M E M O R A N D U M

SACRAMENTO COUNTY DISTRICT ATTORNEY'S OFFICE

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DISTRICT ATTORNEY

DATE: March 22, 2021

TO: Police Chief Daniel Hahn
Sacramento Police Department
5770 Freeport Boulevard, Suite 100
Sacramento, CA 95822

FROM: Sacramento County District Attorney's Office

SUBJECT: In-Custody Death – Reginald Damone Payne (DOB 9/24/1971)
SSD Report No.: SPD-20-62647
Date of Incident: February 25, 2020
Date of Death: March 3, 2020

The District Attorney's Office has completed an independent review of the above-referenced in-custody death. Issues of civil liability, tactics, and departmental policies and procedures were not considered. We only address whether there is sufficient evidence to support the filing of a criminal action in connection with the death of Reginald Payne. For the reasons set forth, we find no evidence of criminal misconduct.

The District Attorney's Office received and reviewed written reports and other items, including: Sacramento Police Department report number 2020-62647 and related dispatch logs and recordings, witness interview recordings, body-worn camera video recordings, and the Sacramento County Coroner's Final Report of Investigation.

FACTUAL SUMMARY

On February 25, 2020, at approximately 7:34 p.m., Harriet Jefferson called 9-1-1 to request medical assistance for her adult son, Reginald Payne. Ms. Jefferson told the 9-1-1 operator that her son was diabetic, that he was acting delirious, and that she believed his blood sugar was "out of whack."

The 9-1-1 operator transferred Ms. Jefferson's call to the Sacramento Fire Department dispatcher. Ms. Jefferson told the Fire Department dispatcher that her son was flailing his arms, speaking incoherently, and appeared to be having a low blood sugar issue. The Fire Department sent two vehicles to respond to Reginald Payne's residence in Sacramento to provide medical assistance. The responding vehicles were a fire engine and an ambulance, with five licensed paramedics and a trainee.

When the Fire Department medics arrived at the residence, Ms. Jefferson told them her son was diabetic and that Fire Department personnel had previously been to the house to assist her son when his blood sugar had gotten low in the past.

Ms. Jefferson led the Fire Department medics to where Reginald Payne was sitting on the couch in the living room. Mr. Payne was approximately 6 feet tall and weighed approximately 250 pounds. Mr. Payne was uncooperative with the medics. They tried to verbally calm and reassure Mr. Payne without success. Mr. Payne was speaking incoherently, swinging his fists, and kicking his feet.

At approximately 7:45 p.m., the Fire Department captain present on scene decided they needed the assistance of the Police Department to restrain Mr. Payne so they could safely evaluate and treat him.

The Sacramento Police Department dispatched three uniformed officers to respond and assist. Sacramento Police Department Officer Kevin Moorman was the first officer to arrive, at approximately 7:51 p.m. He approached the Fire Department personnel for a description of what was needed. The medics informed Officer Moorman that the subject in the living room was experiencing a diabetic emergency and they needed the police officers to restrain him so the medics could test Mr. Payne's blood sugar and determine the necessary treatment.

Due to Mr. Payne's size, Officer Moorman decided to wait for additional officers to arrive before attempting to restrain Mr. Payne. Officer David Mower arrived at approximately 7:55 p.m. and Officer John Helmich arrived at approximately 7:57 p.m. Officer Moorman briefed the other two officers on what was needed.

The three officers entered the home while the medics waited outside. Ms. Jefferson advised the officers that her son was diabetic, had skipped one of his meals, and was having a diabetic episode. Officer Mower advised her that her son was not under arrest and the officers were there just to assist the medics in providing medical aid.

When the three officers entered the living room, it appeared to each of them that Mr. Payne was experiencing a medical emergency. Officer Helmich described Mr. Payne's demeanor as appearing "frantic or panicked." Mr. Payne was flailing his arms and legs and was speaking incoherently. Officers attempted to speak with Mr. Payne. He was not responsive. It did not appear to the officers that Mr. Payne was able to control his actions.

