People’s Investigation:
In-Custody Death of Kayla Moore

Report prepared by
Berkeley Copwatch
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People’s Investigation: In-Custody Death of Kayla Moore

I. General overview

The People’s Investigation into a recent death in Berkeley Police Department custody demonstrates that the City of Berkeley is currently operating without benefit of a clear and responsible approach to managing emergency mental health episodes. Dramatic cuts in mental health services and an expanding policing budget have created a context where it is primarily Berkeley Police who respond to mental health crises even though police training emphasizes priorities different from mental health care concerns. More importantly, officers are not adequately trained to provide mental health care or address mental health issues. It is hazardous and economically unviable to substitute police officers for trained mental health workers. Despite warnings about the preventable harm that occurs as a result of this often violent approach, the city continues to under staff emergency mental health services while supporting increased funding for the number of officers hired and the level of “less lethal” weaponry employed by the department—a clear demonstration of competing agendas. The underfunding of mental health services and lack of mobile crisis team means that there is only police personnel available to respond who are inadequately trained. The dangers inherent in the present situation became evident in the in-custody death of Xavier Christopher Moore, otherwise known as Kayla Moore, on February 13th, 2013 at the Gaia Building in Berkeley.1 A transgender woman of color living with schizophrenia, Kayla Moore was 41 years old at the time of her death in police custody.

Since the Berkeley Police Review Commission (PRC) has become legally mired in restrictive administrative processes and faces endless threats of litigation, it has been rendered unable to critically examine police officer conduct or support community efforts for justice. Additionally, a series of legislative acts and court decisions since the inception of the PRC have succeeded in limiting transparency into internal investigations and disciplinary measures taken against officers. Thus, there are fewer resources available and even less political motivation to determine police custody deaths. The People’s Investigation, unlike the PRC, is not encumbered by restrictions that limit the effectiveness of the PRC. Over the course of the investigation into Moore’s death, we

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1 Throughout the report, we refer to Moore as Kayla Moore to honor her chosen name. While the
have identified specific incidents of officer misconduct including false arrest, excessive force and failure to act in this case. This People’s Investigation report also provides a basis for the police department and the PRC to hold the involved officers accountable for their actions and for the decisions made according to chain of command that led to Moore’s untimely death. It also serves a demand that the public be informed of the department’s response, suggesting disciplinary measures and policy changes as a result of Moore’s death in custody. The People’s Investigation challenges the current situation of shielding officers who respond with excessive, or in the case of Moore, deadly force.

The People’s Investigation was able to review a number of critical documents including the Berkeley Police Investigation of this incident as well as the eventual release of the autopsy. It is our hope that with the release of the People’s Investigation report on Kayla Moore and, in consideration of the findings herein, that the BPD will improve their responsiveness to community efforts to participate in civilian oversight of police and be more responsive to requests for documents and materials, particularly those subject to the California Public Records Act (PRA). This report also invites the Berkeley community to consider critical reforms to policing practices including interacting with Berkeley’s diverse community and training new generations of community-oriented officers. Together with other ongoing People’s Investigations across the Bay Area, we release this report as a component of a shared community defense.

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2 The Berkeley Police Department’s In-Custody Death Investigation: Xavier Moore (2013) includes a number of documents, including a Case Report Summary, the Police Incident Report from the night of the incident, the Case Narrative, Police Report Supplementals from officers involved in the incident, narrative statements from individuals involved or present at the incident, the Case Report Summary, the Report Narrative, the Alameda County Sheriff’s Office Coroner’s Bureau Report, and transcribed interviews between BPD Sgt. Hong and the officers involved in the incident. For the purposes of this report, we refer to the larger investigation report in which all these documents occur by page number in the overall Berkeley Police Investigation report, rather than naming each document in each reference.

3 People’s Investigations are an emergent process and have evolved over time. They draw on a history of community based investigation processes in the Bay Area. These include the work of the Idriss Stelley Foundation, including interviews and research into the Asa Sullivan shooting by members of the San Francisco Police Department in San Francisco in 2006. They also draw on the investigation into the police shooting of an unarmed African American man at 99th and Cherry Street in Oakland in September 2011, conducted by a subcommittee of the Oscar Grant Committee. Beyond the Bay Area, Redwood Curtain Copwatch based in the north coast of California has supported numerous community investigations as an aspect of community justice, and many of the specific cases that this collective followed up on are referenced in this report. This investigation would like to acknowledge that there is a rich history of community investigations, including and beyond the ones included here, that are present in the thinking of this report, and in the investigation as a process.
As a result of the findings of this investigation, we recommend:

• Policy changes in the way officers respond to people experiencing mental health crisis or mental health variance.

• Disciplinary action be taken against the officers involved in the in-custody death of Kalya Moore.

• Changes in how investigations are conducted by the Berkeley Police Department in cases involving deaths of civilians.
II. Summary of events

At approximately 11:48pm on February 12th, 2013 BPD received a call from John Hayes, who had just left the residence located at 2116 Allston Way on the 5th floor of what is locally referred to as The Gaia Building. Hayes had just left apartment 514, Kayla Moore’s residence. A friend of Moore’s, Hayes called BPD worried that Moore was having a mental health episode and was in need of an evaluation and assistance. Neighbors who were interviewed by members of the People’s Investigation reported that they heard no signs of a disturbance and only became aware of any kind of problem at the moment when police officers arrived on the scene. For example, the resident in the adjacent apartment #513 explained to the People’s Investigation that although he had heard a thud against the wall, he did not consider the sound to be a disturbance. Police arrived around 11pm. Residents in apartment #512 reported that they “heard nothing until the police came.”

Prior to the arrival of the BPD officers, there had been an argument in the apartment. Moore had argued with her girlfriend, Angel. Moore’s caregiver, Edward George Sterling, and Hayes arrived on the scene. Moore was agitated and threw a chair at Angel. After Angel left, Sterling began to make food for Moore in an effort to calm her down. Hayes called BPD and told them that he was concerned for Moore’s mental state. Hayes was aware that BPD had done welfare checks on Moore on previous occasions and had persuaded Moore to voluntarily seek assistance in circumstances.

Officer Smith and Officer Brown responded to the call and arrived at the residence at approximately 11:54pm. There they were met by Hayes who told them that Moore was acting strangely. Officer Smith did a background check on both Hayes and Moore as Officer Tu arrived on the scene. Officer Smith was made aware of an outstanding warrant for $5000 on Hayes. He also states that a warrant for a person named “Xavier Moore” was listed but with a date of birth of 1952 (which would have placed Moore roughly twenty years older than she was) and Moore as a San Francisco resident. For this reason, Officer Smith maintains he did not confirm the warrant and relayed to Officer Brown that the warrant had not been confirmed. In her statement, Officer Brown says that she thought the warrant had been confirmed. Officer Brown stated that regardless of the warrant, she still wanted to take Moore into custody for a Welfare and Institutions (W&I) Code 5150 evaluation. Moore was in her own home. Moore’s caregiver was present. It is not clear why Moore’s caregiver was ordered to leave the room once police entered the residence.

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4 People’s Investigation witness interview from February 23rd, 2013.
5 According to Officer Smith’s initial statement, he was dispatched to Allston way at 23:54 “as a cover officer to a report of 5150 off their medication.” Once there he met with Officer Brown and Officer Tu. (BPD Investigation, 12). According to Officer Brown’s initial statement, she and Officer Smith were both dispatched and Officer Tu “attached himself to the call” (BPD Investigation, 8). BPD, “In-Custody Death Investigation,” (2013).
6 Ibid., 12.
7 Ibid., 258-9.
8 Ibid., 9.
Officer Brown “knew of Moore” and was aware that she had mental health issues. Xavier Christopher Moore’s name was conveyed along with some background and instruction that there had been prior “10-42” contacts and “a possible medical eval” would be necessary. Brown also received information about a possible response to a Penal Code 415 when she was dispatched.

Officers were brought to the apartment by Hayes who then opened the door of the apartment with his key. Once officers were on the scene, Moore came to the door in response to officer requests. Moore stepped outside and spoke with Officer Brown who later explained that Moore seemed to be “unfocused” and was not making rational sense. During the interview, Moore expressed her belief that the officers were not really police officers. Officer Smith confirmed the warrant on Hayes and Officer Brown directed Smith to take Hayes into custody. At that point, according to Officer Brown, she made the decision to take Moore into custody, stating “we might as well take him.” She informed Moore about the (unconfirmed) warrant and that she would take her into custody. Moore expressed that she wanted to contact the FBI. When she turned to go back into her apartment, Officer Brown signaled Officer Tu that they should go “hands on.” Based on the Detail Call for Service Report, BPD received an initial call regarding Xavier Moore at 11:51pm on February 12, 2013. Dispatch officer Tyrone McClain contacted Berkeley Fire Department for a gurney at 12:34am. At 12:41am the Detail Call for Service Report indicates that Moore was not breathing.

