Investigating Deaths Involving Law Enforcement

Expanding Transparency and Reducing Delays

2022 – 2023
Contra Costa County
Civil Grand Jury
Report 2304
May 24, 2023

A REPORT BY
THE 2022-2023 CONTRA COSTA COUNTY CIVIL GRAND JURY

725 Court Street
Martinez, California 94553

Report 2304

Investigating Deaths Involving Law Enforcement

Expanding Transparency and Reducing Delays

APPROVED BY THE GRAND JURY

Date 5-31-2023

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GRAND JURY FOREPERSON

ACCEPTED FOR FILING

Date 5/31/23

Hon. JILL C. FANNIN
JUDGE OF THE SUPERIOR COURT

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Contra Costa County Grand Jury Report 2304

Investigating Deaths Involving Law Enforcement

Expanding Transparency and Reducing Delays

TO: Sheriff of Contra Costa County
Contra Costa County District Attorney
President of the Contra Costa County Police Chiefs' Association

Investigating Deaths Involving Law Enforcement
Expanding Transparency and Reducing Delays

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GLOSSARY AND ABBREVIATIONS

Coroner's inquest	In Contra Costa County, a coroner's inquest is a public court hearing led by a hearing officer, at which a jury determines the manner of death from one of four options: (1) natural causes, (2) suicide, (3) accident, or (4) the hands of another person other than by accident
Criminal charge determination	Determination made about filing criminal charges against any person involved in the incident after a factual and legal analysis
DA	District Attorney
District Attorney's LEIFI Policy	Contra Costa County District Attorney's Office policy relating to Law Enforcement Involved Fatal Incidents, October 29, 2018
Incident	Law Enforcement Involved Fatal Incident (LEIFI)
LEIFI	Law Enforcement Involved Fatal Incident
LEIFI Protocol	Contra Costa County Police Chiefs' Association Protocol relating to Law Enforcement Involved Fatal Incidents, 2014
LEIFI Report	Contra Costa County District Attorney's Office report of Law Enforcement Involved Fatal Incidents that includes the criminal charge determination, October 29, 2018
Protocol	Same as LEIFI Protocol
Sheriff's LEIFI Policy	Contra Costa Sheriff's Office Policy and Procedure relating to Law Enforcement Involved Fatal Incidents, 2021

SUMMARY

Deaths involving law enforcement personnel are an issue of great local and national interest. These fatalities negatively impact not only the family and others who knew the decedent, but also law enforcement officers, government agencies, and the public. Every year in Contra Costa County, a number of civilians die in circumstances in which law enforcement personnel are involved in some way.

The civil grand jury researched how our county's law enforcement agencies investigate these incidents. We reviewed the well-publicized 2018 shooting of Laudemer Arboleda by officer Andrew Hall in Danville. We found that nearly 2.5 years passed before officer Hall was criminally charged, by which time he had shot and killed another civilian, Tyrell Wilson. Hall was not charged for Wilson's death. The time taken to investigate and charge Hall is significantly more than in other well-publicized officer-involved deaths, such as the death of George Floyd (charges filed after four days) and of Tyre Nichols (charges filed after sixteen days). We discovered that the average time for these criminal investigations in our county is between 21 and 29 months after the fatal incident. In comparison San Diego County usually completes these investigations and makes charging determination within approximately six months.

The Protocol for Law Enforcement Involved Fatal Incidents (LEIFI) is the policy in Contra Costa County that guides the investigation process. All law enforcement agencies in the county agreed to this Protocol. The Protocol calls for the criminal investigation reports to be completed within 30 days of the fatal incident.

We recommend reducing how long these investigations take and expanding transparency. We also recommend that the district attorney consider completing the investigation and make a criminal charging determination within six months of the incident. To achieve this goal, the district attorney should consider making the criminal charging determination without necessarily waiting on the coroner's inquest. Similarly, the sheriff-coroner should consider holding the coroner's inquest within four to six months of the incident. The sheriff-coroner should give adequate notice of coroner's inquest hearings and make the record of the proceedings accessible to the public.

METHODOLOGY

Documents

The civil grand jury reviewed public documents including the following:

- Protocol for Law Enforcement Involved Fatal Incidents 2014 – Police Chiefs' Association of Contra Costa County;
- Contra Costa Sheriff's Office Policy and Procedure relating to Law Enforcement Involved Fatal Incidents, August 17, 2021;
- Contra Costa County District Attorney's Office policy relating to Law Enforcement Involved Fatal Incidents, October 29, 2018;
- Documents from the websites of the district attorney and sheriff-coroner relating to Law Enforcement Involved Fatal Incidents, including press releases;
- Media reports containing information about fatal and nonfatal incidents in Contra Costa County that involved law enforcement;
- California statutes containing provisions relating to use of force by law enforcement personnel.

Court Hearings

Members of this grand jury attended the coroner's inquest for Naya Jackson (November 18, 2022), Robert Jones (January 13, 2023), and Kent Hickey (January 20, 2023).

Interviews

The grand jury interviewed nine individuals with expertise and information on this topic.

BACKGROUND

On November 3, 2018, Laudemer Arboleda led multiple police officers on a low-speed chase through the Danville streets, after 911 calls reporting suspicious activity. Police officers tried to block his path with two police vehicles, but Arboleda slowly maneuvered between them.

Officer Andrew Hall exited his car and stepped between two police cars as Arboleda attempted to drive between the vehicles. Officer Hall feared that he was about to be run over and discharged his weapon ten times, striking the driver nine times. Arboleda was pronounced dead at the hospital.

The Contra Costa sheriff's office cleared officer Hall of wrongdoing and placed him back on duty. Less than three years later, on March 11, 2021, officer Hall shot and killed another man, 32-year-old Tyrell Wilson, who had approached officer Hall with a knife near the Sycamore Valley Road overpass of Interstate 680. These were the only two police-involved shootings in Danville since 2001.

One month after officer Hall shot Wilson, District Attorney Becton charged Hall with voluntary manslaughter and assault with a semiautomatic firearm for the Arboleda shooting. He was convicted of assault with a firearm and sentenced to six years in state prison. In addition to the criminal case, the county board of supervisors approved a $4.9 million settlement with the family of Laudemer Arboleda to resolve their wrongful death civil case.

The DA took 1.5 years to decide not to file criminal charges against officer Hall for shooting Tyrell Wilson. The county board of supervisors approved a $4.5 million settlement with the family of Tyrell Wilson for their wrongful death civil case.

The length of time to make these charging determinations is significantly more than the four days to charge Derek Chauvin for killing George Floyd in Minnesota, and the sixteen days to indict five officers for killing Tyre Nicholas in Memphis.

The civil grand jury reviewed 31 cases across the United States in which officers were convicted of an on-duty shooting (Appendix 1). The average time to bring criminal charges was eight months, although in most (21) of the cases charges were filed in less than six months. The subject of this investigation is not to question whether Hall should have been charged, but rather why the investigation procedure took 2.5 years, and whether this length of time is an outlier or the norm in Contra Costa County.

DISCUSSION

Why did it take 2.5 years for Officer Hall to be charged?

