

OFFICE OF CORRECTION AND LAW ENFORCEMENT MONITORING

Initial Report on the Andrew Hogan Incident
while in Custody on August 25, 2018

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OIR
GROUP

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Introduction

Andrew Hogan was a pre-trial detainee with a history of mental illness, housed in the custody and care of the Santa Clara County jails. He sustained a traumatic brain injury on August 25, 2018, when he harmed himself as he was being transported from the Elmwood Corrections Facility to Santa Clara County's Main Jail's psychiatric unit.¹ Based on the injury, Mr. Hogan's parents filed a government claim on his behalf. It alleged that jail personnel and leadership were deliberately indifferent to his serious medical needs in violation of his civil rights under state and federal law by failing to provide him safe transport. The claim also alleged a failure to summon medical care, negligence, negligent supervision, intentional and negligent infliction of emotional distress and violations of the Americans with Disabilities Act.

After an investigation and review by the County's Office of County Counsel ("CCO"), the Board approved a settlement of \$10,000,000 plus payment of a Medi-Cal lien (approximately \$200,000) in March 2020.

On August 17, 2021, this Board directed the Office of Correction and Law Enforcement Monitoring ("OCLEM") to review, assess, describe, comment and make recommendations on the issue of disciplinary action or lack thereof undertaken by the Sheriff's Office in connection with the Hogan case.

This report is intended to be an initial review responsive to this Board's direction. As discussed in more detail below, access and timing limitations have prevented us from obtaining and analyzing all of the information needed to fully respond to the Board's direction and to make formal findings, conclusions, and recommendations. We are providing this initial report to the relevant departments for input and will be seeking

¹ The government claim filed on behalf of Andrew Hogan states that the incident occurred when Mr. Hogan was being moved to the "psychiatric unit" of the jails. This report employs the term used in Mr. Hogan's claim.

additional information relating to the questions and concerns raised by our preliminary analysis. We anticipate issuing a more fulsome final report at a later date.

Methodology and Structural Limitations

Beginning in April of this year, OCLEM made requests to the Sheriff's Office for materials relating to the Hogan matter. Initially, all that we received was two documents relating to current inmate transport policy. Recently, we received from the Sheriff's Office materials relating to the incident itself, including summary reports, attachments, and videos and photographs. OCLEM has also reviewed the government claim submitted by the Hogan family and the February 10, 2020 memorandum that County Counsel has made public pursuant to the Board's August 17, 2021 referral.

However, much of the material most germane to this Board's referral has yet to be provided to OCLEM. Despite four requests from OCLEM and the Sheriff's public assertions of support for the reviews and investigations set out in this referral, the Sheriff (through her attorney) has expressly declined to provide us any information relating to the Internal Affairs investigation that her agency appears to have initiated and then deactivated. This declination extended to our requested access to Sheriff's Office supervisors familiar with the Internal Affairs investigation, from whom we sought to gain insight into its substantive and procedural histories.

Without this information, we cannot answer this Board's question about whether any meaningful Internal Affairs investigation was conducted and/or appropriate disciplinary action taken. Accordingly, we plan to use our subpoena authority granted by this Board to compel the Sheriff to provide the critical information.

In addition, the timeline for this preliminary report has not allowed OCLEM to seek information or input from Custody Health regarding reviews or actions that may have been taken in response to the incident, or to receive comments from the departments on our preliminary

analysis. We are providing the preliminary report to the Sheriff's Office and Custody Health for their comments, input, and additional information, and we anticipate providing a final report at a later date, once OCLEM has obtained and analyzed more complete information.

In the interim, we provide to this Board a review of the incident and a preliminary discussion of the potential issues we identified through the materials we did receive.

Factual Summary

Prior to the incident, Andrew Hogan had a history of mental illness. On August 10, 2018, he was arrested for a relatively minor offense. Mr. Hogan, then age 24, was arrested, booked into the Santa Clara County jail, medically evaluated, and initially housed at Elmwood. The dormitory houses some mentally ill inmates who are not suicidal, not aggressive, and who are behaviorally stable when medicated.

Later that day a correctional officer reported that Mr. Hogan had threatened to jump off his top bunk, and at some point Mr. Hogan was placed in the psychiatric unit at the Main Jail, some five and a half miles away from Elmwood, where inmates experiencing acute mental health symptoms are housed.²

Mr. Hogan was returned to general population at Elmwood. But after he expressed concern that inmates would attack him, Elmwood staff moved Mr. Hogan to a direct supervision dorm³ at Elmwood where he could be more closely monitored. Mr. Hogan functioned independently in the dormitory and without further incident from August 17 to August 25.

Elmwood: The Beginning of the Incident

According to an incident report prepared by an Elmwood supervisor, on August 25, 2018 at approximately 0520 hours, Andrew Hogan advised Elmwood correctional staff that he was hearing voices. Mr. Hogan was removed from his housing and placed in a holding cell, and correctional staff requested an assessment from Custody Health.

² Public filings indicate that Mr. Hogan was placed in the psychiatric unit soon after being booked into the jail.

³ This means that staff is stationed within the housing area, thereby allowing them to more immediately and closely monitor the inmates assigned there.

At approximately 0725 hours, Sheriff's staff called Custody Health and asked a clinician when the assessment might occur. According to the Sheriff's Office report, the clinician said that the request for an assessment was not an urgent matter based on the information provided about Mr. Hogan's current status.⁴ The Sheriff's Office reported that the clinician advised that Mr. Hogan be placed back into his dorm and that he would be seen later in the day.

