

**Donald J. Lee, Jr.**

**Chief of Police**



**Key West**

**POLICE DEPARTMENT**

**TO:** Chief Lee

**FROM:** Sergeant Tripp

**DATE:** 12/4/14

**RE:** Eimers After Action Report

On November 28, 2014, Charles Eimers was being taken into custody at South Beach for fleeing a traffic stop. He became unresponsive and later died. This matter will be referred to in this report as the Eimers incident. Because of the seriousness of the matter, an administrative investigation was likely; so, Chief Lee immediately decided to toll the investigative days limited for disciplinary action by statute, using the criminal investigation exception. The Florida Department of Law Enforcement (FDLE) conducted an investigation pursuant to a Memorandum of Understanding (MOU) and the State Attorney's Office (SAO) presented the case to a grand jury, to determine if members of the Key West Police Department (KWPD) were to be held criminally responsible for the death of Mr. Eimers. The Grand Jury found that the members involved in the Eimers incident used reasonable force. The independent investigation appeared to be thorough and the subject members forthcoming. The independent investigation and conclusion sufficiently addressed the issue of excessive force. Based on FDLE's investigation and the conclusion by the Grand Jury, no further internal affairs investigation of excessive force is necessary.

In an incident of this nature, there are typically issues that arise that may lead us to review our behaviors and policies; and to question, commend or correct our actions. At least one of these was dealt with prior to the Grand Jury's conclusion. On December 12, 2013, Detective Stevens was issued a written reprimand and was transferred from detectives to patrol for failing to monitor the status of Mr. Eimers. He then provided inaccurate information to Chief Lee via Captain Smith. Chief Lee relayed this information to the public through a radio interview, the result of which was injurious to the reputation of KWPD. The Grand Jury's report was provided to Chief Lee on August 27, 2014. Both FDLE and the Grand Jury found other things that they recommended we review. Chief Lee and the KWPD intend to address these concerns, along with any others we may find, in this report and subsequent administrative investigations. On September 2, 2014, Chief Lee instructed me to conduct a review and investigation into the Eimers incident. He also instructed me to make Officer Lovette a subject member for decorum and unbecoming conduct policy violations. Upon his review of the in-car



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videos from the incident, Chief Lee asked me to add Officer H. delValle as a subject member for violating pursuit policy with Officer Lovette. I concluded those investigations.

Rather than repeat the facts of the case as stated in the officers' incident reports, FDLE incident reports and the Grand Jury report, I have summarized the actions, both exemplary and in need of improvement, of the KWPD and described how they were important to this incident.

### **The Stop**

The initial stop was valid for an improper pass. Mr. Eimers quickly pulled over. Once the stop was made however, Mr. Eimers opened the driver's side door, yet did not exit. This is unusual behavior and the vehicle should be approached with caution. Officer Celcer recognized that there was something peculiar about the stop upon hearing Mr. Eimers explain his driving behavior as doing God's work. When he went back to his car, Officer Celcer was not shown in the in-car video to have looked behind him, at least until he returned to his car. Though he had heard the strange behavior and the door was open, Officer Celcer briefly compromised his safety by turning his back to the subject vehicle. It is important to note, however, that there was traffic and it was just as important for Officer Celcer to avoid being struck by a passing car.

### **Fleeing the Stop**

When Officer Celcer returned to his car, Mr. Eimers drove off. Officer Celcer made the decision to try to stop Mr. Eimers a second time. He alerted the rest of the department via the radio and Sergeant Zamora and other officers quickly acknowledged him. Officer Celcer passed some cars in the turn lane with his lights and siren on, in order to catch up to Mr. Eimers. Once he caught up to Mr. Eimers and Mr. Eimers started committing traffic violations while fleeing, Officer Celcer continued to follow, passing in a turn lane while using his lights and siren. Sergeant Zamora correctly told him over the radio not to pursue, a proper application of department policy. Officer Celcer replied that it was not a pursuit because of the slow (25-30 mph) speed. Officer Celcer disengaged shortly thereafter.

### **The Pursuit**

Our policy directs officers to use both emergency lights and siren when operating the vehicle in emergency mode (purposely violating traffic rules). After disengaging, Officer Celcer elected to continue to follow Mr. Eimers, without his siren and passed a vehicle in a turn lane and drove in the oncoming lane while passing and crossing through a red traffic light. He then ran another red light without the siren.

