



Ninth Circuit Solicitor's Office

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Solicitor

REPORT ON JAMAL SUTHERLAND'S DEATH AT CHARLESTON COUNTY'S DETENTION CENTER

Jamal Sutherland died on January 5, 2021, after being extracted from a cell within Charleston County's detention center (Sheriff Al Cannon Detention Center - SACDC). Sutherland should not have died the way he did and he was not at fault. Sutherland was mentally ill and he did exactly what we ask of those who suffer from mental illness: he sought professional help when he needed it. Sutherland checked himself into a mental health facility and decompensated while he was there. He was concerned about his treatment there and knew he was not getting better. Sutherland attempted to check himself out the day before he died. The heartbreaking fact is that Mr. Sutherland's death was entirely avoidable. With better treatment, care and concern by all the institutions involved, Jamal Sutherland would not have died the way he did on January 5.

This report contains the factual and legal conclusions of the Ninth Circuit Solicitor's Office regarding Jamal Sutherland's death. Nothing in this document should be construed to imply that Jamal Sutherland is to blame for his death.

This report should be read in conjunction with the *Raney Report* and with the deeply disturbing body worn camera (BWC) videos in mind.

- <https://bit.ly/RANEYREPORT>

CONTEXT OF THE ANALYSIS & DECISION

The Investigation and the Role of the Solicitor

Jamal Sutherland died on January 5, 2021 after detention deputies extracted him from a jail cell at the SACDC. Immediately thereafter, the Charleston County Sheriff's Office called in the South Carolina Law Enforcement Division (SLED) to investigate. The investigation showed that immediately after deputies extracted Mr. Sutherland from his cell, medical personnel contracted to provide health care at the jail began assessing him and eventually attempted unsuccessful life-saving measures. Because of this, the scene was not entirely secure until after medical personnel pronounced Mr. Sutherland's death and they left area. Nevertheless, SLED was able to photograph and collect most relevant physical evidence from the scene.

SLED agents collected body worn cameras from the involved deputies and other surveillance video from the jail. They interviewed witnesses to the removal of Mr. Sutherland from the jail cell and witnesses to staff training, policies and procedures of the jail. SLED agents also obtained hundreds of pages of Mr. Sutherland's medical records and other relevant documents. In addition to the electronic evidence, SLED generated reports totaling nearly 600 pages. All of the materials and electronic evidence gathered by SLED will be available to the public with extremely limited redaction.

As the Solicitor, I do not normally make arrest decisions. SLED, however, has asked that Solicitors across the state make the decisions to prosecute or not at the outset of Officer Involved

Critical Incidents when SLED does not see fit to make a probable cause arrest. I agreed to SLED's request, it is now my task to determine whether anyone involved in Sutherland's death should be criminally prosecuted under state law. On April 29, 2021, I requested that the United States Department of Justice (DOJ) review Mr. Sutherland's death to determine if law enforcement officers violated Mr. Sutherland's civil rights while acting under color of law. The DOJ accepted and their investigation continues.

It is neither my role nor do I have the expertise to critique police training and procedures generally or to determine whether there is a basis for a civil lawsuit and recovery of damages from anyone. My only role is to determine if state criminal charges are viable. Therefore, I must decide whether to prosecute charges, based on the ***legal standard of proof beyond a reasonable doubt*** for each and every element of the crime charged. Prosecutors' professional organizations and the American Bar agree that a prosecutor should only file those charges that she/he reasonably believes will be proven beyond a reasonable doubt at trial and that will support a criminal conviction.

- <https://www.apainc.org/wp-content/uploads/2020/10/Attachment-2-APAs-21st-Century-Principles-of-Prosecution-Officer-Use-of-Force-Cases-2017.pdf>
- https://www.americanbar.org/groups/criminal_justice/standards/ProsecutionFunctionFourthEdition/
- <https://ndaa.org/wp-content/uploads/NDAA-NPS-3rd-Ed.-w-Revised-Commentary.pdf>

Some states provide for a grand jury that can investigate a case by calling witnesses before the grand jury. Unlike those states, South Carolina does not have an investigative grand jury for these matters. Charging decisions in criminal matters are not based on whether or not law enforcement handled the incident appropriately from an administrative or tactical standpoint. Furthermore, the fact that an in-custody death is controversial; the fact a death was avoidable, or that law enforcement did not follow proper policy or procedure does not necessarily make it a criminal matter. As the public has seen in this and other cases, administrative and civil remedies are often options.

I thoroughly reviewed the evidence gathered by SLED and the Charleston County Coroner, Bobbi Jo O'Neal. The Coroner's pathologist, Dr. J.C. Upshaw Downs, determined that the extrication process did not reveal any "unusual or excessive interactions or areas of direct concern." Furthermore, immediately after Jamal Sutherland's death, a certified medical assistant (CMA) who observed the incident opined that the deputies did not act excessively and only tried to restrain Sutherland.¹ In order to move forward with a prosecution in any death case, the State must prove "proximate cause." Because of the disturbing nature of the body worn camera video and my own experience that Sutherland's death seemed at least medically, a homicide, I felt it necessary to have another qualified pathologist review the autopsy. I retained Dr. Kim Collins, a renowned and board certified forensic pathologist. To aid Dr. Collins, I also retained Dr. Laura Labay. Dr. Labay is a board certified forensic toxicologist who holds both a Master's degree and Ph.D. in Toxicology. I believed both the community and the Sutherland family deserved a second look at Dr. Downs' findings in order to determine whether the State could prove the deputies were a proximate cause of Sutherland's death, the first hurdle in a criminal prosecution.

SLED did not opine as to the propriety of the deputies' use of force, nor did SLED's interviews delve into the key issue: each deputy's state of mind and how each was trained. Again, because Dr. Downs was the only person to opine as to use of force, and he stated that he saw nothing unusual or excessive or of direct concern, I felt it necessary to seek an opinion from a qualified expert on the use of force. Whether or not Dr. Downs was entirely correct, it was imperative to have a well-qualified expert witness who *is* trained on these issues weigh-in. To that end, I relied on an

¹ The CMA, however, did not observe the number of taser deployments.

experienced use of force expert, former Ada County Idaho Sheriff Gary Raney. Raney has been involved in law enforcement reform at the national level and currently serves as a United States District Courts' expert under two Use of Force Consent Decrees, one in the Northern District of California and one in the Central District of California. United States Attorney General Eric Holder (of the President Obama administration) appointed Raney to the National Institute of Corrections, the federal agency that guides best practices for jails and prisons and Raney later was elected vice-chair of that organization. Raney has worked as a retained expert for both victims of excessive force and law enforcement accused of using excessive force. I came to Raney after I first approached University of South Carolina Associate Professor Seth W. Stoughton, a use of force expert, for a consultation in this matter. I was familiar with Professor Stoughton from his testimony before the South Carolina Legislature, his presentation for a South Carolina for Justice Reform forum, and his testimony in the Derek Chauvin / George Floyd murder trial. Professor Stoughton advised that he believed an expert who specializes in detention and correction would be a better resource in this case than he. Because I knew of no one who had those credentials, Professor Stoughton helped me find Raney so that I would have a qualified, independent individual to review the use of force in this incident and provide an expert opinion. Professor Stoughton had not worked with Raney but knew him by reputation and felt comfortable making the introduction.