A Sheriff's Office deputy told Mr. Hogan that he would be seen later and that he was going to be returned to his dorm. The Sheriff's Office reported that Mr. Hogan refused and said he wanted to stay in the holding cell. The deputy advised a sergeant of Mr. Hogan's refusal.

At approximately 0806 hours, the same deputy radioed requesting a sergeant respond to the holding cell. The deputy reported that Mr. Hogan was banging his head against the door. Two sergeants responded to the holding cell.⁵

One of the sergeants reported that when they arrived, Mr. Hogan was demanding to be let out of his cell. The other sergeant attempted to have a conversation with Mr. Hogan, calm him and learn about his needs but reported that Mr. Hogan was responding in "incomplete sentences."⁶

The two sergeants decided to move Mr. Hogan to the processing lobby area of the jail for medical evaluation and to expedite his clinical assessment. One of the sergeants instructed Mr. Hogan to place his hands through the tray slot of the holding cell so he could be secured in

⁴ It is unclear to what degree the clinician considered Mr. Hogan's prior custodial behavior set out above in determining the urgency of the situation.

⁵ By this point, Mr. Hogan had been in the holding cell for 2 ½ hours without being evaluated. A review of camera footage confirms that Mr. Hogan had become restless, began to kick and punch the holding cell door, and banged his head on the door, albeit without obvious injury.

⁶ Much of the interactions between Mr. Hogan and Sheriff's Office staff was captured on body-worn or other jail camera video/audio.

waist chains. Initially, Mr. Hogan declined to do so, but eventually he did comply and was waist chained and escorted to the processing area.

Upon arrival in processing, Mr. Hogan was secured to a chair in the lobby. A nurse attempted to conduct a preliminary medical screening Mr. Hogan, but he declined.

At approximately 0827 hours, an assigned clinician arrived and interviewed Mr. Hogan. According to the incident report, following that interview, custody staff prepared to transfer Mr. Hogan to the psychiatric unit at the Main Jail, which, as previously noted, houses inmates experiencing acute mental health symptoms.⁷ The sergeant told Mr. Hogan that he was going to the Main Jail where he would be able to see a doctor. Both sergeants left the area with Mr. Hogan being supervised by deputies.

At approximately 0925 hours, the sergeants were called to assist with the movement of Mr. Hogan to the transport vehicle. Upon arrival, the sergeants observed Mr. Hogan attempt to stand up from the lobby chair; he requested that he be unsecured from the chair so that he could walk around. Mr. Hogan said that he did not feel safe and wanted to be taken somewhere else. The sergeant reported that he soon would be taken to see a doctor downtown. The sergeant reported that Mr. Hogan repeatedly mumbled incomplete sentences, was sweating profusely, and displayed “bizarre” behavior.

Two deputies arrived to transport Mr. Hogan to Main Jail. Prior to unsecuring Mr. Hogan from the lobby chair, the sergeant asked him if he would cooperate with staff by walking to and getting into the van. Mr. Hogan said that he would cooperate.

Mr. Hogan was unsecured from the lobby chair and stood on his own, but then became uncooperative by declining to walk. The sergeant reported that the two escorting deputies maintained control of Mr. Hogan

⁷ This is consistent with Mr. Hogan’s claim, which states that on August 25, 2018, County staff “decided to move Andrew Hogan to the psychiatric unit of their jails located at the main jail.”

by holding onto his arms in order to prevent him from walking away. Mr. Hogan reluctantly allowed staff to reapply leg shackles but had to be coaxed to the van.

Once at the van, Mr. Hogan refused to enter. After much conversation, deputies were able to coax Mr. Hogan into the van. The sergeant reported that Mr. Hogan refused to place his left foot into the caged area of the van, so that the door was not able to be closed and secured. Mr. Hogan then attempted to push the cage door open and leave the vehicle. Over the course of several minutes, Sheriff's Office staff were not able to gain compliance from Mr. Hogan. The sergeant requested assistance from Custody Health staff.

A clinician responded and began speaking with Mr. Hogan. After another several minutes, Mr. Hogan placed his foot into the caged area, allowing the door to be closed and secured.⁸

The van in which Mr. Hogan was transported did not have seat belts or any other restraints in the inmate seating area

The Transport from Elmwood to the Main Jail

Two deputies then left Elmwood and began to transport Mr. Hogan at approximately 0945 hours.⁹ According to the deputies, as reported in an incident report, during the trip Mr. Hogan advised that he did not feel well. One of the deputies told Mr. Hogan that they were taking him to see a doctor. The deputy that was driving the van reported that he heard what sounded like someone hitting the walls in the back of the

⁸ The course of concerning conduct observed of Mr. Hogan that day did not cause any of the Elmwood staff to recommend that he be transported by ambulance or patrol car.

⁹ Mr. Hogan was waist-chained but not otherwise restrained or wearing a safety helmet after being placed in the cage of the van.

van. The deputy said that because he was concentrating on driving, he did not activate his body worn camera.

The passenger deputy advised that while enroute to Main Jail, Mr. Hogan began hitting his head against the caged area of the van and he immediately activated his body worn camera.¹⁰ The deputy said he told Mr. Hogan to stop hurting himself, relax, and sit down. The deputy said that Mr. Hogan ignored his commands and continued hitting his forehead against the van's wall.

The passenger deputy said that he saw Mr. Hogan bleeding from his face and head area, so he contacted a sergeant to advise of the situation. Once Mr. Hogan began self-harming, the transportation deputies sped up and after they pulled off the freeway activated the van's lights and siren. It appears that despite contacting the sergeant, the deputies were not instructed to return Mr. Hogan to Elmwood or transport him to the emergency room of a local medical facility.

