# Report of Investigation
# In-Custody Death

Decedent: Linwood Raymond Lambert, Jr.
Date of Report: May 3, 2016

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## 1. Purpose of Investigation

The primary purpose of the investigation by the Office of the Commonwealth's Attorney of Halifax County is to determine whether any individual bears criminal responsibility for the death of Linwood Raymond Lambert, Jr. My analysis is limited in scope to the application of state criminal laws to the events of May 4, 2013.

The primary legal issues which this report addresses are as follows:

*(1) Whether the tasing or other actions by officers caused or directly contributed to the death of Mr. Lambert;*

*(2) Whether the deprivation of medical care caused or directly contributed to the death of Mr. Lambert; and*

*(3) Whether the officers possessed criminal intent.*

This report does not contain an analysis of any federal law standard, such as excessive force; it does not address employment decisions or policy decisions of the local police department; and it does not purport to address potential negligence or any other standard applied in any civil cause of action.

At my request and by agreement, Michael N. Herring, the Commonwealth's Attorney for the City of Richmond was appointed as a Special Assistant. His purpose has been to aid the investigation by assisting me "in evaluating and providing an independent opinion" as to any charging decisions. In this capacity, he has provided advisory opinions, findings and recommendations. Although Mr. Herring has provided input and guidance on all aspects of this investigation, by agreement, the greatest part of his role has been to investigate, research, analyze and provide a report on the third question above, that is, whether the officers possessed criminal intent. Notably, the absence either of causation or of intent would preclude a finding of criminal responsibility. The analysis and preparation of the causation portion of this report, and Mr. Herring's analysis and report on intent, were prepared concurrently. In the interest of thoroughness, both my analysis of causation, and Mr. Herring's analysis of intent, are contained here. This report concurs in Mr. Herring's findings with regard to criminal intent as referenced below. His full report is attached as Appendix B.

## 2. Facts of the Case

The facts set forth below were derived primarily from videos of the incident and secondarily from interviews with the officers involved and statements of other witnesses.

### 2(A) BEFORE ARRIVAL AT THE HOSPITAL

Linwood Raymond Lambert, Jr., was a guest at the Super 8 Motel in South Boston, Virginia on May 4, 2013. Between 2:46 a.m. and 4:28 a.m., Mr. Lambert made a number of 911 calls from his cell phone at the motel. Although he indicated he had an emergency, he did not respond to the dispatcher's questions regarding the nature of the emergency and, at times, hung up on the dispatcher. The dispatcher attempted to call Mr. Lambert back but was not successful in obtaining information from him. Throughout the calls, he gave incorrect information to dispatch as to what room he was in such that law enforcement's efforts to find him led them to occupants who had not contacted 911. The cell phone he was using to place the calls was not a phone number he had provided to the motel at registration; thus, neither dispatch nor law enforcement could locate him timely to his early calls. The manager reported that a great deal of noise was coming from room 109 and that she believed the caller was there. As law enforcement approached room 109, they heard sounds of metal banging in the room, and they found Mr. Lambert there. Officers Tiffaney Bratton, Clinton Mann and Travis Clay of the South Boston Police Department attended the events which transpired.

Mr. Lambert answered his motel room with a metal bed rail in his hand. He put it down upon the officers' request. Officers observed Mr. Lambert's room in total disarray. Furniture had been dismantled and strewn around the room: The bed had been disassembled; light fixtures had been torn from the walls; tables were overturned. Officers estimated the damages to be greater than $1000, indicating a potential criminal charge of felony property destruction.

Mr. Lambert was behaving bizarrely. He claimed that blood officers had observed on his hands and on a mattress in the room was not his blood. He claimed he had stabbed two people whose bodies were hidden in the ceiling panels in his room. He claimed to have red laser beams all over him, which officers took to mean laser beams from guns. He said repeatedly that people were after him. At one point, he pointed at a corner of his room and told officers that the people who were after him were there. Officers searched

the room and found no other persons or bodies. Mr. Lambert became upset when an individual from another room came into his view. He claimed the man was after him and sought to hide in his room. Officer Clay assured him he would stay with him in the hallway. At times he was talking "gibberish" and his speech was slurred.

Mr. Lambert was also sweating and seemed out of breath. He had a white substance running from his nostrils, and he had white powder under his nose.

Officer Bratton, who was the shift supervisor that morning, asked Mr. Lambert a series of questions about any drug use and his medical condition. He told her had drunk vodka (and officers found a broken vodka bottle in the motel room). He also told her he had not taken any medication, prescriptions, or illegal drugs. He denied being diabetic.

Officers told Mr. Lambert they would get him some help. Although they had probable cause to arrest him for property destruction, they told him they were not arresting him. They intended to take Mr. Lambert to the hospital to meet with the mental health worker on call. The officers understood that Mr. Lambert would be screened medically prior to any mental health assessment, but their primary concern was obtaining a mental health evaluation.

They convinced Mr. Lambert to go with them to the hospital. He allowed his wrists to be cuffed, and he entered Officer Clay's car without incident. Mr. Lambert continued to exhibit paranoia and possible hallucinations on the way to the hospital. He hid from a passing car and sat up only after Officer Clay assured him the vehicle had pulled off. Mr. Lambert continued to talk about the beams of light on him. He was fearful that a car following behind was among those persons he believed were out to get him. Officer Clay assured him that the car following them was Officer Bratton. Officer Clay continuously assured Mr. Lambert that he was safe and that no lights were on him.

**2(B) AFTER ARRIVAL AT THE HOSPITAL**

As Officer Clay pulled into the emergency room parking lot, Mr. Lambert became more agitated. Officer Clay repeatedly assured Mr. Lambert that they were at the emergency room and that he was safe. Mr. Lambert leaned back toward the rear driver's side door and began kicking the rear passenger side door. Officer Clay ordered Mr. Lambert to stop kicking the window. Mr. Lambert kicked the glass several times before it shattered. Officer Clay repeatedly ordered Mr. Lambert to calm down, to which Mr.

Lambert replied, "No, sir!" Mr. Lambert said to take him to the emergency room, and Officer Clay again told him, "We are at the emergency room! Calm down!" Mr. Lambert said, "I already told my Mama who the guys was, what the room number was, and everything." Officer Clay repeated that they were at the emergency room and for Mr. Lambert to calm down. Mr. Lambert made remarks like "I know, I will, okay, please, I'm not going to do nothing" repeatedly. At this point, Officer Clay had moved to the rear driver's side door, and Bratton and Mann were at the rear passenger side door. When officers opened the rear passenger side door, Officer Clay said, "He's coming to you, Clint," referring to Officer Mann.

Mr. Lambert got past the officers and ran directly into the glass sliding doors of the emergency room, knocking the doors off track. Mr. Lambert was 5 foot 8 inches tall and weighed 221 pounds. All three officers ran toward Mr. Lambert. Officer Bratton indicated that she pulled the trigger of her taser which she realized did not contain a cartridge, and she quickly placed a cartridge in the device.[1] Officers Clay and Bratton fired their tasers simultaneously toward Mr. Lambert. At the time the officers did not realize they had both fired the device. The evidence is not clear which officer's device made contact with Mr. Lambert, but it is clear one of them conveyed an electrical current.[2] Mr. Lambert stiffened and fell backwards to the ground. Mr. Lambert hit his head as he fell and received a small cut to his head.

Mr. Lambert attempted to get up, and Officer Bratton tased him in probe mode again. Mr. Lambert screamed and again fell to the ground. The officers ordered him to stay down. Officer Bratton said, "You understand, every time you get up, I'm going to pop you." Mr. Lambert rolled onto his stomach and said, "I didn't do nothing." When he began rolling back and forth, Officer Bratton told him to stop. He said, "Okay, okay" but continued to roll back and forth. Officers ordered him to stay down and roll back over. Mr. Lambert then rolled back onto his back and bent his knees. One of the devices was deployed a third time in probe mode, and Mr. Lambert screamed.

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[1] The video does not contradict Officer Bratton's statements. The video depicts officers running from off camera while the sound of the taser can be heard. Mr. Lambert continued to run toward the emergency room doors. It is reasonable to conclude that a taser was being deployed but not being directed toward Mr. Lambert.

[2] The Report of Autopsy revealed three puncture wounds indicative of taser prongs; the device would convey a charge in prong mode only if two prongs from the same device made contact. See Section 3(B) of this report, below.

Mr. Lambert was seated on the ground and, at this point, moving around as the officers ordered him to get on his stomach. He spoke unintelligibly, then said, "I am." He continued to move around while seated on the ground. Officer Bratton said, "I'm going to light you up again, roll over." One of the tasers was deployed; however, it sparked on the ground and had no apparent contact with Mr. Lambert.

Officers continued to tell him to roll over onto his stomach. Mr. Lambert said, again, "I am. I'm just trying to [inaudible]". Mr. Lambert continued to move while seated toward the emergency room doors and toward Officer Bratton. Officer Bratton ordered him to roll around, and Mr. Lambert said, "I'm trying," then "No, ma'am." Officer Bratton drive stunned him briefly in his left shoulder area. Mr. Lambert pulled away from Officer Bratton, lay on his right side and then rolled onto his back. Officers Clay and Bratton both drive-stunned Mr. Lambert again.[3] Officer Bratton's device contacted Mr. Lambert near his hip while she told him to get on his stomach.[4] Mr. Lambert said, "If ya'll stop I will." Mr. Lambert remained on his back and continued to scoot around on the ground. Officer Bratton discarded the cartridge from her taser.

Officer Clay reached for Mr. Lambert's feet. Mr. Lambert said, "No, sir," and kicked at the officer. Officers then struggled to turn Mr. Lambert onto his stomach, with Officers Mann and Bratton manipulating the top of his body and Officer Clay at his feet. Mr. Lambert was drive-stunned again. Mr. Lambert began to vocalize unintelligibly as Officer Clay struggled to shackle Mr. Lambert's ankles. All three officers struggled to hold Mr. Lambert down until the leg irons were in place.

As the officers stood back from Mr. Lambert, he sat up and stated clearly, "I just did cocaine!" Officer Bratton told Mr. Lambert he was under arrest. Mr. Lambert said, "No, I'm not." He continued to speak unintelligibly at times, rocking back and forth, saying, "Why ya'll trying to kill me" and "Please don't do this to me." Officers ordered him to lie down. Mr. Lambert remained seated upright. Officer Mann removed the probes from Mr. Lambert, and Officer Bratton told him again he was under arrest. She told him to stand

[3] Officer Bratton indicated that Mr. Lambert grabbed her taser briefly. The video view is partially obscured by the positions of the officers, so the video neither contradicts nor corroborates this information. Regardless, this report's analysis does not rely on this information.

[4] The video appears to show one continuous trigger pull from Officer Bratton's drive-stun at Mr. Lambert's shoulder to the drive-stun(s) in his hip area. She pulled her device away from him, but the sound of the taser continued for several seconds with no contact with Mr. Lambert. The device appeared to have intermittent contact with Mr. Lambert during this deployment.

up. Mr. Lambert continued to say, "Don't do it, please," and (seemingly to himself), "Don't run." Officers Clay and Bratton lifted Mr. Lambert to his feet and walked him to the rear passenger side door of Officer Clay's car.

Mr. Lambert either lost his strength or dragged his feet as they neared the car. Officer Bratton told him to stand up, and he said he was trying. Officers managed to get him into the car, apparently by a combination of Officer Clay lifting his feet and Officer Mann pulling him across the back seat from the rear driver's side door. Mr. Lambert muttered in the back seat, seeming to say he had smoked "weed." He was prone on his stomach when Officer Bratton told him to watch his head as they shut the doors. One officer seemed to say to Mr. Lambert, "You alright?" Officer Bratton discovered her phone had been broken during the struggle and commented that Mr. Lambert would pay for her phone.

As the three officers were attending to other matters—taking photos, speaking with hospital personnel, assessing property damage and retrieving the discarded taser cartridges—Mr. Lambert was in the back of the car on his left side, seemingly talking to himself. As officers were discussing the appropriateness of criminal charges, Mr. Lambert interrupted, saying, "You said I wasn't under arrest." Officer Bratton responded, "You are now. We tried to get you some help. You want to act like an idiot, we're going to treat you like one, you are now under arrest." Later, Officer Bratton says, presumably to Officer Clay, "Your camera's on, right?"

Mr. Lambert sat up and hit his head at least twice on the barrier between the front and back seats, and an officer ordered him to stop. He stopped hitting his head, but he began to move around in an agitated fashion in the back seat, rocking the upper part of his body back and forth toward the broken rear driver's side window. Officers ordered him to stop several times. Officer Bratton recognized he had a cut on his head from falling.

Mr. Lambert then leaned back in the seat, bent at the knee, and put his feet through the open window. Officer Clay additionally indicated he was kicking at the door.[5] Officer Bratton told him, "Don't do it, I'm going to light your ass up, don't do it." She ordered, "Put your feet down" multiple times, and said, "Sit up straight, act like you got some sense."

[5] The placement of Mr. Lambert's feet is off camera.

Mr. Lambert remained in the same position as Officer Bratton continued saying, "Put your feet down, put your feet down now." He remained in the same position. Officer Mann opened the rear driver's side door, held his taser to Mr. Lambert's left shoulder, and told him, "Sit up, do it now."

After telling him several times to sit up with no effect, Officer Mann drive-stunned Mr. Lambert. Mr. Lambert reacted visibly, pulling away from him, then reclining again. Officer Bratton said, "Sit your ass up, and act like you got some sense." Officers Bratton and Mann repeatedly told him to sit up. Mr. Lambert seemed to be talking to himself. Officer Mann held the taser to Mr. Lambert's shoulder again and said, "Sit up, or I'm going to tase you again." He pulled the taser away from Mr. Lambert as both officers continued to tell him to sit up and to put his back up. A taser was deployed twice with no apparent effect on Mr. Lambert.[6] Officer Bratton instructed Officer Mann to "hit" him at the same time, and told Mr. Lambert to sit up. Mr. Lambert seemed to say, "I'm not going to sit up." Officer Mann and Officer Bratton drive-stunned Mr. Lambert simultaneously.

Officers continued to tell him to sit up. Officer Mann then pushed Mr. Lambert into a seated position. Mr. Lambert vocalized inaudibly and struggled as Officer Mann reached around Mr. Lambert for the seatbelt and attempted to secure him in the car. Officer Clay told Mr. Lambert, "Don't move," and he placed his fingers under Mr. Lambert's jaw, employing a pain compliance technique to keep Mr. Lambert sitting upright. Officers Clay and Mann reported that Mr. Lambert bit Officer Clay on his hand.[7] Officer Bratton indicated the incident constituted an assault by Mr. Lambert and other violations of law. Officer Mann said, "Man, he's bloody as a hog," "He is fucked up," and "That some [sic] bitch is crazy." Officer Bratton commented, "We are going to have a time with him at the jail," and "Ain't nothing wrong with that motherfucker."

Once Mr. Lambert's seatbelt was in place, Officer Clay asked if the others were ready to leave, and Officer Bratton responds in the affirmative. Officer Bratton asked Officer Mann to take a picture of the broken car window. Shortly thereafter, Officer Clay pulled away from the hospital. Officer Clay reported that Mr. Lambert was breathing as

[6] Officer Mann's taser was in view of the camera and was not being discharged at this point. It is reasonable to conclude that the sound of the taser was from Officer Bratton's device. The device was largely off-camera. Whether the device had contact with Mr. Lambert on these occasions is not clear.
[7] Officer Clay was treated for injuries to his hand. The biting incident occurred outside the view of the camera.

they pulled away from the hospital, and the video appears to corroborate this belief. According to the video, 13-14 minutes passed between the final prong mode tasing at the hospital doors and the departure from the hospital.

As Officer Clay departed the hospital, Officer Bratton called the jail and indicated they had a subject under arrest, named the anticipated criminal charges, and asked for the jail's assistance with him. She also received Mr. Lambert's criminal history from dispatch. When the officers arrived at the jail about six minutes later, Mr. Lambert was not responsive. Officers called for rescue personnel and an automated external defibrillator (AED) device to help resuscitate him. Officer Bratton checked for Mr. Lambert's pulse without success. Officers began CPR and took turns administering chest compressions. Rescue arrived and later transported Mr. Lambert to the hospital where he was declared dead. It is reasonable to conclude that Mr. Lambert most likely died en route to the jail.

Later the same day, on May 4, 2013, Chief Jim Binner of the South Boston Police Department contacted the Virginia State Police to investigate Mr. Lambert's death.