Timeliness of the Solicitor's Report

The Ninth Circuit Solicitor's Office, the South Carolina Law Enforcement Division (SLED), and local law enforcement have agreed to follow the Officer Involved Critical Incident Policy located at <https://www.scsolicitor9.org/files/OICI-Policy.pdf>. Through this policy, I created self-imposed, aspirational goals for making prosecutorial decisions. At page 22, the policy states:

The Solicitor will complete a review of the investigation within 60 days of receipt of the completed investigative case file barring unusual circumstances that require additional time. If at any time during the process, the Solicitor believes further investigation is needed she will notify [SLED] and request the necessary investigative action be taken. If the Solicitor requires additional time to make a decision, she will make a public statement disclosing the need for an extension of time, and the reason for the extension, if appropriate.

As promised, I publicly outlined the nature of the materials upon which we were waiting in order to meet the arbitrary, self-imposed deadline.

In order to evaluate a case for trial and to determine if we could prove any charges beyond a reasonable doubt, many aspects of Jamal Sutherland's death had to be more thoroughly investigated and analyzed. Key among them were the proximate cause of his death and any information that bore on the deputies' states of mind, i.e., their training, experience and explanations for what they did.

The finding of proximate cause is inextricably tied to the autopsy report and the toxicology findings. The taser findings from the deputies' tasers are relevant to proximate cause and the deputies' state of mind. The following dates are highlights of our receipt of pertinent information:

- March 10 Received Axon Report
- March 22 Received Final Autopsy Report (which turned out not to be final, at all)
- April 15 Met with Pathologist Downs and Coroner
- April 20 Met with Pathologist Downs, Coroner and Sutherland Family Attorneys
- April 30 Received SLED Report

- May 19 Received SLED Addendum 1
- June 8 Met (virtually) with Pathologist, Coroner and forensic toxicologist Demi Garvin
- June 10 Conference call with Coroner and forensic toxicologist Demi Garvin
- June 29 Received SLED Addendum 2
- June 30: Received Downs' Amended Final Autopsy Report
- May 17 Met with SLED regarding Axon Report
- May 21 Received Amended Axon Report
- July 8 Received Labay Toxicology Report
- July 14 Received Collins Autopsy Review
- July 24 Received Raney Report (Final)

As stated earlier, SLED did not opine as to the use of force, nor did the Sheriff's Office initially provide all the training materials that factored into Raney's review. In this case and under these facts, proving and understanding the deputies' training was critical. Due to matters beyond our control, Raney's review, analysis and report took much longer than he or I anticipated. Unfortunately, the Sheriff's Office did not provide pertinent training information in a timely manner to either SLED or my office. Likewise, one of the principal vendor trainers for the SOG ceased cooperation with my office. It is wholly unacceptable that the Sheriff's Office informed us of evidentiary discoveries as late as July 7, six months into this investigation and despite repeated requests from SLED and my office. In order for the Sutherlands and the community at large to have confidence in our review, they have to know that we performed our work with all due diligence. We could not assure them that we had conducted a thorough review until we finally gained confidence in July that the Sheriff's Office had provided us enough information to have a clear picture of the state of SOG training before January 5, 2021. As you will see, Mr. Raney's report is comprehensive.

Framework of Analyzing South Carolina Law When a Law Enforcement Officer is Involved in the Death of Another

South Carolina has neither an excessive force nor a use of force statute. We are one of only eight states in the country where the legislature has declined to enact any special or specific criteria for officer involved force. That omission affects the State's ability to hold officers accountable for excessive uses of force. In South Carolina, to prove that an officer is criminally liable for the death of a civilian, the State must prove that the officer 1) caused the death, 2) with a criminal mindset (known as *mens rea*), and 3) that their actions were unlawful. Beyond this, the State must prove each element of the charged crime beyond a reasonable doubt.

Officers are legally permitted to use force, including deadly force, under certain circumstances. In other states and in some federal contexts, the reasonableness of an officer's use of force must be judged from the perspective of a *reasonable officer* on the scene. That is an objective inquiry: the question is whether the officers' actions were "objectively reasonable" in light of the facts and circumstances confronting them, *without regard to the officer's underlying intent or motivation*. In those other jurisdictions, the use of *unreasonable* force exceeds police authority, potentially exposing an officer to criminal liability.

In South Carolina, on the other hand, an officer facing prosecution is held to the standards required of any other citizen, not that of a reasonable officer on the scene. The officer is viewed as a civilian. The officer's mental state is *subjective*, contained entirely within her/his own mind. The officer's personal underlying intent and motivation is the critical issue.

The Impact of a Detention Center Cell Extraction on the Evaluation of Evidence and Law

Whether it be called a jail, a prison, or a detention center, the purpose of the facility is to detain but their walls do not form a barrier separating inmates from the protections of the Constitution. Most importantly, pretrial detainees (unlike convicted prisoners) cannot be punished at all, much less “maliciously and sadistically.” With that acknowledgment, however, it is critical to recognize that inmates cannot be permitted to decide which orders they will obey and when they will obey them. Detention deputies are allowed to act in a good faith effort to maintain or restore discipline not only when they confront immediate risks to physical safety, but also when they attempt to “preserve internal order” by compelling compliance with detention rules and procedures. Courts have given officers “wide-ranging deference” in their determinations that force is required to induce compliance with policies important to institutional security. Deputies cross the line when they use force maliciously and for the very purpose of causing harm or when they inflict pain not to induce compliance, but to punish an inmate for stubbornness or to retaliate for insubordination.

American jurisprudence is well settled on premises that running a detention center is an inordinately difficult undertaking and that safety and order at these institutions require the expertise of correctional officials, who must have substantial discretion to devise reasonable solutions to the problems they face. Like other officers, detention deputies facing disturbances are often forced to make split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving. Management by a few guards of large numbers of prisoners in an institution may require and justify the occasional use of a degree of intentional force. An officer’s decision regarding how much force to use is made in haste, under pressure, and frequently without the luxury of a second chance. The perfection of hindsight’s 20/20 vision cannot require criminal liability for every use of force that proves to be unnecessary in retrospect.

Correctional officers and jailers have one of the highest rates of injuries and illnesses of all occupations, often resulting from confrontations with inmates. Officers work in shifts that cover all hours of the day and night, including weekends and holidays. Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook*, Correctional Officers and Bailiffs, at <https://www.bls.gov/ooh/protective-service/correctional-officers.htm>. Prisons and detention centers are dangerous places to work. Officers are tasked with staying a step ahead of inmates and their creativity. Officers are keenly aware that objects taken for granted and used in everyday life are often transformed into weapons. Toothbrushes, hairbrushes and eating utensils have all been used by inmates to attack other inmates or guards. Plastic can be particularly dangerous when melted or chewed into a sharp shape.

- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563516/>;
- <https://www.nydailynews.com/news/national/shanks-lesser-known-prison-weapons-article-1.2508679>;
- <https://m.magnoliastateline.com/2020/12/14/officer-stabbed-with-shank-made-of-plastic-spoons-and-blanket-during-escape-attempt/>

A “cell extraction” is a detention deputy’s (or corrections officer’s) forceful removal of an inmate who refuses to come out of a cell or other enclosed area of a detention or corrections facility. When undertaken properly, the extraction is a necessary method of maintaining order and security within the detention facility. By definition, however, cell extractions involve force. Inmates who do not want to comply with orders and/or leave their cells often are unpredictable. Cell extraction situations can be combustible. Even when perfectly executed, cell extractions carry risks. See <https://www.nytimes.com/2014/07/29/us/when-cell-door-opens-tough-tactics-and-risk.html>. At the SACDC, a small squad of detention deputies were trained and designated as the Special Operations Group (SOG). SOG Operators were supposed to attend multiple trainings per year and were to be utilized in high-risk situations, including cell extractions. Specific “rules,” i.e., policies, procedures and directives, of the Sheriff Al Cannon Detention Center (SACDC) in effect on January 5, 2021, will

be discussed in other sections of this report, and more thoroughly in the *Raney Report*. Some of the SACDC edicts had a devastating impact on the way events unfolded that morning.