Upon arrival, a Main Jail supervising officer (Supervisor 1) met the transport deputies and Mr. Hogan.

The Elmwood sergeant's written incident report concluded that the actions of the deputies appear to have been "reasonable, justified and consistent with policy."¹¹

¹⁰ Mr. Hogan was violently banging his head on the roof and steel beam in the back of the van. One of the deputies estimated that Mr. Hogan struck his head at least 50 times.

¹¹ Besides the sergeant's initial incident report, it is unclear whether any administrator at Elmwood or from Sheriff's Office command staff investigated, further reviewed, or made any additional determination regarding the propriety of Elmwood staff (including the transportation deputies).

Activity at the Main Jail: Written Accounts from Involved Supervisors

There were several internal incident reports by Sheriff's Office personnel about the sequence of events surrounding Mr. Hogan's arrival at the Main Jail, his time within the transport van as it sat in the jail's intake area, and his ultimate departure for the hospital inside an ambulance. The following are summaries of those reports that reflect the different roles and perspectives of the involved parties.

Report of Supervisor 1

It was four days after the incident that Supervisor 1 was asked to prepare a report relating to the Hogan incident. According to the report, on the date of the incident, Supervisor 1 asked a superior supervising officer (Supervisor 2) whether a report was necessary. The report indicates that Supervisor 2 initially said that the only report required was an Emergency Response Team Activation Report because the incident "belonged" to Elmwood.¹²

According to the report, on the date of the incident, at approximately 1000 hours, Supervisor 1 received a call from the Elmwood complex advising that they had a combative inmate and that he was coming to the Main Jail psychiatric unit. Supervisor 1 had been advised by Elmwood staff that the inmate had to be placed by force into the van.¹³ Supervisor 1 also received a cellphone call from the transporting deputies. Supervisor 1 wrote that it was difficult to hear but that the information was that Mr. Hogan had injured himself and was combative, there was a lot of blood, and they were going to need assistance on the ramp. Supervisor 1 wrote that the deputy's tone of voice did not reflect a sense of urgency; nor was Supervisor 1 made aware of the extent of

¹² It is unclear what caused the change of position by Supervisor 2 about whether Supervisor 1 should write a report about the incident.

¹³ As detailed above, this statement is incorrect; no force was necessary to place Mr. Hogan into the transport van.

Mr. Hogan's self-inflicted injuries. The report indicates that Supervisor 1 assumed that by "assistance," the transport deputy meant officer assistance as well as medical assessment, but Supervisor 1 did not expect a "bodily injury event" upon their arrival. Supervisor 1 wrote that all calls were within minutes of each other.

The report also states that Supervisor 1 had learned from these calls that a Main Jail sergeant who was working that day was related to Mr. Hogan. Supervisor 1 contacted the sergeant, who confirmed the relationship. Supervisor 1 then asked if the relationship was such that the sergeant's presence might help de-escalate the situation. However, Supervisor 1 wrote that the sergeant advised that he did not have a good relationship with Mr. Hogan.

According to the report, Supervisor 1 called a nurse, advised the nurse of the circumstances and asked the nurse to accompany Supervisor 1 to the van upon its arrival. Supervisor 1 continued doing paperwork in intake, until hearing radio traffic from the transport deputies that they had arrived.¹⁴ The report states that Supervisor 1 immediately responded to the ramp with the nurse (for medical assessment) and with a deputy (for assessment of whether Mr. Hogan's actions called for an Emergency Response Team ("ERT") activation).

Supervisor 1 wrote that one of the transport deputies stepped out of the van and told Supervisor 1 that Mr. Hogan had been banging his head, and that there was blood and excrement everywhere. Supervisor 1 wrote that they opened the transportation van side doors and saw Mr. Hogan standing up against the gate, talking and asking for water and medical assistance.¹⁵ Supervisor 1 wrote that there was an extreme amount of blood coming from the top of his head dripping onto his face.

¹⁴ As a result, no medical or jail staff were waiting when the van arrived at the sally port at 1000 hours.

¹⁵ Despite his request, neither water nor medical assistance was provided to Mr. Hogan at that time. Instead the door was closed and he was left by himself.

Supervisor 1 further noticed excessive blood splattered throughout the van cabin.

According to the report, Supervisor 1 asked what the nurse wanted to do, and the nurse indicated that they should call a Code 3 ambulance¹⁶ as a result of the major head injury.¹⁷

The report indicates that due to the amount of blood, as well as the additional information provided, Supervisor 1 advised facility control via radio to call for a Code 3 ambulance, and for the ERT team to “suit up” because there was a lot of blood and a deputy had advised that Mr. Hogan had defecated. Supervisor 1 advised a deputy to ensure ERT wore the “bunny suits” as personal protective equipment for precaution and to alleviate cross-contamination.¹⁸

¹⁶ This terminology relates to the need for an emergency, expedited response that would be accompanied by lights and sirens.

¹⁷ A review of camera footage depicts that two minutes after the van’s arrival, Supervisor 1 is first observed in the sally port area. Supervisor 1 opened the van door for approximately eight seconds and then closed it. Camera footage also established that approximately one minute later, Mr. Hogan yelled that he needed to use the bathroom, although no one was monitoring him. Even though Supervisor 1 had been placed on notice by the nurse of Mr. Hogan’s very serious needs, Supervisor 1 did not endeavor to provide him any immediate medical assistance. Further, Supervisor 1 did not personally monitor Mr. Hogan nor assign anyone else to do so.

