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March 26, 2008

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UNIDENTIFIED**  
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Re: **NOTICE OF CLAIM –Carol Anne Gotbaum’s Death**

KANSAS CITY  
OVERLAND PARK  
WICHITA  
WASHINGTON, D.C.  
PHOENIX  
ST. LOUIS  
OMAHA  
JEFFERSON CITY

This letter constitutes a Notice of Claim served on behalf of Noah Gotbaum, the husband of Carol Anne Gotbaum, Tobias, Nathaniel, and Ella Gotbaum, the natural, minor children of Noah and Carol Gotbaum, and the Estate of Carol Anne Gotbaum (“Gotbaum”), in connection with fatal injuries inflicted upon Carol Anne Gotbaum on September 28, 2007.

On that day, members of the Phoenix Police Department (“PPD”) used excessive and unreasonable force on Carol, as if she was a dangerous criminal, rather than as the sick, intoxicated, and vulnerable person she was. Instead of getting her the medical and mental help she so obviously needed, Officers first restrained her with unnecessary and excessive force, then took her to a holding cell where they shackled her with a chain and left her alone. In the process, they ignored the warning signs that their own policies, procedures, and training materials told them could result in Carol’s death. And it did. Carol died shortly thereafter, in the chains the Officers placed upon her, in the room where they left her all alone and without help.

The facts presented in this Notice of Claim are taken primarily from the reports of the Phoenix Police Department, the Phoenix Fire Department, and the Maricopa County Medical Examiner’s Office autopsy report. Despite a Public Records Request pursuant to A.R.S. § 39–121 *et seq.* the Phoenix Police Department (“PPD”) has not released all of its records of this incident and its aftermath. Those records, once received, will provide additional detail to the claims made herein and may themselves reveal separate, independent claims against the PPD and other individual PPD employees, as yet unidentified, who may have been involved with Carol that day. Even the facts known at this time paint a disturbing picture of gross negligence and deliberate indifference which is more than sufficient to establish wrongful death civil rights violations and to support various legal claims by Carol’s children, Noah, and the Estate of Carol Gotbaum. Once the remaining records are provided to Carol’s family, this Notice of Claim may be amended to reflect the existence of additional defendants and/or additional claims.

### *Carol Gotbaum’s Last Day*

Carol Gotbaum became an alcoholic about 18 months before her death. It began after the birth of her third child and the death of her father. Like so many other alcoholics, Carol functioned well on a day-to-day basis. Likewise, she was ashamed at her illness and only abused alcohol in private settings. Despite her addiction, she was a caring, loving, and responsible mother to her children and wife to Noah.

At first, Carol tried to control her alcoholism on her own, with some imperfect success. She was hospitalized twice after drinking excessively in the months preceding her death, but found herself unable to conquer the compulsion. As a result, Carol and Noah decided that they would travel together to enroll her in a rehabilitation center in upstate New York for treatment. Noah drove Carol, helped get her checked in, visited her during her several-day stay, and picked her up at the end. But, Carol and Noah saw little or no resulting beneficial effect from her short treatment. Carol needed a more drastic step to help her overcome her addiction.

In late September, 2007, with the concurrence of their counselors and the support of their friends, Carol and Noah decided that she would travel alone to Arizona for a 30 day inpatient rehabilitation program at Cottonwood de Tucson, one of the best rehabilitation centers in the Country. Though frightened at the prospect of leaving her children and husband for so long, Carol was determined to beat her

addiction and was committed in her conviction that she would succeed. And she was determined to do it on her own, for her and her family's sake.

Carol was initially scheduled to take a non-stop flight from New York to Tucson on the night of September 26, but changed her plans at the last minute to spend a few more hours with Noah, Tobias, Nathaniel, and Ella. She especially wanted to take her two oldest children to the new school they were starting the next day. So, she rescheduled her U.S. Airways flight to depart New York Friday morning, September 28, arriving in Phoenix at 12:18 p.m., and catch a connecting flight to Tucson at 1:13 p.m.

Carol's initial flight from New York was eventful for her. She admitted to her seatmate, Jodi Hall, that she was on her way to alcohol rehab in Tucson and was both frightened and anxious to begin the process. When Jodi asked why she was traveling alone, Carol told her that it was something she felt she had to do and that it was time she took responsibility for herself and acted like a grownup. Carol was resolute and determined to overcome her addiction. Jodi saw Carol's journal entry for that day: "Remember this day as a new beginning."