On January 5, 2021, the Bond Court summoned Jamal Sutherland via detention deputies for Sutherland's 9:00 a.m. bond hearing. Sutherland refused to leave his cell voluntarily, and SOG Operator Deputy Houle was called to perform a cell extraction. Houle had been told that Sutherland was in jail on an assault and battery charge and that he was combative and had mental health issues. Houle did not know Sutherland's specific history or diagnosis. Houle sought permission to delay the extraction because of his concerns but due to a 2017 directive, his superiors denied his request.²

Houle was the only SOG Operator on duty at the time but he knew that Deputy Fickett, a former SOG Operator, was working as well. Since she was SOG trained, Houle asked Fickett to help him perform the extraction. Before the extraction began, Houle told Sutherland they would have to use force if he would not allow himself to be handcuffed. Sutherland repeatedly stated to Houle, "I'm warning you. I'm warning you." Both Houle and Fickett observed Sutherland with a plastic spoon, acting as if he would use it as a weapon. Fickett was not briefed on Sutherland's mental health issues.

Every decision the deputies made during this incident, in response to their assignment, must be interpreted in light of the context of a detention center cell extraction, the deputies' prior training and the information the deputies had at that time.

EVIDENTIARY OVERVIEW

The Sheriff's Office Policies, Directives and Training Information

Because the State must prove each deputy's state of mind and her/his intentions, it is important to have as much information as possible regarding what each deputy was informed and what each deputy understood regarding the Sheriff's Office's policies and directives related to uses of force. Again, a deputy's state of mind is *subjective*. This means that unlike many other jurisdictions, the "objectively reasonable officer" standard does not apply. The State has to prove what these individuals personally knew, believed and felt as they were interacting with Jamal Sutherland on January 5, 2021. The trajectory of the interaction between the deputies and Jamal Sutherland began with these policies and directives and ended with the deputies' training. The pertinent written policies are linked below while their training is more thoroughly addressed in the *Raney Report*:

- <https://bit.ly/5-036-Special-Management-Unit-82218-Beatty>
- <https://bit.ly/5-0411-Behavioral-Management-Unit-13019-Beatty>
- <https://bit.ly/5-316-SOG-111920-Beatty>
- <https://bit.ly/5-335-Use-of-Force-42717-Beatty>
- <https://bit.ly/5-354-Use-of-Restraints-and-Seclusion-100518-Beatty>
- <https://bit.ly/5-365-EMDT-43018-Beatty>
- <https://bit.ly/5-374-OC-110816-Beatty>
- <https://bit.ly/5-425-Emergency-Restraint-Chair-102320-Beatty>
- <https://bit.ly/9-144-Video-Bond-Hearing-72219-Beatty>

² Houle's requests were to his chain of command. Bond court judges were not consulted or otherwise involved.
<https://bit.ly/MOI-Judge-Mel-Coleman-Rev-by-Ghent>

- <https://bit.ly/9-144-Video-Contra-Bond-Court-Directive-42017-Salters>

Sutherland's Required Appearance at Bond Court

Had the Video Bond Hearing Policy 9-14.4 been followed, the tragic death of Jamal Sutherland may never have occurred. The policy allowed inmates to refuse to appear without force being used. It provided that a detention deputy would follow-up with the inmate regarding participation in a bond hearing at each bond court session. If the inmate continued to refuse, the deputies were to notify the bond court judge. The bond court judge would then decide which course to take, including ordering that the inmate be brought before the judge. In that instance, the Special Operations Group (SOG) was to escort the inmate to bond court. By allowing refusals before skipping to the extreme of a cell extraction, the detention center and the court had options such as mental evaluations and attempts of de-escalation. Had superiors honored his request for a postponement, a cell extraction likely would not have happened and Houle and Fickett likely would have never interacted with Sutherland.

Unfortunately, in April 2017, Policy 9-14.4 was pre-empted by a directive from the upper ranks of the detention center. This directive stated that from that moment forward, when an inmate refused to go to his bond hearing "the first time", deputies were instructed to notify supervisors and contact the SOG for use of an Emergency Restraint Chair (ERC)³. Per Policy 5-42.5, an ERC is used when an inmate is exhibiting uncontrollable or violent behavior. It is intended to assist in the control of combative, self-destructive or potentially violent inmates. Use of the ERC is considered a "Use of Force." If an inmate, like Sutherland, were to refuse to come out of his cell, a cell extraction would be used to get the inmate in an ERC. Because of this directive, detention deputies summoned the SOG, which is considered under Policy 5-31.6 a "last resort in resolving a situation." There appear to have been no policies or procedures specifically related to executing a cell extraction. Likewise, there did not appear to be any retained training materials related to properly executing a cell extraction. Earlier this month, however, some 7 months after Sutherland's death, CCSO provided me with a mélange of SOG training videos and materials that include videos of cell extraction training. To date, it does not appear CCSO provided reference materials to SOG Operators for their use as a resource. In fact, it appears providing such written materials was discouraged.

Statements from the Command Staff

Raney outlines the important facets of the Sheriff's Command Staff interviews regarding bond court practices in his report. The recorded interviews of key CCSO command staff can be found at these links:

- <https://bit.ly/Lt-Brian-Duvall-SLED-Interview-1>
- <https://bit.ly/SLED-MOI-of-2nd-Interview-with-Lt-Duvall>
- <https://bit.ly/Cpt-Greathouse-SLED-Interview>
- <https://bit.ly/Deputy-James-SLED-Interview>
- <https://bit.ly/SaltersE-041621-Audio>

Uses of Force Policies v. Training

Policies

³ To her credit, Sheriff Kristin Graziano quickly implemented changes to bond hearing policy and procedures which should remedy the grave error of the former administration.

As previously discussed, a cell extraction by nature involves the planned use of force and Policy 5-33.5 governed force within the detention center. The Policy provides that force may be used to enforce compliance with rules, regulations and orders when other methods of control have proven insufficient. Both the use of oleoresin capsicum (OC) Spray and electro-muscular disruption technology devices (EMDTs / tasers) are allowed. The policy recognizes that while various levels of force exist, only the level of force which is reasonably appropriate under the circumstances to “successfully accomplish a legitimate correctional purpose” should be used. Factors to be considered are the resources available, the conduct of the inmate, the level of resistance and the relative age, size, strength, skill level of the deputies and inmates.

Policy 5-37.4 regarding OC Spray provides that it may be used during any planned use of force, to include cell extractions. While the policy directs that staff should wait for the OC to take effect, it gives no direction as to how long a deputy should wait for the OC to take effect—only that symptoms usually last 5 to 10 minutes. The application of a “spit mask” is briefly referenced in the Emergency Restraint Chair Policy 5-42.5 but does not appear to be addressed in any detail in the policies and procedures in place on January 5, 2021.

Policy 5-36.5 governs Taser use. Tasers are considered “less lethal weapons” and are designed to incapacitate a subject and when used properly, are less likely to result in death or serious injury than uses of what is commonly referred to as deadly force. Tasers are allowed to be used when the amount of force is objectively reasonable given the facts and circumstances to effectively bring a violent or potentially violent individual under control, including when the violent or potentially violent person is actively resisting, aggressively resisting or displaying aggravated active resistance.

Tasers are designed to give five second bursts of shock. Policy 5-36.5 allows that “additional bursts may be administered by pulling the trigger if the targeted subject is not controlled by the initial burst.” The policy also allows that “if necessary additional five second bursts may be used to control the subject.” There is no direction in the policy as to how many Taser bursts are too many. There is no direction in the policy prohibiting simultaneous Taser bursts. All uses of Tasers are required by CCSO to be “objectively reasonable.”