As the officers were attempting to speak with him, Mr. Payne slid off the couch onto the floor, with his back still up against the couch. The officers approached him to control and restrain his arms and legs so the Fire Department could render aid.

Officers Mower and Helmich took control of Mr. Payne's arms and turned Mr. Payne over onto his stomach. They utilized wrist lock techniques to move Mr. Payne's arms behind his back, and Officer Mower applied handcuffs.

Officer Helmich placed his knee and shin on Mr. Payne's right shoulder to control his arms while the handcuffs were applied. The medics then entered the home and proceeded to test Mr. Payne's blood sugar. Officer Helmich removed his knee from Mr. Payne's shoulder and used his hands to keep Mr. Payne in place. Officer Helmich's knee was on Mr. Payne's shoulder for approximately 90 seconds, but Officer Helmich did not place his body weight on top of Mr. Payne. Rather, Officer Helmich's knee and shin were positioned to prevent Mr. Payne from

moving or rolling over while the medics were trying to assist him.

Officer Moorman controlled Mr. Payne's legs. He did so by bending both legs at the knee, folding one leg inward, and crossing the other leg over it. Mr. Payne was still resisting during this process.

Once Mr. Payne was restrained, the medics pricked Mr. Payne's finger to test his blood sugar level. They determined that Mr. Payne's blood sugar was significantly low. The medics decided to administer a shot of Glucagon, a hormone used to treat severe low blood sugar.

As the officers continued to hold Mr. Payne down with their hands, one of the medics cut a hole in the right shoulder of Mr. Payne's shirt and administered the shot. This occurred at approximately 8:04 p.m.

Prior to the shot being administered, Mr. Payne continued to resist. He spoke urgently and incoherently, moved his head around, and tried to move his chest and legs off the floor. Once the shot was administered, Mr. Payne's condition changed. He stopped resisting and slowly stopped moving and speaking. His body became limp.

At approximately 8:05 p.m., Officer Mower asked the medics if Mr. Payne was okay. One of the medics placed his finger on Mr. Payne's neck and confirmed that Mr. Payne still had a pulse. Medics began placing soft restraints on Mr. Payne's wrists and ankles at approximately 8:06 p.m. and moved him to a gurney for transport to the hospital. Officer Mower removed the handcuffs from Mr. Payne at approximately 8:08 p.m.

Medics brought Mr. Payne out to the ambulance on the gurney. At the ambulance, it was determined that Mr. Payne had no pulse and was not breathing. The medics started and continued performing CPR until Mr. Payne was transferred to the Emergency Room at Sutter Medical Center in Sacramento.

The Fire Department medics were interviewed. Their statements were consistent with the details as described above.

Harriet Jefferson was interviewed by detectives on February 28, 2020. She informed the detectives that as of that date, her son was still in the hospital. She had been told that her son had a heart attack and possibly suffered multiple strokes.

Ms. Jefferson indicated that Mr. Payne's medical condition prior to this incident included bi-polar disorder, diabetes, and kidney disease, for which he was undergoing dialysis three times a week. She stated that she previously had to call for medical assistance when her son's blood sugar was low, but her son had never previously needed to be restrained. She believed when she called 9-1-1 the medics would give her son an I.V. with some sugar.

Ms. Jefferson indicated she was not concerned about the conduct of the officers. She stated she was appreciative of the police officers, as they were reassuring her son throughout the incident that he would be okay, that they asked questions, and behaved nicely. She stated she knew the officers did what they had to do.

Reginald Payne passed away at Sutter Medical Center on March 3, 2020. The attending physician, Dr. Karim Tadlaoui, was not aware of the circumstances that led to Mr. Payne's hospitalization. He documented the cause of death as viral pneumonia, influenza, and acute respiratory failure. Law enforcement was not notified by hospital personnel of Mr. Payne's

death. Based on the findings by the attending physician at the time of death, an autopsy was not performed.

