



Virg Bernero, Mayor

# LANSING POLICE DEPARTMENT

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Mike Yankowski, Chief

## **Internal Board of Review Report on the In-Custody Death of Joseph Manning**

At the direction of Chief Michael Yankowski an Internal Board of Review was convened to review the death of Joseph Manning. Manning died on August 23, 2013 while in-custody at the Lansing Police Department Detention Center. The Internal Board of Review was initiated after the Ingham County Prosecutor determined there would be no criminal charges forthcoming regarding this matter.

The Internal Board of Review was comprised of Captain Daryl Green, Captain Jim Kraus, Captain Darin Southworth, Lieutenant Susan Baylis, Lieutenant Hung Tran, Sergeant Guy Pace, Lead Detention Officer Brian Kelley and Don Kulhanek, Chief Deputy City Attorney.

### **Records Examined:**

1. All associated LPD and MSP police reports.
2. Reports from Stuart Dunnings and the Medical Examiner's Office.
3. Detention and in-car video associated with Manning's arrest and detention custody.
4. Photographs of the scene and Manning's clothing.
5. LPD Operating Procedures 700-28 (Cell Checks), 700-31 (Alert Review at Booking), 700-37 (Detainee Property), 700-38 (Cell Assignment/Transfer), 700-41 (Detention Officer Responsibilities), 700-51 (Detainee Food and Clothing).
6. Operational Procedure 500-4 (Detention of Adults/Juveniles), 600-39 (Police Employee Involved Critical Incident) and 200-8 (Internal Review Board).
7. Detention Center Floor Plan.
8. Jail Cell Check Reader Report 8/23/14 – 8/24/14.
9. Adult Booking Lockup Report 8/23/14 – 8/24/14.
10. Computer Aided Dispatch (CAD) printouts for retail fraud investigation and Detention Center medic request.
11. Media articles.
12. Manning - Offender log and booking history 2007 – 2012.
13. Screen Form/Initial Screening Risk Assessment.



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## **Incident Summary:**

- Joseph Manning was a passenger in a vehicle involved in a retail fraud of liquor from Meijer – 6400 S. Pennsylvania Ave. The vehicle fled and was involved in a hit and run accident. Sergeant Rodney Anderson (Patrol Division) stopped the vehicle at Jolly and Pleasant Grove.
- Manning was lawfully arrested for Obstructing the investigation after fleeing on foot from a vehicle involved in a retail fraud.
- Officer Trevor Arnold transported Manning to the Lansing Police Detention Center.
- Officer Arnold searched Manning in the booking area removing personal property, including, shoes and shoe strings. Manning was not wearing a shirt or belt at the time of booking.
- Manning was booked by Lead Detention Officer (LDO) Gregg Rosenbery. Manning provided a false name and Rosenbery recognized him from previous arrests. Manning was charged with Furnishing False Information and continued to deny his true identity.
- Detention personnel did not physically search or read Manning the initial screening risk assessment questions during the booking period.
- Manning was escorted to isolation cell 6-1 based on his uncooperativeness and request to be alone. Detention Officers Rosenbery, Davis and Kopf with Patrol Officer Arnold assisted with Manning's placement into isolation cell 6-1. At that time, he was wearing sweat pants, socks and underwear.
- It is unclear from formal statements of the involved employees and video review whether a secondary search of Manning's waistband and lower extremities was conducted by detention staff when being placed into isolation cell 6-1.
- Manning stated nothing during the booking process or cell placement to suggest suicidal ideation.
- While in cell 6-1, Manning became verbally disruptive; yelling obscenities, arguing with another inmate, screaming, banging and kicking on the cell Plexiglass.
- Manning used a sock to clog the toilet and purposely flood his cell and surrounding area necessitating the water being shut off to his isolation cell.
- Manning had a history of similar disruptive behavior.
- Sergeant Brian Ellis mopped the floor and created a paper towel barrier on the floor to mitigate water flow from Manning's cell.
- Manning removed his sweatpants in an attempt to disrupt the paper towel barrier.
- Manning and Sergeant Ellis engaged in a pulling match over the sweat pants. Sergeant Ellis tied the pants to a cell bar and left the isolation cell area.
- Manning used a high degree of force to pull the draw string from the sweat pants.