At this point in the report, it is helpful to understand that the Office of the Chief Medical Examiner determined the cause of death was "excited delirium due to cocaine use with subsequent physical restraint including use of electronic conductive devices." Toxicology revealed the presence of cocaine (less than 0.01 mg/L), the cocaine metabolite benzoylecgonine (1.1 mg/L), and a low level of ethanol (0.01% by weight by volume) in Mr. Lambert's body. The medical examiner concluded that the presence of cocaine in its active form caused Mr. Lambert's sudden death.[8]

### 2(C) OFFICERS' STATEMENTS[9]

All officers later supplied statements to the Virginia State Police regarding the event. Each officer also submitted to depositions about these events in the context of a pending federal law suit. In addition, Officer Bratton submitted to an interview by Michael Herring and myself. To the extent their statements directly address their state of mind,

[8] A detailed discussion of the Office of the Chief Medical Examiner's findings appear below in Section 5 below.

[9] This report adopts the analysis of the report of Michael Herring as to the officers' states of mind, as indicated herein. See Appendix B (Report of Findings—Office of the Richmond Commonwealth's Attorney).

they are summarized here. They are more fully presented in the report of Mr. Herring, attached as Appendix B.

Throughout this incident, most noticeably after he was placed in the car, Mr. Lambert had been sweaty and appeared to be out of breath. The officers took this as the consequence of physical exertion and rather than sign that Mr. Lambert might be in physical distress. They believed his failure to comply with their commands throughout the incident was volitional. They did not seem to consider the possibility that he was unable to comply due to a mental health condition or physical exhaustion. They believed Mr. Lambert was unstable and dangerous until the point he was belted into the car. Regardless, they understood that use of the taser in drive-stun mode was an appropriate method of securing Mr. Lambert's compliance to commands.

They did not recognize his condition as life-threatening; rather, because he was talking and breathing in the back seat of the car, they thought his health was secure. They recognized he needed minimal medical attention for the minor cut to head and puncture cites from the taser. They were concerned that Mr. Lambert might have another outburst, and they feared he would pose a threat to the public and the emergency department staff. His persistent need for a mental health evaluation was outweighed in their minds by the severity of his behavior. As a result, they removed him from the hospital.

### 2(D) OFFICERS' TASER DATA

The data downloaded from each taser device reflects the number of deployments or attempted deployments of each device. It also provides the duration of each attempt and the time between each attempt. The time of day logged is not necessarily accurate. The logs do not indicate whether any deployment was successful in the sense that it conveyed electrical current from the device to Mr. Lambert.

#### *(1) Officer Travis Clay*

Officer Clay's synch data indicated he fired his device three times. He indicated he recalled only two deployments. He said the three-second deployment (apparently the one he did not recall) may have occurred if one of the prongs had become dislodged. Officer Clay's taser log indicates he pulled the device's trigger on three (3) occasions within 1 minute 15 seconds:

| | |
|---|---|
| 09:43:20 | 5 seconds |
| 09:44:02 | 3 seconds |
| 09:44:35 | 5 seconds |

***(2) Officer Clinton Mann***

Officer Mann recalled deploying his taser twice in drive-stun mode. Officer Mann's taser log indicates he pulled the device's trigger on two (2) occasions within 54 seconds:

| | |
|---|---|
| 09:32:42 | 3 seconds |
| 09:33:36 | 5 seconds |

***(3) Officer Tiffaney Bratton***

Officer Bratton recalled deploying her taser twice in prong mode. She recalled having pulled her trigger several times—once before Mr. Lambert fell, and several times afterward—without having contact or any apparent effect on Mr. Lambert. She recalled tasing Mr. Lambert multiple times, both in probe mode and drive-stun mode. Officer Bratton's taser log indicates she pulled the device's trigger on sixteen (16) occasions over 11 minutes 33 seconds:

| | |
|---|---|
| 09:15:04 | 2 seconds |
| 09:15:10 | 5 seconds |
| 09:15:18 | 5 seconds |
| 09:15:24 | 3 seconds |
| 09:15:25 | 2 seconds |
| 09:15:34 | 5 seconds |
| 09:15:53 | 5 seconds |
| 09:16:22 | 6 seconds |
| 09:16:28 | 5 seconds |
| 09:16:56 | 10 seconds |
| 09:16:59 | 3 seconds |
| 09:25:43 | 4 seconds |
| 09:26:24 | 5 seconds |
| 09:26:25 | 1 second |
| 09:26:37 | 5 seconds |

## 3. Taser Operation and Effect on the Deceased

One of the central imperatives of this investigations is to determine whether the actions of the police, namely the tasing, caused Mr. Lambert's death. An understanding of the basic operation and modes of a taser is necessary to understand the impact of the tasers on the deceased. This section describes the basic operation of the taser. It also addresses the distinction between "probe-mode" and "drive-stun mode" and the effect each mode of deployment has on the body. Finally, this section provides factual conclusions as to the relevant exposure Mr. Lambert had to the devices during this event.

### 3(A) BASIC TASER OPERATION

A taser is a device manufactured by TASER® International, Inc., and is more generically referred to as a conducted electrical weapon (CEW or ECW) or a controlled electrical device (CED). The weapons of relevance in the current case are each TASER® X26™ models. This report references all such weapons as "tasers."

The information in this section of the report draws primarily from the material law enforcement would have relied on for training at the time of these events and certain materials the medical examiner relied on to determine the pathology of her subject.[10] Other materials were reviewed and considered, including, but not limited to the *2011 Electronic Control Weapon Guidelines*, A Joint Project of: Police Executive Research Forum (PERF), Community Oriented Policing Services (COPS), and US Department of Justice (DOJ) (March 2011) ("PERF report") and *Study of Deaths Following Electro Muscular Disruption,* Department of Justice, Office of Justice Programs, National Institute of Justice, Special Report (May 2011) ("NIJ report"). In addition, I consulted with Lt. A. G. Martin, who is employed by a law enforcement agency outside of Halifax County. Lt. Martin teaches law enforcement taser instructors at Central Criminal Justice Academy and has been certified as a Taser Master Instructor since 2008. He has been a certified Taser Instructor since 1999. He has no known relation to this writer and is not a stakeholder in the outcome of this investigation or the pending civil matter.

[10] Dr. Jennifer Bowers from the Office of the Chief Medical Examiner shared excerpts of some of the materials relied upon within the field of pathology, namely an excerpt from *Forensic Pathology: Principles and Practice*, David Dolinak, M. D., et al, as well as a PowerPoint training slide regarding electrocution deaths.

This report does not attempt to evaluate the safety of tasers in general or present a survey of the vast amount of literature holding divergent views them. This report accepts the current Department of Justice view of the matter: "There is no medical evidence that CEDs pose a significant risk for induced cardiac dysrhythmia in humans when deployed reasonably."[11] Broad questions regarding the general safety of these devices is outside the purview of this report.

### 3(B) PROBE MODE

Tasers can be deployed either in "probe mode" (also referenced as "prong mode" and "dart mode") or in "drive-stun" mode. Probe mode involves the discharge of two prongs from a cartridge housed in the end of the taser, typically at a distance from the subject. When deployed, the probes are designed to pierce clothing and skin and convey an electrical shock to the subject. Both probes must make contact with the subject to complete the electrical circuit for the device to have its intended effect. Upon a successful deployment, the electrical current runs from the taser, down the wire which connects the device to one probe, along the path of least resistance within the skeletal muscle to the second probe, and back to the device. A successful deployment in probe-mode will result in full contraction of the skeletal muscles between the probes. The contraction of the muscles is referenced throughout this report as neuromuscular incapacitation ("NMI").

The taser has an automatic timer such that if the trigger is pulled and immediately released, the device will deploy an electrical current for five (5) seconds. If the trigger is held down continuously, the subject will receive an electrical shock until the trigger is released. The user may flip a safety switch to interrupt the five-second timer.

The level of pain any electrical current creates, and any potential effect on the heart, is due to the amperage the device conveys rather than voltage. According to *Forensic Pathology: Principles and Practice* by David Dolinak, M.D. et al, a text relied upon by the Office of the Chief Medical Examiner, a taser generally delivers a charge of approximately 50,000 volts at approximately two (2) to ten (10) milliamps—well below the range pathologists would anticipate would cause ventricular fibrillation (75-100

[11] See U. S. Department of Justice, National Institute of Justice, *Study of Deaths Following Electro-Muscular Disruption* (May 2011) at 9. The report outlines safe use of the device and is referenced further in this report.

milliamps). Taser training materials report that the TASER® X26™ deploys a charge at about four (4) milliamps. Medical research, the PERF report, and the NIJ report suggest that the risk of ventricular fibrillation from a taser deployment for less than fifteen (15) seconds, whether continuously or in separate deployments, is low. Likewise, taser training materials referencing the PERF Report indicate that up to 15 seconds of exposure to tasing is safe, whether from multiple applications or from one continuous exposure, and that such exposure is well within safety margins for use of the device.[12]

### 3(C) DRIVE-STUN MODE

Deploying a taser in drive-stun mode does not discharge prongs into the subject and does not generally use the prongs to convey electricity to the subject. Instead, the trigger is pulled while the end of the taser is directly against the subject without a cartridge or after the cartridge has been deployed. The electrical current in drive-stun mode runs between two small electrodes on the end of the device, rather than along the probe wires. Although the drive-stun causes pain, the electrical current does not penetrate the skin. Hence, the device used in drive-stun mode does not create any NMI and is not known to cause any cardiac rhythm disturbances.[13]

A taser may create NMI if it is used in the "three-point deployment mode." This method generally follows an unsuccessful probe mode deployment in which only one prong attaches to the subject, or both probes have contact with a subject at a very short distance from one another. In these events, the end of the taser having direct contact with the subject will complete the electrical circuit and extend the NMI between the probe(s) and the end of the taser.

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[12] *2011 Electronic Control Weapon Guidelines*, A Joint Project of: Police Executive Research Forum (PERF), Community Oriented Policing Services (COPS), and US Department of Justice (DOJ) (March 2011). See Also NIJ report at 23-24.

[13] Brief Outline of Partial Selected CEW research and Information at 140-46; NIJ Report at 18, 20 ("The 'drive-stun' or contact mode of CED use is a pain compliance procedure, and does not cause muscular incapacitation enabling restraint.") See also NIJ Report at 10 ("Risk of ventricular dysrhythmias is exceedingly low in drive-stun mode of CEDs because the density of the current in the tissue is much lower in this mode.")

### 3(D) TASER EXPOSURE OF DECEASED

The number of deployments or attempted deployments in the laser logs do not reflect the number of times electrical current impacted Mr. Lambert. As a result, this report cannot conclude that each instance of deployment recorded in the logs represents an instance of exposure to electrical current.

The focus of this portion of the report is to determine the number of successful probe mode deployments. Without question, Mr. Lambert was exposed to multiple deployments of tasers in drive-stun mode. However, because the medical research leaves no basis to conclude that drive-stun mode deployments would likely have any direct effect on Mr. Lambert's health, the inquiry here is limited to the number and duration of probe-mode deployments he experienced.[14] Determining the number of events of neuromuscular incapacitation is critical in this context.

Lt. Martin reviewed the most relevant videos of this event: the fixed camera at the hospital (no sound); the dash camera facing forward from inside Officer Clay's cruiser (with sound); and the camera facing the rear seat of the same police cruiser (with sound). Lt. Martin observed the entirety of the event at the hospital and all tasings depicted in the videos.

Based on his training, experience, and observations, Lt. Martin concluded that Mr. Lambert experienced a total of three (3) events of NMI. Two events were for five seconds and one event was for either 3 or 5 seconds, according to the logs. A fourth probe mode deployment was attempted but was unsuccessful and without any visible effect. Lt. Martin concluded that all other taser deployments depicted in the logs, apart from the NMI events, either were drive-stuns or, in a few instances, occurred without visible contact with Mr. Lambert.

Based on my own observations in watching the videos, and after considering the opinion of Lt. Martin, I conclude that Mr. Lambert was exposed to three (3) taser deployments in probe mode. Mr. Lambert was exposed to multiple other deployments in drive-stun mode. None of the drive-stuns created any muscular contraction, and the research on this subject suggest that no NMI occurred with these deployments. Rather,

[14] The extent to which the deployments as a whole, including drive-stuns, may have contributed secondarily to Mr. Lambert's death, is addressed further in the Medical Evidence section below.

Mr. Lambert experienced three (3) events of NMI of no more than five (5) seconds each. Mr. Lambert's total exposure to an electrical current which created NMI was no greater than fifteen (15) seconds—an amount which falls within the recommended safety limits set out in the taser training materials, the PERF report and the NIJ report.

## 4. An Explanation of Excited Delirium Syndrome

The cause of Mr. Lambert's death was determined by the Office of the Chief Medical Examiner to be cocaine-induced excited delirium. In order to understand this conclusion a working understand of excited delirium syndrome ("ExD" or "ExDS") is essential. The purpose of this section of the report is to provide pertinent background information about the syndrome. Because of controversy surrounding this diagnosis, this section also considers whether ExD is a bona fide medical diagnosis. It also provides a description of the characteristics of the condition as offered by medical research, and it highlights some potential causes of the syndrome as indicated by medical research. Finally, because a critical issue is the whether deprivation of necessary medical care caused Mr. Lambert's death, this section also addresses what treatment might have been available to Mr. Lambert in the event he had been admitted to the hospital rather than removed to the jail.

### 4(A) IS EXCITED DELIRIUM SYNDROME REAL?

The Department of Justice, National Institute of Justice, issued a special report entitled *Study of Deaths Following Electro Muscular Disruption* in May 2011 ("NIJ report") which recognized ExD as "broadly characterized by agitation, excitability, paranoia, aggression, great strength and unresponsiveness to pain" and "frequently associated with combativeness and elevated body temperature." The report further states, "People with multiple conditions may present in this manner, including drug-induced psychosis . . . ." The report recognizes, "ExD is frequently but not always associated with the use of cocaine and other stimulants," and "[r]esearch suggests that individuals with a history of chronic illicit stimulant abuse may be particularly susceptible to excited delirium."[15]

The condition has not been without controversy, it seems, primarily because the diagnosis is often rendered post-mortem after a struggle with police.[16] Some have pointed to the American Medical Association's abstention from recognizing or rejecting the diagnosis as an indicator that the diagnosis is not valid.[17] Regardless, the National

[15] NIJ report at 21.
[16] Id.
[17] For example, see Sullivan, Laura, *Death by Excited Delirium: Diagnosis or Coverup?*, National Public Radio, (2007).

Association of Medical Examiners, as well as the American College of Emergency Physicians, unequivocally recognize the condition.[18] The American Psychiatric Association, although it has not adopted the diagnosis, recognizes "Cocaine-induced Psychotic Disorder"; and, since 2013, lists "Substance Intoxication Delirium" as a category of delirium.[19] Moreover, the NIJ report emphasizes that, whether the specific term is used or not, "ExD-related behavior and medical conditions are well-recognized."[20]

Additionally, a multitude of medical professionals and related groups not only have recognized the diagnosis, but also have made specific recommendations aimed at helping first responders and emergency department staff identify and treat the condition, a prerequisite to saving the lives of individuals presenting with its symptoms.[21]

For purposes of analyzing the applicability of ExD to the instant case, I find insufficient proof to overcome the medical examiner's affirmation that ExD as a bona fide medical condition.

**4(B) WHAT IS EXCITED DELIRIUM SYNDROME?**

The term has been used to refer to a rare subcategory of delirium which has primarily been described after death in the medical examiner literature.[22] It is a serious medical condition requiring emergency medical treatment. ExD is a syndrome; so, by definition, it is a collection of signs and symptoms, not a specific disease.[23]

In *Excited Delirium Syndrome: Cause of Death and Prevention*,[24] Dr. Theresa Di Maio and Dr. Vincent Di Maio describe excited delirium syndrome as follows:

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[18] See Hall, Christine, et al, *Distinguishing Features of Excited Delirium Syndrome in non-fatal use of force encounters*, Journal of Forensic and Legal Medicine, Vol. 41 (2016), 21-27.
[19] *Diagnostic and Statistical Manual*-V (August 11, 2013).
[20] NIJ Report at 21.
[21] For example, see Hall, Christine, et al at 21-27;Schoenly, Lorry, Ph.D., RN, CCHP, *Excited Delirium: Medical Emergency—Not Willful Resistance*, EMS1.com (2015); Gerold, Kevin B., DO, JD, et al, *Review, Clinical Update and Practice Guidelines for Excited Delirium Syndrome,* J. of Special Operations Med., Vol. 15, Ed. 1, 62-69, at 62 (Spring 2015); Roach M.D., Brian, et al, *Excited Delirium and the Dual Response: Preventing In-Custody Deaths,* FBI Law Enforcement Bulletin (2014); Vilke, Gary M., M.D. et al, *Excited Delirium Syndrome (EXDS): Defining Based on a Review of the Literature*, Elsevier, Inc. (2012); Takeuchi, Asia, MD et al, *Excited Delirium,* West. J. Emerg. Med. (2011); and *White Paper Report on Excited Delirium Syndrome,* American College of Emergency Physicians Excited Delirium Task Force (September 10. 2009).
[22] See *White Paper Report on Excited Delirium Syndrome,* American College of Emergency Physicians Excited Delirium Task Force (September 10, 2009).
[23] NIJ Report at 21.
[24] The book is referenced both in the NIJ report and repeatedly throughout medical research on ExD since its publication.

