STATE OF MICHIGAN

IN THE 3RD JUDICIAL CIRCUIT COURT

SHERRY SEARCY,
Individually and as Personal
Representative of the Estate of
BRYANT SEARCY, Deceased,
CHASADIE SEARCY, Individually,

Plaintiff,

v. Case No. 22- -CZ

WAYNE COUNTY;
WAYNE COUNTY SHERIFF'S OFFICE;
THE ESTATE OF BENNY NAPOLEON;
RAPHAEL WASHINGTON;
WARREN EVANS;
DANIEL PFANNES;
ROBERT DUNLAP

Defendant.

Liberty Property Legal, PLLC
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There is no other pending or resolved civil action arising out of the transaction or occurrence alleged in the complaint

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable by right.

COMPLAINT

NOW COME the Plaintiffs, The Estate of Bryant Searcy, Sherry Searcy, and Chasadie Searcy, by and through their Attorneys Liberty Property Legal, PLLC and Jamil Akhtar, and state by the way of complaint against Defendants as follows:

PARTIES, JURISDICTION, AND VENUE

1. Plaintiff Sherry Searcy and Deceased Bryant Searcy were, at all relevant times, husband and wife and residents of the city of Southfield, Oakland County, Michigan. Plaintiff is duly appointed Personal Representative of the Estate of Deceased, for the purpose of pursuing this claim.
2. Decedent was the husband of Plaintiff Sherry Searcy and the father of Plaintiff Chasadie Searcy.
3. Defendant Wayne County is a Charter County organized under the Constitution and Statues of the State of Michigan.
4. Defendant Warren Evans, at all times relevant to this Complaint, was the elected County Executive, who annually prepared the budget for the Wayne County Sheriff's Office and had the statutory authority and duty to implement the Sherriff's Office budget which was approved by the Wayne County Commission.
5. Defendant Wayne County Sheriff's Office was created by the 1963 Constitution of the State of Michigan and is subject to PA 125 of 2003, the Local Correction Officer's Training Act; MCL 791.531 et seq.
6. Defendant, the Estate of Benny Napoleon, deceased, at all times relevant to this Complaint was the duly elected Sheriff of Wayne County and pursuant to the powers

vested in him by Defendant Wayne County; had final decision-making authority as it relates to the promulgation of rules, regulations and other policies and procedures, for the Wayne County Sheriff's Office.

7. At all times relevant to this Complaint, Defendant Daniel Pfannes was the Undersheriff of Wayne County and was the County representative to the Sheriff's Coordinating and Training Council which was established pursuant to PA 125 of 2003.
8. Defendant Raphael Washington at all times relevant to this Complaint was appointed by Defendant Benny Napoleon as the Deputy Chief for the Wayne County Sheriff's Office, to be in charge of the Jail Divisions and Court Divisions; Defendant Washington held said position in violation of sections 2(c), 11, 12 & 13 of PA 125 of 2003.
9. Defendant Robert Dunlap at all times relevant to this Complaint was the Chief of Jails and Director of Classifications for the Wayne County Sheriff's Office Jail Divisions; Defendant Dunlap held said position in violation of sections 2(c), 11, 12 & 13 of PA 125 of 2003.
10. The original injury and all or part of the cause of action arose in the City of Detroit, Wayne County, Michigan.
11. The amount in controversy exceeds $25,000 and is within the jurisdiction of this Honorable Court. MCL 600.605; MCL 600.8301(1).

COMMON FACTUAL ALLEGATIONS

12. Plaintiffs incorporate the preceding paragraphs by reference as though the same were fully set forth herein.
13. On September 2, 2020, Local Corrections Officer Bryant Searcy (hereinafter referred to as "Officer Searcy") was working at the Wayne County Sherriff's Jail Division II, when he

was murdered by inmate DeAndre Williams, during nighttime lockdown. Wayne County Assistance Medical Examiner Omar Rayes, MD, found "that death was caused by asphyxia due to compression of neck and chest." Exhibit 1, Officer Bryant Searcy *"Post Mortem Report"* by Office of the Wayne County Medical Examiner at Bates No. 0069.

14. At all relevant times, Defendants Evans, Napoleon, Pfannes, Washington, and Dunlap knew that Wayne County Jail Division II, housed some of the most dangerous criminals in the United States. As confirmed by Defendant Napoleon's statements in a press conference on September 3, 2020. Exhibit 2, Detroit Free Press *"Wayne County Sheriff's corporal dies after attack at Detroit Jail"* by Frank Witsil at p 2.

15. From at least 2015 and on and after September 2, 2020, Defendants Evans, Napoleon, Pfannis, Washington, and Dunlap personally and collectively, determined or concurred to Defendant Evan's decision to dangerously understaff Sheriff Jail Division II. This cost savings analysis ignored the effect it would have on recognized safety standards.

16. The decision to understaff the jail was a conscious action which demonstrated a pattern of customs, policies, and procedures to leave the Wayne County Jail Division II in disrepair, without adequate safety measures for the officers or inmates, and was done with actual knowledge, and deliberate indifference to injuries they knew were certain to occur.

17. On or about July 21, 2015, the Michigan Department of Treasury sent their investigative findings titled "Report of Wayne County Financial Review Team" to then-Governor Snyder for his review with copies going to Defendant Wayne County and Defendant Evans.

18. The report found that the Wayne County Jail logged an excessive amount of overtime, with the best estimates showing the jail required 1,000 hours of overtime per day. The

reasons found for this shocking amount of overtime were "too few officers, inadequate compensation and insufficient opportunities for advancement." Exhibit 3, 2015 Michigan Department of Treasury Report at p 15.

19. The "Report of Wayne County Financial Review Team" to then-Governor Snyder for his review with copies going to Defendant Wayne County and Defendant Evans showed Defendants knew burnout and fatigue were likely to occur with excessive forced overtime, noting that, "hiring additional officers might improve the quality of services…by reducing the amount of fatigue and burnout resulting from long hours in stressful working conditions." *Id.*

20. A report prepared by Director of Research for the Police Officer Labor Council of Michigan, Nancy Ciccone, found that the Wayne County Sheriff's Department consistently paid starting wages well below their neighboring counties of Macomb, Monroe, Oakland, and Washtenaw from 2017-2020. In 2019, Wayne County paid $5,826, or fourteen percent, less than the average starting wages paid by the above neighboring counties. Exhibit 4, Nancy Ciccone "*Base Wage History – Starting Pay Corrections Deputy.*"

21. Based upon good faith information and belief, from approximately 2015 until September 2, 2020, Defendant Pfannes, who had the responsibility of transmitting statutorily required in service training records to the Sheriffs' Coordinating and Training Council on an annual basis, either intentionally falsified training certifications required by the Sheriffs' Coordination and Training Council; in so doing Defendant Pfannes wanted to make it appear that officers, including decedent Plaintiff Bryant Searcy, were receiving the 20 hours of in-service training required by MCL 791.541, 791.542, 791.543 when

they had not received the required training or Defendant Pfannes failed to report the in-service training as required because it had not been completed. Exhibit 5, Michigan Sheriff Coordinating and Training Council In-Service Training Requirements.

22. Based upon a statement of Training Director of the Sheriff Coordinating and Training Council, Barbra L. Gould, it is not possible to obtain a waiver of the statutorily mandated in service training requirement.

23. Based upon good faith information and belief, from approximately 2015 until September 2, 2020, local corrections officers, including Officer Searcy, were not given dedicated time specifically allotted for training. Local corrections officers as defined by Act 125, PA 2003, were unreasonably expected to conduct their online in-service training while working their regular and overtime shifts, in a purposefully understaffed jail.

24. Based upon good faith information and belief, from approximately 2015 until September 2, 2020, all three Wayne County Jail Divisions had a significant number of computers that did not function correctly or function at all. This forced Deputies to manually enter logs for their shifts and made it difficult or impossible to complete the mandated training on their assigned workstation computers.

25. In 2018, a closed-circuit television security system made by Bosch was installed at the Wayne County Jail. Exhibit 6, Britton Foreman Report on the Security Camera System.

26. That closed circuit television security camera system did not work as designed or intended at the time of installation. *Id.*

27. From the time of installation in 2018 until September 2, 2020, the closed circuit television system was not adequately maintained or repaired, resulting in it not working as designed or intended. *Id.*

28. On or about July 18, 2018, three and a half years after Defendant Evans became the County Executive, the Wayne County Jail became the subject of a Consolidated Consent Order and Settlement Agreement (Michigan 3rd Circuit Court Case # 71-173217-CZ). This order requires the Wayne County Sheriff's Office to maintain appropriate staffing levels based on the inmate population. Despite this order and because of Defendant Evans determination not to hire additional corrections officers, the Defendants Napoleon, Pfannes, Dunlap, and Washington regularly declare staffing emergencies because of their failure to comply with the mandated staffing levels. Exhibit 7, February 8, 2022, *Opinion and Order* Michigan 3rd Circuit Court Case # 71-173217-CZ at p 3.
29. On or about August 18, 2020, according to the Michigan Occupational Safety and Health Administration (hereinafter referred to as "MIOSHA") report Defendants Washington and Dunlap prepared a memo accompanying their August 18, 2020, policy directive regarding "Staff Entering Occupied Housing" which showed they were aware that local corrections officers routinely performed nighttime lockdowns alone without their partner. Exhibit 8, Wayne County Jail Division II Divisional Directive Regarding Staff Entering Occupied Housing Units.
30. Despite actual knowledge that officers were forced to routinely perform lockdowns without a partner, after enacting the directive on staff entering occupied housing, Defendants Washington and Dunlap failed to implement any compliance customs, policies, or procedures and issued no disciplinary reports for non-compliance. *Id.*
31. As reported by MIOSHA, which cited to the National Institute of Justice and Bureau of Prisons policy and standards, the hazards posed by failing to require two officers to conduct lockdown procedures are widely recognized. The industry standard is for at least

two officers to perform counts and for officers to always have backup when dealing with troublesome inmates. Exhibit 9, MIOSHA Inspection Report at p 25-26.

32. The National Institute of Justice found jails should ensure officers always have backup when dealing with troublesome inmates to reduce the risk of injury to the officers. Exhibit 10, National Institute of Justice *Risky Business: Part 1 of 2 in a Series on Correctional Officer Wellness* at p 4.

33. The Department of Justice, Bureau of Prisons Services, Procedure Manual mandates "each count will be conducted with at least two officers." Exhibit 11, Federal Bureau of Prisons *Correctional Services Procedures Manual* at Chapter 3, p 1-7.

34. On or before September 2, 2020, Defendants Sherriff Napoleon, Undersheriff Pfannes, Deputy Chief Washington, and Director of Jails Dunlap knew several Wayne County Sheriff local correction officers were injured by inmates in Wayne County Jail Division II. Exhibit 12, Wayne County Jail Division II *OSHA's Form 300.*

35. On or before September 2, 2020, Defendants Washington and Dunlap knew that inmate DeAndre Williams had a violent criminal history and known propensity for violence while incarcerated.

36. At the time inmate DeAndre Williams murdered Officer Bryant Searcy, he was detained for armed robbery and carjacking charges. His violent history included acts against police officers; specifically, allegations of resisting and obstructing police officers.

37. As of September 2, 2020, DeAndre Williams admitted to Detroit Police homicide investigators that he had been moved at least twice for fighting while incarcerated in the Wayne County Jail; Defendants Washington and Dunlap review on a daily basis officer

reports as to altercations in the jail between inmates. Exhibit 13, Detroit Police Department DeAndre Williams Interrogation Video at 11:29 AM – 11:47 AM.[1]

38. Upon good faith information and belief, the cell block Inmate DeAndre Willliams was assigned to when he murdered local corrections Officer Searcy was classified for only the most dangerous offenders with a propensity for violence.

39. Upon good faith information and belief, on or before September 2, 2020, Defendants Deputy Chief Washington and Director of Classifications Dunlap held their positions in violation of sections 2d, 11, 12 & 13 of PA 125 of 2003 because they had not completed the required 160 hours of certification training, nor did they have the required 20 hours of in-service training. Exhibit 14, Michigan Sheriff Coordinating and Training Council Announcement of Change to Pre-Service Eligibility Standard.

40. On or about September 2, 2020, Officer Searcy was working forced overtime at Wayne County Jail Division II. A jail division which on that night was purposefully understaffed and did not have properly functioning locks on the cells or cameras to monitor both officer and inmate safety, despite housing some of the most dangerous criminals in the United States.

41. At approximately 10 p.m., after working approximately fifteen straight hours, Officer Searcy and his partner, Officer Brad Panek, began the nightly lockdown protocol.

42. Officer Searcy and his partner conducted the lockdown without a partner in accordance with the accepted and regularly practiced custom for the lockdown protocol. Exhibit 9, at Bates No. 0025-0027.

[1] Timestamp taken from the video's internal clock.

43. Shortly after beginning the lockdown protocol, Officer Searcy walked past cell one, which housed DeAndre Williams. As Officer Searcy passed the first cell, DeAndre Williams escaped from his cell by jamming the old mechanical locks with an eraser placed in his cell door. The cell housing him was constructed in 1929. Exhibit 15, Inmate Steven Williams Statement.

44. DeAndre Williams violently threw Officer Searcy to the ground and put him in a choke hold. Officer Searcy yelled for help, but no other officer was able to respond in a timely manner. DeAndre Williams did not get off of Officer Searcy until he was motionless. *Id.*; Exhibit 16, FBI Findings Update Regarding Murder of Bryant Searcy.

45. Williams then took Officer Searcy's key and ran towards the exit door. However, he then decided to return to his cell. Exhibit 15.

46. At approximately 10:10 p.m., Officer Searcy's partner, Officer Brad Panek, turned the corner to go into ward 404, where Officer Searcy was, and found him lying face down on the ground underneath the table in front of cell five. Exhibit 17, Local Correctional Officer Statements to Detroit Police Homicide Investigators at Bates No. 0017.

47. Sometime between 10:12 and 10:15 p.m., an officer-in-trouble alarm indicating an officer needed assistance was sent out to other sheriff local corrections officers. Exhibit 17.

48. When other officers arrived, Officer Panek checked on Officer Searcy, who was unresponsive and had blood coming from his mouth. Panek and other officers took turns giving Officer Searcy chest compressions without success. *Id.* at Bates No. 0017.

49. Officer Searcy was taken from the jail in an ambulance and pronounced dead by approximately 11:15 p.m. *Id.* at p 39.

50. The next day, September 3, 2020, then-Wayne County Sheriff Benny Napoleon held a press conference where he said "I tell people all the time, we house some of the most dangerous criminals in America in the Wayne County jails." Exhibit 2, Detroit Free Press *"Wayne County Sheriff's corporal dies after attack at Detroit Jail"* by Frank Witsil at p 2.

51. From September 3, 2020, to April 22, 2021, MIOSHA investigated violations of workplace safety regulations by the Defendants which led to Officer Searcy's murder. Exhibit 18, MIOSHA *"Citation and Notification of Penalty."*

52. On or about September 3, 2020, the MIOSHA investigator reported that they overheard an employee state "'this is something we have all done before' referring to the ensuring the door was locked and entering an area without backup." Exhibit 9, at Bates No. 0034.

53. The MIOSHA investigator also reported they heard another employee state "'they are finally making changes to the policy we asked for 6 months ago' in reference to how officers are to secure doorways and areas before prisoner areas." *Id.*

54. During the MIOSHA investigation, several then-current employees interviewed by MIOSHA during the investigation acknowledged understaffing and mandated overtime were outside factors that led to Officer Searcy's murder. *Id.* at Bates No. 0038-0041.

55. During the MIOSHA investigation, several then-current officers said they usually work 60-80 hours a week and that inmates were known to be able to "jam" the mechanical locks to stop them from functioning properly. *Id.*

56. During the MIOSHA investigation, the investigator found that "there did not appear to be any active monitoring or review of footage unless an incident occurred." *Id.* at Bates No. 0025-0026.

57. The MIOSHA investigator noted that while she was reviewing the video footage, the clock was approximately sixteen minutes off and "cameras in the ward … were black but from other cameras they should have been on as there was someone in their view moving." *Id.*

58. The MIOSHA investigator also noted there was "very little footage of the CPR [Cardio Pulmonary Resuscitation] being performed were captured, the screens were black. The video recorded might also jump in time." *Id.*

59. The MIOSHA investigator observed these skips "sever[al] times where the time counter jumped ahead seconds or minutes with no explanation or the appearance of deleted footage." *Id.*

60. On or about September 21, 2020, Wayne County Sheriff Deputy Britton Foreman investigated and wrote a report, approved by Captain Fredryn Allen, to explain why the security video system at Wayne County Jail Division II is experiencing technical issues. Foreman found a "multitude of issues" with the system. Exhibit 6.

61. Upon good faith information and belief, Deputy Foreman was responsible for maintaining the closed-circuit television security system due to his technical expertise.

62. Foreman reported that one of the hard drives was bad and needed to be replaced; this was considered "common regular maintenance." Foreman stated that the main issue was that "the recording[s] are missing packets (data) at a time when there should be data." *Id.*

63. Additionally, Foreman's report found, the older analog cameras were not communicating well with the digital system, the motion activated cameras had stabilization issues causing them to "go off 24/7" creating issues with the server, and that the software for the

system was out of date and needed to be updated. The issues resulted in various faults, including but not limited to, events not being recorded in their entirety. *Id.*

64. On or about June 11, 2021, MIOSHA issued a "Citation and Notification of Penalty" for workplace safety regulation violations which contributed to Officer Searcy's murder. Two citations were issued. Exhibit 18.

65. The first was a violation of MCL 408.1011(a) because "the employer did not furnish ... a place of employment which was free from recognized hazards that were causing or likely to cause death or serious physical harm to employees." Specifically, the employer did not ensure the practice of performing lockdowns with a partner, in accordance with established policies was followed." Exhibit 9, at Bates No. 0027.

66. The second was a violation of MCL 408.22112(1) for failing to record the death of Officer Searcy "on the log as required." Exhibit 18.

67. The proposed fine for the two violations was $8000, which is the maximum that MIOSHA can levy.

68. The acts of the Defendants, and each of them, were undertaken willfully, wantonly, recklessly and with deliberate indifference to and callous disregard for Officer Searcy's health, safety, welfare well-being and constitutional rights.

69. As a result of the acts of the Defendants, Officer Searcy was murdered.

COUNT I:

CONTINUALLY OPERATING DANGEROUS CONDITION - INTENTIONAL TORT EXCEPTION TO THE WORKERS COMPENSATION ACT EXCLUSIVE REMEDY IN MCL 418.131(1)

70. Plaintiffs incorporate the preceding paragraphs by reference as though the same were fully set forth herein.

71. Defendants Wayne County, Wayne County Sheriff's Office, Undersheriff Daniel Pfannes, Deputy Chief of Operations in Charge of Jails Raphael Washington, and Director of Classifications Robert Dunlap, in violation of applicable provisions of the Michigan Workers Disability Compensation Act, willfully and purposefully took deliberate acts and omissions with a willful disregard of dangerous conditions in which an injury to Officer Searcy was certain to occur and/or the intent was to injure Officer Searcy.

72. For all of the reasons set forth above, Plaintiffs claim damages economic, non-economic, compensatory, punitive and exemplary for:

a. The death of Officer Bryant Searcy;

b. Funeral expenses;

c. Legal expenses;

d. Past and future medical expenses;

e. Lost work and income;

f. Pain and suffering;

g. Mental anguish and emotional distress, embarrassment, and humiliation;

h. Loss of society and companionship;

i. Loss of enjoyment of life;

j. Such other damages as are available under state and federal law.

WHEREFORE Plaintiff Sherry Searcy, Personal Representative of the Estate of Bryant Searcy, and her daughter Plaintiff Chasadie Searcy requests that this Honorable Court grant their damages, compensatory and punitive, in such amount as to adequately compensate them, along

with attorneys' fees and costs, against Defendants Wayne County, Wayne County Sheriff's Office, Daniel Pfannes, and Robert Dunlap.

COUNT II:
MICHIGAN CONSTITUTIONAL TORT - VIOLATION OF PLAINTIFF'S DECEDENT'S RIGHT TO BODILY INTEGRITY, CONTRARY TO MICHIGAN CONSTITUTION ART. 1, § 17

73. Plaintiffs incorporate the preceding paragraphs by reference as though the same were fully set forth herein.

74. Defendants Warren Evans, Wayne County, Wayne County Sheriff's Office, Benny Napoleon, Raphael Washington, Warren Evans, Daniel Pfannes, and Robert Dunlap exercised governmental power without any legitimate governmental objective and with deliberate indifference to the egregious, non-consensual entry into Officer Bryant Searcy's body, caused or facilitated by their concerted actions, customs, and polices as prohibited by Michigan Constitution Art. 1 §17.

75. For all of the reasons set forth above, Plaintiff claims damages economic, non-economic, compensatory, punitive and exemplary for:

    a. The death of Officer Bryant Searcy;

    b. Funeral exepenses;

    c. Legal expenses;

    d. Past and future medical expenses;

    e. Lost work and income;

    f. Pain and suffering;

    g. Mental anguish and emotional distress, embarrassment and humiliation;

    h. Loss of society and companionship;

i. Loss of enjoyment of life;

j. Such other damages as are available under state and federal law.

WHEREFORE Plaintiff Sherry Searcy, Personal Representative of the Estate of Bryant Searcy, and her daughter Plaintiff Chasadie Searcy requests that this Honorable Court award their damages, compensatory and punitive, in such amount as to adequately compensate them, along with attorneys' fees and costs against Defendants Wayne County, Wayne County Sheriff Office, Raphael Washington, Warren Evans, Daniel Pfannes, and Robert Dunlap.

COUNT III:

LOSS OF CONSORTIUM

76. Plaintiffs incorporate the preceding paragraphs by reference as though the same were fully set forth herein.
77. At all relevant times, Plaintiff Sherry Searcy was the lawfully wedded spouse of decedent Bryant Searcy.
78. At all relevant times, Plaintiff Chasadie Searcy was the daughter of decedent Bryant Searcy.
79. As a proximate result of the causes of action set forth above, Sherry Searcy suffered damages including, but not limited to, loss of consortium, loss of society and companionship, and other damages.
80. As a proximate result of the causes of action set forth above, Chasadie Searcy suffered damages including, but not limited to, loss of love, society and companionship, loss of parental guidance, loss of financial support, and other damages.

81. Plaintiffs Sherry and Chasadie Searcy's damages were caused by the actions of Defendants Wayne County, Wayne County Sheriff Office, Daniel Pfannes, and Robert Dunlap, as previously described.

WHEREFORE Plaintiffs Sherry Searcy and Chasadie Searcy requests that this Honorable Court grant them damages, compensatory and punitive, in such amount as to adequately compensate them, along with attorneys' fees and costs against Defendants Wayne County, Wayne County Sheriff Office, Daniel Pfannes, and Robert Dunlap.

RELIEF

WHEREFORE, Plaintiffs, The Estate of Bryant Searcy, Sherry Searcy, and Chasadie Searcy pray that this Honorable Court:

A. Order that Defendants have committed the intentional tort of "continually operating dangerous condition" and caused Officer Bryant Searcy's death;
B. Order that Defendants have violated Officer Bryant Searcy's right to bodily integrity secured by the Michigan Constitution Art. 1, § 17;
C. Order that Defendants have caused Plaintiffs Sherry Searcy and Chasadie Searcy loss of consortium;
D. Award compensatory and punitive damages against Defendants for all amounts to which Plaintiffs are entitled, including but not limited to loss of income, loss of opportunity, damage to reputation, mental anguish, emotional distress, fright, shock, shame, mortification, legal expenses, and loss of enjoyment of life.
E. Award Plaintiff Sherry Searcy damages in an amount that will fairly and adequate compensate her for her injuries;

F. Award Plaintiff Chasadie Searcy damages in an amount that will fairly and adequate compensate her for her injuries;

G. Award Plaintiffs costs and attorney fees; and

H. Award Plaintiffs any other such relief as this Court deems appropriate.

Respectfully submitted,

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PROOF OF SERVICE

On the 19th day of July 2022, the undersigned certifies that a copy of the foregoing was served upon all parties of record by:

☐ Mailing the same to them at their respective addresses of record with first-class postage fully prepaid and affixed thereon;
☐ Mailing the same to them at their respective addresses of record, certified mail/return receipt requested, with first-class postage fully prepaid and affixed thereon;
☐ Overnight delivery to them at their respective addresses of record;
☐ Hand delivery to them at their respective addresses of record;
☐ Facsimile transmission to them at their respective facsimile numbers;
☐ Other means: _____.

_____.
Affiant

Exhibit 1

OFFICE of the WAYNE COUNTY MEDICAL EXAMINER

1300 East Warren Avenue
Detroit, MI 48207

POST MORTEM REPORT

M.E. CASE NUMBER
20-13194
COUNTY OF DEATH
Wayne
TOWN OF DEATH
Detroit
DATE PRONOUNCED DEAD
Sep 2, 2020

THIS IS TO CERTIFY THAT	PERFORMED A POSTMORTEM EXAMINATION ON THE BODY
Omar Rayes, MD, Assistant Medical Examiner	Searcy, Bryant
AT Wayne County Medical Examiner's Office	ON Sep 4, 2020

SUMMARY & OPINION

It is my opinion that death was caused by asphyxia due to compression of neck and chest.

The decedent was a 60 year old black male who was found unresponsive at a correctional facility. He was conveyed to the hospital but despite life-saving measures he was pronounced dead at 2311 hours, on 9/2/2020.

The decedent was a correctional officer who was involved in an altercation with an inmate at his correctional facility before he was found unresponsive.

Review of a video from a surveillance camera showed an altercation between the suspect and the officer at 10:15:24 pm. A video from another surveillance camera showed the suspect on the top of the officer at 10:18:18 pm.

Postmortem examination revealed abrasions of the head and neck. There were petechiae and subconjuctival hemorrhages in both eyes which were caused by compression of the neck and chest. There were lacerations of the upper labial mucosa and hemorrhages in both upper and lower labial mucosae. This was either caused by blunt force trauma and/or pressure applied to the mouth compressing the labial mucosa against the teeth. Internally, there was hemorrhage of the right temporalis muscle. Additional injuries included: superficial hemorrhage in the soft tissue of the midline of the back and an abrasion of the right popliteal fossa.

The manner of death is homicide.

printed by th

Omar Rayes, MD, Assistant Medical Examiner
October 5, 2020

(report continues on next page)

Cause of Death:

ASPHYXIA DUE TO COMPRESSION OF NECK AND CHEST

Other Significant Conditions:

Manner of Death:

Homicide

NARRATIVE SUMMARY

Case Number: 13194 - 20
Name: Bryant Searcy
Date of Pronounced Death: September 2, 2020
Date of Postmortem Examination: September 4, 2020

EXTERNAL EXAMINATION:

The body was that of a normally developed, normally nourished black male appearing about the recorded age of 50 years. The body measured 5 feet 8 inches in length and weighed 176 pounds. The body was cool, rigor mortis was fully developed, and livor mortis was present posteriorly and fixed. No clothing was received with the body. The head was normocephalic and showed injury described below. The scalp hair consisted of short black stubble with male pattern balding. There was grey-black mustache and beard. The eyes had white sclerae, and brown irides and showed injury described below. The dentition was natural and in good condition. No lesions of the oral mucosa were identified. There were no masses discernible in the neck and the larynx was in the midline. The thorax was symmetrical and unremarkable. The abdomen was rounded. The external genitalia were those of a normal adult circumcised male. The extremities and back showed no significant deformities or other abnormalities. There were multiple monochromatic tattoos present of various styles and motifs, as follows: anterior chest (THANKFUL), abdomen (cross, ring and praying hands designs), back (cross and an illegible design). Fingernail clippings were obtained and retained.

EVIDENCE OF TREATMENT:

Endotracheal and nasogastric tubes were in place. There were intravascular lines in both antecubital fossae. A pulse oximetry electrode was on the right 2nd finger. An intraosseous catheter puncture site was in the left proximal anterior leg. Defibrillator and electrocardiograph pads were in place. Injuries related to resuscitation attempts included: a 1 inch abrasion on the midline chest, and fractures of the sternum, right anterior 4th to 10th ribs, and left anterior 3rd to 6th ribs.

EVIDENCE OF INJURY:

HEAD AND NECK :
On the left parietal scalp were two abrasions measuring 1/2 and 1 inch. On the occipital scalp was a 2-1/2 x 1 inch abrasion. Internally, there was hemorrhage in the right temporalis muscle. There were few petechiae and subconjuctival hemorrhages in both eyes. There were two 1/4 inch lacerations of the upper labial mucosa with hemorrhage of the upper frenulum. There were small areas of hemorrhage in the lower labial mucosa. On the right and left sides of the

neck were two abrasions, each measuring 1/4 inch. On the posterior neck and behind the left ear was a 1/4 inch abrasion.

TORSO:
Internally, There was an area of superficial hemorrhage of the soft tissue on the midline back.

RIGHT LOWER EXTREMITY:
There was a 1 inch abrasion on the right popliteal fossa.

INTERNAL EXAMINATION:

An autopsy was performed utilizing the normal thoraco-abdominal and posterior coronal scalp incisions. The pleural, pericardial, and peritoneal cavities had smooth serosal surfaces and the viscera were in their normal anatomical positions. An anterior neck dissection with internal examination of the underlying muscles, vessels, and structures was performed and was negative for hemorrhage. Except for the above previously described injuries, the internal systems were as follows:

Head:
No abnormality was noted in the reflected scalp, calvarium, dura, meninges or the base of the skull. The 1400 gm brain was free of neoplastic and other focal lesions, infarcts, and hemorrhages. The cerebral vascular system was unremarkable.

Neck:
No abnormality was noted in the cervical muscles, hyoid bone, laryngeal cartilages, trachea, or the cervical vertebral column.

Cardiovascular System:
The 400 gm heart had a normal configuration with an unremarkable epicardial surface and a moderate amount of epicardial fat. The coronary arteries had no significant atherosclerotic disease. No acute thrombi were present. Both ventricles were of normal size and their walls were of normal thickness. No focal endomyocardial lesions were present. The papillary muscles and chordae tendineae were not thickened, and the heart valves were unremarkable. The aorta had no significant aherosclerosis. The major arteries and great veins showed normal distribution.

Respiratory System:
The larynx and trachea were unremarkable. The right and left lungs weighed 600 gm and 600 gm, respectively. There was passive congestion in the parenchyma that was accentuated with dependent lividity. No pulmonary emboli were identified.

Hepatobiliary System:
The 1650 gm liver had firm dark tan surfaces and an unremarkable parenchymal pattern. The gallbladder and biliary tracts were unremarkable.

Hemolymphatics:
The 75 gm spleen had smooth surfaces and dark purple firm pulp. There was no significant lymphadenopathy.

Alimentary System:
The tongue, esophagus, stomach, small bowel, appendix and colon were unremarkable. The lining of the stomach had an intact and unremarkable rugal pattern and the contents of the stomach consisted of approximately 200 ml of brown fluid .

Pancreas:
The pancreas showed an unremarkable tan lobulated pattern.

Endocrine System:

The thyroid gland had a normal bilobed configuration. The adrenal glands were each unremarkable with golden-yellow cortices.

Genitourinary System:
The right and left kidneys each weighed 150 gm. Each kidney had smooth cortical surfaces, normal cortico-medullary regions and no changes in the calyceal systems, pelves, ureters, or bladder.

Musculoskeletal System:
Except for the above noted injuries, all the muscles and axial skeleton were free of any significant abnormalities.

Routine tissue specimens were retained in formalin for one year after autopsy in accordance with the current record retention schedule.

MICROSCOPIC DESCRIPTION

Cassette Summary:
1. Liver
2. Kidneys
3. Lung, right upper and middle lobes
4. Lung, right lower lobe
5. Lung, left upper and lower lobes
6. Heart, left ventricular free wall
7. Heart, septum
8. Heart, septum
9. Brain, cerebral cortex (including meninges)
10. Brain, hippocampus

A section of the liver showed sinusoidal congestion and mild microvesicular and macrovesicular steatosis. Sections of the lungs showed vascular congestion and red blood cells in some of the alveolar spaces. Sections of the heart and brain showed no significant histopathologic abnormalities.

FINAL DIAGNOSES

1. Asphyxia due to compression of neck and chest
   A. Petechiae and subconjuctival hemorrhages, both eyes
   B. Abrasions of neck
2. Abrasions of head
3. Lacerations of upper labial mucosa
4. Hemorrhages; upper and lower labial mucosae and right temporalis muscle
5. Superficial hemorrhage of the soft tissue of the midline back
6. Abrasion of right leg

(End of Report)

NMS LABS

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e-mail: nms@nmslabs.com
Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

CONFIDENTIAL

Toxicology Report

Report Issued 09/18/2020 10:06

To: 10373
University of Michigan - Wayne County
Attn: Dr. Carl J. Schmidt
1300 East Warren
Detroit, MI 48207

Patient Name	SEARCY, BRYANT
Patient ID	20-13194
Chain	20275168
Age Not Given	DOB Not Given
Gender	Male
Workorder	20275168

Positive Findings:

Compound	Result	Units	Matrix Source
Caffeine	Positive	mcg/mL	001 - Peripheral Blood

See Detailed Findings section for additional information

Testing Requested:

Analysis Code	Description
8057B	Postmortem, Expanded w/Vitreous Alcohol Confirmation, Blood - University of MI (Forensic) (CSA)
8050U	Postmortem, Urine Screen Add-on (6-MAM Quantification only) (Forensic)

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Miscellaneous Information
001	Gray Top Tube	9 mL	09/04/2020 10:30	Peripheral Blood	
002	Gray Top Tube	8.75 mL	09/04/2020 10:30	Peripheral Blood	
003	Red Top Tube	1 mL	09/04/2020 10:30	Vitreous Fluid	
004	Green Vial	9.75 mL	09/04/2020 10:30	Urine	
005	White Plastic Container	18.7 g	09/04/2020 10:30	Liver Tissue	

All sample volumes/weights are approximations.

Specimens received on 09/08/2020.

Detailed Findings:

Analysis and Comments	Result	Units	Rpt. Limit	Specimen Source	Analysis By
Caffeine	Positive	mcg/mL	0.20	001 - Peripheral Blood	LC/TOF-MS

Other than the above findings, examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

Reference Comments:

1. Caffeine (No-Doz®) - Peripheral Blood:

   Caffeine is a xanthine-derived central nervous system stimulant. It also produces diuresis and cardiac and respiratory stimulation. It can be readily found in such items as coffee, tea, soft drinks and chocolate. As a reference, a typical cup of coffee or tea contains between 40 to 100 mg caffeine.

   The reported qualitative result for this substance was based upon a single analysis only. If confirmation testing is required please contact the laboratory.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded two (2) years from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Workorder 20275168 was electronically signed on 09/18/2020 09:33 by:

Jolene J. Bierly

Jolene J. Bierly, M.S.F.S., D-ABFT-FT
Forensic Toxicologist

Analysis Summary and Reporting Limits:

All of the following tests were performed for this case. For each test, the compounds listed were included in the scope. The Reporting Limit listed for each compound represents the lowest concentration of the compound that will be reported as being positive. If the compound is listed as None Detected, it is not present above the Reporting Limit. Please refer to the Positive Findings section of the report for those compounds that were identified as being present.