Training

Training materials from the Charleston County Sheriff’s Office were scant. It is clear that in the last several years, training of the SOG was in flux. Joseph Garcia previously operated United States Correction-Special Operations Group (US C-SOG).⁴ Garcia conducted the SACDC SOG training from around 2008 through 2019. He eventually fell in disfavor with some at SACDC and his contract was terminated. The Sheriff’s Office decided to bring training “in house”. The SOG leadership still subscribes to the substance of Garcia’s training but disavows his personal approach. We are informed that much of the substance of what Garcia taught is still used to train SOG Operators.

It was known that SOG training differed in some respects to Detention Center Policies and Procedures. In fact, on more than one occasion, members of the SOG were asked to memorialize these differences for the Sheriff’s Office of Professional Standards. Deputy Fickett made reference to this in a 2018 deposition and Lieutenant Shaw confirmed these events in an interview. When requested by the Solicitor’s Office to provide these memoranda, Shaw was not able to find copies, but he did find a report where he outlined some of the problems with Garcia’s training. <https://bit.ly/2018-Shaw-Stmt-on-Garcia-Training>

My Chief Investigator, Ray Haupt, spoke to and emailed with Garcia on a number of occasions. Garcia has made many claims as to his training superiority though his credibility is

⁴ Garcia now operates the Corrections Special Applications Unit (CSAU).

in question⁵. Despite our requests for his training materials, Garcia has provided little documentation. During our investigation, SLED and we requested copies of these materials from the Sheriff's Office to no avail. Only in the past month were we provided copies of a hard drive containing 162 gigabytes of information.⁶ In digging through the numerous files, we discovered pertinent memoranda. As discussed in the *Raney Report*, we also discovered training videos regarding the use of tasers on passively resisting inmates.

The Video Evidence

Video and audio recordings can be imperfect. Video may be unsteady and low quality and often is limited by the angle from which it is taken. Audio may be garbled, muffled, or indecipherable based on the distance of the recording device from the sounds or the chaos of the situation. Even law enforcement's body cameras may be of limited usefulness in some scenarios, especially when struggles are at close quarters or in lower light.

Unlike too many other cases of officer involved force, Houle and Fickett ensured that their body worn cameras were activated and operational. The detention center also utilized overhead video in the common area of the BMU and it was operational. It was not situated in a way to capture the scene inside Sutherland's cell, but it does corroborate the deputies' descriptions of what happened before the extraction began. Although the audio and video from this incident are not perfect, they are extremely valuable, important evidence. Still, none captures every move of anyone involved. Most of those following this investigation are familiar with the BWC cell extraction videos. The BWC videos along with others that provide context are linked below.

- **Overhead Camera Videos:**

- <https://bit.ly/BMU-Overhead-Fisheye-Camera---Video-1>
- <https://bit.ly/BMU-Overhead-Fisheye-Camera---Video-2>
 - These videos do not contain audio but document the deputies talking to Sutherland before the extraction begins. At approximately 9:29:07⁷ on the video, Houle speaks to Sutherland and this appears to coincide with Houle's first BWC activation.
 - Shortly after 9:29:45, Sgt. Fennell begins speaking to Sutherland. They talk for roughly 12 minutes. <https://bit.ly/Fennell-Incident-Report>
 - Later, Deputy Fickett's BWC video captures Fennell saying to Sutherland, "“Do you want me to cuff you? Do you want me to cuff you? Put your hands through I'll cuff you? Come on. Come on. I got you. We'll take you down there. We'll go down there together.”"

⁵ Articles referencing Joseph Garcia and his training methods:

<https://www.wsj.com/articles/city-probes-contract-to-train-rikers-officers-1472566643>

<https://nypost.com/2016/09/19/rikers-island-vendor-under-fire-has-gone-mia/>

<https://flaglerlive.com/26604/corrections-special-ops-flagler/>

<https://www.prisonlegalnews.org/news/2017/mar/9/rikers-island-guard-trainers-lose-lawsuit-failure-repay-loan/>

⁶ CCSO's Mike Stanley recently informed superiors that the SOG had a computer that the entire team uses that potentially contained pertinent information. At CCSO's request, the County's IT department then searched the computer for relevant files which were found and then reviewed by CCSO leadership and later provided to my office.

⁷ The cameras recording each video in this matter did not have synchronized clocks and therefore show different timestamps for the same events. Likewise, the time clocks on the deputies' tasers are not synchronized with each other or with any of the video timestamps.

- **Houle Body Worn Camera Video 1:**

- <https://bit.ly/Houle-1st-BWC-Video-with-Subtitles>
- <https://bit.ly/Houle-1st-BWC-video>
- This video was activated approximately 14 minutes before the cell extraction begins and captures Deputy Houle's interaction with Sutherland.
- Lt. Duvall first tells Sutherland that he needs to go see the judge so he can "get this thing over with." He tells Sutherland he has to go down and see the judge.
- Houle is with Sutherland for almost a minute and Houle tries to convince Sutherland to allow Houle to handcuff him to go to bond court.
- Lt. Duvall warns Houle that Sutherland has a spoon in his hand, as if he is going to use it as a weapon.
- Houle directs Sutherland to put his hands through the flap so they can put handcuffs on him and take him to bond court. Some of Sutherland's responses are inaudible but he clearly states several times, "I'm warning you."

- **Fickett Body Worn Camera Video 1:**

- <https://bit.ly/Fickett-1st-BWC-Video-with-Subtitles;>
- <https://bit.ly/Fickett-1st-BWC-video>
- This video is only 41 seconds long and documents Fickett's approach to Sutherland's cell.
- As Fickett and Houle approach Sutherland's cell, Deputy Fennell can be heard stating, "Do you want me to cuff you? Do you want me to cuff you? Put your hands through I'll cuff you? Come on. Come on. I got you. We'll take you down there. We'll go down there together. Last chance."

- **Houle Body Worn Camera Video 2 & Fickett Body Worn Camera Video 2:**

- <https://bit.ly/Side-by-Side-Video-with-Subtitles>
- <https://bit.ly/Fickett2ndBWCvideo>
- <https://bit.ly/Houle-2nd-BWC-video>
- These videos have been the most viewed and discussed publicly. My office combined and synchronized the videos so they can be viewed side-by-side. We also added subtitles to the precursor conversations.
 - These are the most important pieces of evidence that show most of the deputies' actions and chronicle the pain of Jamal Sutherland, as well as his statements that he cannot breathe.

Involved Deputies' Statements

In today's justice climate, many officers who are involved in critical incidents refuse to give statements to the independent investigators. When they do offer statements, many officers seek legal representation first. In this investigation, Deputy Houle submitted to two interviews with SLED. The first was on the date of Sutherland's death (January 5) and the follow-up was on January 15. Deputy Fickett submitted to three interviews with SLED. The first was on the date of Sutherland's death (January 5) with follow-ups on January 15 and February 8. On June 23, 2021, Fickett was represented by counsel for a fourth interview under a proffer agreement

with my office.

