A RESOLUTION TO BE
SUBMITTED BY LEGISLATOR BURKE

WHEREAS, the New York State Commission of Correction has released a report determining the Erie County Holding Center was at fault in the death of inmate Richard Metcalf; and

WHEREAS, the report states that the Erie County Sheriff's Office contributed directly to the death of inmate Metcalf due to violating procedure; and

WHEREAS, the report states that the Sheriff's Office used improper restraint methods including securing a spit mask too tightly, not using a restraint chair and using a pillowcase as an improvised mask; and

WHEREAS, the report states that the Sheriff's Office failed to implement a 'crisis intervention plan for inmates undergoing acute psychosis with violent behavior' which was recommended to them after Michael T Bennett, a man suffering from schizophrenia died of asphyxiation after struggling with 6 deputies at the Erie County Holding Center in 2002; and

WHEREAS, inmate India Cummings, believed to be suffering from mental psychosis, died at ECMC after being transported from the Erie County Holding Center with severe injuries in February of 2016; and

WHEREAS, failure to implement proper procedures has put the safety of inmates as well as officers in jeopardy, the Buffalo News reported that an officer suffered a severe concussion during the conflict with inmate Cummings; and

WHEREAS, in 2010, The Justice Department's civil rights division issued findings on six jails nationwide for providing substandard mental health care, the Erie County Holding Center was among them; and

WHEREAS, aside from the tragic loss of life and the dangerous work situation put upon sheriff's deputies, the failure to implement necessary reforms has cost Erie County taxpayers; and

WHEREAS, The family of Michael T Bennett received one million dollars from county taxpayers to settle the wrongful death lawsuit; the family of India Cummngs currently has a lawsuit against the county for her death; the family of Richard Metcalf has publicly stated they too are pursuing a lawsuit against Erie County.

NOW, THEREFORE, BE IT

RESOLVED, that the Sheriff's Office provide quarterly updates on its implementation of the recommendations outlined by the Commission, and be it further

RESOLVED, that this honorable body hereby requests the presence of the Erie County Sheriff to address the concerns outlined in the New York State Commission of Correction's report.

NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Richard Metcalf, an inmate of the Erie County Holding Center	:	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

To: Sheriff Timothy Howard
Erie County Sheriff's Office
10 Delaware Ave.
Buffalo, NY 14202

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Richard Metcalf who died on 11/30/12 , as a result of circumstances which occurred while an inmate in the custody of the Erie County Sheriff at the Erie County Holding Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. Richard Metcalf was a 35-year-old Caucasian male who died on 11/30/12, at 5:17 p.m. at Erie County Medical Center (ECMC) while in the custody of the Erie County Sheriff. Metcalf was hospitalized after a prolonged use of force and an improper restraint by Erie County Sheriff's Deputies while incarcerated at the Erie County Holding Center (ECHC) on 11/28/12. Metcalf's cause of death was listed by the Erie County Chief Medical Examiner, Dr. [redacted] as Acute and Subacute Myocardial Infarction with the manner of death listed as a Homicide. The Medical Review Board has concluded that Metcalf's death was a Homicide caused by the restraint methods used by the Erie County Deputies. A thorough review all of the records, photos, and evidence including videography of the restraint episode, pictures of a spit mask tied in ligature fashion around Metcalf's neck, a pillow case over Metcalf's head, blood in Metcalf's airway, and the transport of Metcalf in a prone position on the ambulance gurney are evidence of the classic elements of a death that was caused directly by traumatic asphyxia with compression of the torso and neck. The Board unilaterally rejects the conclusion of Medical Examiner Dr. [redacted] that Metcalf died from Acute and Sub-Acute Myocardial Infarction. Had Metcalf received appropriate crisis level mental health care for his acute psychosis with proper restraint methods and pharmacologic interventions, and had been the subject of a properly supervised use of physical force, his death could have been prevented.

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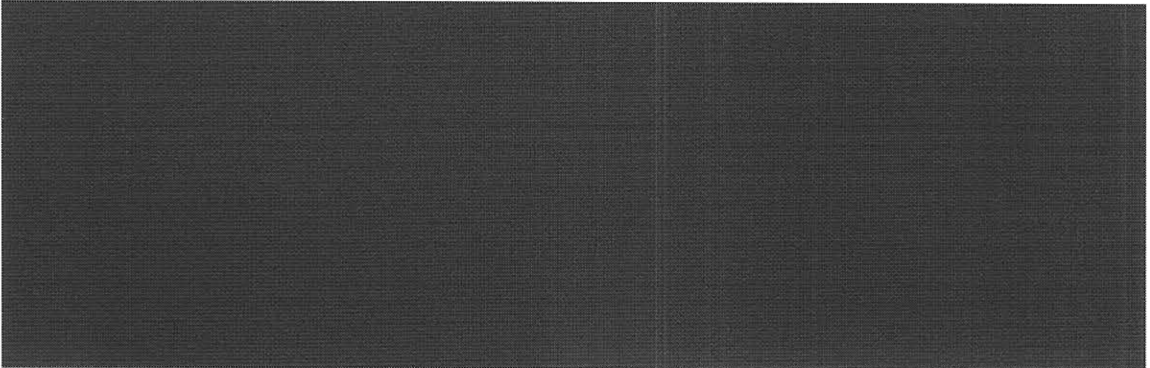
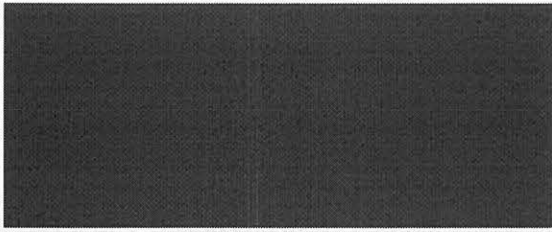
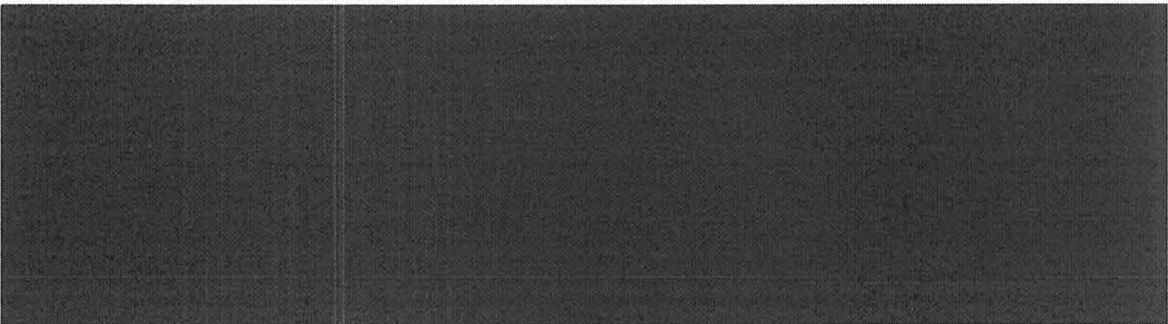
3. 

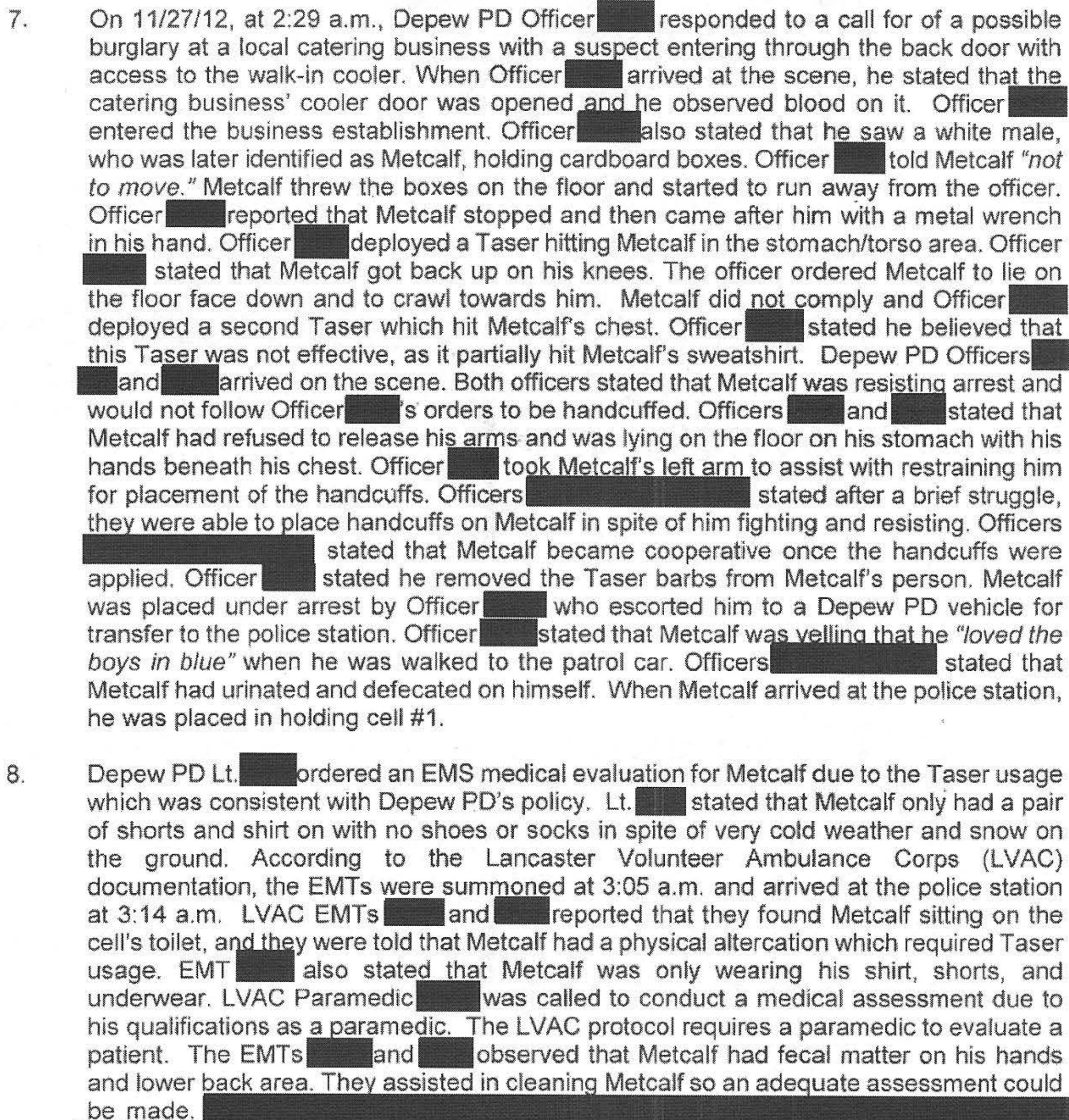


4.