The criminal charges against officer Hall were extraordinary not because 2.5 years passed before they were filed, but because Hall was the first, and as of this time, the only officer to be criminally charged for an on-duty shooting in Contra Costa County. Before Diana Becton took office as DA, the criminal charge determination in a LEIFI investigation was not publicly disclosed. Prior to DA Becton the criminal analysis was made by one individual, a Deputy DA.

Diana Becton was appointed as District Attorney in 2017 to fill a vacancy when the previous DA resigned. She was subsequently elected to the position in June 2018.

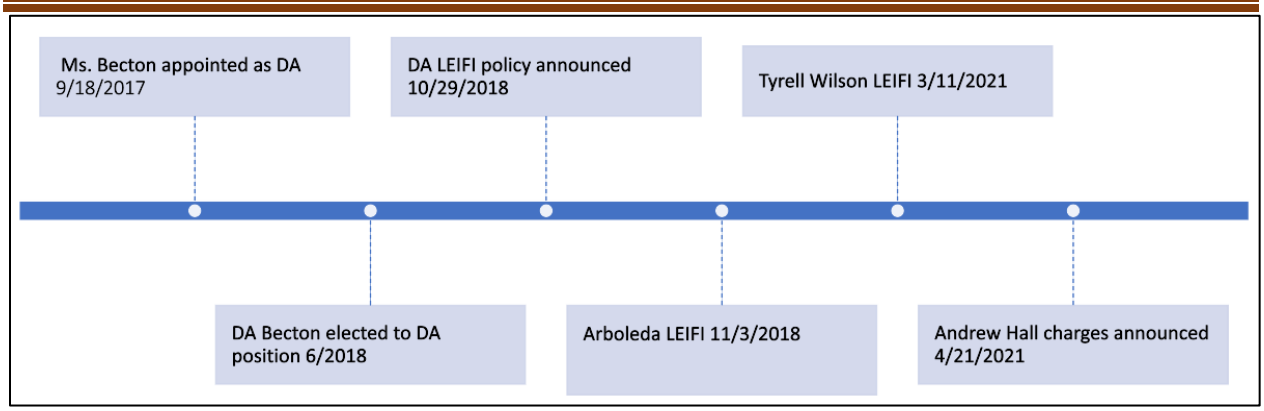
In an October 29, 2018 press release District Attorney Becton announced a new policy for the DA's investigations into incidents in which an officer used deadly force. The policy made no changes for investigation of incidents in which an officer did not use deadly force. Under the new policy, the DA's office will conduct an independent investigation, separate from any investigation by other agencies, when deadly force is used. At the conclusion of the criminal investigation and legal analysis, the district attorney will release a public report if no charges are filed. The reports will be posted on the office's website.

District Attorney Becton stated on October 29, 2018: "One of the primary concerns I heard from residents upon taking office in 2017 was the need for greater transparency in the criminal justice system. With this permanent policy in place, I am confident my office will continue to provide information to the public in a timely and transparent manner."

The press release about the new policy was issued five days before officer Hall shot Mr. Arboleda. At the time of Arboleda's death the old policy was still in place; the DA's new LEIFI policy was not fully implemented until January 2021.

The Arboleda coroner's inquest was held on July 30, 2019; the jury concluded that Mr. Arboleda died at the hands of another, other than by accident. This verdict has no bearing on any criminal or civil liability, but the verdict must be reported to the DA.

A sheriff's office internal affairs administrative investigation was completed and referred to the sheriff immediately after the inquest, on August 1, 2019. The conclusion of this investigation was: "Viewed objectively, the actions taken by Office of the Sheriff personnel concerning Mr. Arboleda were legal, proper, and in congruence with the Contra Costa County Office of the Sheriff Policies and Procedures."



Meanwhile, District Attorney Becton instructed her office to review previous LEIFI incidents dating back to 2017 under the new DA LEIFI policy. Implementation of the new DA policy, and review of older LEIFI cases, created delays in making criminal charge determinations and in disclosing the findings regarding use of deadly force. As a result, at the time of Hall's shooting of Wilson in 2021, the DA had not made a determination regarding Hall's shooting of Arboleda over two years earlier.

In Contra Costa County, before implementation of DA Becton's October 29, 2018, LEIFI policy, there were no public explanations of why law enforcement use of force was reasonable, and no law enforcement officer had ever been criminally charged for excessive use of force. Rather, the public obtained information about incidents exclusively from the coroner's inquest and from press coverage.

How long does it normally take to make a criminal charge determination?

The civil grand jury developed a spreadsheet to compute the time from date of death to date of coroner's inquest, and from date of death to the DA's public LEIFI report on use of force incidents or filing of criminal charges. (See Appendix 2)

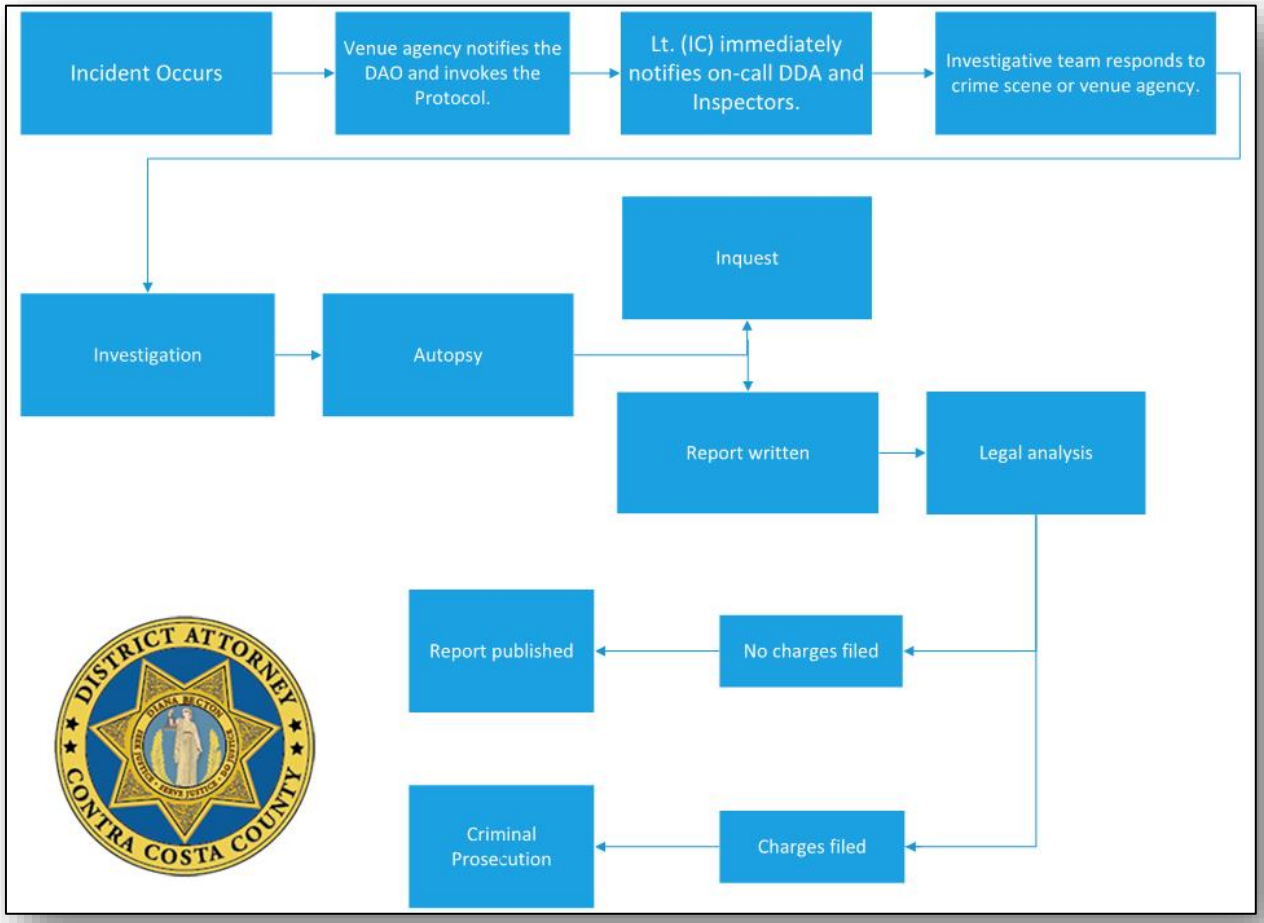
We examined seventeen LEIFI Reports from October 2018 to present and found the time to reach a charge determination averages **25 months**, with a range between 21 and 29 months. We conclude that the 2.5 years in the Arboleda case was longer than average, but not atypical.