At this point, several other cars had joined in following Mr. Eimers. At this point, Sergeant Zamora prudently reminds everyone to have their in-car videos recording, again exercising good judgment,



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applying department policy and demonstrating transparency. Officer H. delValle and Officer Lovette picked up the lead on Truman near Windsor and began to pursue Mr. Eimers until he reached South Beach. This was after Sergeant Zamora gave the order to terminate pursuit over the primary radio channel. Officer H. del Valle used only his emergency lights and intermittent siren as he followed, in his own words (twice), "at a high rate of speed." He passed in an intersection, ran a red light, failed to stop at about eleven stop signs and even passed another police car. Officer Lovette was following Officer H. del Valle, calling out the pursuit as the secondary vehicle and later paralleling for a short time. He used his lights only and did a three point turn at the edge of an intersection, passed in a no passing zone, at a "high rate of speed" (in his own words), ran four stop signs turned his lights off and passed a car in an intersection at another stop sign. These officers continued to make traffic violations for about three and a half minutes. Though Officer Lovette continued in the direction of the final stop (he had lost sight of Officer H. delValle and Mr. Eimers), he terminated his in-car video recording several blocks away. As he did not know at that point where the final stop would be, or if Mr. Eimers would turn around and come back in his direction, the decision to terminate the video was, at a minimum, unwise. It also prevented him from being able to record audio at the final stop, which might have been very important.

There were several other officers, who, to a much lesser extent, violated the emergency vehicle operations policy by violating traffic control devices without proper use of lights and sirens or without just cause.

#### **Final Stop and Approach**

Mr. Eimers finally stopped his car on the sand at South Beach. The way his vehicle was positioned at rest, made it difficult to perform a textbook high risk stop. Officer Wanciak, approached from the front of the vehicle. She could also be seen running apparently with her gun in her hand, a dangerous tactic. Officer H. delValle used his patrol rifle in preparation to defend himself or others. Verbal commands can be heard from both officers.

#### **Use of Force, Prone Restraint, TASER**

Once on the beach, Mr. Eimers initially complied with the officers' commands to lie on the ground in a prone position. Once the officers tried to apply the handcuffs, Mr. Eimers began resisting by pulling and thrashing, making him difficult to handcuff. The force used to gain compliance was limited to physical control techniques such as a modified 3-point pin and restraining Mr. Eimers limbs, which are proper for actively resisting subjects. There is concern in the community and law enforcement, when it comes to prone (face down) restraint. The concern has to do with a phenomenon called positional asphyxia, a condition in which a person is in a physical position that does not allow them to breathe properly. In law enforcement, this condition is of particular concern because we handcuff behind the



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back, which keeps a prone subject from using his arms to keep his body weight off of his chest for more efficient breathing. This can be further complicated if a subject's feet are brought up towards the handcuffs in a position referred to as "hog tying." KWPD policy prohibits people from being restrained in this manner (hog tied) because it places the complete body weight of the subject on his chest and stretches the chest out, making it very difficult to breathe well. Mr. Eimers was not "hog tied." That said, restraining a person in a prone position is taught to all Florida law enforcement officers as the safest method on a high-risk traffic stop and the preferred technique for handcuffing a subject who has shown a propensity for resistance. The caveat is that the subject should be rolled to his side as soon as practical to allow for normal breathing. The testimony in this case is that Mr. Eimers was just handcuffed and still struggling when he stopped breathing. There was no evidence of positional asphyxia or that Mr. Eimers stopped breathing due to an airway obstruction. The use of prone restraint on this high-risk traffic stop was proper and determined not to be a contributing cause of Mr. Eimer's death.

Although there were reports of a TASER being used in this incident, a TASER was not deployed as a response to Mr. Eimers resistance. A TASER was displayed by Officer Lovette, who was going to use it, but elected not to because of an officer safety issue. It should be noted that policy and law allows the use of the device on actively resisting subjects, and thus appropriate in this incident, should an officer have chosen to do so. The use of a TASER camera in this case may have been an important piece of evidence that could have quickly exonerated the officers of alleged TASERing and excessive force. There is no evidence that Lovette turned on his TASER during the struggle.