Jill Jackson, a flight attendant, believes that Carol stopped at the galley and asked for a vodka and tomato juice and a snack box. But Jodi, returning from the restroom, met Carol in the galley and walked with her back to their seats. She did not see Carol drink anything but a ginger ale on the flight. Jodi described Carol as emotional, but optimistic. Jodi recalls that, while Carol shed some tears, she also smiled when talking about Noah, her children, and her hope for a new beginning and a better future.

The plane landed later than expected. Jodi, who has rheumatoid arthritis and lupus and sometimes uses a wheelchair, last saw Carol at the end of the jetway. There she asked Carol if she was alright. Carol assured her she was and that her next gate was nearby.

At 12:51 p.m. Carol and Noah spoke. Carol had tried twice before to reach Noah, but cell service in the airport was intermittent and the calls either could not be completed or were dropped. Carol told Noah that she had had a most inspirational flight and reiterated to him her commitment to get well. At 1:06 p.m. Carol showed up at the gate for her flight. She was told by Rikki Griener, the gate agent, that the door had closed at 1:05 p.m. and that the plane had already backed away from the gate. Griener also told Carol that the flight was overbooked by five passengers and because Carol had failed to check in at the gate (even though it was a connecting flight) her seat had been given away. Griener assured Carol that she would get her on the next flight at 2:58 p.m.

Carol received this news with equanimity. At 1:13 p.m. she called Noah and told him about the delay. They had an upbeat, positive conversation. Three minutes later, they spoke again. Carol told Noah that she was going to rehab "for you and the kids." At 2:26 p.m. she e-mailed him: "FYI I love you."

Then things changed. Despite the prior assurances of the Mesa Airlines gate agent, Carol was, once again, bumped from the next flight, told she could not take the 2:58 flight, and that there would be further delay. She became visibly upset, as the gate agent herself noted. Seeing her distress, another traveler, Marco Torres, offered Carol his own boarding pass for the 2:58 p.m. flight.

Just before 2:46 p.m. Carol presented Torres' boarding pass to the gate agent, but Mesa Airline staff did not let her board the plane. They told Carol that she could not use someone else's boarding pass and that it would be a security breach. The Mesa Airline staff did not offer to reissue the boarding pass to Carol; in fact, they did not even tell her that they could.

The frustration and trepidation that Carol felt that day began to escalate. And then it erupted. Carol began to cry. She yelled that she wasn't a terrorist. She fell to the floor in despair, where she was observed in the fetal position. When she stood up, she flung her Blackberry across the floor and dropped her purse. She screamed and ran up the concourse, waving her arms and yelling: "I'm not a terrorist."

Sharise Benitez, a female TSA, calmly approached Carol and offered to help. (Ms. Benitez and another TSA employee reported that Carol had been yelling that she wanted a woman to hold her.) Ms. Benitez reported that her peaceful approach calmed Carol. But the subsequent approach by the Phoenix Police Department Officers was anything but peaceful. Within seconds of the first PPD officer's arrival, they needlessly escalated the incident.

Called to the scene by the Mesa Airline gate agent, PPD officer Wonya first arrived on the scene at 2:51 p.m. Although Officer Wonya reported that he first asked Carol if she was alright, video surveillance shows that Officer Wonya approached Carol with his hands on his hip-belt, ready to handcuff and arrest her. Within seconds of his arrival, he grabbed her left wrist to handcuff her—she reflexively stepped away. Although Carol had been calm just seconds before when speaking with the TSA agents, she was no longer calm. She repeated that she was not a terrorist and pled with the officer: "I just want a woman to hold me."

By this time, two other male PPD police officers had arrived on the scene, Officer Rigg, with handcuffs already drawn, and Officer Richards. Although the three officers were far larger and stronger than the 123-pound Carol, and although her resistance was limited to shrinking back when they grabbed her, the three police officers kicked Carol's legs out from under her and forced her to the ground. Once on the ground, one of the officers forced his knee into Carol's shoulder, while another pulled her right arm out from under her body. They cuffed her hands behind her back and hauled her to her feet. During this, Carol yelled: "Give me grace." But there was no grace on the concourse that day, nor any patience, understanding, or mercy.