The recorded or memorialized interviews are linked at:

- <https://bit.ly/Fickett-SLED-Interview-1>
- <https://bit.ly/Fickett-SLED-Interview-2>
- <https://bit.ly/Fickett-SLED-Interview-3-MOI>
- <https://bit.ly/Fickett-SLED-Interview-3>
- <https://bit.ly/4-21-2021-Fickett-OPS-Interview>
- <https://bit.ly/Fickett-Proffer-Recording-1>
- <https://bit.ly/Fickett-Proffer-Recording-2>

- <https://bit.ly/Houle-SLED-interview-1>
- <https://bit.ly/Houle-SLED-Interview-2>

Axon Taser Report

<https://bit.ly/REVISED-Axon-Report-5-20-2021>

Tasers are designed to cause neuro-muscular incapacitation (NMI). There are different levels of NMI ranging from limited area effects to significant body lockup. The greater the probe spread, the higher likelihood of NMI. Subjects may maintain muscle control, particularly in arms and legs, depending on many factors including probe locations. While Axon Enterprise gives much advice and many disclaimers, they acknowledge repeatedly that they do not set policy for law enforcement.

Both Houle's and Fickett's tasers recorded information into "Trilogy Logs", which are explained in the above linked report. Both Houle and Fickett were trained that their tasers contained computer chips that recorded their taser use. Many factors affect the effectiveness of a taser including, but not limited to: the spread between the probes, the location of the probes on the subject's body, clothing and movement.

Before reviewing their BWC footage or having access to the Axon Taser Report, Houle described his belief that Fickett's taser was not working properly, with his surmising the prongs were not connected. Though the video shows clearly that Sutherland was receiving some amount of electrical shock, the Axon Report shows that he was not receiving the full charge of Fickett's taser. The BWC videos do not show the actual spread of Fickett's taser probes, and puncture wounds from her taser were not observed at autopsy. Sutherland's jail suit was cut and torn to make way for medical treatment. SLED's crime scene examiners were unable to locate any of the small holes left from where Fickett's taser probe penetrated. Fickett activated her taser 7 times. For 4.6 seconds, the taser lost connection. For 28.4 seconds cumulative of Fickett's taser activation, the taser appears to have had a partial or poor connection. For 2 seconds, it appears the charge was into flesh (versus into the muscle, which is more effective).

As for Houle's taser, the spread of the taser probes was not optimum and did not bring Sutherland to NMI. This is *not* to say that the taser had no effect. The video shows clearly that the probes inflicted pain on Sutherland and caused him to be combative and agitated. It appears from the Axon report that Houle's taser had a constant connection although it appears Houle's probes also were discharged into flesh (as opposed to muscle, which is more effective).



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EVIDENTIARY ANALYSIS

As SLED's investigative file and witness statements will be public, I will not rehash what each witness revealed. I have considered all the statements in the context of what happened to Jamal Sutherland and in light of the accounts of other witnesses, the video evidence, the physical evidence, and all other relevant materials obtained during the course of the investigation.

Bear in mind that, as with all investigations involving multiple witnesses, the accounts are not all consistent. This is not unusual. Witnesses and the people directly involved in disturbing or controversial incidents often have some variance in their accounts. In fact, prosecutors and defense attorneys alike expect this. Reasons for variances are not necessarily nefarious. They include how the mind responds to stress, the witness' vantage point and opportunity to see and hear the event, whether the witness was influenced by bias including implicit bias or bias arising from that person's personal involvement in the event or a relationship with someone involved. In determining why Jamal Sutherland died the way he did, I considered these limitations and gave the most weight to statements that are corroborated by other evidence.

Every real trial lawyer knows that I cannot look at the evidence in the light most favorable to the State or in the light most favorable to a conviction. Instead, to decide whether criminal charges are viable, I must consider how the evidence will be presented and then will be attacked by a competent defense. I must consider the evidence knowing that the State's burden is to prove each element of a crime beyond a reasonable doubt and to understanding that a jury must resolve any doubts in favor of a defendant.

With that in mind, the evidence strongly supports the following series of events:

Events Occurring Before the Cell Extraction and Use of Force

- Jamal Sutherland should not have died in the custody of Charleston County.
 - Sutherland had a long history of schizophrenia.
 - Sutherland had difficulty in managing his schizophrenia in late 2020.
 - Sutherland committed himself to Palmetto Lowcountry Behavioral Health on December 31, 2020.
 - Sutherland requested and was denied a discharge from Palmetto on the morning of January 4, 2021. He complained

that he was doing worse than when he committed himself.
<https://bit.ly/AMA-Discharge>

- Sutherland damaged property and assaulted a staff member at Palmetto shortly before 6:50 pm on January 4. He was arrested by North Charleston Police Department for misdemeanor assault and taken to the SACDC.
- Sutherland appeared to remain in an excited state after his arrest. Because of this, the booking process was not completed and Sutherland was taken to the Behavioral Management Unit (BMU) at SACDC. The Special Management Unit (SMU), which houses mental health patients was full.
- Palmetto did not contact SACDC with any of Sutherland's history. Palmetto did not send or notify SACDC of Sutherland's medication needs.
- Sutherland was never evaluated by medical or mental health care professionals at SACDC (except after he was incapacitated).
- On January 5, 2021, Bond Court summoned Jamal Sutherland via detention deputies for Sutherland's 9:00 a.m. bond hearing.
- Sutherland refused to leave his cell voluntarily, and SOG Operator Deputy Houle was summoned to perform a cell extraction.
- Before Houle (and Fickett) engaged with Sutherland, detention deputies attempted to convince him to voluntarily go to bond court.
- For roughly 12 minutes, Sgt. Fennell talked with Sutherland in an effort to convince him to let them take him to bond court. Fennell noted that Sutherland was agitated and believed he had a sharpened spoon.
- Sgt. Fennell advised Sutherland that the SOG team would remove him by force for him to go to bond court.
- Lt. Duvall spoke with Sutherland on occasion as well, trying to convince him to come out for bond court.
- When told that force would have to be used, Sutherland responded to Sgt. Fennell by walking to the back of the cell and stating, "Pop the pin."
- Houle was told that Sutherland was in jail on an assault and battery charge and that he was combative and had mental health issues.
 - Houle did not know Sutherland's specific history or diagnosis.
 - Fickett was not briefed on Sutherland's mental health issues.
- Because of his concerns, Houle sought permission to delay the extraction but due to a 2017 directive, his superiors denied his request. Despite no consultation with any bond court judge, Houle's superior led him to believe a Judge had ordered Sutherland's appearance.
- Houle was the only SOG Operator on duty at the time but he knew that Deputy Fickett, a former SOG Operator, was working as well. Since she was SOG trained, he asked Fickett to help him perform the extraction.

- Before the extraction began, Houle told Sutherland they would have to use force if he would not allow himself to be handcuffed.
- Sutherland repeatedly stated to Houle, “I’m warning you. I’m warning you.”
- Before the extraction began, Houle and Fickett confirmed to Lt. Duvall that their body worn cameras were activated and that a medical team was present.
- Both Houle and Fickett observed Sutherland with a plastic spoon, and they were concerned he would use it as a weapon.

Use of Force During the Extraction

- Gary Raney outlines the use of force during the cell extraction in great detail. He includes a detailed analysis of the negligence that permeated the process. <https://bit.ly/RANEYREPORT>
 - Both Fickett and Houle made tactical errors that compounded the danger to Sutherland (and themselves) in an already volatile situation.

Events Occurring After Sutherland Was Subdued

Some have questioned the medical care given Sutherland immediately after he was subdued. The involved deputies were assured that the medical team was present during the extraction. Deputy Fickett asked for their help as soon as Sutherland was pulled from the cell. Fickett requested that the nurse remove the taser prongs. One minute later, she asked if the nurses could “check him” and the medical team began their care for Sutherland.