> Excited delirium syndrome involves the sudden death of an individual, during or following an episode of excited delirium, in which an autopsy fails to reveal evidence of sufficient trauma or natural disease to explain the death. In virtually all cases, the episode of excited delirium is terminated by a struggle with police or medical personnel, and the use of physical restraint. Typically, within a few to several minutes following cessation of the struggle, the individual is noted to be in cardiopulmonary arrest.[25]

Drs. Di Maio have indicated that death occurring from excited delirium is characterized by the following[26]:

- Acute onset of symptoms (minutes to hours)
- Delirium with acute, transient disturbance in consciousness and cognition; disorientation; disorganized and inconsistent thought processes; hallucinations; speech disturbances
- Combative or violent behavior
- Use of physical restraint
- Sudden cardiac death within minutes or hours of symptoms
- Lack of response to CPR
- History of stimulant drug use or mental disease

Subsequent studies have included the following features:

- Pain tolerance
- Rapid breathing
- Sweating
- Agitation
- Tactile hyperthermia (hot to the touch)
- Lack of tiring
- Unusual/superhuman strength
- Inappropriately clothed
- Attraction to glass
- Police noncompliance[27]

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[25] Di Maio, Theresa, and Di Maio, Vincent, *Excited Delirium Syndrome: Cause of Death and Prevention* (2004) at 69.
[26] Di Maio, at 18.
[27] *White Paper Report on Excited Delirium Syndrome,* American College of Emergency Physicians Excited Delirium Task Force, September 10, 2009; Hall, Christine, et al at 21-27. For a more comprehensive list, see Vilke, Gary M, M.D. et al, *Excited Delirium Syndrome (EXDS): Defining Based on a Review of the Literature*, Journal of Emergency Medicine, Vol. 43, No. 5, 897-905, at 901, Table 2 (2012).

Sudden unexpected death is a "hallmark" of fatal ExD.[28] Levels of cocaine in cases of fatal ExD can be similar to those noted in recreational drug users,[29] or may be found in very low amounts, that is, at or below detectable levels.[30] In either case, the amount of cocaine detected is typically less than those noted in acute cocaine "overdose" deaths.[31]

### 4(C) WHAT CAUSES EXCITED DELIRIUM SYNDROME?

ExD resulting in death does not have a known, universally accepted etiology; currently, it can be described only by its outward presentation.[32] Likewise, the physiological processes of the syndrome are "complex and poorly understood."[33]

The predominant theory suggests that ExD develops from an over-stimulation of the body's sympathetic nervous system (the body's "fight or flight" response to stress) which results from the combination of intense physical exertion and, either stimulant drug use, or certain pre-existing psychiatric or cardiac diseases.[34] Independently of one another, either strenuous physical activity (whether exercise or a struggle) or cocaine ingestion would activate the sympathetic nervous system.[35] This activation causes the release of certain neurotransmitters (like norepinephrine and epinephrine/adrenaline) in the brain.[36] These neurotransmitters, which are the chemical messengers between neurons or cells,[37] regulate heart rate and other central nervous system functions.[38] Normally, neurotransmitters are released into the synapse (the gap between brain cells) and are rapidly captured and passed to the next cell.[39]

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[28] Vilke, Gary M, M.D. et al, *Excited Delirium Syndrome (EXDS): Defining Based on a Review of the Literature*, Journal of Emergency Medicine, Vol. 43, No. 5, 897-905, at 901 (2012).
[29] Vilke at 900.
[30] Reference to Spitz and Fisher, *Medicolegal Investigation of Death: Guidelines for the Application of Pathology to Crime Investigation* from interviews with and deposition of Dr. Jennifer Bowers. See also Pllanen, Michael, PhD, et al, *Unexpected death related to restraint for excited delirium: a retrospective study of deaths in police custody and in the community*, Canadian Medical Association (1998).
[31] Vilke at 900.
[32] Id.
[33] White Paper.
[34] See Di Maio, NIJ report generally.
[35] See Di Maio at 57, 70.
[36] Id.
[37] Id. at 46.
[38] Id. at 51.
[39] Id. at 47.

Cocaine disrupts normal brain function both by stimulating an excessive release of the neurotransmitters and by interfering with the reuptake of those neurotransmitters.[40] In essence, an excessive amount of dopamine, epinephrine and norepinephrine become trapped in the brain's synapses, not only producing the "high" of cocaine but also over-stimulating the heart and triggering the unexpected onset of delirium and extreme agitation.[41]

Why ExD is fatal in some cases but not others is the subject of discussion, without resolution, in the medical field.[42] Medical research suggests that chronic or repeated use of stimulants may predispose the impairment of the neurotransmitter reuptake process and/or predispose the heart to fatal arrhythmia.[43]

### 4(D) CAN EXCITED DELIRIUM SYNDROME BE EFFECTIVELY TREATED?

The characteristics of ExD overlap significantly with other disease processes, so clinicians can have difficulty identifying it.[44] Nonetheless, the medical literature states that emergency medical providers "must be prepared to aggressively evaluate and initiate care to prevent ExDS patients from spiraling into metabolic failure, which may progress to cardiac arrest."[45] Treatment recommendations include aggressive chemical sedation and cooling of core body temperature.[46] When the individual is combative, rapid restraint which minimizes the time struggling, preferably with the use of multiple trained personnel, is recommended.[19, 47]

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[40] Id at 57.
[41] Di Maio at 71 ("The agitation and struggling resulting from excited delirium will result in additional stimulation of the sympathetic nervous system, independently of the direct action on the brain by the drugs themselves."); Mash, Deborah et al, *Brain biomarkers for identifying excited delirium as a cause of sudden death*, Forensic Science International, Elsevier, Inc. (2009).
[42] Hall, Christine, et al at 21-27; Vilke, Gary M, M.D. et al at 900.
[43] For example, see Di Maio at 71-72; Gerold, Kevin B., DO, JD, et al, at 62-64. Jauchem, James, *Deaths in Custody: Are Some Due to Electronic Control Devices (including TASER devices) or Excited Delirium?"* Journal of Forensic and Legal Medicine, Vol. 17, Issue 1, 1-7 (January 2010). These same sources indicated that genetic abnormalities, heart disease or certain psychiatric diseases, even in the absence of stimulants, may predispose an individual to the onset of fatal ExD.
[44] See *White Paper.*
[45] Id.
[46] Id. See also Vilke, Gary M, M.D. et al, at 902-903. See also Takeuchi, Asia, MD et al, *Excited Delirium*, West. J. Emerg. Med. (2011).
[47] The minimum recommended number of medical personnel to restrain an individual in ExD is six (6). Di Maio at 34.

The NIJ report documents that one in ten cases of ExD result in death.[48] Other sources indicate that two-thirds of ExD victims die at the scene or during transport by paramedics or police.[49] Of those who die from ExD, most are on illegal stimulants, frequently cocaine.[50] Together, these sources suggest that the prognosis of the individual manifesting symptoms of ExD while using illegal stimulants is grim:

> Attempts at resuscitation are usually unsuccessful. If resuscitation is "successful," the individual is found to have suffered irreversible [oxygen deprivation to the brain] and death occurs in a matter of days.[51]

The NIJ report affirms this outlook: "These cases have a grim prognosis and are at high risk of death regardless of police actions or method of subdual."[52] Perhaps the most digestible conclusion about the viability of treatment of ExD is as follows:

> While not universally fatal, it is clear that a proportion of patients with ExDS progress to cardiac arrest and death. It is impossible at present to know how many patients receive a therapeutic intervention that stops the terminal progression of this syndrome. While many of the current deaths from ExDS are likely not preventable, there may be an unidentified subset in whom death could be averted with early directed therapeutic intervention.[53]

"There are insufficient data at this time to determine whether fatal ExDS is preventable, or whether there is a point of no return after which the patient will die regardless of advanced life support interventions."[54] Regardless, early detection of the condition and appropriate treatment offer the individual presenting with ExD the best hope of survival.[55]

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[48] NIJ report at 21.
[49] Takeuchi, Asia, M.D., Ahern, Terence L., B.A, and Henderson, Sean O., M.D., *Excited Delirium*, Western Journal of Emergency Medicine, February 12, 2011.
[50] Di Maio at 35.
[51] Id. at 1.
[52] NIJ report at 21.
[53] Vilke, Gary M, M.D. at 898, which largely echoes the White Paper, describing the proportion of patients whose ExD is fatal as "small."
[54] Id. at 903. See also Dolinak, David, M.D., Forensic Pathology: Principles and Practice (Stating that, once in progress, an agitated delirium event may not be reversible.)
[55] For example, see Gerold, Kevin B., DO, JD, et al, at 62 (Spring 2015).

## 5. Report of Autopsy

This section contains my understanding of the conclusions of the Office of the Chief Medical Examiner for the Commonwealth of Virginia and the reasons behind those conclusions. It contains information drawn from the reports of autopsy, from multiple interviews with the medical examiner, and from a deposition of the medical examiner conducted in the context of the pending federal civil matter. For purposes of the state criminal analysis, I have included the most relevant information from these sources, without attempting to be exhaustive.

The Office of the Chief Medical Examiner produced a Report of Autopsy dated July 23, 2013, and endorsed by Jennifer Bowers, M.D. Dr. Bowers graduated from the College of William and Mary with a Bachelor of Arts and Eastern Virginia Medical School with a Medical Doctorate and a Masters of Biomedical Science. She completed her residency in the field of anatomical and clinical pathology at the University of Florida, and she completed her fellowship in forensic pathology at Virginia Commonwealth University School of Medicine, Office of the Chief Medical Examiner. She is an assistant professor at VCU School of Medicine, and she has been an assistant professor at the Edward Via College of Osteopathic Medicine as well as the Virginia Tech Carilion School of Medicine. She is currently Assistant Program Director for VCU Forensic Pathology Fellowship and is Board Certified in anatomical and clinical pathology and in forensic pathology.

At the time of the examination of Mr. Lambert's body, Dr. Bowers was aware that Mr. Lambert had presented with an altered mental status and had been tased prior to his death. Consequently, she understood the importance of examining Mr. Lambert's body for any indication that tasing may have caused or contributed to his death.

### 5(A) EXAMINATION OF MR. LAMBERT

Dr. Bowers examined Mr. Lambert's outer body and organs. She found three puncture wounds in the mid-abdomen suggestive of taser prongs. She cut out and examined the tissue microscopically at and around each of the three puncture wounds, looking signs of nuclear streaming or other thermal injury to the skin, which would indicate injury from electric current. She found no such injuries.

Dr. Bowers examined Mr. Lambert's heart and ultimately sent it to UCLA to be examined by a specialist in cardiac pathology. Dr. Bowers explained that the heart itself

would not have shown signs of electrocution or any visible injury from electrical current—in fact, even examinations conducted in deaths caused by lightening would not typically reveal injury to the inner organs. Rather, Dr. Bowers indicated, she was seeking signs of cardiac disease, structural abnormalities, or electrical conduction system problems, any of which might have revealed that Mr. Lambert had a particular susceptibility to electrical shock, hence, a predisposition to cardiac arrhythmia from tasing. No such disease or abnormalities were found. As a result, Dr. Bowers concluded that Mr. Lambert had a healthy heart for purposes of her analysis of its susceptibility to electric shock.

Dr. Bowers also requested and received from the Department of Forensic Science a toxicology report of Mr. Lambert's blood. The Certificate of Analysis shows the presence of a low level of cocaine (less than 0.01 mg/L), the cocaine metabolite benzoylecgonine (1.1 mg/L), and a low level of ethanol (0.01% by weight be volume).

**5(B) FIRST REPORT OF AUTOPSY**

The Office of the Chief Medical Examiner employs a peer review process prior to the release of autopsies. Before the issuance of the July 23, 2013 Report of Autopsy, four (4) pathologists, in addition to Dr. Bowers, reviewed or consulted on the report and concurred with its findings. Dr. Bowers considered her observations, training and experience; the report from UCLA regarding the health of Mr. Lambert's heart; and the report of toxicology. She also relied upon the information contained in the materials which had then been provided by the Virginia State Police. This information included the fact that Mr. Lambert was exposed to tasing and exhibited apparent psychosis and combativeness before he became unresponsive.

**(1) *Cause of Death***

Dr. Bowers concluded that "cocaine induced psychosis or cocaine excited delirium as a result of acute cocaine intoxication [was] the cause of sudden death in this case." Dr. Bowers indicated that Mr. Lambert's clinical presentation was "classic" for cocaine-induced delirium or excited delirium. She expressed that the combination of a low level of cocaine, psychotic symptoms, violent behavior and sudden death was the "hallmark" of this condition. The low level of cocaine in the system distinguishes this diagnosis from

a cocaine overdose, which would be accompanied by a high level of cocaine in the system.[56]

Dr. Bowers explained that cocaine is metabolized by the body quickly. As a result, any level of cocaine in the system (as distinguished from the cocaine metabolite benzoylecgonine) would indicate Mr. Lambert was actively under the influence and had used it recently—within 0.7 to 1.5 hours of his death. The low level in Mr. Lambert's system would have indicated either (1) that Mr. Lambert was an experienced user, possibly binging at the time, and that most of the cocaine he had used would have already been metabolized at the point of cardiac arrest,[57] or (2) that Mr. Lambert was an inexperienced user whose system simply could not tolerate his ingestion of the drug, even in small amounts.

Regarding the latter, Dr. Bowers highlighted the importance of understanding that no clinical correlation exists between the level of cocaine in the blood and the likelihood of death. In other words, a low level of cocaine does not indicate a low risk of death. Moreover, she indicated that no studies relied upon in her field have identified an amount of cocaine which is safe to use. Such studies are constrained both by law, ethics, and a multitude of factors which could affect individual tolerance. Given the number of factors which influence the process of metabolism, it appears that, even individuals who have used cocaine safely in the past would not be immune from cocaine-induced death. Dr. Bowers offered this example: "[I]f someone goes cold turkey, they go into rehab and they go back to their [previous] dose, they're going to die." As a result, cocaine is not safe to use at any level: Its presence in the body at any level can cause of death.[58]

**(2) *Contribution of Tasers to cause of death***

In discussing the extent to which the tasing could have caused or contributed to death, Dr. Bowers noted that pathologists have very limited reliable data regarding tasing as a cause of death, noting that clinical trials of this nature are constrained by ethical limitations. Thus, in considering any potential impact the weapons may have on the cause

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[56] This opinion is supported by the medical literature. For example, see Vilke at 900.

[57] See Appendix C for known drug abuse and potential indicators of drug abuse by the deceased.

[58] See also Di Maio, *Excited Delirium Syndrome,* at 57: "Sudden death can occur on the first use of cocaine or unexpectedly thereafter. . . . There is no way to determine who is prone to sudden death after using cocaine. There is no specific level of the drug that causes death. The range of blood levels found in individuals dying of cocaine overdose overlaps the range found with 'recreational' use."

of death, she is professionally limited to the literature accepted within her field and her own experience and training on the subject.

With those limitations in mind, she indicated that, within the field of pathology, the electrical current from a taser is not generally considered lethal when used on a healthy adult. At the time of the examination, Dr. Bowers was aware that Mr. Lambert had been tased in probe-mode, although she was unaware of the multiple uses of the taser in drive-stun mode, in particular in the area of Mr. Lamberts left shoulder. However, she indicated that this additional use of the taser would not change her analysis. Echoing the literature already referenced above,[59] she specifically indicated that any tasing deployed in drive-stun mode would have had no neuromuscular effect; therefore, those deployments would not influence her analysis of the effects of the electrical current on the heart, based on her knowledge of the literature accepted in her field.

She acknowledged, in the hypothetical, that an electrical shock from a taser could be the cause of death if certain risk factors were present:

(i) For instance, she reiterated that certain individuals, such as those with heart disease, structural abnormalities or conduction system abnormalities could be particularly susceptible to injury from tasing. In light of the report from UCLA, and without a family history of heart problems indicating otherwise, Dr. Bowers could not conclude that Mr. Lambert's heart was predisposed to injury from tasing. Dr. Bowers concluded instead that Mr. Lambert was healthy; and a healthy adult in Mr. Lambert's circumstances, without the use of cocaine, would likely have survived being tased.

