided to place him in a restraint belt.

Sgt. Guerra explained in his report that the decision to place the prisoner in a restraint belt was made by him and DO Wright because of Hulon's erratic behavior, his violent movements, and his unwillingness to follow instructions. Guerra believed that placing the restraint belt on him would lessen his ability to harm the officers or himself with violent movements.

While PO Allman held the prisoner's legs, Sgt. Guerra was able to get the restraint around Hulon's midsection. Guerra noted that because of the way that the four officers were positioned in the cell DO Charlie Wright took over placing the restraint belt around the prisoner. Guerra reports that when Wright took over placement of the restraint belt, he attempted to put a wrist lock on Hulon's right wrist. The prisoner continued to struggle and to twist his body and to scream and yell incoherently. He squeezed Guerra's hand and fingers.

During this struggle Hulon again stated that he could not breathe. One of the detention officers then said that they were not on top of him. Neither the reports nor the videos provide a basis for determining which of the detention officers made this statement.

Following this short struggle, Hulon suddenly stopped twisting and the noises he made changed dramatically. Instead of yelling, it sounded as though he were snoring. The detention officers finished putting the restraint belt on him, then turned him on his side. The officers then immediately attempted to stand him up in the corner of the cell. At that point PO Allman noted that he was not responsive,

and his head was slumped down. When PO Allman could not find a pulse, he used his radio to call Lansing Fire Department EMT. The officers then repositioned the prisoner on his back, and did a sternum rub without success.

While the officers attempted to revive Hulon, Sgt. Guerra left the cell to obtain an AED. When he returned with the device the other officers were doing CPR. He and Wright then placed the AED pads on Hulon's body and Guerra activated the AED. The device indicated that no shock was advised, and CPR was continued. Several minutes later the AED advised that CPR be stopped so that another analysis could be done. The AED again indicated that no shock was advised, and that CPR should continue.

The Lansing Fire Department EMT then arrived and took over CPR. They made contact with Sparrow Hospital and were advised to transport Hulon back to that facility. At approximately 1:42 am the prisoner was placed on a stretcher and removed from the detention center.

There are no relevant inconsistencies in the separate reports of PO Allman and Sgt. Guerra concerning the struggle with the prisoner in cell 6-2. This entire struggle was captured on two separate cameras. However, the positioning of the cameras does require some comment as to some of the details of the struggle.

The first video of note is that recorded from PO Allman's body cam. This camera was recording throughout the incident and conforms what this officer wrote in his report. However, as Allman explained, he was holding the prisoner's legs during the struggle. His camera thus recorded what he was seeing, and not details about the actions of the other officers. His body cam simply did not record how the other officers were holding the prisoner or otherwise how they were trying to subdue him.

The second important video was that recorded by the stationary camera in cell 6-2. Because of the angle of the camera shot only the back of DO Warden is seen toward the end of the struggle. It is clear that this detention officer was holding the prisoner down, but it does not show with certainty the part of the prisoner's body that the officer was holding down. The video does not establish with certainty whether Warden was applying pressure to the prisoner's shoulders or to his chest while the restraint belt was being placed around him.

Because DO Wright and DO Warden did not submit a report there is insufficient evidence of the specific manner in which they attempted to subdue Hulon.

Medical Records

As part of the criminal investigation MSP used a search warrant to obtain Mr. Hulon's medical records from Sparrow Hospital in Lansing, Michigan. The medical records indicate that the patient was brought to the emergency room by ambulance at 10:12 pm on April 10, 2020 because of agitation. Nursing notes indicate he was very fidgety and could not hold still on a cot. A Supervisory Resident Note indicates that the patient presents in police custody due to agitation. He admits to methamphetamine use today. Patient admits he is a chronic user but is worried that there were possibly other substances in the drug. He denies any injury or self-harm associated with the drug. He was observed laying on a stretcher, actively twitching.