Even at the point of their first contact with Carol, PPD knew that they were dealing with a medical matter—a sick and disturbed woman. As she herself cried out, Carol was not a terrorist or any other kind of menace. Carol brandished no weapon

and never threatened any officer, citizen, airline employee, airport property, or, even herself. The PPD officers themselves recognized that Carol was "mentally unstable," "hysterical," "irrational." Carol's behavior was clearly out of the ordinary, but it was non-threatening. It was evident that Carol was either mentally ill, intoxicated, in a diabetic emergency, suffering from a seizure disorder, or experiencing a psychotic breakdown. Nevertheless, at no point prior to her strangulation did anyone from Phoenix PD seek any medical input, advice, or assistance.

After they pulled Carol to her feet, two of the three officers dragged and pulled her through the concourse, and down the elevator to the police substation in Terminal 4. Witnesses report that Carol was calm, compliant, and completely quiet when she exited the elevator. She wasn't resisting at all.

Once at the police office, the officers began to search Carol. She yelled that she didn't want anyone touching her. Officer Klepper, a female officer, was called and she and Officer Fulton conducted the search, at one point pushing Carol against the wall. Again, Carol yelled that she was not a terrorist, but a "depressed pathetic housewife."

After the search, the officers took Carol into the holding cell, still cuffed. One officer used his knees to force Carol to sit on a concrete, stationary bench in the cell. With her hands still cuffed behind her back, the officers shackled her to an eyebolt on the bench with a set of leg irons. They then left her alone in the cell, chained, frightened, distraught, and screaming. They did not call for medical advice or assistance and did not monitor, supervise, or observe her.

Some minutes later, two other officers entered the area, heard Carol yelling and, finally, looked into the tank. Afterwards, they reported that Carol looked upset and tearful, but they did nothing at the time.

Eventually, Officer Wonya looked in when he realized he no longer heard noise coming from Carol's cell. Carol was sitting on the floor in front of the bench, her hands were now under her chin, in front of her body, with the chain around her neck. She was not moving. She was not responsive. Only then did police call for medical assistance, but it was too late. Efforts at resuscitation by the officers and later Phoenix Fire Department personnel were unsuccessful. Carol was pronounced dead at 3:29 p.m.

Throughout this time period, Carol's husband Noah was trying to find out what had happened to her. From the time she landed in Phoenix until he lost contact with her, they spoke by telephone at least five times and emailed twice. After he lost contact with Carol, Noah asked Cottonwood de Tucson if they could locate her and arrange to pick her up from the airport. Then Noah called Cottonwood, the airport, and US Airways repeatedly. With each frustrating attempt to locate his wife, Noah became increasingly worried. Noah's initial calls were reported to the PPD by the dispatchers. Though telephone records show PPD knew by then that Carol was dead, they continued to instruct dispatchers to tell Noah only that someone would call him

back. But PPD would not even confirm for Noah that his wife was in their custody until he called the third time. And PPD never bothered to tell Noah that Carol had died, until almost three hours later.

The Maricopa Medical Examiner conducted an autopsy and concluded that Carol's death was caused by accidental asphyxiation. It appears that, while alone and unwatched, Carol struggled against the chains. She accidentally got into a position where the shackles pressed against her neck, cutting off oxygen and blood to her brain, leading to unconsciousness and then death. The Medical Examiner noted that Carol had high levels of alcohol and prescription medicines in her blood, but concluded that Carol died of asphyxia caused by the pressure of the chains PPD used to shackle her.

**The Phoenix Police Officers Engaged in Dangerous Customs and Practices, Subjected Carol to Unreasonable and Excessive Force, Were Callously Indifferent to Her Medical Condition, and Negligent in their Care and Custody of Her**

Sometimes very good people make some very bad mistakes. Sometimes those very bad mistakes can be lethal and ruinous to a family. That is what happened here.

It was obvious to everyone who had contact with or observed Carol at the gate area or in the concourse that afternoon that something was terribly wrong with her—she was sick and disturbed. She was mentally unstable, agitated, anxious, and irrational. She was panicked and frightened, but, she never threatened anyone. Her response to being bumped from first flight was calm; her response to being bumped from the second flight was erratic, not that of the typical irritated passenger. The officers themselves noted her heightened emotional condition in their initial reports, characterizing her as “*irrational and hysterical*.” Officer Rigg even described Carol as “*ranting*” and believed that she was “*mentally unstable*.” And at least one officer later reported having suspected that Carol was under the influence of alcohol.