(ii) In addition, Dr. Bowers acknowledged that an electrical current delivered to the chest directly over the heart, in theory, could interrupt the heart's electrical conduction system. In Mr. Lambert's case, the electrical charges delivered in prong mode occurred at the right and left flank, well below the heart. Dr. Bowers concluded that any charges delivered in drive-stun mode would have had no neuromuscular effect, hence, would not have disturbed the conduction system of

[59] See Section 4(C) above regarding drive-stun mode.

the heart. As a result, Dr. Bowers could not conclude that the locations on Mr. Lambert's body where the tasers were deployed indicated that the tasing caused his cardiac arrhythmia.

(iii) Finally, death immediately following the discharge of a taser would tend to indicate that the electrical shock directly caused or contributed to death. Dr. Bowers noted that a healthy heart recovers quickly—within milliseconds—of tasing. The fact that Mr. Lambert's death did not immediately follow the tasing militated against a finding that the tasing caused or directly contributed to his death.

Dr. Bowers found each of these scenarios inapplicable to Mr. Lambert for purposes of the pathological analysis of the likely effects of the taser.

When I questioned Dr. Bowers about the potential for multiple successive tasings to have a cumulative effect on the heart, she acknowledged that, theoretically, electrical shock could have a cumulative effect on the body; however, she did not have sufficient evidence or empirical data to make any conclusions about any cumulative effect the tasing may have had on Mr. Lambert.

Dr. Bowers excluded electrical shock as Mr. Lambert's cause of death chiefly because an alternative cause of death (cocaine intoxication) was apparent; because the deceased's heart was healthy to the best of her knowledge, hence, not unusually susceptible to the effects of tasing; and because the other risk factors above were not applicable to his case. She concluded that, without the presence of cocaine in Mr. Lambert's system, he would likely not have died.

## 5(C) REVISIONS TO REPORT OF AUTOPSY

After apparent concerns that the public had not fully understood the autopsy, the Office of the Chief Medical Examiner revised the autopsy to clarify the cause of death and to incorporate Dr. Bowers' consideration of relevant video of the event, as well as the taser logs. Prior to the issuance of the December 22, 2015 Report of Autopsy, at least three additional pathologists, including the Chief Pathologist and assistant chiefs, reviewed or consulted on the revised report and concurred with its findings. None of the pathologists in the peer review process of the revised autopsy had participated in the peer review process of the original autopsy.

Dr. Bowers reviewed the most relevant video of the events of May 3, 2013, namely: (1) the hospital's video at the hospital doors; (2) the video from Officer Clay's patrol car facing the hospital doors; and (3) the video of Officer Clay's patrol car's back seat. Dr. Bowers asked for input as to how much exposure to tasing the deceased had. She had heard of media reports that he had been tased 20 times and was seeking further information. In response, I shared with her my conclusion, based on the state police investigative materials, as well as the opinion of Lt. Martin with whom I had consulted (referenced earlier), that the deceased had been tased three successive times in probe mode, and that he had received multiple drive-stuns. Dr. Bowers appeared to have drawn the same conclusion on her own.

### (1) *Tasing did not cause or directly contribute to death*

Dr. Bowers indicated that the new information did not alter her conclusions regarding the cause of death. After reviewing the videos, Dr. Bowers indicated she remained confident that the cause of death was cocaine-induced excited delirium and was not directly the result of the tasing.

Dr. Bowers explained that, had cardiac arrhythmia due to an electrical current been the cause of death or a direct contributing factor of Mr. Lambert's death, his death would have occurred suddenly (within a few minutes) after the discharge of the tasers. She noted the time which elapsed (more than 13 minutes) between the last probe-mode tasing and the point at which the deceased departed from the hospital and soon appeared to stop breathing in transit to the jail. Dr. Bowers indicated this gap in time between tasing and death militated against a conclusion that electrical shock caused cardiac arrhythmia.

### (2) *Tasing indirectly contributed to death*

In addition to considering whether tasing caused or directly contributed to death, she also considered whether it indirectly contributed to his death. An example of tasing indirectly contributing to death, that is, being a secondary cause of death, would be a person being tased on a high structure and sustaining fatal injuries from falling.[60] Dr. Bowers concluded that the use of the taser contributed to Mr. Lambert's death in this secondary sense by exacerbating the cocaine-induced excited delirium syndrome.

Dr. Bowers explained that any stressor can increase heart rate and thereby, in theory, increase the risk of fatal cardiac arrhythmia. She placed the tasing on par with all the stressors present in the situation, such as Mr. Lambert struggling with police, being restrained, being handcuffed, and experiencing pain from any source. She explained that these stressors taken as a whole likely exacerbated the progression of excited delirium syndrome; however, she could not say that the tasing, any more than any other stressor, contributed to death. She explained that the absence of any one stressor among the pool of stressors, even the absence of the tasing, would not likely have made any difference to the progression of the excited delirium syndrome.[61] Nonetheless, she thought it was reasonable to conclude to a reasonable degree of medical certainty that the use of the taser indirectly contributed to death by contributing to the progression of the excited delirium syndrome.

## 5(D) SUMMARY OF MEDICAL EXAMINER'S CONCLUSIONS

Dr. Bowers was willing to acknowledge the possibility, at least in the hypothetical, of the tasing having a direct effect on the death in this case. Her willingness seemed to emanate from the possibility of an undetected cardiac abnormality,[62] as well as an acknowledged limitation of data within the field of pathology regarding the effects of taser

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[60] See U. S. Department of Justice, National Institute of Justice, *Study of Deaths Following Electro-Muscular Disruption* (May 2011).

[61] The NIJ report makes a similar, general conclusion about arrest-related deaths following tasing: ("All aspects of an altercation (including verbal altercation, physical struggle or physical restraint) constitute stress that may heighten the risk of sudden death in individuals who are intoxicated or who have pre-existing cardiac or other significant disease. Medical research suggests that CED deployment during restraint or subdual is not a contributor to stress of a magnitude that separates it from the other stress-inducing components of restraint or subdual.")

[62] I understood from Dr. Bowers that seemingly endless batteries of tests for cardiac abnormalities can be conducted. Many tests are for specific mutations at the molecular level for which no generalized test or screening exists. She indicated the tests can be cost prohibitive and are not typical without having some indication of a particular condition being present.

use on the body generally, and on a person with cocaine-induced excited delirium syndrome specifically. She distinguished those possibilities from any conclusions she could draw to any degree of medical certainty or probability.

Had the events occurred without Mr. Lambert's use of cocaine, Dr. Bowers concluded that he probably would have lived. Had the events occurred without the police deploying tasers, Dr. Bowers concluded to a reasonable degree of medical probability that he would have died from the ingestion of cocaine, unless he could have been treated successfully for the excited delirium syndrome. Dr. Bowers said the limits of her role as a pathologist did not allow her to opine on whether Mr. Lambert could have been saved with treatment.

Dr. Bowers concluded to a reasonable degree of medical certainty that the tasing did not cause or contribute directly to Mr. Lambert's death. She concluded, however, that the use of tasers contributed indirectly to Mr. Lambert's death by exacerbating the excited delirium syndrome. The use of tasers, along with the restraint and other stressors of the situation, would have tended to elevate Mr. Lambert's central nervous system and sympathetic nervous system responses. Dr. Bowers also concluded that the tasing did not contribute to Mr. Lambert's demise any more than the other stressors: The stress of the situation was severe enough that removing the tasers from the circumstances would likely not have changed the progress of the excited delirium. In other words, the excited delirium syndrome would likely have resulted in death, even without the use of the tasers. Dr. Bowers was definitive in concluding that the "fatal wound" was cocaine use.

## 6. Additional Medical Experts

### 6(A) HALIFAX REGIONAL HOSPITAL EMERGENCY ROOM

I consulted with the physician who served for over ten years as the director of the emergency department for Halifax Regional Hospital. I also consulted with the emergency room physician who was on duty during the early morning hours of May 4, 2013. The primary purpose of these interviews was to determine, to the extent possible, what care Mr. Lambert might have received had officers brought him into the local emergency department immediately following the probe mode tasings, rather than removing him to the jail. Both doctors were presented with questions which described a hypothetical patient at the emergency room after being tased and exhibiting each of Mr. Lambert's behaviors and symptoms, as they were known to police at the time of the tasing.

Any patient in this scenario admitted to the local emergency department would have had staff take vital signs and obtain any available medical history to the extent possible. If the patient were unable to give his history, staff would have requested it from whomever brought the patient. The patient would have likely been administered an EKG, blood work, a urine toxicology screen and other testing shortly after his arrival, most likely within 10-15 minutes. Ideally, all the necessary testing could have been conducted within 30 minutes, although it could have taken much longer; and the results of that testing, particularly the blood work and urine toxicology, might have taken 30-60 minutes after submission to the lab. Had the patient experienced cardiac arrhythmia or arrest while at the hospital, standard advanced cardiac life support (ACLS) protocol would have been followed. Both doctors opined that attempting to determine the likely course of treatment Mr. Lambert would have needed or received was speculative without the results of the vital signs and the other tests.

Both doctors indicated that excited delirium was not a term they had used in the emergency room or a diagnosis they would have rendered. Both seemed to understand the term to be a general mental health term. (One of the doctors said he would use the term "altered mental status" instead, a term which indicates confusion without ruling out or specifying the cause of the confusion.) Neither doctor indicated that any specialized course of treatment, such as aggressive chemical sedation, would have been appropriate based on Mr. Lambert's symptoms, behavior and history without further information.

Even in the hypothetical scenario in which a patient was known to have been reliably diagnosed with excited delirium syndrome, neither doctor indicated he would have responded with the specialized course of treatment recommended in the medical literature for treating the condition, such as aggressive chemical sedation. The emergency department director indicated that a larger emergency department in a major metropolitan area might be more accustomed to treating patients presenting with the behaviors and symptoms associated with the condition, and more likely to have a specialized protocol.

Of course, this report does not assume that the local hospital would not have treated him appropriately by treating his symptoms as they surfaced—only that Mr. Lambert's presentation of ExD would not have triggered any aggressive, specialized course of treatment geared toward the condition.

### 6(B) MEDICAL EXPERTS RETAINED IN FEDERAL CIVIL SUIT

I have considered the expert reports of Dr. Michael M. Baden, Dr. Donna M. Gallik, Dr. Randall Tackett, and Dr. Jeremy Brown, each retained by the plaintiffs in the pending civil action. I have also considered the medical reports of Dr. Charles Wetli, Dr. Richard M. Luceri, and Dr. Mark Kroll, each retained by the defendants in the pending civil action. Each of these expert reports addresses some or all of the medical questions of causation presented in this case: Whether the use of tasers caused or directly contributed to death; whether cocaine ingestion caused death; and whether the deprivation of medical treatment following the tasing caused death.

Portions of many of these reports contradicted my own research about excited delirium syndrome, about the impact of taser use on the progress of the syndrome, and about the likelihood of successful treatment following the tasing. Other portions of the reports offered explanations which I had not encountered in my research about the body's reaction to the electrical current from the taser, the physiology behind the body's metabolizing cocaine, and the physiology of excited delirium syndrome.

## 6(C) INDEPENDENT MEDICAL EXPERT

In order to reconcile the contradictions between the reports and address the new information they offered, in addition to answering questions produced by my own research, I sought out independent experts both in pathology and in the treatment of excited delirium syndrome. Despite my best efforts, I was not able to secure appropriate funding to hire a pathologist employed outside of the Office of the Chief Medical Examiner. As a result, I consulted with Dr. Bowers about those questions presented in the civil expert reports and the portions of my research within the field of pathology.

I was able to consult with an emergency room doctor at a major metropolitan hospital emergency department for my questions about the treatment for excited delirium syndrome. The independent expert verified that excited delirium syndrome is a diagnosis accepted and used in the field of emergency medicine. It is recognized by the American College of Emergency Physicians and is part of the core curriculum for emergency medicine and medical toxicology.

Even in major metropolitan emergency department, excited delirium is viewed as a rare condition which can be difficult to diagnose and distinguish from other agitated conditions. The expert opined, however, that he would expect his emergency department's personnel to recognize a diagnosis of ExD for patients presenting with Mr. Lambert's symptoms and history (confusion, disorientation, bizarre behavior, agitation, struggling or resistance, blunted responses to pain, sweatiness and a known history of recent cocaine use).

Once diagnosed with ExD, standard emergent care for an agitated patient would require rapid and aggressive sedation and monitoring. If the patient were hyperthermic, which would be typical with a diagnosis of excited delirium, standard emergent care would also require the administration of cold saline and evaporative cooling. The rapid sedation and the efforts to cool the body are designed to lower temperature and heart rate and, generally, to calm the "fight-or-flight" response of the sympathetic nervous system and avoid cardiac arrest.

The independent expert opined that he could not predict whether a person with ExD would survive the condition with appropriate medical care administered *prior* to any cardiac arrhythmia. In contrast, he opined that an excited delirium patient's survival *after* cardiac arrest would be unlikely

After reviewing the relevant case materials, he concluded that he could find no evidence to contradict the pathologist's diagnosis of ExD in Mr. Lambert's case. Although he could not opine whether Mr. Lambert could have survived if hospitalized, he was pessimistic about Mr. Lambert's prognosis based on his training and experience with the condition.

## 7. Officer Taser Training and Medical Training

The officers' training about appropriate use of the taser, as well as any medical training they had received at the time of these events, is relevant to determine whether they possessed criminal intent either in their use of the tasers on Mr. Lambert or their decision to remove him from the hospital.[63]

### 7(A) TASER TRAINING

Each of the officers involved in this matter had been trained by a certified taser trainer and were themselves certified users of the device. The training materials state that an officer may use the taser in probe mode if he or she reasonably perceives subject to be "an immediate threat of harm/injury" or "fleeing or flight risk from a serious crime."

#### (1) Warnings

Despite the totality of the warnings, officers are taught that the risk of the taser causing ventricular fibrillation is remote and that the devices are basically safe. The warnings for the use of the taser are generally couched in the context of avoiding excessive force liability, a federal law standard. For instance, citing *Graham v. Conner*, Taser states that officers may use the taser, depending on the severity of the crime, if they reasonably perceive an immediate threat to safety of officers or others; if the suspect is actively resisting or attempting to flee; if the circumstances are tense, uncertain, or rapidly evolving. Officers are trained that fear for their safety or the safety of others must be justified by objective factors.

In the same context, the training materials indicate that multiple applications of the taser cannot be justified solely on the grounds that a suspect fails to comply with a command, absent other indications that he an immediate threat or about to flee from a serious crime--especially when more than one officer is present to assist in controlling a situation. Officers are warned to take into consideration whether a suspect is capable of complying with officers' commands.

The taser materials contain warnings to "avoid using [tasers] on [a] person who is actually or perceived to be mentally ill"; but, in the same breath, officers are trained that use of the taser in probe mode "can be effective on subjects affected by chemical or

[63] See Appendix B (Report of Findings—Office of the Richmond Commonwealth's Attorney) for further discussion of training and its impact on the analysis of the officer's state of mind.

mental influences because it is not solely dependent on pain for effectiveness." Officers are warned to "avoid using CEW on elevated risk population member[s], unless necessary and justifiable"; yet persons with ExD are not listed as a category of high risk population. Officers are warned against use of the taser on "Physiologically or Metabolically Compromised Persons" but are not trained officers on how to determine whether a suspect fits this description, except by the following:

> Warnings: Law enforcement personnel are called upon to deal with individuals in crisis who are often physiologically or metabolically compromised and may be susceptible to arrest-related death ("ARD"). The factors that may increase susceptibility for an ARD have not been fully characterized but may include: a hypersympathetic state, autonomic dysregulation, capture myopathy, hyperthermia, altered electrolytes, severe acidosis, cardiac arrest, drug or alcohol effects (toxic withdrawal or sensitization to arrhythmias), alterations in brain function (agitated or excited delirium), cardiac disease, pulmonary disease, sickle cell disease, and other pathologic conditions.

This warning contains one of only a few references to ExD in the training materials, and, again, fails to define these terms or train officers in how to identify an individual meeting these descriptors.

A more descriptive warning appears in the 2013 training materials which were later taught to the officers:

> Should one or more of the following behaviors manifest, the suspect may require immediate medical assistance due to pre-existing conditions, possible overdose, cocaine psychosis, excited delirium, etc. Consider having EMS standing by.
>
> -Bizarre or violent behavior
> -Signs of overheating/profuse sweating
> -Disrobing
> -Violence toward/attacking glass, lights, and reflective surfaces
> -Superhuman strength and endurance
> -Impervious to pain - self-mutilation
> -Loss of consciousness
> -Disturbance in respiratory pattern

Regardless, the officers clearly did not understand ExD and its potential for being deadly. Officers Bratton and Mann recalled having heard the term but not understanding its meaning. Officer Clay claimed not to have heard the term until after these events. At the

time of these events, none of the officers were adequately trained to identify the condition or to respond to it appropriately.