According to Officer Brown, “I signaled to Officer Tu to go hands on and assist me in placing Moore in handcuffs. Officer Tu grabbed Moore’s left wrist. I simultaneously grabbed Moore’s right wrist, in an attempt to apply a control hold and put the cuffs on. Moore immediately started yelling, “No no!”. He attempted to pull away. Officer Tu and I maintained our grasps. Moore continued to violently pull away. While doing so, he pulled Officer Tu and me into his apartment. We all fell on a mattress that was on the floor against the east wall.”

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9 Officer Brown had responded to previous welfare checks, but had not made direct contact with Moore. Berkeley Police Department, “In-Custody Death Investigation: Xavier Moore,” (2013), 92.
10 The dispatch tape says “prior medical.” Dispatch code 10-42 directs officers to “Check on Welfare of” a person. Penal Code 415 is the code for disturbance.
12 Ibid., 8.
13 Ibid., 258-59.
14 Ibid., 9.
15 Ibid.
17 The Detail Call For Service Report is stamped as follows: “Information Redacted is protected from public disclosure by California Government Code 6254FNK.” Berkeley Police Department, Detail Call for Service Report: 12/12/2013 00:00 – 12/12/2013 23:59, (2013), 1-13.
Officer Brown called for back up and Officers Mathis, Gardner, Kastmiler, arrived and assisted in restraining Moore. It is worth noting that Moore weighs 347 pounds and that the officers present wrangled Moore until she was face down on a futon. The situation continued to escalate since, according to officer accounts, Moore resisted the officers.

Moore’s arms were cuffed behind her back and her legs were crossed and forcibly tied with a strap from the police arsenal known as a WRAP device. Some officers reported that after she was fully restrained, she seemed to “calm down” allowing them to roll her onto her left side. According to the 2008 Berkeley Police Department’s WRAP policy, if a subject exhibits sudden quiet or inactivity, it is a sign that immediate medical attention may be required. The policy also states officers should watch for sudden changes in facial coloring. In the police reports in the BPD In-Custody Death Investigation, officers noted what they referred to as her compliance at that time. However, Officer Brown reported that a minute later, she noticed that Moore was not breathing. The officers removed the handcuffs, pulled Moore onto the floor and off of the futon. They called for code three assistance from the Berkeley Fire Department. Officer Tu began chest compressions while Officer Brown “held his head to open up his airways.” No officers present claim to have attempted to assist or restore her breathing.

Paramedics arrived at Moore’s apartment. Upon arriving paramedics who took over chest compressions and administered oxygen. They placed the now unconscious Moore onto a gurney and transferred her to Alta Bates Hospital where she was pronounced dead at 1:34 a.m. on February 13th, 2013.

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19 The WRAP is a restraining device developed in California by Walnut Creek law enforcement officers and first used in San Jose. It is sometimes referred to in all caps (WRAP), and sometimes simply as ‘wrap’ or ‘the wrap’. The writers of this report are unaware of an acronym that the all caps format represents, however for the purposes of consistency we will adhere to Safe Restraints, Inc.’s brand name format of all caps throughout this report. Safe Restraints, Inc. “The WRAP,” (Martinez, California: Safe Restraints, Inc.) <http://www.saferestraints.com/ >. According to the Berkeley Police Department’s 2008 WRAP policy, the WRAP is a temporary restraint device that immobilizes a body by forcing the restrained individual into a seated position with their legs out straight and perpendicular to the body. This is achieved by binding both legs into a leg panel with Velcro straps, and applying an ankle strap, a torso harness, and a handcuff carabiner on the backside. The WRAP is used “to restrain a combative person, to prevent violent/combative behavior, to inhibit a violent subject’s efforts to injure themselves, to prevent a violent subject from causing property damage, and to facilitate safe physical transportation of violent/combative subjects.” The policy states that the WRAP should “only be used by personnel trained in its function and application.” (Berkeley Police Department, “The ‘Wrap Restraint’, Berkeley Police Department Training and Information Bulletin, N. 247, (April 15, 2008). There have been several deaths in custody where the WRAP device was used including at least two in California, Ricardo Escobedo (Redwood City, November 17, 2002) and Shaheed Jamal Daniels (San Jose, July 1, 2000).


21 Ibid., 9; 92.

22 Ibid., 337-8.
Numerous witnesses testified to the large number of police officers on the scene, as well as providing details that several of the police were visibly sweaty and acting in a manner consistent with physical exertion. Witnesses revealed that one officer emerged from Moore’s apartment sweating profusely and with a torn shirt. Witnesses did not confirm a disturbance in the building prior to the arrival of the police although the police and media both reported that they were responding to a call about a disturbance. However numerous accounts document screaming and banging coming from Moore’s apartment following the arrival of the police. At some point, the screaming suddenly stopped. Residents of the Gaia building reported seeing Moore unconscious on a gurney and several witnesses report that a significant portion of Moore’s torso was exposed. Residents also noted seeing the person they identified as Moore’s roommate in handcuffs next to squad cars downstairs.  

III. Summary of officer contact with Kayla Moore on February 13th, 2013.

According to officers interviewed, after entering Moore’s apartment the officers responded to her in the following ways:

- **Officer Brown**
  - Put a control hold on Moore and then she, Moore and Officer Tu all fell onto the futon. Brown says she put her “weight on Moore’s shoulder blades.”
  - “Held his head to open up his airway” after noticing that Moore was not breathing. She called for a mask but did not begin assisted breathing herself. The police investigation states that, “even if Moore did not have valid warrant Brown was intent [on] putting Moore on a 5150 Hold.”

- **Officer Tu**
  - States that he “sprawled onto [Moore’s] hip in an attempt to prevent him from further kicking me.” Tu also put Moore’s right arm in rear wrist lock.
  - Ofc. Smith states that Ofc. Tu was “straddling” Moore and using his weight (200 pounds) to control him.

- **Officer Smith**
  - Helped Officer Brown get Moore’s left hand into cuffs.
  - States that “[Officer Tu] was mostly laying on uh, [Moore’s] legs um, and kept getting bucked up in the air. Um, and he had [Moore’s] right arm

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23 Witness statements from the People’s Investigation.
25 Ibid., 338.
26 Ibid., 92.
27 Ibid., 10.
28 Ibid., 261.
29 Ibid., 12.
behind his back um, and that time I didn’t realize it but he had actually had a handcuff on that hand.”

- Officer Mathis:
  - On restraining Moore’s legs, Ofc. Mathis states that “I was using a fair amount of strength to do so because I could tell he was a big--I could see this was a very big person. Um, you know, kicking and a good sized officer who’s on the back quarter of this individual so I – I knew that I needed to bring, you know, bring some of my size and strength and pull him with it but, ah, I- I quickly found out that I needed to use a little more.”
  - States that throughout he heard Moore screaming, ‘Get off me’: “I remember hearing ‘Get off me’ a few times….I don’t remember specifically what he was screaming… I mean, you hear it, I mean you hear certain things, but you don’t--I drown them out.”
  - States that while Moore was face down on the futon and fully restrained, that he “figured, I’ll go down and do two things. I’ll get the spit hood and then I can bring the Fire Department up with me.”
  - Observes that: “I’ll say the amount of strength that ah, normally I am, I know what I’m doing and normally the amount of pressure and the amount of weight and strength that I use to cross those ankles is usually enough to handle most people. Um, this individual was, you know, maybe that was part of the cause. I don’t know.”

- Officer Gardner:
  - Observes that: “It was apparent that [Moore] would not fit into the WRAP and so we decided that we would, uh, put the hobble restraint from the WRAP on his ankles.”
  - States that: “Oh yeah. I mean, when I was holding down his feet it was –I-it-I-it was all I could do to hold his-his ankles down.”

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30 Ibid., 261.
31 Ibid., 263.
32 Ibid., 183.
33 Ibid., 184.
34 Ibid., 185.
35 Oral interview with Sgt. Hong on 2/13/2013 at 5:10pm. Ofc. Mathis is repsonding the question, “Based on the amount of observation that you had of Mr. (Moore) during your time that you were restraining him do you—could you say based on your training and experience that he was under the influence of anything?” To which Ofc. Mathis responded, “I didn’t have that—enough contact to—to make—to say, you know, whether they were 550 or not.” California Health and Safety Code 11550 refers to people under the influence of a controlled substance. Ibid., 188.
36 Ibid., 212.
37 Ibid., 214.
Observes that: “It was just based on his behavior, it was my suspicion that that’s--that he was under the influence of a--some kind of stimulant.”

**Officer Kastmiler:**
- States that: “I was trying to grab both arms. I noticed that [Moore] was already in handcuffs, but again, he was trying to bring his arms up and he also tried to grab my wrists while he was holding there, but I was trying to hold both of his arms to keep them in that position.”
- States that: “I was holding his two arms and, uh, I was also using my shin and knee on the back of his left leg to keep them stationary on the mattress.”

**Sgt. Cardoza**
- States that: “When I looked inside, there was a group of officers restraining an individual on a mattress inside …the mattress was on the floor and the officers were on top of the individual. The individual was screaming and actively resisting both kicking and fighting the officers.”
- Notes that: “We were able to control Mr. Moore’s ankles by just using the ankle strap of the WRAP and that was it.”