We found that the coroner's inquest adds approximately ten months to the process. Using information on the sheriff and district attorney's websites, we compiled a spreadsheet of LEIFI incidents dating back to 2017 (Appendix 2). Reviewing 55 coroner's inquests between August 2017 and January 20, 2023, we determined that the time from the incident to the coroner's inquest averaged ten months. Because the DA waits for the verdict in the coroner's inquest, the ten months to hold the coroner's inquest adds time to the DA's criminal charge determination.

Are there deadlines for criminal investigations?

Three protocols and policies are relevant to investigations following a LEIFI in Contra Costa County. First, there is the 2014 Police Chiefs' Association Protocol (Protocol). Second, there is a sheriff's office policy and procedure document most recently revised in 2021, that is part of the Office's Policy and Procedures Manual (Sheriff's LEIFI Policy). Third, there is the DA's office policy, announced on October 29, 2018, but not fully implemented for two years (DA's LEIFI Policy).

Following an incident, the sheriff's office, local law enforcement agency[1] and the DA's Office, conduct multi-agency criminal investigations. The DA is also authorized to conduct its own separate criminal investigation. The criminal investigations are separate from administrative and civil investigations.



[1] According to the Protocol, the local law enforcement agency is the agency responsible for the venue (the location of the incident) and the employer of the officer involved in the incident.

The investigatory steps are described in detail in the Protocol, which contains numerous checklists for investigators. These steps are summarized in Appendix 3.
In Contra Costa County, the sheriff is also the coroner and is therefore responsible for the coroner's inquest, which is part of the LEIFI Protocol.

The DA's process is outlined in the flowchart above. The DA's policy requires the DA's investigation be done by a rotating team of DA inspectors and deputy DAs, in tandem with local law enforcement. Once the factual investigation is complete, a report summarizing the investigation is written and the matter is analyzed to determine whether charges should be brought. The DA is responsible for the legal analysis and has exclusive responsibility for the criminal charge determination. The standard for charging is whether the case can be proven beyond a reasonable doubt in a court of law.

The LEIFI Protocol sets a 30-day time goal for investigative reports and states that prompt completion of investigative reports is essential:

> Prompt completion, submission and distribution of reports is essential. All MATF (multi-agency task force) and assisting agencies and investigators will strive for report completion and distribution within 30 days after each Protocol incident. Ref 300, page 44

There is no time deadline for the coroner's inquest.

The DA's LEIFI Policy does not have a required deadline for a criminal charging determination, but the DA has an internal 90-day goal starting after the coroner's inquest. Our analysis indicates that the coroner's inquest is held about ten months after the incident. Adding 90 days for the DA's determination suggests that 13 months is the goal under existing practices, assuming that the coroner's inquest is not held for 10 months.

What is the coroner's inquest and what is its impact?

A coroner's inquest is a public court hearing dating back to medieval England in which a coroner or jury determines the manner of death. In California, Government Code section 27504 provides that the purpose of a coroner's inquest is to determine the medical cause of death and whether the death was by (1) natural causes, (2) suicide, (3) accident, or (4) the hands of another person other than by accident.

The findings of the jury in the coroner's inquest do not determine civil or criminal responsibility on the part of the deceased or any person. In fact, the inquest verdict is inadmissible as evidence in any civil or criminal proceeding[2]. If the inquest determines that death was caused by the hands of another person, then the coroner must report this result to the DA, who is responsible for determining if a criminal prosecution should be initiated.

We are not aware of any other California county that regularly holds coroner's inquests. In most counties the manner of death is determined by a medical examiner or forensic pathologist, not a

[2] Government Code section 27502.2

jury. In Contra Costa County, following the implementation of the Protocol in 1984, the coroner's inquest is a means to "inform the public, the media, and the decedent's family of the facts of each incident and to develop further information about the incident." (Sheriff's LEIFI policy, section (J)(2) at p. 48.)

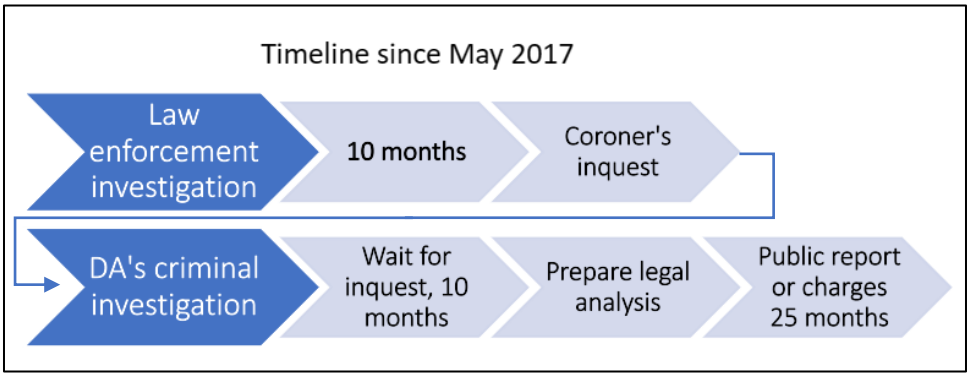
We recognize the value of the increased transparency achieved by the coroner's inquest in our county, especially regarding incidents about which the DA does not release a public report or file criminal charges.

In practice, the DA waits on the coroner's inquest before making or announcing a criminal charge determination, which adds an average of 10 months to the decision process. The Protocol does not, however, require the DA to wait on the coroner's inquest, and indeed recognizes that if criminal charges are brought, there is no need for a coroner's inquest.

Thus, the Protocol contains an internal conflict or ambiguity. While recognizing that the coroner's inquest is unnecessary if criminal charges are brought, it also requires that certain coroner's inquest verdicts be reported to the DA to consider filing criminal charges.