The medical records indicate that hospital staff obtained this history of present illness:

> Patient is a 54 year-old male with a history of substance abuse, that presents today agitation. The patient arrives in police custody where he was asleep during the day and later woke up with bizarre behavior. The officer states the patient was observed removing his clothing then attempting to open a window. The patient states he uses meth multiple times per week most recently last night. He also notes he is injecting after market testosterone once per week and has been doing so for 6 weeks as he lost his insurance. His last injection was 4 days ago. He mentions "some alcohol consumption last night as well.
>
> The initial medical assessment was as follows:
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> 10:30 PM: Male presenting with agitation. He initially presents on exam agitated. Other than agiation (sic) on examination is unremarkable. Overdose is considered however patient states his last ingestion was ~24 hours ago (4-5 hr half life) suggesting that he should have probably cleared meth out of his system by now. He denies more recent use. Will obtain UDS, provide 1 mg Ativan, and monitor…

Following this initial assessment, a Drug Abuse Panel-Urine, was ordered. Records indicate the following results:

Amphetamines/Methamphetamines	-	PresumpPos
Ecstasy	-	PresumpPos
Cocaine, Opiates, Barbiturates	-	Negative

At the time Hulon was brought to the hospital the facility was operating under COVID-19 protocols. The medical records contained a provider statement concerning the impact of the COVID-19 pandemic on clinical decisions. The statement indicates that care for conditions deemed medical or surgical emergencies will proceed as usual, with precautions to prevent virus transmissions. But care for nonemergent conditions will be postponed until requirements for social distancing and other care requirements can be modified.

The patient was diagnosed as having a substance abuse disorder, and a medical decision was made that further hospitalization would be of no benefit. The patient was given instructions to follow up with his primary care provider or return to the emergency room if his critical condition changes. It was noted that the patient was in stable condition and would be discharged to police custody.

Nursing notes indicate that the prescribed medications did little to alleviate the agitation. At 11:30 pm a note was made that the patent was still fidgety after meds. At 11:53 pm it was noted that he was back to tweaking around the bed. A note at 12:53 am on April 11 indicates that as the patient was leaving in police custody he was shouting at the officers and jumping around on the way out. Records indicate he was formally discharged from the hospital at 1:04 am on April 11, 2020.

Additional records indicate that he was brought back to this same hospital only a short time later. Records indicate he arrived at the Sparrow Hospital emergency room at 1:59 am on April 11. Triage notes indicate:

> Pt arrives via EMS who state pt was discharged earlier from hospital, he went to jail where there was an altercation and pt started "gasping and turning blue as they lowered him to the ground" and pt went into cardiac arrest. EMS states pt received immediate CPR. When pt came to ER, he had been asystole for 38 minutes, had been given 4 of epi, and came in on the Lucas CPR machine. Providers and respiratory at bedside upon arrival, pt was transferred to hospital stretcher and CPR was immediately continued.

Nursing notes indicate that emergency procedures were attempted, and an intubation successfully performed. Notes made at 2:00 AM, 2:02 AM, 2:04 AM 2:06 AM, 2:08 AM, 2:10 AM and 2:12 AM all indicate the patient was asystole on monitor and no pulse. Records further give the time of death as 2:12 AM on April 11, 2020.

The Medical Examiner was notified, and arrangements were made to remove the body to the morgue. At 5:52 AM the body was formally discharged from the hospital into custody of the Medical Examiner staff.

Medical Examiner Records

On April 11, 2020 Pathologist Patrick Hansma, DO performed on autopsy on the body of Anthony Scott Hulon and issued a written report on his findings and conclusions. He noted that the body was that of a normally developed white male whose appearance was consistent with the reported age of 54 years. He further noted that the body was 69 inches long and weighed 228 pounds. He described the body as obese. There were no deformities or other abnormalities in his extremities.

External examination noted evidence of recent injuries, which would be consistent with that expected from the nature and extent of medical treatment and the efforts to revive him and from the struggle reported by the officers. Dissection of the wrists and ankles revealed no significant musculoskeletal or neurovascular injuries deep to abrasions noted on the skin.

The doctor also performed an internal examination of body organs and the central nervous system. He labeled nothing as remarkable upon visual inspection and noted microscopic descriptions in his report. He also obtained and preserved specimens, including fingerprints, blood (femoral and subclavin), formalin fixed tissues and vitreous humor.

The relevant specimens were provided to a vendor for a forensic toxicology report. A comprehensive drug panel-blood was performed by AXIS (www.axisfortox.com), and a report was issued on April 22, 2020. The analysis found high levels of amphetamine related substances in the femoral blood sample. The test showed a quantitative result of 93.00 for amphetamines, where the reporting limit was 50 and the reference range 10-100. It further showed a quantitative result of 556 for methamphetamines, where the reporting limit was 50. There was also a positive test for caffeine. However, no testing was done as to ecstasy or testosterone.