PPD officers routinely respond to citizens exhibiting similar behavior and should know how to deal with these situations without causing harm, and certainly without causing death. They are, and should be, trained to assess this type of situation and impose order and calm by their words or by their presence. They are, and should be, trained to know that this was a situation that required immediate medical input or assistance. They are, and should be, trained not to leave someone like Carol alone, particularly once restrained in chains. Unfortunately, these officers either did not receive this training or chose to ignore it. Those officers knew Carol was not dangerous; yet, they treated her like she was, and in a way that dangerous criminals are to be treated under police standards, policies, and training materials. But, different standards, policies, and training are suppose to govern police reaction to sick and vulnerable citizens.

Those officers also knew Carol was sick, intoxicated, and mentally disturbed; yet, they did *not* treat her like she was, and in the way they were supposed to treat and care for the needs of a sick, intoxicated, disturbed and vulnerable citizen under police

standards, policies, and training materials. As a result, their treatment of Carol (or lack thereof) violated a host of national and local standards. It violated the PPD's own policies and procedures. It violated PPD's own training materials. And, it violated notions of common sense and fundamental human decency.

Good people here made lethal, unreasonable mistakes, with catastrophic results for Carol, her three small children and for her husband.

**Phoenix Police Conduct Violated National Police Standards**

***Handling Disturbed or Intoxicated Persons:***

National police guidelines like the International Association of Chiefs of Police ("IACP") Training Keys mandate that, in dealing with disturbed persons like Carol, officers should use a calm, quiet, non-threatening approach and avoid physical contact if the individual is not engaged in destructive behavior.<sup>1</sup> Those standards note that behavior from citizens with mental illness can also be easily confused with behavior due to alcohol intoxication and instruct officers to move slowly and to provide re-assurance to the citizens that they are there to help: "The officer's reaction should be a calm, understanding manner conveying that he is truly concerned and wants to help rather than punish the disturbed person." Under the standards, officers are supposed to call for medical assistance or crisis intervention specialists immediately, to keep the disturbed citizen under observation at all times, and to take steps to keep a low-profile and to defuse the situation.<sup>2</sup>

Carol was clearly disturbed and that was obvious to PPD's personnel. Yet, PPD made no attempt to treat Carol like the "disturbed" person they knew she was. Officers knew that they were dealing with a "***mentally unstable,***" "***irrational and hysterical***" middle-aged woman of slight build that threatened no person and no property. She was calm with TSA agents, just seconds before PPD escalated the situation and approached her—not with calming words, but with cuffs drawn, ready to restrain and arrest her. They never called for medical advice or assistance or took other measures to help Carol or to defuse the situation. Instead, they escalated it by using almost immediate force.

***Use of Force, Arrest, and Detainment:***

National standards also state that officers should never use unnecessary force to arrest a citizen.<sup>3</sup> In deciding whether any force is "necessary," the officers must

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<sup>1</sup> See IACP Training Key #274, p. 57 (attached and included in Appendix A). The Phoenix Police and their trainers are aware of, familiar with, and use these standards in their operations. For example, Ken Johnson is a Lieutenant with the Phoenix Police, a police trainer, and has even overseen the Professional Standards Bureau, Investigations Unit for the Phoenix Police. Lt. Johnson is a certified, nationwide instructor for the IACP.

<sup>2</sup> See *id.*; see also Training Key #487, p. 40-41 (attached and included in Appendix A).

<sup>3</sup> IACP Training Key #249, p.50 (attached and included in Appendix A).

consider (*inter alia*) the seriousness of the crime (if any), the attitude of the citizen, and the physical and mental condition of the citizen. And if force is ultimately used, national standards warn officers that citizens, like Carol, who are exhibiting bizarre behavior and arrested in a heightened emotional state following a physical struggle, must be monitored and visually observed,<sup>4</sup> because they are the most at risk for having an adverse physical response.<sup>5</sup> In fact, officers are instructed to be aware of arrests with emotionally disturbed or intoxicated persons, to “closely” watch them,<sup>6</sup> to keep them under “constant supervision,”<sup>7</sup> and to constantly monitor them for “skin color, breathing, and level of consciousness.”<sup>8</sup>

Law enforcement accreditation standards (“CALEA”)<sup>9</sup> echo those warnings. Citizens who officers suspect may be under the influence of drugs or alcohol, or who are violent or self-destructive, are supposed to “remain under close supervision.” Those standards also mandate that such citizens should *not* be kept in a holding facility,<sup>10</sup> and should never be attached to “fixed objects.”<sup>11</sup>