According to the NYSP Investigative Report, Metcalf's family and friends reported that he displayed increasingly bizarre and erratic behavior for approximately a week before his arrest on 11/27/12. The precipitating event identified for Metcalf's mental health change was difficulties working with his co-workers after he reported one for stealing merchandise. Metcalf was noted to have a paranoid thought process and believed there were people following him. Metcalf's friend also cited an incident approximately on 11/25/12, that Metcalf went to his father's house and jumped through the glass window, suffering cuts on his hands and arms.

5. 

6. According to the NYSP Investigative Report on 11/26/12, before Metcalf's arrest, his girlfriend, ██ reported that Metcalf requested her to pick him up at his place of employment. He told his girlfriend he thought people were out to get him. Metcalf had also sent ██ several phone texts which he cited that people in the store were going to stab him. Additionally, it was noted that Metcalf would not go in his bathroom, as he believed that a person was waiting for him there. Metcalf urinated on himself rather than go into the bathroom. According to ██ on 11/27/12, at approximately 2:00 a.m., Metcalf ran out of his apartment, which he shared with her. Metcalf was wearing only his sweatshirt and shorts when he ran to a local catering establishment with his girlfriend following him. Later, Metcalf stated his rationale for going to the business and into its walk-in cooler was he felt hot and wanted to cool off.



7. On 11/27/12, at 2:29 a.m., Depew PD Officer responded to a call for of a possible burglary at a local catering business with a suspect entering through the back door with access to the walk-in cooler. When Officer arrived at the scene, he stated that the catering business' cooler door was opened and he observed blood on it. Officer entered the business establishment. Officer also stated that he saw a white male, who was later identified as Metcalf, holding cardboard boxes. Officer told Metcalf *"not to move."* Metcalf threw the boxes on the floor and started to run away from the officer. Officer reported that Metcalf stopped and then came after him with a metal wrench in his hand. Officer deployed a Taser hitting Metcalf in the stomach/torso area. Officer stated that Metcalf got back up on his knees. The officer ordered Metcalf to lie on the floor face down and to crawl towards him. Metcalf did not comply and Officer deployed a second Taser which hit Metcalf's chest. Officer stated he believed that this Taser was not effective, as it partially hit Metcalf's sweatshirt. Depew PD Officers and arrived on the scene. Both officers stated that Metcalf was resisting arrest and would not follow Officer 's orders to be handcuffed. Officers and stated that Metcalf had refused to release his arms and was lying on the floor on his stomach with his hands beneath his chest. Officer took Metcalf's left arm to assist with restraining him for placement of the handcuffs. Officers stated after a brief struggle, they were able to place handcuffs on Metcalf in spite of him fighting and resisting. Officers stated that Metcalf became cooperative once the handcuffs were applied. Officer stated he removed the Taser barbs from Metcalf's person. Metcalf was placed under arrest by Officer who escorted him to a Depew PD vehicle for transfer to the police station. Officer stated that Metcalf was yelling that he *"loved the boys in blue"* when he was walked to the patrol car. Officers stated that Metcalf had urinated and defecated on himself. When Metcalf arrived at the police station, he was placed in holding cell #1.

8. Depew PD Lt. ordered an EMS medical evaluation for Metcalf due to the Taser usage which was consistent with Depew PD's policy. Lt. stated that Metcalf only had a pair of shorts and shirt on with no shoes or socks in spite of very cold weather and snow on the ground. According to the Lancaster Volunteer Ambulance Corps (LVAC) documentation, the EMTs were summoned at 3:05 a.m. and arrived at the police station at 3:14 a.m. LVAC EMTs and reported that they found Metcalf sitting on the cell's toilet, and they were told that Metcalf had a physical altercation which required Taser usage. EMT also stated that Metcalf was only wearing his shirt, shorts, and underwear. LVAC Paramedic was called to conduct a medical assessment due to his qualifications as a paramedic. The LVAC protocol requires a paramedic to evaluate a patient. The EMTs and observed that Metcalf had fecal matter on his hands and lower back area. They assisted in cleaning Metcalf so an adequate assessment could be made.

Metcalf was supervised in the ED by Officer

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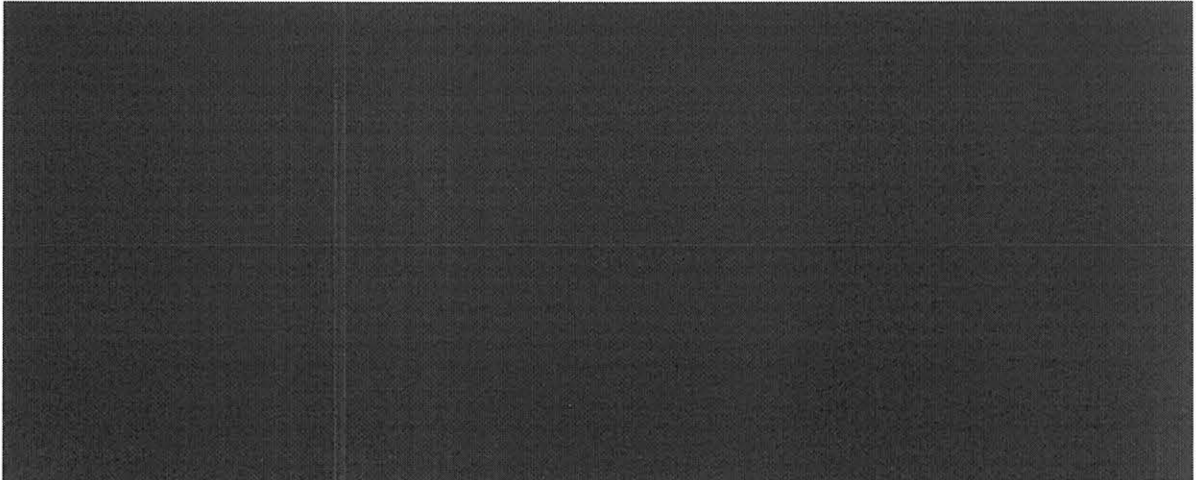

Officer was relieved by Officer in the early morning hours of 11/28/12, at the ECMC ED. Both Officers and Officer stated Metcalf was cooperative in the ED with no incidents of aggressive or unusual behavior. Officer stated that Metcalf ate his breakfast without incident.

10. According to the Depew PD documentation on 11/27/12, at approximately at 9:21 a.m., Metcalf was returned to the Depew PD without incident. At approximately 10:51 a.m., Metcalf was escorted to his arraignment by Depew PD Detective and Lieutenant . Detective reported that when he met Metcalf, he observed a red mark on Metcalf's forehead, and his face had a pinkish color around his eyes and cheeks. Per NYSP documentation, Depew Court Clerk reported that during Metcalf's arraignment, he appeared very quiet but did speak to his father and an attorney. reported that she saw no injuries on Metcalf. Lieutenant and Detective stated Metcalf conversed with his father in the court room, Metcalf was relevant and had appropriate conversation. Depew Town Justice reported that Metcalf appeared to understand where he was and what he was arrested for. Justice described Metcalf's face as appearing slightly redden, but he did not remember any cuts on it. Justice reported that he ordered a psychiatric evaluation due to the police officers' reports of Metcalf's behavior during the arrest. Metcalf was held without bail pending a court ordered mental health exam. At

approximately 10:58 a.m., following his arraignment, Metcalf returned to the holding cell at the Depew PD.

11. Officer ▇▇ completed supervisory rounds when Metcalf was housed in a Depew PD holding cell at intervals approximately every 20 minutes. Detective ▇▇ observed Metcalf sitting in the corner of the cell, and he had placed his shirt over his head like a tent. The detective asked Metcalf if he was okay, and Metcalf replied that he was scared. Officer ▇▇ asked Metcalf what he was scared of and he replied that he was *"just scared."* On 11/27/12, at approximately 1:50 p.m., Detective ▇▇ stated he observed Metcalf putting food into the holding cell's toilet and that he instructed him not to do it. Metcalf was apologetic, stating he would not do it again. However, several minutes later Detective ▇▇ observed Metcalf repeating this action. Detective ▇▇ reported that he thought that Metcalf was on some type of drug or was mentally ill. The detective stated that Metcalf smeared feces on himself and on the cell's floor. Detective ▇▇ stated that Metcalf was not booked at the Depew PD with the routine procedure with a photo and fingerprints taken due to his abnormal behavior.

12. Detectives ▇▇ and ▇▇ were assigned to transport Metcalf from the Depew PD to ECHC. Detective ▇▇ stated that he placed a blanket on the back seat of the patrol vehicle to prevent contamination from the feces. Detective ▇▇ observed Metcalf as non-combative and cooperative but was not acting normally. Metcalf was described as distant and unconcerned about sitting in the feces. Detectives ▇▇ and Detective ▇▇ reported that he observed a small cut over Metcalf's left eye, and his facial skin was pinkish during the transport to ECHC.

13. According to ECHC video-recording on 11/27/12, at approximately 3:34 p.m., Detectives ▇▇ and ▇▇ arrived in the ECHC intake/booking area. Detective ▇▇ stated that one deputy was ▇▇ The ECHC deputies stated that they would be taking Metcalf directly to the shower area and would return the police department's handcuffs to the detectives. Detectives ▇▇ and ▇▇ stated the ECHC deputies told them that Metcalf *"freaked out"* after he was taken to the shower area. Additionally, Detectives ▇▇ and ▇▇ stated that the ECHC deputies reported that they *"had to take him (Metcalf) down."* Detectives ▇▇ and ▇▇ stated they were not able to see Metcalf in the shower area. They also stated that they did not see when he left the shower area. The Depew PD handcuffs were returned to the detectives by the deputies.