**(2) *Use of the Taser***

Officers are trained that the taser "may be a good option for enclosed environments and close quarters such as houses, courts, jail cells, [and] emergency rooms . . . ." The taser training materials stress the recommendation that probes be deployed below the neck area for back shots, and the lower center mass (below chest or heart area) for front shots. Taser recommends these target locations as the most effective in terms of affecting larger muscles (like those in the stomach), avoiding sensitive areas, and increasing the "dart-to-heart" distances. Officers are trained that the greater the distance between the probes, the greater the NMI and the greater the effectiveness of the weapon.

Taser training materials, as well as other reports, recommends against using the taser such that a NMI event occurs more than fifteen (15) seconds, whether in multiple applications or one continuous exposure. The materials further state that officers should use each 5-second CEW cycle as a "window of opportunity" to establish control while the subject is affected by the device.

The taser materials distinguish probe mode from drive-stun mode. Probe mode is considered a more effective use of the weapon, hence, the more desirable deployment method. With regard to technique, the materials recommend against use of drive stun on the head, neck and genitals. They are warned not to use the weapon in drive-stun mode for pain compliance if circumstances dictate that pain is reasonably foreseeably ineffective. The taser materials do not address the appropriateness of use of the drive stun mode for pain compliance, in the context of avoiding civil liability.[64]

**(3) *Taser Policies and Practices of South Boston Police Department***

The South Boston Use of Force policy provides a "Use of Force Wheel" to assist an officer's use of his or her discretion in responding to "perceived threats of aggression" as follows, in ascending order:

[64] The PERF report recommends against using drive-stun for pain compliance; but the officers evidently were not trained with this information. Quite the opposite, the evidence indicates that use of the taser in drive-stun mode was supported by their department.

a. Mere Presence
b. Verbal Command
c. Chemical Spray
d. Defensive Tactics /Open hand
e. Impact Weapons/Canine/Less lethal
f. Deadly Physical Force

The policy further states that the selection from the wheel should depend on the response "to the required level of compliance from an individual that is to be restrained or controlled." The policy recommends "the minimum force option that will safely accomplish lawful objectives."

The policy addresses use of the taser only generally, stating that it may be used only by trained personnel to "temporarily immobilize a subject" or "in defense of an officer or another." The policy indicates the use of the taser "is no longer justified once the subject has been restrained or is under control." At the time of these events, the department's Use of Force policy did not distinguish between use of the taser in probe mode and drive-stun mode; however, it sanctioned the practice of using tasers in drive-stun mode as a method of achieving compliance with commands.[65] In addition, the departmental administration indicated that the officers' use of the tasers in this case comported with departmental expectations.[66]

The officers were certified or re-certified on the use of the taser through the presentation of taser training materials by a designated taser trainer in the department. Matt Gilliam, the lead taser trainer from 2011 to 2014, was deposed in the pending civil matter and indicated that use of the drive-stun for a subject who was not compliant with verbal commands was appropriate.[67] He did not train officers regarding any post-tasing medical care, apart from first aid following the removal of prongs. He did not train officers to look for signs of medical distress in intoxicated individuals or to seek emergent medical care of such individuals following tasing. He also stated that, under the circumstances of

[65] The information is based on interviews with members of South Boston Police Department's administration.
[66] The recent case *Armstrong v. Village of Pinehurst*, 810 F. 3d 829 (4th Circ. 2016), now makes clear law that use of tasers in drive-stun mode as a method of pain compliance, absent a risk of immediate danger, is excessive force. Notably, because the law on this point was not clear until 2016, the officers in that case were granted qualified immunity for multiple drive-stuns of a man for pain compliance when he posed no risk of immediate danger.
[67] Deposition of Greg Matthew Gilliam, *Smalls v. Binner, et al.* (Nov. 18, 2015).

this case, he would not have taken Mr. Lambert into the emergency room but would have opted for any medical treatment to take place at the jail.

Mr. Gilliam also stated that officers generally had discretion to use the tasers for failure to obey commands. This information comports with the department's view that its policies are flexible to the ongoing needs of individual and public safety in the field.[68]

**7(B) MEDICAL TRAINING**

At the time of these events, the officers had received general first aid training and CPR. The officers had not been taught in their basic training at their respective police academies about excited delirium or excited delirium-type behavior.[69] They had been taught only very generally about excited delirium in the context of taser training. Officers Bratton and Mann recalled having heard the term but not understanding its meaning. Officer Clay claimed not to have heard the term until after these events. They had not been taught about the characteristics of the condition, its potentially life-threatening nature, how to avoid its progression, or what treatment was necessary. They had little or no training in general about how to assess a subject medically following use of force.[70]

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[68] Deposition of Lt. D. Barker, *Smalls v. Binner, et al*: "Policies are more of guides. The department expects officers to follow their policies, but not be so bound by them that they're going to do something that causes injury to someone else or themselves. If they deviate from policy -- we have confidence in our officers to have common sense, use common sense, reason, and logic to make the appropriate decision. The job in which we do, there's no way we could ever account for every type of call we can get. I believe we average over 12,000 calls a year. It is hard for us to have specifically a policy that says this situation you do this, this situation you do this. So if they do deviate from policy, they need to be able to explain why they deviated from that policy."

[69] By report, the Department of Criminal Justice Services has recently added a segment on excited delirium syndrome to law enforcement officers' basic training curriculum. No such requirement existed at the time of the event.

[70] See Appendix B (Report of Findings—Office of the Richmond Commonwealth's Attorney) for further discussion of training and its impact on the analysis of the officers' state of mind ("[W]e conclude that at the time of the incident, the officers actually did not have a working understanding of excited delirium such that they would recognize its risk factors during an encounter with a suspect"). See also Memorandum of Opinion, Hon. Jackson L. Kiser, *Smalls v. Binner, et al* (W.D. Va, March 7, 2016) at 14-15.

## 8. Legal Analysis and Conclusions

The primary purpose of this investigation has been to determine whether any individual bears criminal responsibility for the death of Linwood Raymond Lambert, Jr. The broad legal questions this report addresses are whether the tasing or any police action, or the deprivation of medical care, caused Mr. Lambert's death; and whether the officers had criminal intent.

The Commonwealth's Attorney for the City of Richmond, Michael Herring prepared a report containing his findings with regard to intent and his recommendations to me with regard to charging decisions. Mr. Herring's report contains broader findings regarding the reasonableness of the officer's actions. I concur with the findings in his report with regard to the appropriateness of criminal charges. His full report is attached as Appendix B.

This report evaluates the applicability of several potential criminal charges to the circumstances of Mr. Lambert's death, to wit: assault and battery, malicious wounding, unlawful wounding, first degree murder, second degree murder, voluntary manslaughter, and involuntary manslaughter. Each potential charge brings with it particular elements that the Commonwealth must be prepared to prove beyond a reasonable doubt should charges be brought. Should the evidence fail to support any one element of a charge, a criminal prosecution for that charge cannot be sustained.

Assault and Battery is a misdemeanor which, by statute, must be brought within one year of the offending conduct. This charge would have been wholly inappropriate had the investigation revealed that the officers were responsible for the death of Linwood Lambert, Jr. Under Code of Virginia § 19.2-294, bringing such a charge very likely would have precluded the consideration of any felony charge. With the investigation ongoing with regard to the officers' responsibility, any such charging decision within one year of the event would have been premature. Moreover, resolving the investigation prematurely in order to preserve potential misdemeanor charges would have been irresponsible for all interested parties.[71]

[71] See also Appendix B (Report of Findings—Office of the Richmond Commonwealth's Attorney) at 10.

Malicious Wounding is a violation of Code of Virginia § 18.2-51. It consists of maliciously shooting, stabbing, cutting, or wounding any person, or by any means causing him bodily injury, with the specific intent to maim, disfigure, disable, or kill. I concur with Mr. Herring in concluding that the evidence does not support the notion that any officer had specific intent to maim, disfigure, disable or kill Lambert. Unlawful Wounding is a lesser-included offense of malicious wounding. It contains the same elements as malicious wounding except that no proof of malice is required. Without proof of the requisite specific intent to maim, disfigure, disable or kill, this charge is equally inapplicable.[72]

Murder is a common law offense. First degree murder requires proof of a willful, deliberate and premeditated killing, with malice. Second degree murder requires proof of a killing with malice. Malice is that state of mind which results in the intentional doing of a wrongful act to another without legal excuse or justification, which often results from any unlawful or unjustifiable motive including anger, hatred or revenge. No evidence indicates that any officer deliberately caused or wanted the death of Mr. Lambert. The officers' immediate attempts to administer life-saving measures at the jail underscores this conclusion. The officers did not appear to be angry with him, to hate him, or to be seeking revenge against him; therefore, I agree with Mr. Herring's conclusion that the facts are insufficient to prove malice. As a result, neither first nor second degree murder are appropriate to these facts.[73]

Voluntary Manslaughter is an intentional killing committed while in the sudden heat of passion upon reasonable provocation. Heat of passion is any emotion, typically rage or fear, which renders the individual deaf to the voice of reason. The evidence indicates neither that the officers intended to kill Mr. Lambert nor that they were operating under a sudden, reasonably provoked, heat of passion.

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[72] For a full analysis of specific intent to maim, disfigure or disable, as well as malice, see Appendix B (Report of Findings—Office of the Richmond Commonwealth's Attorney) at 16-18.

[73] For a full analysis of intent and malice, see Appendix B (Report of Findings—Office of the Richmond Commonwealth's Attorney) at 16-18. The analysis of malice in the context of murder is the same as its analysis in the context of malicious wounding.

Involuntary Manslaughter is the accidental, unintended killing of another which is the direct result of an individual's failure to perform a legal duty, or their unlawful performance of an otherwise lawful act. It is this theory of the case which has required the most detailed research and attention in the matters of causation and intent.

The Commonwealth's analysis specifically examines (1) whether the death of Linwood Lambert, Jr., was the direct result of the unlawful performance of a lawful act (such as tasing); (2) whether the death of Linwood Lambert, Jr., was the direct result of the officers' failure to perform a legal duty owed to him (like coordinating necessary medical care); and (3) whether the officers were criminally negligent. Both causation and criminal intent must be present for any successful prosecution of involuntary manslaughter. The absence of either causation or intent could conclude the legal analysis; for without proof of both, no criminal charge would be viable. Because the reports addressing causation and intent were prepared concurrently, and in the interest of presenting a full and thorough analysis, the conclusions from both reports are presented here.

***(1) Whether the death of Mr. Lambert was the direct result of the tasings or other actions by officers***

The uncontroverted evidence is that Linwood Lambert, Jr. was disoriented, hallucinating, paranoid, behaving bizarrely, agitated and sweating when police first made contact with him. At the hospital he was noncompliant with police, violent toward glass objects, and appeared to be unusually strong while police attempted to subdue him. Each of these is a characteristic of excited delirium syndrome. The medical examiner concluded unequivocally that Mr. Lambert's ingestion of cocaine, and the cocaine-induced excited delirium which followed, was the direct cause of his death. Had the events occurred without Mr. Lambert's use of cocaine, Dr. Bowers concluded, he probably would have lived. She concluded that the tasers did not directly cause or contribute to his death because his heart was healthy, the location of the taser was not directly over his heart, and he did not develop cardiac arrhythmia immediately after being tased—all indicators that the tasing could have had a more direct role. The medical examiner concluded that Mr. Lambert would likely have died of cocaine-induced excited delirium even without having been tased, and that his use of cocaine was the mechanism of death.

The Commonwealth typically relies on the Office of the Chief Medical Examiner to establish cause of death in any criminal matter. Although the Commonwealth is not bound by a medical examiner's findings, we would necessarily have to overcome those findings with countervailing evidence which proved cause of death by other means. Of particular weight is the evidence that Mr. Lambert was exposed only to three (3) tasings in probe mode for no greater than fifteen (15) seconds. Considering the Department of Justice reports (PERF report and NIJ report) as well as the literature in pathology which state this level of exposure is generally safe, I have no basis to conclude that the tasing caused Mr. Lambert's death rather than his ingestion of cocaine.

I acknowledge a number of voices which decry the use of tasers because of known or perceived dangers—particularly to individuals with an altered mental status. Further research to determine more fully the effects of tasers in this setting may be appropriate. Nonetheless, the Commonwealth is limited to the facts it can prove beyond a reasonable doubt and the reliable expert opinions which are currently available rather than a supposition of what further research might prove.

Having researched the medical examiner's conclusions and finding substantial research supporting them, I have no good faith basis to conclude that the Commonwealth could successfully prove that the tasers were a direct cause of Mr. Lambert's death. Rather, the direct cause of death was cocaine-induced excited delirium, and the mechanism of death was the use of cocaine by the deceased.

***(2) Whether the death of Mr. Lambert was the direct result of the deprivation of medical care***

Officers have an absolute legal duty to coordinate necessary medical treatment for individuals in their custody. Of chief concern is whether the choice to remove Mr. Lambert from the hospital and dispatch him to the jail caused his death.

Unfortunately, whether Mr. Lambert would have survived inside the hospital is a question we cannot answer. We know now that his condition was life-threatening. We know the condition can be difficult even for well-trained medical personnel to diagnose. We know that the local hospital would not have diagnosed Mr. Lambert with excited delirium, and that it was unlikely that he would have received the aggressive, specialized course of treatment (rapid sedation and cooling) which would have been critical to his survival. Even with medical staff attuned to ExD, based on the medical research and the

opinion of an independent medical expert, we know his prognosis was poor. We also know that medical research suggests ExD is particularly dangerous for individuals who use cocaine regularly; and we know that Mr. Lambert was not a naïve user of cocaine.[74]

Without a doubt, removing Mr. Lambert from the hospital significantly diminished, if not eliminated, any chance of successful treatment he may have had. Regardless, because of the divergent opinions about the survivability of the condition as it occurred in Mr. Lambert, the Commonwealth would have had difficulty proving that medical intervention at the point he was subdued would have prevented his ultimate submission to fatal cocaine-induced excited delirium.

***(3) Whether the officers were criminally negligent.***[75]

As Mr. Herring's report more fully describes, criminal negligence requires a higher degree of proof than mistake or simple negligence. It requires proof of negligence so gross, wanton and culpable as to show a callous disregard for human life. The Model Jury Instruction for criminal negligence, based on Virginia jurisprudence, adds the following language to the definition:

> *Criminal* liability cannot be predicated upon every act carelessly performed merely because such carelessness results in the death of another. In order for *criminal* liability to result from negligence, it must necessarily be reckless or wanton and of such a character as to show disregard of the safety of others under circumstances likely to cause injury or death. Unless you believe from the evidence beyond a reasonable doubt that the defendant was guilty of negligence so culpable or gross as to indicate a callous disregard of human life and of the probable consequences of his act, you cannot find him guilty of involuntary manslaughter.

VIRGINIA MODEL JURY INSTRUCTION No. 33.610 (*emphasis added*).

The analysis turns on whether the officers knew or should have known the risk to Mr. Lambert of removing him from the hospital. *See generally Gallimore v. Commonwealth*, 15 Va. App. 288 (1992). The totality of the police actions in this case indicate a clear lack of appreciation for the severity of Mr. Lambert's medical condition and the likelihood of his death.

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[74] See Appendix C for the known indications of historical drug use.

[75] For a full analysis of criminal negligence, see Appendix B (Report of Findings—Office of the Richmond Commonwealth's Attorney) at 18-21.

The officers' actions after Mr. Lambert was secured in the car supports this finding. For instance, one officer complained of her phone being broken and obviously had no thought, as we do now, that Mr. Lambert would soon die. Officers were taking photographs of the scene, talking to potential witnesses at the hospital, and discussing which charges were appropriate while Mr. Lambert, we now know, was deteriorating in the car. Just prior to departing for the jail, one officer said, "We are going to have a time with him at the jail," and stated the belief there was "nothing wrong" with him. As they left the hospital, in what we now know were Mr. Lambert's last moments, one officer was obtaining Mr. Lambert's criminal history and telling dispatch about the charges for which Mr. Lambert had been arrested. These actions indicate that officers expected Mr. Lambert to be alive and under the shadow of criminal charges for his actions. Clearly, the officers did not *know* the risk of removing Mr. Lambert from the hospital.

