# Nathaniel Jones, 04/17/62 - 11/30/03:

# WHAT WE HAVE LEARNED SINCE NOVEMBER, 2003


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# We Must Enforce and Recommit to the Collaborative Agreement

Nathaniel Jones should be alive and with us today. The ACLU Advisory Panel and Counsel to the plaintiffs to the Collaborative Agreement offer their condolences to the Jones family. Although our words certainly cannot bring back Nathaniel Jones, we can work to prevent another tragedy. We hope that his loved ones can take some comfort in the fact that we shall diligently fight to enforce the Collaborative Agreement and the Memorandum of Agreement (the "Agreements"), which, we believe, if followed, lay a foundation that should help avoid such unnecessary deaths in the future.

In August, 2002, the federal court approved a class action settlement ("Collaborative Agreement") establishing extensive police reforms. (See Note 1). Parties included the African American community, the Fraternal Order of Police, and the City of Cincinnati. Additionally, the Department of Justice investigation of use of force in Cincinnati resulted in the Memorandum of Agreement (or "MOA") between the City and the Department of Justice, which was incorporated into the Collaborative. (See Note 2). Many of the reforms called for in these two agreements have been put to the test in the death of Mr. Jones. His death has given rise to questions involving the following issues: 1) Use of Force, 2) The proper deployment of the Mental Health Response Teams ("MHRT"), 3) Emergency medical treatment and 4) The various investigations authorized by the Agreements.

This guide will help members of the community understand the issues raised by this tragedy, how the collaborative agreement addresses those issues, what questions

must be answered from the pending investigations, and how we can hold accountable those responsible for any misconduct, policy and/or procedure problems or insufficient training. At its August 2, 2004 board meeting, the Citizen Complaint Authority, (CCA) sustained allegations of excessive force against three officers involved in this incident and sustained allegations of failure to follow proper procedure against all seven of the officers involved in this incident. Clearly, our system for civilian oversight works and we are proud of the investigation the CCA has conducted.

**What are the Facts as We Currently Know Them?**

Mr. Jones entered the White Castle on Mitchell Avenue between 5:00 and 5:30 a.m. on November 30, 2003. A few minutes later White Castle employees noticed that Mr. Jones had passed out and they called 911. The 911 operator determined that the call involved a medical dispatch and sent a fire squad to the scene. Shortly after engaging Mr. Jones, a member of the fire squad team determined that Mr. Jones was becoming a "nuisance" and called for CPD assistance.

The first police officer at the scene, James Pike, informed dispatch of the need for MHRT trained officer/s. From video taken from another patrol car that arrived on the scene, it appears that Mr. Jones was dancing and waving from a grassy area in front of the White Castle. Shortly after Officer Pike's conversation with dispatch requesting MHRT assistance, the fight, caught on video, began. At the beginning of the video, Mr. Jones is shown swinging at an officer. It appears from evidence revealed from the CCA investigation, that Officer Pike had addressed Mr. Jones. During that struggle, Mr. Jones was struck many times with batons as he was in the process of being restrained. Other officers arrived on the scene and, eventually, Mr. Jones was subdued. The officers who

restrained Mr. Jones were not members of the specially trained mental health team. The specially trained officers never responded to the scene.

Shortly after subduing Mr. Jones, the officers on the scene realized that he was not breathing. One officer took his pulse. The officers on the scene began complaining about why the fire department personnel left the scene. Another officer rolled Mr. Jones on his side. Another officer appeared to pat Mr. Jones to see if he would respond. After approximately two minutes, personnel from the fire department returned to the scene to render assistance to Mr. Jones. Mr. Jones could not be revived and later died. The coroner has stated the cause of death as a medical homicide. The coroner noted that Mr. Jones had PCP and cocaine in his blood stream and that Mr. Jones weighed 348 pounds. The coroner concluded that the encounter with the police led to his death.

**What do the Collaborative Agreement and Memorandum of Agreement Require? What Questions Must be Answered?**

Mental Health Response Team

The Memorandum of Agreement, incorporated into the Collaborative Agreement, requires the CPD to specially train selected officers who can respond to all calls involving persons suspected of mental illness. (§10, MOA). (See Note 3). Moreover, the MOA specifically requires that this training include instruction by alcohol and substance abuse counselors. It is important that the MOA requires alcohol and substance abuse training because often, upon approaching an individual, it is not immediately clear whether the source of that person's mental instability is drug-induced or not. The MOA also requires that these officers be trained in strategies to reduce the tension of an engagement with such a person.