Those standards were not followed with respect to Carol. Officers knew she was disturbed, or intoxicated, or both. She was 45 years old and weighed only 123 pounds. She had no weapon. She made no threats. She was not harming herself and was not a danger to others. She was calm with TSA agents seconds before the PPD rushed onto the scene. But, instead of calling for medical advice or help and closely monitoring Carol and her disturbed condition, PPD officers approached her with cuffs drawn and told her she was under arrest. Then, they subjected this sick, confused mother to grossly excessive force by taking her to the ground, forcing a knee into her shoulder, yanking her arm out from under her and forcibly cuffing her arms behind her back. And, rather than closely monitoring her condition, they instead marched her to a holding cell, where they chained her to a bench and left her alone, with no one observing her.

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<sup>4</sup> IACP Training Key #267, p. 1 (attached and included in Appendix A).

<sup>5</sup> IACP Training Key #412, p. 3 (attached and included in Appendix A).

<sup>6</sup> IACP Training Key #377, p. 98 (attached and included in Appendix A).

<sup>7</sup> IACP Training Key #378, p. 103 (attached and included in Appendix A).

<sup>8</sup> IACP Training Key #429, p. 52 (attached and included in Appendix A).

<sup>9</sup> The Phoenix Police Department is accredited by CALEA.

<sup>10</sup> CALEA Standard 72.5.4 (attached and included in Appendix A).

<sup>11</sup> IACP Training Key # 267, p. 17 (attached and included in Appendix A).

**Phoenix Police Conduct Violated Their Own Policies and Procedures**

In addition to the national standards that were violated, the Officers who arrested, detained, and restrained Carol also forgot, neglected, or ignored their own PPD policies and procedures.

***Handling Disturbed or Intoxicated Persons:***

PPD Operations Orders require officers to provide emergency assistance and request medical attention for any citizens who they recognize to be sick or injured.<sup>12</sup> And they are instructed to recognize signs of sickness and injury, including citizens who are exhibiting bizarre behavior such as shouting, panic, and paranoia.<sup>13</sup> Those policies warn officers that such bizarre behavior is often followed by a period of ***“tranquility, quiet, and then respiratory arrest and sudden death.”*** As a result, policies mandate that whenever bizarre behavior is observed, the first thing officers must do is to summon the paramedics.

Under PPD policies its officers recognized, Carol as a clearly “sick and injured person.” Officers should have immediately called for medical assistance; but they did not. Instead, they used their brute force to arrest and detain her.

***Use of Force, Arrest, and Detainment:***

PPD Operations Orders also govern arrests, use of force, and detainment by officers. Under those policies, officers are only permitted to use a reasonable amount of force against citizens, which must be evaluated in light of (*inter alia*) the severity of the crime, the size of the citizen and whether the suspect poses any immediate threat to the safety of officers or others.<sup>14</sup> If force is used and a citizen is arrested, other policies dictate where those citizens can be taken and detained by officers, as well as how they may be restrained. For example, PPD policies require the Officers to ***“keep their prisoners in sight at all times.”***<sup>15</sup> Policies also indicate that citizens can only be placed into holding cells when awaiting transport to another facility or if they are to be picked-up by a responsible party.<sup>16</sup> And those policies tell officers that they can only attach citizens to fixed objects in holding cells if the citizens are kept in

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<sup>12</sup> PPD Op. Order 4.12, p. 7 (attached and included in Appendix A).

<sup>13</sup> *Id.* at p. 8.

<sup>14</sup> PPD Op. Order 1.5, p. 2 (attached and included in Appendix A).

<sup>15</sup> PPD Op. Order 7.2, p. 1 (attached and included in Appendix A).

<sup>16</sup> PPD Op. Order 7.3, p. 1-2 (attached and included in Appendix A). Recent revisions to Op. Order 7.3 after Carol’s death have added another reason justifying detainment in a holding cell: “Blood alcohol concentration testing or drug impairment evaluations.” That justification did not exist at the time of Carol’s death, in September 2007.

the holding cell for more than one hour and, even then, only if no more than one wrist is attached to the fixed object.<sup>17</sup>

Officers did not follow their own clear procedures here. Considering Carol's physical and mental state, officers should have approached her in a reassuring, calm manner and then immediately called for medical advice or assistance. Instead, they chose force. But there is no reasonable justification for the manner and extent of force used upon her, particularly given the circumstances presented. Those circumstances were obviously not taken into consideration in this case.