**Sergeant Phillips**
- Brought a WRAP to the scene.
- Saw five officers on Moore: Ofc. Brown near the head, Ofc. Tu and Ofc. Smith on the upper body and Ofc. Gardner and Ofc. Mathis were restraining the legs.
- States that: “I couldn’t tell if it was male or female…for the most part the whole back area and the- and the butt area was exposed and I could see that he was nude. I asked Officer Brown –is it male or female. I know that wasn’t…for me it was in my mind. It’s just- I don’t know who we’re dealing with and –or what we are dealing with and if it is female there’s other, you know, factors at play. So I asked and then she told me it’s a male but it was a uh, pre-op transgender or transsexual or something like that and I said okay.”

According to the testimony offered by the above officers in the police investigation there were at least five officers on Moore during the time that the restraint and control techniques were employed. We do not have the exact weight of all officers involved, but accounting for the fact that at the time of deployment they would have been fully dressed

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38 Ibid., 215.
39 Ibid., 277.
40 Ibid., 278.
41 Ibid., 234.
42 Ibid., 236.
43 Ibid., 264.
44 Ibid., 297.
45 Ibid., 298.
with firearms and other gear, the officers would have amounted to significant weight. Even allowing for a range of statures of the officers, it is still likely that each officer would weigh between 140 pounds and 220 pounds each.

We note that several of the officers also specifically reference the amount of force that they were employing against Moore as they struggled to restrain her in her own apartment. This is evident throughout multiple statements in the investigation report. In one instance, the investigation report states, “Sergeant Phillips was concerned about Tu because he was ‘limping,’ ‘out of breath,’ and ‘sweating’ from the struggle and doing chest compressions.” Officers were also preparing to put a spit hood on Moore. She apparently stopped breathing before the hood could be placed over her head.

IV. Context

As Berkeley residents and city leaders examine the events that led to the death of Kayla Moore, it is important to understand the local and national context in which this incident occurred. Since an initial factor that allowed for police to come into contact with Moore was related to her perceived status as a person with mental illness, it is necessary to understand the structure of government services that dispatch police officers to situations involving people experiencing mental health crises.

The scale back of the welfare state and the dismantling of social services at the local and national level has meant drastically reduced mental health care options for the majority of the population. Mental health service funding in California has declined by 21% since 2009. It is estimated that cuts to federal block grants for mental health for 2013 could leave an additional 373,000 adults and children across the state with serious mental health and emotional illness without adequate mental health care. At present, there are an estimated 700,000 mentally ill people in jail and prisons nationally.

As social services continue to recede, we are witnessing a parallel rise in law enforcement budgets and forms of policing that are more violent, intrusive, and heavily armed than ever before. Law enforcement budgets and military level weapons are often heavily supplemented through federally funded grants from the Department of Homeland

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47 Ibid., 190. Other officers statements and also dispatch tapes confirm that there was a plan to use a spit hood as well.
Security distributed at the municipal and state level. This funding does supplies local departments with greater weaponry such as drones, police boats, Tasers, or armored personnel carriers, e.g. the Lenco BearCat which the BPD recently attempted to purchase with Homeland Security Funds.\(^{51}\) These funds also put more officers on the streets as a first level of response in the context of dwindling social services.

Berkeley has kept pace with these trends that have drastically limited the ability of emergency mental health care projects like the Mobile Crisis Unit to respond to the growing number of people impacted by budget cuts. Gaps in adequate care are increasingly filled by the police who have taken over a significant portion of the tasks formerly in the realm of mental health responders and other care workers including extended networks of family and friends. According to Berkeley’s Department of Health Services, the 2011 adjusted budget for Crisis Services, including the city’s Mobile Crisis Unit, was $2,190,967. By 2013, the amount of money allocated for this same purpose was a mere $957,505. This represents a decrease of approximately 56% in just two years.\(^{52}\)

A growing emphasis on ‘security’ and increasingly militarized policing has, in recent years, had a serious impact on people suffering from mental illness or experiencing mental crisis. This includes large numbers of people who cannot afford privatized care. A rising number of news stories and copwatching groups report that veterans returning from wars in Iraq and Afghanistan are among those targeted by local police. In some cases veterans’ mental health crises are the result of inadequate care following the trauma experienced by many for serving in America’s wars. Civilians managing past experiences of trauma, facing mental health crisis, or perceived as mentally ill are also subjected to practices of criminalization that correspond to an escalating militarization.

While there is no national data available on the numbers of mentally ill people killed by police each year, the US Department of Justice estimates that people experiencing mental illness are four times as likely to be killed in interactions with law enforcement compared to the general population.\(^{53}\) One study estimates that half of the between 375 and 500 people shot and killed by police each year in the United States are mentally ill.\(^{54}\)

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\(^{51}\) This purchase order had to be cancelled by BPD in 2012 following a Public Record Act request from Berkeley Copwatch that revealed the pending purchase of the vehicle through a Department of Homeland Security grant. Groups and civilians across Berkeley and the Bay area coordinated to force the BPD and also the University of California Berkely, who was to share the vehicle with the BPD, to withdraw from the purchase.

\(^{52}\) This information comes from a Berkeley Department of Health Services report prepared by the Berkeley Department of Health Services on July 16, 2013 in response to a PRA request from the People’s Investigation and containing information from 2000-1014. Berkeley Department of Health Services, (July 16, 2013).

\(^{53}\) David Arroyo, “Mentally ill four times more likely to be killed by police,” *Las Vegas Guardian Express*, (October 8, 2013), <http://guardianlv.com/2013/10/mentally-ill-four-times-more-likely-to-be-killed-by-police/>.

figure does not include the high numbers of deaths in custody and other incidents involving people classified as mentally ill. The under reporting of death at the hands of law enforcement results from the lack of an investigation since since these deaths do not involve a firearm. Berkeley Copwatch together with various policing watch groups and community defense projects across the Bay Area and beyond continue to document cases where people in mental crisis die as a result of interacting with law enforcement.55

A complete list of shooting deaths of people in trauma or crisis by California law enforcement in recent years would be extensive and would include Idriss Stelley (San Francisco, 2001); Bruce Edward Seward (Hayward, 2001); Matthew Cicelski (Oakland, 2011); Charles Blair Hill (San Francisco, 2011); Pralith Pralourng (San Francisco, 2012) to name just a few. Recent prominent deaths involving people with mental health issues interacting with law enforcement personnel without a firearm include two brought to prominence by Redwood Curtain Copwatch of Eureka: Hupa man Peter Stewart who died in June of 2007 when the Eureka Police Department and Pelican Bay SWAT team surrounded the home where he was staying days after a premature release from a mental health care facility. They fired 50 canisters of tear gas into the home and then refused to allow firetrucks to put out the fire after the house ignited.56 Martin Cotton Jr. of Eureka was beaten to death by several officers on a main street in daylight in August of 2007.57 Redwood Curtain Copwatch also has made visible the case of Cheri Lyn Moore who was killed in April of 2006 by a Eureka Police Department SWAT team in her home during a time of crisis.58 More recent cases where severe beatings by law enforcement resulted in death include Kelly Thomas of Fullerton (July 2011) and Hernan Jaramillo of Oakland (July 2013).59

In Alameda County, the absence of a fire arm means that the District Attorney’s office is not required to conduct an investigation into the death, even in the most brutal of cases. This leaves the investigation up to the police themselves, including in cases where large numbers of officers may have been involved and which would reflect poorly on the department were the investigation to find against the officers. In several recent cases, the beating deaths of homeless people have gone relatively unnoticed without investigation. This means that it is local groups and concerned civilians that pursue various forms of investigations to push these incidents into public view. This pressure often forces cities to respond to the violence executed by their police departments.

55 Among these are Redwood Curtain Copwatch <http://www.redwoodcurtaincopwatch.net/>; Idriss Stelley Foundation <http://mysite.verizon.net/vzeo9ewi/idrissstelleyfoundation/>; No Justice, No Bart <http://nojusticenobart.blogspot.com/>; <Indybay at http://www.indybay.org/>. 56 See “What Happened to Peter Stewart?” <http://redwoodcurtaincopwatch.net/node/44>. 57 See “The Death of Martin Fredrick Cotton II” <http://redwoodcurtaincopwatch.net/node/29>. 58 See “The Killing of Cheri Lyn Moore” <http://redwoodcurtaincopwatch.net/node/625>. 59 Kelly Thomas had been diagnosed as schizophrenic. Hernan Jaramillo was not known to be suffering from any form of mental illness, but is included here as a civilian who died in custody on the sidewalk after being dragged from his home by police. Witnesses report Hernan repeatedly crying out for air under the weight of several Oakland Police Department officers.
Rising rates of police attacks on the mentally ill have recently resulted in several cities bringing in the Civil Rights Division of the Department of Justice (DOJ) to review the issue at the department level. The findings following these DOJ reviews advocate implementation of de-escalation techniques and the addition of new positions within the department that will focus on police interactions with people in mental crisis or experiencing mental health differences.