The DA's LEIFI policy notes that the coroner's inquest "has no bearing on the civil or criminal responsibility of the deceased or any other person(s) involved in the incident." Also, the DA's LEIFI flowchart indicates that the legal analysis and subsequent charge determination are independent of the coroner's inquest.

The impact of the coroner's inquest on the DA's decision process is to extend it 10 months on average. This impact can be seen in the diagram below.



The spreadsheet in Appendix 2 indicates that the time from incident to charging decision is presently 25 months, with the first 10 months, on average, awaiting the coroner's inquest. Our investigation also reveals that the time for the criminal charge determination has shortened significantly, and that this improvement is due to the new investigation process introduced by DA Becton and because her team has worked through the backlog.

Nevertheless, if the DA always waits for the coroner's inquest, then the criminal charge determination will still take at least 13 months.

How long should it take to make a criminal charge determination?

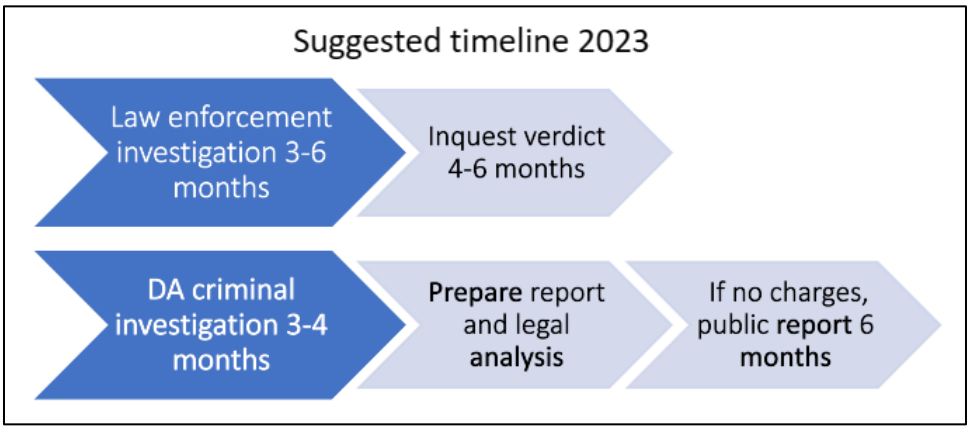
We conclude that the criminal charge determination can be made in six months from the incident for two reasons. We therefore recommend that the District Attorney consider revising the policies and practices of the office to achieve this goal.

First, internal guidelines and authoritative departmental sources suggest six months is reasonable and appropriate. The Protocol states that the investigators must strive to complete the criminal investigation report within 30 days. If that is achieved, additional investigation and analysis could be done in the following five months to achieve a criminal charge determination within six months.

An authoritative interviewed source reported that the investigation can be completed in three to four months. Adding two to three months for further analysis suggests that a criminal charge determination within six months is feasible. Further, if the DA did not have to wait for the coroner's inquest, a criminal charge determination within six months is well within reach.
At the same time, we recognize the DA's internal goal to make the criminal charge determination within 90 days of the coroner's inquest and that the DA's six most recent charge determinations were made less than six months after the coroner's inquest. We also note that the Protocol states that prompt completion of the investigation is "essential."

Second, we looked for charge determination benchmarks elsewhere in California. San Diego County law enforcement agencies have committed to completing their investigations within 90 days if feasible, and the district attorney's office has committed to having their review completed within 90 days if feasible. (San Diego County DA website). The goal for San Diego County is to decide whether to charge an officer for an officer involved shooting within six months. San Diego does not regularly conduct a coroner's inquest.

There were 52 cases of officer involved shootings in San Diego County from 2019 to 2022. The average time for the criminal charging determination (justified use of force) was seven months, with most of the cases meeting the six-month goal. In the only case in which an officer, Aaron Russell, was charged with manslaughter, the DA took 73 days to file charges. He was subsequently convicted.



Can the District Attorney make charge determinations faster?

Here we summarize our findings and recommend that the time to make a charge determination be reduced from 25 months to 6 months.

Finding 1A: Despite policies and internal goals, the DA's office takes too long to make a criminal charge determination in a fatal incident involving law enforcement officers.

Criminal charge determinations (LEIFI reports) have been published 21 to 29 months after such incidents. The Protocol requires that its parties strive to complete investigation reports within 30 days of the fatal incident. The DA's office has a 90-day goal to complete criminal charge determination after the completion of the coroner's inquest.

Finding 1B: The criminal investigation process has significantly improved since 2018.

First, criminal charge determinations are now publicly disclosed (LEIFI report) in all instances in which an officer used deadly force. Second, these reports provide a clear and comprehensive analysis of the criminal charge determination that obviates the need for a coroner's inquest regarding those incidents. Third, the DA's Office has instituted a 90-day goal to make a charging determination after the coroner inquest. Fourth, such reports were not previously made public.

Finding 1C: The DA's office waits on average 10 months for the coroner's inquest to be held.

We question if this is necessary before making the criminal charge determination. The verdict of the coroner's inquest has no bearing on the criminal responsibility of any person(s) involved in the incident and is not required before deciding whether or not to charge any individual. Furthermore, the Protocol recognizes that a coroner's inquest is not needed when criminal charges are filed.

Recommendation 1: For incidents in which a member of a law enforcement agency uses deadly force, the district attorney should consider releasing a public report about the incident or filing charges within six months of the incident and without necessarily waiting for the coroner's inquest.

Is the coroner's inquest timely and does it provide sufficient transparency?

The Sheriff's LEIFI Policy provides:

> INQUESTS. In each police involved fatal incident where a member of the public dies and where no criminal charges have been filed, a coroner's inquest will normally be held.
>
> The purpose of the inquest is to develop any further evidence and to inform the public of the facts of the incident.
>
> Sheriff's LEIFI Policy Section (J)(2) at page 48.

One of the primary purposes for coroner's inquests is to provide transparency regarding incidents involving law enforcement. The Legislature requires that these proceedings be open to the public. However, in Contra Costa County, the coroner's inquests are not consistently publicized in advance.

State law requires that coroner's inquest testimony be transcribed at county expense and filed with either the court clerk or the coroner[3]. In Contra Costa County, the coroner is the designated entity. However, the availability of a record of the proceeding, other than the verdict itself, is not made public.

When coroner's inquests are scheduled with the court, family members of the deceased are notified, as are members of law enforcement, the DA's office, and testifying witnesses. Generally, a press release from the sheriff/coroner's office is used to notify the public about the inquest.

Members of the civil grand jury attended three coroner's inquests, listed below. These coroner's inquests were poorly advertised, if at all, as in the Hickey inquest. The other two inquests we attended were publicized only one or two days in advance and on obscure websites.

Using the Google search engine, we were unable to find the coroner's inquest for Robert Jones in advance, but the Bing search engine found the notification on the www.thepress.net website. None were advertised on the sheriff's press release or coroner's inquest web pages.