While the way Sutherland’s medical distress was addressed is an issue, courts have recognized that lay people are not qualified to determine medical fitness, whether physical or mental, and that is why prisons in detention centers employ independent medical experts. Detention center deputies are not trained medical personnel and they are entitled to rely on the opinions, judgment, and expertise of medical personnel concerning the course of treatment which the medical personnel deem necessary and appropriate for the inmate.⁸

LEGAL ANALYSIS

The Law of Criminal Responsibility for the Death of Another

Proximate Cause

To prove any of the criminal offenses outlined below, the State must prove beyond a reasonable doubt that a defendant’s act was the proximate cause of death. Proximate cause is the immediate cause. It is the cause without which the death of the victim would not have resulted. There may be more than one proximate cause and the acts of two or more people may combine to be a proximate cause of the death of a person. A defendant’s act need not be the sole cause of the death, but it must be a proximate cause.

⁸ See *Griffin v. Cellman*, No. CV 0:17-152-MGL-PJG, 2018 WL 3104285, at *6 (D.S.C. Feb. 20, 2018), *report and recommendation adopted*, No. CV 0:17-00152-MGL, 2018 WL 1443948 (D.S.C. Mar. 22, 2018), *aff’d*, 748 F. App’x 521 (4th Cir. 2019). The cited case is instructive in addressing any claim that the deputies were derelict in their reliance on the detention center’s chosen medical team.

While many lay people believe that the BWC video speaks for itself and is the only evidence that matters in this investigation, seasoned trial attorneys, judges and investigators know that in order to prosecute the involved deputies, the State must prove beyond a reasonable doubt the deputies were the proximate cause of Jamal Sutherland's death. The video *alone* would not suffice. The first autopsy report in and of itself provided reasonable doubt as to the deputies' hand in Sutherland's death. While I am not a medical doctor, I was concerned by the pathologist's statements that the video of the extrication did not reveal any "unusual or excessive interactions or areas of direct concern." I certainly was concerned by what I saw on the videos.

On the other hand, I was not alarmed by the pathologist's decision to label the manner of death as "undetermined." The word "homicide" is not equal to or synonymous with any crime in South Carolina. Many prosecutions move forward when a manner of death is "undetermined," and sometimes cases deemed a "homicide" are not a crime. In fact, the National Association of Medical Examiners notes that the term "homicide" with regard to a death certificate is a "neutral" term that does not indicate or imply criminal intent, a determination within the authority of legal processes. (For reference, see the National Association of Medical Examiners, *A Guide for Manner of Death Classification* (1st ed. 2002).

I sought a review from board certified pathologist Dr. Kimberly Collins. Because Dr. Collins was not allowed to meet with or speak to the forensic toxicologist involved in the case, I also had to retain the services of Dr. Laura Labay. Their reports are linked here:

- <https://bit.ly/Collins-Opinion-71421>
- <https://bit.ly/Labay-Expert-Report-NMS-Labs>

Not surprisingly to me, Dr. Collins deemed Jamal Sutherland's death a "homicide", as did the original pathologist in a later report. She explained the basis of her opinion as follows:

While Mr. Sutherland was at the Charleston County Detention Center, he was very agitated, delusional, and paranoid, and showing signs of his underlying diagnosis of schizophrenia. As witnessed and seen on video, these signs and symptoms were magnified during the extraction process. While Mr. Sutherland's position during extraction and the deputies' use of a spit cap may have contributed to his excitement or agitation, he did not die from suffocation or asphyxiation. Likewise, while the deputies' use of conducted electrical weapons (tasers) may have contributed to Mr. Sutherland's excitement or agitation, he did not die from the taser applications themselves. The deputies' actions (taser, spit cap, positioning) alone were unlikely to have killed him. The combination of the schizophrenia, medications administered, absence of medications, and the deputies' actions killed Sutherland.

It is my opinion that the absence of the aforementioned prescribed and needed antipsychotic, antianxiety, and antidepressant medications increased his psychotic behavior at this time. This resulted in an extremely agitated psychotic schizophrenic individual who was attempted to be extracted.

The medications that were present in his system also played a role in his death. Specifically, chlorpromazine and olanzapine. Both of these drugs are antipsychotic agents. When taken they can prolong the QT interval of the heart, cause dysrhythmia (or bad heart rhythm), and can lead to sudden death. Olanzapine can affect the blood pressure and heart rate, and in some patients compounding the effects of chlorpromazine. On top of this, diphenhydramine can cause dose related cardiac adverse attacks including dysrhythmia.

Mr. Sutherland did not have the proper prescribed medications in his system to control his psychotic, schizophrenic, and anxious behavior. Therefore, he was in a highly agitated state at the Charleston Detention Center especially upon extraction. Such an agitated state can result in increased heart rate, increased blood pressure, and dysrhythmia. In addition, the drugs that were present in his blood are known to have the potential to lead to adverse cardiac effects including dysrhythmia. The medications administered, and not administered, coupled with his schizophrenia could have killed him even without the deputies' involvement.

It is my opinion that the mechanism of death is dysrhythmia due to adverse drug reactions, lack of proper antipsychotic medication, underlying schizophrenia, and deputies' actions. The manner of death is homicide.

While the physical evidence discovered at autopsy is not definitive, I have no doubt that the State could prove the deputies were one of the proximate causes of Sutherland's death. In addition to Dr. Collins' and Dr. Labay's findings, the video evidence is compelling. Proving proximate cause, however, does not necessarily mean proof of a crime under South Carolina law.

Without question, if we were to proceed to trial, the defense would have fodder to challenge this assertion. A seasoned defense attorney would begin by stressing the original pathologist's assertion that, "a visual review of the extrication process fails to document any unusual or excessive interactions or other areas of direct concern" along with the CMA's observation. <https://bit.ly/CMA-Burch>

Even though proximate cause would be challenged, I am convinced the State could prove the deputies were a proximate cause to Sutherland's death and for purposes of this analysis, I am *presuming* as much. Sutherland came into distress during the subdual process. The deputies pepper sprayed him, tased him, utilized a spit mask, handcuffed him and placed him in the prone position. He died immediately after the deputies ceased their interactions with him. The actions of others in administering various drugs combined with the deputies' actions exacerbated Sutherland's excited state which led to an adverse pharmacotherapeutic effect causing Sutherland's death.⁹

Houle's & Fickett's Intent

As explained earlier, an officer facing prosecution in South Carolina is held to the same standards as any other citizen, not that of a reasonable officer on the scene. The officer is viewed as a civilian. The officer's mental state is *subjective*, contained entirely within her/his own mind. In determining whether the defendant's beliefs were reasonable, the jury would be instructed that a *belief might be reasonable even though it is mistaken*; the standard is what a person of ordinary intelligence and prudence would have believed in the defendant's position under the circumstances that existed at the time of the alleged offense. The reasonableness of the deputy's beliefs must be determined from the standpoint of the deputy at the time of the deputy's acts and not from the viewpoint of the public now.

The events leading to Jamal Sutherland's death are well established by the evidence: Fickett's and Houle's actions are very well documented in their body worn camera videos and in the Axon taser report. ***The issue in this matter is not what the deputies did; it is the state of mind of each of them, individually.*** The question is what the State can prove regarding what each knew, felt and believed. As in any case, we look to all of the circumstances surrounding a suspect's actions to help determine her/his state of mind. Each of the crimes below has a different element of proof for a suspect's state of mind.

⁹ South Carolina's criminal law allows for a combination of actions to culminate in the proximate cause of death. There may be more than one proximate cause.

Murder

In South Carolina, murder is defined as an unlawful killing of another with malice aforethought. The State must prove the defendant killed another person with malice aforethought. “Malice” is hatred, ill will, or hostility towards another person. “Malice” is the intentional doing of a wrongful act without just cause or excuse and with an intent to inflict an injury or under circumstances showing an evil intent; malice need not exist for any particular time before the act is committed.