Ms. Jefferson left a voicemail for detectives on March 11th regarding the police report from the incident. In that message she informed detectives that her son had died on March 3rd.

Thereafter, the Sacramento Police Department asked the Sacramento County Coroner's Office to review the circumstances of Mr. Payne's death. However, Mr. Payne's body had already been cremated and no autopsy could be performed.

Dr. Katherine Raven, a pathologist with the Sacramento County Coroner's Office, reviewed medical records, investigative reports, and body-worn camera video of the incident. Based on that review, Dr. Raven listed the cause of death as sudden cardiac arrest while being restrained in prone position.

According to Dr. Raven, although the attending physician attributed Mr. Payne's death to influenza, the attending physician was not aware of Mr. Payne's restraint. Dr. Raven opined that restraint could not be excluded as a contributing cause due to Mr. Payne's prone position, physical pressure on his chest, and the temporal relationship of his unresponsiveness with the restraint. However, Dr. Raven also acknowledged that the "natural disease processes identified by the attending physician would have more than likely contributed to the death."

Body-worn camera video from all three police officers was reviewed. The videos depict the events as described above.

LEGAL ANALYSIS:

The Office of the District Attorney reviews deaths that occur while in police custody to assess and apply the law relating to police use of force and to determine if the officers' acts fall within the state laws of criminal responsibility.

Officers Moorman, Mower, and Helmich restrained and placed handcuffs onto Reginald Payne to assist the Fire Department medics in providing medical care to Mr. Payne, who was experiencing a medical emergency and was unable to care for himself. Ordinarily, the restraint and handcuffing of an individual would constitute a detention or arrest that would need to be predicated on the existence of probable cause to believe a crime had been committed. (See California Penal Code sections 834, 835a.)

However, the Fourth Amendment is not implicated when officers act for a lawful purpose other than suspicion of involvement in criminal activity. Such circumstances exist when an officer is engaged in one of "those innumerable miscellaneous tasks which society calls upon police to do which have nothing to do with the detection of crime such as giving aid to persons in distress . . . assisting the elderly or disabled . . . and protecting persons from harm." (See *In Re Tony C.* (1978) 21 Cal.3d 888, 895-896; *Batts v. Superior Court* (1972) 23 Cal.App.3d 435, 438-439.) Considering the medical emergency Mr. Payne was experiencing and the circumstance that medics needed Mr. Payne to be restrained in order to provide treatment, the officers acted lawfully in restraining and handcuffing Mr. Payne to allow the medics to provide medical care.

Further, as there is no credible evidence to support a finding that any of the three officers intentionally tried to harm Mr. Payne, the only possible source of criminal liability is under California Penal Code section 192(b), involuntary manslaughter. The relevant portion of Penal

Code section 192(b) defines involuntary manslaughter as a "killing . . . in the commission of a lawful act which might produce death . . . without due caution and circumspection." The statutory phrase "without due caution and circumspection" has been described by the California Supreme Court as the equivalent of "criminal negligence." (See *People v. Penny* (1955) 44 Cal.2d 861, 869-880; *People v. Stuart* (1956) 47 Cal.2d 167, 173-174.)

Under California law, more than ordinary negligence is required to support a charge of involuntary manslaughter. Evidence must prove that a person acted in an aggravated, culpable, gross, or reckless manner, a manner so imprudent as to be incompatible with a proper regard for human life, or in other words, a disregard of human life or an indifference to consequences of the act. (*Somers v. Superior Court* (1973) 32 Cal.App.3d 961, 968-969.) Further, the evidence must prove that the consequence of the negligent act could reasonably have been foreseen, and it must appear that the death or danger to human life was not the result of inattention, mistaken judgment, or misadventure, but the natural and probable result of an aggravated, reckless, or grossly negligent act. (*People v. Villalobos* (1962) 208 Cal.App.2d 321, 326-328; *People v. Rodriguez* (1960) 186 Cal.App.2d 433, 437-441.)