¹⁸ Supervisor 1 was aware of the nurse’s initial assessment of a major injury. However, as an apparent concern about jail staff being contaminated from the existence of Hogan’s bodily fluids observed in the van, Supervisor 1 decided that Mr. Hogan would remain in the van until the ERT assembled to remove him. The audio from jail cameras recorded Supervisor 1 saying that, in the meantime, Mr. Hogan could “do all the damage he wants.”

Supervisor 1 closed the doors of the van, leaving no one to monitor Mr. Hogan as he continued to bleed and decompensate. On the recordings, Mr. Hogan can be heard over the course of several unattended minutes, repeatedly yelling irrational statements with less and less vigor as he eventually lapses into unconsciousness.

According to the report, Supervisor 1 then went back into the intake area with the nurse and deputy to retrieve a hand-held camera. Supervisor 1 gave the camera to one of the deputies to record Mr. Hogan's activity while he remained in the van.

Supervisor 1 wrote that Supervisor 2 and another supervising officer (Supervisor 3) arrived on scene. The report indicates that Supervisor 2 took over authority of the scene and advised Supervisor 1 to request mental health to assist. Supervisor 1 wrote that the nurse was preparing the paperwork for the ambulance's arrival.

According to the report, Supervisor 1 went back outside and saw the ambulance at the gate and advised control that the ambulance had arrived. Supervisor 1 asked for an estimated time of arrival for ERT and that they indicated they were on their way. Supervisor 1 wrote that a San Jose Fire rescue team then arrived.

According to Supervisor 1's report, the ERT arrived and Supervisor 3 advised of the plan of entry. According to Supervisor 1's report, the gate was opened and ERT members removed Mr. Hogan from the van and placed him on a gurney, at which point ambulance personnel began to provide care to Mr. Hogan.¹⁹

The report states Supervisor 1's view that based on observations and information provided, Supervisor 1 made the safest and most reasonable decision as events were unfolding, keeping in mind the

¹⁹ A review of camera footage establishes that the arrival of the ambulance occurs at 1014 hours. The camera that had been placed in the van shows Mr. Hogan speaking rationally for the last time at 1015 hours as he then slips into making repeated incoherent statements. At 1016 hours a San Jose fire truck arrives. However, since the ERT had not yet assembled, neither ambulance nor fire personnel immediately provided medical treatment to Mr. Hogan. At 1021 hours, the ERT finally appeared; by that time it appears as if Mr. Hogan had become unconscious. Cameras captured outside medical assistance standing around waiting for ERT and talking casually with jail staff as Mr. Hogan lapses into unconsciousness.

At 1023 hours, the ERT removed Mr. Hogan from the van. Mr. Hogan arrived at the hospital at 1050 hours.

safety of staff and the inmate as a priority. According to the report, Supervisor 1 wanted responding staff to wear personal protective equipment prior to entering the area or moving the inmate. Supervisor 1 did not know if Mr. Hogan had a weapon or if he had any injuries which would be exacerbated if they moved him without medical guidance.

The report also states that Supervisor 1 advised the nurse that Supervisor 1 did not recall seeing medical assist in observing Mr. Hogan while the nurse was completing paperwork.

Report of Supervisor 2

According to a report prepared on the date of the incident by Supervisor 2, at about 1004 hours, Supervisor 2 heard Supervisor 1 request via radio for a Code 3 ambulance and activated the Emergency Response Team to the Main Jail intake ramp. The report states that Supervisor 2 immediately responded to the intake ramp area with another supervising officer. Supervisor 2 reported that Supervisor 1 was next to the transport van with the two transport deputies.

Supervisor 2 reported that after receiving a debriefing from the transport deputies, Supervisor 2 entered the front passenger door to talk with Mr. Hogan. Supervisor 2 reported that Mr. Hogan requested to see a doctor. According to Supervisor 2's report, it appeared that Mr. Hogan was hearing voices. Supervisor 2 also noted that he was yelling profanity and advising that he had been "set up."

Supervisor 2 reported stepping out of the van and instructing Supervisor 1 to have Mental Health and a nurse standby. According to the report, Supervisor 1 informed Supervisor 2 that Mr. Hogan had already been evaluated earlier at Elmwood.

Supervisor 1 also told Supervisor 2 that the nurse had assessed²⁰ Mr. Hogan when he arrived and had already requested a Code 3

²⁰ It is unclear what the "assessment" by the nurse consisted of, whether it was based on merely speaking to Mr. Hogan and/or visual observations through

ambulance. Supervisor 2 advised Supervisor 1 that mental health and medical staff needed to be on scene while they were waiting for the ambulance in order to help calm Mr. Hogan as well as provide emergency triage as needed.²¹

Supervisor 1 told Supervisor 2 that Mr. Hogan was uncooperative, aggressive, and there was blood “everywhere.” Supervisor 2 learned that Supervisor 1 activated ERT to assist removing Mr. Hogan out of the van.

Supervisor 2’s report is consistent as to the chronology of paramedic and San Jose Fire Department response, followed by the delay in action before the arrival of Main Jail ERT. It adds that, at approximately 1018 hours, jail medical staff also responded to the intake ramp; however, they left the scene upon observing the presence of outside emergency personnel.

ERT members eventually carried the unresponsive Mr. Hogan from the van onto the ground and then placed him on the gurney. Paramedics then transferred Mr. Hogan to the hospital.²²

Supervisor 2 advised a sergeant to contact the Jail Crimes Unit to notify them of the incident. While the van was initially “secured” for evidence, the JCU sergeant advised a Main Jail sergeant to contact Hazmat to clean the van.

the van window. Because the cage was not opened until ERT arrived, it was certainly not based on any sort of “hands on” physical assessment.