[3] Government Code, sections 27502-03

Coroner's Inquest	Inquest Date	Date of Notification	Advanced Notification (days)	Source
Naya Jackson	11/18/22	11/16/22	2	KTVU.com
Robert Jones	1/13/23	1/12/23	1	www.thepress.net
Kent Hickey	1/20/23	None	N/A	N/A

If members of the public did not attend the inquest in person, the one-page inquest verdict would be the sum of what information is publicly available. However, by statute the inquest hearing is recorded by a court stenographer and the proceedings are transcribed at county expense and available in the coroner's office. The transcription is not mentioned on the inquest verdict or elsewhere on the sheriff-coroner's website. Also, the verdict in the Kent Hickey inquest, held on January 20, 2023, has, as of May 8, 2023, not been posted or referenced on the sheriff-coroner's website.

Further, there is no section on the sheriff-coroner's website where information about all prior coroner's inquests is consolidated.

The DA's website provides an example of posting all LEIFI reports in one section of the site. That section also includes the DA's LEIFI policy. The San Diego County website also provides an example of posting information about investigations into officer-related fatalities.

We noted earlier that coroner's inquests presently take an average of ten months to complete and that the DA waits for completion before making a criminal charge determination.

Given the goal in the Protocol to complete the criminal investigation reports within 30 days and that doing so is "essential," and that an authoritative source reported to us that all aspects of the investigation could be done in as little as three months and up to six months, the sheriff-coroner should consider completing the coroner's inquest within four months of the incident, but no later than six months.

Completing the coroner's inquest within six months would reduce the time for the DA criminal charge determination to nine months, and less if the DA did not wait for the coroner's inquest.

Finding 2A: The coroner's office takes too long to conduct coroner's inquests.

For the time period between 2017 and 2022, the coroner's inquests were held ten months after a fatal incident involving law enforcement officers, on average. The policy (LEIFI Protocol) sets a goal of 30 days for the completion of investigation reports and states that this is "essential." The LEIFI Protocol and authoritative internal sources indicate that the investigation of an incident can be completed more expeditiously and within four months after an incident.

Finding 2B: The coroner's inquest provides transparency.

Particularly if there is no direct use of force by law enforcement agencies (such as in-custody deaths and vehicle pursuits) and if the DA does not file charges or release a public report the coroner's inquest provides information about the facts of the incident that would not otherwise be known.

Finding 2C: The public notification of coroner's inquests and accessibility to inquest hearing transcripts is inadequate.

Of the three inquests that the grand jury attended, none provided more than two days advance notice. Only the verdict following the coroner's inquest is published on the sheriff-coroner's website. Other information about the inquest is not posted. Information about the availability of the transcript of the inquest hearing is not posted on the sheriff-coroner's website.

Recommendation 2A: For fatal incidents in which a member of a law enforcement agency is involved, the sheriff-coroner should consider completing the coroner's inquest within four months of the incident but no later than six months.

Recommendation 2B: The sheriff-coroner should consider providing advance notice to the public of all upcoming coroner's inquests, including the location, date, and time.

Recommendation 2C: The sheriff-coroner should consider posting press releases concerning all upcoming coroner's inquests on the sheriff's website.

Recommendation 2D: The sheriff-coroner should consider posting information about prior coroner's inquests, including the verdict and how to obtain a copy of the transcript. This information should remain available on the sheriff-coroner's website and/or other sites known and accessible to the public.

Does the Protocol need to be updated?

The Protocol has not been updated since 2014. There have been several statutory enactments since 2014 that have implications for LEIFI procedures. The Police Chiefs' Association and other parties to the Protocol may be well-advised to review and revise portions of the 2014 Protocol and the appended checklists to ensure consistency with current state law and with the policies of the DA and Sheriff's offices.

Finding 3A: The Protocol has not been updated since 2014.

Finding 3B: Since 2014, there have been changes in state law, including, but not limited to, Government Code sections 7286(b) (requiring that agencies adopt policies that include immediate reporting of excessive force, separate reporting to the Department of Justice, and other procedures) and 7286.5 (transport restrictions), and Penal Code sections 832.5 (retention of certain records), 832.7 (providing that certain factual information is not privileged), and 832.13 (requiring immediate reporting of all uses of force), and new policies in the offices of the DA and sheriff.

Recommendation 3: The parties to the 2014 Protocol should consider updating the Protocol to ensure that it is in compliance with current state law, the procedures identified in the DA's LEIFI Policy, and any applicable changes in the Sheriff's LEIFI Policy. This should include updating the checklists that are part of the Protocol.

REQUIRED RESPONSES

Pursuant to California Penal Code § 933(b) et seq. and California Penal Code § 933.05, the County of Santa Clara 2022 Civil Grand Jury requests responses from the following governing bodies:

Responding Agency	Findings	Recommendations
Contra Costa County District Attorney	F1A – F1D, F3A, and F3B	R1 and R3
Contra Costa County Sheriff-Coroner	F2A – F2A, F3A, and F3B	R2A – R2C, and R3

These responses must be provided in the format and by the date set forth in the cover letter that accompanies this report. An electronic copy of these responses in the form of a Word document should be sent by e-mail to ctadmin@contracosta.courts.ca.gov and a hard (paper) copy should be sent to:

Civil Grand Jury – Foreperson
725 Court Street
P.O. Box 431
Martinez, CA 94553-0091

INVITED RESPONSES

The Grand Jury invites the following individual(s) to respond:

Invited Responses to:	Findings	Recommendations
President of the Contra Costa County Police Chiefs' Association	F3A and F3B	R3

These responses should be provided in the format and by the date set forth in the cover letter that accompanies this report. An electronic copy of these responses in the form of a Word document should be sent by e-mail to ctadmin@contracosta.courts.ca.gov and a hard (paper) copy should be sent to:

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725 Court Street
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Appendices

Appendix 1. Charging time for officer involved shooting incidents in the United States where an officer was convicted (2017–2022)