The CPD has adopted a procedure (§12.110) regarding the handling of persons suspected of being mentally ill. (See Note 4). Furthermore, CPD has trained at least 100 officers in the strategies necessary to deal with such persons. According to this procedure, these MHRT officers are intended to be the primary officers "handling the situation". Finally, if there is not an emergency, the CPD procedure requires a MHRT officer from another district to be contacted if the MHRT officer from the district where the event is unfolding is not available.

The Agreements and the CPD procedure, therefore, give rise to several questions in the Jones case. First, was it an emergency situation when Officer Pike arrived upon the scene? When he was informed that the MHRT officer in that district was unavailable, could he (along with officer Osterman) have waited for an MHRT officer from another district? Are there sufficient numbers of MHRT trained officers throughout the police force?

The CCA make several recommendations for amending the current MHRT policy. First, they assert that the policy should include information regarding the recommendation that officers maintain a positional gap (including watching from their vehicles) between themselves and what was, initially, a dancing Mr. Jones. This recommendation is stated in the CPD Tactical Patrol Guide. Additionally, they recommend that the use of force policy recommendations re escalation and de-escalation of confrontations be incorporated into this policy.

Use of Physical Force

It is clear from the video that police eventually used a significant amount of force to subdue Mr. Jones. The MOA required the CPD to draft a new use of force policy

(§12.545). That policy requires, among other things, that force be proportional to the resistance offered by an individual. Additionally, the agreements require officers to use the least force necessary to restrain the suspect. The use of force policy encourages officers to consider options including: disengagement, area containment, waiting out a subject, summoning reinforcements, calling in specialized units, and higher levels of force. CPD procedure §12.545 requires that officers be prepared not only to escalate the use of force but also de-escalate the use of force as necessary. When force is required, the officers also have at their disposal chemical agents, beanbag shotguns, 40mm foam rounds, etc. Additionally, the CPD use of force procedure reminds officers to protect the welfare of the community and asserts that where the suspect poses no immediate threat of death or serious physical harm to others, that deadly force is not authorized.

With the MOA and these procedural requirements in mind, several questions arise.

*1. Was there time for Officer Pike to not engage Mr. Jones but rather monitor him until properly trained MHRT personnel could arrive on the scene?*

*2. How/why did Mr. Jones go from dancing on the grass in the parking lot, clearly posing no threat to himself or others, to assaulting an officer?*

*3. Should Officers Pike and Osterman have considered using other means (e.g., beanbag, foam rounds) to subdue Mr. Jones and, if so, when?*

*4. Were the officers sufficiently trained in the use of such other means? At any time during the altercation was Mr. Jones provided the opportunity to submit?*

*5. Given Mr. Jones' size, was he capable of complying with the officers' demand to place his hands behind his back and, if not, were the officers sufficiently sensitive to this fact?*

*6. Was the use of the PR 24 batons consistent with CPD policy?*

*7. With 4-5 officers on top of Mr. Jones at various times, at any time did these officers consider de-escalating their use of force? Are they trained to make such determinations under situations such as that with Mr. Jones?*

The CCA investigation arrived at the following conclusions with respect to these questions. The report asserts Officers Pike and Osterman's approach of Mr. Jones was inappropriate in that they did not exhaust all of their options prior to approaching him. Furthermore, the investigation found that the use of the PR-24s was inconsistent with CPD policy insofar as Mr. Jones was not allowed the opportunity to comply with the officers commands. The CCA sustained allegations of excessive force, arising from the use of the PR 24s, against three of the seven officers involved in this incident.

Use of Chemical Agents

Both the MOA and the CPD procedure manual (§12.545) specifically address the use of chemical spray by officers. Both require that, unless it would pose a danger to the officer involved, a person should be warned prior to the use of a chemical irritant. Additionally, the MOA requires that an officer not keep a "sprayed" person in a face down position any longer than absolutely necessary. Finally, the MOA requires that chemical spray may be used on a restrained person if, without the use of the spray, the

person is either likely to suffer injury, or escape. These requirements of both the MOA and the CPD procedure manual give rise to the following questions.