Voluntary Manslaughter

Voluntary manslaughter requires proof of two elements, a sudden heat of passion and sufficient legal provocation: Voluntary manslaughter is the unlawful killing of a human being in sudden heat of passion upon sufficient legal provocation. Heat of passion alone will not suffice to reduce murder to voluntary manslaughter. Both heat of passion and sufficient legal provocation must be present at the time of the killing. The sudden heat of passion, upon sufficient legal provocation, which mitigates murder to manslaughter, while it need not dethrone reason entirely, or shut out knowledge and volition, must be such as would naturally disturb the sway of reason, and render the mind of an ordinary person incapable of cool reflection, and produce what, according to human experience, may be called an uncontrollable impulse to do violence.

Involuntary Manslaughter

To establish Involuntary Manslaughter, the State must show the defendant killed another person without malice and unintentionally while the defendant was engaged in either (1) an unlawful activity not amounting to a felony and not naturally tending to cause death or great bodily harm; or (2) a lawful activity with a reckless disregard of the safety of others. S.C. Code Ann §16-3-60. *See State v. Collins*, 409 S.C. 524 (2014). Reckless disregard for the safety of others means the actor is not interested in the consequences of his or her acts or the rights and safety of others.

These crimes are the available options for holding someone responsible for another’s death in this context (as opposed to vehicular homicides, child homicides, etc.) On these facts, the State could not prove beyond a reasonable doubt that either Deputy Fickett or Deputy Houle acted with malice or in the heat of passion or with a *conscious* disregard of the risk of Sutherland’s death. There is no evidence that either acted out of hatred or anger. There is no evidence that either had an uncontrollable impulse to do violence. Finally, the evidence does not show that either of the deputies was uninterested in the consequences of his or her actions and that they simply did not care about Sutherland’s safety. Similarly, the State cannot disprove beyond a reasonable doubt that after Fickett’s second taser use, the deputies believed they were acting in their own defense or in defense of each other. *The fact that they likely were mistaken does not convert their actions into a crime.*

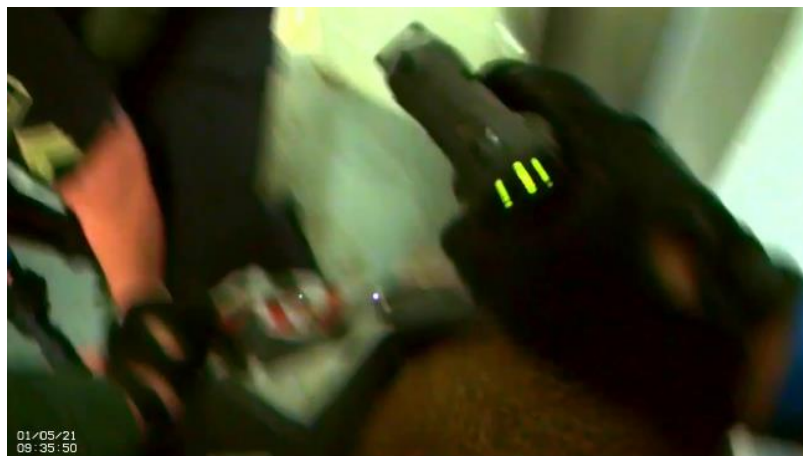
Key Factors in determining the deputies individual and subjective states of mind are as follows:

- Deputy Houle’s expressed and confirmed concern over performing a cell extraction to take Jamal Sutherland to bond court and his confirmed attempt to postpone the bond hearing.

- Deputy Fickett's and Deputy Houle's legitimate belief that a judge had given them lawful orders to produce Jamal Sutherland for bond court and that their superiors authorized a cell extraction.
- Expert Gary Raney's report on training, policy, patterns and practice within the SACDC had a tremendous impact on the deputies' states of mind. Specifically:
 - The SACDC policy was insufficient to guide SOG practices.
 - The SACDC had no policies or procedures on cell extractions.
 - Training and supervision are the greatest influences on deputy's behavior and for all topics related to the use of force in this event, the SACDC's training was seriously insufficient. Even worse, the culture of the SACDC leadership was to look the other way when policy violations occurred and to sanction training that preferred the use of force over avoidance and de-escalation techniques.
 - The insufficient staffing of the extraction that followed the misguided SOG training, was the responsibility of the CCSO administration.
 - Videos of Fickett's training show that she was, at least at one point, trained to use a taser on passively resisting inmates. Most similarly situated jails would not authorize the use of a taser under similar circumstances but some do, so Raney cannot assert that the use violated generally accepted practices.
 - While there are generally accepted jail practices for the taser in standard situations, there are none that specifically guide the frequency and cumulative exposure against a real or perceived risk of serious bodily injury. It is recognized that the more instances and the longer the exposure, the greater the risk. While shocking to watch, nothing can definitively establish that Fickett's use was unreasonable or violated generally accepted jail practices when her perceptions are considered.
 - The frequency of taser use and the simultaneous applications are damning for the deputies. Generally accepted jail practices restrict the use of a taser to three applications for a cumulative fifteen seconds under normal circumstances. The most common exception is when there is an imminent risk of serious bodily injury to the deputies and, as used here, serious bodily injury includes fractures, lacerations and more serious injuries. When Sutherland (understandably) became agitated and frantic from the taser shocks while having a loose handcuff on his wrist, there was a legitimate risk of Houle suffering serious bodily injury.
 - The deputies had (*and have*) erroneous perceptions regarding positional and compressional asphyxia. Even the Sheriff's Office of Professional Standards validated their misperceptions.
- Deputy Fickett and Deputy Houle ensured that their BWCs were activated before the cell extraction began.
- Deputy Fickett and Deputy Houle's documented concern over the appearance that Sutherland may use a spoon or tray as a weapon.
- Deputy Fickett's statement to Sutherland after the pepper spray that, if he will come to the door, they will get him out of there.
- Deputy Houle's pleas to Sutherland in an effort to convince Sutherland to cooperate. These include statements like:
 - "Hey, if you don't comply, we're going to use force.
 - {After pepper spray} "Hey, it's going to feel better if you come to the door and get out of there."
- Deputy Fickett's statements to Houle before the first taser that if Sutherland turns the other way, she is going to "hit him with the taser."
 - Fickett later explained that she did not want Sutherland to climb on anything

because that would eliminate the safer taser opportunity. If Sutherland, who was behaving erratically, were on top of something, the risk of him falling and seriously hurting himself would be too great. She wanted to tase him while his feet were on the ground. (Fickett was trained to use taser on passively resisting inmates.)

- Deputy Fickett's proffer statements explaining that she used her taser because the taser is viewed as a safer, less dangerous use of force in the detention center than use of "hard empty hand control."
- Deputy Fickett's statements to Sutherland in an effort to convince Sutherland to cooperate so that she would not have to tase him again.
 - Fickett to Sutherland, "Stop, stop, stop, stop. You still got probes in you."
- Deputy Fickett's proffer statement explaining that after her first taser deployment, she did not tase Sutherland when she believed he was complying enough for Houle to get him handcuffed. It was only when she (mistakenly) believed that Sutherland was trying to turn to get up, that she deployed her taser the second time.
- Deputy Fickett and Deputy Houle's reporting that Sutherland would not comply and continued to try to get up.^{10 11}



¹⁰ Naturally, Sutherland being mentally ill and experiencing the shock of tasers caused this frantic behavior. Sutherland should not have been placed in this predicament and he was *not* the author of his own demise.