Nor was Carol restrained properly. She was placed into a holding cell for no stated reason, even though policies mandate that citizens only be placed into holding cells when awaiting transport to another facility or, if they are to be picked-up by a responsible party. Here, officers handcuffed Carol and attached both of her wrists to a fixed object in the holding cell, using leg irons. Leg irons were not designed to be used that way. And Carol had only just arrived at the cell, so there was no justification under the policies to attach her to the fixed object and, certainly, not to attach both of her wrists. Yet, that is precisely what caused her death—attaching both of her wrists to a fixed object using a long chain. Instead of calling for medical advice or help and constantly observing her as PPD policies required, these officers chose to march Carol through the terminal to their office, where they chained her to a bench in the holding cell and left her alone, with no one observing her. By the time they returned to check on her, it was too late. She died in their custody. She would not have died, had officers followed their own policies.

#### **Phoenix Police Conduct Violated Their Own Training Guidelines**

The Police conduct also violated their own, written, PPD training materials.

#### ***Handling Disturbed or Intoxicated Persons:***

PPD Lesson Plan, Sudden Custody Death, warns officers about improperly restraining detainees who are acting bizarrely, particularly when a struggle ensues during the arrest and restraint.<sup>18</sup> The same Lesson Plan teaches, tests, and warns officers to look for signs of "potential fatalities," including bizarre behavior, shouting, incoherence, fear, panic, and paranoia—all signs exhibited by Carol on that day. These materials also teach officers to recognize these symptoms and to respond to these disturbed citizens by trying to calm them through verbal communications. They are cautioned to avoid physical confrontations.

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<sup>17</sup> PPD Op. Order 7.1, p. 1 (attached and included in Appendix A).

<sup>18</sup> PPD Lesson Plan, Sudden Custody Death, p. 5-9 (attached and included in Appendix A).

Carol's behavior was recognized by the arresting officers as that of an irrational, distressed person.<sup>19</sup> That should have provided a clear warning to officers about how to handle Carol in a manner consistent with PPD's training. It did not.

***Use of Force, Arrest, and Detainment:***

PPD training materials also teach officers to consider the circumstances when using any force—circumstances that include the mental and physical condition of the citizen (among others).<sup>20</sup> Officers are taught the potential consequences of using force inappropriately on someone who is sick and acting bizarrely. They know that asphyxiation can occur whenever someone on drugs, intoxicated with alcohol, or who is acting bizarrely is restrained after a struggle with officers: "Drugs and/or alcohol plus wrestling and/or arrest plus hog-tie/restraint = probable fatality = LAW SUIT."<sup>21</sup> They are taught, as a general rule, never to chain citizens to a fixed object.<sup>22</sup> And they are taught to recognize the ultimate dangerous sign—"Sudden tranquility"—which precedes death.

The take down and arrest of Carol Gotbaum violated these (and other) written PPD training materials. The officers' aggressive, physical, excessively forceful arrest was followed by improperly shackling her, and then leaving her unwatched. Carol's agitated and clearly abnormal behavior culminated in a period of sudden tranquility and death, as she lost consciousness from the chains the officers had placed upon her. Even then, she would have been saved had the officers followed their training and policies and stayed with her to watch her; unfortunately, they did not.

**Phoenix Police Conduct Violated Common Sense**

At trial, the jury will be instructed to not only use the Judge's instructions of the law, but their own experiences and common sense in rendering a verdict. Here, Plaintiffs have already retained one of the nation's most renowned police procedure experts to testify in this case. He is an expert that usually testifies on behalf of the Police, defending Police conduct. But, here, he was appalled by the evidence of the

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<sup>19</sup> In fact, the training materials discusses that citizens exhibiting bizarre behavior and other factors are those most at risk for "Sudden Custody Death Syndrome." The Lesson Plan Re: Sudden Custody Death Syndrome instructs that the bizarre behaviors can also be caused by narcotic and alcohol abuse, including the use or failure to use prescription medications. The Lesson Plan lists several "fatal[]" signs for officers to recognize, including bizarre behavior, shouting, incoherence, fear, panic, and paranoia—all signs exhibited by Carol. See also PPD Training Bureau Module, OC Spray/Body Cuff/Carotid/RIPP Restraint, p. 16-20 (attached and included in Appendix A).

<sup>20</sup> AZ Post 600 Hour Basic Course, Use of Force, at PPD001698-99 (attached included in Appendix A).