²¹Camera footage confirmed that Supervisor 2 arrived at the sally port area at approximately 1008 hours and video shows the supervisor talking to Supervisor 1. Supervisor 2 is seen talking to Mr. Hogan briefly and remaining in the area, but there is no video evidence (or otherwise) that Supervisor 2 ensured that jail staff attempted to attend to Mr. Hogan’s expressed needs, medically triaged him, or otherwise assisted him.

²²To reiterate, ambulance personnel were on scene for six minutes before the ERT removed Mr. Hogan from the van. By then, Mr. Hogan was unconscious.

At about 1045 hours, the Assistant Sheriff was advised of the incident.

At about 1100 hours, Supervisor 2 conducted a debriefing with a group of Main Jail supervising officers and advised them that it was critical to have mental health and medical staff on scene during a medical incident or when dealing with mentally ill inmates, especially inmates who were pending transfer to the jail psychiatric unit. Supervisor 2 reported that the supervising officers were advised that medical and mental health staff needed to stay engaged with an individual such as Mr. Hogan to try to keep him calm and to provide emergency treatment as needed.

Report of Supervisor 3

The aforementioned Supervisor 3 was also working Main Jail on the date of the incident. Supervisor 3 was asked five days later to document Supervisor 3's own actions.

The resulting report indicates that Supervisor 3 heard that the ERT was being activated for a combative inmate on the booking ramp.

Supervisor 3 indicated that the combative inmate, later identified as Andrew Hogan, was being transferred from the Elmwood facility to Main Jail.

Supervisor 3 made contact with other staff and Supervisor 2 on the booking ramp. Supervisor 2 told Supervisor 3 to make sure that Mental Health representatives were coming to the booking ramp. According to the report, other jail staff informed Supervisor 3 that there was blood and feces spread throughout the van cage area. Supervisor 3 reported that Mr. Hogan continued to yell and bang the cage inside the van.

Supervisor 3 further reported that the van was directed to move to the other side of the ramp in order to gain a tactical advantage for ERT and provide more room for EMS and Fire personnel to work.

Supervisor 3 reported that by the time EMS arrived, Mr. Hogan had become "quiet" inside the van. The report indicates that Supervisor 3 advised EMS personnel of the situation and made them aware of the blood and feces in the van. Supervisor 3 reported that a few moments later San Jose Fire arrived, and Supervisor 3 advised them of the

situation. Supervisor 3 reported that EMS personnel returned with protective equipment and Supervisor 3, EMS, and Fire walked up to the van.

Supervisor 3 reported that the van doors were opened and that San Jose Fire wanted to open the van cage door but Supervisor 3 recommended not doing so given Mr. Hogan's prior hostile behavior. Supervisor 3 reported that Mr. Hogan was lying on the van bench with his leg stretched out and pressed against the cage door. Supervisor 3 wrote that Mr. Hogan was breathing but not responding to verbal commands. The report states that, fearing that this was a "ploy or trick," Supervisor 3 wanted to be safe and wait until ERT was present when the cage door was opened just in case Mr. Hogan became physically hostile. Supervisor 3 further wrote that it was necessary to have ERT members in protective equipment in case they were exposed to bodily fluids.

Supervisor 3 wrote that after a few minutes, ERT arrived and lined up for the extraction of Mr. Hogan. Supervisor 3 reported that the cage door was opened, and Mr. Hogan was removed from the cage without any resistance and placed on the floor on his side. Supervisor 3 reported that ERT assisted EMS personnel while they evaluated Mr. Hogan and then placed him in the ambulance for transport to the hospital.

ERT Report

A member of the ERT also prepared a Team Activity Report. The ERT report indicated that the team was activated at 1004 hours by Supervisor 1 due to a "combative" inmate. According to the report, the inmate (later identified as Andrew Hogan) was covered in blood and refused to get out of the transportation vehicle. Seven members of ERT responded to the ERT "dress out" room and changed into special protective gear.

The ERT report indicated that at approximately 1010 hours, the ERT members responded to the Main Jail entrance. According to the report, once the team had fully deployed, an ERT sergeant and deputy directed Mr. Hogan to exit the vehicle, but he refused to comply with their orders.

The report indicated that Mr. Hogan, who was previously displaying hostile behavior, being argumentative and thrashing around in the security cage was now laying on top of the bench unresponsive. The report stated that the ERT leader gave Mr. Hogan directives to exit the van, but Hogan continued to be unresponsive.

The ERT report stated that at approximately 1018 hours, the ERT leader directed the team to take control and help Mr. Hogan out of the vehicle in order to be medically assessed by paramedics. The report indicated that Mr. Hogan did not respond to the team's orders but did not resist efforts to remove him from the van. According to the report, team members first placed Mr. Hogan on the ground and then were directed to place him onto a gurney so that he could be assessed and treated by paramedics. The report indicates that at approximately 1019 hours, Mr. Hogan was secured to the gurney using leather restraints and at 1031 hours, Hogan was placed inside the paramedic van.²³

Report by Supervisor 2: Additional Information²⁴

Supervisor 2 reported that the next day a review of facility video footage revealed additional information that supplemented Supervisor 2's understanding of what had occurred. The video showed that the two transport deputies arrived at the intake ramp at 1002 hours, and one of them walked into intake control and requested assistance. The review showed that Mr. Hogan was yelling as follows:

²³ The ERT report raises a number of questions regarding its accuracy. OCLEM has seen no evidence (video or otherwise) suggesting that Mr. Hogan was "combative" in the sense of being physically aggressive to any jail, medical, or mental health staff. Nor has OCLEM seen any evidence that Mr. Hogan "refused" to get out of the transport van prior to ERT arriving; Mr. Hogan was never ordered to exit the van by initial jail staff and he was non-responsive to verbal commands issued by Supervisor 3. And Mr. Hogan "refused" to comply with ERT's orders to get out of the van because he was apparently unconscious when those orders were given.