Many community members oppose the expansion of law enforcement budgets that encourage police to respond to mental health concerns. Rather they support the use of trained mental health professionals and other care workers as a more appropriate solution to reduce the escalating violence against the mentally ill. Diverse groups emphasize the need to develop care alternatives and new forms of community response. Several organizations encourage people to seek alternatives to calling the police. Other initiatives in reimagining a caring response to individuals in crisis include exploring the possibilities of safe houses for people in crisis, and relying on strategies of accompanying where mental health advocates and care workers accompany police to 5150 calls as a first line of contact and negotiation with a goal of deescalation.

There are also direct community response alternatives that do not rely on state institutions or social services, including community medics dispatching to sites to provide care on an on-call basis. By placing care in the realm of community control, these projects can redefine the relations of the community to the state and serve as a critical site for demilitarization. These projects coincide locally with the work of autonomous collectives that emphasize the importance of rebuilding a social infrastructure of care as central to larger projects of community safety.

Often groups advocate for more officer training as a temporary measure to mitigate police violence against specific groups, even as they question the wisdom of sending

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60 These cities include New Orleans, Seattle, and Portland (Oregon).  
62 This concern was central to the community forum Cops or Counselors? hosted by the People’s Investigation and held at the East Bay Media Center in Berkeley on May 30, 2013. 
63 Although different in their emphases and strategies, this is the case for groups like Berkeley Copwatch in Berkeley <http://www.berkeleycopwatch.org/> and Critical Resistance in Oakland <http://criticalresistance.org/>. 
64 We learned of these alternative from discussions with mental health workers and advocates over the course of the investigation. For example, members of Peers Envisioning and Engaging in Recovery Services (PEERS) of Oakland have advocated safe houses as among possible alternatives to respond to people in crisis; http://www.peersnet.org/ 
65 This is the project of the People’s Community Medics of Oakland <http://www.peoplescommunitymedics.org/>. 
66 This is among the themes currently developed through Universidad de la Califas in its recent convening of the Democracy Ateneo <http://ccra.mitodedigital.org/democracy_ateneo> in San Jose.
armed agents to respond to any health crisis. The San Francisco Police Department shot and killed Idriss Stelley in 2001 when they responded to a call from his girlfriend that was explicit about his experiencing mental variance. Following the shooting, his mother, Mesha Irizarry spearheaded an effort to pressure the SFPD to institute mandatory Crisis Intervention Training (CIT). Even with this training requirement in place, interactions between law enforcement and mentally ill continue to result in the death of the mentally ill person. The SF Examiner reported in 2011 that the majority of San Francisco Police officers involved in recent deadly shootings of mentally ill people in San Francisco had completed the mandatory forty hours of Crisis Intervention Training (CIT). The SFPD recently discontinued its CIT officer training program.

The case of Moore’s death in Berkeley makes visible two different questions of police training: the first involves the logic of training law enforcement as first responders to health care crisis; and the second involves the importance of awareness training and efforts within the department to address sexual and gender difference.

People in need of care who encounter police are often simply left at local jails. It has been estimated that around 50% and possibly upwards to 70% of inmates at the Alameda County Jail (Santa Rita) suffer from mental illness. Incarceration in Santa Rita and other jails may be the only time many of these inmates receive any medical or psychiatric treatment, in the form of doctors or counselors working within the prison system. When released, many of those who received care in prison or jail then have few options to continue with any form of support. For many, any medications they might have received do not extend far beyond the prison or jail walls; thus many untreated or under treated people are sent back into communities with no adequate net of services or community infrastructure to support them.

Further, the disturbing upward trend of violence against queer and trans people across the United States occurs in parallel with increased police violence against transgender groups. People identifying as transgender or in processes of transition or gender

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68 The SFPD has launched successive campaigns to acquire Tasers, arguing that tasers could replace the cancelled CIT program and save lives. Police arguments frequently highlight the life-saving potential of Tasers in instances of uncertainty even as death rates associated with use of Tasers continue to rise dramatically across the United States. Further, it is common across Police departments for law enforcement to leverage killings of mentally ill people in their municipal bids to acquire Tasers. Many opposing groups across the Bay argue that as deadly and often brutal attacks on mentally ill people by law enforcement continue to escalate, adding Tasers to the police arsenal is not a viable, humane or even logical option. Ultimately, based on sustained community pressure, the SFPD decided that the risks far outweighed the benefits of using tasers and efforts to acquire them for the department were abandoned. The Idriss Stelley Foundation and the SF BayView Newspaper continued to oppose the use of Tasers in San Francisco and have repeatedly forced the department to abandon its quest to arm its officers with the devices.
nonconformity frequently experience violence in interacting with law enforcement. In a 2011 incident in California a federal law enforcement agent was captured on video tasing a transgender woman in the stomach and when she collapsed, tasing her again between her legs. This was after the officer established that she was transgender by confronting a seemingly inconsistent state-issued license. The attack takes place while the woman is clearly holding her hands in the air and posing no threat to the officer.

The cuts to social services, reductions in police training programs, and the rapid militarization of the police converge with alarming frequency (and even predictability) on particular groups of the communities’ most vulnerable people. These are often people who do not conform to certain norms of whiteness or follow gender expectations, or versions of mental “correctness” and “stability.” Often these norms reflect status quo understandings of what determines a successful or meaningful life, or even a life worth living. An unwillingness or inability to conform to these norms make some populations and lives more vulnerable to violence and more likely to be targeted by police.

Several recent community investigations have meticulously documented violence against black and brown people by police nationally. These community research projects challenge mainstream media efforts that dehumanize people when they are killed by police and at the same time reveal a legal apparatus organized to protect police privacy and personnel files. Through a variety of methods aimed at accountability and transparency, groups are also working to reassess justice efforts at the community level. It is in this context that the People’s Investigation into the death in custody of Kayla Moore was initiated in Berkeley in February of 2013.

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70 Local websites and collectives that address police abuse directed at queer, transgender, and gender nonconformity include Bay of Rage, Oakland’s Occupy Patriarchy and the Tsega Center, a feminist space in East Oakland. These sites and collectives highlight for example the unsolved murder in Oakland of trans woman of color Brandy Martell (April 29, 2012), believed to be a victim of a hate crime. The Tsega Center is named in memory of Occupy Oakland activist Tsega, a woman of color murdered by her boyfriend on July 30, 2012. See The Tsega Center <http://thetsegacenter.wordpress.com/>. Other local groups like Communities United Against Violence (CUAV) also address the violence and targeted hate crimes that LGBTQQ people continue to face (LGBTQQ: Lesbian, gay, bisexual, transgender, queer, and questioning; See the CUAV website at <http://www.cuav.org/>.


V. People’s Investigation process

People’s Investigations are community based independent inquiries into incidents of police violence and misconduct. They are also responses to a lack of transparency around police conduct, and compromised review boards. These are collaborative, grassroots initiatives and are a way for us to become involved in sharing and producing information about police excess in the community. This process can supplement the work of lawyers and support court cases by providing narratives to counter official reports and mainstream media portrayals that criminalize and dehumanize people targeted by law enforcement. The information produced can also inform direct action tactics and other political strategies towards greater community safety. These investigations also provide an open space for us to come together and share in the process of research that is put in service of diverse efforts to take control of our own safety as a community. Thus these investigations emerge from a desire to organize ourselves to address safety beyond the institutions of the state. People’s Investigations place the survivor, or in other cases, the victim’s family and friends, at the center of an effort to determine what happened, discover how it could have been avoided, initiate a process of reprimand against offending officers and make sure families do not suffer reprisals or are denied justice. Specifically, these investigations are committed to supporting the family to seek and determine forms of justice; to aiding families to secure responsible legal counsel; and to working collaboratively to review information and organize actions and responses.

The People’s Investigation into the death in custody of Kayla Moore commenced immediately following news of Moore’s death and as of the release of this report, is ongoing. A key innovation of this report is the effort to make explicit or visible how the police officers interacted with Kayla prior to, during, and after the events in question. By observing all of the officers and their specific interaction with her we can observe in detail the violent disregard of her dignity and humanity such that she ended up dead. The research process, including the graphing of each individual officer’s actions that night as reported in the official police record and reproduced in the police investigation, makes it possible to see the series of interactions with the state, including with individual officers. The People’s Investigation claims that the investigation is as important as other aspects of policing; it is also an indictment of police actions.

Berkeley Copwatch learned of the in custody of death of Kayla Xaiver Moore on February 13th as reported in various Berkeley newspapers in the days following the incident at 2116 Allston Way (Gaia Building).

Over the course of the next few days Berkeley Copwatch sent members of an investigative team on two separate occasions, February 22nd and 23rd, to the Gaia Building where the incident occurred to speak with residents and locate witnesses. Both teams documented the results of their conversations among residents; both teams documented the results of the conversations.

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and interviews. Following the investigative teams’ visits to the site of the incident, Berkeley Copwatch made contact with Moore’s family and friends as well as identified concerned civilians thus collectively launching the People’s Investigation.