14. According to ECHC video-recording on 11/27/12, at approximately 3:38 p.m., Metcalf was taken to the shower area by Deputies ▇▇ and ▇▇ due to being covered in feces and urine. Deputy ▇▇ reported that he observed bruising on Metcalf's face. Sgt. ▇▇, who was assigned in the intake/booking area, did not initially observe Metcalf's arrival due to an interaction with another inmate. Sgt. ▇▇ reported that he was on his way back to the booking area when he overheard a disturbance in the shower area. Sgt. ▇▇ observed ECHC Deputies ▇▇ and ▇▇ attempting to take Metcalf into the shower due to soiling himself. Sgt. ▇▇ stated that he observed Metcalf crying, yelling, and mumbling. Sgt. ▇▇ reported that when Metcalf straighten himself, he observed that Metcalf had left sided facial swelling and an abrasion on his forehead. Sgt. ▇▇ reported Metcalf acted disorientated and attempted to talk to Metcalf to calm him down. Sgt. ▇▇ ordered Metcalf to be escorted to the isolation area by the two deputies. Sgt. ▇▇ reported he had Metcalf sit on a bench and continued to talk to him. Sgt. ▇▇ stated that he told Metcalf that he would be taken to medical and would receive attention. The sergeant reported that he did this because Metcalf appeared delusional or had something wrong with him. Once Metcalf

appeared calm, Deputies [redacted] and [redacted] escorted Metcalf directly from the isolation room to the medical unit. According to the NYSP Investigative Report, Sgt. [redacted] stated Metcalf was in the isolation room for 45 minutes until he went to the facility nurse.

15. On 11/27/12, during the evening shift from 3:00 p.m. to 11:00 p.m., RNs [redacted] and [redacted] were assigned to the medical intake area to assess newly admitted inmates.

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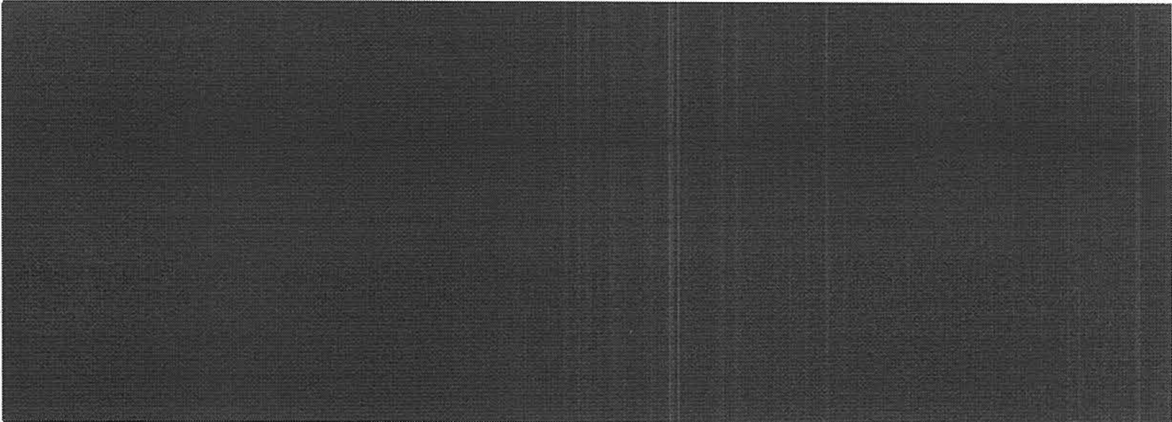
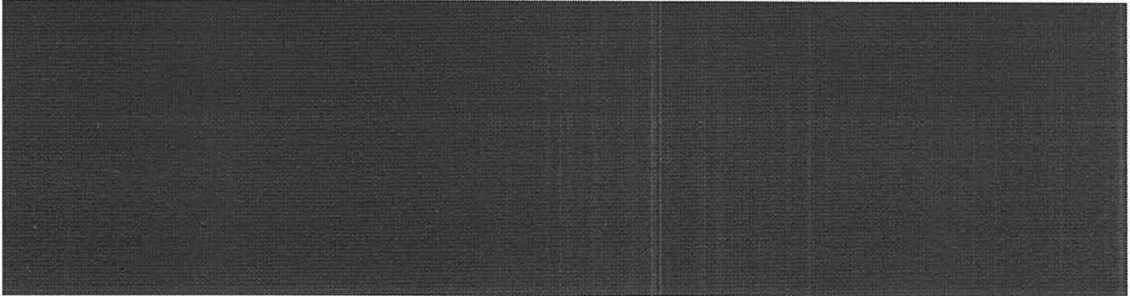
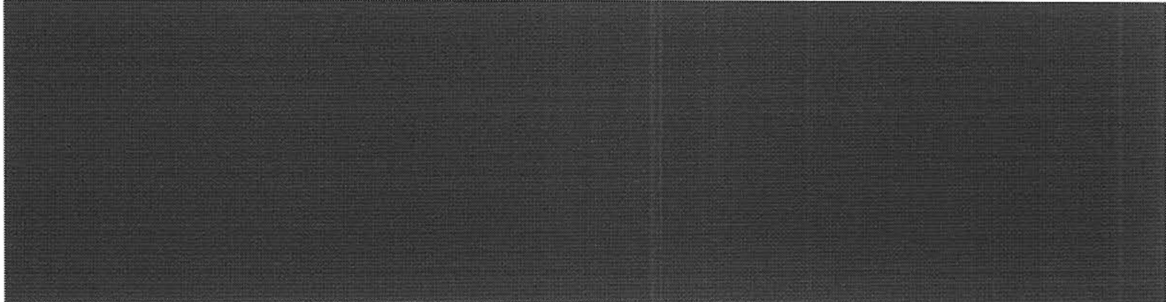
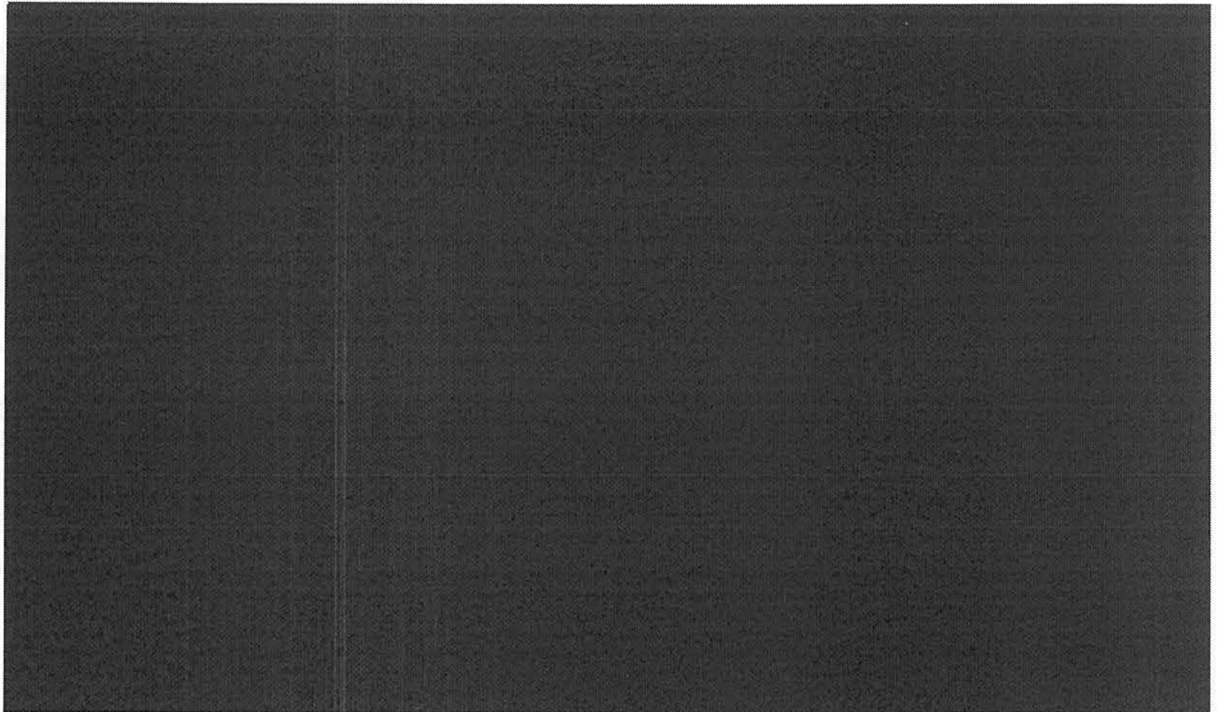


17. 

18. According to the Rural Metro Medical Services documentation on 11/27/12, at approximately 6:40 p.m., EMTs [redacted] and [redacted] arrived at the ECHC's medical unit. Rural Metro Ambulance documentation reported the EMTs were dispatched to the ECHC for an assault.

According to the NYSP documentation on 11/27/12, Deputy [redacted] rode in the Rural Metro ambulance with Metcalf, and Deputy [redacted] followed in the patrol car transporting Metcalf to ECMC ED.

19. 



20. The security log book reported that at 10:40 p.m., Metcalf returned from ECMC. Metcalf was transported back to ECHC by Deputies ███ and ███. A Use of Force form was completed by Deputy ███ The report indicated that Metcalf was ordered by Deputy ███ to go to the isolation room in the booking area. Metcalf refused to walk to the isolation room, became uncooperative, and attempted to enter another intake room. Deputies ███ and ███ reported that they attempted to secure Metcalf with handcuffs and were met with immediate resistance. At this time, Deputy ███ secured Metcalf's left arm while Deputy ███ took his right arm. Deputy ███ assisted with the handcuff placement and secured them. Deputies ███ and ███ then escorted Metcalf to the isolation room. The deputies did not report that Metcalf was taken down to the *"ground."* The deputies also reported that Metcalf was intentionally hitting his forehead on the wall. The security log book reported that at 11:01 p.m., Metcalf was moved to isolation room. The Use of Force Report cited that the nature of Metcalf's injuries before the Use of Force were bruising and brush burn on face and forehead. The nature of the injuries following the Use of Force was opening of brush burn on face and forehead causing bleeding. Deputy ███ reported that a sergeant took photographs of Metcalf. Deputy ███ stated that the injuries he reported on the Use of Force Report were prior injuries and were not from the incident that had just occurred.