²⁴ Even though part of the original report dated, August 25, 2021, Supervisor 2's report includes a "Conclusion" that references observations made the next day.

Get me out of here. I am fuckin' dying. Please get me out. Please, I need medical. Hey, my fuckin' head split open. My fuckin' head is bleeding. Please, get me out of here. I need to talk to a doctor. I need water....

Supervisor 2 reported that at 1004 hours a nurse arrived and assessed Mr. Hogan while outside the van and requested an ambulance to transport Mr. Hogan to a local hospital, Code 3. Supervisor 2 reported that after the nurse assessed Mr. Hogan, the nurse and Supervisor 1 left the scene and walked into the intake sally port. Supervisor 2 wrote that two minutes later, Main Jail deputies left the scene and returned to intake sally port, leaving the transport deputies with Mr. Hogan by themselves.

Supervisor 2 wrote that review of the video footage gave the impression that Supervisor 1 did not engage or interact with Mr. Hogan during the entire incident. Supervisor 2 wrote that there was therefore uncertainty as to how Supervisor 1 could make a determination that Mr. Hogan was uncooperative and aggressive – a characterization that had supposedly formed the basis for requesting an ERT response. Supervisor 2 wrote that as a result of waiting for ERT to suit up, Mr. Hogan did not receive first aid until after paramedics arrived.²⁵

Supervisor 2 wrote that after the nurse assessed Mr. Hogan, no other jail medical staff were present until after paramedics arrived. Supervisor 2 reported that even though Mr. Hogan had sustained a major head injury no additional medical staff responded despite an express request for them to do so.

Supervisor 2 wrote that Supervisor 3 arrived on scene at 1011 hours and that Supervisor 2 did not see Supervisor 3 make verbal contact with Mr. Hogan during the entire incident.

²⁵In fact, Mr. Hogan was not given any medical attention until ERT suited up, arrived, and pulled him out of the van, minutes *after* EMT had already arrived.

Based on these factors, Supervisor 2 recommended further inquiry into this incident.²⁶

Subsequent Developments

As noted above, the Sheriff's Office has thus far declined to provide information about any further investigation into this incident or disciplinary action taken in response. Based on the February 10, 2020 memorandum made public by the Board, we understand that approximately one month after the incident, a Sheriff's Office Internal Affairs officer began investigating allegations of negligence and poor judgment.

Meanwhile, we understand from other public sources that a supervising officer involved in the incident publicly supported the Sheriff in her successful campaign to be re-elected in November of 2018, and that the Sheriff promoted that officer in December 2018.

As indicated in the February 10, 2020 memorandum, it appears that ultimately the Internal Affairs investigation into the incident involving Mr. Hogan was closed without any conclusions being reached.

The Hogan Family Legal Claim

The claim filed against the County by Paula Canny, an attorney on behalf of the Hogan family, alleged a number of conduct shortcomings on the part of jail staff, including the following:

- The Sheriff's Office failed to provide Mr. Hogan necessary care, including protective headgear to prevent self-harm during his transport.

²⁶ It should be noted that Supervisor 2's multi-pronged criticisms of Supervisor 1 emerged from a scene at which Supervisor 2 was present, but during which Supervisor 2 did not intervene or direct Supervisor 1 to take another course of action.

- Mr. Hogan should have been transported by the Sheriff's Office from Elmwood to the Main Jail by ambulance or by any means where he could not self-harm.
- When Mr. Hogan began banging his head severely and repeatedly against the van wall with his unprotected head, Sheriff's Office staff did nothing except photograph and video tape Mr. Hogan and made no meaningful effort to help him and protect him from injury.
- Upon arrival at the Main Jail, Sheriff's Office personnel unreasonably delayed opening the van doors, failed to monitor him and did not provide necessary medical care.
- Each of the following individuals were legally and actually responsible for the occurrences and injuries suffered by Mr. Hogan while in custody: Custody Division of the Santa Clara County Sheriff's Office; Sheriff Laurie Smith; Undersheriff Rick Sung, other unnamed individuals.
- The Sheriff, Undersheriff, and unnamed others were negligent and deliberately indifferent to Andrew Hogan on the date that he suffered his severe injury and violated Mr. Hogan's state and federal civil rights to be free from deliberate indifference.
- The Sheriff, Undersheriff and unnamed others were responsible for Mr. Hogan's injuries including negligent hiring, training, supervision, discipline, review, and staffing.
- The Sheriff, Undersheriff and unnamed others contributed to or caused the injuries to Mr. Hogan because of their individual acts, customs, practices, policies, procedures and actions failed to institute, require, and enforce proper and adequate training, discipline, supervision, policies, and procedures to deal with mentally ill inmates.
- The Sheriff, Undersheriff and unnamed others covered up violations of constitutional rights by failing to properly investigate

and evaluate complaints of excessive or unreasonable use of force, and abuse and mean treatment of mentally ill persons, by ignoring or not properly investigating claims of unconstitutional or unlawful conduct and not disciplining such conduct, by allowing and tolerating an atmosphere of violence and intimidation, of racism, classism, and discrimination against mentally ill inmates, and to use and or tolerate inadequate and deficient procedures to review and investigate misconduct claims.