Based on his observations and the results of the toxicology report, Dr. Hansma made anatomic diagnoses which included acute methamphetamine intoxication and hypertensive and atherosclerotic disease. In consideration of the autopsy findings and the reported circumstances surrounding the death he determined that the cause of death is positional asphyxia. He further concluded that hypertensive and atherosclerotic cardiovascular disease are contributory causes. He classified the manner of death as homicide.

Positional Asphyxia – Sudden Death

Positional (postural) asphyxia can be generally defined as a form of mechanical asphyxia that occurs when a person is immobilized in a position which impairs adequate pulmonary ventilation and thus results in respiratory failure. In

some cases, the body position has a direct hindering effect on normal circulation and venous return to the heart, which may be contributing factors to the obstruction of normal gas exchange. Positional asphyxia is a rare cause of death and is usually accidental. However, it has been linked with torturing and homicide.

The mechanism of asphyxia can be elicited in a variety of ways. One way is when the inversion of the whole body or the upper part interferes with normal respiration and blood circulation due to the increase in the intrathoracic pressure and the compression of inferior vena cava. Another is when restricted posture of the neck causes partial or complete airway obstruction. A third is when the compression or flexion of the torso reduces total lung volume and functional residential capacity and pulmonary expansion, eventually making breathing ineffective.

The law enforcement community has long recognized that a sudden in-custody death may be the result of the phenomenon called positional asphyxia. The National Criminal Justice Reference Service (NCJRS), an office within the U.S. Department of Justice, maintains a library of materials that highlight the latest research published or sponsored by the Office of Justice Programs. Within that library is a training bulletin on positional asphyxia issued by the Chicago Police Department in March 1999. In that bulletin officers are advised that positional asphyxia is when a death occurs because a subject's body interferes with breathing. The bulletin explains in simple language that the phenomenon can occur when a subject's chest is restricted from expanding properly or the position of the subject's head obstructs the airway.

The bulletin goes on to note that the risk of positional asphyxia increases in the presence of alcohol intoxication, drugs, physical ailments delirium or respiratory disease. It cautions officers to avoid potentially dangerous restraint positions during arrest and transportation. It further cautions against leaving a subject in control restraints lying on his/her back or stomach and against putting weight on the suspect's back for a prolonged period of time.

Legal Standards:

Because the evidence indicates that the prisoner's death occurred while he was in police custody, and that the struggle with the officers was a proximate cause of the death, it is necessary to identify the legal standards under which the officers' conduct should be reviewed. Here the evidence should be examined under the Michigan legal standards regarding Homicide and Misconduct In Office.

Homicide

The evidence in this case requires consideration of three separate offenses in the Homicide category: First Degree Murder (MCL 750.316), Second Degree Murder (MCL 750.317) and Manslaughter (MCL 750.321).

Murder may generally be defined as the unlawful killing of another with one of three alternate states of mind. The mental state or malice that a prosecutor must prove is (1) the intent to kill, or (2) an intent to do great bodily harm, or (3) the willful disregard of the likelihood that the natural tendency of the defendant's behavior is to cause death or great bodily harm. People v Hopson, 178 Mich. App. 406 (1989). These elements establish Second Degree Murder. First Degree Premeditated Murder is Second Degree Murder plus proof that death resulted from a premeditated and deliberate intent to kill. People v Irby, 129 Mich. App. 306 (1983). In order to prove murder it is also necessary to establish that the killing was not excused, justified or mitigated to manslaughter.

Manslaughter is a common law offense which is defined as the unlawful killing of another without malice. The law recognizes two separate forms of manslaughter. Voluntary manslaughter is the intentional killing of another under a sudden heat of passion caused by adequate provocation. Involuntary manslaughter is the unintentional killing of another without malice in the doing of an unlawful act not naturally tending to cause death or great bodily harm; in negligently doing some act lawful in itself; or by the negligent omission to perform a legal duty.

In order to support a charge of involuntary manslaughter based on a defendant's omission to perform a duty, the prosecution is required to show (1) the existence of a legal duty; (2) the defendant's knowledge of that duty; (3) that the defendant willfully neglected or refused to perform the duty; (4) that the failure was grossly negligent of human life; and (5) the death was caused by the defendant's failure to perform his or her duty. People v Moye, 194 Mich. App. 373 (1992). Not every degree or carelessness or negligence, if death ensues, renders a person guilty of involuntary manslaughter. The act or omission must be of such nature that the person's conduct may be classified as gross, wanton or willful. People v Campbell, 237 Mich. 424 (1927).