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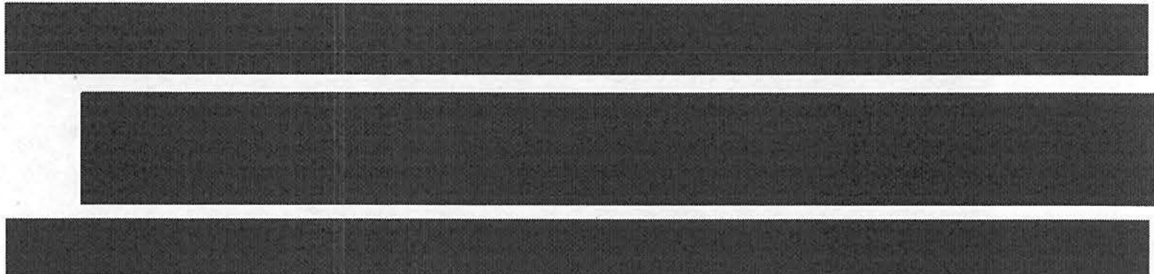
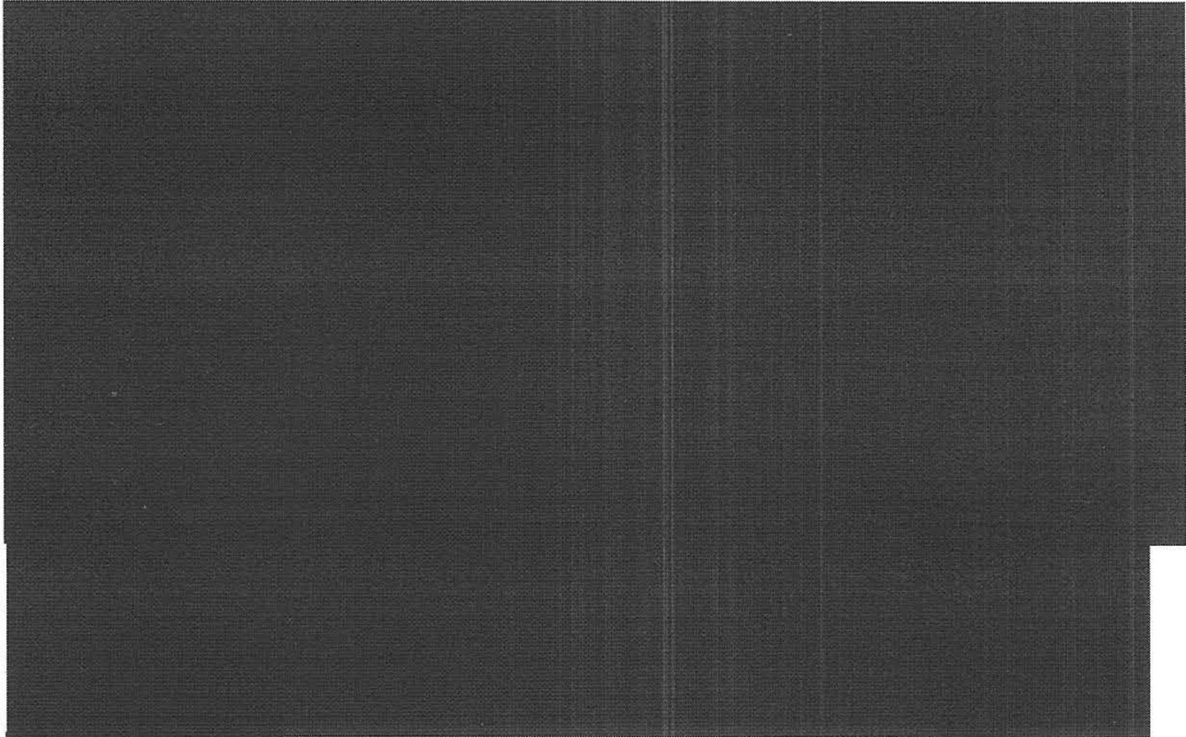
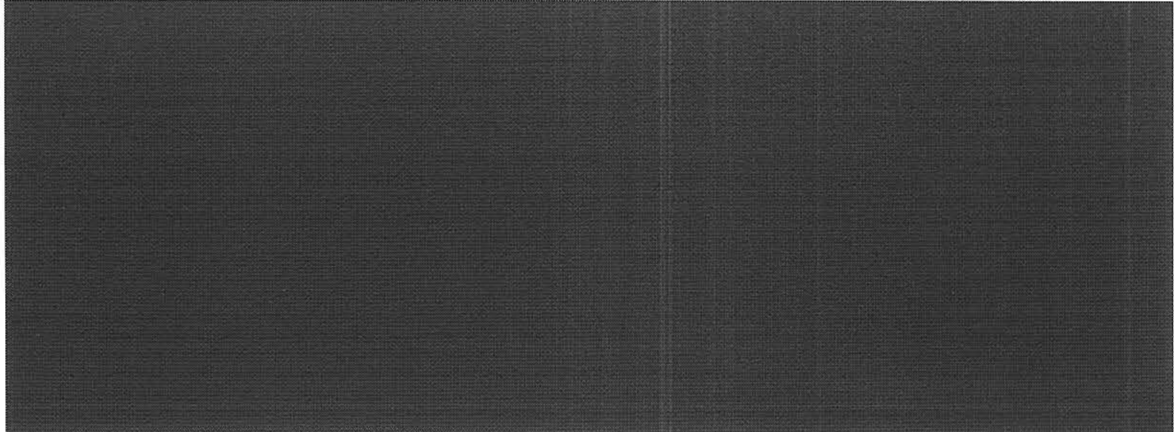


According to the Booking/Intake Security log on 11/27/12, at 11:45 p.m., Metcalf was moved to Delta Short.

22. 

The Medical Review Board opines that LMHC failed to recognize Metcalf's signs and symptoms of acute psychosis and failed to initiate an appropriate treatment plan including immediate referral to psychiatry.

23. 

[redacted] The Medical Review Board opines that with two hospital emergency room admissions within a 48-hour period and continued complaints of unresolved acute anxiety should have prompted the NP to immediately refer Metcalf to psychiatry for an evaluation.

24. On 11/28/12, at approximately 1:00 p.m., Deputy [redacted] who the assigned classification officer, completed the security Initial Classification Instrument. Deputy [redacted] documented that Metcalf had a violent felony, this was first incarceration and was over age 35. Under the section that asked *"Has medical or mental health staff requested special needs housing?"* Deputy [redacted] circled *"no."* Metcalf's total score was *"5."* Metcalf was approved for general supervision with no special needs. According to the NYSP investigative report, Deputy [redacted] stated that he was walking Metcalf to his cell after his classification and noticed that Metcalf kept looking behind him. Deputy [redacted] stated that Metcalf told him that he did not want to get beat up again. Deputy [redacted] reported that Metcalf stated that the Depew PD officers had beat him up. Deputy [redacted] had Metcalf lift his shirt and Deputy [redacted] stated he saw Taser marks and dozens of black and blue marks on Metcalf's chest, stomach, back, and face. Deputy [redacted] stated that Metcalf answered all his questions and appeared to be coherent. Deputy [redacted] stated that Metcalf's biggest concern was getting beat up again. Deputy [redacted] reassured Metcalf that he would be okay, and he appeared to become calm. Deputy [redacted] did not take any photographs of Metcalf's injuries or notify a supervisor.

25. On 11/28/12, at 1:45 p.m., there was a security log entry that Metcalf was moved to Echo-Long cell #2. On 11/28/12, at 2:32 p.m., there was a notation that *"Metcalf was complaining of pain, medical notified."* There is no documentation that indicates that medical personnel saw or evaluated Metcalf for this complaint.

26. At approximately 4:30 p.m., Metcalf asked Deputy [redacted], who was an ECHO-Long Housing Officer, to be lock-in because he felt scared. Deputy [redacted] stated that this was not a usual request from an inmate. Deputy [redacted] stated he locked-in Metcalf, and Metcalf ate his dinner without incident.

27. On 11/28/12, at approximately 10:15 p.m., Deputy [redacted] observed Metcalf acting in an irrational manner in his cell. Deputy [redacted] stated Metcalf was biting and punching himself as well as picking at scabs on his arms with a plastic fork. Deputy [redacted] reported that he tried to speak to Metcalf and asked him for the fork. Metcalf responded by throwing the fork at him. Deputy [redacted] notified Deputy [redacted], an ECHO-Long Housing Officer, about Metcalf's behavior. Deputies [redacted] stated they heard Metcalf making statements that made no sense. Metcalf was saying he was *"radioactive"* and *"slaughter house."* Deputy [redacted] notified Sgt. [redacted] who was on different a housing unit, regarding Metcalf's behavior. Sgt. [redacted] was the supervisor for ECHO-Long, Metcalf's housing unit. Sgt. [redacted] and Deputy [redacted] initially responded to the disturbance with Metcalf. Deputy [redacted] reported that he observed Metcalf biting his fingers and toes, as well as hitting himself. Sgt. [redacted] went to the cell and attempted to talk to Metcalf to calm him down. Sgt. [redacted] told Metcalf to follow his order to place his hands behind his back so that he could place handcuffs on Metcalf's wrists. Metcalf did not comply with Sgt. [redacted]'s order. Sgt. [redacted] repeated the instructions; however, Metcalf ignored them. Sgt. [redacted] decided to complete a cell-

extraction. The restraint chair could not be used, as it was not functioning correctly and needed to be repaired. Sgt. [redacted] called for a response team.