Acode 8050U - Postmortem, Urine Screen Add-on (6-MAM Quantification only) (Forensic)

-Analysis by Enzyme Immunoassay (EIA) for:

Compound	Rpt. Limit	Compound	Rpt. Limit
Amphetamines	500 ng/mL	Fentanyl / Metabolite	2.0 ng/mL
Barbiturates	0.30 mcg/mL	Methadone / Metabolite	300 ng/mL
Benzodiazepines	50 ng/mL	Opiates	300 ng/mL
Cannabinoids	50 ng/mL	Oxycodone / Oxymorphone	100 ng/mL
Cocaine / Metabolites	150 ng/mL	Phencyclidine	25 ng/mL

Acode 8057B - Postmortem, Expanded w/Vitreous Alcohol Confirmation, Blood - University of MI (Forensic) (CSA) - Peripheral

-Analysis by Enzyme-Linked Immunosorbent Assay (ELISA) for:

Compound	Rpt. Limit	Compound	Rpt. Limit
Barbiturates	0.040 mcg/mL	Gabapentin	5.0 mcg/mL
Cannabinoids	10 ng/mL	Salicylates	120 mcg/mL

-Analysis by Headspace Gas Chromatography (GC) for:

Analysis Summary and Reporting Limits:

Compound	Rpt. Limit	Compound	Rpt. Limit
Acetone	5.0 mg/dL	Isopropanol	5.0 mg/dL
Ethanol	10 mg/dL	Methanol	5.0 mg/dL

-Analysis by High Performance Liquid Chromatography/Time of Flight-Mass Spectrometry (LC/TOF-MS) for: The following is a general list of compound classes included in this screen. The detection of any specific analyte is concentration-dependent. Note, not all known analytes in each specified compound class are included. Some specific analytes outside these classes are also included. For a detailed list of all analytes and reporting limits, please contact NMS Labs.
Amphetamines, Anticonvulsants, Antidepressants, Antihistamines, Antipsychotic Agents, Benzodiazepines, CNS Stimulants, Cocaine and Metabolites, Hallucinogens, Hypnosedatives, Hypoglycemics, Muscle Relaxants, Non-Steroidal Anti-Inflammatory Agents, Opiates and Opioids.

Office of the Wayne County Medical Examiner

1300 East Warren Avenue

Detroit, Michigan 48207

Case Registration Summary

M.E. Case No.
20-13194
Police File No.

9/2/2020

Name of Deceased	Age	DOB	Race	Sex
Bryant Searcy	50	[redacted]	Black	Male

Reported By: [redacted]

Reported From [redacted]

Agency Addres [redacted]

Telephone #: [redacted]

Brief Circumstances: [redacted]

Decedent's Residence [redacted] Southfield MI 48033

Telephone #:

Marital Status: Married

Next of Kin: [redacted] NOK Phone: [redacted]

Address:

Event Address: [redacted] Detroit MI

LSA: 9/2/2020

Transported From: [redacted] Via:

Status at Hospital: Chart #: [redacted]

Arrived at Hospital:

Pronounced Dead: By [redacted]

Doctor / Hospital Comments:
WORKSHEET FOR HOSPITAL CASES

HX:
Length of time in hospital: 34 minutes
Were they transferred from another facility? no
If yes, which facility and dates of admission and discharge:
Repeat for each facility:

Describe hospital course of the deceased:
Admitting diagnosis: asystole

Diagnostic tests and procedures with results: ultrasound of lungs and abdomen with no findings

Surgical procedures: none

Hospital course [redacted]

No admission blood drawn. No UDS done.

GOL (Gift of Life candidate): unknown

Office of the Wayne County Medical Examiner

1300 East Warren Avenue

Detroit, Michigan 48207

Case Registration Summary

M.E. Case No. 20-13194
Police File No.

9/2/2020

Medical history (including medications): none

Social history (includes illegal drugs in the past, abused prescription drugs, attempted suicide): none

NONE

Body Ordered to MEO:

Officer:

Police Information:

Notified:

Police Case #:

Police Comments:

Provisional Manner of Death: Homicide

Type of Place Where Injury Occurred:

Address where Injury Occurred: 570 Clinton, Detroit. Workplace.
WC Correctional facility

Date of Injury:

Additional Case Comments:

I ALL ordered in cases MUST have COVID-19 Checklist wdhin Event Scene
1. The following information must be obtained on ALL deaths:
? Any presumptive or confirmed diagnosis of COVID-19 infection-NO
? Any signs of infection (fever, shortness of breath, sneezing, coughing, chest pain, body aches)-NO
? Any recent travel (if so, where)-NO
? Any contacts, family, or friends with suspected or confirmed diagnosis of COVID-19 infection or signs of infection-NO
? Were nasopharyngeal and oropharyngeal swabs performed for Respiratory Viral Panel and/or COVID-19-NO
a. If so when? What are the results?
? Any underlying medical conditions-NO
? Any recent primary care visits-NO
? Request medical records and imaging-NO

Name of person attending autopsy:

Agency:

Patricia Graves

Exhibit 2

Detroit Free Press

Wayne County Sheriff's corporal dies after attack at Detroit jail

FRANK WITSIL | Detroit Free Press

The death of a Wayne County Sheriff's corporal who died in the hospital after authorities said he was "viciously assaulted" Wednesday night by a 28-year-old Detroit inmate likely will focus new attention on long-standing problems at the aging jail.

"It is with deep sadness we announce the death of one of our own," Sheriff Benny Napoleon said Thursday at a news conference, his voice cracking with emotion as he described the late-night skirmish with a prisoner that knocked the deputy out. "At the end of the struggle, we believe he lost consciousness."

to open a cell during lockdown in the Division 2 jail at 525 Clinton St., and attack the corporal.

In addition, the sheriff's office has reviewed video recordings of the incident and is investigating whether internal policies and procedures were followed and need to be updated.

"The jail is a dangerous place," Napoleon said, pointing out that the county's William Dickerson Detention Facility in Hamtramck was named after a sergeant who was shot and killed when he intervened in an escape attempt in 1991. "I tell people all the time, we house some of the most dangerous criminals in America in the Wayne County jails."

During the pandemic, the sheriff added, the jail population has been reduced to protect inmates from the coronavirus, leaving the most dangerous criminals in lockup. He said the prisoner who attacked Searcy has a long rap sheet.

Napoleon said over his 46-year career, he has faced too many officers' deaths, and yet he still struggles to find the right words to say.

Searcy is survived by his wife, Sherry, who the sheriff said he spoke to at Detroit Receiving Hospital on Wednesday night, and his college-age daughter, 21.

Napoleon said police officers and officials from across the state — including Macomb County Sheriff Anthony Wickersham, Michigan State Police Col. Joseph Gaseper, and Wayne County Prosecutor Kym Worthy — have offered their condolences and support.

Second District state police personnel plan to wear a dark band over their badges to honor Searcy's sacrifice and his service to the people of Wayne County up until the day of his funeral.

"When you lose an officer in the line of duty — whether it's a jail facility or somewhere else — it tugs at you, hits you hard," Wayne County Executive Warren Evans said at the news conference. "It could have been any of us."

Detroit Free Press

Read more:

$520K in grants take aim at racial injustice in Michigan

Michigan State Police investigate I-94 shootout that tied up traffic

Searcy was assaulted at about 10 p.m. and "gravely injured," Pfannes said. The corporal was treated at the jail by paramedics and then rushed to Detroit Receiving. Funeral arrangements for Searcy were not yet available.

The inmate who authorities said attacked Searcy was not identified. He was taken into custody by Detroit police and is now being held at the Detroit Detention Center on Mound Road, which is staffed by the Detroit Police Department and the Michigan Department of Corrections.

The detention facility where Searcy was attacked — sometimes called the Old Wayne County Jail — is among the oldest operating jails in the country. The 770-bed facility opened in 1929 and holds hundreds of maximum security inmates.

In July, a doctor who inspected Wayne County's three jails as part of a lawsuit over conditions related to the pandemic said the aging facility where Wednesday's assault occurred is in a state of severe disrepair. He recommended the county stop housing inmates there as soon as possible.

But decrepit conditions at Wayne County's jails are nothing new. In 2015, the Free Press reported that problems included malfunctioning equipment, drain fly larvae and organic matter in showers. Lock boxes controlling cell doors have a confusing set of knobs.

Evans, who began his career in law enforcement as a Wayne County sheriff's deputy and later became sheriff, said that "words cannot express the magnitude of the loss and pain we feel today." Searcy, he said, served during his administration and was someone who had a good record and a lot of friends.

He added that his death "is a jarring reminder of the danger the men and women in law enforcement face on every shift" and a painful experience for other officers who know that "by the grace of God" it could have been one of them.

Detroit Free Press

Memorial donations to help the family can be made online through the Officer Collin Rose Memorial Foundation, a nonprofit organization aimed at providing emotional and financial support to line-of-duty survivors.

Contact Frank Witsil: 313-222-5022 or fwitsil@freepress.com. Staff writers Angie Jackson and Eric D. Lawrence contributed to this report.

Exhibit 3

3500 (Rev. 04-15)

STATE OF MICHIGAN
DEPARTMENT OF TREASURY
LANSING

RICK SNYDER
GOVERNOR

NICK A. KHOURI
STATE TREASURER

DATE: July 21, 2015

TO: Governor Snyder

FROM: Wayne County Financial Review Team:
Frederick Headen
Jeffrey S. Bankowski
Thomas M. Davis
Sharon L. Madison
Clarence L. Stone, Jr.

SUBJECT: Report of the Wayne County Financial Review Team

On July 7th, 9th, 10th and 17th, 2015, Wayne County Financial Review Team members met and reviewed information relevant to the financial condition of Wayne County. Based upon those reviews, the Review Team concludes, in accordance with Section 5(4)(b) of Public Act 436 of 2012, the Local Financial Stability and Choice Act, that a financial emergency exists within Wayne County.

I. Background

A. Preliminary Review

On June 19th through June 30th, 2015, the Department of Treasury conducted a preliminary review of the finances of Wayne County to determine the existence of probable financial stress. The preliminary review of Wayne County resulted from the conditions enumerated in subdivisions (a), (p), (r), and (s) of Section 4(1) having occurred within the County.[1] The preliminary review found, or confirmed, the following:

---

[1] Subdivision (a) provides that "[t]he governing body or the chief administrative officer of a local government requests a preliminary review. The request shall be in writing and shall identify the existing or anticipated financial conditions or events that make the request necessary." Subdivision (p) provides that "[t]he municipal government has ended a fiscal year in a deficit condition as defined in section 21 of the Glenn Steil state revenue sharing act of 1971, 1971 PA 140, MCL 141.921, or has failed to comply with the requirements of that section for filing or instituting a financial plan to correct the deficit condition." Subdivision (r) provides that "[t]he local government has been assigned a long-term debt rating within or below the BBB category or its equivalent by 1 or more nationally recognized credit rating agencies." Subdivision (s) provides "[t]he existence of other facts or circumstances that, in the state treasurer's sole discretion for a municipal government, are indicative of probable financial stress or that, in the state treasurer's or superintendent of public instruction's sole discretion for a school district, are indicative of probable financial stress.

The preliminary review also was predicated upon the assertion in the County Executive's June 17, 2015, request that the condition in subdivision (o) ["A court has ordered an additional tax levy without the prior approval of the governing body of the local government."] had occurred. As explained on Page Thirteen, that assertion was incorrect.

- County officials violated requirements of Section 17 of Public Act 2 of 1968, the Uniform Budgeting and Accounting Act.[2] Section 17 of the Act provides, in part, that "the legislative body of the local unit shall amend the general appropriations act as soon as it becomes apparent that a deviation from the original general appropriations act is necessary and the amount of the deviation can be determined."

  For example, for the County's 2014 fiscal year, General Fund expenditures in the "County Jail," "Prosecuting Attorney's Office," and "Sheriff's Department" activity lines exceeded budgeted revenues by $14.8 million, $2.7 million, and $1.0 million, respectively. In addition, several revenue line items including "Transfers In" did not meet expectations, falling short by over $42.0 million. Consequently, the net budgeted change in fund balance was a negative $18.9 million.[3]

- For the last several fiscal years, County officials failed to file with the Michigan Department of Treasury a financial audit that conformed to the minimum procedures and standards required of local governments by the Uniform Budgeting and Accounting Act. Local governments are expected to adopt annual budgets on an activity level or lower (for example, "Prosecuting Attorney" or "Sheriff"). The County's recent financial audit did not comply with this requirement by reporting budgets on the higher, function level (for example, "Public Safety").[4]

- The County ended a fiscal year in a deficit condition and was in breach of its obligations under a deficit elimination plan. For the County's 2014 fiscal year, deficits existed in the entity-wide governmental activities of $373.0 million in unrestricted net assets. Unrestricted General Fund deficits peaked at $156.4 million in 2013 and were reduced to $82.8 million in 2014. The recent reduction in the deficit was primarily due to a transfer of $91.6 million from the Delinquent Tax Revolving Fund, which will increase borrowing costs to the County when collecting delinquent taxes on behalf of local governments within the County. (According to County officials, $153.4 million more was to be transferred in 2015.) Unrestricted deficits in the General Fund began in the 2008 fiscal year, with an unrestricted deficit of $10.6 million. Without taking remedial measures, County officials projected a $171.4 million deficit by fiscal year 2019.

  Other funds that had deficits in 2014 were the Health Fund ($5.0 million), the Nutrition Fund ($3.2 million), the Community and Economic Development Fund ($2.3 million), the Wetlands Mitigation Fund ($1,000), and the Regional Jobs and Economic Growth Fund ($1,000).

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[2] Those provisions, in the main, require local officials annually to adopt a balanced budget which sets forth a statement of estimated revenues, by source, in each fund maintained by the local government for the ensuing fiscal year; to monitor actual revenues and expenditures during the course of a fiscal year; to amend an adopted budget as necessary to ensure that expenditures do not exceed available revenues; and to refrain from incurring expenditures in excess of amounts appropriated by the local legislative body.

[3] The fiscal year of the County is October 1 through September 30.

[4] County officials, and their audit firm, disagreed with this finding asserting that the level of budget detail was proper.

- County officials had not filed an adequate or approved deficit elimination plan with the Department of Treasury for fiscal years 2010, 2011, and 2012. For fiscal year 2013, County officials proposed to transfer $81.0 million from the Delinquent Tax Revolving Fund ($91.6 million actually was transferred) and to create a Waste Water Authority to realize a one-time payment of $121.0 million from participating communities. However, the proposed deficit elimination plan was not certified by the Department of Treasury because the plan did not qualify. No deficit elimination plan had been submitted for the County's 2014 fiscal year; it was due when the County's most recent audit report was submitted at the end of March 2015.

- On May 29, 2015, the Wayne County Circuit Court entered a $49.3 million judgment against the County in the case of *Wayne County Employees Retirement System* v *the Charter County of Wayne*. Subsequently, on June 4, 2015, the County Commission voted to remit the judgment amount by transferring money from the Delinquent Tax Revolving Fund. However, the County Executive vetoed the action and the veto was not overridden. Because the County lacked the financial ability to remit the judgment from existing resources, County officials acceded to having a judgment placed upon the County's summer property tax rolls.

- The County's primary pension plan was 45.1 percent funded and had a liability of $910.5 million based upon the last actuarial valuation dated September 30, 2013, in contrast to a 94.8 percent funding ratio and a total liability of $49.6 million in 2004. Over the past 10 years, the pension funding ratio decreased by 52.4 percent, while the unfunded liability increased to more than 18 times its 2004 level. The decreased funding ratio was caused by reopening plans to new members in 2002 and 2008, underperforming investments, increasing payrolls, and generous incentives including for early retirement that waived age requirements and enabled eligible persons to purchase years of service at discounted rates.

- Recently, the County's credit rating was downgraded by the three major credit rating services. Moody's rating is now at Ba3, Fitch's rating is at B, and Standard and Poor's rating is at BB+. The ratings by Fitch's and Standard and Poor's are classified as non-investment grade, speculative, or junk, while Moody's rating is only slightly better.

- Total long-term obligations of the County, including component units but not pension obligations, were $3.3 billion as of the 2014 fiscal year. Total obligations compared to total Net Position (i.e., debt to equity ratio) were 2.2 (i.e., long-term obligations were 2.2 times the size of the County's Net Position).

- Over the past several years, taxable valuation of real and tangible personal property within the County declined approximately 24 percent, reducing the amount of property taxes received by the County and underlying units of local government. Since 2007, the property tax revenues in the County's General Fund decreased by over $155.7 million, as total General Fund expenditures increased by over $50.0 million.

- For the last several years, County officials had issued tax anticipation notes to meet cash-flow shortages. The amounts borrowed for these purposes were $60.0 million in 2009, $100.0 million in each of the years of 2010 through 2012, $90.0 million in 2013, and $75.0 million in 2014. The prolonged use of short-term borrowing evidenced a declining cash position. County officials projected significant cash shortages of over $100.0 million in its General Fund until September 2015 when the summer property tax levy is collected.

- Total interfund borrowing in fiscal year 2012 was $110.9 million, an increase of $95.5 million from the prior year. The majority of the interfund borrowing, $87.4 million, went to the General Fund. In 2013, total interfund borrowing increased to $148.8 million. Approximately $106.0 million of this amount was owed to other funds by the General Fund, while another $21.4 million was owed by the Juvenile Justice Fund. In fiscal year 2014, total interfund borrowing decreased to $64.7 million. The General Fund owed roughly $39.5 million of that amount to the Delinquent Tax Revolving Fund.

- County officials made significant recurring interfund transfers. For the past five years, County officials transferred from the General Fund to other funds an average of $109.5 million annually. Sixty-seven percent ($73.9 million) of those transfers were to the Juvenile Justice Fund and 13 percent ($14.5 million) were to Non-major Governmental Funds. Over the same period, the average annual transfer out of the Delinquent Tax Revolving Fund was $35.7 million; the majority of those transfers were to the General Fund, ranging from $4.0 million in 2010 to $91.6 million in 2014.

- In September 2011, construction began on a $300.0 million jail to replace and consolidate three aging jail facilities. In June 2013, construction was halted when estimates put the cost of completion at $391.0 million. From May 1, 2014 to April 30, 2015, County officials spent roughly $14.3 million on construction-related debt service and an additional $725,000 for site preservation. It was unclear whether County officials would sell the site or complete the construction.

On June 30, 2015, the State Treasurer submitted the foregoing preliminary review to the Local Emergency Financial Assistance Loan Board. On July 1, 2015, the Local Emergency Financial Assistance Loan Board determined that probable financial stress existed for Wayne County.[5]

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[5] Under the prior emergency management statutes (Public Act 101 of 1988; Public Act 72 of 1990, the Local Government Fiscal Responsibility Act; and Public Act 4 of 2011, the Local Government and School District Fiscal Accountability Act), a preliminary review reached a conclusion regarding whether a serious financial problem or probable financial stress existed in the unit of local government that was subject to the review. However, under the current Act, a preliminary review reaches no such conclusion. Instead, pursuant to Section 4(2) of the Act, "[t]he state financial authority [the State Treasurer or Superintendent of Public Instruction] shall prepare and provide a final report detailing its preliminary review to the local emergency financial assistance loan board... Within 20 days after receiving the final report from the state financial authority, the local emergency financial assistance loan board shall determine if probable financial stress exists for the local government."

B. Review Team Findings

On July 2, 2015, the Governor appointed a five-member Financial Review Team. The Review Team convened on July 7th, 9th, 10th and 17th, 2015.

1. Conditions Indicative of a Financial Emergency

The Review Team found, or confirmed, the existence of the following conditions based upon information provided by County officials or other relevant sources:

- As summarized in **Table 1**, the County's last four annual financial audits reveal notable variances between General Fund revenues and expenditures as initially budgeted, as amended, and as actually realized. For example, in two fiscal years, 2012 and 2013, revenues were overestimated by $12.5 million and $26.5 million, respectively. In addition, County officials underestimated actual expenditures in three of the fiscal years by amounts ranging from $16.7 million to $23.7 million. In general, the amended budgets reflected increased revenues that never materialized, and increased expenditures, but not to the extent of amounts actually expended.

Table 1

General Fund Revenues and Expenditures as Initially Budgeted, Amended, and Actual (In Thousands)

	2011	%	2012	%	2013	%	2014	%
Revenues								
Budgeted	$570,015		$542,227		$643,036		$624,323	
Amended	$563,590		$545,395		$653,445		$542,109	
Actual	$566,811		$532,919		$626,906		$565,086	
Variance	$3,221	0.57	($12,476)	(2.29)	($26,539)	(4.06)	$22,977	4.24
Expenditures								
Budgeted	$461,817		$434,297		$551,215		$579,283	
Amended	$462,884		$436,060		$561,864		$489,452	
Actual	$461,836		$459,761		$578,523		$506,676	
Variance	$1,048	0.23	($23,701)	(5.44)	($16,659)	(2.96)	($17,224)	(3.52)

Source: Annual Financial Audits, 2011 through 2014

- Similarly, as shown in **Table 2**, variances also existed between interfund transfers to and from the General Fund as initially budgeted, as amended, and as actually realized. On the plus side, transfers out of the General Fund were generally less than finally budgeted. In contrast, County officials amended the budgets for three of the years in question to increase the level of transfers in. However, those increased amounts were not realized. For example, in 2014, County officials originally budgeted $73.8 million in transfers into the General Fund. Subsequently, the budget was amended to increase that amount to $138.8 million. Ultimately, only $96.0 million in incoming transfers were realized, leaving the budget $42.7 million short of expectations.

Table 2

General Fund Transfers In and Transfers as Initially Budgeted, Amended, and Actual (In Thousands)

	2011	%	2012	%	2013	%	2014	%
Transfers In								
Budgeted	$1,103		$1,122		$39,245		$73,781	
Amended	$16,979		$130		$69,559		$138,752	
Actual	$16,987		$17,281		$49,045		$96,051	
Variance	$8	0.05	$17,151	131.93	($20,514)	(29.49)	($42,701)	(30.77)
Transfers Out								
Budgeted	$120,194		$109,066		$129,310		$102,377	
Amended	$117,036		$109,479		$129,321		$100,725	
Actual	$115,571		$113,158		$107,756		$82,763	
Variance	$1,465	1.25	($3,679)	(3.36)	$21,565	16.68	$17,962	17.83

Source: Annual Financial Audits, 2011 through 2014

- The structural General Fund deficit cited in the County Executive's June 17, 2015, preliminary review request was not based upon information contained in the County's financial audits. For example, the preliminary review request noted accumulated General Fund deficits of $157.5 million and $88.4 million for fiscal years 2013 and 2014, respectively. In fact, the ending balances in the General Fund in those years were a negative $145.6 million and a negative $73.8 million, respectively ($156.4 million and $82.8 million, respectively on an unrestricted basis).

  Furthermore, the preliminary review request appears to have utilized the terms *accumulated* deficit and *operating* deficit as interchangeable terms, which they are not. A standard definition of an operating deficit is that expenditures exceed revenues. However, as depicted in **Table 3**,

the County's General Fund actually realized operating surpluses during each of the last four fiscal years (i.e., revenues exceeded expenditures). This fact was noted in a July 8, 2015 analysis of the County Commission's Office of Fiscal Agency which stated that "[t]he County ended FY 13-14 (September 30, 2014) with a $58 million [General Fund General Purpose] operating surplus of revenues over expenditures (before transfers)."

Table 3

Statement of General Fund
Revenues, Expenditures, and Change in Fund Balance
(In Thousands)

	2011	2012	2013[6]	2014
Revenues	$566,811	$532,919	$536,624	$565,086
Expenditures	$461,836	$459,761	$488,241	$506,676
Operating Surplus (Deficit)	$104,975	$73,158	$48,383	$58,410
Other Financing Sources (Uses):				
Transfers In	$16,987	$17,281	$49,045	$96,051
Transfers Out	($115,571)	($113,158)	($107,756)	($82,763)
Other	$2,719	$11	--	$75
Total Other Financing Sources (Uses)	($95,865)	($95,866)	($58,711)	$13,363
Special Item	($43,057)	($30,444)	--	--
Net Change in Fund Balance	($33,947)	($53,152)	($10,328)	$71,773
Beginning Fund Balance[7]	($47,934)	($81,881)	($135,238)	($145,566)
Ending Fund Balance	($81,881)	($135,033)	($145,566)	($73,793)

Source: Annual Financial Audits, 2011 through 2014

[6] It should be noted that the County's 2013 financial audit contained different General Fund revenues and expenditures on Page 36 ("Statement of Revenues, Expenditures, and Change in Fund Balances") than on Page 121 ("Budgetary Comparison Schedules"). As a result, fiscal year 2013 General Fund revenues and expenditures in Table 3 do not match those in Table 1.

[7] The beginning Fund Balance for 2013 was restated from a negative $135,033 to a negative $135,238.

However, the Office of Fiscal Agency's qualification "before transfers" is a significant one for two reasons. First, in each of the four fiscal years depicted in **Table 3**, General Fund operating surpluses were more than offset by transfers out of the General Fund to other funds. Second, with the exception of fiscal year 2014, transfers out of the General Fund also exceeded transfers into that fund. Indeed, over the course of the four-year period, transfers out of the General Fund exceeded transfers in by an aggregate of $239.9 million. In short, interfund transfers, and the manner in which County officials amended annual budgets in estimation of them, had a discernible and significant impact upon the County's General Fund year-end balances.

- As depicted in **Table 4**, County officials engaged in unbudgeted expenditures in violation of Sections 17 through 20 of Public Act 2 of 1968, the Uniform Budgeting and Accounting Act.

Table 4

Major Governmental Funds Expenditures
In Excess of Budgeted Appropriations

Program Area	Amount of Unbudgeted Expenditure
County Jail	$14,754,000
County Prosecutor	$2,698,000
Stadium and Land Development	$1,302,000
County Sheriff	$1,028,000
County Executive	$729,000
Heath Programs (Other)	$547,000
Economic Development Corporation	$437,000
Corporation Counsel	$267,000
Medical Examiner	$194,000
Personnel (General Government)	$181,000
Health and Training Programs	$47,000
Sheriff Drug Enforcement	$46,000
Veterans Affairs	$30,000
County Jail (Medical)	$12,000
Community and Economic Development	$2,000
Total Unbudgeted Expenditures	$22,274,000

Source: Annual Financial Audit, 2014

This finding regarding expenditures in excess of budgeted appropriations mirrors one from the preliminary review which, as here, was based upon information contained in the County's 2014 financial audit. In its June 30, 2015, reply to an interim version of the preliminary review, the County Commission took exception to that finding. Having cited a provision of the Uniform Budgeting and Accounting Act, the County Commission's replied thusly:

> The commission, and presumably the CEO's administration, does not interpret this statutory provision to require amendment of the appropriations act based upon precise amounts of financial information disclosed [through the County's financial audit] nearly six months after the end of the fiscal year covered by the appropriations act. However, if authoritative interpretation of this statutory exists to the contrary, the County Commission, and presumably the CEO's administration, stands ready to review and consider it going forward.

The reply of the County Commission misapprehended the point of the preliminary review finding, as well as the relevant requirements of Act 2. As indicated earlier, those provisions of Act 2 require, among other things, that local officials amend an adopted budget to the extent necessary to prevent budgeted expenditures from exceeding available revenues. The requirement is intended to lessen the likelihood of deficit spending.

The preliminary review did not suggest that County officials should have amended the 2014 fiscal year budget based upon subsequent financial audit findings. To the contrary, Section 17 of the Act requires an amendment to occur contemporaneously, "as soon as it becomes apparent that a deviation from the original general appropriations act is necessary and the amount of the deviation can be determined." The preliminary review did no more than what this Review Team report does in regards to the unbudgeted expenditures in question: to confirm their occurrence and the fact that their occurrence violated Act 2.

2. Review Team Meetings

On July 7, 2015, Review Team members Jeffrey S. Bankowski, Thomas M. Davis, Frederick Headen, Sharon L. Madison, and Clarence L. Stone, Jr., met Cary Vaughn, Audit Manager, Local Audit and Finance Division, Bureau of Local Government Services; and with Mark Kettner, of the certified public accounting firm Rehmann Robson, LLC.

On July 9, 2015, Review Team members Jeffrey S. Bankowski, Thomas M. Davis, Frederick Headen, Sharon L. Madison, and Clarence L. Stone, Jr., met with Warren C. Evans, County Executive; Richard Kaufman, Deputy County Executive; Richard Hathaway, Chief Assistant Prosecuting Attorney; Donn Fresard, Chief of Staff; Rosalyn Gibson, Chief of Finance & Administration; Jerome Crawford, Chief of Legislation; Benny N. Napoleon, County Sheriff; Daniel Pfannes, Undersheriff; Robert Dunlap, Director of Jail Classification; Tony Saunders, Management and Budget Director; Mathieu Dube, Deputy Chief Financial Officer; Kevin Haney, Budget Director; Jerome

Pokorski, Assistant Budget Director; Gary Woronchak, County Commission Chairperson; Alisha Bell, County Commission Vice Chairperson; Jewel Ware, County Commission Vice Chairperson; Ray Basham, Tim Killeen, Richard LeBlanc, Martha G. Scott, and Ilona Varga, County Commissioners; Cathy M. Garrett, County Clerk; Patricia Ways, County Clerk's Office; Barbara Johnson, Chief Deputy Register of Deeds; Soumaya A. Harb, Deputy Register of Deeds; David Szymanski, Chief Deputy County Treasurer; Christa McLellan, Deputy County Treasurer; Albert Garrett, President, AFSCME Council 25; Edward McNeil, Special Assistant to the President, AFSCME Council 25; Richard Johnson, Staff Representative, AFSCME Council 25; Wendy Lukianoff, President, AFSCME Local 25; Thomas Richards, President, AFSCME Local 101; Charles Lindenmuth, Vice President, AFSCME Local 101; Levy White, President, AFSCME Local 409; Kimberly Dotch-Heard, Negotiation Team, AFSCME Local 409; Joyce Ivory, President, AFSCME Local 1659; Lenore Davis, Vice President, AFSCME Local 1659; Tina Turner, Negotiation Team, AFSCME Local 1659; Denis Martin, President, AFSCME Local 1862; Christopher Roggero, President, AFSCME Local 2057; Edward Bagdasarian, AFSCME Local 2057; Arash Roshanrouz, President, AFSCME Local 2926; and Eric Lentz, Vice-President, AFSCME Local 2926.

On July 10, 2015, Review Team members Jeffrey S. Bankowski, Thomas M. Davis, Frederick Headen, Sharon L. Madison, and Clarence L. Stone, Jr., met with Zenell Brown, Court Administrator, Third Circuit Court; Violet Leonard, Finance, Third Circuit Court; Tish King, Director, Personnel and Human Resources; Livia Calderoni, Director, Benefits and Disability Administration Division; Teri Dennings, Chief Labor Relations Analyst; Robbin Rivers, Analyst, Labor Relations Division; Brian Manning, Director, Children and Family Services; Thomas Kochis, Director, Health and Human Services, Department of Health, Veterans and Community Wellness; Mouhanad Hammami, Chief of Health Operations; Department of Health, Veterans and Community Wellness; Brian Earle, President, Police Officers Association of Michigan; David LaMontaine, Business Agent, Police Officers Association of Michigan; Zenna Faraj Elhasan, Corporation Counsel; LaToya McBean, Deputy Corporation Counsel; June Lee, Assistant County Executive; Terry Spryszak, Director, Public Services Department; Beverly Watts, Deputy Director, Public Services Department; Rosalind F. Downer, Finance, Public Services Department; Ken Kucel, Director, Public Services Department and Wayne County Drain Commissioner; Lawrence Verbiest, Association Executive, Government Administrators Association; Lorenzo Blount, Government Administrators Association; Amy Miller Vandawalker, President, Government Administrators Association (Professional Engineers Chapter); Daniela Frederick, President, Dietitians & Nutritionists Association; Tom Scott, Eastern Director, International Union of Operating Engineers, Local 324; Elizabeth Patterson, President, Government Administrators Association (Wayne County Professional Nurses Association); Cassandra A. McDonald, President, Government Administrators Association (General Fund); Margaret Reyes-Howard, Government Administrators Association; and Patricia Pena, Government Administrators Association.

Also, on July 10, 2015, Review Team members Jeffrey S. Bankowski, Thomas M. Davis, Frederick Headen, Sharon L. Madison, and Clarence L. Stone, Jr., conducted a public information meeting in Wayne County pursuant to Section 5(2) of the Local Financial Stability and Choice Act. Review

Team members discussed with approximately 45 County residents in attendance the statutory process, indicated that Review Team members had met with various County and union officials, and received comments from approximately 12 County residents.[8]

3. Other Considerations

In addition to the foregoing findings, the Review Team offers the following in support of its conclusion that a financial emergency exists within Wayne County:

a. County Government.

The application of Public Act 436 of 2012, the Local Financial Stability and Choice Act, to Wayne County poses issues of first impression. While Act 436 is the fourth financial emergency management statute enacted since 1988, none of them have been applied to county government until now. Therefore, insights gained from prior statutory applications to other categories of local government offers few, if any, reliable guideposts here.

County government is, in certain respects, unique among local governments in this State. Counties originated, in part, as an administrative extension of State government. Furthermore, several departments of county government are headed by separately elected officials whose offices are enumerated in the State Constitution. These are: a Clerk, Prosecutor, Register of Deeds, Sheriff, and Treasurer. It should be noted that the State Constitution merely established these offices; it did not enumerate their respective duties and powers, leaving that to the Legislature to provide by law.[9] However, some of the case law construing Section 4 of Article 7 of the State Constitution has, in respect to County Prosecutors and Sheriffs, rendered ambiguous what was plain constitutional text.

The Michigan Court of Appeals has held that "[w]hen officers are named in the Constitution they have a known legal character. The Legislature may vary the duties of a constitutional office, but it may not change the duties so as to destroy the power to perform the duties of the office." *Brownstown Township* v *Wayne County*, (68 Mich App 244, 248; 1976), citing *Allor* v *Board of County of Wayne*, (43 Mich App 76; 1880). Likewise, Michigan courts have held that the powers and duties of county prosecutors include not just those set out in statute, but also those functions that may be necessarily implied from those specifically mentioned. *Bloss* v *Williams*, (15 Mich App 228, 233; 1968).

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[8] The Review Team also gave consideration to correspondence submitted to State officials by an official of the Detroit Wayne Mental Health Authority.

[9] Section 4 of Article 7 of the Michigan Constitution provides that "[t]here shall be elected for four-year terms in each organized county a sheriff, a county clerk, a county treasurer, a register of deeds and a prosecuting attorney, whose duties and powers shall be provided by law. The board of supervisors in any county may combine the offices of county clerk and register of deeds in one office or separate the same at pleasure."

The fact that certain county offices are constitutionally based can pose administrative and operational challenges not found in other local governments. Consider annual budget formulation, adoption, and monitoring, for example. Separately elected county officials may have views regarding how much funding is necessary to discharge their legally required responsibilities, views that may differ from those of the county's chief administrative officer who proposes a budget, or the board of commissioners which enacts it, or both. In turn, separate election and constitutional antecedents may imbue such an official with a degree of independence regarding his or her budget once enacted that renders centralized monitoring and enforcement of budgetary constraints more difficult. In the case of the Wayne County Sheriff and Prosecutor, budgetary differences with the County Executive and County Commission often have been resolved through litigation.

b. Retirement System Judgment Levy.

On May 29, 2015, the Wayne County Circuit Court entered a $49.3 million judgment against the County in the case of *Wayne County Employees Retirement System* v *the Charter County of Wayne*.

The litigation resulted when County officials removed $32.2 million from an Inflation Equity Fund and applied that amount as an offset against the annual required contribution by the County to its defined benefit pension system. The Inflation Equity Fund was the source from which the so-called thirteenth checks were remitted to County retirees and other beneficiaries.

Background. The County Commission established the Inflation Equity Fund by ordinance effective on July 24, 1986. The purpose of the fund was "to address the impact of inflation on the buying power of pension income." Therefore, the board of trustees of the County's Retirement Commission were authorized not more often than once a year to "distribute to retired members and survivor beneficiaries a percentage of the balance in the [fund]."

The amount credited to the fund at the end of a fiscal year was based upon investment earnings in the County's defined benefit pension system in excess of a threshold rate of return, multiplied by the actuarial present value of defined benefit pension system assets.[10] For example, between 1986 and 2009, $293.2 million was credited to the fund, and this despite the fact that the County's defined benefit pension system was underfunded.

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[10] In *Wayne County Employees Retirement System and Wayne County Retirement Commission* v *Charter County of Wayne and Wayne County Board of Commissioners*, decided on May 9, 2013, the Michigan Court of Appeals described the process as follows:

> The actuarial present value of the [County's] pensions was $611,233,276 in 1998. The actual rate of investment return on the actuarial value of retirement system defined benefit assets was 10 09 percent. The threshold rate of investment return set by the Retirement Commission was 8 percent. The excess rate of return therefore 2.09 percent, which is multiplied by the actuarial present value of the pensions (was $611,233,276). The product is $12,774,775, which was the amount credited to the [Inflation Equity Fund] in 1998.