<sup>21</sup> These same materials also provide officers with case studies where, like here, subjects exhibiting these symptoms died shortly after struggling with officers and being restrained. See PPD Lesson Plan Re: Sudden Custody Death Syndrome (attached and included in Appendix A).

<sup>22</sup> PPD Lesson Plan Re: Defensive Tactics, p. 14 (attached and included in Appendix A).

Police conduct in this case when compared to national standards, polices and procedures, and written training materials. And he will explain to the jury how inappropriate and reckless the Police conduct was in this case.

But Plaintiffs do not necessarily need an experienced expert to tell the jury how shocking the Officers' conduct was with respect to Carol. The Police conduct violated all standards of reasonableness. It was obvious that Carol was frightened, emotional, and irrational. She was shouting, yelling, and crying. But she was not threatening to harm herself, anyone else, or anyone's property. She carried no weapon. She was not physically imposing (she was 45 years old and weighed only 123 pounds).

Common sense should have prevailed. Faced with a clearly irrational, hysterical, and mentally unstable woman, officers should have, at a minimum, summoned medical advice or assistance, kept Carol in their sights, and attempted to calm her without physical force, like the TSA agents had done with success. But the officers did not: good people making lethal, unreasonable mistakes, with catastrophic results. Drawing upon their own experiences and common sense, the jury will undoubtedly conclude that the Police conduct was reckless and unreasonable. And their determination will be confirmed and bolstered by PPD's own written guidelines and the testimony from Plaintiffs' expert. Even PPD's own expert will be forced to admit mistakes by the officers on cross-examination.

**Claims Against the City, the Phoenix Police Department, the  
Phoenix Police Officers, for Carol's Death**

Carol's children, Noah, and Carol's Estate have causes of action for negligence, reckless conduct, gross negligence, and deliberate indifference, dangerous customs, policies, training, practices, ratification or a policy of inaction, unreasonable and excessive use of force under Arizona law and 42 U.S.C. § 1983, and claims under the Adult Protective Services Act and the ADA against all of the above-named individuals and entities and others yet unidentified.

Under Arizona law, a cause of action is stated under A.R.S. § 12-611 *et seq.* for wrongful death, which allows the survivors of a deceased person to recover money damages from defendants who proximately cause the death of another through their negligence, gross negligence, bad faith, and deliberately indifferent conduct, like the claims of Noah, the children and the Estate have in this case. At trial, these survivors will be entitled to present evidence of aggravating factors under A.R.S. § 12-613 in support of their damage claims.

**Damages Sought for Carol's Death**

The children and Noah are entitled to monetary damages for past, present, and future loss of the love, affection, and companionship of their wife and mother, as well as past, present, and future anguish suffered because of her death. Carol's Estate is entitled to damages in the form of pre-death pain and suffering, loss of life, and

economic damages. The claimants will be entitled to recover punitive damages as well as their attorneys' fees.

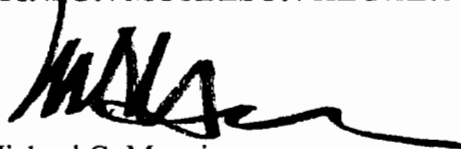
A.R.S. § 12-821.01 requires that Noah, the children and the Estate include in this Notice of Claim a specific dollar amount for which their claims can be settled. That amount is \$2,500,000 for Noah, \$4,500,000 for the children and \$1,000,000 for the Estate. The evidence gathered so far supports both that figure and our belief that a jury would award a much greater amount than that claimed.

This is not the first time that the City has been sued for use of excessive force and overreaction resulting in the death of a citizen. In 1998, a jury awarded the family of Edward Mallet \$45 million for his death at the hands of the Phoenix police. Mallet, a double amputee, was stopped for an alleged traffic violation. Inexplicably, the officers struggled with him, placed him in an unauthorized choke hold, and sat by when he stopped breathing, taking no action to resuscitate him. The Mallet jury was enraged by these actions and wanted, by their verdict, to send a message to the Phoenix Police Department—a message that has obviously been forgotten in the intervening years.

That forgotten message left Noah without a wife and Tobias, Nathaniel, and Ella without a mother. What more will it take for this City to remember its duty to care for the sick and vulnerable in its midst, those like Carol Gotbaum?

Sincerely,

STINSON MORRISON HECKER LLP

A handwritten signature in black ink, appearing to read "Manning", with a long horizontal flourish extending to the right.

Michael C. Manning

MCM:LEO