28. At approximately 10:20 p.m., deputies responded to Metcalf's cell. They were Sgt [redacted] Deputies [redacted] and [redacted] Deputy [redacted] stated that he went to Metcalf's cell but did not enter it due to the space limitations. Sgt. [redacted] was in charge of the use of force for Metcalf. Deputy [redacted] was ordered by Sgt. [redacted] to go to controls and open Metcalf's cell. Deputy [redacted] then stayed at the controls to operate the gate. Sergeants [redacted] stated that Metcalf was self-injurious and was banging his head against the wall and floor. He was also biting his arms and smearing the blood on the walls. Sgt. [redacted] stated that Metcalf was taken down to his bunk. Metcalf resisted by placing his hands under his chest while in the prone position. Sgt. [redacted] stated that the deputies moved Metcalf to the cell floor so that his hands could be restrained and then placed into handcuffs. Sgt. [redacted] reported that he secured Metcalf's legs. Metcalf's right arm was secured behind his back by Deputy [redacted] Metcalf's left arm was positioned behind his back by Deputy [redacted] Metcalf was handcuffed and removed from the floor. Metcalf was taken out of his cell. Metcalf ambulated to the hallway escorted by Sgt. [redacted], Deputy [redacted] and Deputy [redacted] The intent of this transfer was to have Metcalf examined by the nursing staff. Sgt. [redacted] stated that during the escort to the Delta medical examination room, Metcalf began to spit large amounts of blood at the deputies, and he continued to resist.

29. According to the ECHC video-recording on 11/28/12, at approximately 10:22 p.m., Metcalf was seen entering the elevator. Metcalf was handcuffed behind his back with three officers restraining him. Metcalf was resisting the officers. There were three officers who placed Metcalf on the wall of elevator in the corner with his head down. There were also three different deputies in attendance in the elevator who did not restrain Metcalf, for a total of six deputies in the elevator. Deputy [redacted] stated that he heard a commotion coming from the elevator area. He then saw Metcalf exiting the elevator with the deputies. Deputy [redacted] stated Metcalf was out of control and spitting blood everywhere. Deputy [redacted] stated that Metcalf was uncooperative during the escort to the medical unit. Metcalf was taken to the Delta medical examination room by three deputies, and the three other deputies were walking behind them.

30. The ECHC video-recording shows that on 11/28/12, at approximately at 10:23 p.m., Metcalf was observed in the Delta medical examination room. The video-recording shows the door of the examination was closed shortly at 10:23 p.m. A deputy opened the examination room door at 10:25 p.m. Metcalf was observed to be struggling with the deputies. The Delta exam room has two entrances in which both were used by the deputies to gain access. Sgt. [redacted] stated that Metcalf was spitting blood in the exam room, which hit the medical equipment and the officers' clothes. Metcalf was placed face down in the prone position on the medical table due to this behavior. Sgt. [redacted] reported that he was at the head of the exam table controlling Metcalf's head. Sgt. [redacted] stated he secured Metcalf's head in the downward position so the other staff would not be struck by blood. Sgt. [redacted] reported that it took four deputies to restrain Metcalf on the table.

31. On 11/28/12, at 10:24 p.m., RN [redacted] was observed entering the Delta medical examination room to evaluate Metcalf. RN K.M. reported that he observed Metcalf face down in the prone position on the examination table surrounded by multiple deputies who were restraining him. The registered nurse described Metcalf as resisting, combative, kicking his legs, and spitting blood at the deputies. RN [redacted] reported that he was notified by Sergeants [redacted] and [redacted] that Metcalf had been self-injurious and combative including

banging his head against his cell walls and floor. The sergeants stated to RN [redacted] that Metcalf was biting and stabbing himself in the forearm with a plastic fork. RN [redacted] stated Metcalf was handcuffed behind his back and was shackled at the ankles by the deputies. RN [redacted] stated that he was unable to gain close proximately to Metcalf to assess his injuries due to his combativeness. Sergeants [redacted] and [redacted] requested an EMS ambulance be called to transport Metcalf to ECMC for his injuries and behavior. [redacted] The Comprehensive Psychiatric Emergency Program (CPEP) requires an emergency encounter and triage before mental health medications are ordered. The ECHC Use of Force Report dated 11/28/12, at 11:20 p.m., was competed by Sgt. [redacted] reported that the nature of Metcalf's injuries before the use of force were *"multiple cuts/abrasions and bruising."* The nature of the injuries following this use of force was listed as: *"unknown transported to the hospital."* The Medical Review Board opines that the Erie County Holding Center and Erie County Mental Health failed to have an adequate crisis intervention plan for inmates who are experiencing acute psychosis with violent behavior and revisits prior Medical Review Board concerns from the Matter of Michael Bennett (DOD: 7/5/02), who died while in custody at ECHC in a similar manner in 2002, under a prior sheriff's administration. Had an appropriate plan been established and an emergent chemical restraint ordered and administered, Metcalf's violent behavior may have been managed safely.

32. According to the ECHC video-recording, at approximately 10:28 p.m., Sgt. [redacted] entered the examination room and he saw Sergeants [redacted] and Deputy [redacted] holding Metcalf down on the examination table. Sgt. [redacted] stated that someone requested a spit mask. Sgt. [redacted] stated that he obtained one from another room. At 10:29 p.m., a deputy was observed with a spit mask in his hand and entered the exam room. Sgt. [redacted] reported that he handed the spit mask to someone but could not recall who it was. Deputy [redacted] stated that he entered the examination room and reported someone gave him a spit mask. Deputy [redacted] gave the spit mask to Sgt. [redacted] According to the NYSP Investigative Report and Sgt. [redacted] Sgt. [redacted] secured the spit mask loosely over Metcalf's head and face but did not tie the mask. Sgt. [redacted] reported that the spit mask was placed over Metcalf's head with the blue part in the front. Deputies [redacted] reported that they did not see anyone tie the spit mask. Metcalf chewed a hole through the mask and began to spit blood.

33. According to the ECHC video-recording, at 10:42 p.m., a deputy was observed bringing a pillow case in the exam room. According to the NYSP Investigative Report, Sgt. [redacted] stated he placed the pillow case loosely over Metcalf's head securing it when Metcalf's head was in the downward position. Sgt. [redacted] stated that he had previously received retraining on the use of a spit mask. This is a violation of Erie County Sheriff's Office Policy and Procedure #04-09-02 entitled Restraint Chair; Section (B) Use of Spit Mask which states:

> *"Hoods, bags, or other devices covering the head and face, which may interfere with normal breathing are prohibited."*
>
> *"A spit mask maybe used when an inmate is attempted to spit on staff placing the inmate in a restraint chair. Only a mask specifically designed as a spit mask is authorized. NO improvised masks are permitted."*

> *"The spit mask should be placed over the inmates head and tied in the back. It should not be tied tightly around the inmates face or neck. At all times the inmates ability to see and ability to breath comfortably must not be obstructed."*

RN [redacted] stated that he was unable to observe the spit mask or pillow case applied to Metcalf's head as he was talking by telephone to the physicians.

34. The Medical Review Board opines that Sergeant [redacted] applied a dangerous and unauthorized restraint device on Metcalf that, from the physical post mortem findings, caused Metcalf to have severely restricted breathing. Additionally, Erie County Sergeant [redacted] who oversaw the use of force was immediate responsible for the care, custody, and treatment of Metcalf and failed to properly supervise staff and prevent dangerous and unauthorized restraint methods. The failures of both sergeants to properly oversee Metcalf's condition and supervise staff directly resulted in Metcalf's demise and is in violation of Correction Law 500-C.

35. On 11/28/12, at 10:24 p.m., Rural Metro EMTs [redacted] were contacted for the transport of a patient with a psychiatric emergency from ECHC to ECMC. According to Rural Metro Medical Services documentation, at 10:46 p.m., EMTs [redacted] arrived at ECHC. According to the ECHC video-recording at approximately at 10:49 p.m., the Rural Metro EMTs were observed with their stretcher at the medical exam room where Metcalf was located. Per the ECHC video-recording at 10:50 p.m., EMTs [redacted] were observed pushing their stretcher into the exam room. EMT [redacted] came out of the exam room less than a minute later. Both EMTs [redacted] stated that a deputy gave an order for EMT [redacted] to leave the exam room due to Metcalf's behavior. She was observed standing by the door until 10:51 p.m. and then goes back into the exam room. RN [redacted] stated that he gave the Rural Metro EMS a report on Metcalf and observed the deputies securing Metcalf on the EMS stretcher. At 10:52 p.m., Metcalf's stretcher exited the medical exam room. A deputy was observed at the top of the stretcher where Metcalf's head was located and pushing the stretcher in the hallway. Metcalf's head was covered. EMT [redacted] was observed at the foot of Metcalf's stretcher. EMT [redacted] came out of exam room and followed the stretcher.

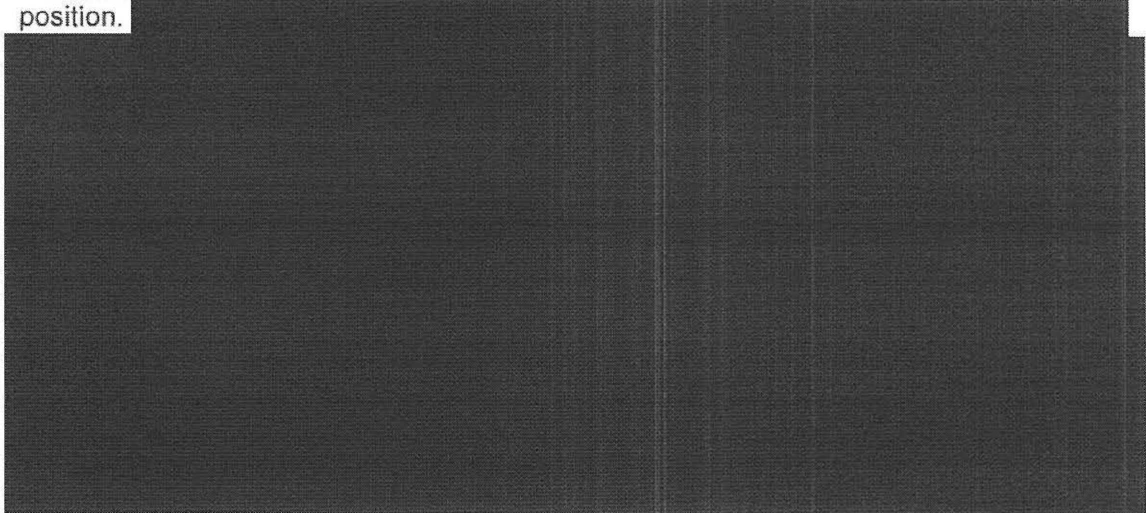
36. Rural Metro Ambulance EMTs [redacted] provided statements to the NYS Department of Health; Bureau of Emergency Medical Services as part of their investigation for this incident. The EMTs also supplied supporting depositions to the NYSP for their investigative report of Metcalf's death. EMTs [redacted] stated that the deputies told them Metcalf was combative, belligerent towards the staff, and spitting blood. EMTs [redacted] and [redacted] stated that they observed the patient face down on the examination table, with his hands handcuffed behind him and his feet also cuffed with a chain. EMT [redacted] stated that he entered the examination room with the stretcher and observed the inmate moving and making noise. EMTs [redacted] stated that Metcalf had a pillow case over his head, and there were five to seven deputies holding him down. EMT [redacted] stated that he asked the deputies why it was necessary for a pillow case over Metcalf's head he was told by the deputies that they needed to cover Metcalf's head to prevent him spitting blood. EMT [redacted] stated that he asked to move to Metcalf's head in order to assess him. The deputies told EMT [redacted] they needed to hold Metcalf down for safety reasons. EMT [redacted] stated that he was unable to gain access to Metcalf's head to assess him. EMT [redacted] stated that Metcalf was not actively resisting while he was present.