However, by the end of the County's 2010 fiscal year, due to financial difficulties within the County, the County Commission adopted an ordinance that modified the Inflation Equity Fund in two material respects. First, the amount of fund proceeds that the County's Retirement Commission could distribute to retirees and beneficiaries was limited to no more than $5.0 million per year. Second, the balance in the fund was limited to a maximum of $12.0 million. The balance in the fund at the time was approximately $44.0 million. Therefore, one effect of the ordinance was to authorize the transfer of the $32.2 million "excess" to the County's defined benefit pension system and to credit the amount against the County's annual required contribution.

In May 2013, the Michigan Court of Appeals concluded, among other things, that the $32.2 million transfer from the Inflation Equity Fund to the County's defined benefit pension system violated State law. On appeal, the Michigan Supreme Court, in December 2014, reached the same conclusion, but upon the more nuanced basis that the transfer violated the "exclusive benefit rule" of Public Act 314 of 1965, the Public Employee Retirement System Investment Act.

The Supreme Court returned the matter to the Wayne County Circuit Court for entry of monetary judgment. The requirement that the $32.2 million be returned to the Inflation Equity Fund, together with interest lost to the fund due to the transfer, resulted in an aggregate judgment of $49.3 million.

Since the County lacked the financial ability to remit the judgment from existing resources, County officials acceded to having an amount placed upon the tax rolls of the County pursuant to Section 6093 of Public Act 236 of 1961, the Revised Judicature Act of 1961. As a result, the judgment is being collected from County property taxpayers during the summer 2015 property tax levy.[11]

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[11] Among the conditions in Section 4(1) of the Local Financial Stability and Choice Act that the County Executive's June 17, 2015, request for preliminary review asserted had occurred, was that of subdivision (o) which states that "[a] court has ordered an additional tax levy without the prior approval of the governing body of the local government." In its June 30, 2015, written reply to the interim version of the preliminary review, the County Commission asserted that the condition in subdivision (o) had *not*, in fact, occurred because an additional tax levy had not been ordered by a court.

The assertion of the County Commission is correct. The Wayne County Circuit Court entered a $49.3 million judgment against the County, but did not order that the judgment be paid by means of a judgment levy. However, the fact that the judgment was placed upon the County's tax roll by County officials rather than by a court misses the larger point: due to financial mismanagement by County officials, County residents are paying millions of dollars more in property taxes this summer than otherwise would have been the case.

It is noteworthy that one County official stated to the Review Team that "[w]hat's more, the levy, when collected, will satisfy and pay the judgment with this new revenue stream and therefore will not constitute any burden on county finances." The statement reflects no recognition of the fact that repayment of the amount in question will not be a burden on *county* finances only because County officials transferred that burden to County *taxpayers'* finances.

c. Wayne County Jail.

The Jail Division of the Wayne County Sheriff's Department presently operates three detention facilities: the Andrew C. Baird Detention Facility, the Old Wayne County Jail, and the William Dickerson Detention Facility. According to information from the Sheriff's Department, the three facilities in the aggregate house an average daily population of approximately 2,200 individuals. This is despite the fact that existing court orders or consent orders limit the daily population to less than 1,800 individuals.

State law requires that each county provide a suitable and sufficient jail and places custody of the jail in the County Sheriff. [12] In 2011, Wayne County officials appear to have arrived at a consensus that the County's jail was neither suitable nor sufficient. Therefore, County officials approved the construction of a new jail facility, together with the issuance of $300.0 million in bonds to finance its construction. Approximately $200.0 million in bonds were issued (authorization for the remaining $100.0 million lapsed) and roughly $150.0 million was expended.

However, on August 15, 2013, the Wayne County Building Authority voted to discontinue further work on the partially constructed new jail facility due to approximately $47.0 million in cost overruns. County officials initiated litigation, which is ongoing, against the contractor and project manager. The status of the partially constructed jail remains an ongoing financial concern for several reasons. First, annual debt service upon the bonds that were issued is approximately $14.3 million. Second, there seems to be agreement among County officials that the existing detention facilities are inadequate in certain respects.

Therefore, County officials continue to be confronted by a Hobson's choice: either expend funds to complete the partially constructed jail or renovate the existing detention facilities. Some County officials estimated that the cost of the former option would be several hundred million dollars due, in part, to the fact that the partially constructed jail has deteriorated from exposure to the elements over the two years since construction was halted. Furthermore, there is general agreement that the partially constructed jail as designed would not provide the Sheriff's Department with the capacity required to house even the existing jail population. Of manifest concern to the Review Team was the fact that there appeared to be no consensus among County officials about how to proceed regarding this issue.

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[12] Section 16 of the Revised Statutes of 1846 provides, in part, as follows:

> Each organized county shall, at its own cost and expense, provide at the county seat thereof a suitable courthouse, and *a suitable and sufficient jail* and fireproof offices and all other necessary public buildings, and keep the same in good repair. Emphasis supplied.

Section 75 of the Revised Statutes of 1846 provides that "[t]he sheriff shall have the charge and custody of the jails of his county, and of the prisoners in the same; and shall keep them himself, or by his deputy or jailer."

d. Jail Operations Overtime.

The decision making process utilized by County officials has proven problematic. For example, for several years staff of the Sheriff's Department has logged considerable overtime in regards to jail operations. Some estimates provided to the Review Team presently place the amount of overtime at nearly 1,000 hours per day.

The reasons for the amount of overtime appear to be several: too few officers; inadequate compensation and insufficient opportunities for advancement, making it difficult to recruit and retain high quality employees; unsavory working conditions within the existing detention facilities; the fact that individuals are hired as police officers, but essentially perform the duties of corrections officers; and, candidly, the impact upon final average compensation, and therefore pension benefits, of those who work overtime.

The Review Team discussed this issue with a number of County and union officials. Not one of them disagreed that it would be more prudent to hire additional officers than to continue to pay exorbitant overtime. Indeed, some of those officials indicated having done, or reviewed, analyses of how many new officers could be retained (even at increased rates of pay) without a net increase in costs because of offsetting savings that would be realized from decreased overtime. Furthermore, several officials noted that hiring additional officers might improve the quality of services provided in the existing detention facilities by reducing the amount of fatigue and burnout resulting from long hours in stressful working conditions.

Nevertheless, despite recognition of the problem of overtime, and despite general agreement among County officials in regards to possible solutions, the problem remains. County officials have been unable to convert recognition and agreement into an effective course of action to resolve the problem.

e. Retirement System.

As noted in the preliminary review, the County's retirement system was significantly underfunded, at approximately 45 percent as of September 30, 2013. (According to County officials, the funding level increased to 47 percent as of September 30, 2014.) However, as recently as 2004, the funding level was at more than 90 percent. A number of events led to present circumstances, including underperforming investments, a lack of effective oversight, increased payrolls, a multiplicity of different plans, and generous incentives for early retirement that waived age requirements and enabled eligible persons to purchase years of service at discounted rates.

The Review Team was informed that one of the unions with which the County bargains has proposed that County officials transfer administrative, managerial, and investment responsibilities for the retirement system to the Municipal Employees Retirement System of Michigan. While the Review Team expresses no opinion upon the merits of the proposal, there is no indication that County officials have to date given the matter serious consideration.

In addition, the County's obligation for Other Post-Employment Benefits (i.e., healthcare coverage for County employees and retirees) is significant. According to the County Executive's Recovery Plan, unfunded healthcare-related liabilities were estimated to be $1.3 billion as of the last actuarial valuation. Furthermore, funds that have been set aside for this purpose amount to less than one percent of liabilities. Indeed, the Recovery Plan noted that healthcare-related liabilities represent 40 percent of the County's long-term financial obligations. Yet, despite the financial significance of this matter, County officials have made no discernible effort to resolve it.

f. Ineffective Communication.

There appears to have been, and remains, a lack of effective communication, both within the administrative structure of the County and between that structure and the County Board of Commissioners. For example, several Commissioners advised the Review Team that they learned through the media of the decision by the County Executive to transmit the June 17, 2015, request for a preliminary review to the State of Michigan. Given the significant role that the County Commission will play in the resolution of the County's financial woes, the reason for such an oversight in communication was not readily apparent to the Review Team.

Likewise, numerous union officials indicated that they had offered various suggestions to improve the County's financial and operational condition. These included concessions in the form of counterproposals. These counterproposals were made either directly to County officials or indirectly to labor relations staff representing County officials. However, union officials indicated that they had received no meaningful response. The Review Team expresses no opinion concerning the merits of the various suggestions and counterproposals. However, the apparent inability of County officials to offer meaningful responses further underscores a lack of effective communication.

C. Conclusion

Based upon the foregoing information, meetings, and review, the Review Team confirms the findings of the preliminary review, the determination of the Local Emergency Financial Assistance Loan Board, and concludes that a financial emergency exists within Wayne County.

II. Section 5(3) Requirements

Section 5(3) of the Act requires that this report include the existence or an indication of the likely occurrence of any of the conditions set forth in subdivisions (a) through (m).[13] The conditions in subdivisions (b)(*iii*), (e), and (k) of Section 5(3) exist or are likely to occur, as follows:

- As noted in the preliminary review, the County's primary pension plan had a funding level of 45.1 percent and had a liability of $910.5 million based upon the actuarial valuation dated September 30, 2013. The funding level increased to 47 percent as of September 30, 2014, according to the County Commission's Office of Fiscal Agency. (Section 5(3)(e).)

- The County had a cumulative General Fund deficit of $73.8 million as of September 30, 2014, which will not be eliminated within the two-year period preceding the end of the fiscal year of the County during which this Review Team report is received. (Section 5(3)(b)(*iii*).)

III. Review Team Report Transmittal Requirements

Section 5(3) of the Act also requires that a copy of this report be transmitted to the Wayne County Executive, County Commissioners, the Speaker of the House of Representatives, the Senate Majority Leader, and each State Senator and Representative who represents Wayne County.

cc: Warren C. Evans, County Executive
Wayne County Board of Commissioners
Kevin Cotter, Speaker of the House of Representatives
Arlan B. Meekhof, Senate Majority Leader
Michigan Senators representing Wayne County
Michigan Representatives representing Wayne County

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[13] Subdivisions (a) through (m) of Section 5(3) of the Act provide as follows:

> (a) A default in the payment of principal or interest upon bonded obligations, notes, or other municipal securities for which no funds or insufficient funds are on hand and, if required, segregated in a special trust fund.
>
> (b) Failure for a period of 30 days or more beyond the due date to transfer 1 or more of the following to the appropriate agency:
>
> (*i*) Taxes withheld on the income of employees.
>
> (*ii*) For a municipal government, taxes collected by the municipal government as agent for another governmental unit, school district, or other entity or taxing authority.
>
> (*iii*) Any contribution required by a pension, retirement, or benefit plan.

- During the current fiscal year (May 2015), County records reflected a negative cash balance in the General Fund of $170.3 million. Stated another way, the General Fund owed other County funds, including some restricted funds, an aggregate of $170.3 million. (Section 5(3)(k).)

(c) Failure for a period of 7 days or more after the scheduled date of payment to pay wages and salaries or other compensation owed to employees or benefits owed to retirees.

(d) The total amount of accounts payable for the current fiscal year, as determined by the state financial authority's uniform chart of accounts, is in excess of 10% of the total expenditures of the local government in that fiscal year.

(e) Failure to eliminate an existing deficit in any fund of the local government within the 2-year period preceding the end of the local government's fiscal year during which the review team report is received.

(f) Projection of a deficit in the general fund of the local government for the current fiscal year in excess of 5% of the budgeted revenues for the general fund.

(g) Failure to comply in all material respects with the terms of an approved deficit elimination plan or an agreement entered into pursuant to a deficit elimination plan.

(h) Existence of material loans to the general fund from other local government funds that are not regularly settled between the funds or that are increasing in scope.

(i) Existence after the close of the fiscal year of material recurring unbudgeted subsidies from the general fund to other major funds as defined under government accounting standards board principles.

(j) Existence of a structural operating deficit.

(k) Use of restricted revenues for purposes not authorized by law.

(l) The likelihood that the local government is or will be unable to pay its obligations within 60 days after the date of the review team's reporting its findings to the governor.

(m) Any other facts and circumstances indicative of local government financial emergency.

Exhibit 4

Base Wage History - Starting Pay Corrections Deputy
(10/1 of each year)

County	2017	Rank	2018	Rank	2019	Rank	2020	Rank	2021	Rank	2022	Rank	2023	2024
Macomb 1/	$45,783	2	$46,698	2	$47,165	2	$48,418	2	$49,386	1	$50,374	1	exp 12/31/22	
Monroe (hired prior to 1/1/11) 2/	$40,098	3	$40,491	3	$40,906	3	$41,321	3	$43,549	2	$46,061	2	$48,659	$51,106
Oakland CD I* 3/	$37,420	5	$38,543	4	$39,314	4	$40,101	4	exp 9/30/21					
Washtenaw 4/	$37,157	6	$37,904	6	$38,666	6	$38,859	7	$39,735	5	$40,629	5	Reopener	Reopener
AVERAGE	**$40,115**		**$40,909**		**$41,513**		**$42,175**		**$44,223**		**$45,688**		**$48,659**	**$51,106**
Wayne 5/	**$31,183**	**7**	**$31,183**	**7**	**$35,687**	**7**	**$38,916**	**6**	**$40,862**	**4**	**$42,905**	**4**	**exp 9/30/23**	
Wayne Below Avg	**$8,932**		**$9,726**		**$5,826**		**$3,259**		**$3,361**		**$2,783**			
Monroe (hired on or after 1/1/11) 2/	$38,089	4	$38,460	5	$38,853	5	$39,247	5	$41,409	3	$43,833	3	$46,344	$48,681
Oakland CD II 3/	$50,491	1	$52,005	1	$53,045	1	$54,106	1	exp 9/30/21					

Source: Collective Bargaining Agreements

*The overwhelming majority of Corrections Deputies are currently in the Corrections Deputy I rank.

1/ A $2,100 lump sum payment was received in 2017 and $1,000 in 2018.

2/ Work 2,184 hrs p/year

3/ Oakland County has a very lucrative TA that has been ratified by the BU but not yet by the County. It combines the road & corrections Deputies to an approximate new DI starting wage 10/1/21 of $43,790 and DII of $58,819 (plus a $3,250 retention bonus, 10/1/22; DI: $45,542 DII: $61,172, 10/1/24: DI: $46,908 DII: $63,007, 10/1/25 & 10/1/26: 2% w/ Me too w/ general non-represented employees.

4/ 2% ($1,176) non-structural (not rolled into base) increase 1/1/17 and .5% ($311) in 2020.

5/ $650 bonus received on 10/1/16 prospectively (plus $650 - $1,300 depending on Healthcare contract) + a one time retention bonus of $1,500 in 2020. Additionally, steps to maximum pay reduced from 8 to 6 effective 10/1/19

Exhibit 5

In-Service Training

Once employed by an agency and MSCTC Corrections Certified, all full or part-time Corrections Officers must complete a minimum of 20-hours of In-Service Training to maintain their Corrections Certification. The 20-hour yearly In-Service Training requirement must be comprised of:

1. At least 3 training topics,
2. 2-hours of Mental Heath Training,
3. No more than 5-hours in firearms training.

Please see below for a list of approved MSCTC In-Service Training Topics.

Please Note: *Completing the 160 hour Local Corrections Officer Academy or the 96 hour Re-Entry/Core Training program will satisfy the In-Service training requirement for the calendar year in which the Academy or Re-Entry/Core Training is completed.*

- Blood Borne/Airborne Pathogens

- Body Worn Cameras and Video Surveillance Equipment
- Bomb Threat
- Cell Extraction
- Chemical Agents
- Computer Training
- CPR/First Aid
- Correctional Law
- Corrections Staff Management/Supervisory Training
- Critical Thinking
- CTO Training
- Cultural Diversity
- Custody & Security
- Danger Zone Defensive Tactics
- Defensive Tactics
- Direct Supervision Concepts
- Disaster Plan Training
- Domestic Violence
- Driver Training
- Drug Recognition
- Electronic Control Devices
- Ethics
- Evidence Technician/Collection
- Firearms (Max. of 5 hours per year)
- Fire Safety
- Gang
- Inmate Behavior
  - Autism Training
- Inmate Classification
- Inmate Disciplinary Process
- Inmate Supervision
- I.P.C.
- Jail Evacuation
- Medical Administration (required by NCCHC accreditation)
- Medical Confidentiality (H.I.P.A.A.)
- Mental Health
- M.S.D.S./Hazardous Materials
- P.B.T.'s
- Policy & Procedure Updates
- PREA
- Prisoner Transport/Management
- Radio Training
- Receiving & Screening
- Report Writing
- Riot Control
- Stress Management
- Suicide Awareness
- Universal Precaution
- Workplace Harassment

Contact Us

Exhibit 6

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09-08-20	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	09-09-20	900-01

Homicide

On 09-08-2020, I went to Division 2 to extract video data from a camera on Ward 404. I was able to successfully extract and export the requested data, all data was turned over to Internal Affairs Captain Fredryn Allen.

Incident No. 10530-20

File Class: 900-01

Page	Investigated By	Officer's Signature	Reviewed By
1 of 1	Britton Foreman		#75

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09-08-20	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report: 09-09-20	Primary File Class: 900-01

Homicide

On 09-21-2020, I was asked to give and explanation on why the Bosch Video Management System at Division Two is experiencing technical issues with it's video cameras (both analog and digital) and its recordings from the VMS it's self. I have spent time triaging the VMS at Division Two attempting to gain an insight on what is happening. I have discovered that there are a multitude of issues that are happening with the system not just a singular one. I have also discovered that this system has probably never worked entirely correctly since Wayne County Building's had Cornerstone Detention Install the system approximately in 2018 .

One of the 8 T.B Ray hard drives were bad when I went back into the server room. I had replaced and reformatted a new 8T.B hard drive,
this is a common regular general maintenance.

The main issue is the fact that the recording are missing packets (data) at time when there should be data, Now the cameras are set up for Motion +. That means that when the camera's detects motion the VMS starts to record 10 seconds before the alarm (Motion). So, with that said there will be time's on the VMS where there is no data recorded because there is no alarm setting it off. The problem inlays where there is a alarm and it is recording and then the [illegible] drop off and then some time goes by and then it picks it back up and then drops back off again.

Most of the cameras (416) at Division Two are older analog [illegible] the VMS is a digital system. So, in order to get the analog cameras onto the VMS we have what is called Bosch Video [illegible] what these encoders do is 16 analog cameras plug into the encoder and the encoder is assigned [illegible] from 1-26) that I.P communicates and takes the analog converts it to digital [illegible] encoders firmware wasn't communicating well with the VMS so [illegible] this seemed to help out a bit but we are still having the same issue recurring [illegible]

Another issue that is happening is some of the ( ) of the older analog cameras are having image stabilization issues causing alarms for those cameras to go off 24/7. This is putting unneeded processing [illegible] on the VMS causing possible resource speed and issues on the server. I have identified 14 newer analog cameras that I will work towards replacing the really bad analog cameras.

I have engaged Com-Tech who is the vendor who had built Cornerstone Detention [illegible] through the issues with them on this system and also have engaged Bosch directly. One issue is a known problem that we may need to upgrade to BVMS version 8.0 or higher. Version 7.5 (the [illegible] version) we are on [illegible] some of these issues we are experiencing. In order to upgrade our version I need to get [illegible] we have and the licenses we have are upgradeable. Com-Tech is looking into this right now [illegible]

Page	Investigated By	Officer's Signature	Reviewed By
1 of 1	Britton Foreman		Sgt. Fredon Allen #75

Incident No. 10530-20

File Class: 900-01

Exhibit 7

STATE OF MICHIGAN

IN THE THIRD JUDICIAL CIRCUIT COURT FOR THE COUNTY OF WAYNE

Wayne County Jail Inmates, et al.,
Plaintiff,

v.

Case No. 71-173217-CZ
Hon. Timothy M. Kenny

William Lucas, et al.,
Defendants.
_____/

OPINION & ORDER

At a session of this Court
Held on: February 8, 2022
In the Coleman A. Young Municipal Center
County of Wayne, Detroit, MI

PRESENT: Honorable Timothy M. Kenny
Chief Judge
Third Judicial Circuit Court of Michigan

The Wayne County Sheriff moves this Court to declare that staffing emergencies within the Wayne County Jail constitute a departmental emergency pursuant to the Consolidated Consent Order and Settlement Agreement (Order). He seeks to have the Court declare a Sheriff's departmental emergency to order non-jail assigned deputies to work overtime as needed at Wayne County Jail facilities. Plaintiffs, Wayne County Jail inmates and defendant, Wayne County Executive concur with the Sheriff's motion. The Wayne County Board of Commissioners take no position due to an absence of sufficient information to form a response to the motion.

On July 20, 2018 this Court signed a Consolidated Consent Order and Settlement Agreement (Order) document. It consolidated all previous orders and amendments into one updated document. The Order specifically set forth a number of enumerated rights and responsibilities of the Wayne County Sheriff and his staff. It is important to note page 4 of the Order, Section I B (3) states as follows:

"The parties agree that paragraph 12 of the 11/16/2005 Consent Order and Settlement Agreement reads as follows:

> The case captioned *Wayne County Jail Inmates, et al. v William Lucas, et al.*, Civil Action No 71-173-217-CZ, shall be and is hereby dismissed with prejudice; provided, however, that this Court shall retain jurisdiction for the purpose of enforcing the terms and provisions of this Consent Order and Settlement Agreement, including all orders and terms of settlement set forth or described herein, all of which shall have the force and effect of permanent injunctive orders. Further, all parties stipulate and agree, and the Court finds, that the orders set forth in this Consent Order and Settlement Agreement are necessary, <u>are narrowly drawn</u>, and are the least intrusive means necessary to prevent violations of constitutional rights." (Emphasis added).

The Order authorizes the Wayne County Sheriff to re-deploy deputies assigned to the Wayne County Jail to assignments outside the jail on a temporary basis when certain temporary conditions require Sheriff's personnel to be deployed elsewhere in order to carry out the Sheriff's constitutional or legislatively mandated responsibilities, Section II B 2 (a).

The Order also provides that the Sheriff must maintain an appropriate staffing level depending upon the inmate population, Sections II A (3) and II B (1). The inability to comply with the requirement set forth in the Order results in the Wayne County Sheriff declaring a staffing emergency.

Since late November, 2021 the Sheriff has had to declare over 20 staffing emergencies due to an inability to have sufficient deputy sheriffs in the jail. The inability to provide sufficient staff has, according to the motion, been as a result of the Wayne County Sheriff's deputies' union taking the position that deputies not assigned to work inside any of the jail facilities cannot be mandated to work overtime at the jail. The union cites a November 15, 2021 arbitration ruling that deputies' assigned to the Third Circuit Court cannot be forced to work jail overtime pursuant to the provisions of the Collective Bargaining Agreement with the Sheriff's Department.

Clearly, there is a need to provide additional deputy personnel at the jail in order to maintain the needed staffing levels for the current jail population. Current staffing levels at the jail particularly harmed by the COVID pandemic, FMLA and sick calls indicate that maintaining required jail staffing for all three shifts will be extraordinarily challenging.

Although the motion seeks to have the Court declare a departmental emergency, authority exists within the Order as well as the Collective Bargaining Agreement between the Wayne County Sheriff's Department and the deputies' union to permit the Sheriff to declare a departmental emergency and address the personnel challenges. While the Wayne County Sheriff seeks to have the Court order a departmental emergency in order to achieve the required staffing levels as set forth in the Order, the "narrowly crafted orders" of the Consolidated Consent Order and Settlement Agreement

do not expressly authorize the Court to declare a "departmental emergency" at the Wayne County Sheriff's Department. Nowhere in the July 20, 2018 Order is there reference to the Court declaring a departmental emergency. However, the Order does provide the Wayne County Sheriff with the authority to temporarily re-deploy staff in order to meet the circumstances that currently exist during the pandemic. Specifically, under Section II STAFFING B 2 (d) states:

"The provisions above do not limit the Sheriff's ability to temporarily re-deploy staff for a limited time due to unforeseen emergencies or circumstances outside of the jail, such as natural or public health disasters, power blackouts, terrorist attacks, riots, mass demonstrations, hazardous material spills, airplane crashes, a threat to the life or health of a public official, or relief of a governmental agency's special response unit in an extended barricaded gunman situation." (Emphasis added)

Additionally, article 17.1 A and G of the Collective Bargaining Agreement between the Sheriff's Department set forth circumstances under which a departmental emergency may be declared. Section 17.1 A states:

"An employee's assigned work hours shall not be changed once the 28-day schedule has been posted, except by mutual agreement between the officer and the division commander, or in the event of a stated or unanticipated departmental emergency situation, or upon a ten (10) day notice to the officer by his or her divisional commander." (Emphasis added)

Additionally, Subsection G states in part:

"It is expressly understood that no officer will be ordered to work in excess of 56 hours in any one (1) week, except in departmental emergencies." (Emphasis added)

Based upon this Court's review of the Consolidated Consent Order and Settlement Agreement and the language of the pertinent portions of the Collective Bargaining Agreement between the Sheriff's Union and the Wayne County Sheriff's Department, the authority to declare a departmental emergency rests with the Sheriff and not with the Court.

The Sheriff's Department is required to comply with the staffing requirements as set forth in the 2018 Consolidated Consent Order and Settlement Agreement. It is left to the Sheriff to determine how those staffing requirements will be met.

The motion for the Court to declare a departmental emergency in the Sheriff's Department is DENIED.

February 8, 2022
Date

Hon. Timothy M. Kenny
Chief Judge
Third Judicial Circuit Court of Michigan

Exhibit 8

[redacted]

Exhibit 1

10/19/20

Exh 1

Wayne County Sheriff's Office
Jail Division II

Divisional Directive

To: All Jail Division II Personnel
From: [redacted]
Date: August 18, 2020
Re: Staff Entering Occupied Housing Units ***(COJ2 20-02)***

This directive is to document and confirm the existing practice of when staff members are allowed to enter occupied housing units at Jail Division II. Staff may only enter occupied housing units under one of the below conditions:

1. All inmates on the ward have been locked in their cells. Officers may enter the housing unit, as long as they have an officer occupying the gate and control box area on the outside of the housing unit. The officer entering the housing unit shall leave their keys with the officer that is covering the entrance, and control box. The officer entering the ward shall check each cell door manually on their way down the ward to ensure that they are secure. An example of this would be preforming the headcount, card and armband verification check, or lock down at 2200 hrs.

2. A supervisor is on scene and has authorized the entrance. This shall only be done with the sufficient manpower to control the situation. An example of this is conducting a security inspection.

3. An emergency code situation. In order to protect and save lives, in life-threatening situations officers shall enter housing units, where calls for assistance, and duress alarm activation have occurred. Officers shall wait for necessary man power to enter and secure the housing unit, leaving an officer to control the gate and control box area. Officers shall leave their keys with the officer that is covering the control box and gate area, before entering the housing unit. Every responding officer shall document in their report their role in the emergency response. An example of this is a suicide attempt or assault situation.

[redacted]

Jail Division II

Exhibit 2

10/19/10 [redacted] email

POST ORDERS JD2 09-02
Revision Date: 5/1/09

GENERAL TOPIC: Post Orders
SPECIFIC TOPIC: Duty Station - Afternoons

PURPOSE

The purpose is to provide officers with an overview of job responsibilities for assignments to Division II Floor Security assignments.

STATEMENT

The Wayne County Sheriff's Department is committed to providing its officers with guidance and direction in performance of employment duties through the use of Departmental Rules and Regulations, including, but not limited to:

* Departmental General Orders/Memoranda
* Standard Operating Procedures
* Jail Rules and Regulations
* State and Local Law
* County Civil Service Rules

Further, departmental supervisory personnel are always available to provide on site supervision and direction where appropriate.

As with this divisional memo, policies and procedures provide officers with relevant information necessary to fulfill departmental expectations.

PROCEDURE

1.0 Introduction

The Duty Station Officer is an integral component of the overall security of the jail. The Duty Station officer is a member of the floor security team that on each floor ensures that the interior of their floor is secure.

2.0 Reporting for Duty

.01 All assigned Duty Station Officers must report for duty on time and in proper uniform. See Standards of Conduct 4.15

.02 Officers are required daily to complete the departmental payroll time card. See 88-6 and 02-06 Completing Time Cards and Receiving Overpayment.

Pg 6 info

.03 Communicate with previous shift for information on events or problems that may require attention and/or follow-up.

.04 Read and follow Duty Station post orders. Be held accountable for the completion of all duties specified in the floor security post orders.

.05 Conduct a prep radio check with the front desk to ensure prep radio is working.

.06 Officers assigned to each duty station are to log in on duty in the post activity section on the IMS computer.

3.0 General Instructions

.01 Officers shall observe the chain of command and paramilitary protocol at all times.

.02 Officers shall check for the appropriate duty station Jail Operations Manual, log book and all emergency equipment, universal precautions kit, AMBU bag, self-contained breathing apparatus (SCBA) fire extinguishers, fire hoses, fire blanket, clean-up kit and a prep radio. Officers shall enter the condition of the above mentioned emergency equipment on the post check off section on the IMS computer and additional information enter in the browse post notes.

.03 Officers shall indicate in the post notes any key rings in use at the Duty Station and document which key rings are assigned to a particular officer.

.04 Officers shall make an IMS Activity Log entry for each event or activity that occurs. See Divisional Directive 01-03 INMATE MANAGEMENT SYSTEM ENTRIES.

.05 Officers assigned to this post are responsible for maintaining a secure, safe and sanitary environment for staff and inmates.

.06 Officers assigned shall keep the Duty Stations secure and not allow inmates to congregate or loiter in the Duty Station area.

.07 Officers assigned shall keep the Duty Stations and hallways clean and free of any items that are not required.

.08 Officers assigned shall ensure that the inmate housing units are kept clean and that no soiled linens, mattresses or garbage bags are left on the floor.

.09 Officers assigned shall enter all items or equipment issued to inmates into the IMS. See Divisional Directive 01-03.

.10 Officer assigned shall not leave the floor for any reason, unless authorized by command staff or for the purpose of responding to codes as specified in emergency policies and procedures.

.11 Officers shall not conduct any inmate disciplinary moves unless a sergeant is present.

.12 Officers shall respond to all codes specified in emergency policies and procedures.

.13 Officers shall complete all reports before going off duty.

.14 Officers shall not leave a duty station until they have been properly relieved of duty by another officer.

.15 Officers shall identify and report any facility maintenance issues or malfunctioning or defective equipment on a work order.

.16 Officers shall provide security and supervise inmate behavior on the wards.

.17 Officers shall conduct searches of all inmates and their property prior to placing the inmates on the ward.

.18 Log the name and number of inmates leaving or returning and the reason for the move to or from the wards in the IMS computer.

.19 Officers will assist in medical service delivery by escorting the nurse or removing an inmate for a medical treatment at the request of a nurse.

.20 Officers shall follow the inmate mail policy when retrieving or distributing inmate mail.

.21 Officers shall maintain the necessary supply of inmate forms and distribute them upon request.

DUTY STATIONS

HOURS OF DUTY AFTERNOONS

1500 - 2300	Sunday through Saturday

REQUIRED OFFICER EQUIPMENT

Appropriate Departmental Uniform
Handcuffs and Key
Black Ballpoint Pen
Flashlight
Identification
Micro-Shield
Small Note Pad

AFTERNOON SHIFT DUTY STATION ASSIGNMENTS

1500: Shift Change on Post:

4.0 Duty Station Officer

.01 Be briefed by Officer going off duty, (face-to-face relief).

.02 Enter yourself on the computer and log into the IMS system.

.03 Log the required information into the post activity section. Log the required activity in the post log section of IMS also. See Divisional Directive 01-03.

.04 Conduct a computer/card count as indicated: Access the Post Inmate Status Board corresponding to the assigned duty station.

.05 Compare the inmate floor cards to the post inmate status board in the IMS.

.06 The inmate names, booking numbers and cell numbers must be matched with the information contained in the corresponding post status board.

.07 The computer/card count must be documented in the post activity section of the IMS. The total number of inmates shall also be entered along with the ratio of black and white inmates.

5.0 Continuous Rounds for Afternoon Shift Patrol Officer:

1500: Time Slot Responsibilities:

Old Side Rounds

1500 - 1700	Round Officer
1700 - 1820	Utility Officer
1820 - 2020	Desk Officer

2020 - 2120	Round Officer
2120 - 2220	Desk Officer
2220 - 2300	Utility Officer

Annex Side

1500 - 1700	1st Slot Officer Round
1500 - 1820	Lunch
1820 - 2020	2nd Slot Officer Round
2020- 2120	1st Slot Officer Round
2120 - 2220	2nd Slot Officer Round
1600 - 1700	Feeding
1900 - 2130	Visits Per/Pro
2200	Lockdown

.01 The continuous rounds patrol officer will take the floor cards after the duty station officer has completed the computer/card count and match the floor card to the appropriate inmates on the appropriate wards.

.02 After conducting the formal head count, the continuous rounds patrol officer shall meet with the duty station officer to ensure that the information gathered from the head count is accurate.

.03 The number of actual inmates and cards must match what the duty station officer calculated.

.04 Any discrepancies in the headcount or computer/card count must be reported to shift command immediately.

.05 Upon completion of the formal head count the continuous rounds patrol officer shall assume continuous rounds of the inmate wards. See Divisional Memo 03-03A Revised.

6.0 1600: Continuous Rounds Patrol Officer

.01 The continuous rounds patrol officer shall ensure that a complete round was made of all wards prior to delaying rounds and going to lunch. See Divisional Memo 03-03A Revised.

7.0 1600: Duty Station Officer

.01 During the officer lunch period the duty station officer shall maintain their position on the post.

.02 1600 - 1700: Meal period, no more then 40 minutes per officer to include travel time. See Divisional Memo 03-03A Revised.

8.0 Feeding

.01 Each inmate must be given by hand his own food tray.

.02 Carts to elevator after collection.

.03 Trays to be placed on cart by officer.

.04 The duty station officer shall conduct a complete round of the entire floor upon the return of the continuous rounds patrol officer.

.05 After a complete round is made the duty station officer may leave the floor for lunch. This process shall continue until all officers have had a lunch period.

.06 The continuous rounds patrol officer shall assume the duties of the duty station officer during this period.

9.0 1800: Continuous Rounds Patrol Officer

.01 The continuous rounds patrol officer shall resume continuous rounds of the entire floor.

10.0 1900 - 2130: Visits - Afternoon - Personal/Professional

.01 Each side of floor is responsible for their own inmates.

.02 Personal - 30 minutes. Inmate must be logged in and out of the IMS system.

.03 Professional - Inmates must be searched prior to and after all professional visits.

1[illegible]0 2200: Lookdown

.01 Two (2) officers each ward. First officer checks from catwalk, shower and bars of cells.

.02 Old side - Gates locked, then one (1) officer goes on ward and hand checks the bars.

12.0 2230: Duty Station Officer

.01 The duty station officer shall conduct a second computer/card count as indicated: Access the Post Inmate Status Board corresponding to the assigned duty station.

.02 Compare the inmate floor cards to the post inmate status board in the IMS.

.03 The inmate names, booking numbers and cell numbers must be matched with the information contained in the corresponding post status board.

.04 The computer/card count must be documented in the Post activity section of the IMS.

.05 The total number of inmates shall also be entered along with the ratio of black and white inmates.

13.0 Continuous Rounds Patrol Officer

.01 The continuous rounds patrol officer will take the floor cards after the duty station officer has completed the computer/card count and match the floor card to the appropriate inmates on the appropriate wards.

.02 After conducting the formal head count, the continuous rounds patrol officer shall meet with the duty station officer to ensure that the information gathered from the head count is accurate.

.03 The number of actual inmates and cards must match what the duty station officer calculated.

.04 Any discrepancies in the headcount or computer/card count must be reported to shift command immediately.

.05 Upon completion of the formal head count the continuous rounds patrol officer shall assume continuous rounds of the inmate wards. See Divisional Memo 03-03A Revised.

14.0 2250: Duty Station Officer

.01 The duty station officer shall prepare for all shift change by making sure that the officers coming on duty are briefed and that all duty station equipment and keys are transferred.

15.0 2300: Duty Station Officer/Continuous Rounds Patrol Officer

.01 Off Duty.