¹¹ The "freeze frames" from the deputies' BWC video clips are captured at approximately 25 frames per second. The human eye likely captures information much faster. <https://azretina.sites.arizona.edu/index.php/node/837>

- Deputy Fickett and Deputy Houle’s reported concern over Sutherland resisting by his grabbing Houle’s leg:



- A handcuff that is only attached to one uncontrolled wrist is known to be a potentially dangerous weapon. For the period of time when Sutherland was frantic, and no doubt in pain from the taser, everyone was in danger.
- Despite some claims, Deputy Fickett and Deputy Houle did not deploy their tasers after Sutherland is handcuffed and subdued and they did not stand on Sutherland.
- Neither Deputy Fickett nor Deputy Houle use profanity or slurs directed toward Sutherland.
- Deputy Fickett made an effort to get Sutherland medical care.
 - Fickett informed the nurse that Sutherland had “two probes in the front if [she] can get them.”
 - Deputy Fickett requested that a nurse (a minute after the probes are removed) to check on Sutherland.

Many people may still adamantly (and understandably) believe that the deputies' actions during the cell extraction was "excessive force" but that is not the standard. The standard is whether the State can prove, beyond a reasonable doubt, that each deputy acted either with malice aforethought or in the heat of passion or with conscious disregard for Sutherland's risk of death. The deputies' tactics during the cell extraction were flawed. They were negligent but they also complied with much of their training, policy and procedures. As a policy matter, Sheriff's Office training at the detention center must change. For now, in this case, it would be impossible for any prosecutor to argue in a courtroom that the deputies acted with the requisite criminal intent by following their training.

BASIS OF DECISION

My decision whether or not to pursue criminal charges is based on my almost 30 years of experience as a prosecutor. I approached this case and applied the same standard based on the facts and the law as I would when considering criminal charges in any matter. I am guided and informed by the ethical duties suggested by the American Bar Association and other professional organizations. As noted previously, the ABA Standards for Criminal Justice Relating to the Prosecution Function, Standard 3-4.3 provides in part that "[a] prosecutor should seek or file criminal charges only if the prosecutor reasonably believes...that admissible evidence will be sufficient to support conviction beyond a reasonable doubt."

Where I do not have expertise, I sought out those who do. I met with Dr. J.C. Upshaw Downs, the pathologist who performed the autopsy on three occasions. I spoke with Demetra Garvin, the forensic toxicologist retained by the Coroner. I retained board certified and renowned pathologist Dr. Kimberly Collins and forensic toxicologist Dr. Laura Labay. All of their insights were important for establishing whether or not the State could prove the proximate cause of death.

On the critical issue, I sought a specialist. Renowned use of force expert Seth Stoughton recognized the impact that the detention setting would have on this analysis and knew this was a specialized area of expertise. Because of this, I sought the aid of Gary Raney, a recognized expert in use of force in the detention setting. Raney is eminently qualified for this role was able to evaluate this case impartially. The *Raney Report* alone demonstrates why the State could not prove criminal charges beyond a reasonable doubt.

IN CONCLUSION

Based on the facts and the law, I know that the evidence would not support convictions of Lindsey Fickett or Brian Houle. I evaluate evidence in any matter using nearly 30 years of experience, prosecuting and trying cases in both federal and state courts. I have helped convict a sheriff, an ex-sheriff, a mayor and other police officers of criminal offenses. I understand more than many the intricacies of prosecuting someone from law enforcement. I know the importance of holding those who have sworn to protect us accountable for their bad behavior. It is the issue of our time.

As a citizen of this great state having watched the gut wrenching video of Jamal Sutherland dying, this was a difficult decision. As an experienced trial attorney, however, I know I had no real choice. The drip, drip of information that we needed from various entities was maddening; the lack of any sense of urgency, exasperating. I could have declined to prosecute

this case solely on the original pathologist's autopsy report. Many believe the original autopsy report alone made it ethically impossible for me to seek an indictment. I agreed, but I pushed forward to determine if the pathologist's far-reaching conclusions in areas arguably beyond his expertise were correct. I believed Jamal Sutherland, his family, our community and deserved to know more about how and why he died. This report and the materials that support it will help do that. Equally important, I hope this report and the underlying investigation will bring about much needed change in how our detention center operates and in how mentally ill citizens are treated in our community. I hope the public will join me in applauding Sheriff Graziano for the changes she already has implemented to address some of these issues and in demanding more comprehensive changes in the County's detention center operations.

I know that I cannot imagine what it must be like to watch your own child die, much less at the hands of another. I know that I cannot imagine what it feels like to watch people who look just like me killed due to unnecessary and excessive police violence. I know that some of my friends and constituents will feel disappointment and outrage at my decision. People in this state and in this country may be angry, but I am sworn to make prosecutive decisions based on the facts and law, not on emotion or political pressure. Justice is not borne of a prosecution based on public outrage or a prosecution designed to calm critics.

Dated this 26th day of *July*, 2021.

Solicitor Scarlett A. Wilson
Ninth Judicial Circuit

APPENDIX

Prior Training Hyperlinks:

- <https://bit.ly/CELL-EXTRACTION-USE-OF-TASER-MAJOR-SMITH-PRESENT>
- <https://bit.ly/TASER-USAGE-MAJOR-SMITH-PRESENT>
- <https://bit.ly/Training-One>
- <https://bit.ly/Training-Two>
- <https://bit.ly/Training-Three>
- <https://bit.ly/Training-Four>
- <https://bit.ly/Fishburne-Concerns-Redacted>

BWC Freeze Frames (best viewed after downloading):

- <https://bit.ly/Fickett-BWC-Clip-1-Sutherland-on-ground-after-tasing>
- <https://bit.ly/Fickett-BWC-Clip-2---Sutherland-on-hip-with-hands-behind-back>
- <https://bit.ly/Fickett-BWC-Clip-3---Houle-hand-to-neck-Fickett-Taser-Sutherland-to-ground>
- <https://bit.ly/Fickett-BWC-Clip-4---Fickett-Tasers-3-7>
- <https://bit.ly/Fickett-BWC-Clip-5---Fickett-Drive-Stun-to-right-hip-thigh>
- <https://bit.ly/Fickett-BWC-Clip-6-Sutherland-hand-on-ground-pushing-up>
- <https://bit.ly/Fickett-BWC-Clip-7-Houle-Knee>
- <https://bit.ly/Fickett-BWC-Clip-8-Sutherland-head-moving-probes-in-back>
- <https://bit.ly/Fickett-BWC-Clip-9---Sutherland-arm-moving-Hey-stop>
- <https://bit.ly/Fickett-BWC-Clip-10-Sutherland-arm-moving>
- <https://bit.ly/Fickett-BWC-Clip-11-Probe-removal>
- <https://bit.ly/Houle-BWC-Clip-1-Sutherland-with-spoon>
- <https://bit.ly/Houle-BWC-Clip-2-Sutherland-reaching-for-tray>
- <https://bit.ly/Houle-BWC-Clip-6-Fickett-Taser-1>
- <https://bit.ly/Houle-BWC-Clip-3-Fickett-Taser-2-Houle-Taking-Sutherland-to-ground>
- <https://bit.ly/Houle-BWC-Clip-4-Houle-Tasers-1-3>
- <https://bit.ly/Houle-BWC-Clip-5-Sutherland-probes-in-back>

CCSO Professional Standards:

- <https://bit.ly/Fickett-First-Termination-Letter>
- <https://bit.ly/Fickett-Second-Termination-Letter>
- <https://bit.ly/Houle-First-Termination-Letter>
- <https://bit.ly/Houle-Second-Termination-Letter>
- <https://bit.ly/OPS-Report-Redacted>