Incident Date	Charging Date	Days to charge	Months	Officer	Victim
8/27/2021	1/18/2022	144	4.80	Brian Devaney	Fanta Bility
8/27/2021	1/18/2022	144	4.80	Sean Dolan	Fanta Bility
8/27/2021	1/18/2022	144	4.80	Devon Smith	Fanta Bility
7/27/2021	3/28/2022	244	8.13	Cecil Morrison	Michael Whitmer
6/23/2021	9/17/2021	86	2.87	Michael Davis	Hunter Brittain
4/11/2021	4/14/2021	3	0.10	Kim Potter	Daunte Wright
10/23/2020	9/23/2021	335	11.17	Terence Sutton	Karon Hylton-Brown
10/23/2020	9/23/2021	335	11.17	Andrew Zabavsky	Karon Hylton-Brown
5/25/2020	6/3/2020	9	0.30	J. Alexander Kueng	George Floyd
5/25/2020	6/3/2020	9	0.30	Thomas Lane	George Floyd
5/25/2020	6/3/2020	9	0.30	Tou Thao	George Floyd
5/25/2020	5/29/2020	4	0.13	Derek Chauvin	George Floyd
5/1/2020	7/13/2020	73	2.43	Aaron Russell	Nicholas Bils
1/25/2020	5/18/2020	114	3.80	Joel Streicher	Ceasar Stinson
12/27/2019	12/12/2020	351	11.70	Albin Pearson	Henry Berry
12/3/2019	6/19/2020	199	6.63	Eric J. DeValkenaere	Cameron Lamb
10/12/2019	12/20/2019	69	2.30	Aaron Dean	Atatiana Jefferson
7/4/2019	7/3/2020	365	12.17	Joshua Taylor	Jared Lakey
7/4/2019	7/3/2020	365	12.17	Brandon Dingman	Jared Lakey
1/24/2019	1/25/2019	1	0.03	Nathaniel Hendren	Katlyn Alix
1/13/2019	8/15/2020	580	19.33	Anthony Fox	George Robinson
1/4/2019	1/2/2020	363	12.10	Andria Heese	Gabriella Curry
11/3/2018	4/21/2021	900	30.00	Andrew Hall	Laudemer Arboleda
9/18/2018	5/16/2022	1,336	44.53	Stephen Flood	Wendy Newton and Nicolette Green
9/8/2018	2/4/2019	149	4.97	James O'Brien	Demetrius Shankling
9/8/2018	2/4/2019	149	4.97	Adam Lunn	Demetrius Shankling
7/26/2018	9/27/2018	63	2.10	Andrew Delke	Daniel Hambrick
4/3/2018	8/2/2018	121	4.03	William Darby	Jeffrey Parker
12/27/2017	10/9/2020	1,017	33.90	Eric Ruch	Dennis Plowden
12/24/2017	11/14/2018	325	10.83	Mike Holmes	Shelby Comer
11/15/2017	12/5/2017	20	0.67	Keith Sweeney	Dustin Pigeon
8/26/2017	12/20/2017	116	3.87	Mark Bessner	Damon Grimes
7/15/2017	3/20/2018	248	8.27	Mohamed Noor	Justine Damond
7/8/2017	12/13/2017	158	5.27	Phillip Barker	James Short
4/29/2017	5/5/2017	6	0.20	Roy Oliver	Jordan Edwards
Average		244	8.15		

Appendix 2. LEIFI timeline detailed analysis

The purpose of the LEIFI timeline spreadsheet is to compute the time between the date of the incident and the date of the coroner's inquest, and how long it takes the DA's office to issue their public report on use of force, in the absence of criminal charges.

The LEIFI timeline charts shown below are compiled from that spreadsheet and sorted by date of inquest.

The time from the fatal incident to the date of the coroner's inquest verdict is the time necessary to complete the LEIFI investigation by law enforcement.
From the earliest inquest verdict dated Aug 26, 2017, to most recent inquest verdict dated Jan 20, 2023, the length of time from Date of Death to Inquest is on average **9.9 months**.

	Elapsed Time			
Avg Period: Death --> Inquest (where inquest held)	**Period**	**Count**	**Mean Days**	**Mean Months**
	Post-Covid	13	293	9.6
	During Covid	17	380	12.5
	Pre-Covid	25	254	8.3
	Entire Period	55	302	9.9

Contra Costa County Courts were closed intermittently for jury trials (including inquests) during Covid lockdowns, which caused coroner's inquest delays. The dates courts were closed totaled nearly 7.5 months between March 2020 and February 2022.

Therefore, we separated the time for inquest verdicts into pre-Covid, Covid, and post-Covid as shown above. Nine to ten months between date of death and coroner's inquest seems to be the norm for LEIFI law enforcement investigations.

The DA's LEIFI policy states the inquest will generally be done before the DA's public use of force report. This causes a months-long delay before the final legal analysis and determination of appropriate use of force.

Avg Period: Inquest --> DA decision (where decision made)	Period	Count			Mean Days	Mean Months
	Post-Covid	6			175	5.8
	During Covid	5			340	11.2
	Pre-Covid	6			630	20.7
	Entire Period	17			384	12.6

Avg Period: Death --> DA decision (where decision made)	Period	Count	Mean Days	Mean Months		
	Post-Covid	6	637	20.9		
	During Covid	5	737	24.2		
	Pre-Covid	6	891	29.3		
	Entire Period	17	756	24.8		

As shown on the table above, since the new policy was established in October 2018, the 17 DA public reports were published an average of **24.8 months** after the incident. Of those 17 cases, only one use of force case was found not justified and charges were brought against the officer. The most recent post-Covid DA reports were announced within 20.9 months after the incident.

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	LEIFI Timelines since 2017-2022										
	Name	Date of Death	Date of Inquest	# Days Death to Inquest	# Months Death to Inquest	DA decision	Date of DA decision	# Days since death	# Months since death	# Days since Inquest	# Months since Inquest
Post Covid	Frank Correa	8/26/2022	not yet			No announcement to date					
	Eduardo Martinez	7/9/2020	none			Reasonable use of force	10/11/2022	824	27.1	Not done	Not Done
	Jose Luis Lopez	3/17/2020	none			Reasonable use of force	10/19/2022	946	31.1	Not done	Not Done
	Kent Hickey	6/26/2022	1/20/2023	208	6.8	No use of force by law enforcement					
	Robert Jones	3/22/2022	1/13/2023	297	9.8	No announcement to date		349	11.5	52	1.7
	Naya Jackson	6/22/2022	11/18/2022	149	4.9	No use of force by law enforcement		257	8.4	108	3.5
	Guadalupe Zavala	12/10/2021	9/16/2022	280	9.2	CA DOJ reviewing under AB 1506		451	14.8	171	5.6
	Laurent Vallee	2/12/2022	9/9/2022	209	6.9	No use of force by law enforcement					
	Jesocimo Rilles	2/4/2022	8/26/2022	203	6.7	No use of force by law enforcement					
	Sergio Escalera-Valdez	12/15/2021	7/29/2022	226	7.4	Reasonable use of force	2/3/2023	415	13.6	189	6.2
	Tyrell Wilson	3/13/2021	7/22/2022	496	16.3	Insufficient evidence to prove beyond reasonable doubt that Deputy Hall is criminally liable	10/28/2022	594	19.5	98	3.2
	Caleb Pelletier	1/6/2022	7/8/2022	183	6.0	No use of force by law enforcement					
	Patrick Watkins	5/20/2021	5/27/2022	372	12.2	Reasonable use of force	11/18/2022	547	18.0	175	5.7
	Arturo Gomez	2/24/2021	4/29/2022	429	14.1	No use of force by law enforcement	1/13/2023	493	16.2	259	8.5
	Jonathan Lynn Richardson	4/1/2021	4/15/2022	379	12.5	No use of force by law enforcement					
	Ivan Gutzalenko	3/10/2021	3/18/2022	373	12.3	No use of force by law enforcement					