As detailed above, the matter was settled for over \$10,000,000.00.

Relevant Jail Policies

At the time of the incident involving Mr. Hogan, the Sheriff's Office did not have any policy governing transport of mentally ill inmates between jails. Policy did exist that stated that inmates could be transported by ambulance to a medical facility, but that was not the practice at the time. Instead, inmates were waist-chained (but not seat belted) and placed within a secured cage in the back of a van.

After the Hogan incident, the Assistant Sheriff at the time and a lieutenant from Elmwood authored a memorandum advising correctional staff that inmates placed on a 5150 hold would only be transported via sedan or ambulance.

Approximately 30 days after the incident, a subsequent memo authored by an Elmwood lieutenant advised Sheriff's Office staff that the jail had designated a former patrol car for use in transporting inmates placed on a 5150 hold from Elmwood to the Main Jail. The memorandum indicated that the primary purpose of the vehicle was for transporting mentally ill inmates and this function shall take precedence over all other purposes.

Analysis: Unresolved Issues of Accountability and Potential Discipline

As noted above, the Sheriff's Office apparently implemented some changes in procedure to prevent mentally ill inmates being transported the way in which Mr. Hogan was in August 2018. But while the aforementioned changes are commendable, they accomplish only part of a thorough and legitimate review process. The forward-looking reforms must be accompanied by an appropriate reckoning with accountability issues for involved personnel – including potential disciplinary consequences for those whose performance violated agency policy, training, or expectations. Based on available information, we believe, as did the Sheriff's Office initially, that a formal Internal Affairs investigation was necessary for such a reckoning. Moreover, the heretofore unexplained closure of the Sheriff's Office administrative case is itself highly irregular and problematic.

In light of the incomplete information we have to date, we are not in a position at this time to make definitive findings or conclusions, but we have identified questions and concerns that merit further inquiry. We discuss the remaining unanswered questions and identified concerns as follows:

The conduct and decision-making of Supervisor 1 on August 25, 2018 raised significant concerns. As noted above, Supervisor 2's incident report raised several issues regarding Supervisor 1's decision-making and recommended "further inquiry." In addition to the issues identified by Supervisor 2, our questions include:

- Was Supervisor 1's failure to be waiting at the sally port area for Mr. Hogan to arrive consistent with the expected duty of care of a custody supervisor?

- Was Supervisor 1's eight-second assessment of Mr. Hogan when Supervisor 1 opened the van door sufficient to meet the expected duty of care of a custody supervisor?
- Was Supervisor 1's comment that "he could do all the damage that he wants" (referring to Mr. Hogan) consistent with Sheriff's Office policy regarding the professionalism and care expected of custody supervisors and does it suggest a lack of caring about whether Mr. Hogan continued to self-harm?
- Did Supervisor 1 have sufficient information about Mr. Hogan's condition to determine that ERT had to be summoned to extract him from the van?
- Did Supervisor 1 fail in supervisory responsibilities when Supervisor 1 left Mr. Hogan largely unattended until the ERT was able to prepare and respond?
- Did Supervisor 1 accurately depict the events in writing the incident report?

There were also questions regarding the performance of Supervisor 2 with regard to the care of Mr. Hogan:

- Did Supervisor 2 sufficiently supervise the Sheriff's Office response after Mr. Hogan arrived at the jail?
- Did Supervisor 2 learn enough about Mr. Hogan's condition upon arrival at the sally port area to fully consider Supervisor 1's decision to wait until ERT arrived before providing medical care to Mr. Hogan?
- Did Supervisor 2 do enough to ensure that Mr. Hogan was monitored by jail staff, medical staff, and mental health staff prior to him being extracted by ERT?
- Should Supervisor 2 have countermanded Supervisor 1's decision to wait until ERT could muster, respond, and extract Mr. Hogan from the van before providing him medical care?

- Should Supervisor 2 have ensured that Mr. Hogan's worsening condition could be closely monitored while he remained in the van cage so that the decision to delay care could continually be revisited?

These types of questions and concerns are best addressed by an Internal Affairs investigation. Investigators should conduct formal interviews, collect and review video and documentary evidence, and analyze the acts and decision-making of subject officers. As detailed above, the preliminary information²⁷ and concern about this incident was apparently sufficient to trigger an Internal Affairs investigation. However, also as detailed above, the Internal Affairs investigation appears to have been abruptly halted before the investigation could be completed or any findings made.²⁸

Once an Internal Affairs investigation is initiated, it should be the extraordinary circumstance that would cause it to be closed without a finding. The interruption of the fact collection process means that leadership remains in the dark about precisely what happened. And the lack of a determination means that the subject employees are neither held accountable nor exonerated depending on the outcome of the investigation. Any decision to inactivate an internal investigation must

²⁷There were issues with regard to the initial collection of information from involved personnel both at Main Jail and at Elmwood. While Supervisor 2, the leader of the ERT, and a sergeant at Elmwood all prepared contemporaneous incident reports, it was not until several days later that Supervisor 1 (and other supervising officers) were asked to prepare reports. An incident of this magnitude should have triggered an order from Sheriff's command that contemporaneous reports be written by all Sheriff's Office personnel who had involvement with Mr. Hogan from his initial movement out of the dorm in Elmwood to his transport to the hospital from Main Jail.