Exhibit 9

Inspection Report

May 26, 2021 12:39 PM

RID	CSHO ID	Supervisor ID	Inspection Number	Optional Report Number	Case Closed Date
0552652	H0595	W2301	1491741		

Establishment Name	Wayne County Sheriff Office		Doing Business As (DBA)				
Ownership Type	Local Government	Type of Business		Primary NAICS	922120		
Site Address	525 Clinton St Detroit, MI 48226	Site Phone	(313) 224-0555	Extn		Site FAX	
Business Address	525 Clinton St Detroit, MI 48226	Business Phone		Business FAX			
Mailing Address	525 Clinton St Detroit, MI 48226	E-mail					
Site Activity		Site NAICS	922120			Days on Site	3
Federal EIN		DUNS		Temporary or Fixed Site?			
State Estab Id		DUNS plus4		CAGE Code			
Construction Type							

Parent Company Legal Name			Parent Company Trade Name/DBA		
Parent Company Address		Phone Number		Extn	
TIN / EIN			DUNS		
CAGE Code			DUNS plus4		

Entry	09/03/2020	First Closing Conference	04/22/2021	
Opening Conference	09/03/2020	Second Closing Conference		
Walkaround	09/03/2020	Exit		

Inspection Initiating Type	Fatality/Catastrophe	Secondary Type	
Other Initiating Type		Inspection Category	Health
Scope of Inspection	Partial	Reason No Inspection	
Migrant Farm Worker	N	Expln. for No Insp.	
State Strategic Initiatives			
National Emphasis			
State/Local Emphasis			
Primary Emphasis			

Additional Codes			
Type	ID	Value	Description
S	12	VI 10	*Enter good faith reduction points

Employed in Establishment	120	Walkaround?	Y	Advance Notice?	N
Covered By Inspection	[redacted]	Interviewed?	Y	Flag for Follow-up	N
Controlled By Employer	3,500	Union?	Y	Reason for Follow-up	
Is this Company a current federal contractor?		Unknown			

Related UPA		
Activity Number	Activity Type	Establishment Name
1657089	FAT/CAT	Wayne County Sheriff Office

Related Inspections		
Inspection Number	Related Inspection Type	Establishment Name

SVEP Information					
SVEP Case?	Post Citation	Post Citation SVEP	Is this inspection	Is an Imminent	Date Imminent Danger

	SVEP Action	Action Date	related to a previous SVEP inspection?	Danger Notice included in this case?	Notice was issued
N	None		N	N	

Employer Representatives Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email		Participation			Closing Conference, Walk Around

Employer Representatives Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email		Participation			

Employer Representatives Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email		Participation			Opening Conference, Closing Conference

Employer Representatives Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	

Address				Interviewed?	N
Home		Mobile		Fax	
Email			Participation		Closing Conference
Employer Representatives Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email			Participation		Closing Conference
Employees Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email			Participation		
Employees Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email			Participation		
Employees Contacted					
Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	Y

Wayne County Sheriff Office

Inspection Nr 149174 1

Home	Mobile	Fax
Email	Participation	

Employees Contacted

Name	Job Title	Occupation
Address		Interviewed? Y
Home	Mobile	Fax
Email	Participation	

Employees Contacted

Name	Job Title	Occupation
Address		Interviewed? Y
Home	Mobile	Fax
Email	Participation	

Employees Contacted

Name	Job Title	Occupation
Address		Interviewed? Y
Home	Mobile	Fax
Email	Participation	

Union Information

Union Name	Wayne County Deputy Sheriffs' Association/POAM	Local
Rep Name	Job Title	Occupation
Address		Interviewed? N
Home	Mobile	Fax
Email	Participation	Opening Conference

Union Information					
Union Name	POAM		Local		
Rep Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email			Participation		Closing Conference

Union Information					
Union Name	POAM		Local		
Rep Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email			Participation		Closing Conference

Union Information					
Union Name	POAM		Local		
Rep Name	[redacted]	Job Title	[redacted]	Occupation	
Address				Interviewed?	N
Home		Mobile		Fax	
Email			Participation		Closing Conference

Denial of Entry			
Denial Date/Time	Stage	Reason	Re-entry Date/Time

CSHO Signature		Date	

M Brad 6/9/21

Investigation Summary

Reporting ID	Investigation#	UPA Number	Event Date	Event Time	Construction
0552652	129302	1657089	[redacted]		No

Establishment Info

Establishment/DBA Name	Wayne County Sheriff Office

Site Information

Street Address 1	525 Clinton St				
Street Address 2					
County	WAYNE				
City	Detroit	State	MI	Zip Code	48226

Event

Type of Event	[redacted]		
Number of Employees			
Fatalities	Hospitalized	Non-Hospitalized	Unaccounted
1	0	0	0

Abstract

What was employee doing just before incident occurred?	Employee was performing [redacted] procedures.
What happened?	The employee was working alone before an inmate escaped his cell and [redacted] to the [redacted]
What was the injury or illness?	Employee was [redacted] and dies from [redacted] injuries.
What was the object or substance that directly harmed the employee?	Inmates body including fists and feet

Victim			
Injured/Deceased Name	[redacted]		
Gender			
Age			
Victim Injury	Fatality-OSHA covered		
Cause	[redacted]		
Nature of Injury	Other		
IMMLang?	N		
Next of Kin			
Next of Kin Name	[redacted]		
Relationship to Deceased			
Mailing Address	[redacted]	Phone Number	
Mailing City	[redacted]	State [redacted]	Zip Code [redacted]

Construction Related Details

Basic Information

Construction?	No

Construction Information

Is this a Building Site?			
Number of Stories (if building site):		Type of Construction:	
Height in Feet (if not building site):		Description if Type of Construction is "Other":	
Construction End Use:			

Incident Information

Operation Performed At Event:		Distance of the Fall (in feet):	
Worker height above ground/floor) before fall (in feet):			
Cause of Accident:		Description if Cause of Accident is "Other":	

F "ALITY INTAKE WORKSHEET

☐ MIOSHA Covered ☐ Not Covered ☒ Undetermined, CSHO Supervisor will follow-up

Received By	Receipt Type	Date Received	Time Received (am/pm)
Al Cudney	Choose an item.	9/3/2020	11:34 am

Establishment Name	Wayne County Sheriff Department – Division 2 Jail		
Site Address	525 Clinton St Detroit, MI 48226	Site Phone	(313) 224-2247
Business Address	Click here to enter text.	Business Phone	Click here to enter text.
Mailing Address	Click here to enter text.	# Employees in Est.	Click here to enter text.

Ownership	Local Government	Est. Type	Unknown	NAICS look up	922140

Reported By	Name	Phone	Title
Employer/Employer Rep	[redacted]	[redacted]	[redacted]

# Hosp	0	# Unaccntd	0	# Fatal	1	# Non hos	Click here to enter text.
Event Date	[redacted]	Event Time	After 10pm	Inspection?	Choose an item.	If no insp, why?	Choose an item.

Victim Name	M/F	Age	Occupation
[redacted]	[redacted]	[redacted]	[redacted]

Covered Incident Type	"Not-Covered" Incident Type
[redacted]	Click here to enter text.

Preliminary Description	Employee was [redacted] an inmate and died during treatment at the hospital.

Continue if Program Related Only:

NOK Name	[redacted]	Relationship	[redacted]
Address	[redacted]	Phone	[redacted]
Note here with reason if sending NOK is not appropriate for this circumstance.	Click here to enter text.		

CSHO ID	CSHO Name	Supervisor ID	Supervisor Name	Date Opened
H0595	Eric Eno	W2301	Megan Brock	9/3/2020

Fatality/Catastrophe Report

Wed Sep 09, 2020 11:47:08 AM

RID	Office Name	Activity Number	Activity Type	Receipt Date	Receipt Time	Receipt Type	Received By
0552652	MIOSHA General Industry Safety & Health Division	1657089	FAT/CAT	03-SEP-2020	11:30 AM	Phone	Z2114

Establishment Name	Wayne County Sheriff Office		Doing Business As (DBA)		
NAICS Inspected	922120		Primary NAICS	922120	
Site Address	525 Clinton St DETROIT, MI, 48226	Site Phone		Site FAX	
Business Address	525 Clinton St DETROIT, MI, 48226	Business Phone		Business FAX	
Mailing Address	525 Clinton St DETROIT, MI, 48226	Mgmt. Official		Mgmt. Official Phn.	
Type of Business		Type of Site Activity			
Number of Employees		Ownership	Local Government		

Event Date	[redacted]	Event Time	[redacted]	Do Insp?	Y	Reason No Insp	
No. Hospitalized	0	No. Unaccounted	0	No. Fatalities	1	No. Non-Hospitalized	0
Classification	Fatality	Employer Report Date	03-SEP-2020	Employer Report Time		11:30 AM	
Date Office Notified Incident Has Become a Fatality							

Source Type	Source Name	Phone
Employer/Employer Representative	[redacted]	[redacted]

Incident Type	Struck By
Preliminary Description (Hazard Description and Location	Employee was [redacted] an inmate and died during treatment at the hospital.
National Emphasis	
Local Emphasis	
Federal Strategic Initiatives	

Additional Codes			
Type	ID	Value	Description
S	03	[redacted]	

INSPECTION GUIDELINES

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sheriff Office Insp#: 1[illegible] 1741 CSHO: H0545

TYPE OF BUSINESS: Prison

E/E ORGANIZATION OR UNION (NA FOR NONE): Wayne County Deputy Sheriffs Assoc / POAM

ORGANIZATION ADDRESS: Sandoke Site ~~[illegible]~~ CITY, STATE, ZIP CODE: TELEPHONE:

REPRESENTATIVE:	TITLE:	E/R REP	E/E REP	OPEN	WALK AROUND	CLOSE	REPORT Send To	INTER VIEW
[redacted]	[redacted]	X		X	X	X		
		X		X				
		X		X		X	X	
			X	X				
			X	X		X	X	
		X	X			X		
			X			X		
		X				X		

OK to Email Closing Letter to E/R?
☐ Yes ☐ No

OPENING CONFERENCE GUIDELINES

Date: 9/13/20

☒ CET Services?

Explained the Following to Employer:

☒ Purpose of Visit
☒ No Advance Notice
☒ Rights and Responsibilities
☒ Walk Around Requirements
☒ Need for Photos & Samples
☒ Required Records and Posters
☒ Requirement to Interview Employees
☒ Employee Discrimination

CLOSING CONFERENCE GUIDELINES ☐ On-Site ☒ Phone

Date: 4/22/21

☒ Discussed Inspection Findings
☒ Provided & Discussed Applicable Standards & Regulations
☒ Discussed Alleged Violations, Abatement Dates, & Abatement Assurance
☒ Explained Citation & Penalty Process (Penalty Reduction Given, E/R Must Post Citations)
☒ Discussed Payment of Penalty Regardless of Abatement of Item
☒ Explained Appeal Process (ISA, Formal Appeal & PMA)
☒ Explained Proposed Citations Subject to Supervisor Review
☐ Advised Possibility of Follow-up Visit

OTHER

☒ I&I Review ☒ Workers' Comp? ☐ Customer Comment Card Given

ERGONOMIC GUIDELINES

☐ Assessed Workstations
☐ Interviewed Employees
☐ Issued Ergonomic Recommendations
☐ Reviewed Injury/Illness Log Specifically For Ergonomic Injuries/Illnesses
☐ Evaluated Ergonomic Program (Training, Assessment, Controls, Medical)

ADDITIONAL INFORMATION:

108 total
20 [illegible]
10 [illegible]
10 Sgt
2 Lt

[redacted]

JAIL DIVISION 2
525 CLINTON STREET
DETROIT, MI 48201
OFFICE: (313) 224-0555
abulifan@waynecounty.com
www.sheriffconnect.com

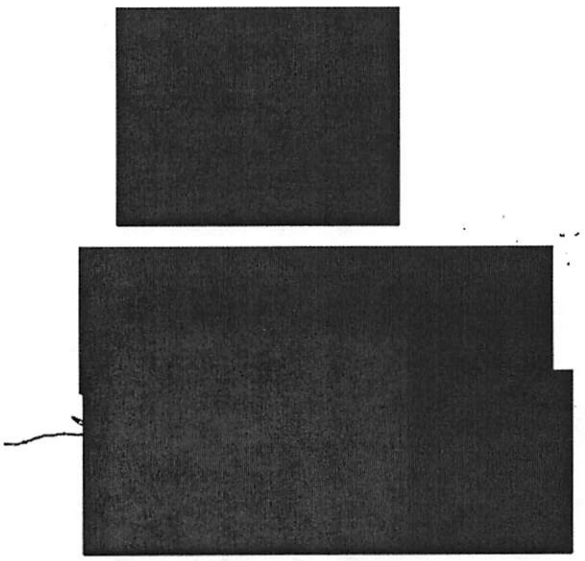
WAYNE COUNTY DEPUTY SHERIFFS' ASSOCIATION / POAM

[redacted]

Union Hall

27056 Joy Road, Redford, Michigan 48239

Office [redacted] Fax 313.937.9165
Mobil[redacted]yahoo.com



SITE-SPECIFIC SARS-COV-2 EXPOSURE ASSESSMENT AND CONTROL PLAN

Establishment Name: Wayne County Sheriffs Office	MIOSHA Staff: Eno	Date: 09/03/20

EXPOSURE ASSESSMENT (Assess the risk of SARS-CoV-2 exposure to MIOSHA staff)

Exposure Risk (pick one): ☐ Lower ☒ Medium ☐ High ☐ Very High (per OSHA Guidance)

List locations and activities in establishment where MIOSHA staff could be exposed to SARS-CoV-2:

Hallways and offices where staff work.

List factors affecting exposure risk [see sections XVIII (A)(9) and (B)(1)(a)]:

Prison populations are at higher risk due to limited medical care and number of people grouped together.

EXPOSURE CONTROL PLAN (List measures MIOSHA staff will use to protect themselves from exposure)

Hazard Isolation

- ☐ Conduct entire inspection remotely
- ☒ Limit time at establishment
- ☒ Take low exposure risk route into establishment
- ☒ Establish staging area with low exposure risk
- ☐ In very high exposure risk areas, omit walkaround
- ☐ In high exposure risk sites, keep walkaround focused and brief
- ☒ Plan walkaround by learning remotely about work operations and their locations
- ☒ Do not enter very high exposure risk areas
- ☐ Conduct interviews remotely from employees
- ☒ Interview employees away from their workstations and exposure risk
- ☒ Conduct program and record reviews remotely
- ☒ Conduct closing conference by phone
- ☐ Other:

Administrative & Work Practice Controls

- ☒ Keep 6 feet from others
- ☒ Avoid handshakes
- ☒ Wash hands frequently
- ☒ Use hand sanitizer
- ☒ Always wash hands that are visibly soiled
- ☒ Do not touch face with hands
- ☒ Do not touch contaminated surfaces
- ☒ During interviews have employees and employer reps wear masks or cloth face coverings
- ☒ Have employees decontaminate before employee interviews, if appropriate
- ☐ (For IHs) Have employees put on and remove air and noise monitoring equipment themselves
- ☐ (For IHs) Wipe down air and noise monitoring equipment with antiseptic towelette after removal from employee
- ☒ Immediately remove oneself from sick people
- ☐ Other:

Personal Protective Equipment

- ☐ Respiratory protection Type: _____
- ☐ Gloves
- ☐ Gown
- ☐ Other:
- ☐ Face Protection Type: _____
- ☐ Eye Protection Type: _____
- ☒ Cloth face covering

If PPE is to be used, list when and where it will be used:

Cloth face covering when inside facility and interacting with people.

)OD FAITH WORKSHEET

Michigan Department of Labor & Economic Opportunity
MIOSHA

Est. Name:	Insp #:	CSHO:
Wayne County Sheriff Office	1491741	H0595

Site Address:
525 Clinton St, Detroit, MI 48226

Factors	Good Faith Points Earned
Compliance: **Greater/High=0 * Greater/Low/Med. or Lesser/Med./High=3 * Lesser/Low=5 * OTS=9**	enter 9, 5, 3, or 0 0
Cooperation: Delayed getting interviews and other walkaround information	enter 4, 2, or 0 2
Correction/Mitigation: Corrected recordkeeping citation	enter 3, 1, or 0 1
Postings/Logs: Log citation	enter 3, 1, or 0 1
PPE:	enter 3, 1, or 0 3
Housekeeping:	enter 3, 1, or 0 3
MIOSHA Training Institute or Equivalent Training:	enter 3, 1, or 0
Miscellaneous Circumstances:	enter a number from -6 to 0 to +6
Total Points Earned:	10
Total Reduction:	10%

- 25 points or greater = 30% reduction
- 15-24 points = 20% reduction
- 5-14 points = 10% reduction
- 0-4 points = 0% reduction

Emphasis 2.1
Promoted safety and health management systems during this MIOSHA visit: ☑

Violation Worksheet

Print Date: June 10, 2021

Inspection Number	1491741
Opt. Insp. Number	

Establishment Name	Wayne County Sheriff Office				
DBA Name					
Type Of Violation	Serious	**Citation Number**	1	**Item/Group**	1
Standard	408.1011(a)				
Alleged Violation Description	408.1011(a): ACT 154, MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ACT An employer shall furnish to each employee, employment and a place of employment that is free from recognized hazards that are causing, or are likely to cause, death or serious physical harm to the employee. (The employer did not furnish employment and a place of employment which was free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that an employee was exposed to [redacted] hazards. On [redacted] the employer did not ensure that the practice of performing evening lockdown rounds with a partner, in accordance with established policies, was followed. An employee conducting the evening [redacted] alone died due to injuries caused from a [redacted] an inmate that had escaped from their cell.) Among other methods, a feasible abatement method to correct this hazard is to: a. Retrain employees to perform the nighttime lockdown procedure with a partner as required by the employer's internal standard operating procedure and industry standards. b. Update surveillance equipment and perform regular review of videos by members of management to ensure compliance with established policies. This could also include reviewing rounds in real-time, periodically throughout the shift. c. Establish an auditing policy to ensure employees are performing the task with a partner, in accordance with established policies. This may include, but not be limited to, sergeants and other members of management to conduct audits during the nighttime lockdown rounds to ensure they are done properly. d. Implement controls or devices which would mandate two people be present during rounds in each area to perform the operation. The devices would not be able to be operated successfully by a single employee.				

	Alternately, implement documentation verifying two people perform rounds as required by policy and an audit schedule to identify non-compliance with the policy.		
Recommended Abatement Action			
# Instances	1	**# Exposed**	[redacted]
Special Enforcement Type		**Related Event Code (REC)**	FAT/CAT/Accident
General Duty Key Words	Workplace Violence	**Employer's Relation to Hazard**	All
Photo/Video Number		**Substance Codes**	

Penalty

Severity	High		
Severity Justification	Death from injury or injuries due to assault by an inmate.		
Probability	Greater		
Probability Justification	An employee was [redacted] a prisoner who escaped from their cell and died as a result of their injuries.		
Gravity	High	**Gravity based Penalty**	$7,000.00
# of Times Repeated		**Multiplier**	
Size	0%	**Good Faith**	0%
History	0%		
Calculated Penalty	$7,000.00	**Proposed Penalty**	$7,000.00 MB
Size Justification			
Good Faith Justification			
History Justification			
Calculated Penalty	$7,000.00		
Proposed Penalty	$7,000.00		
Proposed Penalty Justification			

Abatement Details

# Days to Abate	20 working days	**Abatement Status**	
Abatement Due Date		**Date Abated**	
Abatement	Yes	**Date Verified**	

Documentation Required?			
Abatement Completed Description			

Multi-Step Abatement

Type/Other Type	# Days to Abate	Abatement Due Date	Completed (Status)	Verify Date

Employee Exposure

Violation Instance	# Exposed to Instance	Employer	Name and Address Telephone Numbers	Duration	Frequency	Proximity
1	[redacted]	Wayne County Sheriff Office	[redacted] Home Phone: Personal Mobile:	[redacted]	[redacted]	

Worksheet Details

A) Hazards-Operation/Condition-Accident: : The employer did not furnish employment and a place of employment which was free from recognized hazards that were causing or likely to cause death or serious physical harm to employees. On [redacted] the employer did not ensure that the practice of performing [redacted] with a partner, in accordance with established policies, was followed. An employee died as a result of injuries caused by an inmate while conducting [redacted] by [redacted]

Based on information provided by video surveillance, management and employee interviews [redacted] was [redacted] and killed by an [redacted] during the [redacted] in the [redacted] cell area. The inmate had waited until [redacted] had passed before exiting from his cell. When [redacted] was at the end of the cell area the [redacted] from behind. The [redacted] started around [redacted] on [redacted] The employee passed away as a result of injuries sustained.

[redacted] was not working with [redacted] partner during these rounds on this day. The facilities [redacted] (Post Orders [redacted] revised 5/1/09, Specific Topic: Duty Station - Afternoons) (see Exhibit 2) stated on p. 6 (Section 11.0: 2200: Lockdown) for 2200 Lockout that two officers are on each ward. The first officer checks from catwalk, shower and bars of cells. On the Old side, gates locked, then one officer goes on ward and hand checks bars. A Divisional Directive had been issued on August 18, 2020 (Exhibit 1), regarding Staff Entering Occupied Housing Units. The directive stated staff can enter occupied housing units when all inmates on the ward have been locked in their cells, in which case officers may enter the housing unit, as long as they have an officer occupying the gate and control box area on the outside of the housing unit. The example given of when this may occur included lock down

at 2200 hrs. [redacted] had gone to perform [redacted] procedures down cell [redacted] area. It was policy to have a second officer stationed at the controls for the cell doors during these rounds.

The facility did have video surveillance of the areas, but it did not always function properly as they were meant to be activated by motion which did not always trigger them to start recording. There did not appear to be any active monitoring or review of the footage unless an incident occurred. Sergeants and higher levels of management performed regular walk arounds of the facility however they did not appear to coincide with the [redacted] schedule.

Feedback indicated these nighttime [redacted] may have been done without a partner at times in the past, possibly due to employees being required to work extra hours and shifts regularly because of staffing level needs.

1) There was a policy in place (Exhibit 2) that identified the need to conduct lockdown rounds with a partner. 2) Employees had been trained on the policy. 3) There was no indication that these rounds were audited by management to determine compliance with their internal procedures. The video monitoring system was not watched by anyone during real-time and did not record date/time correctly. No measures were in place that would mandate the rounds be made by two employees together. 4) There were no records of discipline related to not following procedures based on feedback from the employer. Due to being short-staffed and working additional hours, employees may have attempted to perform the job more efficiently by not performing the work with their partner as required.

B) Equipment:

C) Location: Ward 404

D) Injury/Illness (and Justifications for Severity and Probability):

E) Measurements: Employee Interviews
Field Narratives
News Articles on incident from Free Press and Detroit News dated 09/03/2020
Exhibit 1, Staff Entering Occupied Housing Units dated August 18, 2020
Exhibit 2, SOP Post Orders, page 6
Exhibit 3, Officer Activity Logs (time leading up to event)

F) Employer Knowledge: The employer was aware employees performed nighttime [redacted] procedures by [redacted] the inner cell area and had a SOP (Exhibit 2) and memo dated August 18, 2020 (Exhibit #1). The directive stated staff can enter occupied housing units when all inmates on the ward have been locked in their cells, in which case officers may enter the housing unit, as long as they have an officer occupying the gate and control box area on the outside of the housing unit. Often one name noted under 'Remarks' for each Pod/Block during 2200 timeframe for Rounds on Officer Activity Log.

-Post Orders JD2 09-02 revised 5/1/09, Specific Topic: Duty Station - Afternoons
-Divisional Directive had been issued on August 18, 2020 regarding Staff Entering Occupied Housing Units

The employer had members of management perform rounds and had video cameras and the ability to review the footage.

G) Comments: 1. The employer failed to keep the workplace free of a recognized hazard to which employees were exposed: On [redacted] the employer did not ensure that the practice of performing evening [redacted] with a partner, in accordance with established policies, was followed. An employee conducting the evening [redacted] alone died due to injuries caused by an [redacted] with an [redacted] that had [redacted] from their cell.

2. The hazard was recognized:

Industry-related information. See associated websites:

-https://nicic.gov/jail-standards-and-inspections
-https://nij.ojp.gov/topics/articles/correctional-officer-safety-and-wellness-what-we-learned-research-literature
-https://nij.ojp.gov/topics/articles/risky-business-part-1-2-series-correctional-officer-wellness
Article states to ensure officers always have backup when dealing with troublesome offenders.
-https://www.bop.gov/policy/progstat/5500_014_CN-1.pdf (U.S. Department of Justice Federal Bureau of Prisons Correction Services Procedures Manual)
Ch. 3, Page 1 states counts will be conducted with at least two officers¿One staff member will count while the second staff member stands in a position to observe inmate movement.

OSHA archived note related to citation at jail/prison facility:
https://www.osha.gov/news/newsreleases/region4/06122012

3. The hazard was causing or was likely to cause death or serious physical harm: [redacted] was [redacted] by a prisoner who [redacted] from their cell and died as a result of their injuries on [redacted]

4. There was a feasible and useful method to correct the hazard:

a. Retrain employees to perform the nighttime [redacted] procedure with a partner as required by the employer's internal standard operating procedure and industry standards.
b. Update surveillance equipment and perform regular review of videos by members of management to ensure compliance with established policies. This could also include reviewing rounds in real-time, periodically throughout the shift.
c. Establish an auditing policy to ensure employees are performing the task with a partner, in accordance with established policies. This may include, but not be limited to, sergeants and other members of management to conduct audits during the nighttime [redacted] to ensure they are done properly.
d. Implement controls or devices which would mandate two people be present during [redacted] in each area to perform the operation. The devices would not be able to be operated successfully by a single employee. Alternately, implement documentation verifying two people perform [redacted] as required by policy and an audit schedule to identify non-compliance with the policy.

H) Other Employer Information:

Violation Worksheet

Print Date: June 10, 2021

Inspection Number	1491741
Opt. Insp. Number	

Establishment Name	Wayne County Sheriff Office				
DBA Name					
Type Of Violation	Other-than-Serious	**Citation Number**	2	**Item/Group**	1
Standard	408.22112(1)				
Alleged Violation Description	408.22112(1): ADM PART 11, RECORDING AND REPORTING OF OCCUPATIONAL INJURIES AND ILLNESSES You must consider an injury or illness to meet the general recording criteria, and therefore to be recordable, if the injury or illness results in any of the following: (a) Death. (b) Days away from work. (c) Restricted work or transfer to another job. (d) Medical treatment beyond first-aid. (e) Loss of consciousness. (An employee work-related death, which met the general recording criteria, was not recorded on the log as required.)				
Recommended Abatement Action					
# Instances	1	**# Exposed**	[redacted]		
Special Enforcement Type		**Related Event Code (REC)**	FAT/CAT/Accident		
General Duty Key Words		**Employer's Relation to Hazard**	All		
Photo/Video Number		**Substance Codes**			

Penalty

Severity	Minimal
Severity Justification	The injury or illness most likely to result would probably not cause death or serious physical harm from lack of recording death.
Probability	Greater

Probability Justification	Per 2020 FOM		
Gravity		**Gravity based Penalty**	$1,000.00
# of Times Repeated		**Multiplier**	
Size	0%	**Good Faith**	0%
History	0%		
Calculated Penalty	$1,000.00	**Proposed Penalty**	$1,000.00
Size Justification			
Good Faith Justification			
History Justification			
Calculated Penalty	$1,000.00		
Proposed Penalty	$1,000.00		
Proposed Penalty Justification			

Abatement Details

# Days to Abate		**Abatement Status**	Corrected During Inspection
Abatement Due Date		**Date Abated**	04/23/2021
Abatement Documentation Required?	Yes	**Date Verified**	04/23/2021
Abatement Completed Description	Corrected 300 logs provided by the employer		

Multi-Step Abatement

Type/Other Type	# Days to Abate	Abatement Due Date	Completed (Status)	Verify Date

Employee Exposure

Violation Instance	# Exposed to Instance	Employer	Name and Address Telephone Numbers	Duration	Frequency	Proximity
1	[redacted]	Wayne County Sheriff Office	[redacted] Home Phone: Personal Mobile:	[redacted]		

Worksheet Details

A) Hazards-Operation/Condition-Accident: An employee, [redacted] was killed at work by an [redacted] while performing their work duties. The employee's death was not recorded on the log as required based on the 2020 log provided by the employer in November 2020 (incident occurred September 2020).

B) Equipment:

C) Location:

D) Injury/Illness (and Justifications for Severity and Probability):

E) Measurements: 2020 OSHA 300 Log provided by employer in November 2020 email

F) Employer Knowledge: Employer was aware of the recording criteria as they kept previous logs and knew of the employee's death.

G) Comments:

H) Other Employer Information:

FIELD NARRATIVE

Michigan Department of Labor and Economic Opportunity
MIOSHA

Est. Name: Wayne County Sheriff's Office | Insp # 1491741 | CSHO: H0595

Street:	City:	State:	Zip Code:	Telephone:
525 Clinton Street	Detroit	MI	48226	313.224.0555

Date/Ref	Inspection Findings
Fatality	[redacted] was killed by an [redacted] while performing [redacted] duties during the nighttime [redacted] procedure.

The employer did not furnish employment and a place of employment which was free from recognized hazards that were causing or likely to cause death or serious physical harm to employees. On [redacted] the employer did not ensure that the practice of performing evening [redacted] rounds with a partner, in accordance with established policies, was followed. An employee died as a result of injuries caused by an [redacted] while conducting evening [redacted] rounds by [redacted]

Based on information provided by video surveillance, management and employee interviews [redacted] was [redacted] and killed by an [redacted] during the nighttime [redacted] in the [redacted] cell area. The [redacted] had waited until [redacted] had passed before [redacted] from [redacted] cell. When [redacted] was at the end of the cell area the [redacted] from [redacted] The [redacted] started around [redacted] on [redacted] The employee passed away as a result of injuries sustained.

[redacted] was not working with [redacted] partner during these [redacted] on this day. The facilities SOP (Post Orders JD2 09-02 revised 5/1/09, Specific Topic: Duty Station - Afternoons) (see Exhibit 2) stated on p. 6 (Section 11.0: 2200: Lockdown) for 2200 Lockout that two officers are on each ward. The first officer checks from catwalk, shower and bars of cells. On the Old side, gates locked, then one officer goes on ward and hand checks bars. A Divisional Directive had been issued on August 18, 2020 (Exhibit 1), regarding Staff Entering Occupied Housing Units. The directive stated staff can enter occupied housing units when all inmates on the ward have been locked in their cells, in which case officers may enter the housing unit, as long as they have an officer occupying the gate and control box area on the outside of the housing unit. The example given of when this may occur included lock down at 2200 hrs. [redacted] had gone to perform nighttime [redacted] procedures down cell [redacted] area. It was policy to have a second officer stationed at the controls for the cell doors during these rounds.

The facility did have video surveillance of the areas, but it did not always function properly as they were meant to be activated by motion which did not always trigger them to start recording. There did not appear to be any active monitoring or review of the footage unless an incident occurred. Sergeants and higher levels of management performed regular walk arounds of the facility however they did not appear to coincide with the nighttime lock down schedule.

Feedback indicated these nighttime lock downs may have been done without a partner at times in the past, possibly due to employees being required to work extra hours and shifts regularly because of staffing level needs.

1) There was a policy in place (Exhibit 2) that identified the need to conduct [redacted] with a partner. 2) Employees had been trained on the policy. 3) There was no indication that these [redacted] were audited by management to determine compliance with their internal procedures. The video

	monitoring system was not watched by anyone during real-time and did not record date/time correctly. No measures were in place that would mandate the [redacted] be made by two employees together. 4) There were no records of discipline related to not following procedures based on feedback from the employer. Due to being short-staffed and working additional hours, employees may have attempted to perform the job more efficiently by not performing the work with their partner as required. Citation issued for a general duty clause for the employer not providing a safe working environment free of recognizable hazards and for not recording the incident on the OSHA 300 log.
General Duty Elements	1. The employer failed to keep the workplace free of a recognized hazard to which employees were exposed: On [redacted] the employer did not ensure that the practice of performing evening [redacted] with a partner, in accordance with established policies, was followed. An employee conducting the evening [redacted] alone died due to injuries caused by an [redacted] with an [redacted] that had [redacted] from their cell. 2. The hazard was recognized: Industry-related information. See associated websites: -https://nicic.gov/jail-standards-and-inspections -https://nij.ojp.gov/topics/articles/correctional-officer-safety-and-wellness-what-we-learned-research-literature -https://nij.ojp.gov/topics/articles/risky-business-part-1-2-series-correctional-officer-wellness Article states to ensure officers always have backup when dealing with troublesome offenders. -https://www.bop.gov/policy/progstat/5500_014_CN-1.pdf (U.S. Department of Justice Federal Bureau of Prisons Correction Services Procedures Manual) Ch. 3, Page 1 states counts will be conducted with at least two officers¿One staff member will count while the second staff member stands in a position to observe inmate movement. OSHA archived note related to citation at jail/prison facility: https://www.osha.gov/news/newsreleases/region4/06122012 3. The hazard was causing or was likely to cause death or serious physical harm: [redacted] was [redacted] by a [redacted] who [redacted] from their cell and died as a result of their injuries on [redacted] 4. There was a feasible and useful method to correct the hazard: a. Retrain employees to perform the nighttime [redacted] procedure with a partner as required by the employer's internal standard operating procedure and industry standards. b. Update surveillance equipment and perform regular review of videos by members of management to ensure compliance with established policies. This could also include reviewing rounds in real-time, periodically throughout the shift. c. Establish an auditing policy to ensure employees are performing the task with a partner, in

	accordance with established policies. This may include, but not be limited to, sergeants and other members of management to conduct audits during the nighttime [redacted] to ensure they are done properly. d. Implement controls or devices which would mandate two people be present during [redacted] in each area to perform the operation. The devices would not be able to be operated successfully by a single employee. Alternately, implement documentation verifying two people perform [redacted] as required by policy and an audit schedule to identify non-compliance with the policy.
Note	The IH was informed that the incident had been added to the appropriate OSHA 300 log and the IH asked that it be provided to [redacted] by the end of the day. No additional information was provided to the IH during the closing.

FIELD NARRATIVE

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sheriff's Office | Insp # 1491741 | CSHO: H0595

Street:	City:	State:	Zip Code:	Telephone:
525 Clinton Street	Detroit	MI	48226	313.224.0555

Date/Ref	**Opening Conference**
09/03/20	Trade Secrets: NA Photos/Videos: NA
	The IH arrived onsite around 12:25 pm and was asked to take a seat in the waiting area until [redacted] was able to speak with him. A few moments later the IH spoke to the [redacted] briefly and explained why he was there but the IH was told [redacted] could not answer any questions until [redacted] had authorization as it was still an active crime scene with local Detroit Police detectives investigating and internal affairs. [redacted] did state that the incident was caused by [redacted] not following procedures and that the victim's [redacted] would most likely be reprimanded and terminated. The [redacted] asked the IH to wait in the hallway until [redacted] had further news and joined a conference phone call with other [redacted] to discuss the situation. Around 1:19 the IH was given the contact information for the [redacted] for Sheriff's Office. The IH talked to [redacted] and explained his reasons for being there and conducted an opening conference. [redacted] asked that the IH email all questions and requests through [redacted] and [redacted] would answer them as best [redacted] could. The IH will email questions when he returned to his OWS. The IH then had the local [redacted] for Wayne County Deputy Sheriffs' Association/POAM contacted and around 2:00pm the IH held an opening conference with [redacted] at the site. Afterwards the IH left the site and informed his supervisor of the situation. The IH returned to his OWS around 3:00 pm.
	During the time the IH was waiting on the benches just inside the main hallway between the entry desk and the [redacted] office the IH overheard several conversations from [redacted] arriving or leaving the site. [redacted] stated "this is something we have all done before" referencing the not ensuring the door was locked and entering an area without backup. Another [redacted] stated that "they are finally making changes to the policy we asked for 6 months ago" in reference to how officers are to secure doorways and areas before entering prisoner areas.