Misconduct In Office

The crime of Misconduct in Office is a common law offense that entails corrupt behavior by a public officer in the exercise of the duties of his or her public office while acting under the color of his or her office. People v Coutu, 459 Mich. 348 (1999). The crime of Misconduct in Office encompasses malfeasance (the doing of a wrongful act), misfeasance (the doing of a lawful act in a wrongful manner) and nonfeasance (the failure to do an act required by the duties of the office). People v

Thomas, 438 Mich. 448 (1991). In Michigan this common law offense has been modified by statute as to the failure to do an act required by the duties of the office. Under MCL 750.478 it is now a one year misdemeanor for a public officer to willfully neglect to perform a duty required by law.

Conclusion:

The video evidence establishes that the Lansing P.D. officers acted professionally and treated Mr. Hulon with dignity and respect throughout the time he was in custody. There is no evidence that any officer ever lost patience and intentionally inflicted any injury on their prisoner or acted in any way to intentionally inflict harm. When he showed unusual behavior, they took him to the hospital for evaluation. When they transported him back to detention they took reasonable steps to make him as comfortable as the circumstances would permit.

The fatal struggle in the cell must be viewed in the context of all the surrounding circumstances. The decision to place a restraint belt around him was not unreasonable under the circumstances. He simply did not hold still while the officers tried to release him from the ankle and hand cuffs. His continuing agitation and movements led the officers to a reasonable belief that he might harm them or himself if the belt was not put on him.

The evidence strongly suggests that Mr. Hulon was not intentionally resisting the officers when he did not comply with their lawful commands to remain still while they removed the cuffs. Rather the evidence suggests that he could not control his movements at the time. He thus did not refuse the commands. Rather, he was simply not able to hold still so that they could safely return him to the cell.

Mr. Hulon was an experienced meth user who regularly used the drug over a long period of time. But he recognized something was wrong with his body when he was interviewed by medical staff at the hospital. He feared that the meth he had used the day before was laced with some other substance. The presumptive positive for ecstasy found in his blood at the hospital, and his continued agitation beyond such time as the effects of meth would be expected to last, supports the theory that he unknowingly ingested an unknown dangerous substance that affected his behavior.

But no matter what the reason that he did not allow the officers to safely remove his restraints, the fact remains that he did not co-operate. The relevant question is whether the officers acted reasonably when they forcibly attempted to place the restraint belt on him. A police officer is justified in using reasonable force to subdue an unruly prisoner. The question of reasonableness should be viewed in the context of the totality of the circumstances.

Here the struggle was brief, and no further force was used once the restraint belt was in place. Once the belt was on, they did not continue to hold him down. As soon as the officers recognized that he was not breathing, they took reasonable steps to revive him. They attempted a sternum rub, then CPR and an AED. They promptly called EMS.

While the evidence is not sufficient to clearly establish how DO Warden was holding the prisoner during the struggle, or to indicate the location on Hulon's body where the force was being applied, that in and of itself is not sufficient to justify a criminal charge. The video establishes a melee where the officers were simply trying to get the prisoner under control. They did not use choke-holds, weapons, or similar dangerous means in their attempt to put on the belt. PO Allam simply did his best to hold the prisoner's legs so that the officers would not get kicked. The other officers simply wrestled with the prisoner for the reasonable purpose of putting on the belt.

Here there is no evidence from which an intent to kill or seriously injure Mr. Hulon can be inferred. Furthermore, the force used by the officers was justified, even though it led to the prisoner's death. Murder charges cannot be supported.

Likewise, there is insufficient evidence to support a Manslaughter charge. The officers certainly had a duty to protect Mr. Hulon from harm while he was in custody, and to refrain from actions which would cause him harm. However, the evidence demonstrates that throughout his confinement they acted to protect him by ensuring the medical evaluation, using no more force to restrain him than was required by the circumstances, and by promptly summoning EMS when he went into distress. There is simply insufficient evidence to demonstrate conduct or omission rising to the level of gross negligence.

While the officers were clearly acting in the exercise of their duties or under the color of office when they struggled to place the restraint belt on the prisoner and afterward, the evidence is simply insufficient to establish they were engaging in corrupt behavior or that they willfully neglected to perform a duty required by law.

The evidence developed during the investigation simply fails to establish the use of unreasonable force by any or the officers. A warrant should be denied, and the file should be closed.