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- Manning tied the string around his neck, stepped onto the toilet and positioned the draw string onto an unknown portion of a ceiling fixture.
- Manning placed his left foot on the floor while his right foot appeared to slip off the toilet seat.
- The draw string could not support Manning's weight and he fell to the floor, creating a ligature which was not readily visible.
- Manning got back to his feet, walked around the cell and continued to bang on the Plexiglass for a period of time before lying down on the floor.
- Sergeant Ellis requested Officer Arnold to inquire about medication needed by Manning. Upon checking with Manning, Officer Arnold found him unresponsive.
- Sergeant Ellis, all Detention Officers, Officer Schlagel, Officer Hough and Officer Arnold immediately responded and started resuscitation efforts. LFD was immediately summoned to provide emergency medical services.
- Detention staff discovered the ligature around Manning's neck and Rosenbery immediately cut it from his neck.
- The Lansing Fire Department transported Manning to Sparrow where he was ultimately placed into a medically induced coma and connected to a breathing ventilator.
- MSP investigators were briefed on the incident immediately after the transfer of Manning to the hospital per LPD 600-24 (Outside Investigations).
- On August 30, 2013, Joseph Manning was removed from life support and died.
- On April 23, 2014, after his review, Ingham County Prosecutor Stuart Dunnings provided a statement that no criminal charges would be issued against departmental staff.



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### **Summary of Findings:**

- The initial contact, patrol response to resistance and arrest of Manning were all valid and consistent with LPD policies and procedures.
- Officer Arnold searched Manning during the booking process.
- It is unclear if Detention staff conducted a secondary search of Manning.
- Failure to conduct a secondary search would be inconsistent with LPD practice.
- Manning never displayed any signs of suicidal ideation that would have triggered a different response on the part of the involved employees.
- Per policy and for safety reasons, uncooperative detainees may be taken directly to an isolation cell and bypass the booking desk.
- LPD booking and search procedures appear consistent with other lock-up facilities reviewed.
- Comparative analysis of other agencies' policy for addressing draw strings has not resulted in a clear "best practice."
- Detention Staff were exceptionally busy attending to their duties on the night of this incident.
- The Detention staff must monitor over 40 video cameras. Therefore, the audio is not turned on. Audio is available; however constant audio monitoring is not a standard Detention practice.
- Manning's disruptive behavior in the isolation cell is not uncommon and inmates routinely yell obscenities, scream, argue, and kick the Plexiglass.
- All involved LPD personnel responded properly to render emergency aid to Manning.
- LPD personnel promptly began life-saving efforts as trained and knew exactly where to retrieve emergency equipment for rapid intervention.
- All involved Detention Officers declined the opportunity to make a statement to MSP and this Internal Board of Review on the advice of their union counsel.
- The LPD command decision to contact MSP for an outside investigation and the handling of all involved employees was consistent with policy.
- LPD policies and procedures were sufficient to properly handle such an event. This is evidenced by the fact numerous Detention Center suicide attempts have been thwarted making this event the first of its kind resulting in death.



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### **Recommendations:**

- Strategic placement of signage in the Detention area to remind LPD staff to search inmates before cell placement and ensure compliance with LPD 700-41 (Detention Officer Responsibilities).
- Do risk assessment questionnaire for all inmates whenever practical, LPD 700-38 (Cell Assignment/Cell Transfer).
- A shop vacuum was purchased to mitigate the flooding of cells by detainees.
- All draw strings in clothing will be removed during the booking process or the garment confiscated. Associated policies will be amended accordingly.
- When practical, police officers will dissuade arrestees from bringing garments with attached draw strings into the Detention Center.
- Mount coat hooks in the Detention facility to store coats with draw strings in lieu of cutting them, when practical.
- Explore utilization of the Michigan Sheriffs Jail Death Review Team for the review of future incidents.
- Whenever possible increase Detention staffing during problem solving and other occasions when elevated arrest rates are anticipated. Assign the extra staff to monitor video surveillance of detainees, specifically those in isolation cells.

### **Conclusion:**

This Internal Board of Review recognizes the tragic loss of Joseph Manning and the resultant pain his family has endured. While we regret not being able to intervene soon enough to stop Joseph Manning's self-harming actions, officers worked swiftly to save his life once it was discovered he was in distress.

Lansing Police Department Detention staff has successfully disrupted every other suicide attempt in facility history which is a credit to the professionalism, training and experience of staff members. This Board of Review has been valuable in ensuring current policies and practices address the profound operational realities of complex inmate behavior. As a result, the Board of Review is confident that the recommendations offered can be implemented promptly, seamlessly, and will decrease the probability of a like incident occurring in the future.