FIELD NARRATIVE

Michigan Department of Labor and Economic Opportunity

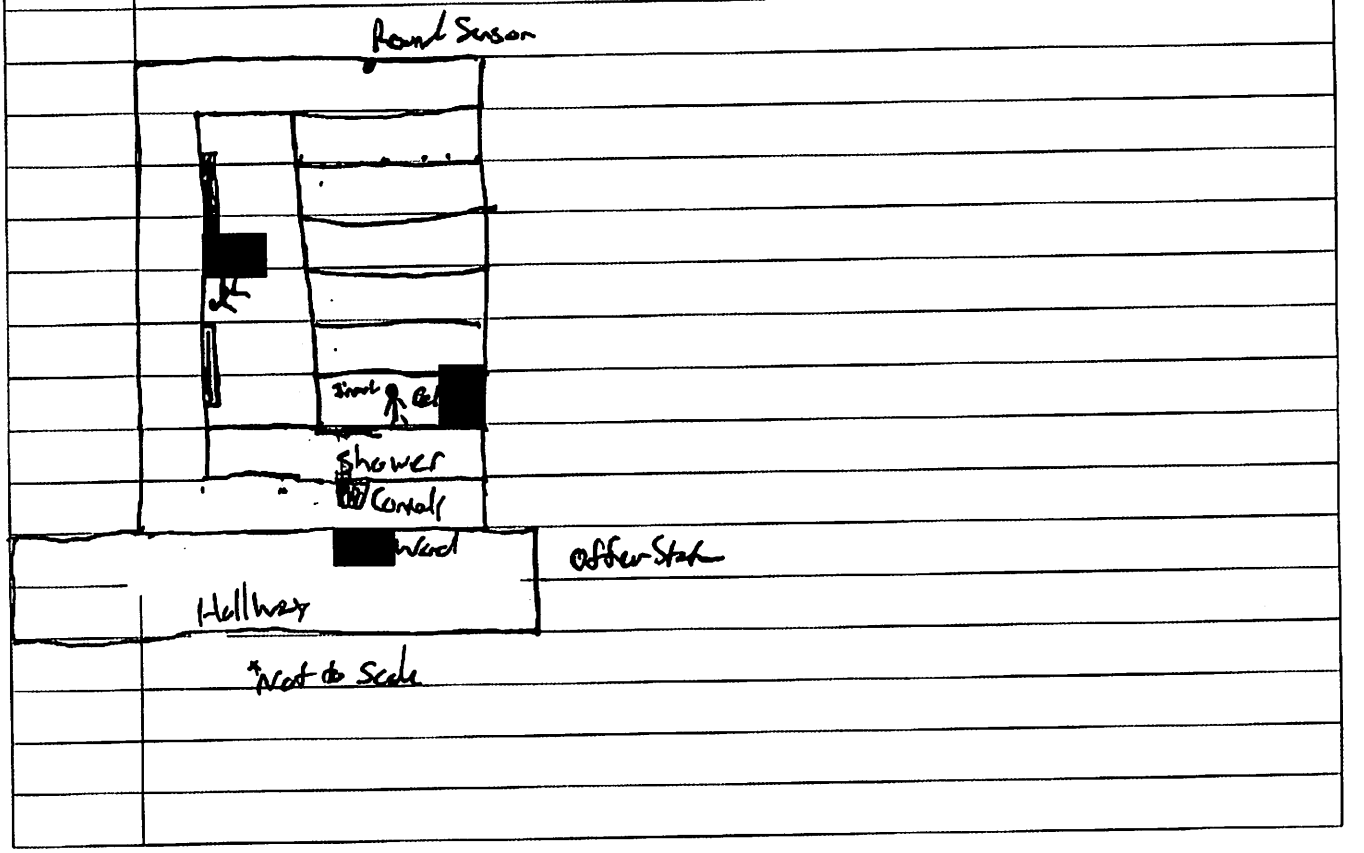
MIOSHA

Est. Name: Wayne County Sheriff's Office Insp # 1491741 CSHO: H0595

Street:	City:	State:	Zip Code:	Telephone:
525 Clinton Street	Detroit	MI	48226	313.224.0555

Date/Ref	**Walkaround and Employee Interviews**

The IH arrived onsite around 1:30 pm and was asked to take a seat in the waiting area until [redacted] was able to speak with [redacted]. A few moments later [redacted] stepped out of [redacted] office and escorted the IH to a conference room where the employee interviews would be conducted and called for [redacted] the [redacted] to come to the room. The IH was escorted to the [redacted] floor to ward [redacted] where the incident occurred. The IH was shown where the inmate cell was and where the [redacted] took place and where [redacted] was found [redacted]. The IH was also shown how the doors were opened and closed by mechanical levers. The IH was informed the [redacted] occurred as the [redacted] was conducting [redacted] at [redacted] for the night and had to walk in the area to physically ensure all of the doors were locked and only one inmate in each cell. Normally the [redacted] walk the outer perimeter and have a wand they press to a sensor at the end to log they had completed a round. See sketch below of area. The IH then conducted employee interviews of several employees working during the time of the incident and responded in some fashion. [redacted] was still on leave and had not returned to work. The [redacted] provided information to the IH to contact the union to attempt to set up a time to conduct [redacted] employee interview as [redacted] was the only employee in the area that could have direct knowledge of the events that occurred.



FIELD NARRATIVE

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sheriff's Office | Insp # 1491741 | CSHO: H0595

Street:	City:	State:	Zip Code:	Telephone:
525 Clinton Street	Detroit	MI	48226	313.224.0555

Date/Ref	**Review of Video Footage**
11/12/20	The IH arrived onsite at 4747 Woodward Avenue, Detroit, MI which was the headquarters for Wayne County Sheriff Office (WCSO). The IH was met by [redacted] who took the IH to the Internal Affairs (IA) area located in the basement to a desk to watch footage of the attack on [redacted] stated [redacted] had worked at the Div [redacted] Jail some years ago and had recently been promoted to [redacted] and the review of the footage and [redacted] report of the incident was [redacted] first assignment.
	Through [redacted] investigation [redacted] had determined the clock on the footage was approximately 16 minutes off. [redacted] determined this by cross referencing the time stamp on the video when the alarm was pulled and comparing it to when it was recorded on the shift commanders log.
	[redacted] stated the main cameras for the area capture images at Cells 1, 3, 5, 7, 9, the shower area and duty station desk which connect to the other wards on the floor. [redacted] also stated that the cameras work by motion sensors, but that due to age, design or software do not always function properly. The IH observed while watching the footage of the [redacted] that cameras in Ward [redacted] were black but from other cameras they should have been on as there was someone in their view moving. Additionally, very little footage of the CPR being performed were captured, the screens were black. They video recorded might also jump in time. This was observed by the IH watching the video as [redacted] saw sever times where the time counter jumped ahead seconds or minutes with no explanation or the appearance of deleted footage. There were 9 cells and a shower in the ward.
Approx. time	Timeline of events based on counter on videos (time not adjusted for possible 16 minutes inaccuracies)
[redacted]	Inmates in their cells and doors shut. The inmate sat on his bed and extended his foot. [redacted] stated [redacted] believed the inmate did this so when [redacted] would test the cell door it would feel like it was latched securely.) [redacted] enters the ward and [redacted] is similarly heading to ward 405/406.
[redacted]	[redacted] cell door after [redacted] has walked past.
[redacted]	Inmate attacks [redacted] from [redacted] as [redacted] is near the end [redacted] of the doors, about cell [redacted]
[redacted]	[redacted] and the inmate are still [redacted] near cell [redacted]
[redacted]	[redacted] appears to have [redacted] to the [redacted] on [redacted] with the [redacted] on [redacted] of [redacted]
[redacted]	[redacted] is [redacted] on the [redacted] near cell [redacted] with the [redacted] on [redacted] of [redacted]
[redacted]	The [redacted] gets up off of [redacted]
[redacted]	The [redacted] moved to the controls to "throw the bars" in an attempt to open the other cells. [redacted] was seen going between the bars and their own cell several times. [redacted] stated [redacted] believed the [redacted] was doing this when [redacted] was [redacted] the doors in [redacted] area to mask the sound of "throwing the bars".

FIELD NARRATIVE

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sheriff's Office Insp # 1491741 CSHO: H0595

[redacted]	[redacted] is seen returning to the duty station from ward [redacted]
	[redacted] ward [redacted] and [redacted] appeared to be in [redacted] cell at this time.
	[redacted] set off the alarm and radios for help. [redacted] runs the bars to make sure all inmates were secured in their cells.
	[redacted] rush to the area to respond to the alarm.
	The [redacted] arrives to the area.
	The jail nurse arrives to the area.
	EMT's arrive at the back-loading area.
	EMT's are seen entering the building.
	EMT's enter ward [redacted] and appear to take over CPR/lifesaving measures.
	[redacted] is observed leaving ward [redacted] (identified by [redacted]
	[redacted] is carried off the floor to the elevators. While waiting for elevator they continued CPR.
	EMT's and [redacted] moved to elevator.
	EMT's and [redacted] moved to ambulance.
	The ambulance leaves the facility to Detroit Receiving Hospital.
	Detroit Police Department on the scene (Based on [redacted] recollection as the footage of that was not saved.)
	Basic elements of the sequence of events: The [redacted] was approximately 5 minutes in duration. Approximately 5 minutes after the [redacted] ended [redacted] arrived at the area. [redacted] responded to the alarm approximately 20 seconds after it was sounded. The [redacted] arrived approximately 3 minutes after the alarm was sounded. EMT's take over CPR approximately 14 minutes after the alarm sounded. EMT's leave the site approximately 20 minutes after arriving.

INTERVIEW STATEMENT

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sherriff's Office Insp#: 1491741 CSHO: HO595

E/E Name [redacted]				
Street:	City:	State:	Zip Code:	Telephone: Contact site
☒ Current Employee: [redacted]				
☐ Former Employee, Last day worked:				
☐ Other:				
My occupational/job duties are/were: [redacted] and [redacted]				

Interview:

#1 Did you know or work with [redacted]
[redacted] stated that [redacted] did not regularly work with [redacted] but knew [redacted] from passing in the hallways. [redacted] was usually [redacted] Mos[redacted] had the same partner each shift unless someone called in or was on leave and had a replacement placed with them. Usually 2 people to a floor.

#2 Tell me about a typical day working here.
[redacted] stated that a typical day involves making rounds every hour on the floor/ward and using a device to record the round. Handle any issues that come up with inmates.

#3 Are you aware of the incident that occurred that led to [redacted] death?
[redacted] stated that the attack happened after [redacted] when the officer was doing [redacted] for the night which entailed ensuring the cells only had one occupant and that the doors were locked. The area was Ward [redacted] and the [redacted] was in th[redacted] cell. [redacted] heard a bell go off/Code 10 [redacted] rushed from th[redacted] floor annex to the area. When [redacted] arrived all inmates where in their cells and [redacted] was there. [redacted] stated [redacted] had done what [redacted] was supposed to do in this type of incident and locked down the area/cells. The EMT's arrived and took [redacted] away.

#4 Has a similar incident occurred while you were working or to you?
[redacted] stated this was an unusual event, [redacted] was not aware of something like ever happening.

#5 Were there policies or training in place that could have prevented this?
[redacted] stated [redacted] had been trained like the other [redacted] on how to conduct check. They were supposed to be done with a partner there when running the bars, locking down the cells using the mechanical levers. In the past inmates have managed to manipulate the bars and jam them up so they don't work properly. One of the reasons they make the rounds to ensure all the cells are locked properly.

#6 Were there outside factors that led to this incident occurring?
[redacted] stated that they had mandatory over time frequently as not enough officers were assigned at the jail. They can only work 56 hours but that can be overrode if management declared an emergency which they did often. Some officers to save time might do the rounds separate instead of together to speed up the process when checking their wings. [redacted] stated [redacted] always went with [redacted]

[redacted] stated [redacted] had no work-related injuries or illnesses in the past 5 years.

"I have read the above and it is true and I (☐ do ☐ do not) request that my statement be held confidential to the extent allowed by law."			
Signature of Interviewee:	Date:	CSHO Signature	Date: [redacted]

0038

INTERVIEW STATEMENT

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sherriff's Office Insp#: 1491741 CSHO: HO595

E/E Name: [redacted]				
Street:	City:	State:	Zip Code:	Telephone: Contact site

☒ Current Employee: [redacted]

☐ Former Employee, Last day worked:

☐ Other:

My occupational/job duties are/were: [redacted]

Interview:

#1 Did you know or work with [redacted]
[redacted] stated tha[redacted] knew [redacted] and had worked the [redacted] with [redacted] in the past. [redacted] was [redacted] Most officers had the same partner each shift unless someone was on leave and had a replacement. There was usually 2 people to a floor to watch the wards.

#2 Tell me about a typical day working here.
[redacted] stated that a typical day involve[redacted] people entering the building, [redacted] them in and taking their [redacted] and notifying [redacted] superiors as needed.

#3 Are you aware of the incident that occurred that led to [redacted] death?
[redacted] stated that the [redacted] happened around [redacted] on the [redacted] was outside after [redacted] shift in civilian clothes talking to a few people when they were informed of an [redacted] and the others ran to the back, someone called 911, and they waited to watch for the ambulance. The fire department showed up first and the EMS showed up a few minutes later. The EMS people brough[redacted] down in a chair and placed [redacted] on a gurney and continued CPR. Another [redacted] in the stairwell and they had the fire department help with [redacted] never went upstairs so could not speak to the incident. [redacted] had then left and was called back later by [redacted] to work the day shift [redacted] was onsite when the IH arrived onsite to do the opening conference.

#4 Has a similar incident occurred while you were working or to you?
[redacted] stated this was an unusual event, something like this had never happened.

#5 Were there policies or training in place that could have prevented this?
[redacted] stated [redacted] had been trained like the other [redacted] on how to conduct checks during the day and at [redacted] They were supposed to be done with a partner when running the bars, locking down the cells using the mechanical levers. [redacted] was not sure why officers would not be together but was not up there to know.

#6 Were there outside factors that led to this incident occurring?
[redacted] stated that they had mandatory overtime frequently there was not enough officers were assigned at the jail. They usually only have 2-3 people per floor and should have more. They usually work 60-80 hours a week. [redacted] was not sure what led to the incident and did not want to speculate. When working with a partner on the floor [redacted] always worked with them.

[redacted] stated [redacted] had [redacted] injured [redacted] in the past, but was not sure when.

"I have read the above and it is true and I (☐do ☐ do not) request that my statement be held confidential to the extent allowed by law."			
Signature of Interviewee:	Date:	CSHO Signature:	Date: [redacted]

INTERVIEW STATEMENT

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sherriff's Office Insp#: 1491741 CSHO: HO595

E/E Name [redacted]				
Street:	City:	State:	Zip Code:	Telephone: Contact site
☒ Current Employee: [redacted]				
☐ Former Employee, Last day worked:				
☐ Other:				
My occupational/job duties are/were: [redacted]				

Interview:

#1 Did you know or work with [redacted]
[redacted] stated that [redacted] did not work with [redacted] but knew [redacted] from seeing [redacted] in the building. [redacted] was [redacted] Most [redacted] had the same partner each shift unless someone was on leave and had a replacement. There was usually 2 people to a floor to watch the wards.

#2 Tell me about a typical day working here
[redacted] stated that a typical day involves [redacted] with the [redacted] and [redacted] to see wha [redacted] were scheduled to see them. [redacted] would [redacted] them up and [redacted] them to the medical area and ensure they behaved.

#3 Are you aware of the incident that occurred that led to [redacted] death?
[redacted] stated that the [redacted] happened around [redacted] when [redacted] was doing [redacted] for the night which involved [redacted] that the cells were [redacted] and only had one occupant in them. The area was Ward [redacted] and the [redacted] was in the [redacted] cell. [redacted] heard a bell go off, a Code 10 [redacted] rushed from th [redacted] floo [redacted] to the area. When [redacted] arrived all inmates were locked in their cells. [redacted] was administering CPR on [redacted] and checking [redacted] pulse. [redacted] was [redacted] stated [redacted] had done wha [redacted] was supposed to do in this type of incident and locked down the area/cells. The EMT's arrived and took [redacted] away.

#4 Has a similar incident occurred while you were working or to you?
[redacted] stated this was an unusual event, [redacted] was not aware of something like ever happening.

#5 Were there policies or training in place that could have prevented this?
[redacted] stated [redacted] had been trained like the other [redacted] on how to conduct checks during the day and at [redacted] They were supposed to be done with a partner when running the bars, locking down the cells using the mechanical levers. With the mechanical nature of the bars inmates have been able to tamper with the bars and jam them up so they don't work properly. One of the reasons they make the rounds to ensure all the cells are locked properly and why you need a partner.

#6 Were there outside factors that led to this incident occurring?
[redacted] stated that they had mandatory over time frequently as not enough officers were assigned at the jail. They usually only have 2-3 people per floor and should have more. They usually work 60-80 hours a week. [redacted] was not sure what led to the incident and did not want to speculate, but stated [redacted] always worked with [redacted] partner. [redacted] stated [redacted] always went with [redacted] partner.

[redacted] stated [redacted] had injured [redacted] during a mini riot a few years back but did not take any time off. [redacted] just manned up.

"I have read the above and it is true and I (☐ do ☐ do not) request that my statement be held confidential to the extent allowed by law."			
Signature of Interviewee:	Date:	CSHO Signature	Date: [redacted]

0040

INTERVIEW STATEMENT

Michigan Department of Labor and Economic Opportunity

MIOSHA

Est. Name: Wayne County Sherriff's Office Insp#: 1491741 CSHO: HO595

E/E Name: [redacted]				
Street:	City:	State:	Zip Code:	Telephone: Contact site
☒ Current Employee: [redacted]				
☐ Former Employee, Last day worked:				
☐ Other:				
My occupational/job duties are/were: [redacted]				

Interview:

#1 Did you know or work with [redacted]
[redacted] stated that [redacted] knew [redacted] from the building but [redacted] had been [redacted] to the [redacted] from the [redacted] duties as the [redacted] was not operating during Covid-19. [redacted] was [redacted] as far as [redacted] knew. Most officers had the same partner each shift unless someone was on leave and had a replacement. There was usually 2 people to a floor to watch the wards.

#2 Tell me about a typical day working here.
[redacted] stated that a typical day involves performing [redacted] and checking on inmates and ensuring the cells were locked when needed such as at night during lockdown.

#3 Are you aware of the incident that occurred that led to [redacted] death?
[redacted] stated that the [redacted] when [redacted] was on the [redacted] floor. The alarm had gone off and [redacted] responded. [redacted] had helped perform CPR and [redacted] believed all of the inmates were locked in their cells. EMT's took over the CPR from [redacted] when they arrived. [redacted] was in the area when [redacted] arrived. There was [redacted] on the floor, and [redacted] was [redacted] had [redacted] from the stress of the event and was taken and checked out.

#4 Has a similar incident occurred while you were working or to you?
[redacted] stated this was an unusual event, something like this had never happened.

#5 Were there policies or training in place that could have prevented this?
[redacted] stated [redacted] had been trained like the other [redacted] on how to conduct [redacted] during the day and a [redacted] They were supposed to be done with a partner when [redacted] th [redacted] the cells using the mechanical levers. [redacted] was not sure why officers would not be together but was not up there to know.

#6 Were there outside factors that led to this incident occurring?
[redacted] stated that they had mandatory overtime frequently as there was not enough officers were assigned at the jail. They usually only have 2-3 people per floor and should have more. They usually work over 40 hours a week. [redacted] was not sure what led to the incident and did not want to speculate. When working with a partner on the floor [redacted] always worked with them.

[redacted] stated [redacted] had no work-related injuries or illness in the past 5 years.

"I have read the above and it is true and I (☐ do ☐ do not) request that my statement be held confidential to the extent allowed by law."			
Signature of Interviewee:	Date:	CSHO Signature [redacted]	Date: [redacted]

0041

Exhibit 10

Risky Business: Part 1 of 2 in a Series on Correctional Officer Wellness

March 31, 2018

Security and stability in prisons and jails are critical to administer justice, protect the public and ensure the safety of incarcerated persons. This responsibility falls heaviest on the shoulders of front-line corrections officers (COs) working within facilities on a day-to-day basis. As COs work to maintain peaceful order within facilities and between incarcerated persons with histories of mental illness, substance abuse and violence, they also routinely put themselves in harm's way. This is why being a CO is considered one of the riskiest professions.

Between 2005 and 2009, the rate of sustained, nonfatal workplace injuries per 1,000 COs was 33, which ranked third only to police officers and security guards.[1] Between 1999 and 2008, 113 U.S. COs lost their lives in the line of duty.[2] COs also deal with high levels of stress, burnout and a variety of other mental health-related consequences. These factors may have contributed to the estimated 16 percent of COs who, between 2000 and 2008, resigned from their posts after only three years on the job.[3] Turnover figures are often higher for individual corrections departments.

These impacts can have damaging effects on the wider prison institution. Staff shortages and officer absences from work

This article originally appeared in *Corrections Today* as submitted by the National Institute of Justice. It is reprinted with permission of the American Correctional Association, Alexandria, VA.

View part 2 of this series, *Officer Safety*

can create a cycle of low officer-to-incarcerated person ratios and threaten the security of the facility. Given these circumstances, it is imperative that the safety and wellness of COs is made a priority within corrections facilities and for future corrections research.

Risks and dangers faced by COs

A recent National Institute of Justice (NIJ)-supported paper by Frank Ferdik and Hayden Smith reviewed the available research on CO safety and wellness in an effort to uncover the risks COs confront within their line of work, the policies and programs that could improve their safety, and the limitations of the current research on keeping COs safe.[4] This article discusses what the authors found about the risks faced by COs and their impact on institutional stability to help guide corrections policies and practices to improve safety and minimize the risk of burnout and turnover.

The authors found that following several legislative reforms started in the 1970s that included "get tough on crime" policies such as mandatory minimum sentences and law for those who habitually commit crimes laws,[5] correctional institutions experienced dramatic changes in the composition of the incarcerated population. Not only did the total number of incarcerated individuals skyrocket from roughly 300,000 to more than 1.5 million between 1975 and 2013, but the percentage of people imprisoned for violent crimes increased from about 40 percent in 1985 to more than 60 percent by 2013.[6] Although incarceration rates have declined in recent years, the modern-day CO is still required to interact with and supervise individuals in a dangerous environment.[7]

The authors found a variety of dangers and risks correctional officers face in the course of doing their job, which fall across the following five categories:

1. **Work-related dangers.** This includes persons with infectious diseases, prison gangs, disruptive behavior, contraband presence, persons with mental illness and prison riots.
2. **Institutional-related dangers.** In this category are role ambiguity or role conflict, demanding work obligations, poor leadership, trust or support, no input into decision-making, inadequate resources and employee benefits, extended hours, coworker conflict, and understaffing.
3. **Psychosocial dangers.** Work or family conflict, and media or political scrutiny fall under this umbrella. Mental health risks. Stress and burnout are two examples.
4. **Physical health risks.** This refers to injuries and death.[8]

These risks build upon one another to adversely impact the COs, their family, and the overall institution in which they work.

Consequences of risks

Numerous consequences have been linked to the safety and wellness risks confronting COs:

- Fatigued staff and high turnover rates can limit officers' ability to monitor the incarcerated population.
- Coworker conflict can increase stress levels and lead to decreased work performance or being distracted while on the job.
- Frequent turnover can worsen budget constraints and force remaining officers to work with inoperable weapons, radios and other necessary equipment.

COs also disproportionately experience higher rates of physical health problems, such as chronic neck, back and knee injuries; heart disease; diabetes; high cholesterol; and hypertension, compared with crisis counselors and law enforcement personnel.

The mental and physical strain of the profession can lead to even graver consequences. In a study of more than 3,000 corrections professionals, 27 percent of officers reported symptoms of post-traumatic stress disorder.[9] Worse still, the suicide rate for COs is 39 percent higher than that of the general working-age population.[10]

Policies to promote health and safety

Correctional researchers, administrative officials and prison systems seem to have not prioritized the health and safety concerns of COs. While some facilities have begun to implement programs and policies to improve CO health and reduce stress, such as employee assistance programs and peer-support programs, these have not been used on a large scale, nor has their effectiveness been evaluated. These programs may also neglect some of the risks described above that affect CO wellness and safety.

The authors identified a few key elements to reducing CO stress and burnout. First and foremost, is the recognition by administrative officials and other correctional stakeholders that the profession is dangerous and comes with threats to CO health. This also involves changing the "machismo" culture inside corrections that perceives needing assistance or being honest

about the negative impacts of the job as a sign of weakness to one that recognizes the importance of external support to ensure and improve individual well-being.

Other policies to reduce work and institutional-related risks, include:

- Heightened intake procedures to identify problematic individuals.
- Improved communication channels between correctional line staff.
- Separation of gang members.
- Ensuring officers always have backup when dealing with troublesome individuals.
- Instruction and training on mediation tactics to de-escalate volatile situations.
- Provision of additional therapeutic services, where possible, for persons with mental disorders.[11]

While the past several decades have produced important insights into the working conditions of corrections officers and their general well-being, there needs to be more knowledge about the specific factors that contribute to fatal and nonfatal workplace injuries, poor health, mental health issues, and officer suicide. Further research on these factors can help correctional administrators prevent workplace injury and related health issues, as well as intervene to protect COs from risky and dangerous situations.

To support corrections administrators in this effort, NIJ has committed to invest in safety, health, and wellness research — as described in a strategic research plan. Only with a greater understanding of these problems can corrections develop and evaluate the programs and policies to improve CO safety and wellness, reduce the rate of officer stress and burnout, and further the ability of COs to maintain order within correctional facilities.

Notes

[note 1] Harrell, E. (2011). Workplace violence, 1993-2009 (Report No. 233231). Washington, D.C.: Bureau of Justice Statistics.

[note 2] Konda, S., Reichard, A. A., & Tiesman, H. M. (2012). Occupational injuries among U.S. correctional officers, 1999-2008. Journal of Safety Research, 43(3),181–186.

[note 3] Management and Training Corporation. (2010). Correctional officers: strategies to improve retention, second edition. Centerville, UT: Management and Training Corporation

corporation.

[note 4] Ferdik, F., & Smith, H. (2017). Correctional officer safety and wellness literature synthesis (Report No. 250484). Washington, D.C.: National Institute of Justice.

[note 5] Mackenzie, D. L. (2001). Sentencing and corrections in the 21st century: Setting the stage for the future (Doctoral dissertation, University of Maryland). Proquest.

[note 6] Walmsley, R. (2013). World population list, 10th edition. Essex, UK: International Centre for Prison Studies.

[note 7] Glaze, L. E., & Kaeble, D. (2014). Correctional populations in the United States, 2013 (Report No. 248479) Washington, D.C.: Bureau of Justice Statistics.

[note 8] Ferdik, F., & Smith, H. (2017).

[note 9] Spinaris, C. G., Denhof, M. D., & Kellaway, J. (2012). Posttraumatic stress disorder in United States correctional professionals: Prevalence and impact on health and functioning. Florence, CO: Desert Waters Correctional Outreach.

[note 10] Stack, S. J., & Tsoudis, O. (1997). Suicide risk among correctional officers: A logistic regression analysis. Archives of Suicide Research, 3(3), 183–186.

[note 11] Burke, T. W., & Owen, S. S. (2010, July 1). Cell phones as prison contraband. Law Enforcement Bulletin. Retrieved from https://leb.fbi.gov/articles/featured-articles/cell-phones-as-prison-contraband.

Cite this Article

Read More About:

Stress American Correctional Association (ACA) Law enforcement personnel

Post-traumatic stress disorder (PTSD) Correctional officers

Officer Safety and Wellness Initiatives Wellness Officer safety

NIJ Safety, Health, and Wellness Strategic Research Plan

Social and Behavioral Science

Date Published: March 31, 2018

U.S. DEPARTMENT OF JUSTICE
OFFICE OF JUSTICE PROGRAMS

Exhibit 11

U.S. Department of Justice
Federal Bureau of Prisons

CHANGE NOTICE
OPI: CPD/CPB
NUMBER: 5500.14, CN-1
DATE: August 1, 2016

Correctional Services Procedures Manual

/s/
Approved: Thomas R. Kane
Acting Director, Federal Bureau of Prisons

This Change Notice (CN) implements the following change to Program Statement 5500.14, **Correctional Services Procedures Manual**, dated October 19, 2012. Chapter 1, page 1, paragraph 2 will read as follows. Changes are marked with a highlight.

In order to allow for training and annual/sick leave, a position is calculated at 210 days per year. The subtotal (man days) is divided by 210. The result is the number of positions required to staff the Correctional Services Department.

Example: 50 (total number of 7 Day Posts) x 364 = 18,200

20 (total number of 5 Day Posts) x 260 = 5,200

10 (total number of 3 Day Posts) x 156 = 1,560
Subtotal: 24,960 (total man days)

24,960 divided 210 = 118 positions plus 180 man days, which equals 119 positions. A remainder of 72 or more is one additional position.

U.S. Department of Justice
Federal Bureau of Prisons

Program Statement

OPI: CPD
NUMBER: 5500.14
DATE: 10/19/2012
SUBJECT: Correctional Services Procedures Manual

1. PURPOSE AND SCOPE. To implement policies, procedures, and guidelines to protect the public and maintain a secure, safe and orderly living and working environment for inmates and staff.

This Program Statement promotes standard management practices for correctional staff in all Bureau institutions, while recognizing differences among institutions that vary in missions and security levels.

2. PROGRAM OBJECTIVES. The expected results of this program are:

a. Security posts will be established through meaningful post orders; using a standard roster.

b. Security will be maintained by well-trained, highly professional correctional staff, guided by clearly written policy and procedures and led by Captains and Lieutenants who monitor operations, train, advise, and consult with those staff.

c. Tools, equipment, and materials will be properly used, stored, and inventoried.

d. Continuous inmate accountability will be maintained through a system of accurate counts and census checks.

e. Trained canine units will be established in approved Bureau institutions and be available to other institutions as needed.

f. When mutual Bureau/FBI activity is required to resolve an emergency incident, prior exchange of information and planning will have occurred, and a plan of action will be in place and applied.

g. Major incidents will be investigated by After-Action Review Teams, appointed by Regional Directors.

h. Staff will be assigned to posts or duties requiring the use of firearms only after receiving training and continued requalification with the issued weapon.

i. Inmates sent from Bureau institutions to local medical facilities for medical treatment will be supervised by competent and qualified contract personnel when appropriate.

3. DIRECTIVES AFFECTED

a. Directives Rescinded

PS 1440.01	Providing Emergency Assistance to Local Law Enforcement Agencies (5/18/94)
PS 5500.08	Canine Units, Full Service (9/17/97)
PS 5500.10	Guard Service at Local Medical Facilities (3/1/99)
PS 5511.06	Accountability for Inmates (8/4/97)
PS 5558.14	Firearms and Badges (8/24/00)
PS 5568.05	After-Action, Reporting and Review (10/26/00)

b. Directives Referenced

PS 1210.23	Management Control and Program Review (8/21/02)
PS 1280.11	JUST, NCIC, and NLETS Telecommunications Systems (1/7/00)
PS 1380.05	Special Investigative Supervisors Manual (8/1/95)
PS 1480.05	News Media Contacts (9/21/00)
PS 1600.08	Occupational Safety and Environmental Health (8/16/99)
PS 2000.02	Accounting Management Manual (10/15/86)
PS 3000.02	Human Resource Management Manual (11/1/93)
PS 3420.09	Standards of Employee Conduct and Responsibility (2/5/99)
PS 3906.16	Employee Development Manual (3/21/97)
PS 4400.04	Property Management Manual (8/13/01)
PS 4500.04	Trust Fund/Warehouse/Laundry Manual (12/15/95)
PS 5100.07	Security Designation and Custody Classification Manual (9/3/99)
PS 5162.04	Categorization of Offenses (10/9/97)
PS 5216.05	Juvenile Delinquents, Juvenile Justice and Delinquency Prevention Act (9/01/99)
PS 5324.03	Suicide Prevention Program (5/3/95)

PS 5538.04	Escorted Trips (12/23/96)
PS 5566.05	Use of Force and Application of Restraints on Inmates (7/25/96)
PS 5580.06	Personal Property, Inmate (7/19/99)
PS 5800.13	Inmate Systems Management (6/28/02)
PS 5800.10	Mail Management Manual (11/30/95)
PS 5890.13	SENTRY National On-line Automated Information System (12/14/99)
PS 6000.05	Health Services Manual (9/15/96)

U.S. Department of Justice Office of Investigative Agencies Policies, Resolution 14, and Attachments A and B (Policy Statement-Use of Deadly Force and Commentaries) (10/17/95)

4. STANDARDS REFERENCED

a. American Correctional Association 4th Edition Standards for Adult Correctional Institutions: 4-4091(M), 4-4172, 4-4174, 4-4177, 4-4178, 4-4179, 4-4180, 4-4181, 4-4182, 4-4183, 4-4184, 4-4185, 4-4187, 4-4188, 4-4196, 4-4202, 4-4204(M), and 4-4205(M)

b. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF-1D-18(M), 3-ALDF-1F-05, 3-ALDF-2G-03, 3-ALDF-3A-03, 3-ALDF-3A-05, 3-ALDF-3A-06, 3-ALDF-3A-07, 3-ALDF-3A-08, 3-ALDF-3A-11, 3-ALDF-3A-12, 3-ALDF-3A-14, 3-ALDF-3A-15, 3-ALDF-3A-22, 3-ALDF-3A-28, 3-ALDF-3A-30, and 3-ALDF-3A-32(M)

c. American Correctional Association 2nd Edition Standards for Administration of Correctional Agencies: 2-CO-3A-01

d. American Correctional Association Standards for Adult Correctional Boot Camp Programs: None

5. PRETRIAL/HOLDOVER PROCEDURES. Procedures required in this Program Statement apply to pretrial/holdover inmates and INS Detainees in Bureau Custody.

6. DEFINITIONS. Throughout this Program Statement, there is reference to guidelines and requirements based on the security levels of institutions. For the purpose of security level identification, administrative facilities will be governed under the same guidelines as medium security facilities, unless otherwise noted.

7. REPRODUCTION OF ATTACHMENTS. All attachments included in this Program Statement may be reproduced locally or acquired via BOPDOCS.

8. RETENTION OF DOCUMENTS FOR CORRECTIONAL SERVICES. In order to maintain a record of past information, the retention of these documents must be stored for future reference. The duration for each document is listed on the Retention of Documents List (Attachment A).

9. IMPACT ON MASTER AGREEMENT. This document is to be reviewed in conjunction with the negotiated Master Agreement. If there are any contradictions between the two documents, the Master Agreement will prevail.

10. INSTITUTION SUPPLEMENTS. The following provisions of this Manual require Institution Supplements:

a. Chapter 2 (page 1), Section 200.1, tool control procedures and tool control inspection system.

b. Chapter 2 (page 2), Section 201.2, a list of all tools by Class AA, A, and B including descriptions and size of all tools currently in use.

c. Chapter 2 (page 4), Section 204.2, procedures for using the Government-wide Credit Card Program to purchase tools.

d. Chapter 2 (page 9), Section 207.1, procedures to carry out the tool survey process including the destruction of any surveyed tools.

e. Chapter 3 (page 4), Section 304.1, guidelines and procedures for conducting census checks.

/s/
Charles E. Samuels, Jr.
Director

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COUNTS - CENSUS CHECKS

300. BASIC PRINCIPLES

1. Each institution will conduct, at a minimum, five official inmate counts during every 24-hour period. On weekends and holidays an additional count will be conducted at 10:00 a.m.

- The daily 4:00 p.m. count and 10:00 a.m. count (on weekends and holidays) will be stand-up counts.

Institutions with secure cell space are required to lock the inmates in their cells for all official counts, unless the inmates are on out-counts in areas such as Food Service, Hospital, visiting room, etc.

2. The master count will be maintained in the Control Center. The Control Center Officer will be notified of any changes in an inmate's status, such as housing unit and job assignments, admission to hospital, etc. The official count will be readily available on the Master Count Sheet or in SENTRY.

3. Each count will be conducted with at least two officers. There will be no inmate movement during an official count. The count process will not be interrupted under any circumstances, other than by an emergency. Exceptions to the no inmate movement must be when inmates are in the wrong place for a count and have to be moved by direct staff escort to their proper place of count.

Staff must not be distracted during the count.