1. *Was Mr. Jones warned prior to the use of the chemical irritant?*

2. *Was it necessary to use the chemical spray on Mr. Jones given the fact that several officers were on top of him?*

3. *Was he kept in a face-down position longer than was necessary, thus aggravating the health problems he was then experiencing?*

With the conclusion of the CCA investigation into this incident, we now have answers to some of these questions. The second use of chemical irritant was found improper by the CCA investigators as Mr. Jones had already been subdued by that time. Moreover, the CCA found that the officers on the scene left Mr. Jones in a prone position for a period exceeding necessity and this violated their training.

Mobile Video Cameras

It is fair to say that the CPD sped up its effort to outfit all patrol cars with video cameras as a result of the Collaborative Agreement and the MOA. The CPD procedure (§12.537) regarding video cameras was revised pursuant to the Memorandum of Agreement. Given the possibility that this procedure does not cover incidents like that involving Mr. Jones, the Collaborative Agreement provides the forum in which the Parties may remedy, as much as practical, this failing.

First Aid to Mr. Jones

None of the police officers provided meaningful first aid to Mr. Jones. Mr. Jones had been in a prone position on his stomach both during and shortly after the altercation.

This position, given his size, created a significant risk of suffocation or positional asphyxia. He further laid in CPD custody for another two minutes before the fire personnel returned to commence resuscitation efforts. One of the major questions therefore is, *Why the CPD personnel at the scene failed to render CPR to Mr. Jones after they had identified that he had stopped breathing and why was he left in a prone position on his stomach for approximately 40 seconds?* Unfortunately, the Agreements do not specifically address the issue of CPD CPR training or first aid to suspects in police custody. However, CPD policy does address positional asphyxia. The CCA sustained allegations of failure to follow procedure against all seven officers with regard to their failure to, as soon as possible, place Mr. Jones in a position in which he could breath.

**How do the MOA and the Collaborative Agreement help Answer these Questions?**

Citizen Complaint Authority

The Collaborative Agreement and the MOA contain provisions outlining the role of the Citizen Complaint Authority (the CCA). Last year the City of Cincinnati passed an ordinance establishing the CCA pursuant to these agreements. (Article XXVIII of the Administrative Code (amended 6-26-02, Ordinance No. 108-2002)). The CCA is a citizen-led organization that has a professional, independent investigation team that investigates all serious police uses of force as well as other allegations of police misconduct. The CCA must ensure that incidences of police misconduct are neither swept under the carpet nor given half-hearted review by the CPD but rather are thoroughly reviewed. The CCA also reviews complaints to determine whether there are any patterns (e.g., repeat officers, repeat citizen complainants, and repeat complaint

circumstances). Such review can alert the CPD and the public at large to any issues that require a systemic solution. In short, the CCA is designed to address the full range of cases – those where misconduct is the fault of officers not following policy and training as well as those where the policy and training themselves are the problem.

According to the requirements of the MOA, the CCA sends out an investigator to the scene upon notification that a serious use of force has occurred. If the CCA finds cause, an investigation is opened promptly. The CCA should complete its investigation within 90 days of the initiation of the investigation. It should be noted that the finding of drugs in Mr. Jones' system shall not prejudice the outcome of the CCA investigation. All citizens – even those who are drunk or high – deserve professional, unbiased police service.

What are the Possible Outcomes of the CCA Investigation?

As stated above, the CCA investigation sustained allegations of excessive force against three of the officers involved in this incident and sustained allegations of failure to follow procedure against all seven officers with respect to their failure to place Mr. Jones in a position in which he could breathe. With respect to the excessive force allegations, the CCA recommended severe discipline. With respect to the failure to follow proper procedure, the CCA recommended re-training. Furthermore, the CCA recommended that the policy with regard to may determine that police procedures present larger, systemic problems. CPD may change its procedures in response. The Collaborative Agreement also contains evaluation mechanisms to address such systemic problems. If the parties find that systemic problems persist, there are provisions for using

the Collaborative Agreement to press for policy reforms in order to accomplish the goals set out in the agreement.

Other Investigations

The Homicide unit of the CPD, the Internal Affairs unit of the CPD, and the Hamilton County Prosecutor all will be investigating the Jones case. The Hamilton County Prosecutor found no basis for criminal charges against any of the officers involved in this incident. The CPD internal investigation has not been concluded at this time. They will be looking for violations of existing procedure and criminal law. Only the CCA has the broad mandate to look at the procedures themselves and suggest changes that may be necessary in them as well. Finally, the FBI may review this incident to determine if any of Mr. Jones' civil rights were violated.