As part of the People’s Investigation, members of Berkeley Copwatch began requesting documents from the Berkeley Police Department. This included their Crisis Intervention Training (CIT) Orientation package; the Detail Call for Service Report; their “WRAP” restraint policy; their Transgender Awareness policy; the coroner’s report and the police investigation report. Berkeley Copwatch also requested budget information on mental health services from the Berkeley Department of Health Services. From the family, and this was later corroborated by police documents, we learned that officers had been to Moore’s residence previously in response to moments when Moore was experiencing mental crisis. Thus, officers were aware on the night of the in-custody death that Moore was someone with a past history of emotional crisis. Dispatch and at least some dispatched officers had prior knowledge of Moore’s condition. They knew that this contact would require an evaluation of Moore’s medical situation (“Med eval”).

On April 1, 2013 we sent a Public Records Act Request (PRA) to the District Attorney’s office. The District Attorney did not respond to the PRA. The office alerted us that no investigation had been completed by their office because this was not an officer involved shooting. We learned that without the discharge of a firearm, the incident is left for the police department to investigate since the District Attorney’s office does not conduct an independent investigation.

We contacted the Coroner’s Office at the Alameda County Sheriff’s Department to determine the status of Moore’s case (#2013-00-538) and to gather the autopsy and toxicology reports. Here we discovered that there was a police hold in place from the Berkeley Police Department insuring that no information could be released to the public. We were informed that it could take up to 6-8 months for the records to become public. In addition, we learned that officers requested a “Wrap” device and a spit hood to be used on Moore. As part of the investigation, we requested information on the department’s WRAP policy and also policies such as the use of spit hoods. While we were able to access the Berkeley Police Department’s WRAP policy dated from 2008, we learned that there are no policies for the BPD governing the use of spit hoods.

The People’s Investigation organized together with concerned citizens and various groups across the Bay Area to demand that the Berkeley Police Department release the BPD in-custody death investigation and the coroner’s report detailing the findings of their investigation regarding that evening. These demands were asserted at a rally and speak out at the Berkeley City Council Meeting on April 30, 2013 where one member of the family was forcefully handled by police officers on the floor of the council meeting. Within days, the Berkeley Police Department released the investigation and the coroner’s report.

It can be very useful to review old reports or policy statements. For example, we reviewed the Berkeley Police Review Commission Report of Findings based on a Board
of Inquiry Hearing held May 21-22, 1991. This particular inquiry and report, known as the “Lindstrom Report,” revolved around the death in custody of James Lindstrom who was a schizophrenic man. He stopped breathing following a beating by Berkeley Police officers who also kneeled on his chest.

The investigation also required that we meet with members of the Berkeley Mental Health Commission and other groups, including Peers Envisioning and Engaging in Recovery Services (PEERS) a nonprofit group dedicated to providing a variety of mental health services. It can be very useful to meet with groups organized around similar cases across the Bay, where police responded to people in mental health crisis and in some cases, killed the person in crisis. With these groups, we discussed the state of mental health services in Berkeley, and we learned of viable alternatives that do not involve the police as the first responders. We attended meetings of the Mental Health Commission, and invited members of the community to speak with us further about these possibilities. Collectively we generated options that would better serve the community and those in crisis, including families who struggle to support loved ones who experience crisis.

We also spoke with witnesses and neighbors at the memorial celebration and gathering outside of the Gaia building. On April 17, 2013, on what would have been Kayla’s birthday, Berkeley Copwatch, together with Kayla’s family and friends and other groups organized a celebration remembering Kayla’s life. We gathered in front of the Gaia building where Kayla had lived and died. We celebrated Kayla with blown up photographs of a smiling Kayla and Kayla flashing a peace sign, and with poetry and music, cupcakes, and flowers. The space of the celebration allowed us to collectively contest any attempt to erase her life or to criminalize her in the media. The space also made it possible for the People’s Investigation to generate new information. We were able to speak with people who lived in the building about what they had witnessed the night Kayla died. We spilled out into the street and talked to people throughout the afternoon and handed out hundreds of flyers demanding the release of the police investigation report and coroner’s report. In a large festive group we then made our way


76 The birthday celebration for Kayla parallels the escrache, a political space that emerges in Argentina organized by families and friends of people disappeared by the Argentinian state. In the escrache, people gather to celebrate missing comrades but to also expose the violence directed at them without expecting any specific form of “justice” or punishment carried out by the state. The space of the escrache not only promotes new approaches to justice but generates information about resistance to state violence. See Brian Whitner, Genocide in the Neighborhood (Oakland: Chainlinks, 2009). This celebration parallels another local project of remembering and making visible grief and violence, Our Hallowed Ground (a project of Love Balm for My Spirit Child). Artist Arielle Brown collaborated with mothers and grandmothers across the Bay Area who have lost children to police and street violence and gathered testimonios of life and loss. These testimonios generated monologues that were then performed on the sidewalk or street where the loss happened, making visible the militarization occurring in our communities, the violence disproportionately experienced by people of color, and the complexity of social networks that violence interrupts.
to the Berkeley Police Department, with our music and banners, and an oversized Public Records Act Request that we had crafted together on a posterboard demanding that the police release the results of the investigation and the coroner’s report. We taped this to the door of the Police Department and held a rally out front where people shared stories of police killings and violence. In addition to the interviews conducted in the days directly following Kayla’s death in February, we were able to gather more information and contacts as well as compare the statements gathered over the course of the investigation to the evidence and overall narrative of the police investigation report.

Following the release of the investigation report, which included the coroner’s report, we made copies and distributed them across members of the People’s Investigation team, including family members. We used the investigation report as an opportunity to gather everyone involved and some supporters to generate more information about the case and to advance a shared analysis that would encourage new strategies to emerge collectively. As part of that effort, we created a graph of all the officers involved in order to mark out the responses of each officer, including each officer’s role in the incident, their statements about that night, and recorded reflections on what happened in the room. We were able to observe that police officers knew whose apartment they were entering, and that they acknowledged a prior history with Moore including recognition of her mental health issues. In order to understand what the officers who responded knew about Moore, how they participated and what their various levels of understanding about what was happening at the time, and most importantly, the amount of force being applied to Moore at any given moment, we created a graph of officer interaction with Moore. We began classifying key information gleaned from each officers’ statements to investigators about the incident which were contained in the final police investigation report. In a vertical column on the left side of the spreadsheet, we listed all of the officers who participated in restraining Moore on February 13th, 2013. In a row across the top, we wrote critical questions, including:

- Which officers believed that they were acting in service of a valid warrant?
- What prior knowledge did responding officers have before they arrived?
- How did each officer apply force to restrain Moore?
- What did each officer observe other officers doing?
- Which officers assisted in resuscitation efforts?

These questions, as well as others, were answered as we read each officer's statements and inserted relevant quotes into the corresponding cell. The result was that we were able to take the totality of responses and make visible patterns that make explicit the officer’s interactions with Moore. Patterns included a) most officers were applying their strength and weight to restrain Moore b) some officers knew her from past incidents c) no officers identified themselves as offering Moore artificial respiration as she was dying. It is from here that we formulated our analysis of the policies, protocols, and training.

We then read the draft of the People’s Investigation report and the police investigation report against various reports from other similar incidents including from different states and from the United States Department of Justice investigations of police responses to
people suffering mental crisis. We also reviewed the situation nationally and noted trends. From here, we deliberated collectively on recommendations.

VI. Analysis of Policies, Protocols, and Training

1. Procedure/Policy Issues
   A. Police conducted an inappropriate background check. The caller who contacted BPD to request assistance was John Hayes, who resided in the same apartment as Moore. He reported that Moore was having a mental health episode and that Moore had demanded that Hayes leave the apartment. When officers arrived on the scene, Hayes provided information to officers and assisted police entering into Moore’s residence. BPD later ran a background check on Hayes and discovered that he had an outstanding warrant for $5000. He was immediately arrested. The People’s Investigation asks why Hayes was given a background check. Unless there is a reasonable suspicion to place a person under detention for a specific criminal act, we are concerned that the routinization of background checks can dissuade individuals from seeking the assistance of city services. Further, people should not be subject to background checks or arrested based on their proximity to an unrelated situation that involves the police. This practice widens the net of police surveillance and discipline in a way that threatens individual rights and liberties.

   B. There was an unnecessary escalation of the situation. According to the officers’ descriptions of events, it is evident that there is no significant difference in police protocols for dealing with a resistant suspect of a crime and an individual in the midst of a mental crisis. It is evident to the People’s Investigation that there were no efforts by officers to employ even basic de-escalation techniques such as listening to the person, explaining what was happening or going to happen, and allowing time for questions or discussion. There was no attempt to minimize physical contact with the person. Starting from the moment of entry, force was the primary tactic employed to address Moore and resolve the situation. There were no Crisis Intervention Team officers or emergency mental health workers available or called to the scene.