The officers understood Mr. Lambert's behavior was related either to a mental health condition, his ingestion of cocaine, or both; but they did not consider the behavior might be related to a rapidly deteriorating physiological condition. We know from the medical evidence discussed above that Mr. Lambert's condition can mimic other agitated conditions, and that trained medical personnel have difficulty recognizing the condition. In addition, we know that police were not trained to recognize the urgency of his condition.[76] Based on the facts of this case, I cannot conclude that officers *should have known* he required emergency medical care.

Because officers did not appreciate Mr. Lambert's need for emergency medical care, their removal of him from the hospital, although heart-rending, was reasonable. Recall that officers knew Mr. Lambert needed medical attention for the cut to his head and probe wounds, but they concluded this need was not urgent and could be attended by the jail. They were aware he still needed a mental health evaluation but concluded this need, likewise, was not urgent. In contrast, officers concluded that Mr. Lambert's violent outburst upon their arrival at the hospital signified the potential danger he might be to the staff and public in the hospital. They concluded that the need to contain Mr. Lambert at the jail was urgent, and that this need outweighed the minimal medical

[76] Police departments' protocols which assist police in identifying and reacting appropriately to the ExD suspects are emerging, but such policies are apparently rare. I am aware of police protocols for ExD in Seattle, Washington; Lenexa, Kansas; Lynchburg, Virginia; and Vancouver, Canada.

attention they perceived he needed. This conclusion, although we know now to be erroneous, was reasonable.[77]

I cannot conclude that the officers were indifferent to whether Mr. Lambert lived or died, which is the essence of criminal negligence. Even if I could faithfully conclude that Mr. Lambert's death was the direct result of the officers' actions or omissions, which I cannot, I agree with Mr. Herring's opinion that the evidence fails to support a good faith basis to believe the officers' actions were so culpable or gross as to indicate a callous disregard of human life. I concur with Mr. Herring's conclusions that the evidence does not support a finding of criminal negligence. Because both causation and intent are lacking, no charge of involuntary manslaughter is viable.

As previously stated, the purpose of this report is limited to determining whether any criminal law violations were committed by the officers in this case. Whether any of their acts constitute civil negligence or trigger any other type of civil liability is beyond the scope of this report, and I make no such findings.

For all the foregoing reasons, I find there is no good faith basis to believe any violation of state criminal law applies to the facts of this case and, therefore, I decline to seek criminal charges against the officers.

[77] Mr. Herring and I concur in this conclusion. See Appendix B at 9.

## Appendix A

VIRGINIA STATE POLICE INVESTIGATIVE MATERIALS

Virginia State Police Summary Letter dated October 28, 2013

911 CAD Summary Reports Calls: 13-018175, -76, -77

Statements Officer Travis Clay (Files #13-83-02-0489-29, -58, -69)

Statements Officer Clinton Mann (Files #13-83-02-0489-23, -60, -67)

Statements Officer Tiffany Bratton (Files #13-83-02-0489-49, -59, -68)

Taser Device Report Officer Travis Clay (File #13-83-02-0489-55)

Taser Device Report Officer Tiffany Bratton (File #13-83-02-0489-56)

Taser Device Report Officer Clinton Mann (File #13-83-02-0489-57)

Interview Lt. Dennis Barker (File #13-83-02-0489-34)

Contact Chief Jim Binner (File #13-83-02-0489-12)

Contact Cedric Jones (File #13-83-02-0489-28)

Interview Diane Karen Posey (File #13-83-02-0489-2)

Interview Katrina Lambert (File #13-83-02-0489-27)

Interview Laura Beth Fallen (File #13-83-02-0489-15)

Interview Jordan Leeann Wade (File #13-83-02-0489-37)

Interview Jessie James West (File #13-83-02-0489-3)

Interview Patricia Slayton Blevins (File #13-83-02-0489-6)

Interview Jamie Elizabeth Morgan (File #13-83-02-0489-5)

Interview Kathy A.Terry (File #13-83-02-0489-4)

Vehicle Release (File #13-83-02-0489-42)

Interview Geri L. Jones (File #13-83-02-0489-4)

Interview Sgt. Lynn Oliver (File #13-83-02-0489-39)

Search Warrants (Files #13-83-02-0489-38, -44)

Return on Search Warrant (File #13-83-02-0489-35)

Cellular Telephone (File #13-83-02-0489-32)

Interview Deputy Joseph Adams (File #13-83-02-0489-53)

Crime Scene Reports (Files #13-83-02-0489-33, -36)

Estimate for Repairs (File #13-83-02-0489-61)

Email of AED Report (File #13-83-02-0489-64)

Note Copy of PDF Made and Copy of Video File (Files #13-83-02-0489-52, -65)

Contact Master Officer Anthony Lovinetti (File #13-83-02-0489-62)

Obtain (2) DVD-R Discs Halifax Regional Hospital (File #13-83-02-0489-48)

Copy CR-R, Download DVD-R Discs and Video Files (Files #13-83-02-0489-45, 46, -47)

Obtain CD-R and Letter Lt. Dennis W. Barker (File #13-83-02-0489-43)

List of Items Provided Lt. Dennis W. Barker (File #13-83-02-0489-40)

Note Download and Forward Photographs (Files #13-83-02-0489-13, -14)

Criminal History Linwood Raymond Lambert, Jr.

Videos Hospital; Officer Bratton- Super 8; Officer Bratton- Hospital

DVD's (AED Report, Hospital, Phone, Super 8, Vehicle, Sally Port, Intake, Pictures- Linwood Lambert)

Report of Autopsy

# ADDITIONAL INVESTIGATIVE MATERIALS

## Interviews and Consultations

Consultations with Michael Herring

Consultation with Central Virginia Criminal Justice Academy

Consultations with Office of the Attorney General

Consultations with Department of Justice, Civil Rights Division

Consultation with independent medical expert

Consultation with Virginia State Bar, Board of Ethics

Interviews with Jennifer Bowers, M.D.

Interview with Officer Tiffaney Bratton

Interviews with out-of-state medical examiners (2)

Interviews with Lt. Anthony Martin

Interviews with Chief J. Binner and Lt. D. Barker of South Boston Police Department

Interview with William Bell, M.D., Sentara Halifax Regional Hospital

Interview with Victor Mihal, M.D., Sentara Halifax Regional Hospital

Meeting with James Daniels, counsel for defendants (Smalls v. Binner, et al)

Meeting with Tom Sweeney, counsel for plaintiffs (Smalls v. Binner, et al)

## Depositions

Deposition of Officer T. Bratton

Deposition of Officer T. Clay

Deposition of Officer C. Mann

Deposition of Captain J. Binner

Deposition of Lt. D. Barker

Deposition of M. Gilliam (TASER trainer)

Deposition of W. Fallen (TASER trainer)

**Expert Reports**

Report of Michael M. Baden, M.D. (Plaintiff)

Report of Donna M. Gallik, M.D. (Plaintiff)

Report of Randall L. Tackett, Ph.D (Plaintiff)

Report of Charles V. Wetli, M.D. (Defense)

Report of Richard M. Luceri, M.D., FACC, FAHA

**Records**

Training records for T. Bratton

Training records for C. Mann

Training records for T. Clay

Full file from the Office of the Chief Medical Examiner (including UCLA cardiac report)

South Boston Police Department General Orders Manual (including personnel, administrative and operations policies)

Town of South Boston Personnel Policy

TASER Training Materials, Power Point (V.18) (2011)

TASER Training Materials, Power Point (V.19) (2013)

**Research on Excited Delirium Syndrome and Taser Usage**

***Books***

Mark L. Debard, MD, FACEP, et al., White Paper Report on Excited Delirium Syndrome: ACEP Excited Delirium Task Force Sept. 10, 2009.

Theresa G. Di Maio and Vincent J.M. DiMaio, Excited Delirium Syndrome: Cause of Death and Prevention (Taylor & Francis 2005).

David Dolinak, MD, et al., Forensic Pathology: Principles and Practice (Elsevier/Academic Press, 2d ed. 2005) (excerpt)

***Studies and Articles***

Amnesty International's continuing concerns about taser use, AMNESTY INTERNATIONAL USA, PRESS RELEASE (March 28, 2006).

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## Appendix B

In RE: Death of Linwood Raymond Lambert

Report of Findings – Office of the Richmond Commonwealth's Attorney

On April 1, 2015, pursuant to VA Code § 19.2-155, the Circuit Court of the County of Halifax appointed the Richmond Commonwealth's Attorney (CA) to "assist the Attorney for Halifax County in evaluating and providing an independent opinion to her in the above–styled matter." In such capacity, this office provides the following non-binding and advisory opinions, recommendations and findings to the CA for Halifax County. The CA for Halifax County retains sole authority to initiate state criminal proceedings against any and all persons involved in the above-styled matter. Per agreement with the Halifax CA, and for the sake of efficiency, this report is limited to a review of police use of force and does not address questions related to the cause of death.

It is undisputed that on May 4, 2013 Linwood Lambert (Mr. Lambert) died in the custody of three South Boston police officers, Corporal Tiffany Bratton, Officer Travis Clay and Officer Clinton Mann (the officers). On December 22, 2015, the Office of the Medical Examiner issued an amended autopsy report that described the cause of death as "excited delirium due to cocaine use with subsequent physical restraint including use of electronic conductive devices [ECDs]." The Virginia State Police (VSP) investigated the matter and tendered reports to the Halifax CA throughout the spring and summer of 2013. Federal civil claims filed by the executrix of the decedent's estate are pending against the officers and other South Boston officials.

For purposes of this report, we reviewed various materials provided by the Halifax CA. Included among them was the complete VSP report (with footage), deposition transcripts from the civil proceeding, all autopsy reports, South Boston police training protocols and records (regarding use of force), and training materials for the use of Taser Conducted Electronic Weapons (tasers). With the exception of Corporal Bratton (now Sergeant), whom we interviewed in person, civilian witness accounts were obtained from the VSP report. We also reviewed the recent Federal District Court ruling on the defendant's plea of qualified immunity.

## FINDINGS OF FACT

Having thoroughly reviewed the various materials related to the incident, we made the following conclusions of facts, which we deemed germane to our analysis:

Motel Service Call

On the evening of May 4, 2013 Officers Bratton, Clay and Mann of the South Boston police department responded to calls for service at a nearby Super 8 motel. (They were assisted by Joseph Patrick Adams, a deputy with the Halifax Sheriff's Department.) After initial unsuccessful attempts to identify the source of the calls, with the help of a desk clerk/manager, they eventually made contact with Mr. Lambert in room 109. That same manager recounted an earlier interaction with Mr. Lambert that alarmed her because of noises coming from the room, his refusal to open the door and his strange statements about the police. Additionally, a motel guest described loud noises and yelling coming from the room. All three officers (and the deputy sheriff) were consistent in their descriptions of Mr. Lambert as "sweating profusely," being "paranoid" about "beams" of light, and hallucinating or referring to nonexistent people and events. More specifically, both Corporal Bratton and Officer Mann recall him saying that he had "stabbed" several people in his room. In fact, there was no evidence that he had harmed any other person in his motel room. The officers (and the motel clerk) consistently described the room as in "total disarray," with several damaged fixtures, broken furniture, "a broken vodka bottle" and small amounts of blood on the bed sheets. Officer Clay told the VSP investigator that he had observed a "white substance" (or powder) above Mr. Lambert's upper lip and near his nostrils.

Corporal Bratton was the shift supervisor on the night in question. By coincidence, she was also the field training officer for officers Clay and Mann when they were hired. Corporal Bratton assumed command of the scene and led the interaction with Mr. Lambert. Once the room had been secured, and Mr. Lambert had been frisked for weapons, she questioned him about any health conditions and his use of drugs or alcohol. According to the VSP report, Corporal Bratton described him as occasionally "incoherent," but she understood him to say that he had no underlying health problems, was not on drugs or medication, and that he had drank

"all" the vodka. Both Corporal Bratton and Officer Mann testified in deposition that they were unaware of Officer Clay's observation of the "white substance" near Mr. Lambert's nostrils. Notwithstanding his appearance and the condition of the room, none of the officers described any resistance from Mr. Lambert when he was handcuffed at the motel and taken into emergency custody for a mental health assessment. During their depositions and police interviews, the officers maintained that Mr. Lambert was taken the emergency room (ER) to determine whether he should be committed to a mental health facility. While they assumed that an assessment would include a general physical health screening, they were primarily concerned with his mental condition.

Emergency Room Incident

Video footage from Officer Clay's patrol car reveals that en route to the ER, the officer was patient and made every effort to calm and reassure Mr. Lambert of his safety. During the ride, Mr. Lambert remained handcuffed in the back seat of the patrol car. Although he was paranoid and exhibited behavior consistent with his demeanor at the motel, he was not violent. When the vehicle arrived at the hospital, however, Mr. Lambert suddenly kicked out the car window and demanded to be taken to the ER. Officer Clay forcibly commanded him to stop kicking and tried to calm him. He also told Mr. Lambert that they had in fact arrived at the ER. Mr. Lambert made various comments, including "yes sir," "I will" and "ok I'm not going to do nothing." He also explained that he'd given his mother the identity of the people (imaginary) who had stalked him at the motel. Although communicative, Mr. Lambert's speech was fragmented and somewhat nonsensical.

Video footage from the ER rescue door shows Mr. Lambert running from the vehicle and the three officers, with his hands cuffed behind his back. Footage from Officer Clay's dash camera shows him violently colliding, shoulder first, with the ER entrance door. The officers followed Mr. Lambert and immediately tased him with the incapacitating probe mode. Although he initially collapsed to the ground, and sustained minor head laceration as he fell, he appeared to attempt to regain his footing. Corporal Bratton warned that "every time [he] got up, [she] was going to pop him." He was then re-tased in the probe mode by officers Bratton and Clay. While they tased him, they commanded him at various times to "stay down," "roll over" and "roll

around." Corporal Bratton warned: "I'm going to light you up again." Eventually, the probes were dislodged as Mr. Lambert rolled about on the ground. Officers Bratton and Clay then repeatedly tased him in the non-incapacitating, but painful, drive-stun mode. As they tased him, they commanded him to "roll around," "roll on to your stomach," and "get on your belly." Throughout this seizure at the entrance door, Mr. Lambert blurted out various statements such as "ok, ok," "I'm trying," "no sir" and "no ma'am." At one point he stated "If y'all stop I will." Discharge logs from the taser devices indicate that during this initial seizure, Corporal Bratton fired her device eleven (11) times, while officer Clay fired his three (3) times. Although Mr. Lambert screamed and stiffened his body when being tased, and did not again flee, his continued nonsensical responses to their commands suggested that his mental state did not improve after the tasing.

When it appeared that he was no longer attempting to get up, the officers physically struggled with him on the ground in an effort to apply leg restraints. All tasing ended once the officers applied the leg restraints. Mr. Lambert also appears to have stopped struggling. At that point, and for the first time, he revealed that he had used cocaine. He repeatedly asked the officers to stop stating "please don't do this to me," and he accused them of trying to "kill" him. When the officers informed Mr. Lambert that he was under arrest, he replied "no I'm not." Video footage shows the officers raising Mr. Lambert to his feet in handcuffs and leg restraints and escorting him away from the entrance door toward a patrol car. The use of force incident to this initial seizure effectively ended.

Patrol Car Incident

Although there is no video footage of their arrival at the patrol car, there is audio of constant incoherent mumblings from Mr. Lambert along the lines of "please don't do this to me." There is also audio of the officers repeatedly directing him to "stand up" so they could place him in the patrol car. Indeed, the recording suggests that the officers were struggling to put him in the car. At one point Corporal Bratton tells him to "watch your head," and one of the male officers says, presumably to Mr. Lambert, "you alright?" An officer (presumably Clay) says "what do I do if he gets to fighting like he's doing now, just drive"?

Video footage from Officer Clay's patrol car shows Mr. Lambert entering the back seat. He remained handcuffed and leg shackled. All officers remained outside the vehicle discussing the situation and preparing to transport him to jail. Mr. Lambert continued to mumble incoherently as he rocked his body in all directions. At one point (16:40-16:50) his breathing appeared labored and he mumbled a statement that sounds like "help me." No officer recalled him asking for help, and Corporal Bratton testified in deposition that she could not hear it during replay of the video footage. Mr. Lambert remained conscious with his eyes open and appeared to bang his head against the vehicle. From outside the vehicle Corporal Bratton ordered him to "stop." Mr. Lambert remained upright and with labored breathing until he lowered his body onto the seat and raised his feet toward the window. Corporal Bratton then issued a series of commands or threats (17:29-18:00): "don't do it, don't do it;" "I'm going [to] light your ass up;" "Don't do it;" "Put your feet down;" "Sit up and act like you got some sense."