Although the term "negligence" is used in both criminal and civil actions, it is defined differently in each. Criminal negligence differs from civil, or "ordinary negligence," in that it requires a finding of more aggravated reckless conduct (i.e., the standard of measuring the conduct itself is greater). Further, criminal negligence requires a higher standard of proof than ordinary negligence (i.e., proof beyond a reasonable doubt). Our review includes no legal or factual analysis of whether there is any evidence of civil negligence in this case.

The determination of whether or not conduct rises to the level of criminal negligence must be determined from the conduct itself and not from the resultant harm. (*Somers v. Superior Court*, supra, 32 Cal.App.3d at p. 969; *People v. Rodriguez*, supra, 186 Cal.App.2d at p. 440.)

Here, Officers Moorman, Mower, and Helmich acted reasonably when they restrained Reginald Payne in his living room at the request of Fire Department medics so that the medics could provide medical assistance to Mr. Payne during his diabetic emergency.

Mr. Payne's mother had called 9-1-1 because her son was experiencing a diabetic emergency. Five licensed paramedics responded and saw that Mr. Payne was undergoing a medical emergency. However, they were unable to evaluate or treat Mr. Payne due to his size and his physical resistance. Mr. Payne was speaking incoherently and flailing his arms and legs. They requested that Police Department officers respond to restrain Mr. Payne to allow them to test Mr. Payne's blood and administer the appropriate treatment.

When the three officers arrived, they consulted with Mr. Payne's mother and the paramedics. They approached Mr. Payne and were able to observe his distress. They made attempts to calm Mr. Payne by speaking to him, without success. Accordingly, they decided to restrain Mr. Payne by turning him onto his stomach and placing him in handcuffs so he could be treated by the medics.

As shown in the body-worn camera video, the officers used minimal force, used calm voices, and rubbed Mr. Payne's back in an effort to reassure him so the medics could proceed. Although Officer Helmich placed his knee and shin on Mr. Payne's right shoulder for approximately 90 seconds, he did not place his body weight on Mr. Payne in a manner that would obstruct his breathing.

Officers Moorman, Mower, and Helmich had no warning signs that Mr. Payne might experience a cardiac event. The immediate danger to Mr. Payne was his diabetic emergency resulting from his low blood sugar. The officers' actions were solely designed to allow Mr. Payne to receive the treatment he required.

Moreover, the officers were not negligent for failing to provide care or monitoring Mr. Payne more closely. When Mr. Payne was taken to the ambulance, it was observed that Mr. Payne was not breathing and it was then determined he had no pulse. However, when Mr. Payne became non-responsive in the living room, Officer Mower asked the medics if Mr. Payne was okay. One of the medics confirmed that Mr. Payne had a pulse. Custody was transferred to the licensed paramedics on scene. Clearly, it was reasonable for the officers to defer to the medics for all decisions regarding the medical care or treatment for Mr. Payne.

Considering the totality of circumstances, it cannot be said that the officers acted in an aggravated, culpable, gross, or reckless manner. They did not act with a disregard for human life or an indifference to the consequences of their actions. In fact, the officers clearly demonstrated a proper regard for the life of Reginald Payne.

CONCLUSION

Applying the controlling legal standards to the factual record in this case, we find no credible evidence to support an allegation of criminal negligence or excessive force against Officers Moorman, Mower, or Helmich. Rather, the objective evidence supports a finding that the officers' conduct was reasonable given the circumstances they encountered.

Accordingly, we will take no further action in this matter.

Cc: Sacramento Police Department Detective David Putman #870
Sacramento Police Department Officer Kevin Moorman #621
Sacramento Police Department Officer David Mower #1028
Sacramento Police Department Officer John Helmich #589
Office of Public Safety Accountability
Kimberly Gin, Sacramento County Coroner's Office