One staff member will count while the second staff member stands in a position to observe inmate movement. When the first staff member completes the count, the staff member will change positions. The second staff member will conduct the count while the other staff member observes the inmates. If the staff members count totals do not match, a recount will be conducted in the same manner. Two staff members may count simultaneously (one behind the other) if a third staff member is available to observe inmate movement or all cells are secure before the count begins.

If the totals do not match after the second count, the Operations Lieutenant will be notified via the Control Center. The Operations Lieutenant will dispatch a third officer/staff member to the location to assist with the count. The third

officer/staff member will observe the inmates while the other staff members conduct a double count.

4. Staff will not conduct a count based upon movements, sounds, or configurations from a covered bed.

Staff will ensure they are positively observing human flesh before counting any inmate.

5. The staff members conducting a specific unit count will not leave the unit until the Control Center accepts that particular unit count.

6. When counting at night, a flashlight must be used judiciously; however, enough light will be shown on the inmate to leave no doubt the officer is counting human flesh.

301. OFFICIAL COUNTS

1. The official count is to be taken at specific times during each 24-hour period.

2. "Out counts" will be kept to a minimum. All "out counts" of more than five inmates must be counted by two staff members using detail cards or inmate identification cards for identification. Out counts will not be prepared by inmates.

The detail supervisor will sign his/her "out count" sheets prior to submission to the Operations Lieutenant. The Operations Lieutenant will sign and approve the "out count" prior to submission to the Control Center for the official counts.

3. At MCCs, FDCs and MDCs, where there is continuous inmate movement in and out of the institution, ISM staff will provide an out-count of inmates who are presently out of the institution during counts.

ISM staff will provide a count slip, signed by two staff members, verifying ISM has documentation that the inmates are in other law enforcement officials' custody.

4. Each count must be reported verbally to the Control Center for verification. If the count does not match the Master Count in the Control Center, the reporting staff members must recount when the Operations Lieutenant is notified by the Control Center.

If the second count does not match the Control Center's count, the Operation Lieutenant will order a bed-book (picture card) count. This count requires that each inmate is counted by identifying the inmate using the bed book picture card. At the completion of this count, any discrepancy will be identified.

The official count will not be cleared until all count slips are received and verified in the Control Center.

5. A Lieutenant will take at least one count on the morning and evening shifts.

6. Count slips, out count sheets, and official count sheets must be prepared in ink and retained for 30 days. The count must have the names (printed and signed) of both officers (staff) who conducted the count.

- Altered/illegible count slips are not acceptable.

302. EMERGENCY COUNTS

1. This is an official count taken at times other than that specified for a regular official count. The Captain will authorize emergency counts during weekday operations. During evening, morning, and weekend operation, this authority is delegated to the Operations Lieutenant.

2. When perimeter visibility is limited by fog, power failures, or for any other reason, it is necessary to count at more frequent intervals than the regularly scheduled official counts.

303. OFFICIAL COUNT FORM. All official counts are to be recorded on the SENTRY generated form. If SENTRY is unavailable, or time does not permit the entering of all out counts, the Official Count form (Attachment B) will be used.

The format will not be altered; although, the size may be increased to provide space for additional units or "out-counts."

304. CENSUS CHECKS. To ensure effective accountability of inmates, census checks must be conducted at all institutions. Census checks identify inmates in unauthorized and unassigned areas.

- This check is not an official or total head count.

1. Census Checks. All Departments must conduct a census of all inmates assigned to their area during each work period (AM and PM). It is each department's responsibility to document the results of each census check; for example, AM census check completed at 8:40 a.m. with no discrepancies, PM census check completed at 8:40 p.m. with one inmate out of bounds. Discrepancies and action taken must be listed.

Institutions will set guidelines and procedures for conducting the census check in an Institution Supplement.

2. Detail Accountability Checks. Lieutenants will conduct accountability checks for all work details each month. To ensure compliance with this requirement, 25% of all inmate details will be checked each week.

These checks are conducted to identify inmates in unauthorized areas, and to determine the presence and accuracy of detail cards (crew kit cards). Discrepancies will be immediately corrected. These checks are in addition to the AM/PM census checks the detail supervisors/foremen conduct.

a. Accountability checks will be conducted randomly throughout the month at various times with no prior notification.

b. The Captain's office must maintain documentation of all detail accountability checks for 30 days.

3. Lockdown Accountability Checks. Each institution will conduct a monthly institution accountability check. The purpose of this accountability is to identify inmates in unauthorized areas throughout the institution - not to obtain a total head count.

a. The accountability check will be announced at a random time and date with no prior notification.

b. Upon hearing the announcement of a lockdown accountability check, staff must secure all entrances and exits in their area, stop all inmate movement, and must survey their area of responsibility to account for and verify inmates authorized/unauthorized to be in the area.

Staff will identify inmates assigned to the detail or area who cannot be accounted for during the accountability check. The Lockdown Census forms must be completed on all accountability checks (Attachment D), which includes:

(1) Names and register numbers of inmates found in unauthorized areas and

(2) Names and register numbers of inmates assigned to the detail who cannot be accounted for.

305. CONTROL CENTER RECORDS. Picture cards of all inmates assigned to the institution will be on file in the Control Center. Control Center records must accurately document:

- Custody;
- Sentence information (MCC/MDC exempt); and
- Other necessary security and control information.

306. DAILY CHANGE/TRANSFER SHEET. A SENTRY generated list which denotes changes in an inmate's status must be published each regular work day.

The list includes:

- Housing unit assignment;
- Job assignment; and
- Medical idle or convalescence which exceeds one day.

A copy of this document must be available to staff who supervise inmate details and each employee responsible for preparing the list of changes.

Inmates will not be involved in the process or publication of the change/transfer list.

307. INMATE CALL-OUTS. The call-out sheet lists time and location for inmates who have scheduled appointments with staff, i.e., medical, dental, educational, etc. This information will be made available to all concerned staff and posted in the inmate housing units.

Special precautions must be established to ensure that inmates are unable to circumvent the procedures or make additions and deletions which undermine the accountability system. The employee who places an inmate on call-out must ensure the requested inmate arrives at the allotted time.

If an inmate does not arrive at the prescribed time, the requesting staff member must contact the staff responsible for the inmate's accountability. If efforts to locate the inmate fail, the inmate must be reported to a lieutenant immediately as missing and appropriate actions will be initiated to locate the inmate.

308. PASS SYSTEM. All institutions that adopt a pass system must implement the following elements to ensure the program is not compromised.

- Establish a method of daily accountability for all passes issued each work day.
- Identify an employee to check each issued pass against the stub or copy remaining in the pass book.
- Maintain a log to document discrepancies.
- Develop a system of reporting pass system discrepancies to the Lieutenant's Office.
- Implement a follow-up system by the Lieutenant's Office which includes written notification to the responsible employee with copies submitted to the Captain and responsible employee's department head.
- Departments with noted discrepancies must submit a report of action denoting steps taken to correct discrepancies to the Lieutenant's Office.
- Frequent discrepancies within the same department must be reported to the respective Associate Warden.

Follow-ups and accountability for each pass are key elements in any effective pass system.

309. DETAIL/CREW KIT CARDS. Control Room Officers must ensure each crew kit has current detail cards on all inmates assigned to the detail. At a minimum, crew kit cards must provide:

- Names of the inmates;
- Register number;
- Current photo (a new photo must be made whenever an inmate's appearance changes);
- Job assignment;
- Quarters assignment;
- Custody level; and
- Any special conditions.

Detail supervisors will be responsible for inmates whose cards are included in the respective crew kits and the accountability of the crew kits when checked out from Control Center.

Inmates will never be allowed to handle detail/crew kits and/or the cards assigned to the kits.

310. SPECIAL ACCOUNTABILITY. A staff member must observe all inmates confined in continuous locked down status, such as administrative detention or disciplinary segregation, at least once in the first 30 minute period of the hour (example, 12:00 a.m. - 12:30 a.m.) followed by another round in the second 30 minute period of the same hour (example, 12:30 a.m. - 1:00 a.m.), thus ensuring an inmate is observed at least twice per hour. These rounds are to be conducted on an irregular schedule and no more than 40 minutes apart. All observations must be documented.

Closer observation may be required for an inmate who is mentally ill, or who demonstrates unusual or bizarre behavior.

For specific instructions and guidance for the supervision and monitoring of suicidal inmates refer to the following Program Statements.

- Health Services Manual
- Suicide Prevention

Exhibit 12

[redacted] 4/23/21 en1

OSHA's Form 300 (Rev. 01/2004)
Log of Work-Related Injuries and Illnesses

Attention This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 20

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

As of Date:
Event Range: 1/1/2020 To 12/31/2020
180 Day Rule: True
Event Based: False
Run Date: 4/23/2021

Establishment Name: Sheriff Jail Division II Security & Service F071
City: _____ State: _____

Identify the person			Describe the case			Classify the case (CHECK ONLY ONE box for each case based on the most serious outcome for that case)				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness:					
(A) Case No.	(B) Employee's name	(C) Job title (e.g. Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	Death (G)	Remained at Work: Days away from work (H)	Remained at Work: Job transfer or restriction (I)	Remained at Work: Other recordable cases (J)	Away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin Disorder (2)	Respiratory Condition (3)	Poisoning (4)	Hearing Loss (5)	All Other Illnesses (6)
EV20201300060	[redacted]			(Mallory Ingram) 4 SW.	(Mallory Ingram) "THUMB" EE was subduing an inmate and hu[redacted] left thumb with the taser prong.	☐	☐	☐	☑	0 days	0 days	☑	☐	☐	☐	☐	☐
EV2020100007				(Mallory Ingram) 3 Old	(Mallory Ingram) "BACK" EE was pushing a wrap bucked into the closet and [redacted] a strain i[redacted] lower back.	☐	☐	☑	☐	0 days	7 days	☑	☐	☐	☐	☐	☐
EV2020100002				Jail Building	"WHOLE BODY" EE was exposed to covid-19	☐	☑	☐	☐	40 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				(Leslie Karen) Frank Murphy Hall of Justice	"WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☑	☐	☐	180 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100005				Old Jail-Division 2	"COVID-19"	☐	☑	☐	☐	115 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				(Mallory Ingram) Unknown.	(Mallory Ingram) "WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				Unknown	"WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☑	☐	☐	67 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				(Mallory Ingram) Unknown.	"WHOLE BODY" EE was exposed to COVID-19 through inmate contact.	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				(Mallory Ingram)Unknown.	"WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				(Mallory Ingram) Unknown	"WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				FMHJ	Covid-19	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				(Leslie Karen) Cowdy Jail	"WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001				(Mallory Ingram) Unknown.	"WHOLE BODY" EE was exposed to COVID-19 through inmate contact.	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
					Page Totals ➤	0	4	1	8	402	7	2	0	11	0	0	0

Be sure to transfer these totals to the Summary Page (Form 300A) before you post it.

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Injury (1) Skin Disorder (2) Respiratory Condition (3) Poisoning (4) Hearing Loss (5) All Other Illnesses (6)

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

Attention This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 20

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

As of Date:
Event Range: 1/1/2020 To 12/31/2020
180 Day Rule: True
Event Based: False
Run Date: 4/23/2021

Establishment Name: Sheriff Jail Division II Security & Service F071

City: _____ State: _____

Identify the person			Describe the case			Classify the case				Enter the number of days the injured or ill worker was:		Check the "Injury" column or choose one type of illness:					
(A) Case No.	(B) Employee's name	(C) Job title (e.g. Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from scalding broth)	Death (G)	Days away from work (H)	Job transfer or restriction (I)	Other recordable cases (J)	Away from work (K)	On job transfer or restriction (L)	Injury (1)	Skin Disorder (2)	Respiratory Condition (3)	Poisoning (4)	Hearing Loss (5)	All Other Illnesses (6)
EV2020130207[redacted]				(Mallory Ingram) Unknown.	"WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☑	☐	☐	180 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001[redacted]				(Mallory Ingram) Unknown.	"WHOLE BODY" EE was exposed to COVID-19 through inmate contact.	☐	☐	☐	☑	3 days	6 days	☐	☐	☑	☐	☐	☐
EV2020100001[redacted]				(Mallory Ingram) unknown.	"WHOLE BODY" EE was exposed to COVID-19 through inmate contact.	☐	☐	☐	☑	9 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001[redacted]				Div II Floor Security	"WHOLE BODY" EE was exposed to COVID-19 through contact, tested positive.	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100001[redacted]				(Mallory Ingram) Unknown.	(Mallory Ingram) "WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☑	☐	☐	12 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100002[redacted]				Jail	"WHOLE BODY" EE was exposed to COVID-19 through contact.	☐	☑	☐	☐	180 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100003[redacted]				Old Jail Div 2	"COVID-19"	☐	☐	☐	☑	0 days	0 days	☐	☐	☑	☐	☐	☐
EV2020100002[redacted]				WCJ Division 2 W/307	"BACK/LEGS" EE fell against the bars and pulled a muscle in [redacted] back and legs while trying to restrain an inmate.	☐	☑	☐	☐	15 days	6 days	☑	☐	☐	☐	☐	☐
[redacted]2020100003				Jail Div 1 Use to Ward	"ARM" EE was attempting to move inmate to new housing and inmate swung at EE	☐	☐	☐	☑	0 days	0 days	☑	☐	☐	☐	☐	☐
EV2020100003[redacted]				Lincoln Hall	Inmate attack, multiple trauma, EE death.	☑	☐	☐	☐	0 days	0 days	☑	☐	☐	☐	☐	☐
EV2020100000[redacted]				Old Jail Div 2	"ELBOW" EE was attacked by an inmate and was defending themselves and hurt elbow	☐	☑	☐	☐	27 days	61 days	☑	☐	☐	☐	☐	☐
EV2020100000[redacted]				Old Jail- Div 2	"KNEE" EE was attempting to get off a rolling chair and injured knee	☐	☐	☐	☑	0 days	9 days	☑	☐	☐	☐	☐	☐
EV2020100000[redacted]				Old Jail-Div 2	"COVID-19"	☐	☑	☐	☐	20 days	0 days	☐	☐	☑	☐	☐	☐
					Page Totals ➤	1	6	0	6	454	69	5	0	8	0	0	0

Be sure to transfer these totals to the Summary Page (Form 300A) before you post it.

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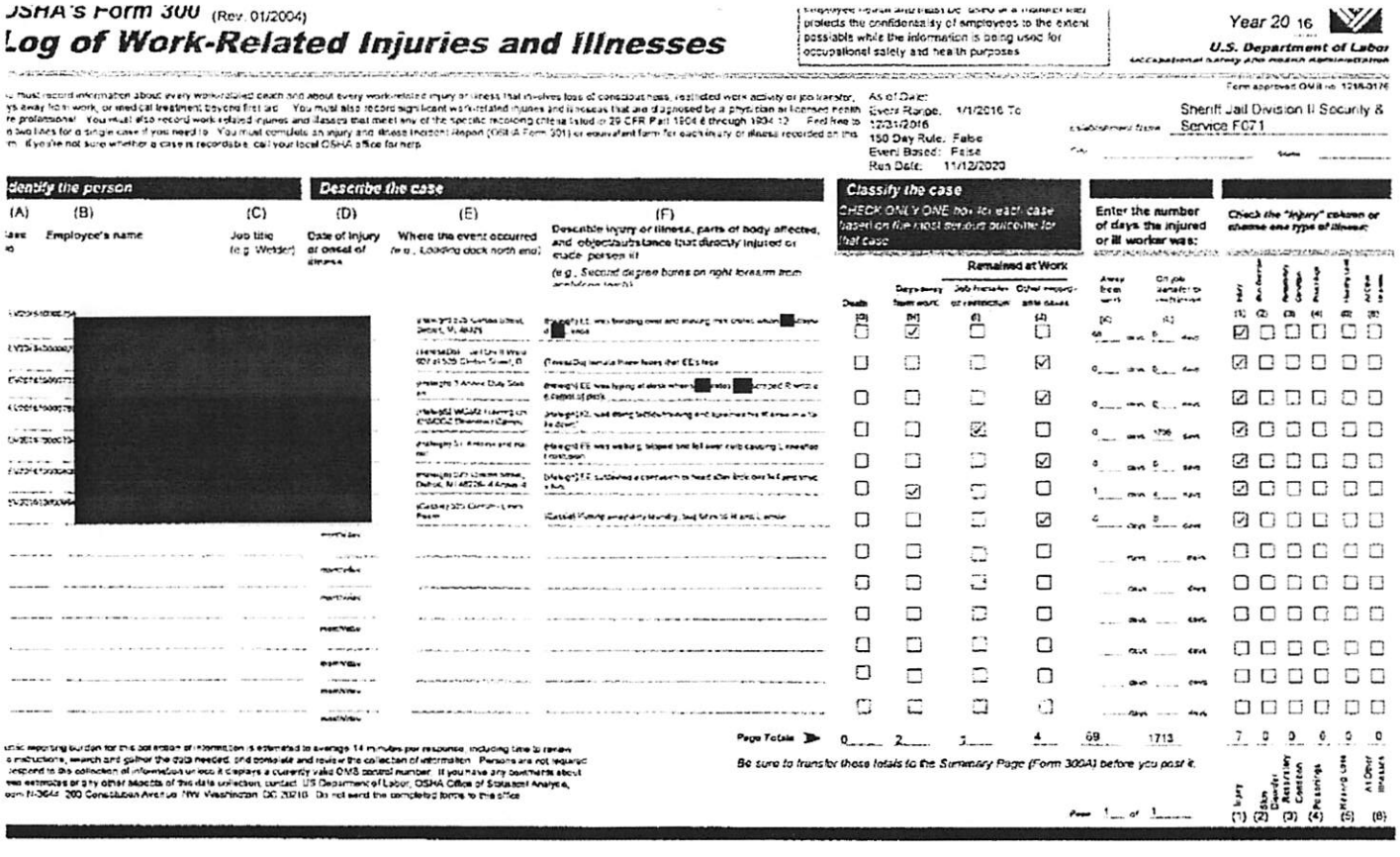

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

Employee names and titles be listed in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes

Year 20 16

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

As of Date:
Event Range: 1/1/2016 To 12/31/2016
180 Day Rule: False
Event Based: False
Run Date: 11/12/2020

Establishment name: Sheriff Jail Division II Security & Service F071

City: State:

Identify the person

(A) Case no.

(B) Employee's name

(C) Job title (e.g., Welder)

Describe the case

(D) Date of injury or onset of illness

(E) Where the event occurred (e.g., Loading dock north end)

(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)

Classify the case

CHECK ONLY ONE box for each case based on the most serious outcome for that case

Death (G)	Days away from work (H)	Remained at Work: Job transfer or restriction (I)	Remained at Work: Other recordable cases (J)
☐	☑	☐	☐
☐	☐	☐	☑
☐	☐	☐	☑
☐	☐	☑	☐
☐	☐	☐	☑
☐	☑	☐	☐
☐	☐	☐	☑
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
☐	☐	☐	☐
Page Totals ➤ 0	2	1	4

Enter the number of days the injured or ill worker was:

Away from work (K)	On job transfer or restriction (L)
60 days	0 days
0 days	0 days
0 days	0 days
0 days	1706 days
0 days	0 days
1 days	6 days
6 days	0 days
69	1713

Check the "injury" column or choose one type of illness:

Injury (1)	Skin Disorder (2)	Respiratory Condition (3)	Poisoning (4)	Hearing Loss (5)	All Other Illnesses (6)
☑	☐	☐	☐	☐	☐
☑	☐	☐	☐	☐	☐
☑	☐	☐	☐	☐	☐
☑	☐	☐	☐	☐	☐
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☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
☐	☐	☐	☐	☐	☐
7	0	0	0	0	0

Be sure to transfer these totals to the Summary Page (Form 300A) before you post it.

Page 1 of 1

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Exhibit 13

Detroit Police Department DeAndre Williams Interrogation Video
"A22-02340 Redacted Interveiw cameras 9-3-2020.mp4"

LAW DEPARTMENT

Coleman A. Young Municipal Center
2 Woodward Avenue, Suite 500
Detroit, Michigan 48226-3437

Phone 313•224•4550
Fax 313•224•5505
www.detroitmi.gov

February 22, 2022

Sent Via Email:
SSDS518@GMAIL.COM

Sherry Searcy
24295 Ormond Dr.
Southfield, MI 48083

RE: **Freedom of Information Act Request A22-02340, DATED February 14, 2022 Concerning City of Detroit Records Pertaining to Cpl. Bryant Searcy**

Dear Ms. Searcy

This letter serves as the City of Detroit's response to the above-referenced matter. Your request was received at the City of Detroit Law Department Freedom of Information Act Section, on **February 16, 2022**. Thank you for your patience in this matter.

Your request seeks:

> Pursuant to, and in accordance with, the applicable provisions of the Michigan Freedom of Information Act (FOIA), I am requesting a copy of the Detroit Police Department's complete investigation report / file as it relates to the death of my husband, Cpl. Bryant Searcy, of the Wayne County Sheriff's Department, who was murdered while on duty and working in Jail Division II on September 2, 2020.

The Detroit Police Department (DPD) conducted a search and retrieval of the requested records and submitted them to the Law Department. DPD personnel provided to the Law Department, three hundred seventy (370) pages of documents, and one (1) interrogation video that is twenty minutes in length. Prior to release, City of Detroit Law Department personnel must conduct a line-by-line review of the records in order to separate exempt from non-exempt information. Review of the records, and redaction of the written records by the Law Department will require an estimated five and one-half (5.5) hours of staff time at an hourly rate of $33.60 plus benefits. Redaction of the video record by the Law Department will require an estimated one (1) hour of staff time at an hourly rate of $46.63 plus benefits. These hourly rates are commensurate with the lowest paid personnel capable of performing the task in the respective departments. See, Section 4(1) and (3) of the Michigan Freedom of Information Act, MCL 15.234(1) and (3). Accordingly, the City will incur total estimated cost in the amount of Three Hundred Ten and

50/100 ($310.50) in order to comply with your request.

If you wish to proceed with this request, we require that you submit a deposit in the amount of one-half (½) of the total estimated labor cost, in accordance with MCL 15.234(8). Accordingly, please forward your check or money order in the amount of **One Hundred Fifty-Five and 25/100 Dollars ($155.25)** made payable to the **"City of Detroit"** no later than April 12, 2022. Please note that we do not accept cash.

Upon receipt of your deposit, in accordance with MCL 15.234(1) and (3), we will provide you with: a supplemental written response outlining the information that has been exempted from the record; the legal authority for each exemption; and the cost for you to obtain a copy of the record. In that regard, please note that the City charges $1.00 for compact disk (CD) or $0.10 per page for copies of ten (10) or more pages. *Please note that if we are not in receipt of your deposit by the above-referenced date, we shall consider your request abandoned and close our file on this request, pursuant to MCL 15.234(14).*

Please see enclosed Fee Itemization Form and make your check or money order payable to "City of Detroit". Additionally, **include the FOIA request number listed above on the memo line of your check/money order or on a separate note** and forward to my attention. It is important to note that we do not accept cash. **Additionally, please do not write on the check outside of the memo line as our bank will not process checks with writing outside of the memo line. Failure to comply with these policies will result in your check being returned to you.** I estimate review of the record will take four (4) weeks once we receive your deposit.

Please be advised that, due to the COVID-19 pandemic, the City of Detroit Law Department would prefer that all letters, payments and other correspondence pertaining to new or pending FOIA requests be sent via email or the U.S. mail. We will send all correspondence to members of the public via U.S. Mail and/or email as appropriate. Please contact Jack Dietrich at 313-237-5030, if this policy creates a hardship for you. Thank you in advance for your compliance with this policy.

Please Note: The attorneys who work on FOIA matters are working remotely and are not located in CAYMC.

You can find the summary of the City of Detroit Freedom of Information Act procedures and guidelines at www.detroitmi.gov and specifically at https://detroitmi.gov/document/foia-procedures-and-guidelines and https://detroitmi.gov/how-do-i/request-document/foia-freedom-information-act-request.

Please note that pursuant to Section 10 and 10a of the Act, MCL 15.240 and 15.240a, a person receiving a written denial of a request or receiving a letter to submit the labor costs may do one of the following:

1) Submit a written appeal to the head of the public body denying the request. Such appeal, if submitted, should specifically state the word "appeal" and identify the reason or reasons for reversal of the disclosure denial. MCL 15.240(1)(a) and MCL 15.240a(1)(a); or
2) Commence an action in the circuit court to compel the disclosure of the public records within 180 days after the public body's denial of the request, MCL 15.240(1)(b), or 45 days after the public body's request for labor costs, MCL 15.240a(1)(b). If a court finds that the information withheld by a public body is not exempt from disclosure, or that the labor costs requested by the public body exceeds the amount permitted, the requesting party may receive the requested record and, at the discretion of the court, reasonable attorney fees and /or cost. MCL 15.240(6) and (7), and MCL 15.240a(6) and (7).

Very truly yours,

Devin F. Farrelly
Assistant Corporation Counsel
FOIA Section
City of Detroit Law Department
(313) 237-3013
Farrellyd@detroitmi.gov

FOIA FEE ESTIMATE *pursuant to MCL 15.234(8)*

pursuant to MCL 15.234(4),
effective January 1, 2019

File Number: A21-18679

Line	warrants Reference	Component	Amount	Subtotal	Total
1	§ 4(2)	Fringe benefit multiplier rate, maximum 50%	34.173%		
2	§ 4(1)(b)	**Labor for reviewing and redacting**			
3		hourly wage of lowest paid employee capable of work	$33.60		
4	LAW	fringe benefit multiplier @ 34.173%	134.2%		
5	Dept.	modified hourly wage = line 3* line 4	$45.08		
6		number of hours, rounded down to .25 increment	5.5		
7		line 5 multiplied by line 6	0	$247.94	
8		hourly wage of lowest paid employee capable of work	$46.63		
9	LAW	fringe benefit multiplier @ 34.173%	134.2%		
10	Dept.	modified hourly wage = line 8* line 9	$62.56		
11		number of hours, rounded down to .25 increment	1		
12		line 10 multiplied by line 11		$62.56	
13		**Estimated Total - Labor for searching & examining**			$310.50
14	§ 4(1)(b)	**Labor for reviewing and redacting**			
15		hourly wage of lowest paid employee capable of work	$33.60		
16		fringe benefit multiplier @ 34.173%	134.2%		
17		modified hourly wage = line 15* line 16	$45.08		
18		number of hours, rounded down to .25 increment			
19		line 17 multiplied by line 18			
20		**Estimated Total - Labor for reviewing and redacting**			$0.00
21	§ 4(1)(e)	**Labor for duplicating**			
22		hourly wage of lowest paid employee capable of work			
23		fringe benefit multiplier @ 34.173%	134.2%		
24	Dept.	modified hourly wage = line 22* line 23			
25		Number of hours, rounded down to next increment			
26		line 24 multiplied by line 25			
27		hourly wage of lowest paid employee capable of work			
28		fringe benefit multiplier @ 34.173%	134.2%		
29	Dept.	Rev			
30		Number of hours, rounded down to next increment			
31		line 29 multiplied by line 30			
32		**Estimated Total - Labor for duplicating**			$0.00
33		**Estimated TOTAL Labor costs - sum of lines 13, 20, and 32:**			$310.50
34	§ 4(9)	**Reduction in labor costs for late written response**			
35		number of business days late	0		
36		reduction at 5% / day = 0.05 x line 35	0%		
37		maximum reduction	50%		
38		lesser of line 36 or line 37	0%		
39		Reduced amount = line 38 x line 33			$0.00
40		**Estimated Amount Chargeable for Labor Costs, after applicable reduction:**			$310.50

CONTINUED ON NEXT PAGE

FOIA FEE ESTIMATE *pursuant to MCL 15.234(8)*

pursuant to MCL 15.234(4),
effective January 1, 2019

warrants

File Number: A21-18679

40		**Estimated Amount Chargeable for Labor Costs, after applicable reduction (copied from page 1):**		**$310.50**
41	§ 4(1)(d)	**Estimated cost of paper copies**		
42		number of 8½ x 11 or 8½ x 14 sheets		
43		price for 8½ x 11 or 8½ x 14 sheets	$0.10	
44		line 42 multiplied by line 43		
45		color or other size copies, size: ___ x ___		
46		actual price per page		
47		line 45 multiplied by line 46		
48		color or other size copies, size: ___ x ___		
49		actual price per page		
50		line 48 multiplied by line 49		
51		**Total - estimated cost of paper copies**		**$0.00**
52	§ 4(1)(c)	**Estimated cost of electronic media**		
53		Number of CD's @ $1.00		
54		Number of Flash Drives		
55		Number of Tapes		
56		Other:		
57		Sum of lines 53 - 56		
58		**Total - estimated cost of electronic media**		**$0.00**
59		**Estimated Costs of paper copies and electronic media - sum of lines 51 and 58:**		**$0.00**
60	§ 4(1)(f)	**Estimated cost of mailing**		**$0.00**
61	§ 4(2)	**Reduction for indigency or qualifying non-profit**		
62		Affidavit/information provided: Y/N?		**$0.00**
63		**Estimated Net Charge after any reductions, but not less than zero - sum of lines 40, 59, 60, and 62:**		**$310.50**
64		**MAXIMUM AMOUNT FOR DEPOSIT - 50% of line 63, but only if line 63 exceeds $50.00:**		**$155.25**
65		Sum of deposits, previous payments, other credits:		
66		**CREDIT - for deposits and other previous payments:**		**$0.00**
67		**DEPOSIT REQUIRED - Line 64 offset by line 66, but not less than zero:**		**$155.25**

Include the FOIA request file number listed above on your check/money order. Failure to include the FOIA request number will result in your check being returned.

Exhibit 14

On September 12, 2013, the Michigan Sheriffs' Coordinating and Training Council (MSCTC) approved and adopted a revised standard which changes the requirements for maintaining pre-service eligibility. The revised standards are listed below.

FOR THOSE CANDIDATES GRADUATING PRIOR TO SEPTEMBER 12, 2013

If a candidate graduated from a 160 hour Local Corrections Officers Academy approved by the MSCTC or from an associate or baccalaureate degree program offered by an accredited institution of higher education which incorporates a 160 hour Local Corrections Officer Academy approved by the MSCTC prior to September 12, 2013, a candidates pre-service eligibility will be valid for two (2) years.

After a candidate's two years of eligibility has ended, the candidate may maintain the pre-service eligibility by demonstrating completion of at least 20 hours of annual in-service training approved by the MSCTC. The required 20 hour annual training will include at least three subject areas and contain no more than 10 hours of firearms training. It will be the candidate's responsibility to furnish the MSCTC with proof of meeting the annual 20 hour in-service training requirement utilizing the list of MSCTC-approved in-service training topics listed on the MSCTC web site.

FOR THOSE CANDIDATES GRADUATING AFTER SEPTEMBER 12, 2013

Beginning September 12, 2013, a candidate's pre-service eligibility will be valid for one (1) year after graduation from a 160 hour Local Corrections Officers Academy approved by the MSCTC or from an associate or baccalaureate degree program offered by an accredited institution of higher education which incorporates a 160 hour Local Corrections Officer Academy approved by the MSCTC.

After one year from the date of graduation the candidate may maintain the pre-service eligibility by demonstrating completion of at least 20 hours of annual in-service training approved by the MSCTC. The required 20 hour annual training will include at least three subject areas and contain no more than 10 hours of firearms training. It will be the candidate's responsibility to furnish the Council with proof of meeting the annual 20 hour in-service training requirement utilizing the list of MSCTC-approved in-service training topics listed on the MSCTC web site.

Exhibit 15

STATEMENT FORM

☒ INTERVIEW ☐ INTERROGATION

Detroit police Page 1 of 2 ✓

Contact Location (Check One):

☐ Walk-In to Police Facility ☒ In Field/At Scene ☐ Hospital ☐ Conveyed by a DPD Member (Complete Witness Conveyance Form)

Location/Place: WCS

Print Information:

					FILE/CASE NO. 2009020431	
STATEMENT TAKEN BY: RANK, FIRST / LAST NAME, BADGE: Sgt. Todd Eby #S-628				PRECINCT/COMMAND: HTF		
DATE STATEMENT TAKEN: 9.3.20	START TIME: 3:45 AM			END TIME: ~~3:50 AM~~ 4:46 AM		
NAME OF PERSON PROVIDING STATEMENT: Steven Williams	D.O.B. [redacted]	AGE: 38	SEX: M	RACE: M	HGT.: 6'4"	WGT.: 220
SOC. SEC. NO. (LAST 4 DIGITS):	RESIDENCE: [redacted]			PHONE: BUS. RES. [redacted]		
EMPLOYER	DEPARTMENT			BADGE NO.	SHIFT	
RESIDING WITH: [redacted]	CHILDREN / SCHOOL:					
RELATIVES / FRIENDS:	ADDRESS			PHONE:		
REVIEWING SUPERVISOR RANK, FULL NAME, BADGE (PRINT): Sgt. Todd Eby #S-628				SIGNATURE OF REVIEWING SUPERVISOR:		
DATE: 9-3-20	TIME: 9:00 AM			PRECINCT/COMMAND: HTF		

Q: Describe the incident involving the assault of Dep. Searcy?
A: Refused to answer any questions
Q: Did you request to be return so that you can provide a Statement?
A: yes, he was my favorite deputy
Q: Describe the incident
A: In the afternoon I was playing cards with Tyron Ivey & Deandre Williams approached us & asked us a few questions about what cross streets we are located at. Tonight I obs. Williams place an eraser in the cell to prevent the locking mechanism from engaging. When the cell was closing the eraser prevented Deandre's cell from closing. When Deputy Searcy walked by Deandre Williams jumped out his cell & attacked Ded. Searcy. I obs. Deandre throw Dept Searcy to the ground & put him in a choke hold. When Deandre get up off Dep Searcy, he was motionless &

~~Refused 9.3.20 3:50 AM~~

C of D- 72-ST (4-76) SIGNATURE OF PERSON PROVIDING STATEMENT / DATE AND TIME OPD-103 (Rev 04/2014)

Steven Williams 9-3-2020 4:46 AM

0222

PRINT NAME Steven Williams (CONTINUED) Page 2 of 2

Deandre took Dep. Searcy's key & ran towards the exit door. Deandre heard the Deputy's coming & got spooked & then ran back to his cell. When Deandre got back to his cell I heard him state "I choked that bitch out!" I also obs. blood on Deandre's T-shirt. The Deputy's responded & took me out my cell & put me here.

Q: Do you know if Deandre had issues with Dep. Searcy?

A: No I think Deandre was trying to escape & would have done that to any deputy

Q:

A: When Searcy walked by to check his cell, Deandre jumped out & they were tussling. Deandre took Dep. Searcy to the ground & put him in a choke hold saying "Go to sleep, go to sleep!". When Deandre got up Searcy was motionless & Deandre took his keys & ran to the exit door attempting to escape. Deandre must have gotten spooked because he ran back to his cell while wiping blood off his face. When Deandre got back to his cell he washed his ~~head~~ hands & was trying to cut his fingernails while saying "I choked that bitch out!"

Steven Williams 9-3-2020 9:46 AM

D-72-ST (4-76) SIGNATURE OF PERSON PROVIDING STATEMENT / DATE AND TIME CPD-103 (Rev. 04/2014)

Exhibit 16

FBI FINDINGS UPDATE			
FBI FINDINGS:	None at this time		
SENT TO:	N/A	**DATE/TIME:**	N/A
UPDATED BY:	N/A	**DATE/TIME:**	N/A

RESPONSE TEAM REPORT			
MOTIVE:	Police	**WEAPON TYPE:**	Personal (Hands, etc.)
DATE/TIME TEAM NOTIFIED:	09/03/2020 01:46	**DATE/TIME TEAM ARRIVED:**	09/03/2020 02:38
FIRST OFFICERS AT SCENE:	PO. B. Panek		**UNIT:** 0305
ASSISTING HOMICIDE TEAM:	Lt. Gardner / Sgt. Jones / Sgt. McEntire / Sgt. Eby / Det. Lane / Det. Houser / D/Tpr. Clark / D/Tpr. Chang		
EVIDENCE TECHNICIAN(S):	Schulz / Sheridan		**UNIT:** 4712
MEDICAL EXAMINER:	N/A (ME#20-13194)	**ARRIVAL TIME:**	N/A
OTHERS AT SCENE:	N/A		
SCENE LOCATION:	525 Clinton Street (Wayne County Jail)		
SCENE TYPE:	Jail – inside		
LIGHTING:	Artificial lighting		
ODOR	None		
TEMPERATURE:	72 degrees		
WEATHER CONDITIONS:	Indoor		

CANVASS:

Inmates housed on the cell block were isolated to be interviewed. Cameras are mounted along the west wall of the ward.