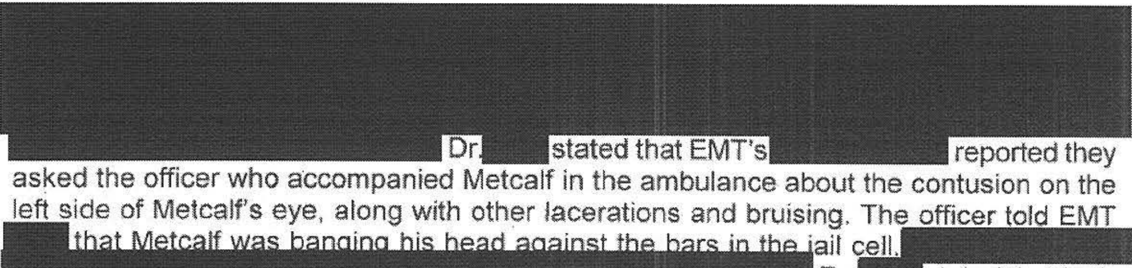
37. EMT ▇▇ stated that the deputies lifted and put Metcalf on the stretcher with his face down. The deputies told EMT ▇▇ that Metcalf was going to be moved onto the EMTs stretcher the same way he was on the examination table. EMTs ▇▇ reported that they asked if Metcalf could be placed on his back for health reasons. The deputies denied this request and told EMTs ▇▇ that Metcalf needed to be on his stomach for control as he had been fighting the deputies and spitting blood. Metcalf was placed on the stretcher by the deputies. EMT ▇▇ reported that the deputies would not let him place the stretcher restraint belts on Metcalf with the exception of one belt on the stretcher in the torso area. Sergeants ▇▇, and Deputy ▇▇ reported that the EMTs had asked the deputies to leave Metcalf on his stomach for the stretcher transport. According to the NYSP Investigative Report, Sgt. ▇▇ stated that the EMTs told him to leave the pillow case on Metcalf and to place Metcalf face down onto the stretcher. EMT ▇▇ reported that the deputies would not let him or EMT ▇▇ control the stretcher where Metcalf's head was located. However, after asking, the deputies allowed EMT ▇▇ to push Metcalf's stretcher at the feet.

38. According to the ECHC video-recording, at approximately at 10:52 p.m., the EMTs stretcher was seen leaving the medical exam room. Metcalf was in the medical examination room for approximately twenty nine minutes from 10:23 p.m. to 10:52 p.m. Approximately seven deputies exited the medical examination room after Metcalf's stretcher was moved in the hallway towards the elevator. A correction deputy was seen pushing at the end of the stretcher where Metcalf's head was located. EMT ▇▇ was observed walking at the stretcher where Metcalf's feet were located. EMT ▇▇ was walking behind two deputies as Metcalf's stretcher was exiting the medical exam room. The ECHC video-recording showed that throughout the entire transfer to the Rural Metro ambulance a deputy was pushing the stretcher where Metcalf's head was located. EMT ▇▇ was pushing the stretcher at Metcalf's feet. EMT ▇▇ followed behind the stretcher. Additionally, a deputy was pulling on the shoulder restraint strap over Metcalf's right shoulder. At 10:52 p.m., Metcalf's stretcher was wheeled inside the elevator with EMT ▇▇ located at the middle of the stretcher. An officer was still pulling the shoulder strap buckle of the stretcher at the head of the stretcher. Deputies are observed at Metcalf's head as the stretcher was removed from the elevator. According to the NYSP Investigative Report, EMT ▇▇ stated that Metcalf's breathing became shallower during the transport to the ambulance. EMT ▇▇ stated that Metcalf's movements and noises decreased while in the elevator and stopped when they left the elevator and went down the hallway to the ambulance.

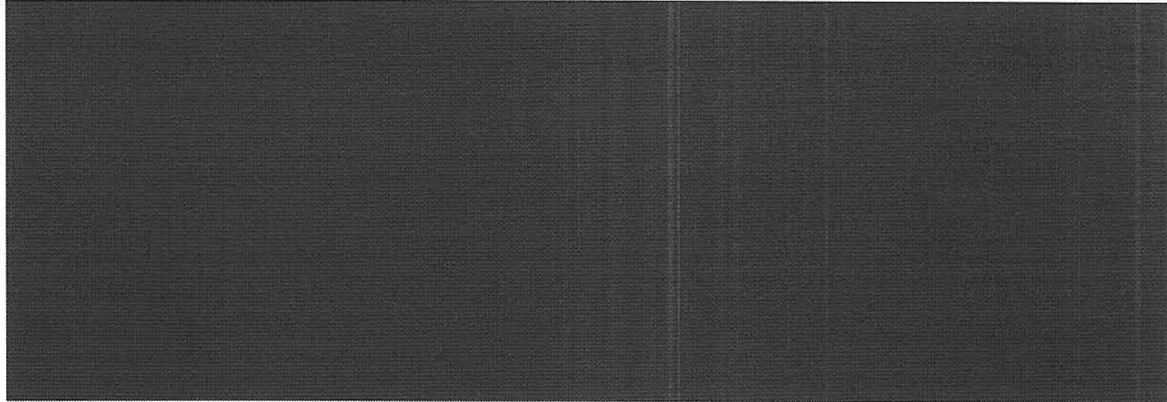
39. On 11/28/12, at 10:54 p.m., Metcalf's stretcher exited the facility through the ECHC intake sally port with a deputy still at the head of the stretcher. EMT ▇▇ was at the foot of the stretcher with EMT ▇▇ walking behind the stretcher. Approximately five additional officers also exited the sally port behind EMT ▇▇. EMT ▇▇ reported that as the deputies transferred Metcalf's stretcher to the ambulance, he went to Metcalf's head to begin to assess him. EMT ▇▇ removed the pillow case from Metcalf's head. EMT ▇▇ and EMT ▇▇ stated that they observed a spit mask tied very tightly around Metcalf's neck, in flagrant violation of Erie County Sheriff's Office Policy and Procedure #04-09-02 entitled Restraint Chair; Section (B) Use of Spit Mask. EMT ▇▇ and EMT ▇▇ reported the spit mask was tied so tight that ▇▇ had to use his scissors to cut the spit mask off. ▇▇

40. EMT told the deputies to give him a handcuff key as he was *"working a code."* The deputies gave him the key. EMT had difficulty removing the handcuffs. A deputy jumped in the ambulance and took the cuffs off. EMT turned Metcalf to the supine position.



41. 

Dr. stated that EMT's reported they asked the officer who accompanied Metcalf in the ambulance about the contusion on the left side of Metcalf's eye, along with other lacerations and bruising. The officer told EMT that Metcalf was banging his head against the bars in the jail cell. Dr. stated that both EMTs were visibly upset about the emergency call, and he advised them to notify their supervisor.

42. 

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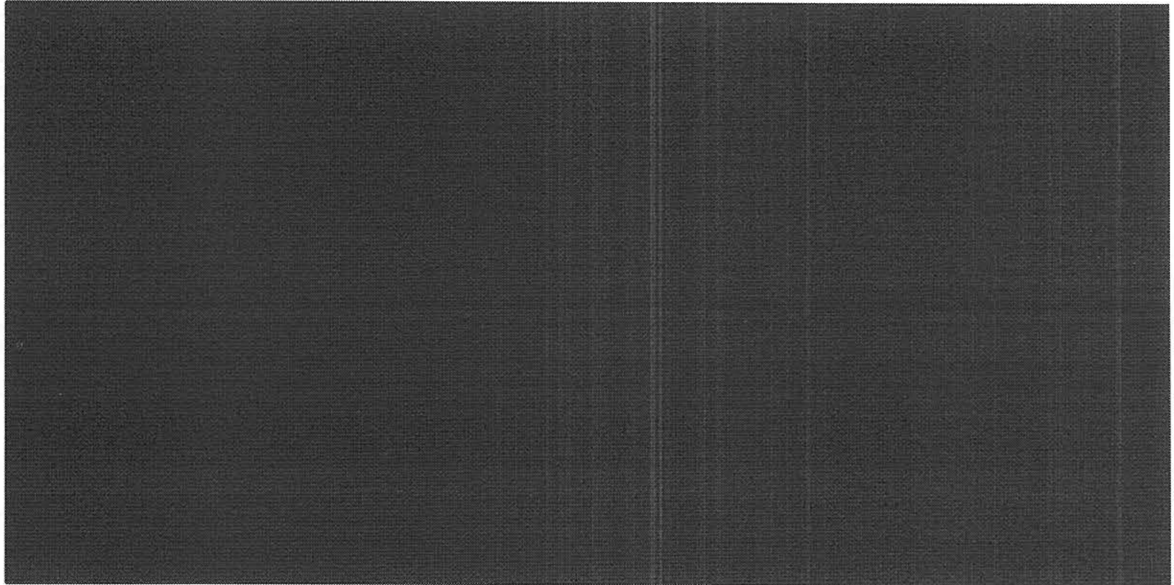
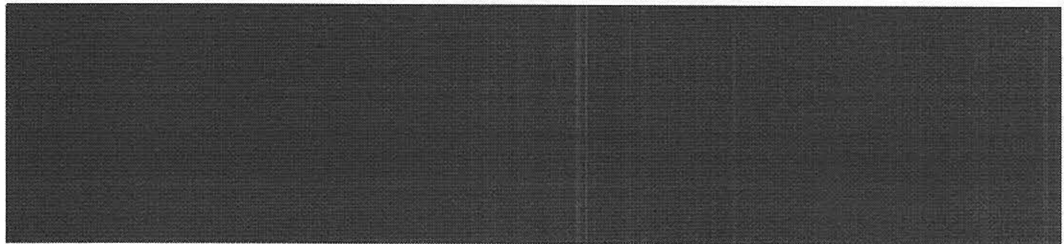
44. 