What if the Community is not Satisfied with the Progress of the CPD?

The Collaborative Agreement and the MOA call for an independent Monitor to ensure that the parties follow the agreements. The Monitor has substantial authority. The agreement has five broad goals:

First Goal: Police Officers and Community Members Will Become Proactive Partners in Community Problem Solving

Second Goal: Build Relationships of Respect, Cooperation and Trust Within and Between Police and Communities

Third Goal: Improve Education, Oversight, Monitoring, Hiring Practices and Accountability of CPD

Fourth Goal: Ensure Fair, Equitable, and Courteous Treatment for All

Fifth Goal: Create Methods to Establish the Public's Understanding of Police Policies and Procedures and Recognition of Exceptional Service in an Effort to Foster Support for the Police

In addition to the terms reviewed above, the agreements have many terms including provisions on community problem oriented policing, bias free policing, and evaluation. The agreements are specific and detailed and seek nothing short of a major overhaul of policing in Cincinnati. We have much work to do. Every citizen has a stake in this effort. To learn more visit the following websites listed in the notes section below. Or contact plaintiffs' counsel at the addresses set out below.

**Conclusion**

The death of Mr. Jones death on November 30, 2003 was a tragedy, one made even more distressing by the arrival of the holiday season. This community, however, must recommit itself to racial healing and improved police-community relations. The parties to the Collaborative Agreement and the Memorandum of Agreement took the concerns of the community quite seriously before binding themselves to these Agreements. Cincinnatians do not have to wonder whether this incident requires us start at ground zero with respect to police uses of force. In fact, the Collaborative Agreement and the MOA both lay the foundation for correct action in these instances and, where necessary, for holding those accountable through independent investigation when tragedies take place. Police and Union leadership should not be defensive and simply keep repeating that nothing went wrong. A man who should be alive is dead. His family and this community deserve answers. Our Collaborative Agreement is the path to restoring trust and reducing the risk that his will happen again. Let's recommit ourselves to vigorous enforcement of that agreement.

Submitted to the Community by Plaintiffs' Counsel to the Collaborative

And the ACLU Advisory Panel:


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## Notes

1. The Collaborative Agreement may be found in its entirety at:

   http://www.acluohio.org/issues/racial_profiling/finalsettlement.pdf.

2. The Memorandum of Agreement may be found in its entirety at:

   http://www.cincinnati-oh.gov/police/downloads/police_pdf5112.pdf.

## Notes Continued

3. The Memorandum of Agreement text regarding the training of officers capable of handling mentally impaired persons states:

   > The CPD will create a cadre of specially trained officers available at all time to respond to incidents involving person who are mentally ill. These specially trained officers will assume primary responsibility from responding to incidents involving persons who are mentally ill. They will be called to the scene of any incident involving a person who is mentally ill, unless the need for fast action makes this impossible. These officers will respond to any radio run known to involve a person who is mentally ill (including escapes from facilities or institutions). The officers selected for this training should be highly motivated volunteers and should receive high level, multi-disciplinary intervention training, with a particular emphasis on de-escalation strategies. This training will include instruction by mental health practitioners and alcohol and substance abuse counselors. The CPD will develop and implement a plan to form a partnership with mental health care professionals that makes such professionals available to assist the CPD on-site with interactions with persons who are mentally ill.

4. The CPD policy explanation of its procedure §12.110 regarding the training of officers to address mentally impaired persons reads as follows:

> Mental Health Response Team (MHRT) officers will be the first responders, when available, on all runs involving suspected mentally ill individuals. If two MHRT officers are available, they will be dispatched as a team. When necessary a cover car will be dispatched. If the run is an emergency and no MHRT officer is available, beat cars will be dispatched immediately and an MHRT officer from another district will be notified to respond. If the run is **not** an emergency and no MHRT officer is available, the nearest available MHRT officer from an adjoining district will be dispatched as the primary car.
>
> An MHRT officer on the scene of a suspected mentally ill individual will be the primary officer handling the situation. They will also be responsible for transporting the individual, if necessary, to the hospital.