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	LEIFI Timelines since 2017-2022										
	Name	Date of Death	Date of Inquest	# Days Death to Inquest	# Months Death to Inquest	DA decision	Date of DA decision	# Days since death	# Months since death	# Days since Inquest	# Months since Inquest
	LEIFI Timelines since 2017-2022										
	Name	Date of Death	Date of Inquest	# Days Death to Inquest	# Months Death to Inquest	DA decision	Date of DA decision	# Days since death	# Months since death	# Days since Inquest	# Months since Inquest
Covid	Michael Madison	2/1/2021	2/18/2022	382	12.6	No use of force by law enforcement					
	Ivan Sandoval	2/16/2021	12/10/2021	297	9.8	No use of force by law enforcement	8/31/2022	561	18.4	264	8.7
	Jeremy Waring	9/28/2020	11/19/2021	417	13.7	No use of force by law enforcement					
	Steven Trottier	7/23/2020	10/29/2021	463	15.2	No use of force by law enforcement					
	Tyler Dickens	5/17/2020	10/1/2021	502	16.5	No use of force by law enforcement					
	Juan Carlos Barraza	4/16/2020	9/17/2021	519	17.1	Reasonable use of force	11/9/2022	937	30.8	418	13.7
	Angelo Quinto	12/24/2020	8/20/2021	239	7.9	Reasonable use of force	9/2/2022	617	20.3	378	12.4
	Ezekiel McCoy	11/17/2020	5/28/2021	192	6.3	No use of force by law enforcement					
	Kentreal Irving	10/7/2020	5/28/2021	233	7.7	No use of force by law enforcement					
	Gregory Lane Lynds	10/17/2020	4/30/2021	195	6.4	No use of force by law enforcement					
	Levele Williams	9/24/2020	4/30/2021	218	7.2	No use of force by law enforcement					
	Enrique Camberos Pina	10/16/2019	4/16/2021	548	18.0	No use of force by law enforcement					
	Omar Jalal Harb	7/18/2019	4/16/2021	638	21.0	No use of force by law enforcement					
	Donald Eversen	12/1/2019	11/18/2020	353	11.6	Reasonable use of force	10/5/2021	674	22.1	321	10.5
	Luc Ciel	4/11/2019	11/6/2020	575	18.9	Reasonable use of force	9/21/2021	894	29.4	319	10.5

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	LEIFI Timelines since 2017-2022										
	Name	**Date of Death**	**Date of Inquest**	**# Days Death to Inquest**	**# Months Death to Inquest**	**DA decision**	**Date of DA decision**	**# Days since death**	**# Months since death**	**# Days since Inquest**	**# Months since Inquest**
	Samuel Martinez	12/26/2019	10/1/2020	280	9.2	No use of force by law enforcement					
	Benito Carrasco	8/18/2019	9/23/2020	402	13.2	No use of force by law enforcement					

	LEIFI Timelines since 2017-2022										
	Name	Date of Death	Date of Inquest	# Days Death to Inquest	# Months Death to Inquest	DA decision	Date of DA decision	# Days since death	# Months since death	# Days since Inquest	# Months since Inquest
Pre-Covid	Maria Barraza	4/13/2019	1/16/2020	278	9.1	No use of force by law enforcement					
	Miles Hall	6/2/2019	12/5/2019	186	6.1	Reasonable use of force	5/7/2021	705	23.2	519	17.1
	Leartis Johnson	3/7/2019	11/26/2019	264	8.7	No use of force by law enforcement					
	Steven Hankins	2/8/2019	11/19/2019	284	9.3	Reasonable use of force	9/13/2021	948	31.1	664	21.8
	Paul Ridgeway	12/5/2018	10/23/2019	322	10.6	Reasonable use of force	8/24/2021	993	32.6	671	22.0
	Karthik Kandaswamy	11/4/2018	10/4/2019	334	11.0	No use of force by law enforcement					
	Narayan Raymond Sanwal	11/27/2018	9/26/2019	303	10.0	No use of force by law enforcement					
	Michael Hernandez	10/30/2018	9/24/2019	329	10.8	No use of force by law enforcement	7/28/2021	1002	32.9	673	22.1
	Marcus Lamont Bray	9/28/2018	9/17/2019	354	11.6	Predates new DA LEIFI protocol					
	Laudemer Arboleda	11/3/2018	7/30/2019	269	8.8	Voluntary manslaughter, use of semi-automatic firearm	4/21/2021	900	29.6	631	20.7
	Dwight Dwayne Dunn	9/15/2018	6/20/2019	278	9.1	Predates new DA LEIFI protocol					
	Louis Marsh	8/23/2018	5/30/2019	280	9.2	Predates new DA LEIFI protocol					
	Salvador Contreras Morales-Cazares	10/22/2018	4/18/2019	178	5.8	Reasonable use of force	12/28/2020	798	26.2	620	20.4
	Lawrence Leo Martin IV	7/21/2018	3/27/2019	249	8.2	Predates new DA LEIFI protocol					
	Linda June Thomas	6/4/2018	2/28/2019	269	8.8	Predates new DA LEIFI protocol					
	Phillip Andrew Jacobson	6/12/2018	2/26/2019	259	8.5	Predates new DA LEIFI protocol					
	David Lamarc Hubbard	2/7/2018	1/30/2019	357	11.7	Predates new DA LEIFI protocol					

	LEIFI Timelines since 2017-2022										
	Name	**Date of Death**	**Date of Inquest**	**# Days Death to Inquest**	**# Months Death to Inquest**	**DA decision**	**Date of DA decision**	**# Days since death**	**# Months since death**	**# Days since Inquest**	**# Months since Inquest**
Pre-Covid	James Cooper	1/24/2018	1/3/2019	344	11.3	Predates new DA LEIFI protocol					
	Lloyd Harris	2/8/2018	10/30/2018	264	8.7	Predates new DA LEIFI protocol					
	Dean Amons Jr.	1/12/2018	6/28/2018	167	5.5	Predates new DA LEIFI protocol					
	Antonio Cacatian	12/18/2017	4/26/2018	129	4.2	Predates new DA LEIFI protocol					
	Darrell Barboa	8/2/2017	3/28/2018	238	7.8	Predates new DA LEIFI protocol					
	Zepp Crouchet	7/3/2017	1/4/2018	185	6.1	Predates new DA LEIFI protocol					
	Nathan Banks	6/16/2017	10/10/2017	116	3.8	Predates new DA LEIFI protocol					
	Marie Cherie Gaglione	5/14/2017	8/26/2017	104	3.4	Predates new DA LEIFI protocol					

Appendix 3. LEIFI Protocol and Policies

Contra Costa County Police Chiefs' Association LEIFI Protocol, 2014

This Protocol lays out in detail the investigatory procedures that should be implemented following a LEIFI and includes many checklists for different aspects of the investigations. For purposes of this report, we draw attention to the following provisions of the Protocol:
The Protocol is a formal, multi-party agreement. (Protocol section (C), p. 9.) The parties to this Protocol include the police chiefs of all cities and police districts in the County, the sheriff, the DA, the Martinez office of the California Highway Patrol, and several other law enforcement agencies with a presence in the county.

Under the Protocol, "Law Enforcement-Involved Fatal Incidents" or LEIFIs are broadly defined and include fatalities of civilians that are actually or conceivably a result of conduct of law enforcement agency personnel or law enforcement operations including deaths while in custody, during attempts to detain, or within 48 hours of release. (Section (D)(16), p. 11.)