A 1998 BPD report cites Sergeants Lopes and Faeth offering recommendations for families dealing with crisis. They state that callers should be prepared to provide a brief description of the individual’s behavior (and likely outcome) to the police dispatcher. If a caller can recognize and communicate to dispatch that an individual may, for example, be experiencing a psychotic break which in the past has led to prolonged hospitalization, the

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77 In one recent study as many as 45% of respondents reported that they would not contact police if they were a victim of or witness to crime for fear of triggering an investigation of their status. This is particularly true for populations stigmatized in the media and elsewhere and for those specifically targeted by a variety of law enforcement agencies through practices that include immigration enforcement, racial profiling, and anti-homeless harassment. These figures are from a recent report by Nik Theodore, “Insecure Communities: Latino Perception of Police Involvement in Immigration Enforcement,” (Chicago: Department of Urban Planning and Policy, University of Illinois at Chicago, May 2013).
officer is able to eliminate other possibilities and respond accordingly. In the case of Moore, officers responding to the call were aware of Moore’s history of crisis, a fact which statements from both Moore’s family and the police investigation confirms.

The joint investigation by the United States Department of Justice’s Civil Rights Divisions and United States Attorney’s Office for the the District of Oregon of the Portland (Oregon) Police Bureau (2012) emphasizes in its assessment of police responses to people experiencing mental illness that “the usual command and control approach does not work effectively with people in a mental illness crisis…. If the response is to reassure the individual of safety, there may be a de-escalation. But, if the response is command and control, it may increase the level of fear and result in an escalation.” The investigation summary also points out that, “not all police contacts with people with mental illness are with people in ‘crisis.’” Often times, individuals with mental illness may not be in a crisis, but instead will demonstrate signs and symptoms of their illness, which can be perceived as criminal behavior. The report notes the dangers of criminalizing people with mental illness. These dangers are significantly more likely to occur if the response to people with mental illness comes from officers trained to respond to criminals instead of people experiencing variances in mental health.

C. Officers demonstrated an inability to interpret verbal cues and an inability to remember these. It is evident in the police investigation report, statements, and the witness interviews conducted by the People’s Investigation, that officers were unresponsive to any communication from Moore throughout the incident. Most officers involved in the incident have little or no recollection of the words Moore was using or what she was communicating during the struggle. Those who remember her words recall things like, “get off me.” Neighbors of Moore recounted hearing Moore yell, “get off me,” “don’t touch me,” and “you’re hurting me.” This failure to respond to the detainee can be considered a factor in escalating a situation that could have been handled without engaging in such drastic physical contact and struggle.

D. Officers failed to disengage. When it became apparent that taking Moore into custody was going to be more difficult than first imagined—and several officers attest to this realization in their statements throughout the police investigation report—officers should have withdrawn and reassessed the objectives of their plan. Officers needed to assess whether it was worth risking Moore’s life with excessive force to protect her from herself. Officers did not disengage even when they realized that the level of force necessary was greater than the threat the situation posed. They also knew Moore was


80 This information is from witness statements, including from the People’s Investigation.
physically compromised due to her weight, disability, and possible drug use that day. Repeated efforts to win her cooperation and calm the situation should have been made. They should have recognized the coalescence of factors that are known to contribute to positional asphyxia and made efforts to reduce these risks.

E. Officers failed to make use of caregiver present to de-escalate. Officer Brown engaged with Moore and subsequently fell onto the futon in Moore’s apartment with Moore and Officer Tu. At this time, Officer G. Brown reported that she saw another man in the apartment. This was Edward George Sterling, Moore’s caregiver and friend of many years. Sterling could have been instrumental in calming the situation if he had been allowed to remain and to speak with Moore. Unfortunately, Officer Brown ordered Sterling out of the apartment for fear that he might be “dangerous.”81 To reiterate, Moore’s caretaker had been in the apartment with Moore prior to the BPD’s arrival and had been engaged in a series of strategic practices to calm Moore down, including making Moore something to eat. A reassessment of the situation on the part of the BPD that allowed Moore’s trusted caretaker back into the apartment might have resulted in a different chain of events that evening.

F. There was inadequate response from officers as first responders. No officers attempted to do assisted breathing support and no officers had a safety mask with which to cover the subject’s mouth and begin assisted breathing. Moore’s life might have been saved if officers had been willing and able to provide this assistance.

A situation occurred in Ohio when following an arrest, a woman fell down repeatedly and became incoherent. Officers neglected to summon medical assistance following the arrest. When the case was heard in the Supreme Court in 1989, the ruling noted, “it may happen that in light of the duties assigned to specific officers or employees the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need. In that event, the failure to provide proper training may fairly be said to represent a policy for which the city is responsible, and for which the city may be held liable if it actually causes injury.”82

G. There was an unnecessary call for a spit hood. As Kayla Moore was struggling for her life, Officer Mathis reports that he went down to his squad car to get spit hoods with the intention of placing one on Moore’s face. Currently, BPD has no policies

81 This directly contradicts the recommendations of Lieutenant Russell Lopes of the Berkeley Police Department, who in a 1998 NAMI presentation offered a number of actions families in crisis can take before calling the police. The summarized presentation makes the suggestion, “try to contact your regular care provider, psychiatrist, or therapist. Perhaps the problem can be handled by an adjustment in the client’s medication or other non-confrontational approach” (Rafael Herrera, Sergeant David Faeth, David Wee, and Lieutenant Russell Lopes, “What Happens When You Have to Call the Police?,” speaker notes compiled by Thomas T. Thomas, National Alliance on Mental Illness (NAMI): East Bay Chapter (May 27, 1998), <http://www.thomastthomas.com/NAMI.htm>.

82 City of Canton, Ohio v. Harris, 489 U.S. 378.
governing the use of spit hoods.\textsuperscript{83} However, there are serious issues of concern raised around the use of spit hoods, including an inability of hooded subjects to identify arresting and assisting officers, the tendency for spit hoods to escalate the subject’s level of fear as well as the enhanced likelihood of choking or aspiration of blood or vomit that could result from the impact of the hood, especially if this person is thought to be under the influence of drugs or alcohol. Covering an already compromised person’s face impedes the ability of officers to safely monitor the respiration of that individual.

H. Officers demonstrated insensitivity towards a transgender person. While the People’s Investigation was able to procure BPD policy on Transgender Awareness the documentation of the officers’ verbal and active responses throughout the incident evidences a lack of sensitivity to Moore’s gender and body. This may have played a critical role in the officers’ decisions about how to respond or what first aid they were willing to provide to her when she stopped breathing. Testimony by one officer to a superior officer reveal that he was uncomfortable and possibly unfamiliar with transgendered people. An officer discussed or referenced Moore as an “it” throughout the encounter and subsequently in testimony, referring to her as, “it was a uh, pre-op transgender or transsexual or something like that.”\textsuperscript{84} These statements demonstrate discomfort on the part of an officer with the body before them.\textsuperscript{85} Officers allowed her to be stripped of her clothing and transported nude. These attitudes of the officers reveal an alarming willingness to disregard the dignity of a member of our community and as a result place that person at risk of serious bodily injury or even death.

2. Officer Misconduct Issues

A. There was no legal basis for arresting Moore. Officer Brown did not have a legal basis for attempting to take Moore into custody. There was no probable cause to arrest Moore on scene for any criminal activity. The warrant from San Francisco was not confirmed. The police investigation attests to the fact that the warrant was not confirmed: “Smith told Brown about the warrant but advised he was unsure if it was for Moore because of the birth year.”\textsuperscript{86} Officer Smith stated that he told Officer Brown that he needed to confirm the existence of a valid warrant. Officer Brown decided to proceed with the arrest without confirmation of the warrant. Despite the fact that the “records bureau operator advised of no warrant for Moore. Smith passed on the information to Brown on a field interview card.”\textsuperscript{87} Furthermore, Officer Brown did not have justification based on her own observations to assert that Moore was a danger to herself or others. In fact, Moore was in her own home with her caregiver when police officers arrived.

\textsuperscript{83} A PRA from Berkeley Copwatch confirmed that the BPD does not have a spit hood policy.
\textsuperscript{84} Berkeley Police Department, “In-Custody Death Investigation: Xavier Moore,” (2013), 298.
\textsuperscript{85} BPD bulletins warn that, “Since the expansion of the definition of gender now includes transgendered people, harassment and victimization of individuals who have changed their sex, or who are in the process of sex reassignment, or who have gender presentations or characteristics that seem to conflict with an observer’s perception of the individual’s sex, is not to be condoned or sanctioned.” Berkeley Police Department, “Transgender Awareness,” Berkeley Police Department Training and Information Bulletin, N: 275, (January 2000), 2.
\textsuperscript{86} Berkeley Police Department, “In-Custody Death Investigation: Xavier Moore,” (2013), 86.
\textsuperscript{87} Ibid., 87.
B. Police engaged in an excessive use of force. Officers knew that Moore was very overweight, possibly under the influence of alcohol and/or drugs, and that she had a history of mental illness. Attempting to violently restrain Moore on the futon contributed to the risks of positional asphyxia and other potentially lethal outcomes. Although she, together with the officers who had approached her “hands on,” accidentally landed on the futon when two officers attempted to arrest her, they should not have attempted to restrain her and take her into custody by straddling her. According to Brown, Tu straddled Moore.\(^{88}\) Several officer statements also confirm that the full body weight of several officers was employed to prevent Moore from kicking, even after her arms had been handcuffed behind her back.\(^{89}\)

Recently the Department of Justice investigated the Portland Police Bureau as part of an effort to review the Department’s responses to community members experiencing mental health crisis.\(^{90}\) Drawing on *Graham v. Connor*, the report notes that claims of excessive force “in the context of an investigatory stop, arrest, or other ‘seizure’ of a free individual are analyzed under the Fourth Amendment’s objective reasonableness standard.”\(^{91}\) They note that courts adjudicate in individual cases whether less intrusive alternatives existed to the level of force employed. Also of importance is whether police officers issued proper warnings prior to employing force, and “whether it should have been apparent to officers that the person they used force against was emotionally disturbed.”\(^{92}\) Notably, “[e]ven when an emotionally disturbed individual is ‘acting out and inviting officers to use deadly force,’ the governmental interest in using such force is diminished by the fact that the officers are confronted, not with a person who has committed a serious crime against others, but with a mentally ill individual.”\(^{93}\) Unreasonable seizure of a person is a type of excessive force under the Fourth Amendment.