Shortly thereafter, the footage shows a door opening and Officer Mann extending his taser onto Mr. Lambert's shoulder. He forcibly commanded him to "do it now," which he explained in his deposition to mean lower his feet and sit up. The footage also shows Corporal Bratton placing her taser on his leg from the other side of the vehicle. Both officers continued to demand that he sit up and lower his feet to the floorboard. When he failed to comply, they simultaneously tased him in the drive- stun mode (18:00). Corporal Bratton repeated her earlier command, this time more forcefully: "Sit your ass up and act like you got some sense!" Mr. Lambert recoiled in pain from the drive-stun tasing, but he in no way seemed to comprehend, or otherwise respond, to the verbal commands. As he lay on the seat breathing heavily, they repeatedly (at least five times) command him to "sit up." Officer Mann threatened to tase him again. They then tased him when he failed to sit up. Although Mr. Lambert appeared to grimace in pain, he did not or could not sit up, even after being drive-stunned. Thereafter, and with considerable effort, Officer Mann leaned his body into the vehicle, pushed Mr. Lambert upright and fastened the seat belt. From the other side, Officer Clay applied pressure below Mr. Lambert's right cheek to prevent him from slumping to the other side. Although not clear from the video footage, the officers believe that Mr. Lambert attempted to bite Officer Clay. There was no additional tasing or other force applied to him in the back seat.

After Mr. Lambert was stabilized in the seatbelt, the officers continued to prepare to transport him to the jail. They photographed him, the damaged vehicle and the hospital door. Meanwhile, Mr. Lambert remained restrained in the back seat and continued to breathe heavily. By this point, he had stopped talking but was still conscious. Photographs reveal a moderate amount of blood on his right cheek and running along his face and neck. There is audio of Officer Mann stating that Mr. Lambert was "bloody as a hog." He later clarified in deposition that he only meant that there was blood smeared on his face, not that he was seriously bleeding. He also characterized him as "fucked up" but again clarified in deposition that he was not referring to any need for medical attention. Officer Mann laughed when hospital personnel asked if Mr. Lambert would be brought inside. He advised that they had intended to get him a mental health assessment ("we thought he was crazy,") but decided to transport him to jail because he had "done some cocaine." All officers testified that at no point did they or anyone else assess Mr. Lambert for signs of distress or the need for medical care. The officers assumed that his labored breathing was a natural consequence of exertion. They also all regarded his condition as non-urgent, requiring nothing more than first aid. In radio communications, Corporal Bratton advised her dispatcher to notify the jail that she and her colleagues would "need help" because they "had one resisting."

When they arrived at the jail sally port, Officer Clay discovered Mr. Lambert restrained and unresponsive in the back seat. They immediately returned him to the ER, where he was pronounced dead. On December 22, 2015, the medical examiner issued an amended autopsy, noting that the manner of death was accidental and the cause of death was "Excited delirium due to cocaine use with subsequent physical restraint including use of electronic conductive devices."

Officers' State of Mind

The officers' statements to the VSP were consistent with their respective deposition testimony (which was expectedly more detailed). There was no evidence of collusion in their statements to investigators or in their depositions. We chose to personally interview Corporal Bratton because she was in charge of the encounter. Her interview occurred after we had reviewed the training materials and depositions of the three officers and their supervisors.

All officers insist that although Mr. Lambert was handcuffed behind his back when he ran into the ER door, he was not restrained or under control. They cite his strange behavior at the motel coupled with his sudden outburst in the parking lot as evidence of his instability and volatility. After the initial prong-mode tasings, they believed that pain compliance through successive drive-stuns was an appropriate means of getting him to roll over. They continued to drive-stun him while he voiced a willingness to comply. Video footage shows that the drive-stuns were painful, but there is no indication that they paused for a reasonable time to see if he would comply. They all assumed that because he was talking, he was capable of complying with their commands, but chose not to. They viewed the tasing outside the ER door as a necessary intervention to prevent him from getting inside. They also regarded him as a threat to himself; although, for purposes of our analysis we considered this a secondary consideration. They all believed Mr. Lambert posed a threat to the safety of ER personnel and patients, and they feared that they could not contain him in the ER in the event of an outburst. In depositions, they all acknowledged that other suspects had undergone secure mental health evaluations in the ER. The officers felt that any cause for a mental health assessment was outweighed by Mr. Lambert's unpredictable behavior. Notably, there is no evidence that they sought guidance from the ER staff.

Once they returned him to the patrol car, they believed he posed a threat to officer safety, even though he remained handcuffed behind his back and in leg shackles. Indeed, they regarded him a threat to officer safety until he was seat belted in the rear of the patrol car. All tasings in the rear of the patrol car were for pain compliance. In deposition and their interviews with the VSP, they each described his failure to sit up as volitional and treated it as form of active resistance. There is no indication that they considered the possibility that he was incapable of complying because of his mental state or physical condition. Again, they also thought he attempted to bite Officer Clay while they attached the seatbelt.

Each of the officers had been trained on the use of tasers, and each understood that deployment should be justified by the hazards of an encounter. In other words, the officers had been trained that their tasers were not to be used as punishment or absent a reasonable apprehension of danger or harm. Their training also cautioned against simultaneous, repeated or prolonged exposures (beyond 15 seconds) and warned of a greater risk of adverse event if the

suspect were under the influence of narcotics. Finally, the officers' training cautioned against deployment if the suspect was incapable of volitional compliance.

Bratton and Mann had a vague familiarity with the term "excited delirium," including that it was a risk factor, but neither professed any ability to recognize or respond to it. Officer Clay testified that he first heard the term "excited delirium" at headquarters and after the incident. All officers had been trained to administer first aid and to assess a suspect's need for medical attention.

Corporal Bratton, in her capacity as supervisor, concluded that Mr. Lambert needed to be removed from the hospital grounds and taken to a secure facility. She believed that his injuries were minor and that a jail nurse would assess him and render necessary care. Corporal Bratton acknowledged that Mr. Lambert was at an increased risk for cardiac arrest after the cumulative tasings in front of the entrance door and in the back of the patrol car. None of the officers, however, believed he was in distress; rather, they assumed he was exhausted from exertion. Similarly, none of them believed he needed to be assessed after all of the tasing ended. They cited his ability to talk (apparently without regard to the content of his statements) as evidence that he was not in respiratory distress. In sum, they appear to have concluded that he did not require medical attention because he wasn't bleeding profusely, was conscious and was talking.

## CONCLUSIONS REGARDING THE OFFICERS' STATE OF MIND

In light of our findings of fact, we reached the following conclusions regarding the officers' state of mind:

1. Clearly, Mr. Lambert was exhibiting symptoms of diminished capacity. Everyone who encountered him at the motel described bizarre behavior. Indeed his statements and the condition of his room suggested that he was utterly delusional. No experienced officer should have regarded him as a reliable historian. Officer Clay's observation of the white substance (powder) above Mr. Lambert's mouth should have put them on notice that he had likely ingested narcotics. Moreover, his continued

paranoia regarding "beams" of light and "people" trying to get him should have alerted the officers to the likelihood that he was under the influence and capable of erratic behavior.

2. The officers **reasonably** feared that Mr. Lambert posed a risk of harm or danger to the ER staff and patients when he suddenly slammed into the entrance door at full speed, after violently kicking out the patrol car window.

3. The officers **unreasonably** concluded that in order to gain compliance with their commands it was necessary to drive-stun Mr. Lambert while he was on the ground in front of the ER door. Since he was handcuffed and surrounded, they should have afforded him an opportunity to roll over, particularly since he repeatedly said he would comply. The intervals between the drive-stuns did not allow them to adequately assess his willingness or ability to comply.

4. Once Mr. Lambert had been placed in the patrol car, in handcuffs and leg shackles, he was no longer a threat to the ER staff, and he did not pose a serious threat to the safety of the officers. All of the drive-stun tasing in the patrol car was intended to gain compliance through pain. In fact, they repeatedly inflicted pain to get him to sit up. No one seemed to consider that all of the previous tasing, in conjunction with his underlying compromised mental condition, might not allow him to comply. He did not respond to repeated commands to "sit up" and "do it now," even when subjected to the painful drive-stuns. And certainly neither the yelling nor the profanity from Corporal Bratton was constructive. The officers insist that Mr. Lambert's attempt to bite Officer Clay was evidence of his resistance. They seem to ignore that he may have been trying to get relief from Officer Clay's hand pressing against the nerve below his jawbone (yet another pain compliance technique). The officers' use of force in the car was **unreasonable**. More importantly for our analysis, they failed to consider, or were perhaps ignorant of, the possibility that Mr. Lambert's body was no longer capable of responding to the pain stimulus.

5. After they secured Mr. Lambert with the seatbelt they photographed the scene. Obviously, as they photographed Mr. Lambert, they would have noticed that although the bleeding was not profuse, he was clearly struggling to breathe. Unfortunately no one bothered to check any of his vitals such as breathing, pulse or pupil dilation. No one sought an opinion from trained ER staff who were mere steps away. Finally, no one monitored him while he was in the patrol car in case his condition deteriorated. Had they done so, they might have heard him say "Help me," or they might have noticed his decline before they departed for the jail. Instead, Officer Mann joked about him "bleeding like a hog" and laughed at the idea of taking him into the ER for the mental health assessment, because of his uncontrollable behavior. Thinking that Mr. Lambert needed nothing more than first aid for his head wound, Corporal Bratton directed that they transport him to jail, where he would eventually be assessed by a nurse. They seemed to have a singular focus - processing his charges. There is no evidence that it ever occurred to them to check on the actual health of the man in the back seat.

## CHARGING ANALYSIS

Mr. Lambert died on May 4, 2013. The statute of limitations for any misdemeanor assault charge expired no later than May 5, 2014. The VSP tendered its complete report to the previous Halifax County CA, on October 28, 2013. Neither he, nor the current CA, Tracy Martin, initiated misdemeanor assault charges against the officers. Indeed, to date, Ms. Martin continues to investigate the matter. We believe both of these decisions were sound. Given the gravity of what happened to Mr. Lambert, misdemeanor assault charges would hardly have been appropriate. Also, convictions for such a lesser charge legally may have foreclosed the more important opportunity to investigate the officers' conduct for felony charges such as unlawful and malicious wounding, or involuntary manslaughter (criminal neglect). Because of Ms. Martin's patience, we have the additional information of the amended Autopsy and the extensive deposition testimony, with training materials. Any decision made without reviewing these materials would have been premature.

In Virginia, and throughout the United Sates, police officers may arrest a suspect who commits a crime in their presence. See VA Code § 19.2-81. In this case, there was probable cause to arrest Mr. Lambert for damaging the motel room and for damaging the police cruiser. Although his diminished capacity was certainly a mitigating factor, as the officers initially chose to have him assessed for mental illness, there would have been a good faith basis to arrest him for property damage. Likewise, where the officers' conduct is under review, there must be probable cause for any felony indictments. Our determination of probable cause includes consideration of their unlawful intent or unlawful neglect. Both are a function of their state of mind.

Taser Training

The South Boston police department regarded tasers as non-deadly force, namely "that which is neither likely nor intended to cause death or serious injury." See General Order 112.ADM (2012). That same General Order requires that tasers be available only to "personnel who have been specifically trained in its use." It goes on to limit the use of the tasers to: (1) temporarily immobilize a subject; and (2) in defense of an officer or another. The General Order is silent regarding drive-stun application. It does provide, however, that upon removal of the taser probes, "should further medical attention be needed ... an officer may take the suspect to the ER before transporting to the Magistrate's Office." We ultimately interpret the entire General Order to authorize officers to determine the appropriate quantum of force in light of the totality of the circumstances, including exigencies.

The officers all acknowledged that they received additional taser training, prior to the encounter with Mr. Lambert. That training included guidance on probe versus drive-stun mode. In light of the incapacitating effect, it recommends use of probe mode only if an officer reasonably perceives a subject to be an immediate threat or fleeing (or a flight risk) from a serious offense. Regarding drive-stun mode, the training materials recommend deployment to gain volitional compliance when feasible. Several conditions should be established:

- Verify that the subject is capable of complying
- Avoid conflicting commands
- Warn of imminent use

- Provide time for volitional compliance - including time to recover from extreme pain, an opportunity for the subject to gather oneself, and opportunity for the subject to consider a refusal to comply.

Regardless of the mode, the taser training warns against exceeding 15-seconds of exposure, through multiple or continuous applications, without justification. The training warns against repeated, prolonged or extended applications, where practical. It further advises officers that each application constitutes a separate use force, and cites examples of federal case law proscribing successive applications, absent immediate threat of harm or flight from a serious offense. Finally, the training materials advise officers to use the window between applications as an opportunity to apply handcuffs, and it cautions them to "Be aware that emotionally disturbed persons, focused, intoxicated, deaf and excited delirium individuals may not comply with verbal commands."

Although the training materials mention excited delirium, there is no detailed discussion of the condition. Nevertheless, Greg Matthew Gilliam, the former officer responsible for the officers' training, testified in deposition that he would not "sign off on certifying them if they did not understand" the "information and warnings contained in the Taser PowerPoint presentation and warnings." (Gilliam deposition, pp. 16-17) Despite Mr. Gilliam's assurances, we conclude that at the time of the incident, the officers actually did not have a working understanding of excited delirium such that that they would recognize its risk factors during an encounter with a suspect.

Seizure at ER Door

Mr. Lambert was seized at the hospital because of his outburst, which included the smashed car window and the damage to the ER door. We do not conclude that the seizure was incident to arrest; rather, the officers were responding to the threat posed by his erratic behavior. While there are no reported Virginia cases directly on point, state and federal case law (primarily in the context of civil claims for excessive force) has long held that the police may use a reasonable amount of force where there is probable cause that a suspect poses a threat of serious bodily harm to the officer or others. That force may even be deadly or harmful depending on the nature of the threat. See *Tennessee v. Garner*, 471 U.S. 1 (1985) and *Graham v. Connor*, 490

U.S. 386 (1989). See e.g. *McCracken v. Commonwealth*, 39 Va App 254 (2002). As noted above, the officers reasonably feared that Mr. Lambert might injure persons inside the ER when he slammed into the door. Also, notwithstanding the very disturbing images of Mr. Lambert being tased, there probably was no safer way to intervene when he initially ran into the door. Although Mr. Lambert was running away from the officers and toward the hospital, their decision to tase him in the probe mode was a function of their immediate fear that he would enter the ER or encounter another person while out of control. The circumstances did not warrant firearms, and tackling him with restraint holds arguably presented a greater risk of injury to Mr. Lambert and the officers. Under these circumstances, courts weigh the risk of harm to the suspect posed by the police applied force against the threat the officers tried to eliminate. See *Scott v. Harris*, 550 US 372, 383 (2007). Accordingly, we recommend no indictments for the initial seizure and tasing.

The video footage plainly shows that the officers continued to tase him while he was on the ground in front of the ER door. During VSP interviews and throughout their depositions, the officers maintained that Mr. Lambert would pose a threat to himself and others if he regained his footing. They continued to tase him to ensure that he did not stand up and to force him to roll over onto his stomach. The officers chose not to attempt to manually reposition him on the ground because they believed he was out of control, and because they felt that the handcuffs would not prevent further outbursts. At that time, he and the officers were talking excitedly, and he had demonstrated a propensity for erratic and uncontrollable behavior. Since they had surrounded him, and he was in handcuffs, common decency might have warranted longer intervals of observation to see if he would comply with their commands. Ultimately, however, while other departments might use the incident footage as a training tool on **how not to police**, and while ordinary citizens may cringe when viewing the footage, "the reasonableness of a particular use of force muse be judged from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight." See *Graham v. Connor*, 490 U.S. 386, 396-397 (1989). While we certainly do not condone the number of times they drive-stunned him in front of the ER door, we cannot say that their decision to tase him for pain compliance was unreasonable, certainly for purposes of criminal prosecution. Accordingly, we recommend no indictments for the continued drive-stun tasing in front of the ER door.

Tasings in the Patrol Car

Once Mr. Lambert had been placed in the patrol car, he posed a minimal threat, at most. He was handcuffed, leg shackled, exhausted and confined to the back seat. The officers should not have apprehended any harm to themselves, as the chances of him getting out of the vehicle were remote. The officers apparently feared that he was preparing to kick out a second window when he lay down on the seat and raised his feet. They responded by repeatedly and loudly commanding him to stop. They decided that he was resisting because he would not follow their commands. They then resorted to drive-stun pain compliance. Despite being drive-stunned several times, Mr. Lambert did not sit up in the seat. His breathing remained labored, and his speech was less coherent. Eventually, Officer Mann leaned into the vehicle and used his body to push Mr. Lambert upright. Perhaps the most difficult challenge in our analysis has been determining the officers' intent. Each repeat viewing of the footage is just as disturbing and offensive as the first. Every time we hear Officer Mann laugh and Corporal Bratton curse and threaten Mr. Lambert, we are reminded that professionalism is not something to be taken for granted. Ultimately, our analysis is guided by an application of the law, not our emotion. As such, we conclude that the officers' fear of a restrained, but reclined, Mr. Lambert was **unreasonable**. We further conclude that they unreasonably drive-stunned him for pain compliance and in reaction to his "resistance."