OBSERVATIONS

The scene is Ward 404 of the Wayne County Jail Division 2 located at 525 Clinton. Ward 404 is a rectangular shaped cell block with 9 cells running along the east side with cell 1 the furthest south and cell 9 the furthers north. The entrance/exit door to the cells is on the south end of the ward. There is a metal bar barrier separating the cells from a walkway on the west side of the ward. As you enter the ward, cell 1 is to the immediate right. Entering the scene, all of the cell doors were open. To the immediate right, is cell #1, which housed the suspect. Cell #1 is a rectangular jail cell spanning approximately 4 feet north to south and 8 feet east to west. A bed runs along the south end of the jail cell and a sink/toilet is in the northeast corner. The mattress pad is observed on top of the bunk folded over along with several items including clothing and towels on the floor to the north of the bed. On the side with the cells there are two bench/tables along the barrier. Table #1 runs from cells 4 to cell 6. Table # 2 runs from cell 7 to cell 9. On top of table #1, there was an AED, medical tubing, and a manual respirator. Underneath table #1 there was a thin trail of blood running north and south for approximately 2-3 feet. There was nothing of noteworthy regarding table #2.

SUMMARY

On 09/02/2020 at 2216 hours, officers were dispatched to Division 2 Jail (525 Clinton) in reference to Deputy Bryant Searcy being assaulted by an inmate. At 2225 [redacted]

[redacted] All of the inmates in the Ward were separated and would later be interviewed.

According to a report completed by Officer Brad Panek, at approximately 2200 hours lockdown began on Wards 404, 405, 406, 407, 408, 409, and 410. SEARCY was tasked with locking down Ward 404. PANEK completed the lockdown of Ward 406 prior to heading to Ward 404 to assist SEARCY at approximately 2210 hours. Upon entering Ward 404, PANEK observed SEARCY lying face down underneath the table near cell #5, PANEK then pulled the duress alarm before making sure all cell doors of Ward 404 were secured. Others arrived at the Ward and medical aid was given to SEARCY. SEARCY was unresponsive and an AED along with CPR was utilized. Nurses Lucretia Shakhan and Wylita Peterson arrived on scene to assist. Detroit Fire/EMS Unit 8 arrived on scene and loaded SEARCY onto a gurney and would be transported to [redacted]

Sgt. White ordered all of the inmates to be taken out of the Ward and placed in separate cells away from the scene. While moving inmate Steven Williams to another cell, WILLIAMS advised that the inmate in cell #1 rigged his cell door to slide it open then choked SEARCY from behind. It was believed at first that SEARCY's keys were missing but they were later located by Deputy Alex Wade in the key box in the Ward.

According the report completed by Cpl. Michelle Canady, a check of the all the inmates hands in Ward 404 was completed. Upon checking the hands of the inmate in cell #1, Devante Williams, blood was observed under his fingernails.

All of the inmates housed in Ward 404 at the time of the incident were interviewed by Detectives assigned to the Homicide Task Force at the Wayne County Jail Division 2. Inmate Kenneth Lee Matlock was interviewed by D/Tpr. Chang. MATLOCK stated lockdown happened around 10:00, and he was in cell #9. SEARCY checked his bars and MATLOCK washed his face and took his shoes off. The next thing he heard is SEARCY being given CPR. He advised SEARCY was a good deputy and didn't have any enemies that he knew of. He did not give any detail of seeing any confrontation in his statement.

D/Tpr. Chang interviewed inmate Antonio Richard. RICHARD said he is in cell #5. SEARCY did the lockdown at around 10:00. He described SEARCY as a, "cool dude." While SEARCY was doing the lockdown he heard some shuffling then saw SEARCY laying on the ground. Another deputy came in and sounded the alarm. He did not see anything else.

DPD Sgt. Eby interviewed inmate Steven Williams. Steven Williams advised he observed inmate Deandre Williams place an eraser in his cell door to prevent the locking mechanism from working. Deandre jumped out of his cell and attacked SEARCY by throwing him to the ground and choking him out. While choking SEARCY, Deandre was saying, "Go to sleep." After choking him out he grabbed SEARCY's keys and ran toward the exit door. Deandre heard the deputies coming so he went back into his cell. While Deandre was in his cell he said, "I just choked that bitch out." He observed blood on Deandre's shirt and on his face. Deandre started washing his hands and clipped his fingernails when he got back to his cell. He also advised earlier that day Deandre approached him while Steven was playing cards and asked weird questions like, "what crossroads are we at?"

Sgt. Eby interviewed inmate Tywon Ivey. IVEY stated he went to sleep around 9:30-10. A Deputy came by and tapped on his foot to wake him up. That's when IVEY observed the Deputy laying on the ground surrounded by other deputies. IVEY said he didn't see what happened.

Det. Lane interviewed Devonte Banks who was housed in cell 3 at the time of the incident. BANKS stated he observed SEARCY doing the lockdown and the inmate from cell 1 come up from behind him and started fighting him. SEARCY was yelling for help but was losing the fight. The inmate then tied the deputies hands up with the deputy's headphones and took his keys. The inmate tried opening the cell doors, but then went back to his cell. He described the inmate choking SEARCY with his hands and using a headlock until he stopped moving. BANKS thought the inmate's name was "William or something like that." He stated the inmate said before that he was given the order to start something because everyone is fed up for being locked up for so long with no court. BANKS stated he tried to warn the Deputy that the inmate was coming up behind him and that other inmates tried flushing toilets and turning on the TV to get help to them.

Det. Houser interviewed inmate Faraj Morris. MORRIS was housed in cell 4 at the time of the incident. He stated he had a sheet covering his cell because he was using the bathroom. He heard a Deputy come in and say "What the fuck did you guys do?" He did not see what happened to the Deputy.

Det. Houser interviewed inmate Deangelo Dukes. DUKES stated he saw one guy on top of the Deputy and was choking him. The deputy was calling for help and was trying to fight back. That is all DUKES stated he saw.

Video footage from Ward 404 was viewed and the following observations were made. Let it be noted, the video is of poor quality and skips often making the times jump. On the camera near cell 7, the inmates enter their cells at approximately 10:14 PM. At 10:15PM an inmate is observed struggling with Cpl. Searcy. The video then jumps to 10:31 where responding Deputies on scene. On camera covering cell 9, the only video that is

captured is Cpl. Searcy struggling with an inmate at approximately 10:15. The camera covering cell 1 shows Deandre Williams entering his cell and at 10:14:28 he bends down near the track of the cell door. At 10:14:59 WILLIAMS opens his cell door goes down the cell block towards cell 9. At 10:20 WILLIAMS runs by the frame toward the exit of the Ward. At 10:21 WILLIAMS renters his cell and closes his door. He is observed wearing a white t-shirt throughout the entire incident. Footage from the camera that covers cell 5 captures WILLIAMS on top of Cpl. Searcy underneath the table at 10:15. WILLIAMS gets up off of Cpl. Searcy at 10:19 and heads toward the Ward exit door.

ADDITIONAL INVOLVEMENT INFORMATION

FATAL VICTIM(S):

NAME/DOB:	On Duty Wayne County Sheriff Deputy	**HANDS BAGGED:**	Yes

ID MADE BY (NAME/ADDRESS/PHONE):	N/A
FAMILY CONTACTED (NAME/ADDRESS/PHONE):	Yes
DATE/TIME FAMILY CONTACTED:	09/03/2020 N/A

MISCELLANEOUS VICTIM INFORMATION:

N/A

MISCELLANEOUS WITNESS INFORMATION:

Kenneth Lee Matlock DOB: [redacted]
Antonio Deshaun Richard DOB: [redacted]
Steven Williams DOB: [redacted]
Tywon Ivey DOB: [redacted]
Devonte Banks DOB: [redacted]
Faraj Morris DOB: [redacted]
Deangelo Dukes DOB [redacted]

MISCELLANEOUS ARRESTEE INFORMATION:

Deandre Donte Williams B/M/28 DOB: [redacted]

PROPERTY INFORMATION

CELL PHONES RECOVERED (NAME/#/CARRIER):

N/A

EVIDENCE LIST:

The scene was processed by Evidence Techs Sheridan and Schulz. First, they responded to the fourth floor attorney holding cell where suspect, Deandre Williams was secured. WILLIAMS was shirtless and had on green pants with black slip on shoes. Photographs were taken of WILLIAMS' person. A scratch/cut was observed on WILLIAMS' left elbow. His pants and shoes were collected. After collecting this evidence, they responded to Ward 404 to process the scene.

The following items were taken from the scene and entered into property as evidence:
1) Green pants and shirt were recovered from the floor of cell #1.

2) Swabs taken from the mouth piece of manual respirator that was observed on top of the south table/bench of Ward 404

3) Swabs taken from blood underneath table/bench

No shirt was located in cell #1. Responding jail personnel did not observe WILLIAMS wearing a shirt at the time of their arrival and it is believed he may have flushed his shirt down the toilet. After processing the scene, the Evidence Techs were requested to meet Sgt. Shannon Jones at [redacted] to collect further evidence.			
RESPONSE TEAM ADMINISTRATIVE INFORMATION			
NOTIFICATIONS:	None		
OFFICER COMPLETING:	D/Tpr. Pirvu	**DATE/TIME:**	09/03/2020 07:00
SUPERVISOR:	Lt. Gardner	**DATE/TIME:**	09/03/2020 07:00

Exhibit 17

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09/02/2020	10530.20
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	09/02/2020	900-1

Video Evidence

I, Investigator Dwight Pearson, assigned to the Wayne County Sheriff's Office, Internal Affairs Section, turned over Video Evidence from the Wayne County Jail, Division 2, Ward 404, over to the Detroit Police Department, Homicide Task Force, Detective Patrick Lane. The Video Evidence is from the incident that occurred September 2, 2020 at approximately 10:00 pm.

Incident No. 10530.20

File Class: 900-1

Page	Investigated By	Officer's Signature	Reviewed By
01	Investigator Dwight Pearson #2534		

WAYNE COUNTY SHERIFF'S OFFICE

ORIGINAL INCIDENT REPORT

DATE REPORTED	INCIDENT NO.	YEAR
09/02/2020	10530-20	2020
TIME RECEIVED	FILE CLASS	LOCAL
2237	900-1	02
LOCATION OF INCIDENT		VENUE
525 Clinton St, Detroit MI 48226		82/99

COMPLAINANT		TELEPHONE NO.	
Corporal Bryant Searcy		[redacted]	
ADDRESS: STREET & NO.	CITY	STATE	ZIP CODE
[redacted]	Detroit	MI	48226

INCIDENT STATUS ☐ 0 OPEN 1 LEIN VALIDATION 2 UNFOUNDED 3 EXCEPTIONAL CLEARANCE 4 INACTIVE 5 CLOSED 6 OPEN PENDING RELEASE OF PROPERTY 7 TOT OTHER POLICE DEPT

NATURE OF INCIDENT

Homicide

At 2200 hours Corporal Bryant Searcy and I, Officer Brad Panek, began to lock down the inmates for the night. I started at Ward 409/410 locking down the inmates, checking that the cell bars were secured and Corporal Searcy started on Ward 404. I continued to lock and check Wards 408, 407, 405 and Ward 406 in that order. I went to Ward 404 to assist Corporal Searcy with the lock down procedure as I noticed the outer door was still open.

At approximately 2210 hours I turned the corner going into Ward 404. I noticed Corporal Searcy lying face down on the ground underneath the table in front of Cell#5. All Inmates were in their cells with the doors closed except for Cell #5. I immediately called a CODE 10, Ward 404 and pulled the duress alarm. While waiting for officers to respond I ran the bars again to ensure cell doors were closed. As Officers arrived, we went onto Ward 404 and immediately checked on Corporal Searcy who was unresponsive and had blood coming from his mouth. An Officer called over the prep to bring the AED and to call 911.

Officers, including myself rotated taking turns giving chest compressions. As [redacted] I then waited for further instruction.

Sergeant Sean White gave the order to handcuff all inmates and transport each Inmate from Ward 404 to the center hallway holding cells on different floors. Officer Jerome Freshley and I transported Inmate Williams, Steven #19-10308 to the 5th floor hallway holding cell. Inmate Williams asked us "what happened?" I stated to Williams "you tell me, that's why we are taking you guys to separate floors." Inmate Williams then stated "Cell 1 rigged his door to slide it open and chocked him out from behind". I then asked if he "was sure it was cell 1 and was he the only one involved" in which Williams responded, "yes". Officer Freshley and I both immediately went back to the fourth floor and informed Sergeant White of the information we were just given. I was then ordered by Sergeant White to report to shift command and wait for further instruction.

Page	Investigated by	Officer's Signature	Reviewed By
1/1	Ofc Brad Panek #2851	Brad Panek #2851	[signature] 467

Case: 10530-20 File Class: 900-1

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09/02/2020	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report: 09/02/2020	Primary File Class: 900-1

Homicide

At approximately 2215 hours on 9-2-2020, I responded to a Code 10 call to 4-Old. Upon arrival I saw Ofc. Brad Panek standing near Ward 404. We ran onto the Ward were we found Cpl. Bryant Searcy lying face down under the table. I then pulled Cpl. Searcy by his feet from under the table and flipped him onto his back. I saw that his eyes appeared to be glassy and there was blood on his lip. At some point I yelled for EMS to be called. I then checked the hands of the Inmates in the last few cells for a sign of a fight, I did not see anything. At some point somebody [redacted] Between two of my sets of compressions I ran to get a blanket from the dirty linen bucket, at the request of one of the EMS technicians, so that Cpl. Searcy could be carried off the Ward. I then assisted in carrying Cpl. Searcy off Ward 404 while carrying the oxygen tank in my other hand. We then carried Cpl. Searcy to the employee elevator and down to the turret where he was placed on the gurney. I was then ordered by Sgt. Sean White to return to 4-Old to look for Cpl. Searcy's keys, which at the time were thought were missing. The keys were recovered by Ofc. Alex Wade without the need for a sanitation inspection, they were in the 404 gear box. I then assisted in handcuffing and escorting all Inmates off of Ward 404 to various secure locations to be interviewed separately. I handcuffed a few Inmates and escorted one to empty Ward 504.

Incident No. 10530-20

File Class: 900-1

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Deputy Edmund Tech #4225		

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☑ Supplementary Incident Report ☐ Additional Incident Page No. ____	September 2, 2020	10530-20
	Date of Supplementary Report September 3, 2020	Primary File Class 900-1

Homicide

Subject: Corporal Bryant Searcy

On Wednesday, September 2, 2020, at approximately 2215 hours, I was completing lock down procedures on 6-Annex. I heard an officer call for assistance on 4-Old via the prep-radio. I ran down the Annex stairwell and then to Ward 404.

When I arrived, I saw Officer Brad Panek standing near the table/bench in front of cells 4, 5, 6. I saw that he was trying to evaluate Corporal Bryant Searcy. Searcy was laying on the ground, non-responsive. [redacted]

After securing Cpl. Searcy in the ambulance, I reported to 4-Old per Sergeant Sean White. I was ordered to run the bars for each cell individually while officers handcuffed the inmates on the ward and escorted them off of the ward.

1/1	Investigated By Cpl. Kevin Moore #1097	Officer's Signature Cpl. Kevin R. Moore #1097	Reviewed By Sgt. [illegible] #467

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09/02/2020	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	09/02/2020	900-1

HOMICIDE

On 9/2/2020 I was assigned to Div.2 5 Annex. At around 1016hrs I heard an unknown voice over the prep radio call out Code 10, 4 Old. My partner Edmond Tech and I both responded to 4Old. I followed my partner onto ward 404. Upon arriving on the ward I heard Ofc. Brad Panek say "I seen cell 6 was open". I immediately looked around to secure the cell bars closes to me and to take down a blanket that was covering a complete view inside of cell 7. I then noticed Ofc. Panek and Ofc. Tech kneeling over Cpl. Bryant Searcy. Cpl. Searcy was laid under the day room table. He had blood on his mouth. Ofc. Panek and Ofc. Tech called out Cpl. Searcy name several times. Ofc. Tech then pulled Cpl. Bryant Searcy from up under the day room table by his feet. I then called for a nurse to respond to 4 Old over the prep radio. I then exited the ward to direct the responding nurse to the ward and clear a path. I then took turns with other officers... Cpl.Kevin Moore, Edmond Tech, Brad Panek, Cpl. Jerome Jenkins, [redacted] After Cpl. Searcy was removed from the ward, I was directed to go back on the ward to make sure no nurse or officer equipment was left behind on the ward. I was also advised to make sure no inmate on ward 404 had any conversations with each other. I then assisted with handcuffing and escorting inmate #20-1920 Fields, Erik to the 4th floor hallway holding cell from ward 404 to be interviewed separately from any other inmates.

Incident No. 10530-20

File Class: 900-1

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Brown,Stephanie #2316		462

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09/02/2020	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	09/02/2020	900-1

Homicide

At approximately 2214 hours, I was ordered by Sgt. D Migliaccio to call 911 for a duress alarm on 4 Old. After contacting 911 I responded to 4 Old. Upon my arrival, I observed Cpl. B. Searcy laying on the floor in the day area of Ward 404. I remained at the shower door area of the ward to keep a clear path for responding medics. While standing there, I observed the inmate in Cell#1 attempting to wash/wipe his hands. He began stating to me "What happened down there". I didn't acknowledge the inmate but further payed attention to the inmates actions. The inmate in Cell#1 was later identified as Williams, Deandre#20-2495. I assisted with transport of Inmate Morris, Faraj#19-12584 to Ward 107 pending an interview. I further assisted with finding where all the inmates assigned to Ward 404 where being held for interview to turn over to Internal Affairs.

Page	Investigated By	Officers Signature	Reviewed By
1/1	Cpl. Spencer, Leonard#1349	#1349	Sgt. #467

Incident No. 10530-20

File Class: 900-1

3/16

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	08/02/2020	10530
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	08/03/2020	900-1

Homicide

On September 02, 2020 while escorting a inmate to a newly assigned housing unit I, Officer Matthew Roby, heard the duress alarm from 4-Old go off. Inmate Mitchell, Israel #20-0647 was placed securely in a 6th floor hallway holding cell, then I was able to respond to 4-Old for the code. Upon reaching the 4-Old duty station, I noticed Corporals Raymon Alam and Kevin Moore entering Ward-404. I entered the Ward behind them to find Officer Brad Panek standing near Corporal Bryant Searcy who was lying on the ground in the day room area. After having a closer look at Cpl. Searcy [redacted] Sergeant Sean White and Officers Edmund Tech and I were able to escort Cpl. Searcy to the Division II Turret using a blanket provided by Ofc. Tech. Upon making the Turret, I assisted in placing Cpl. Searcy onto an awaiting gurney. I was instructed by Sgt. White to make 4-Old and assist with movements. I assisted with transporting inmates; Banks, Devonte #18-20538 to a 5th floor holding cell, Ivey, Tywon #19-22381 to Ward-504 [empty ward], and Morris, Faraj #19-12584 to Ward-107 [empty ward]. All inmates were handcuffed [di/tc] before being moved. All movements took place without incident.

Page	Investigated By	Officer's Signature	Reviewed By
1 of 1	Officer Matthew Roby #4206	#4206	4C7

Incident No. 10530

File Class: 900-1

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	9/2/20	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report: 9/2/20	Primary File Class: 900-1

HOMICIDE

On 9/02/2020 at approximately 2215 hours I, Deputy Lonnie Sanders during my security rounds, heard a code 10 via prep radio for 4 Old. I responded to 4 old Ward,404 along with Officer Tech and other officers. On entering the Ward all inmates were in their cells and the ward appeared clear until we seen Corporal Bryant Searcy laying face down under the inmate common area table with blood under his head and his handcuff key and round pipe on the floor next to him. Officer Tech, Officer Panek, and I pulled Corporal Searcy out from under the table turned him over. Corporal Searcy was unconscious and unresponsive. I called over prep radio for all available Nurses to respond to 4 Old Ward 404 Stat (immediately) that Corporal Searcy is down (Officer Down) . Other Deputies entered the ward and checked Corporal Searcy's vital signs as I ordered all inmates to place their hand out their cell and checked all the inmates knuckles for any sign for blood, scratches or bruising and all looked to be clear of any signs of a fight. Officer Brown asked me to shut the water off to the cells just in case their was fowl play and the inmates could not flush any evidence . I then went into the pipe chase and shut off the water to each cell. I returned back onto the ward and Deputies [redacted] At this time I called over prep Radio to check Searcy for the Floor keys and a response was "there are no keys are on Searcy". At this time Officer Wade found them in the cell lock box area. Deputy Brown and I stayed on the ward to make sure no inmates were able to get any left over items from the Nurses and Paramedics . Once Searcy was in transport all available Deputies returned to Ward 404 and each inmate was handcuffed (DL/TC) and escorted off the Ward and to separate floors to be interviewed at a latter time. Deputy Evans and I escorted Richard, Antonio 19-21238 through the stairwell up to the 6th Floor Medical holding cell area. I returned back to Ward 404. Officer Wade relieved me so I could return to 4 Old. Once I returned to 4 Old the area was secure and all responding Officer were to meet in shift command counseling room.

Time : 2237
Case : 10530-20

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Deputy Lonnie Sanders #4078	#4078 Officer Lonnie Sanders	Sgt. K. Wade #42

Incident No. 10530-20

File Class: 900-1

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	9-2-2020	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report: 9-2-2020	Primary File Class: 900-1

Homicide

On 9-2-2020 at approximately 2015 hours a code 10, Assault on Staff was called out via prep radio. Cpl. Raymon Alam then called out via prep radio to contact 911 and for someone to respond with an AED unit. I instructed Cpl. Leonard Spencer to call 911 and I responded to Ward 404 with the AED. Upon arrival, an AED unit was already in use. I then instructed Cpl. Alam to report to the Turret area to assist with the arrival of EMS. I reported to Shift Command to advise Lt. Steve Melnyk of the situation. I then went to the ground level to have the elevator ready for EMS arrival. Upon their arrival Cpl. Alam escorted them to Ward 404. I instructed Cpl. Michelle Canady to remain on the Ground floor to assist with the elevator. I reported back to Shift Command. At approximately 2315 I received a phone call from Cpl. Charlie Murray, he informed me that Cpl. Bryant Searcy had just been pronounced deceased. I informed Lt. Steve Melnyk of this information.

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Sgt. Deana Migliaccio #366	Sgt. D. Mig. 366	Sgt. [illegible] 467

Incident No. 10530-20

File Class: 900-1

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☑ Supplementary Incident Report ☐ Additional Incident Page No.	09-02-2020	10530-20
	Date of Supplementary Report 09-02-2020	Primary File Class 900-1

Homicide

On the September 02, 2020, at approximately 2212 hours, I (Raymon Alam) responded to Duress Alarm Code 10 on Ward# 404 officer need assistance. Up on arrival I observed Corporal Bryant Searcy on the ground in the middle of Ward# 404. He was unconscious and appeared to have blood coming from his mouth. I also observed all the inmates on Ward# 404 were locked down. Officers Brad Panek, Stephanie Brown, Edmund Tech and Kevin Moore [redacted] I immediately notified Shift Command via perp radio and stated "Officer Down notified E.M.S. A.S.A.P. and we need a defibrillator".

Sergeants Sean White And Dean Migliaccio arrived on the scene with defibrillator. At which time I went to the Div. Two Turret to what for E.M.S. arrival. At approximately 2220 Detroit Fire Medic# 8 arrived. I escorted Medics Donald Bayer and Steven Hazelton to Ward# 404 and took over the scene. I assisted the Medics and several officers in carrying Corporal Searcy to the turret and placed him in the E.M.S. At approximately 2246 Medic# 8 cleared the turret.

Incident No. 10530-20

File Class 900-1

Page	Investigated By	Officer's Signature	Reviewed By
1 OF 1	RAYMON ALAM # 1626	# 1626	467

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☑ Supplementary Incident Report ☐ Additional Incident Page No. ____	09/02/2020	10530-20
	Date of Supplementary Report 09/03/2020	Primary File Class 900-1

Homicide

At 2213 hours I responded to a duress alarm on the fourth floor, 4-old. When I arrived I saw other officers running to ward 404, I heard officers saying it's Searcy. As I stepped onto the ward I observed Corporal Bryant Searcy lying on the floor underneath one of the tables. While on the ward the call went out to check hands to see who had bruises. I was standing by the first three cells, and observed no bruises on the inmates' hands. However, I noticed as the inmate in cell one held out his hands that he had blood under one of his fingernails. As the ambulance arrived at 2220 hours myself, along with Corporal Jerome Jenkins went down to the ground floor to meet the Medic #8 and escort them up to the fourth floor. I also remained on the ground floor to wait for word to call the elevator back down to the ground floor when EMS was ready to transport. EMS departed the building at 2246 hours.

Incident No. 10530-20 File Class 900-1

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Corporal Michelle Canady #1334	Michelle Canady	

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☑ Supplementary Incident Report ☐ Additional Incident Page No. ___	09/02/2020	10530-20
	Date of Supplemental Report 09/02/2020	Primary File Class 9900-1

Homicide

Subject 1: Matlock, Kenneth 2020-00025216 B/M DOB [redacted] H 6' W 250

On Tuesday, September 2, 2020 I Officer, Disa Douglas responded to an Officer Assault at Division 2 at approximately 2235 hours. When I arrived I assisted in escorting inmate Matlock 20-25216 from the 4th floor to floor 7 holding cell with Officer I. Chahine. I sat and watched inmate Matlock while he was in the holding cell until was relieved back to Division 1.

	Investigated By	Officer's Signature	Reviewed By
1/1	Officer Disa Douglas		

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	9/2/20	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report: 9/2/20	Primary File Class: 900-1

Homicide

On 9/2/20 at approximately 2010Hrs, I was in shift command, when I heard over via prep radio code 10 on 4-Old. I immediately responded with Sgt. Sean White via stairway to the 4th floor. Upon arriving to Ward 404, I observed officers attending to Cpl. Bryant Searcy, who was lying on his back and on the cement floor, near the ward dining table. Cpl. B Searcy [redacted]

While Cpl. J. Jenkins went down the turret to assist Detroit Fire Rescue Medic #8, I attempted to retrieve video of the incident to see how Cpl. B. Searcy ended up on the cement floor, which might have provided valuable information in Cpl. B. Searcy's treatment. I was able to pull up video footage on Ward 404, camera #5 using the date 9/2/20 at approximate time 2018hrs. In the video footage, I could see an inmate lying underneath the dining table. Shortly after, you can see the inmate get up from underneath the table and run towards cells #1-3. After retrieving the video footage, I left it on the screen in shift command, so that the Wayne County Sheriff Office Internal Affairs Unit could view it. I then was advised by Lt. Steve Melnyk to accompany the family of Cpl. B. Searcy at [redacted] Capt. Gabe Hardwick provided me transportation to [redacted] Upon arriving at [redacted] Cpl. Charlie Murray was with Cpl. B. Searcy. Cpl. C. Murray advised that the [redacted] medical staff advised him that Cpl. B. Searcy was deceased. Capt. Gabe Hardwick and I then stood bye and provided assistance. After being pronounced deceased, I was provided Cpl. B. Searcy's chart number [redacted] the attending physician. After providing assistance, Sgt. Gabe Hardwick and I returned to Jail Division #2. No further incident to report.

Incident No. 10530-20

File Class: 900-1

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Sgt. Kenneth Tjernlund #478	#478	

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09-03-2020	10530
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	09-03-2020	9900-1

Homicide

Subject: Corporal Bryant Searcy

On Thursday, September 2, 2020, at approximately 2230, I, Deputy Jerome Freshley III, was informed by Sergent Daniel Carmona that an Officer was down at Division 2 and to assist with the situation. I immediately ran to Division 2 along with Deputies Alexandria Evans, Enin Talley, Disa Douglas, and Ariana Ayala. While waiting on Division's 2 elevator, multiple Deputies and EMS personnel came off the elevator escorting Corporal Bryant Searcy to the ambulance. I immediately followed. After Cpl. Searcy was escorted onto the ambulance, Sgt. Sean White immediately stated to perform a santiation inspection on ward 404 to find keys that inmates may have taken. Multiple Deputies and I went to ward 404 to assist. While at ward 404, Sgt. S. White stated to handcuff and escort the inmates to different floors and to make sure the inmates are separated.

While escorting inmate Williams,Steven #19-10308 to the 5th floor holding cell along with Deputy Brad Panek, inmate Williams,Steven stated the inmate in cell 1 (Williams, Deandre #20-2495) "rigged his cell door so it wouldn't close and he choked Cpl. Searcy". Inmate Williams,Steven also stated that "his shirt should have blood on it."

Deputy Panek and I immediately informed Sgt. White of this information. I was told by Sgt. White to search inmate Williams, Deandre cell to search for the shirt. I could not find the bloody shirt. I did find an inmate uniform in cell 1 and placed it outside of cell 1. Shorty after, I searched inmate Williams,Deandre cell (cell 1)again to search for the shirt. Chief Dunlap witnessed me searching the cell and immediately ordered me to stop and exit the cell. I immediately followed the order that was given. Shortly after, I was instructed by Sgt. White to wait in Divisions 2 conference room and wait for further orders.

Incident No. 10530

File Class: 9900-1

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Jerome Freshley III #4256	#4256	Sgt. [illegible] 40

3/16

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☐ Supplementary Incident Report ☐ Additional Incident Page No. ____	9/2/2020	10530-20
	Date of Supplementary Report 9/28/2020	Primary File Class 900-1

Homicide

On September 2, 2020, I, Officer Alexandra Evans, was assigned as a Security Support officer at Jail Division I. At approximately 2237 hours, I was informed by Sergeant Daniel Carmona that there had been an assault on an officer at Division II. With Sergeant Carmona's permission, Officers Disa Douglas, Ariana Ayala, Jerome Freshley, Enin Talley and I immediately responded to Division II through the tunnel connecting the jails in order to provide assistance.

When we arrived on the scene, I observed Corporal Bryant Searcy being carried down the hall to an ambulance by several Division II officers. We were instructed that we needed to stand clear in order to allow the ambulance to enter the back gate. I stood back and awaited further orders.

Sergeant Sean White then instructed that we report to 4 Old, where I assisted in escorting inmates off the ward to separate holding areas. Once the inmates were secured, I returned to 4 Old and was instructed by Sergeant Deborah Martin to stand by in order to provide further assistance as needed. I remained on duty in this capacity until I was instructed by Sergeant White to report to 6 Old to provide security for an inmate who had been escorted to one of the holding cells in the medical area. I remained on duty on 6 Old until relieved by a dayshift officer.

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Ofc. Alexandra Evans 39987	Alexandra Evans	[illegible] 513

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☐ Supplementary Incident Report ☐ Additional Incident Page No. ____	09/02/2020	10530-20
	Date of Supplementary Report 09/30/2020	UDD 900-1

Homicide

At 2200 hours I, Corporal Damone Lee was at the front door of Division two old jail. When I heard duress alarm activated. I also heard a code ten called over the prep radio, When Lieutenant Steve Melnyk asked was there anybody in the turret? I immediately went and retrieve a set of keys for the turret to let Fire/EMS into the Jail. While in the turret I open, and closed the doors several times over the course of the incident. I left turret area at 2315 hours and returned to my assigned duties front gate.

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Cpl, Lee, Damone #1573	Cpl Damone Lee	Lt SMelnyk #130

WAYNE COUNTY SHERIFF'S OFFICE	Original Date	Incident No
☐ Supplementary Incident Report ☐ Additional Incident Page No. ____	September 02, 2020	10530-20
	Date of Supplementary Report September 30, 2020	Primary File Class 900-1

Homicide

At 2200 hours I, Corporal Charlie Murray was at the front door of Jail Division 2, when I heard a Code 10 over the radio and then the Duress Alarm. Lt. Melnyk stepped out of his office and asked is there anyone in the turret. I immediately locked the front door and went to the turret to escort Fire/EMS to 4 Old. I later escorted the EMS to [redacted] via Unit #340.

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Cpl. Charlie Murray #1101		#150

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☐ Supplementary Incident Report ☐ Additional Incident Page No. ____	9/2/2020	10530-20
	Date of Supplementary Report 9/28/2020	Primary File Class 900-1

Homicide

On September 2, 2020, I, Officer Enin Talley was assigned as a Security Support officer at Jail Division one. At approximately 2237 hours, I was informed by Sergeant Daniel Carmona that there had been an assault on an officer at Division II. With Sergeant Carmona's permission, Officers Disa Douglas, Ariana Ayala, Jerome Freshly, Alexandria Evans and I immediately responded to Division II through the tunnel connecting the jails in order to provide assistance.

When I arrived on the scene, I observed Corporal Bryant Searcy being carried down the hall on a sheet or a stretcher by the ambulance crew. I immediately started transporting inmate Dukes, Deangelo 19-12424 to 6 old ward 607 cell #2 with the assistants of Officer Alexandria Evans without incident. When I arrived back on the 4th Floor Sergeant Debra Martin stated I can return to division one.

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Talley, Enin #4015		Sgt. D. Hall

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☐ Supplementary Incident Report ☐ Additional Incident Page No. ____	09/02/2020	10530-20
	Date of Supplementary Report 09/30/2020	1300 900-1

Homicide

At 2200 hours I, Corporal Damone Lee was at the front door of Division two old jail. When I heard duress alarm activated. I also heard a code ten called over the prep radio, When Lieutenant Steve Melnyk asked was there anybody in the turret? I immediately went and retrieve a set of keys for the turret to let Fire/EMS into the Jail. While in the turret I open, and closed the doors several times over the course of the incident. I left turret area at 2315 hours and returned to my assigned duties front gate.

Page	Investigated by	Officer's Signature	Reviewed By
1/1	Cpl, Lee, Damone #1573	Cpl Damone Lee	Lt SMelnyk #130

WAYNE COUNTY SHERIFF'S OFFICE	Original Date	Incident No.
☐ Supplementary Incident Report ☐ Additional Incident Page No. ____	September 02, 2020	10530-20
	Date of Supplementary Report September 30, 2020	Primary File Class 900-1

Homicide

At 2200 hours I, Corporal Charlie Murray was at the front door of Jail Division 2, when I heard a Code 10 over the radio and then the Duress Alarm. Lt. Melnyk stepped out of his office and asked is there anyone in the turret. I immediately locked the front door and went to the turret to escort Fire/EMS to 4 Old. I later escorted the EMS to [redacted] via Unit #340.

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Cpl. Charlie Murray #1101		#130

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09/02/2020	10530-20
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	10/01/2020	900-1

Homicide

On October 1st, 2020 I was instructed by investigator Dwight Pearson (Internal Affairs) to submit this report concerning the afternoon shift on September 2nd, 2020. From 1400 hours to 1500 hours I generated a PJ-83 and assembled a report packet (PJ-89's, JMS report, departmental forms) for an attempted suicide (PJ-83 #10491-20) that occurred during the day shift. I was assigned to conduct security rounds (utility) for the 4th floor on the afternoon shift. After conducting a round at approximately 2130 hours I informed the officers assigned to the 4th floor that I would be off duty at 2200 hours, and for them to conduct the 2200 hour utility round to which all agreed. After 16 hours on duty (0600 hours to 2200 hours) I went to Shift Command and stated I would be returning in the morning for the day shift and exited the facility.

Incident No. 10530-20

File Class: 900-1

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Sergeant Richard Perkins #457		#430

3/16

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☐ Supplementary Incident Report ☐ Additional Incident Page No. ____	9/2/2020	10530-20
	Date of Supplementary Report 9/28/2020	Primary File Class 900-1

Homicide

On September 2, 2020, I, Officer Alexandra Evans, was assigned as a Security Support officer at Jail Division I. At approximately 2237 hours, I was informed by Sergeant Daniel Carmona that there had been an assault on an officer at Division II. With Sergeant Carmona's permission, Officers Disa Douglas, Ariana Ayala, Jerome Freshley, Enin Talley and I immediately responded to Division II through the tunnel connecting the jails in order to provide assistance.