The Protocol identifies three investigations that must be pursued following a LEIFI. (Section (H)(1)(a) – (c), p. 25.) First, a criminal investigation, to ascertain if laws were broken and charges should be filed. This criminal conduct could be by the officer or the civilian. Second, an administrative investigation to determine, for instance, if agency personnel followed internal procedures and training. Third, an investigation in anticipation of civil claims or litigation filed against the agency.

For the criminal investigation, the Protocol sets a goal for completion of investigative reports within 30 days after the incident. (Section (H)(3)(x)(4) p. 44 ("All . . . agencies and investigators will strive for report completion and distribution within 30 days after each Protocol incident.").)

The criminal investigation is conducted by a multi-agency task force that includes investigators from the sheriff's office, the DA's office, the agency with territorial jurisdiction over the incident, the agency that employs the officer involved in the incident, and possibly others. (Section B, p. 8.) Each of these parties has equal standing and authority in the investigation. (Ibid.)

The Protocol allows that, when deemed appropriate by the DA, the DA may perform its own investigation separate from the multi-agency investigation. (Section (H)(3)(w)(2), p. 43 ("The DA's Office has its own separate investigative authority and may perform independent investigations of incidents, separate from the [multi-agency task force] or any other investigations, when deemed appropriate by the DA or his/her designated alternate in his/her absence.").)

The Protocol includes provisions for a coroner's inquest. (Section (J)(2), p. 48 ("A coroner's inquest be held after the Criminal Investigation . . . is completed."); see also attachment F.) The Protocol states that coroner's inquests serve two purposes: to inform the public, media and interested parties about the incident, and to develop further information about the incident. (Section (J)(2) p. 48.)

The Protocol specifies that the coroner's inquest will be before a jury and that the verdict will include "findings regarding (a) the name of the decedent; (b) the time and place of death; (c) the medical cause of death; and (d) whether the death was by natural causes, suicide, accident, or death at the hands of another other than by accident." (Section (J)(2) p. 49.)

The Protocol allows discretion not to have a coroner's inquest for a death that is completely unremarkable and non-controversial, or when criminal charges have been filed (in which case information about the incident would be revealed through the criminal proceedings.) (Section (J)(3) p. 49.) For a coroner's inquest not to be held, there must be agreement by the sheriff, DA, and the police chief with territorial jurisdiction (if applicable). (Section (J)(3) p. 49.) The Protocol also notes that under California law a coroner's inquest must be held if the attorney general, the DA, the sheriff, city prosecutor or city attorney, or a chief of police in the county request. (Section (J)(5) p. 49; see also California Government Code section 27491.6.)

In other words, a request by any one of several individuals is sufficient to trigger a coroner's inquest, but only if there is unanimous agreement will an inquest not be held. According to the Protocol, an inquest is "normally" held. In effect, a coroner's inquest is always held following a LEIFI in this County.

The Protocol was last updated in 2014.

Sheriff's Office General LEIFI Policy and Procedure, last updated August 17, 2021

The sheriff's office has additional procedures regarding LEIFI investigations and these have recently been updated and reflect changes in state law, e.g., reporting requirements to the Department of Justice. (Section VII, Procedure 4.) This policy is incorporated into the Office of the Sheriff's Policy and Procedures Manual, revised in 2022.
For purposes of this report, we draw attention to the following provisions of the sheriff's office policy:

The scope of the sheriff's office policy is broader than that of the Protocol because it may be invoked not only for fatalities, but also serious injuries. (Section II(B) p. 1 ("[D]irectly involving two or more people in which an on-duty or off duty police employee is involved and death or serious injury results.").)

As to coroner's inquests, the policy states that "[I]n each police involved fatal incident in which a member of the public dies and where no criminal charges have been filed, a coroner's inquests will be held." (Section III(G).) This provision suggests that the decision as to whether or not to file criminal charges is made prior to the decision as to whether or not to hold a coroner's inquests, and if there is a decision to file charges, then an inquest may not be held.

The policy also gives discretion not to hold an inquest if "the police actions are very clearly justified, and media interest is low." (Section III(G)(a).) In other words, the sheriff's policy is consistent with the Protocol in providing that the coroner's inquests are the norm but may not be held if criminal charges are filed or if the incident is non-controversial.

As does the Protocol, the sheriff's office policy states that the "purpose of the inquest is to develop any further evidence and to inform the public of the facts of the incident." (Section III(G)(a).)

DA's Law Enforcement Involved Fatal Incidents Policy, effective October 29, 2018

Since at least 2018, the DA has had a separate LEIFI policy. It relates only to the DA's office and, relative to the Protocol and the sheriff's office policy, is much briefer. For purposes of this report, we draw attention to the following provisions of the DA's policy:

The DA's LEIFI policy applies in a narrower set of circumstances than the Protocol and sheriff office policy, and it applies only to the DA's office. The specific provisions of the policy are triggered only when law enforcement uses deadly force and not, for instance, when a death arises from a vehicular pursuit or is considered a suicide or accident while in detention.

"When deadly force is used by law enforcement, the public has a right to expect the Contra Costa County District Attorney's Office to conduct a thorough, transparent, and independent investigation." (DA LEIFI Policy.) The DA's LEIFI Policy also explains that the Protocol applies to a significantly broader range of incidents than the DA's policy in that several types of incidents investigated under the Protocol do not involve use of force by law enforcement personnel (such as suicides, vehicle pursuits, in custody deaths), and that non-fatal incidents are also investigated under the Protocol (such as non-fatal incidents that involve a use of force by law enforcement personnel or associated with alleged criminal conduct by an employee of a law enforcement agency.)

When the DA's LEIFI policy applies, i.e., following use of deadly force by an officer, the DA's office does an investigation that is separate and independent from the multi-agency investigation under the Protocol. While the Protocol refers to a single criminal investigation in which various agencies have equal authority and standing, it gives the DA discretion to perform its own investigation, and by the DA's October 2018 policy, the DA will do so when an officer has used deadly force. "It is important to note that although the [criminal] investigations happen simultaneously, each agency is conducting its own independent investigation." (DA LEIFI Policy.)

Further, if an officer has used deadly force and when the DA does not file criminal charges, the DA releases a report on the investigation to the public. (DA LEIFI Policy.). There is no public report if criminal charges are filed or if the DA determines that the death was not caused by the use of deadly force by an officer. (DA LEIFI Policy.)

The DA's policy states that, "[i]ndependent of the DA's Office" the coroner conducts a coroner's inquests in "most" LEIFIs. "The verdict in the coroner's inquest has no bearing on the civil or criminal responsibility of the deceased or any other person(s) involved in the incident." (DA's LEIFI Policy.) If the DA issues a public report of its investigation, "[g]enerally, the report will be issued after the coroner's inquest." (DA's LEIFI Policy.)

There appears to be a tension between the DA's policy statements that the coroner's inquest has no bearing on criminal responsibility for the LEIFI and the fact that the DA generally waits for the coroner's inquest verdict before issuing a public report of its criminal investigation. If there is no relationship between the two determinations it is not clear why one is contingent on the other.

The DA's policy does not set any deadlines or aspirational timeframes for issuing a public report or filing charges, other than to state that "[a]ll cases will be reviewed in a timely manner in accordance with the Protocol."