45. On 11/30/12, Metcalf was released from the custody of Erie County Sheriff's Department.

46. The NYS Department of Health: Bureau of Emergency Medical Services received an incident report completed by , the supervisor at Rural Metro Medical Services. of NYS Department of Health Bureau of EMS Investigation provided the DOH EMS Reportable Incident Report to the NYS Commission of Correction after Metcalf's death. NYS DOH: Bureau of Emergency Medical Services conducted their own investigation into the Metcalf incident and determined that there was no negligence or violations of Public Health Law or Regulations on the part of the EMTs. This incident was also reviewed by Rural Metro Medical Services Medical Director, Dr. The Bureau cited that the Rural Metro EMTs acted appropriately given the circumstances of the emergency.

47. A forensic examination was conducted by the Medical Review Board's forensic pathologist of the microscopic slides obtained during Metcalf's autopsy

48. These findings support that Metcalf's respiratory acidosis and ultimate cause of death was suffocation due to airway obstruction and compression of the chest.

49. These fractures were indicative of traumatic injury and not consistent with resuscitative efforts.

50. The NYSP crime scene photographs of the spit mask used on Metcalf showed several knots that tied the strings of the mask together. Photographs taken of Metcalf at his autopsy show visible striations across his face further indicating that the spit mask was tied inappropriately around his neck.

51. A review of the statements given to the NYSP for their investigation into Metcalf's death, as well as those from the NYS Department of Health Bureau of EMS's Investigation, reveal that there are conflicting accounts of this incident. The correctional deputies reported that the Metro Rural EMTs asked to keep Metcalf on his stomach during the transport; however, statements given by the Metro Rural EMTs indicate that their request to turn Metcalf on his back to the supine position was refused by the deputies. Additionally, the EMTs stated they were told that they could not access Metcalf's head nor direct the stretcher during Metcalf's transport to the ambulance. A review of the ECHC video-recording gives credibility to this claim as a deputy was observed controlling Metcalf's stretcher where his head was for the entire transport from the Delta medical examination to the exit doors of ECHC. Additionally, deputies reported that Metcalf was yelling and moving during the entire transport to the ambulance. The EMTs disputed this report stating that there was no noise or movement from Metcalf when the stretcher was going to the ambulance after exiting the ECHC elevator. The ECHC video-recording supplies no sound to determine such. A review of the ECHC video-recording by SCOC staff observed no movement from Metcalf on the Rural Metro stretcher from approximately 10:52 p.m. to 10:54 p.m. when exiting the ECHC sally port on 11/28/12.

52. From the crime scene photographs it was learned that the spit mask used on Metcalf was a product from *"The Safariland Group"* named *"The Spit Net™."* A review of the conditions/instructions in the enclosed protective wrapping that comes with the spit mask state:

> *"Do not use on anyone that is having difficulty breathing. Or is bleeding profusely from mouth or nose area*
> *Bring the straps under the armpits and through the loops in the back*
> *Tie the two straps together to secure the Spit Net in position. The straps should be snug to keep the Spit Net in place, but should not interfere with circulation or breathing."*

Since this incident ECHC has changed their policy that only now sergeants can apply spit mask on inmates.

53. Eight inmate witnesses, who were incarcerated at ECHC at the time on Metcalf's housing unit for his use of force on 11/28/12, stated the following to NYSP Investigators:

54. Witness stated in part that he never saw the inmate but could hear the inmate yelling and acting crazy. He heard an officer say something to the inmate about not wiping blood on the walls of his cell. stated that inmate was yelling slaughterhouse. stated that a short time later he could hear several officers enter the cell block area and give the inmate commands that he did not appear to be following. reported that one of the officers said something to the fact that the inmate must be on bath salts or something, also stated the deputies should just have sedated the inmate because it sounded like he was getting out of control. stated that the inmate kept screaming *"Slaughterhouse."* reported that he did not see any type of physical alteration take place between the officers and the inmate.

55. Witness reported that he recalled seeing the white male in cell # 2 and spoke to him briefly. He noticed that the inmate had a black eye and some bruising on his face. stated the inmate asked him when he ( ) was walking by his cell what he was there for. stated he then asked an officer why the guy was in jail, and he was told for burglary. went back to the inmate and told him why he was in jail. reported that the inmate didn't seem right and said it seemed like the inmate was high on something or had something wrong with him. said Metcalf was seen by the forensic staff at the holding center and then kept in his cell, said that they gave Metcalf his food in the cell then a short time later when he walked by the cell #2, he saw the inmate poking himself with a plastic fork and wiping the blood on his bars of his cell. The officer went to the cell and told the inmate to stop picking at his arms with the fork. then stated that when the inmate didn't stop, the officer told the inmate to give him the fork. thought the inmate threw the fork toward the bars and it may have hit the officer. then said the officers ordered all the inmates into their cell and a few minutes later a group of officers came on the block. stated he could not see anything but said that it sounded like the officers went into the cell and took the inmate to the ground and handcuffed him. said he saw a lot of blood on the bars before the officers secured the inmate.

56. Witness stated that he remembered a white kid (Metcalf) coming on the block. also remembered seeing the kid with blood over all over his arms and that he was picking at his arm with a fork then sticking it into his arms causing more bleeding. stated that Metcalf was writing his name on the cell wall with his blood, that the kid was banging his head on the bars or the wall, and yelling slaughter house, get me out of here. stated there was an obvious mental issue going on with this kid. stated he could see into the cell and could hear the officers telling the kid to knock it off, and there was no one in his cell. also stated it seemed like the guy was tripping or something similar. After a while, a bunch of officers came on to the block to take him out because he was being very disruptive. heard one officer keep telling him (Metcalf) to stop sticking himself with a fork. stated that more officers were called in because he would not stop, and then the inmates were told to lock in their cells so they could get him out. said about six officers came into the block and stated he could not see from his cell but could hear them fighting to get him out of the cell. stated that he heard the kid was carried out of his cell from another inmate. reported that the officers were trying to get the kid to stop in a nice way with the blood, but he would not listen.

57. Witness stated shortly after Metcalf was brought into the facility, all of the inmates in the area were given free time to go outside of their cells. Metcalf did not leave his cell and

seemed scared. He said Metcalf stayed in the cell and kept saying that he was innocent, and he did not know why he was inside of the cell. He continued by stating Metcalf also thought that someone was going to take his food and hurt him. Metcalf was in his cell for about two hours, and most of the time he just sat in his cell being quiet. [redacted] then stated Metcalf started cutting and biting the scabs on both of his arms. Metcalf was cutting himself with a plastic fork and then wiped and spit blood all other the walls and bars of his cell. Metcalf was yelling *"slaughter house"* over and over. [redacted] reported after a short period of time, the guards locked everyone down and tried to go in and clean up the cell. After being locked back into his cell, [redacted] could not see what was going on but could hear the rest of the incident. [redacted] stated he heard a guard ask Metcalf why he was doing that to himself, and then he heard a guard say something to Metcalf about Metcalf trying to cut him with a knife. [redacted] stated he heard this guard call for assistance from other guards to come in and take Metcalf out of his cell. While Metcalf was in his cell, he was saying things like he was a political refugee, he was innocent and did not do anything, and things about the slaughter house. [redacted] reported that Metcalf was really acting crazy and demented and noticed that Metcalf had a busted up eye that was purple in color and appeared to be swollen but did not notice any other marks on Metcalf's face or body. [redacted] reported he did not see Metcalf get assaulted by any inmate or guard at the facility.

58. Witness [redacted] stated that he remembered that a white guy (Metcalf) was being in and put in a cell just a couple of cells down from his. [redacted] indicated he couldn't see this subject very good and could not tell if he was injured when he came in. As soon as the guy got into his cell, he was yelling for help and acting crazy. [redacted] thought that the guy had a mental issue and they would eventually take him out. According to [redacted] later in the day Metcalf was pounding on the , and he [redacted] did not know what he was pounding them with, his head or his hands, but there was a bunch of blood on the bars of the cell. [redacted] stated he did not remember the officers going in to get him.

59. Witness [redacted] stated he was housed on Echo Block cell #1, when a white male, Metcalf, was brought into cell # 2. [redacted] did not see the inmate very well and did not notice any injuries on him. [redacted] indicated that after the inmate was in his cell for about a half an hour, he started yelling that he needed help. After a while, the inmate was not getting the help he wanted, he started banging. [redacted] was not sure if Metcalf was banging his head or his fists. [redacted] stated that the inmate was also yelling things like slaughterhouse. About an hour later approximately five officers came to the block and went into cell #2. [redacted] stated he heard what sounded like someone hitting the floor, and then he heard the inmate say *"stop, you're hurting me."* [redacted] stated it was clear that there was an altercation going on in the cell, and then the officers had the inmate handcuffed, and they carried Metcalf out of the cell. [redacted] thought that three officers carried Metcalf out and on the way to the elevator, the inmate was still yelling for *"help."*

60. Witness [redacted] stated that he was in cell #3, and a white inmate (Metcalf) was in cell #2. He said that the inmate was yelling for help, and he asked him what was wrong. The inmate told him what had happened, and the inmate told him that he had been beaten up the day before by the officers in the jail. [redacted] reported that the inmate kept yelling for help and kept saying *"this is slaughter house."* A little while later, all the inmates were locked down, and he could hear the inmate in cell #2 banging the cell bars with something. According to [redacted] a few minutes later an officer walked up in the front of cell #2 and told the inmate that was yelling to stop banging and to stop picking his arms. When the guy did not stop the officer called for help and said that they were going to have to go in and get him. [redacted] said about 7 to 8 officers showed up and told the inmate to get to the back of his cell. The

inmate was not listening and kept yelling for help. The officers opened up the cell and went in to get the inmate. ████ reported it sounded like they were fighting inside of the cell and added that he saw one of the officers holding a spit mask that they used to put over his head to keep him from spitting. ████ said that the officers carried the inmate out of the cell and in the opposite direction of his cell. ████ said that he did not see any blood on the inmate.