C. The officers on scene failed to provide crucial breathing assistance. Based on our review of officer statements, there was no attempt to provide respiratory exchange after officers realized that Moore was not breathing prior to the arrival of paramedics. The police investigation states that Officer Tu initiated chest compressions but no assisted breathing was administered to Moore to accompany these efforts.\(^{94}\) Officers can reasonably be expected to understand the risks of positional asphyxia. Clearly, placing an overweight drug user on her stomach with her face down or to the side, engaging in a prolonged and exhaustive struggle to handcuff her, and allowing four to five officers to apply their full strength and body weight to stop Moore from struggling would increase the risk of death or bodily harm. Although the autopsy lists “drug toxicity” as the cause of death,\(^{95}\) the actions of officers could certainly have contributed to this lethal outcome.

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\(^{88}\) Ibid., 91 .
\(^{89}\) Ibid., 17-19.
\(^{90}\) September, 2012.
\(^{92}\) *Glenn v. Washington County*, 673 F.3d 864, 872 (9th Cir. 2011).
\(^{93}\) Ibid., 876.
\(^{94}\) Berkeley Police Department, “In-Custody Death Investigation: Xavier Moore,” (2013), 9, 337.
\(^{95}\) Ibid., 113.
Moore was completely able bodied before she encountered officers. It is dangerous and irresponsible for officers to have allowed this confluence of factors to occur. Police officers who make the decision to engage in forceful restraint techniques against an individual should also be prepared in the event that this force results in the subject’s cessation of respiratory function.\footnote{A recent study in the journal \textit{Medicine, Science, and the Law} addressing death during restraint warns that as part of officer training, “instructors must stress vigilance in monitoring the subject’s condition. The process of hypoxia is insidious, and subjects might not exhibit any clear symptoms before they simply stop breathing. Generally, it takes several minutes for significant hypoxia to occur, but it can happen more quickly if the subject has been violently active and is already out of breath. If the subject experiences extreme difficulty breathing or stops breathing altogether, officers must take steps to resuscitate the subject and obtain medical care immediately.” J. Parkes, “Sudden Death During Restraint: Do Some Positions Affect Lung Function?” \textit{Medicine, Science and the Law}, 48 (2) (2008): 137-41.}

3. Investigation Flaws

A. There was not adequate documentation of search warrant status or evidence gathered. The People’s Investigation is interested to know on what authority evidence was taken from the apartment of Kayla Moore. We were unable to locate certain investigative materials in the police report, including a search warrant and affidavit for search warrant if it exists. This makes it difficult for independent investigations and concerned civilians to verify that proper procedures were followed.

The police investigation lists two pages of items taken.\footnote{Berkeley Police Department, “In-Custody Death Investigation: Xavier Moore,” (2013), 337.} On what basis were these items collected? According to BPD General Order I-16 Section 20 (a) Despite the Directive of WI 8102 (a), officers shall not enter a mentally disordered person’s residence, or if in the residence at the time of detention/apprehension, search areas beyond the person’s immediate control solely to seize a firearm or deadly weapon without express consent or a search warrant.” The People’s Investigation would hope that such a prohibition would extend these protections to non-lethal articles of evidence as well. If the search of the premises was justified, it would be important to include the legal basis for the search in the report.

B. There is inadequate process for gathering witness testimony. The official police investigation into the in-custody death fails to provide the transcribed interviews of witnesses. The witness statements in the police investigation are paraphrased throughout. At no point in the report were witnesses able to represent themselves in their own words or are their statements unmediated by official viewpoints. Audio recordings of field interviews and complete transcriptions of witness interviews would reflect a more accurate representation of the incident and better account for the exact details regarding the incident.

C. The investigating officer failed to gather information on the mental state of Moore and other information relevant to her well being. The investigator, Sgt. Hong, asks leading questions that shift the focus of the case towards a subject who is treated as a
criminal. Not surprisingly, Moore was also misrepresented in the public record. Hong asks each officer involved whether they believed that Moore’s behavior was related to drug or alcohol use.\(^9\) As the investigator, Hong did not ask whether Moore’s behavior might likely have been related to a mental condition or whether any official evaluation of Moore had been conducted. There was no Application for Emergency Psychiatric Detention form included in the BPD’s investigation into this incident. In the absence of officer responses and the absence of the application for Emergency Psychiatric Detention, it is not possible to ascertain whether officers conducted any evaluation of Moore’s mental state.

In addition, the investigator did not ask officers if they were informed about or trained in regards the dangers of positional asphyxia, in-custody death syndrome, or excited delirium. At no time did the investigating officer ask any of the officers at the scene if there was any assessment of what was causing Moore to resist and what the risks to Moore’s health were. This failure could reflect a profound disregard for their training. When officers are authorized to employ restraint techniques on people with mental health issues as well as resistant criminal suspects, there is a greater overall incidence of physical contacts, and thus, a greater probability of injury. The city government must address concerns raised when the police force is called on to respond to people with mental health issues or who are experiencing crisis.

In order to reduce medically serious and lethal outcomes, incidents must be evaluated as to whether officers executed actions within training protocols. The goal will be to determine if they were not prepared properly or acted in contradiction to their training. Failure to gather information from officers on their awareness of the dangers of this kind of restraint in this type of situation undermines any confidence officers are able to respond to health crises. A lack of oversight undermines the ability of the department to assess whether to adjust training or consequence misconduct by officers.

**VII. Recommendations**

1. Procedure/Policy issues

A. For Berkeley Community

   - Seek alternatives to police when a person is experiencing a mental crisis. Inviting the police into a tense situation can lead to escalation and seriously increase the risk of harm or death to the individual in distress. The inadequacy of the emergency mental health systems is producing lethal consequences for families across the country. Learn more about emotional CPR training and continue to build networks of support so that community based care can be increased. Emotional CPR (eCPR) is a project of the National Coalition for Mental Health Recovery (NCMHR) and is “an educational program designed to teach people to assist others through an emotional crisis by three simple steps: connecting,

\(^9\) See for example, Berkeley Police Department, “In-Custody Death Investigation: Xavier Moore,” (2013), 166; 215.
empowering, and revitalizing. These steps emphasize the need for deep listening and establishing a feeling of safety, encouraging people to feel more engaged in life, assisting others to reconnect with support systems and loved ones, and supporting people to resume routines to establish health. At the center of eCPR is a sense of “practiced presence” that affirms a sense of mastery for the person experiencing crisis. In short, the healing process is achieved through connections to community.

Contact Peers Envisioning and Engaging in Recovery Services (PEERS) 333 Hegenberger Road, Oakland CA 94621, Phone (510) 832 7337 to learn more about alternatives.

- Lobby for City resources to be directed away from police hardware and away from increases in police personal. Instead, lobby for resources that can establish an emergency mental health delivery system that does not feature police as the first point of contact for mentally ill people in crisis.

B. For Berkeley Police Department

- Cease background checks on reporting parties without reasonable suspicion. Police officers should not run background checks on individuals who report suspicious activity to police unless reasonable suspicion for a detention of that person is present.

- Create clear distinction between “Command and Control” and “Medical evaluation” protocols. Train all officers to be able to identify and respond to people with developmental disabilities, mental illness, and people having serious mental health episodes. This includes introducing de-escalation techniques for all officers. There should be clear protocols established to work with other responders in situations involving mental health variance, not just the few who choose to take Crisis Intervention Training offered by the county of Alameda. This should be a mandatory training for all officers at the police academy. CIT should be expanded and mandatory for all law enforcement personnel. Measures should be taken to discipline officers, including supervising sergeants, who fail to recognize and revise plans of action in accordance with the dangerous set of circumstances that the arresting officers either precipitate or allow to develop.