Although the recent case of *Armstrong v Pinehurst*, 810 F.3d 892 (4th Cir. 2016) had not been decided as of the date of Mr. Lambert's death, the Fourth Circuit's discussion of tasing suspects with diminished capacity is certainly instructive. There a group of police officers surrounded a mentally ill man who had fled from an ER mental health evaluation. Although the man was unarmed, he had darted in and out of traffic and exhibited bizarre behavior that certainly suggested he posed a threat to himself. When the officers caught up to him, he wrapped himself around a utility pole and refused to comply with their verbal commands. Following a warning, one of the officers drive-stunned him five (5) times over the course of two minutes. The Court noted that "Rather than have its desired effect, the tasing actually increased [his] resistance." A group of officers managed to physically detach him from the pole, take him to the ground, handcuff him in the rear and place a knee in his back. Because the man continued to kick, the officers placed him in leg shackles. At some point he lay motionless in the grass,

face down. The officers were unable to resuscitate him. In a §1983 civil claim for excessive force, the Court ruled that the tasing was excessive. It nevertheless granted the officers qualified immunity because the Fourth Circuit had not previously established that such use of force was excessive. Of importance to us was the Court's warning that "While qualified immunity shielded the officers in this case from liability, law enforcement officers should now be on notice that such taser use violates the Fourth Amendment." *Estate of Armstrong*, slip opinion, p. 11.

The Fourth Circuit cited other cases where it had rejected the officer's claim that tasing was warranted by the threat posed by a suspect's resistance, particularly when the suspect exhibited diminished capacity:

- *Orem v. Rephann*, 523 F.3 442, 447-49 (4th Cir 2008) – "Orem was handcuffed, weighed about 100 pounds, had her ankles loosened in the hobbling device which Deputy Boyles was tightening and was locked in the back seat cage of [his] car…"
- *Meyers. V. Baltimore County*, 713 F.3d 723, 733-734 (4th Cir. 2013) – "It is an excessive and unreasonable use of force for a police officer repeatedly to administer electrical shocks with a taser on an individual who no longer is armed, has been brought to the ground, has been restrained physically be several other officers, and no longer is actively resisting arrest." "Even noncompliance with police directives and non-violent physical resistance do not necessarily create a continuing threat to the officers' safety."
- *Rowland v. Perry*, 41 F.3d 167, 172-174 (4th Cir. 1994) – punching and slamming a relatively passive mentally delayed man
- Several other cases were discussed but are omitted herein for the sake of efficiency.
- (Judge Kiser also relied heavily on the *Orem* and *Meyers* decisions in partially denying the officers pleas of qualified immunity in the pending civil claim brought by Mr. Lambert's estate.)

Ultimately, the Court held that "In all of these cases, we declined to equate conduct that the police officer characterized as resistance with an objective threat to safety entitling the officer to escalate force. Our precedent, then, leads to the conclusion that a police officer may only use serious injurious force, like a taser, when an objectively reasonable officer would conclude that the circumstances present a risk of immediate danger that could be mitigated by the use of force.

At bottom, "physical resistance" is not synonymous with "risk of immediate danger." *Estate of Armstrong*, slip opinion, p. 8. Likewise, in the instant matter, we do not believe that Mr. Lambert was actively resisting when he reclined in the back seat and failed to sit up. More importantly, however one characterizes his actions, we do not believe he posed a significant threat to the officers. Given that Mr. Lambert (while in the backseat of the patrol car) was neither actively resisting the officers, nor posed an objective threat to safety, we conclude that the officers' actions of repeatedly drive-stunning Mr. Lambert in the back of the patrol car were **unreasonable**.

Malicious or Unlawful Wounding

It is important to note that in Virginia, there are no special use of force statutes governing police behavior. Moreover, very few cases have addressed use of force in the context of a criminal prosecution of a police officer. Virginia is no different from other states, however, in requiring that police applied force be reasonable and proportionate under the circumstances. See e.g. *Bufford v. Commonwealth*, 09 Vap UNP 0630084 (2009). Thus, a police officer "cannot kill unless there is necessity for it, and the jury must determine upon the testimony the existence or absence of the necessity. They must judge of the reasonableness of the grounds upon which the officer acted." "The law does not clothe him with the authority to judge arbitrarily of the necessity." See *Couture v. Commonwealth*, 51 Va App 234, 656 SE2d 425 (2008) (citing *Hendricks v. Commonwealth*, 163 VA 1102, 178 S.E. 8 (1935)).

Against this backdrop, we must consider whether the officers violated VA Code § 18.2-51, commonly known as malicious wounding and the lesser included unlawful wounding. The elements of the offense distill to a significant bodily injury deliberately caused with the "specific intent to maim, disfigure, disable or kill the victim of the attack." See *Commonwealth v. Vaughn*, 263 Va. 31, 35 (2002). If the injury is inflicted maliciously, and with the requisite intent, then the offender may be prosecuted for a class 3 felony. Malice is that "state of mind which results in the intentional doing of a wrongful act to another without legal excuse or justification ...and may result from an unlawful or unjustifiable motive including anger, hatred or revenge. [It] may be inferred from a deliberate, willful and cruel act..." See VA Model Jury Instruction No. 37.200 (case citations omitted). In the absence of malice, an offender may be

prosecuted for unlawful wounding, a class 6 felony. Essential to a prosecution for either offense is the specific intent to maim, disfigure, disable or kill. We found no precedent to suggest that police officers are subject or entitled to a unique intent analysis where their conduct is the subject of a prosecution. See e.g. *Phillips v. Commonwealth*, 25 Va. App. 144 (Va. Ct. App. 1997).

Rarely does the subject of a criminal investigation declare his/her intent. Instead, it is often inferred from the facts and circumstances of a case, including the conduct and statements of the actor. See *Lindsey v Commonwealth*, No.0137-89-2 (Ct. of Appeals Oct. 9, 1990) and *Waller v. Commonwealth* No. 1696-89-3 (Ct. of Appeals Nov. 20, 1990). Moreover, Virginia law allows an inference that a person intends the natural and probable consequences of his voluntary actions. See VA Model Jury Instruction No. 2.600. See also *Moody v Commonwealth*, 28 Va App 702, 508 S.E.2d 354 (1998).

Mr. Lambert was in custody in the back seat of the car. He and the officers had been embroiled in a lengthy, tense seizure, during which (at least in their eyes) he had repeatedly failed to follow their commands. Although we do not believe Mr. Lambert posed a significant threat to the officers, they clearly considered the possibility that he was preparing to kick at the door or window. In that regard, their repeated commands to sit up and lower his feet were perfectly reasonable, even though in retrospect he may have been reclining because of his deteriorating condition. Their decision to coerce compliance through repeated tasing, however, was not reasonable. A fair interpretation of the footage is that the officers became frustrated (perhaps even angry) with Mr. Lambert when he failed to sit up. The yelling and profanity certainly suggest as much. There is no doubt in our minds that the officers' behavior fell below society's expectations of acceptable policing. But unlike the Federal Court which evaluated the evidence in the plaintiff's best light in ruling on the officers' civil plea of Qualified Immunity, our recommendation on criminal charges must be grounded in a good faith assessment of probable cause. See Rule 3.8 of the VA Rules of Professional Conduct.

Obviously, the officers drive-stunned Mr. Lambert with the specific intent to inflict pain. But, they inflicted that pain to gain compliance, as they thought tasing was a safe way to force him to sit up, thereby eliminating any threat posed by his raised feet. Of course, nothing prevented them from attempting the maneuver that eventually worked, namely pushing his body

up since he remained cuffed and shackled. For purposes of a criminal charging decision, however, the fact that the officers did not make the smartest choice (and we are being generous) does not mean that the officers had the requisite level of criminal intent to support a criminal charge of malicious or unlawful wounding.

We conclude that although the officers were intentionally inflicting pain to gain compliance, they were not trying to punish, torture or gratuitously hurt Mr. Lambert. Evidence of either would constitute malice. Moreover, there is not a scintilla of evidence that they drive-stunned him with the intent to maim, disfigure, disable or kill. Importantly, at least to us, they did not tase him in probe mode when he was restrained in the back seat. Also, the footage indicates that they expected Mr. Lambert to sit up and be seat belted. They were not trying (or intending) to permanently incapacitate or seriously injure him, as contemplated by VA Code § 18.2-51. In fact, they fully expected him to sit up, regain his senses, and be taken to jail. There being insufficient evidence to show that the officers acted with malice or the intent to maim, disfigure, disable or kill, we do not believe there is probable cause to seek indictments for malicious or unlawful wounding.

Deliberate Indifference

We believe the incident also warrants an analysis of whether the officers' conduct supports indictments for manslaughter for their failure to obtain medical care. In a recent opinion, the Virginia Supreme Court recognized its longstanding definition of Involuntary Manslaughter as "the killing of one accidentally, contrary to the intention of the parties, in the prosecution of some unlawful, but not felonious, act, or in the improper performance of a lawful act." See *Noakes v. Commonweatlh*, 280 Va. 338, 699 S. E. 2d 284 (2010). To convict a person of involuntary manslaughter caused by the improper performance of a lawful act, the Commonwealth must show that the improper performance of the lawful act amounted to not mere negligent performance; rather, that it was done in a "grossly negligent and culpable way to indicate an indifference to consequences or an absence of decent regard for human life." See *Noakes*, 280 Va. at 345 (citations omitted). Finally, under an objective standard, "gross negligence amounts to criminal negligence where acts of a wanton or willful character, committed or omitted, show a reckless or indifferent disregard of the rights of others, under

circumstances reasonably calculated to produce injury, or which make it not improbable that injury will be occasioned, and the offender knows, or is charged with the knowledge of, the probable result of his acts." See *Noakes*, 280 Va. at 346, (citing Brown *v Commonwealth*, 278 Va. 523, 685 S.E.2d 43 (2009)).

We have previously concluded that there was probable cause to detain and arrest Mr. Lambert for property damage. Thus, they were engaged in a lawful, custodial arrest. While there was insufficient evidence of criminal intent to warrant indictments for felony assault, we nevertheless concluded that the amount of force (tasings on the ground and in the back seat) was unreasonable. Our analysis therefore turns to the officers' decision to transport him to jail without any medical assessment. More specifically, given that officers applied an unreasonable amount of force, the relevant inquiries are: (1) whether the officers were, or should have been, aware of his deteriorating physical condition; and (2) whether their failure to obtain medical care was the product of recklessness or indifference.

By the time of Mr. Lambert's death, he had been in the officers' sole custody and control for well over an hour. They had interacted with him in several settings and witnessed dramatic changes in his behavior. Initially, they sought help for his compromised mental state, but they abandoned that plan when he shattered the car window and damaged the ER door. We believe the officers recognized that Mr. Lambert's outbursts were the result of his mental condition. Once he demonstrated a propensity for violence, however, for the remainder of the encounter, the officers were focused on any threat Mr. Lambert posed to themselves, hospital staff, property and perhaps himself. Although we do not believe Mr. Lambert was volitionally resisting in the back seat, the officers clearly thought he posed a threat and continued to apply force. When they secured him in the seatbelt, any arguable exigencies had passed, so that only their judgment prevented them from obtaining medical care.

The fact that the officers photographed Mr. Lambert after all the tasing had ended indicates that they were aware of his injuries; indeed, they made a record of them. Likewise, they made no effort to conceal his condition, as Officer Mann audibly joked about his bleeding and commented to a hospital employee that they decided not to bring him into the ER for the mental health evaluation. Mr. Lambert does not appear to have lost consciousness at any time

prior to transport, and the bleeding from his head wound was not profuse. We believe the footage plainly shows labored breathing, but the officers attributed it to exhaustion, not medical distress. Their depositions have afforded us a much clearer view of their sense of Mr. Lambert's condition. By all of their accounts, once Mr. Lambert had been secured, the officers regarded the situation as a normal prisoner transport. More importantly, they did not believe he showed signs of serious injury or physical decline.

We conclude that the officers regrettably did not appreciate the gravity of the situation. Indeed, the evidence suggests that the officers were utterly ignorant of the consequences of their actions. Specifically, we find no evidence to disprove that they thought the repeated drive stuns would have no impact beyond short-term pain. Although we find no evidence of willful ignorance, the record certainly suggests that they operated under a cloud of professional ignorance. Shockingly, they were clueless to the potentially bad outcome for a forcibly restrained, mentally disturbed prisoner, who had ingested cocaine and alcohol, and been subjected to roughly 17 tasings. In other words, it never occurred to them that Mr. Lambert might be in the early stages of physical distress, rather than exhausted from "resistance."

The evidence indicates that the police department deployed the tasers after "training" that made passing references to significant risk factors such as excited delirium. Clearly, the officers did not recognize its symptoms and did not have a functional understanding of the condition. Moreover, because Mr. Lambert did not lose consciousness, and the officers equated his nonsensical ramblings with communication, they did not recognize his decline. Instead, they simply viewed him as a disruptive, mentally ill detainee. Ultimately, we find that perhaps because of inadequate training, the officers' behavior fell below acceptable policing standards. Indeed, their behavior was negligent in that they failed to perform a duty of care, which included: (1) ensuring that Mr. Lambert received a mental health evaluation; (2) ensuring that he was safely restrained, and (3) ensuring that he was medically assessed before being transported to the jail. We do not believe, however, that there was evidence of criminal negligence. Specifically, the officers did not display a callous disregard or indifference for Mr. Lambert's well being. Instead, what began as a constructive intervention for a citizen experiencing a mental health crisis, evolved into a series of forcible seizures, for which they were miserably unprepared. At a minimum, they certainly did not display the requisite competence and proficiency to use tasers.

The Supreme Court of VA has spoken clearly in *Brown* and *Noakes* that mere negligence is insufficient to support a conviction for involuntary manslaughter. Therefore, we do not recommend indictments for involuntary manslaughter under a theory of criminal neglect.

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## Appendix C

The Office of the Commonwealth's Attorney may examine the known criminal history of suspects and witnesses when making charging decisions. Mr. Lambert's falls into neither category; but his criminal history was supplied by the Virginia State Police and is part of their investigative file. In this case, any evidence of historical abuse of illegal substances by Mr. Lambert, including that which may be demonstrated by his criminal record, can lend credence to the diagnosis of cocaine-induced excited delirium. Although a naïve cocaine user may suffer from this condition, medical research suggests that individuals with more regular drug abuse may be particularly susceptible to the condition.[1]

Moreover, it is not uncommon for individuals who abuse illegal drugs to engage in theft-related crimes or to sell their drug of choice as source of income and a means to support their drug habit. As a result, Mr. Lambert's known history of drug use, and any historical indicators of drug use such as crimes related to theft or drugs, are especially relevant.

(1) *Drug Abuse*

The investigation of the Virginia State Police revealed that Mr. Lambert had a history of illicit drug use. Mr. Lambert's estranged wife reported that he had abused either heroin or cocaine by injecting it at an earlier time in his life when he had been arrested. (VSP File 13-83-02-0489-27). An investigator for a law firm retained by the Lambert family also reported Mr. Lambert had a history of cocaine use. (VSP File 13-83-02-0489-28). In addition, a front desk clerk at the Super 8 motel in South Boston stated she believed Mr. Lambert had a history of using marijuana at the Super 8 during past stays at the motel.

On May 4, 2013 a search warrant was executed on the 2002 Chrysler 300 (VA registration WXW-1837). An off-white powder-like substance was located in a plastic

[1] Di Maio at p. 71-72; Gerold, Kevin B., DO, JD, et al, *Review, Clinical Update and Practice Guidelines for Excited Delirium Syndrome,* J. of Special Operations Med., Vol. 15, Ed. 1, (Spring 2015) at p. 62-64. Jauchem, James, *Deaths in custody: Are some due to electronic control devices (including TASER devices) or excited delirium?"* Journal of Forensic and Legal Medicine, Vol. 17, Issue 1, pp. 1-7 (January 2010).

container in a suitcase in the trunk of the vehicle believed to have been used by Lambert. It was identified as having the same consistency as the street drug "Molly," typically known as Ecstasy or MDMA (methylenedioxy-methamphetamine). No forensic testing was provided to confirm the identity of the substance.

(2) *Criminal activity*

According to the National Crime Information Center, Linwood Raymond Lambert, Jr., between 1989 and 2007, had been convicted of numerous property-related crimes, including robbery, burglary, larceny, forgery, unlawful entry and property damage.