61. Witness ████ recalled seeing a white male acting strange while he was there (at ECHC). He did not recall the inmate's name but stated it was a white male with a medium build. ████ indicated he was in one of the middle cells of the row, and the subject in question was a few down from him. ████ recalled looking at the subject while the subject was still in his cell and said that it appeared that the inmate was just dazing off into space. ████ said that he witnessed the inmate picking at his arms with a plastic fork. ████ stated that he thought the inmate should have been placed in a forensic unit or a medical unit, because he seemed strange like something was wrong with him. ████ stated that late that evening, all of the inmates were told to lock in their cells, and no one knew why. They realized it was because they were going to have to deal with the inmate that was acting strange. ████ heard the officers giving the inmates commands like *"put your hands behind your back."* He believed that they were going to hand cuff the inmate. He then heard the inmate yelling *"help me" and slaughterhouse"* before being taken off the unit. ████ said that he heard one of the officers say *"this fucker just threw blood on me."* ████ also said he heard the officers telling the inmate to give them the fork he was picking at himself with. ████ stated that at no time did he witness any officer hit or touch the inmate.

62. The Erie County District Attorney's Office requested that the New York State Police: Bureau of Criminal Investigation conduct an independent investigation of circumstances surrounding Richard Metcalf's death. At the completion of the investigation, the Erie County District Attorney's Office did not bring forth any criminal charges, and a Grand Jury was not convened to review the matter.

RECOMMENDATIONS:

TO THE OFFICE OF THE SHERIFF OF ERIE COUNTY:

1. The Sheriff shall develop a Crisis Intervention Training for the Erie County deputies specific to identify and safely manage inmates with mental illness who are in a crisis state.

2. The Sheriff shall develop a policy and procedure to photograph inmates who enter the Erie County Holding Center who are observed with injuries.

3. The Sheriff shall establish a policy that corrections staff should not interfere with emergency medical services when they are attempting to assess and administer medical care to inmate in need of such unless there is a serious and *immediate* threat to the safety and security of the facility.

4. The Sheriff shall mandate compliance with Erie County Sheriff's Office Policy and Procedure #04-09-02 entitled Restraint Chair; Section (B) Use of Spit Mask which states:

> *"Hoods, bags, or other devices covering the head and face, which may interfere with normal breathing are prohibited. A spit mask maybe used when an inmate is attempted to spit on staff placing the inmate in a restraint chair. Only a mask specifically designed as a spit mask is authorized. NO improvised masks are permitted. The spit mask should be placed over the inmates head and tied in the back. It should not be tied tightly around the inmates face or neck. At all times the inmates ability to see and ability to breath comfortably must not be obstructed."*

5. The Sheriff shall continue with mandatory annual training on the use and application of spit masks and other restraints with continued compliance.

6. The Sheriff shall monitor the status of the restraint equipment used to control inmates' behavior. Attention should be given that if deficiencies exist that the prompt repair should be initiated.

7. The Sheriff shall conduct an investigation into the conduct of Sgt. [redacted] who violated Erie County Sheriff's Office Policy and Procedure #04-09-02 entitled Restraint Chair; Section (B) Use of Spit Mask and dangerously applied an unauthorized restraint to Metcalf. At the completion of the investigation, administrative action shall be taken for any identified misconduct.

8. The Sheriff shall conduct an investigation into the conduct of Sgt. [redacted] who failed to properly supervise staff during the use of force of force on Metcalf and failed to maintain a correctional facility in a safe, stable, and humane manner and in violation of NYS Correctional Law. At the completion of the investigation, administrative action shall be taken for any identified misconduct.

TO THE DIRECTOR OF ERIE COUNTY FORENSIC MENTAL HEALTH SERVICES:

1. The Director shall develop a comprehensive response plan with the Erie County Sheriff for humane response and safe management of inmates who are in mental health crisis. The plan should include procedures for restraint, referral for hospitalization, crisis intervention techniques and emergency pharmacologic interventions.

2. The Director shall conduct a thorough investigation and review of Richard Metcalf's mental health care while incarcerated at the Erie County Holding Center. The review shall focus on why clinicians failed to recognize a patient with acute psychosis and in need of immediate referral to a psychiatric provider.

TO THE ERIE COUNTY MEDICAL EXAMINER:

That the Erie County Medical Examiner review the forensic pathology of this case in light of the findings of the Medical Review Board with an eye toward a restatement of the cause of death to better reflect the circumstances and the autopsy findings that Metcalf died from traumatic asphyxia and [redacted] was not a factor in this case.

TO THE ERIE COUNTY DISTRICT ATTORNEY OFFICE:

That the District Attorney take official notice of the findings of the Medical Review Board in the case cited herein, with the newly revealed evidence that supports Metcalf's cause of death was a homicide due to traumatic asphyxia, and initiate a criminal investigation into the matter.

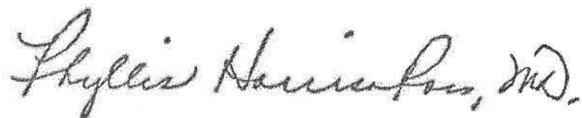
TO THE CHAIR OF ERIE COUNTY LEGISLATURE:

As the governing body responsible under Correction Law section 501 to appoint a physician to the jail of the county, the Erie County Legislature shall take notice of the findings of the Medical Review Board, and review the continued service of the current appointee.

TO THE ASSISTANT ATTORNEY GENERAL FOR CIVIL RIGHTS, U.S. DEPARTMENT OF JUSTICE:

That the Assistant Attorney General for Civil Rights take official notice of the findings of the Medical Review Board in the case cited herein and initiate both individual criminal civil rights investigations and a CRIPA investigation into the Erie County Sheriff's Office confinement and treatment of Richard Metcalf.

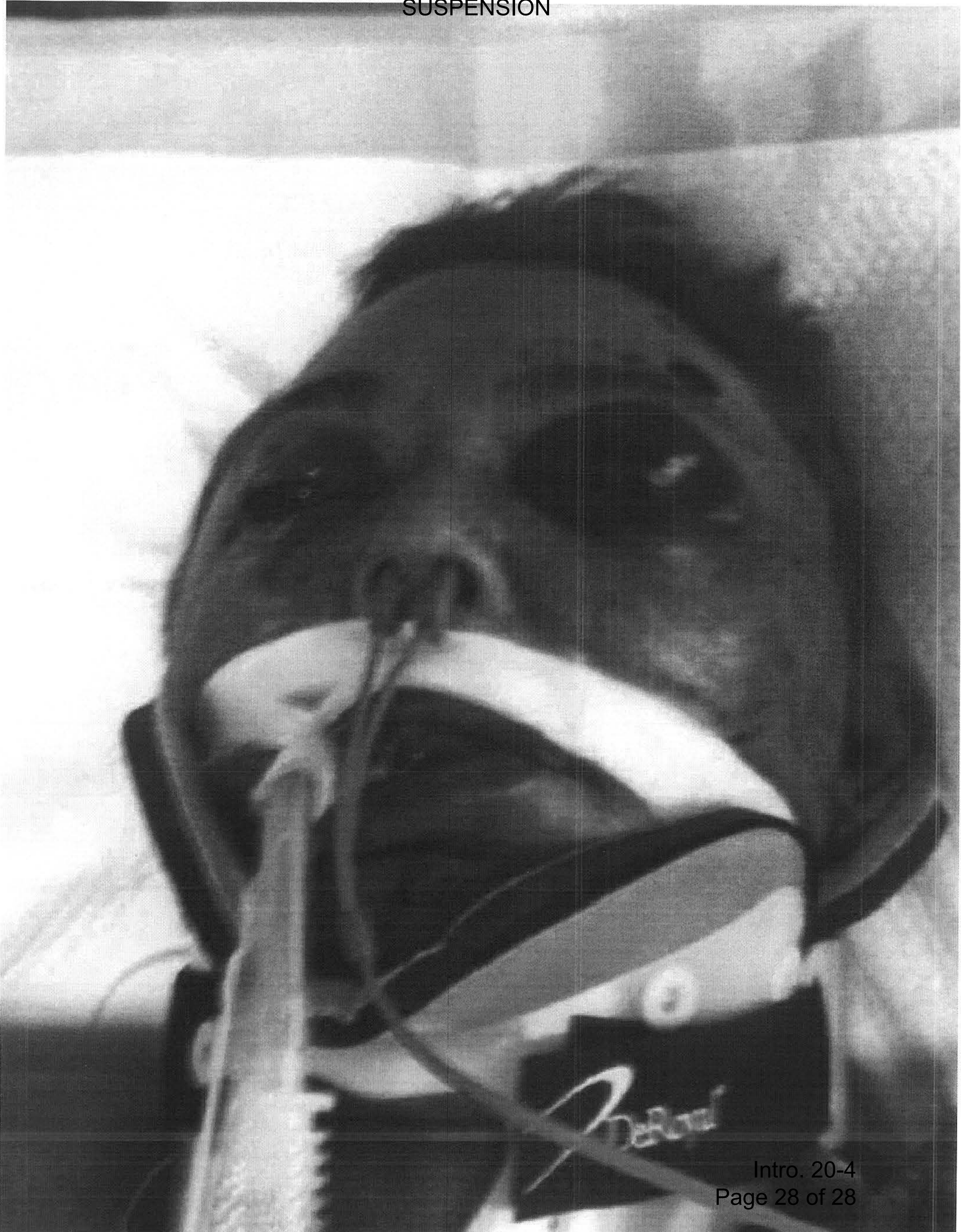
WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this September 27, 2016



Phyllis Harrison-Ross, M.D.
Commissioner

PHR:JS:cmo
12-M-152
9/16

Cc: Gail Burstein M.D., Commissioner
Erie County Department of Health
Dr. Tara Mahar, Ph.D., Chief Medical Examiner
Erie County
Frank A. Sedita, District Attorney
Erie County
John J. Mills, Chair
Erie County Legislature
Michael A. Siragusa
Erie County Attorney
Benjamin C. Mizer, Assistant Deputy Attorney General for Civil Rights
US Department of Justice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