Though "deadly force" was not used, KWPD policy on Responsibilities at a Deadly Force Incident gives instructions that might have been used in this incident. Making the scene secure, providing medical attention, making proper notifications, preserving the scene (including witnesses), remaining at the scene, briefing the supervisor, writing a report and investigating are responsibilities of the officers. Once a supervisor has arrived and medical attention is provided, the supervisor is to set up a command post, record events, make notifications, separate the involved members and debrief them, while maintaining scene integrity, diagraming the scene and reporting with a Response to Resistance Incident Report. The department should consider adding in-custody deaths, regardless of force used, to the policy.

### **Providing Assistance**

Some officers who were not wearing the gloves during the struggle may not have had time to put them on prior to touching Eimers. As the other officers recognized this, they relieved each other. This was an important action because it showed that the officers were concerned for their safety and aware of department policy. All officers reported that medical attention was given immediately upon



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recognizing that Eimers was not breathing. Restraints were removed and Emergency Medical Services (EMS) was notified immediately. Two officers, H. del Valle and Celcer, were highly trained in EMS. They took charge of the emergency medical treatment. They communicated to each other to get emergency medical supplies from their vehicles, obtain an AED from the restaurant, and move vehicles so that EMS could have easy access to the beach. Sergeant Zamora was present almost immediately at the beach (he assisted in the handcuffing portion) and requested a detective within 20 minutes of Eimers going unconscious.

### **The "Armed Man" Call**

Within 30 minutes of Eimers going unconscious, a call of an armed man on Northside Drive was dispatched. It was quickly discovered that the man was pointing a hand exerciser at traffic and not a gun. Officers Medina, Garrido, Galbo, T. Calvert, Lovette and Sergeant Zamora responded to it. The six of them can be seen standing in the street together with the handcuffed subject. It is important to note that an armed man offers an immediate danger to the public and a quick, overwhelming response is dictated. Rescue had already been to South Beach and attended to Mr. Eimers. There was no immediate danger to officers or the public at the Eimers incident when the call was dispatched. Therefore, a significant amount of officers leaving the beach scene was prudent.

### **Scene Security and Witness Interviews**

Detective Stevens reported that he arrived at the beach scene after Eimers had been taken to the hospital. He said Sergeant Zamora, Officer Celcer, and Officer H. del Valle were on the scene when he arrived. He said he asked Officers Celcer and H. del Valle to remain on the scene for Detective J. Calvert to take charge. Stevens then went to the hospital to conduct an investigation there. He said he had requested Detective J. Calvert's help via Detective Sergeant Rodriguez. Celcer left the scene for the hospital to work on his part of the investigation, before Detective Stevens. Detective Stevens left the beach and Sergeant Rodriguez was at the scene when Stevens returned. Sergeant Rodriguez had identified three employees of the restaurant (Southernmost Beach Café 1405 Duval) who had information about the incident. They were interviewed by Stevens and FDLE Agent Quad. These interviews were completed before 4:30 pm. Detective Sergeant Rodriguez did not complete a report. Detective Calvert's response was limited to processing the scene. There was no crime scene log, which would have documented who was on the scene, what times they were present, and their duty.

According to officers and detectives, there was no clear "officer in charge" of the scene. Essentially, the scene was secured with a tape border with one or two officers as security. Sergeant Zamora and most of the officers left the scene to the man with the gun call and did not return to take control. Detective Stevens left the scene to go to the hospital. Detective Calvert only processed the scene. Detective Sergeant Rodriguez was busy with witnesses until FDLE arrived. At that time, Detective



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Sergeant Rodriguez said that the FDLE supervisor started giving direction to her people. However, this was a significant time after the incident and so potential witnesses would have had plenty of time to leave the area without being identified. Some of the officers who left the scene claimed to have asked they were needed for anything else and were told that they were not. Overall, it appears that there was no effective scene management, or use of personnel.

### **The Recordings**

Officer Celcer's COBAN body microphone appeared to have worked, but did not pick up audio well. Officer Lovette's COBAN stopped recording prior to his arrival at the scene. Officer del Valle's ICOP was on but his body microphone was off. Officer Medina's ICOP was on and his body microphone was on his body and worked. Once he was actually on the beach, the body microphone was too far from the in-car receiver and audio recording was intermittent. Officer Medina's body microphone recorded officers stating, "Stop resisting." Though there is not a COBAN recording of Officer Garrido's response to the Eimers incident, there is one for the call that followed. Officer Garrido's body microphone was not recording on that call. Officer Wallis had his COBAN on, but his body microphone was not recording. Officer Wanciak's ICOP was recording but the body microphone was off. Officers T. Calvert, Galbo, Garrido and Sergeant Zamora did not have in-car video recordings. There is a significant amount of information that might have been captured had these body microphones been recording.