Peace Officers Standards and Training (POST) certified officers acting as first responders should be capable of providing more than the most basic techniques of CPR. POST training stresses the basics of C-A-B (circulation-airway-breathing) and Berkeley officers’ training should align with the POST standards, according to Berkeley Police Public Information Officer Jennifer Coats. In normal circumstances officers would be expected to administer respiratory assistance. It is of great concern to us that the officers were either unable or unwilling to provide some type of rescue breathing. Further investigation in this area should be conducted to determine the reasons for the failure to assist in the application of life saving techniques.

Clarify training protocols. To many people involved in social services the following topics for training of officers are considered commonplace. However, if officers lack these skills, direct/explicit instruction should be provided.

- Recall and respond techniques: Officers need training in how to hear individuals, how to recall what is being said and how to respond appropriately. If a person declares they are in pain, officers should be held accountable for responding to that person’s communication. Injuries to the individual being detained should be evaluated according to whether they could have been avoided.

- Disengagement Strategies: Officers need to know when it is in the interest of safety to disengage from a confrontation and regroup in order to ensure the safety of all persons involved. Evaluation of the whole situation relative to the immediate objective is required. Ability to work with friends and family of the person in crisis should be emphasized and encouraged.

- De-escalation Techniques: Officers need to know how to use their words and their body language to calm a person in distress. This is similar to CIT program. Officers should be required to identify de-escalation techniques, employ them and be required to use them early in citizen-police encounters.

- Transgender Awareness: Officers working in a diverse, urban area need to understand the current issues in gender awareness and how to show respect for all people regardless of their perceived gender. This training should be required of all BPD officers.

C. For the Berkeley City Council
Identify a civilian point of contact for Berkeley citizens to call when they need help managing a mental health crisis. The City of Berkeley needs to ensure the delivery of emergency mental health services to its residents. Staffing and funding levels are currently too low to provide for adequate crisis intervention and assessment. Revise emergency response system protocols so that Berkeley
officers are only called in when the situation has escalated to the point of imminent danger or where a dangerous weapon is involved. Otherwise, mental health workers should be the primary point of contact during mental health emergencies.

2. Misconduct/Criminal Violations

A. For Berkeley Community
The people of Alameda County must demand that ALL in custody deaths be investigated and the results of these investigations should be provided to the families and the public. It is important to note that on April 1, 2013, in response to a direct inquiry from the People’s Investigation, the main office of the District Attorney for Alameda County explained that the District Attorney’s office does not initiate investigations of in-custody deaths unless the incident involves a firearm. A Public Records Act request was sent to the District Attorney’s office for further clarification asking for written confirmation that this failure to investigate is a matter of policy, but as of this writing, no response has been received.

Some of the officers involved in restraining Kayla Moore should have been disciplined and, in some cases, investigated for possible criminal activity related to their actions on the night of Moore’s death. We believe that some of the officers involved are potentially dangerous to people with mental health challenges and SHOULD NOT be responding to situations where interactions with people with mental health issues might be required unless or until they have received adequate training.

B. For Berkeley Police Department/Police Review Commission
The following allegations of misconduct have been examined by the People’s Investigation process and we believe that there is evidence to support the following allegations against these officers. Although we do not have access to additional confidential personnel information, we base our conclusions on information presented in the Berkeley Police investigation of this incident as well as supporting documentation.\(^{101}\)
We believe that this information justifies action on the part of the Chief of Police to inquire if it is warranted to discipline officers for their conduct related to this incident.

Allegation #1: False arrest
Subject Officers: G. Brown #16 and K. Tu #38

Basis: Officer Brown proceeded with an arrest and Officer Tu assisted without having confirmation of a warrant for the arrest of Moore. While Officer Smith ran a warrant check on Moore, the only thing that came back about Moore was a “caution code” associated with her name. According to Officer Smith, “And a $10,000 warrant out of

\(^{101}\) Supporting documentation includes BPD CIT orientation manual and training bulletins, BPD Detail Call for Service Report, People’s Investigation witness statements, and other sources. Please see selected sources at the end of this document for a list of primary documents and their citations.
San Francisco came up but I didn’t have a birth date. So I didn’t know for certain if that was them or not but when I ran his name through Telecom they didn’t come back with any warrant.”

No officer should take a person into custody for an outstanding warrant, unless that warrant is confirmed at/bys the time of arrest.

Allegation #2: Excessive Force
Subject Officers: G. Brown #16, K. Tu #38, N. Kastmiler#104, Officer Smith #3, Officer Mathis #80, Officer Gardner#121, Sgt. Cardoza #S-31, Sgt. A. Phillips#S-17

Basis: These officers and their supervisors are trained in the dangers of positional asphyxia and should have recognized the danger that they put Kayla Moore in when they allowed dangerous conditions to continue without interruption. The visible factors were a) an obese person b) possibly on drugs c) struggling with officers d) face down on a futon. These are all factors that officers should have known could contribute to a lethal outcome. Not only did five to six officers restrain Moore through the use of their full strength and their full body weight while she was face down, they needlessly prolonged the confrontation by insisting that her lower legs be restrained. Officers could have stepped away to a safe distance from the individual and de-escalated the situation. Handcuffed and face down, she did not pose an immediate danger to the officers.

The amount of force used to restrain Moore was unnecessary to ensure officer safety and other techniques for gaining compliance should have been employed.

Allegation #3: Failure To Act
Subject Officers: G. Brown #16, K., N. Kastmiler#104, Smith #3, Officer Mathis #80, Gardner#121, Sgt. Cardoza #S-31, Sgt. A. Phillips#S-17

Basis: With or without a legal basis, once BPD officers handcuffed Moore and assumed custody of her, they also assumed responsibility for her medical situation and any condition that they themselves had caused. Once it became known that Moore was not breathing, officers rightly removed the handcuffs, began chest compressions and ensured that her airway was not obstructed. Officer Tu was doing chest compressions, but none of the other officers involved or their supervisors actually provided Moore with assistance breathing. Officer Brown states that “We immediately removed the handcuffs, laid him on his back and began CPR and was relieved by Berkeley Fire Department (BFD).” Officer Tu’s statement corroborates that they “began CPR”. In fact, Officer Brown who was “holding [Moore’s] head” states, “And I said, ‘Someone run downstairs, get a mask, get a mask.’ And they said, ‘B-BFD’s here.’” However, based on the investigative notes, it is clear no officer attempted to provide artificial respiration.

103 Ibid., 337.
104 Ibid.
105 Ibid., 9.
106 Ibid., 11.
107 Ibid., 338.
All of the officers had a moral, if not legal, responsibility to assist Moore as she lay on the floor, unable to breath. These officers should have been qualified to provide assisted breathing in addition to chest compressions. It is disturbing that none of the officers or supervisors present even had a safety mask to use for the purpose of providing assisted breathing. Even without the mask, it is possible that, had one of those provided Moore with artificial respiration, she might not have died.

3. Improving Future Investigations
Overall, the Berkeley Police Department’s In-Custody Death investigation was helpful to the People’s Investigation and we note that the BPD was more transparent in its investigation into Moore’s death than it has been at other times. We hope that this will continue to be the case. We hope that BPD can appreciate the many reasons why a family that loses a loved one needs accurate information as soon as possible. Releasing the police report and finally allowing the coroner’s report to be released was helpful for us in formulating our understanding of events and enabling us to make better recommendations.

There are however key areas in need of improvement in the Berkeley Police Department’s investigation process to insure that the ways that police document and later investigate their own actions are accountable to their own policies and procedures and transparent to the people:

- Create direct transcripts of witness statements as well as those of the police officers. Paraphrased statements do not hold up to transcribed ones. If officers in the field conduct interviews, these should be recorded, pending permission of the witness. The investigation is a critical aspect of policing. This requires an attentiveness throughout the investigative process to record and reproduce accurate information and to provide documentation that clarifies the decisions made by officers throughout the incident.

- Provide primary source documents:
  - “Affidavit for Search Warrant” for the apartment of Kayla Moore would be one. Why was the apartment searched? What were they looking for? Was this part of an investigation? The Affidavit for Search Warrant would be most helpful in answering these questions.
  - A transcript of the intial call for assistance from Mr. Hayes to dispatch would confirm what the officers knew about the scene before they entered.

- Assess what questions could have been asked, including:
  - Did Kayla Moore demonstrate any behavior that made you think that she might have some kind of mental illness?
  - What do you know about the dangers of positional asphyxia and safety measures to prevent it?
  - Did you or any officers attempt to offer any kind of assisted breathing to Moore? Why or why not?
- Make public investigator findings and recommendations
  The public should also be informed as to what the official position of the BPD is and whether this death should be reviewed further and efforts made to prevent this type of tragedy in the future. The public would like to know whether the Chief believes that something went wrong that night and what he intends to do to prevent similar episodes from happening or if he considers this incident to have been unavoidable.
Selected Reports and Policy Documents

Berkeley Department of Health Services, report prepared by BDHS in response to a PRA request from the People’s Investigation and containing information from 2000-1014. (July 16, 2013).

Berkeley Police Department, Crisis Intervention Training (CIT) Orientation package, (March 27, 2013).


People’s Investigation, witness interviews conducted February – April, 2013 (2013).