²⁸ Based on the available information, it is not clear whether this incident was subject to a "Root Cause Analysis" internal review. Current policy seemingly would require this incident to be the subject of such a process: a multi-department investigation and review coordinated by Custody Health that is intended to identify the reasons for such tragic episodes and devise remedies to reduce the likelihood of future similar occurrences.

be supported by documentation clearly explaining the rationale for doing so.²⁹

Because the Sheriff has refused to provide OCLEM with any documents relating to the Internal Affairs case, or access to Internal Affairs leadership, we have no ability to independently evaluate the rationale for the Sheriff's Office closure of the case. As stated above, we therefore intend to exercise our subpoena authority as needed to carry out our responsibilities, per both the OCLEM ordinance and this Board's recent referral as to the Hogan case in particular.

There was other decision-making and conduct relating to the Hogan incident that, based on the information currently available to OCLEM, should have also been subject of additional review:

- **The Delay by Custody Health in Interviewing Mr. Hogan**

As noted above, Custody Health failed to respond to conduct the requested assessment for over two hours that Mr. Hogan was required to wait in a holding cell. When custody inquired about the delay, they were reportedly advised that Mr. Hogan was not a priority and that he should be returned to the dormitory. It is unclear whether there was any follow up of this issue by Custody Health, and it would be important to learn whether the clinician

²⁹ Publicly available information suggests that the investigation may have been irregular in other ways that merit attention. Public sources indicate that one of the supervising officers involved in the incident was a leader of the Correctional Peace Officer's Association, which provided significant support for the Sheriff's reelection. Public sources also indicate that the Sheriff promoted that officer soon after the election and just a few months after the incident involving Mr. Hogan. These facts, taken together with the unexplained closure of the Internal Affairs investigation, certainly raise the question of whether the officer's position in the union and its support for the Sheriff's political campaign played a role in the decision to deactivate the Internal Affairs investigation. But those concerns cannot be definitively assessed without OCLEM obtaining the requested information and access to Sheriff's supervisory Internal Affairs personnel.

was asked to document and explain the reason for the delay in seeing Mr. Hogan.³⁰

- **The Decision to Transport Mr. Hogan in the Caged Van**

It was foreseeable that Mr. Hogan might harm himself during the trip to the Main Jail, given that he banged his head against the holding cell wall earlier that day and initially would not allow the van doors to be closed. Yet the Sheriff's Office made no further inquiry into the choice by supervisory jail staff (in concert with the Custody Health clinician) to remain committed to the transport van. The van was not equipped to prevent self-harm, and no one rode with Mr. Hogan in the back of the van to prevent him from harming himself. Once inside the moving van, Mr. Hogan began striking his head in a caged area where no one could stop him.

The Sheriff's Office should have made further inquiry into these questions so that a more complete factual record could have been compiled, and an appropriately robust analysis be made of the decision-making and conduct of involved personnel. Moreover, we intend to seek information about whether Custody Health made further inquiry regarding the participation by the clinician regarding this question.³¹

- **The Decision to Continue to the Main Jail After Mr. Hogan Began to Harm Himself in the Van**

The transport deputies radioed for advisement and direction to supervisors once Mr. Hogan began hitting his head against the

³⁰ OCLEM intends to follow up with Custody Health regarding this question.

³¹ While, as detailed above, there was no policy preventing Elmwood staff from using the caged transport van to transport mentally ill inmates, the question was whether the particular circumstances in this case warranted a consideration of potential alternatives, especially the prior evidence of Mr. Hogan's attempt to self-harm and his articulated reluctance to enter the van.

van walls and were instructed to continue to the Main Jail. Yet there was no inquiry into whether that instruction was appropriate under the circumstances. Nor was there any inquiry into whether the transport deputies could have taken other action to halt the self-harm, such as pulling the van over and attempting to control Mr. Hogan so that he could no longer harm himself. In fact, as noted above, the Sheriff's Office command did not even ask the relevant personnel to document their actions and explain their decision-making, in spite of the numerous repeated times that Mr. Hogan struck his head against the inside of the van during the trip.

- **The Decision by Supervisor 3 to Wait for ERT Arrival Before Providing Mr. Hogan with Medical Care**

As detailed above, Supervisor 3 admitted to choosing not to provide EMT access to Mr. Hogan to render aid until ERT arrived and extracted Hogan from the caged area of the van. However, it appears that there was no full factual explication of this decision by the Sheriff's Office.³² Nor was there any detailed analysis by the Sheriff's Office of the soundness of Supervisor 3's decision.

Conclusion and Next Steps

Underlying the deeply unfortunate outcome of this case is the baseline question of whether Mr. Hogan should have even been in custody at the time of the incident, given the relatively minor nature of the charged offense and the precarious status of his mental health. While that issue is deserving of further attention as part of the larger discussion of the County's justice system, the reality is that mentally ill individuals who do happen to be in custody incur an obligation on the Sheriff's Office to keep them safe from themselves. Here, there was an abject failure to

³²A robust investigation would have included interviews of responding EMT's and San Jose Fire to learn of their observations and actions.

do so, resulting in liability and, more importantly, the life-altering injury of a person to whom the County was responsible.

But in spite of these dire consequences, there remains no available evidence to establish that appropriate accountability measures or comprehensive remedial actions were pursued by the Sheriff's Office. On the contrary, irregular procedures and incomplete explanations have compounded the initial concerns that were generated by the incident itself. This reality falls well short of the reasonable expectations for transparency and understanding that are sought by your Board and the general public.

OCLEM appreciates the referral from this Board as an attempt to better understand what occurred, and the reasons for the truncated Internal Affairs investigation. In the absence of a sudden reversal on the part of the Sheriff's Office as to cooperation with our requests for information and access, we will work to accomplish our monitoring responsibilities through the subpoena process. And we will of course keep this Board apprised of our progress in that regard.