When we arrived on the scene, I observed Corporal Bryant Searcy being carried down the hall to an ambulance by several Division II officers. We were instructed that we needed to stand clear in order to allow the ambulance to enter the back gate. I stood back and awaited further orders.

Sergeant Sean White then instructed that we report to 4 Old, where I assisted in escorting inmates off the ward to separate holding areas. Once the inmates were secured, I returned to 4 Old and was instructed by Sergeant Deborah Martin to stand by in order to provide further assistance as needed. I remained on duty in this capacity until I was instructed by Sergeant White to report to 6 Old to provide security for an inmate who had been escorted to one of the holding cells in the medical area. I remained on duty on 6 Old until relieved by a dayshift officer.

Page	Investigated by	Officer's Signature	Reviewed By
1/1	Ofc. Alexandra Evans 39987	Alexandra Evans	#373

WAYNE COUNTY SHERIFF DEPT.	Original Date	Incident No.
☐ Supplementary Incident Report	09/03/2020	10530-20
☐ Additional Incident Page No. ___	Date of Supplemental Report 09/28/2020	Primary File Class 9900-1

HOMICIDE

Subject: Corporal Bryant Searcy

On Thursday, September 2, 2020, at approximately 2230 hours, I, Deputy Ariana Ayala, was informed by Sergeant Daniel Carmona that an Officer was attacked by an inmate at Division 2 and to assist with the situation. I immediately ran through the tunnel to Division 2 along with Deputies Alexandria Evans, Enin Talley, Disa Douglas, and Jerome Freshley. While waiting on Division's 2 elevator, multiple Deputies and EMS personnel came off the elevator carrying Corporal Bryant Searcy to the ambulance. Sergeant Sean White immediately stated to perform a sanitation inspection on ward 404 to find station keys that inmates may have taken. When arrived to ward 404, Sergeant S. White stated to handcuff and escort the inmates housed on ward 404 to different floors to essentially separate each inmate. A Division 2 Officer handcuffed an inmate from the 404 ward and I then escorted him with assistance from two Division 2 Officers, to the first floor where the inmate was placed in a holding cell. I supervised the inmate in the holding cell for approximately an hour and a half. Until I was relieved by Officer Mackey. I then headed back to Division 1 where Sergeant D. Carmona stated that I was no longer needed

1/1	Investigated By	Officer's Signature	Reviewed By
	Officer Ariana Ayala	Ariana Ayala	#823

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☒ Supplementary Incident Report	09-02-20	10530
☐ Additional Incident Page No. ____	Date of Supplementary Report: 09-03-20	Primary File Class: 900-1

Homicide

Victim: Corporal Bryant Searcy DOB 01-30-1970 Badge # 3342

On 09-02-20, at approximately 2214 hours, I overheard the duress alarm sound at Jail Division II. Shortly after, I overheard calls on the prep radio for EMS to be called and that an officer was down. I contacted Commander Alan Bullfant by telephone and notified him about the developing incident. I responded to Shift Command and the sergeants had responded to the floor. I then instructed Corporal Damone Lee to report to the Turret and Corporal Charlie Murray to meet the ambulance to escort the officer to the hospital. A voicemail was left for Captain Gabriel Hardwick via phone.
I attempted to reach the sergeants via prep radio to receive an update on the events on the floor. A short time later Sergeant Deana Migliaccio returned to Shift Command and stated that Corporal Bryant Searcy was found unresponsive on the floor of Ward 404. I updated Commander Bullfant on the situation and he stated that Detroit Police and Internal Affairs had already been notified. Sergeant Kenneth Tjernlund was instructed to report to [redacted] to monitor Officer Searcy.
Chief Dunlap, Deputy Chief Washington, Commander Bullfant, Captain Hardwick, Internal Affairs Sergeant Debra Martin and Captain Fredryn Allen all responded to Jail Division II.
At approximately 2315 hours, I was notified by Sergeant Migliaccio that Corporal Searcy had been declared deceased. Commander Bullfant was updated on the situation and Detroit Police Officer R. Hamani Badge 2012 and Officer B. Gibbings Badge 2633 were notified that Homicide would be needed to respond.
At approximately 0230 hours, Detroit Homicide arrived and took control of the scene.

Incident No. 10530

File Class: 900-1

Page	Investigated By	Officer's Signature	Reviewed By
1/1	Lieutenant Steve Melnyk #130	Lt. Melnyk #130	

WAYNE COUNTY SHERIFF	Original Date	Incident No.
☑ Supplementary Incident Report	9.2.20	10530
☐ Additional Incident Page No. ____	Date of Supplementary Report	Primary File Class
	9.2.20	9000-8

Homicide

Jenkins,Jerome Cpl

On todays date at approximately 2248 hours I was off duty at this time, I was in the parking lot behind Division 2 in the turret area. I noticed Cpl Jenkins sitting on the stairs inside the turret. While Cpl Searcy's ambulance was get ready to leave, Cpl Jenkins just fell over onto the stairs. I along with other Officers went running to his aid. I along with other Officers were checking on Jenkins trying to get him . I got a hold of a firefighter who was present to assist with Cpl Jenkins. The unknown firefighter requested another ambulance for Cpl Jenkins. Cpl Jenkins became conscious and was talking. Cpl Jenkins was getting loaded into the ambulance, I asked him if he would me to call his wife, he stated yes and gave me her cell number. I made notification to his wife and said that they were going to [redacted] I called Sgt. Timothy Lasiter and he said to come back and help.

Incident No. 10530

File Class: 9000-8

Page	Investigated By	Officer Signature	Reviewed By
1/1	Cpl Chris DeGasperis # 1483	1483	

Exhibit 18

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
BARTON G. PICKELMAN, DIRECTOR

SUSAN CORBIN
ACTING DIRECTOR

June 11, 2021

Mr. David Melton Jr., General Counsel
Wayne County Sheriff Office
4747 Woodward Ave
Detroit, MI 48021

Dear Mr. Melton:

RE: Inspection # 1491741

On September 3, 2020, the Michigan Occupational Safety and Health Administration (MIOSHA), General Industry Safety and Health Division began an occupational health inspection at your worksite located at:

525 Clinton St
Detroit, MI 48226

This inspection has resulted in at least one citation. Please review the citation(s) for information regarding penalties, abatement requirements, deadlines, settlement agreement instructions, and appeal information. Enclosed you may find additional information such as recommendations, data sheets, and supplemental information on occupational safety and health.

MIOSHA standards as well as additional consultation, education, and training materials are located online at www.michigan.gov/miosha. Please direct all correspondence to our office in Detroit, located at 3026 W. Grand Blvd Suite 9-450 Detroit, MI 48202. If you should have any questions concerning this matter, please contact me at 313-456-4054. Your personal support and interest in the safety and health of your employees is appreciated.

Sincerely,

Megan Brock
Health Supervisor

MB:dm

Enclosures: Citations

CC: Cp. Leonard Wolons, Chief Steward Div. II
Wayne County Deputy Sheriffs' Association/POAM
27056 Joy Rd
Redford, MI 48239

Michigan Department of Labor and Economic Opportunity
Michigan Occupational Safety and Health Administration (MIOSHA)
MIOSHA General Industry Safety & Health Division
530 West Allegan Street
P.O. Box 30644
Lansing, MI 48909
Phone: (517) 284-7750 Fax: (517) 284-7755

Citation and Notification of Penalty

To:
Wayne County Sheriff Office and its successors
525 Clinton St
Detroit, MI 48226

Inspection Number: 1491741
Inspection Date(s): 09/03/2020 - 04/22/2021
Issuance Date: 06/11/2021

Inspection Site:
525 Clinton St
Detroit, MI 48226

Reporting ID: 0552652
CSHO ID: H0595
Optional Report Number:

SUMMARY: An inspection at the site noted above has revealed conditions we believe do not comply with the provisions of the Michigan Occupational Safety and Health Act, Act 154, of the P.A. of 1974, as amended (MIOSH Act). The nature of such alleged violation(s) is described on the citation(s) with reference to the applicable standards, rules, regulations, orders and provisions of the Act. Following is a list of items the employer must consider carefully, to resolve the issues alleged in the citation(s). Following this numbered summary is a more detailed explanation of the requirements.

1. The violation(s) alleged in the citation(s) must be corrected on or before the date(s) shown in the line marked "Date By Which Violation Must Be Abated". If the line is marked "Immediately Upon Receipt," the violation must be corrected on or before the date that the citation is received by the employer. If the violation was corrected during the inspection, the line will be marked "Abated." or "Corrected during inspection." Correcting a violation does not eliminate the requirement to pay the penalty nor does payment of the penalty negate having to correct the violation.
2. A copy of the citation(s) must be posted at or near the location of the violation(s) for a minimum of 3 days or until the item(s) have been corrected, whichever is later.
3. Documentation of abatement must be provided to the issuing division. Failure to provide such documentation may result in a follow-up inspection.
4. The employer may enter into a Penalty Reduction Agreement (PRA) that can result in a 50% reduction in any assessed penalties. The employer should apply for a PRA online at www.michigan.gov/mioshapra within 5 workdays upon receiving a citation(s) if interested. An employer without access to a computer may contact the issuing division to request a PRA.
5. The employer may file a first appeal for modification or dismissal of a citation item and/or any proposed penalty or request an extension of time for abatement. **The appeal must be in writing and be postmarked within 15 workdays of receipt (workday is defined below).** The first appeal can also result in a penalty reduction of up to 50%. If an appeal is untimely, the citation(s) become a Final Order of the Board of Health and Safety Compliance and Appeals (Board) and is no longer subject to review by the issuing division. An employee or employee representative may appeal abatement dates.
6. Except under a PRA monetary penalties must be paid within 15 workdays of a citation becoming a Final Order of the Board.
7. The employer may file a request for an extension of time to abate a citation(s) that has become a Final Order of the Board. Such a request must be in writing and received or post marked no later than 1 working day following the abatement date.
8. It is unlawful to discriminate against an employee for exercising any of their rights under MIOSHA.

Note: As defined in statutes, "workday" or "working day" means any day other than a Saturday, Sunday, or state legal holiday. The state legal holidays are:

January 1, New Year's Day
The third Monday in January, Martin Luther King, Jr. Day
February 12, Lincoln's birthday
The third Monday of February, Washington's birthday
The last Monday of May, Memorial or Decoration Day
July 4, Independence Day
The first Monday in September, Labor Day
The second Monday in October, Columbus Day
November 11, Veterans' Day
The fourth Thursday of November, Thanksgiving Day
December 25, Christmas Day

Please note whenever January 1; February 12; July 4; November 11; or December 25 fall on a Sunday, the next Monday following is deemed a public holiday (non-working day) for appeal purposes. However, there is no compensating day when one of the five dated holidays falls on a Saturday. Also, when computing the 15 working days, you do not count the date on which it is received; you start with the next working day. Additionally, the count is based on when the citation was received at the employer's location, not when it got to any particular person or office at the employer's location.

I–CITATIONS: The nature of the alleged violation(s) is described on the enclosed citation(s). These conditions must be corrected on or before the date(s) shown in the line marked "Date By Which Violation Must Be Abated." The issuing division may be contacted by telephone at the number indicated on the front of the citation for the purpose of discussing any issues related to the inspection or citation(s).

A copy of the citation(s) must be posted at or near the location of the violation for a minimum of 3 days or until the items have been corrected, whichever is later. The MIOSH Act provides for civil penalties of up to $7,000 for each violation for failure to comply with posting requirements.

When compliance is achieved, a copy of the citation must be signed and returned to the issuing division along with documentation of abatement.

Documentation of abatement for citation items originally classified as "serious," "repeat," "fail-to-abate," "willful," or "instance-by-instance," require documentation as deemed appropriate by the issuing division. Examples of documentation for these violation classifications are:

(a) A detailed description of how the violation was abated.
(b) Work orders or an invoice indicating the corrective work that has been done.
(c) Photographs of the abated conditions.
(d) Other forms of conclusive evidence that your employees are no longer exposed to the hazard.

For citation items classified as "other," submitting to the issuing division a signed copy of the citation item indicating the item has been abated is acceptable documentation of abatement. Submitting a document in writing, certifying abatement of the particular citation item is also acceptable for citation items classified as "other."

If the employer does not provide adequate documentation of abatement, a re-inspection may be conducted. Failure to correct an alleged violation within the abatement period may result in new or additional proposed penalties.

Correcting a violation prior to the expiration of the abatement date does not eliminate the requirement to pay the penalty. Payment of the penalty does not eliminate the requirement of correcting the violation.

II–PENALTY REDUCTION: In addition to the appeal rights afforded by the MIOSH Act, the Michigan Occupational Safety and Health Administration has implemented a program for negotiating an expedited settlement of penalties with the employers known as a Penalty Reduction Agreement (PRA). This is a program designed to reach abatement of the hazard at the earliest possible opportunity and reduce the need for formal appeals. The penalty reduction (PRA) can result in a penalty reduction of 50% provided the issuing division and the employer agree to a number of specified conditions. These conditions include an agreement by the employer to accept all of the citations issued and to:

(a) Not appeal further.
(b) Abate all items within the abatement period.
(c) Provide proof of abatement.
(d) Pay all agreed upon penalties as required (within 15 working days of approval of the PRA.)

(e) Abide by any other mutually agreed upon actions.

Inspections involving a fatality, the Severe Violator Enforcement Program (SVEP), or willful citations are not eligible for the program. Construction citations must be confirmed as corrected by the issuing division before a penalty reduction agreement can be approved.

If you are interested in pursuing a PRA, you should apply online at www.michigan.gov/mioshapra **within 5 workdays upon receipt of the citation(s)**, but no later than the 15th workday beyond receipt of the citation(s). If you do not have access to a computer, you should contact the issuing division within the same timeframe to request a PRA. If the employer wishes to accept the conditions stated above and the process can be completed within 15 workdays from receipt, then no appeal need be filed.

III–CITATION APPEAL: An employer may file a first appeal to the issuing division in writing for modification or dismissal of a citation item and/or any proposed penalty or an extension of time for abatement. The first appeal can also result in a penalty reduction of up to 50% providing the issuing division and the employer agree to the conditions (a) through (e) as stated in Section II, PENALTY REDUCTION (above).

An employee or employee representative may appeal in writing the reasonableness of the abatement date(s). The envelope containing an appeal must be postmarked no later than the 15th workday following receipt of the citation.

If a citation is not appealed within 15 workdays of receipt, then the citation becomes a Final Order of the Board of Health and Safety Compliance and Appeals (Board). Final Order citations are not subject to review by the issuing division unless the Bureau of Hearings establishes good cause for the late appeal.

An appeal must specify the item(s) appealed and that portion of the item (e.g., violation, abatement date, penalty) which is being appealed and include a certification that the appeal has been posted or given to affected employees or their representatives. If the issuing division meets with the employer to discuss an appeal, the issuing division will notify the employee representative and allow attendance at the meeting.

The issuing division will notify an employer of its decision within 15 workdays of the receipt of the employer's written appeal. The decision must be posted at the location of the subject citation.

If an employer, employee or employee representative is not satisfied with this decision then they may file a second appeal. The appeal must be in writing and the envelope containing the second appeal must be postmarked within 15 workdays of the receipt of the issuing division's decision on the first appeal. If the issuing division's decision is not appealed then the citation becomes a Final Order of the Board.

IV–PAYMENT OF MONETARY PENALTIES: Unless subject to a PRA, payment must be made within 15 workdays of the date a proposed penalty of a citation becomes a Final Order of the Board. This would be the 30th workday after receipt of each citation item that is not appealed. For payment of a penalty, make a check or money order payable to the "State of Michigan" and remit to the issuing division at the address shown on the citation. Please record the inspection number, citation and item number on the check, money order or transmittal letter.

V–EXTENSION OF TIME TO ABATE: An employer may file a petition for modification of abatement date(s) (PMA) on an item of a citation, which has become a Final Order of the Board. The PMA must be submitted to the issuing division in writing by personal delivery or postmarked no later than one day following the abatement date, and a copy posted near the place the citation was posted. An employer must have made a good faith effort to correct the violation by the abatement date, and has or will not be successful because of factors beyond the employer's reasonable control. A PMA must include:

(a) Steps taken to achieve compliance.

(b) The specific additional abatement time necessary.

(c) The reasons the additional time is needed.

(d) Available interim steps being taken to safeguard the employees against the cited hazard during the abatement period.

(e) A certification that a copy of the PMA has been posted for employees at the location of the subject citation. The posted copy must remain posted for a minimum of 10 workdays.

If the issuing division or affected employees file an objection to the PMA within 10 workdays of the employer's filing date, the Board will schedule a hearing and advise the employer of the date, time, and place of the hearing.

VI–EMPLOYEE DISCRIMINATION: Section 65 of the MIOSH Act, prohibits discrimination by an employer against an employee for filing a complaint or exercising any rights under the MIOSH Act, as amended. If an employee believes that he or she was discharged or otherwise discriminated against as a result of filing a complaint, they may file a complaint with the MIOSHA Employee Discrimination Section within 30 days after the violation occurs.

VII–STATE CONSULTATION EDUCATION AND TRAINING SERVICES: The MIOSHA Consultation Education and Training (CET) Division offers a wide range of services to help businesses with their health and safety practices. CET services include: helping employers create a Safety and Health Management System, seminars and workshops, onsite consultations, hazard surveys, an equipment loan program and information material. The majority of CET services are provided free of charge to Michigan employers and employees. For information on these services, contact the CET Division at (517) 284-7720 or visit their web site at www.mi.gov/miosha.

Michigan Department of Labor and Economic Opportunity
530 West Allegan Street
P.O. Box 30644
Lansing, MI 48909
Phone: (517) 284-7750 Fax: (517) 284-7755

Inspection Number: 1491741
Inspection Date(s): 09/03/2020 - 04/22/2021
Issuance Date: 06/11/2021
Optional Reporting Number:

Citation and Notification of Penalty

Company Name: Wayne County Sheriff Office and its successors
Inspection Site: 525 Clinton St, Detroit, MI 48226

Citation 1 Item 1

Type of Violation: **Serious**

408.1011(a): ACT 154, MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ACT
An employer shall furnish to each employee, employment and a place of employment that is free from recognized hazards that are causing, or are likely to cause, death or serious physical harm to the employee.

(The employer did not furnish employment and a place of employment which was free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that an employee was exposed to struck-by hazards. On September 2, 2020, the employer did not ensure that the practice of performing evening lockdown rounds with a partner, in accordance with established policies, was followed. An employee conducting the evening lockdown rounds alone died due to injuries caused from a physical assault by an inmate that had escaped from their cell.)

Among other methods, a feasible abatement method to correct this hazard is to:

a. Retrain employees to perform the nighttime lockdown procedure with a partner as required by the employer's internal standard operating procedure and industry standards.
b. Update surveillance equipment and perform regular review of videos by members of management to ensure compliance with established policies. This could also include reviewing rounds in real-time, periodically throughout the shift.
c. Establish an auditing policy to ensure employees are performing the task with a partner, in accordance with established policies. This may include, but not be limited to, sergeants and other members of management to conduct audits during the nighttime lockdown rounds to ensure they are done properly.
d. Implement controls or devices which would mandate two people be present during rounds in each area to perform the operation. The devices would not be able to be operated successfully by a single employee. Alternately, implement documentation verifying two people perform rounds as required by policy and an audit schedule to identify non-compliance with the policy.

Date By Which Violation Must be Abated July 15, 2021
Proposed Penalty $7,000.00

Michigan Department of Labor
and Economic Opportunity
530 West Allegan Street
P.O. Box 30644
Lansing, MI 48909
Phone: (517) 284-7750 Fax: (517) 284-7755

Inspection Number: 1491741
Inspection Date(s): 09/03/2020 - 04/22/2021
Issuance Date: 06/11/2021
Optional Reporting Number:

Citation and Notification of Penalty

Company Name: Wayne County Sheriff Office and its successors
Inspection Site: 525 Clinton St, Detroit, MI 48226

Citation 2 Item 1

Type of Violation: **Other-than-Serious**

408.22112(1): ADM PART 11, RECORDING AND REPORTING OF OCCUPATIONAL INJURIES AND ILLNESSES
You must consider an injury or illness to meet the general recording criteria, and therefore to be recordable, if the injury or illness results in any of the following:

(a) Death.
(b) Days away from work.
(c) Restricted work or transfer to another job.
(d) Medical treatment beyond first-aid.
(e) Loss of consciousness.

(An employee work-related death, which met the general recording criteria, was not recorded on the log as required.)

Date By Which Violation Must be Abated: Corrected During Inspection
Proposed Penalty: $1,000.00

Authorized Signature

Michigan Department of Labor and Economic Opportunity
530 West Allegan Street
P.O. Box 30644
Lansing, MI 48909
Phone: (517) 284-7750 Fax: (517) 284-7755

Inspection Number: 1491741
Inspection Date: 09/03/2020 - 04/22/2021
Issuance Date(s): 06/11/2021
Optional Reporting Number:
CSHO ID: H0595

PROPOSED PENALTY INVOICE

Company Name: Wayne County Sheriff Office and its successors
Inspection Site: 525 Clinton St
Detroit, MI 48226

Summary of Penalties for Inspection Number: 1491741

Citation 1 Item 1, Serious	$7,000.00
Citation 2 Item 1, Other-than-Serious	$1,000.00
TOTAL PROPOSED PENALTIES:	**$8,000.00**

Correcting a violation prior to the expiration of the abatement date does not eliminate the requirement to pay the penalty. Payment of the penalty does not eliminate the requirement of correcting the violation.

The state does not agree to any restrictions or conditions or endorsements put on any check or money order for less than full amount due, and will cash the check or money order as if these restrictions, conditions, or endorsements do not exist.

Payment must be made within 15 working days of the date a proposed penalty of a citation item becomes a final order of the board. This would be the thirtieth (30th) working day after receipt of each citation item which is not appealed. For the payment of any penalty, make a check or money order payable to the "State of Michigan" and remit to the Department of Labor and Economic Opportunity at the address shown on the citation. PLEASE RECORD THE APPLICABLE INSPECTION NUMBER, CITATION NUMBER(S) AND ITEM NUMBER(S) ON THE CHECK, MONEY ORDER OR YOUR TRANSMITTAL LETTER.

Enclose this invoice page (or a copy thereof) with your payment.

Authorized Signature

Exhibit 18

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
BARTON G. PICKELMAN, DIRECTOR

SUSAN CORBIN
ACTING DIRECTOR

June 11, 2021

Mr. David Melton Jr., General Counsel
Wayne County Sheriff Office
4747 Woodward Ave
Detroit, MI 48021

Dear Mr. Melton:

RE: Inspection # 1491741

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Sincerely,

Megan Brock
Health Supervisor

MB:dm

Enclosures: Citations

CC: Cp. Leonard Wolons, Chief Steward Div. II
Wayne County Deputy Sheriffs' Association/POAM
27056 Joy Rd
Redford, MI 48239

Michigan Department of Labor and Economic Opportunity
Michigan Occupational Safety and Health Administration (MIOSHA)
MIOSHA General Industry Safety & Health Division
530 West Allegan Street
P.O. Box 30644
Lansing, MI 48909
Phone: (517) 284-7750 Fax: (517) 284-7755

Citation and Notification of Penalty

To:
Wayne County Sheriff Office and its successors
525 Clinton St
Detroit, MI 48226

Inspection Number: 1491741
Inspection Date(s): 09/03/2020 - 04/22/2021
Issuance Date: 06/11/2021

Inspection Site:
525 Clinton St
Detroit, MI 48226

Reporting ID: 0552652
CSHO ID: H0595
Optional Report Number:

SUMMARY: An inspection at the site noted above has revealed conditions we believe do not comply with the provisions of the Michigan Occupational Safety and Health Act, Act 154, of the P.A. of 1974, as amended (MIOSH Act). The nature of such alleged violation(s) is described on the citation(s) with reference to the applicable standards, rules, regulations, orders and provisions of the Act. Following is a list of items the employer must consider carefully, to resolve the issues alleged in the citation(s). Following this numbered summary is a more detailed explanation of the requirements.

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8. It is unlawful to discriminate against an employee for exercising any of their rights under MIOSHA.

Note: As defined in statutes, "workday" or "working day" means any day other than a Saturday, Sunday, or state legal holiday. The state legal holidays are:

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The third Monday in January, Martin Luther King, Jr. Day
February 12, Lincoln's birthday
The third Monday of February, Washington's birthday
The last Monday of May, Memorial or Decoration Day
July 4, Independence Day
The first Monday in September, Labor Day
The second Monday in October, Columbus Day
November 11, Veterans' Day
The fourth Thursday of November, Thanksgiving Day
December 25, Christmas Day

Please note whenever January 1; February 12; July 4; November 11; or December 25 fall on a Sunday, the next Monday following is deemed a public holiday (non-working day) for appeal purposes. However, there is no compensating day when one of the five dated holidays falls on a Saturday. Also, when computing the 15 working days, you do not count the date on which it is received; you start with the next working day. Additionally, the count is based on when the citation was received at the employer's location, not when it got to any particular person or office at the employer's location.

I–CITATIONS: The nature of the alleged violation(s) is described on the enclosed citation(s). These conditions must be corrected on or before the date(s) shown in the line marked "Date By Which Violation Must Be Abated." The issuing division may be contacted by telephone at the number indicated on the front of the citation for the purpose of discussing any issues related to the inspection or citation(s).

A copy of the citation(s) must be posted at or near the location of the violation for a minimum of 3 days or until the items have been corrected, whichever is later. The MIOSH Act provides for civil penalties of up to $7,000 for each violation for failure to comply with posting requirements.

When compliance is achieved, a copy of the citation must be signed and returned to the issuing division along with documentation of abatement.

Documentation of abatement for citation items originally classified as "serious," "repeat," "fail-to-abate," "willful," or "instance-by-instance," require documentation as deemed appropriate by the issuing division. Examples of documentation for these violation classifications are:

(a) A detailed description of how the violation was abated.
(b) Work orders or an invoice indicating the corrective work that has been done.
(c) Photographs of the abated conditions.
(d) Other forms of conclusive evidence that your employees are no longer exposed to the hazard.

For citation items classified as "other," submitting to the issuing division a signed copy of the citation item indicating the item has been abated is acceptable documentation of abatement. Submitting a document in writing, certifying abatement of the particular citation item is also acceptable for citation items classified as "other."

If the employer does not provide adequate documentation of abatement, a re-inspection may be conducted. Failure to correct an alleged violation within the abatement period may result in new or additional proposed penalties.

Correcting a violation prior to the expiration of the abatement date does not eliminate the requirement to pay the penalty. Payment of the penalty does not eliminate the requirement of correcting the violation.

II–PENALTY REDUCTION: In addition to the appeal rights afforded by the MIOSH Act, the Michigan Occupational Safety and Health Administration has implemented a program for negotiating an expedited settlement of penalties with the employers known as a Penalty Reduction Agreement (PRA). This is a program designed to reach abatement of the hazard at the earliest possible opportunity and reduce the need for formal appeals. The penalty reduction (PRA) can result in a penalty reduction of 50% provided the issuing division and the employer agree to a number of specified conditions. These conditions include an agreement by the employer to accept all of the citations issued and to:

(a) Not appeal further.
(b) Abate all items within the abatement period.
(c) Provide proof of abatement.
(d) Pay all agreed upon penalties as required (within 15 working days of approval of the PRA.)

(e) Abide by any other mutually agreed upon actions.

Inspections involving a fatality, the Severe Violator Enforcement Program (SVEP), or willful citations are not eligible for the program. Construction citations must be confirmed as corrected by the issuing division before a penalty reduction agreement can be approved.

If you are interested in pursuing a PRA, you should apply online at www.michigan.gov/mioshapra **within 5 workdays upon receipt of the citation(s)**, but no later than the 15th workday beyond receipt of the citation(s). If you do not have access to a computer, you should contact the issuing division within the same timeframe to request a PRA. If the employer wishes to accept the conditions stated above and the process can be completed within 15 workdays from receipt, then no appeal need be filed.

III–CITATION APPEAL: An employer may file a first appeal to the issuing division in writing for modification or dismissal of a citation item and/or any proposed penalty or an extension of time for abatement. The first appeal can also result in a penalty reduction of up to 50% providing the issuing division and the employer agree to the conditions (a) through (e) as stated in Section II, PENALTY REDUCTION (above).

An employee or employee representative may appeal in writing the reasonableness of the abatement date(s). The envelope containing an appeal must be postmarked no later than the 15th workday following receipt of the citation.

If a citation is not appealed within 15 workdays of receipt, then the citation becomes a Final Order of the Board of Health and Safety Compliance and Appeals (Board). Final Order citations are not subject to review by the issuing division unless the Bureau of Hearings establishes good cause for the late appeal.

An appeal must specify the item(s) appealed and that portion of the item (e.g., violation, abatement date, penalty) which is being appealed and include a certification that the appeal has been posted or given to affected employees or their representatives. If the issuing division meets with the employer to discuss an appeal, the issuing division will notify the employee representative and allow attendance at the meeting.

The issuing division will notify an employer of its decision within 15 workdays of the receipt of the employer's written appeal. The decision must be posted at the location of the subject citation.

If an employer, employee or employee representative is not satisfied with this decision then they may file a second appeal. The appeal must be in writing and the envelope containing the second appeal must be postmarked within 15 workdays of the receipt of the issuing division's decision on the first appeal. If the issuing division's decision is not appealed then the citation becomes a Final Order of the Board.

IV–PAYMENT OF MONETARY PENALTIES: Unless subject to a PRA, payment must be made within 15 workdays of the date a proposed penalty of a citation becomes a Final Order of the Board. This would be the 30th workday after receipt of each citation item that is not appealed. For payment of a penalty, make a check or money order payable to the "State of Michigan" and remit to the issuing division at the address shown on the citation. Please record the inspection number, citation and item number on the check, money order or transmittal letter.

V–EXTENSION OF TIME TO ABATE: An employer may file a petition for modification of abatement date(s) (PMA) on an item of a citation, which has become a Final Order of the Board. The PMA must be submitted to the issuing division in writing by personal delivery or postmarked no later than one day following the abatement date, and a copy posted near the place the citation was posted. An employer must have made a good faith effort to correct the violation by the abatement date, and has or will not be successful because of factors beyond the employer's reasonable control. A PMA must include:

(a) Steps taken to achieve compliance.

(b) The specific additional abatement time necessary.

(c) The reasons the additional time is needed.

(d) Available interim steps being taken to safeguard the employees against the cited hazard during the abatement period.

(e) A certification that a copy of the PMA has been posted for employees at the location of the subject citation. The posted copy must remain posted for a minimum of 10 workdays.

If the issuing division or affected employees file an objection to the PMA within 10 workdays of the employer's filing date, the Board will schedule a hearing and advise the employer of the date, time, and place of the hearing.

VI–EMPLOYEE DISCRIMINATION: Section 65 of the MIOSH Act, prohibits discrimination by an employer against an employee for filing a complaint or exercising any rights under the MIOSH Act, as amended. If an employee believes that he or she was discharged or otherwise discriminated against as a result of filing a complaint, they may file a complaint with the MIOSHA Employee Discrimination Section within 30 days after the violation occurs.

VII–STATE CONSULTATION EDUCATION AND TRAINING SERVICES: The MIOSHA Consultation Education and Training (CET) Division offers a wide range of services to help businesses with their health and safety practices. CET services include: helping employers create a Safety and Health Management System, seminars and workshops, onsite consultations, hazard surveys, an equipment loan program and information material. The majority of CET services are provided free of charge to Michigan employers and employees. For information on these services, contact the CET Division at (517) 284-7720 or visit their web site at www.mi.gov/miosha.

Michigan Department of Labor and Economic Opportunity
530 West Allegan Street
P.O. Box 30644
Lansing, MI 48909
Phone: (517) 284-7750 Fax: (517) 284-7755

Inspection Number: 1491741
Inspection Date(s): 09/03/2020 - 04/22/2021
Issuance Date: 06/11/2021
Optional Reporting Number:

Citation and Notification of Penalty

Company Name: Wayne County Sheriff Office and its successors
Inspection Site: 525 Clinton St, Detroit, MI 48226

Citation 1 Item 1

Type of Violation: **Serious**

408.1011(a): ACT 154, MICHIGAN OCCUPATIONAL SAFETY AND HEALTH ACT
An employer shall furnish to each employee, employment and a place of employment that is free from recognized hazards that are causing, or are likely to cause, death or serious physical harm to the employee.

(The employer did not furnish employment and a place of employment which was free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that an employee was exposed to struck-by hazards. On September 2, 2020, the employer did not ensure that the practice of performing evening lockdown rounds with a partner, in accordance with established policies, was followed. An employee conducting the evening lockdown rounds alone died due to injuries caused from a physical assault by an inmate that had escaped from their cell.)

Among other methods, a feasible abatement method to correct this hazard is to:

a. Retrain employees to perform the nighttime lockdown procedure with a partner as required by the employer's internal standard operating procedure and industry standards.
b. Update surveillance equipment and perform regular review of videos by members of management to ensure compliance with established policies. This could also include reviewing rounds in real-time, periodically throughout the shift.
c. Establish an auditing policy to ensure employees are performing the task with a partner, in accordance with established policies. This may include, but not be limited to, sergeants and other members of management to conduct audits during the nighttime lockdown rounds to ensure they are done properly.
d. Implement controls or devices which would mandate two people be present during rounds in each area to perform the operation. The devices would not be able to be operated successfully by a single employee. Alternately, implement documentation verifying two people perform rounds as required by policy and an audit schedule to identify non-compliance with the policy.

Date By Which Violation Must be Abated: July 15, 2021
Proposed Penalty: $8,000.00

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Inspection Number: 1491741
Inspection Date(s): 09/03/2020 - 04/22/2021
Issuance Date: 06/11/2021
Optional Reporting Number:

Citation and Notification of Penalty

Company Name: Wayne County Sheriff Office and its successors
Inspection Site: 525 Clinton St, Detroit, MI 48226

Citation 2 Item 1

Type of Violation: **Other-than-Serious**

408.22112(1): ADM PART 11, RECORDING AND REPORTING OF OCCUPATIONAL INJURIES AND ILLNESSES
You must consider an injury or illness to meet the general recording criteria, and therefore to be recordable, if the injury or illness results in any of the following:

(a) Death.
(b) Days away from work.
(c) Restricted work or transfer to another job.
(d) Medical treatment beyond first-aid.
(e) Loss of consciousness.

(An employee work-related death, which met the general recording criteria, was not recorded on the log as required.)

Date By Which Violation Must be Abated: Corrected During Inspection
Proposed Penalty: $1,001.00

Authorized Signature

Michigan Department of Labor and Economic Opportunity
530 West Allegan Street
P.O. Box 30644
Lansing, MI 48909
Phone: (517) 284-7750 Fax: (517) 284-7755

Inspection Number: 1491741
Inspection Date: 09/03/2020 - 04/22/2021
Issuance Date(s): 06/11/2021
Optional Reporting Number:
CSHO ID: H0595

PROPOSED PENALTY INVOICE

Company Name: Wayne County Sheriff Office and its successors
Inspection Site: 525 Clinton St
Detroit, MI 48226

Summary of Penalties for Inspection Number: 1491741

Citation 1 Item 1, Serious	$7,000.00
Citation 2 Item 1, Other-than-Serious	$1,000.00
TOTAL PROPOSED PENALTIES:	**$8,000.00**

Correcting a violation prior to the expiration of the abatement date does not eliminate the requirement to pay the penalty. Payment of the penalty does not eliminate the requirement of correcting the violation.

The state does not agree to any restrictions or conditions or endorsements put on any check or money order for less than full amount due, and will cash the check or money order as if these restrictions, conditions, or endorsements do not exist.

Payment must be made within 15 working days of the date a proposed penalty of a citation item becomes a final order of the board. This would be the thirtieth (30th) working day after receipt of each citation item which is not appealed. For the payment of any penalty, make a check or money order payable to the "State of Michigan" and remit to the Department of Labor and Economic Opportunity at the address shown on the citation. **PLEASE RECORD THE APPLICABLE INSPECTION NUMBER, CITATION NUMBER(S) AND ITEM NUMBER(S) ON THE CHECK, MONEY ORDER OR YOUR TRANSMITTAL LETTER.**

Enclose this invoice page (or a copy thereof) with your payment.

Authorized Signature