The recordings from the Eimers incident were not immediately identified as evidence. Only Officer Celcer documented that he had an in-car video recording as evidence. This is a problem because our storage system is set to delete the videos in order to make space available for new videos. If a video is kept as evidence, it will be stored until it meets retention guidelines.

### **Patient or Prisoner?**

There was no officer assigned to stand by with Mr. Eimers in the hospital. If we were going to place Mr. Eimers under arrest, an officer should have been assigned to guard him. Upon admittance to the hospital, Mr. Eimers was not charged with a crime. It was the intention of Officer Celcer to obtain a warrant. He was waiting for Eimers to regain consciousness. Though Detective Stevens asked the hospital to make him aware of status changes, Eimers was free to leave should he have regained consciousness. There are exceptions listed in the arrest policy under Discretion and Alternatives to Arrest; including Baker Act. In the future, I suggest that we require contact with a Bureau Commander or the SAO for direction on arrest status to avoid confusion on the part of KWPD and the hospital.



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The Restraints and Transportation of Persons in Custody policy provided instruction to the supervisor on the actions to be taken at the hospital. He may have had an officer stand by at the hospital (requiring the Captain's approval), however the Sheriff's Office no longer conducts bedside booking.

Detective Stevens gave instructions to the nurse at the hospital to call him if there was a change in status. He also spoke with Trevor Eimers on December 4 concerning Charles Eimer's vehicle. Trevor did not mention to Stevens his intention to withdraw life support that day. Doing so may have saved Detective Stevens and the department from embarrassment. Unfortunately, Stevens did not find out until December 10 that Eimers died on the 4<sup>th</sup>. There was also confusion as to who ordered the cremation of Mr. Eimers. According to funeral home records, Trevor Eimers authorized the cremation of Charles Eimers on December 5<sup>th</sup>.

There is a definite need to enhance communications with the hospital and document it in a report. The instructions need to be precise and the reason for detention or notification clear. The State Attorney needs to be contacted immediately to determine if criminal charges are preferred and, action must be taken following the conversation. Additionally, Detective Stevens completed his report on December 17 and it was not approved until April 9. Though it is standard procedure for detectives to finish their reports after the investigation is over, the details of his observations and actions were only available to those who asked. If they did not ask the "right" questions, they would not know what was happening in the investigation.

### **The Second Video**

Recently, Mr. Eimers Estate's attorneys provided us with a second video made by a tourist on the day of the incident. We reviewed it and found that it more clearly depicted how the officers did not appear to use unreasonable force and how they provided emergency medical care, including CPR, to Mr. Eimers.

### **Retraining and Policy Changes Done and Needed**

A process for determining arrest status of hospitalized subjects needs to be documented.

Officers need to be reminded about looking behind them when returning to their car on a traffic stop and also the dangers of running with a gun in their hand.

Conducting unorthodox high risk traffic stops should be covered in training.

As part of our regular training process, supervisors and I have already reminded all officers to test their TASERS and in-car video system, including the internal and portable microphones, daily and



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repeatedly report malfunctions or face disciplinary action. I reminded supervisors that they will be held accountable for following-up on the testing process. The use of these devices, when required and the documentation of use needs to be enforced stringently. Proper and immediate marking of recordings and documenting their existence in reports is essential for evidentiary and exculpatory purposes. This should include who downloaded them, if applicable, and where they are stored.

A refresher in prone restraint and recovery needs to be done, along with possible modifications or additions to the restraint policy.

What constitutes active pursuit and how it differs from trying to stop a vehicle needs to be addressed department-wide. The policy needs to be enforced stringently.

Emergency vehicle operations policy needs to be reviewed and enforced stringently. The policy may need to be modified.

Supervisors need to be re-trained on their responsibilities in a pursuit and at a critical incident. All supervisors are responsible for maintaining scene management until relieved. The commander needs to make sure everyone knows who is in charge and document his/her actions in a report.

The Memorandum of Understanding between KWPD and FDLE needs to be reviewed and possibly modified.

There should be part of our policy that addresses handling cases where there is an in-custody death or suspects in critical condition, even if the condition is not a result of the arrest. It could be included in the RRI policy. Even though this incident doesn't meet the criteria for a RRI report because the death was not due to injury, there needs to be a documented process.



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