State of Connecticut OFFICE OF INSPECTOR GENERAL



Report Concerning the Death of Jamal Linton Who Died on January 26, 2025 While in the Custody of the Stamford Police Department

> Eliot D. Prescott Inspector General

TABLE OF CONTENTS

INTRODUCTION	4
INVESTIGATION	4
Arrest	4
Booking	5
Monitoring	8
Electronic Log	11
Cell Video	12
Scene	12
Medical Records	18
Office of the Chief Medical Examiner	18
FINDINGS	19
LEGAL STANDARD	20
ANALYSIS	21
CONCLUSION	22
APPENDIX	23
Substitute Clothing	23
Prisoner Safety Screening Form	24
Remedial Actions by the Stamford Police Department	26

ACKNOWLEDGEMENTS

The Office of Inspector General acknowledges the assistance provided to this investigation by the following:

Stamford Police Department

Office of the Chief Medical Examiner

INTRODUCTION

On Sunday January 26, 2025, at approximately 7:34 a.m., officers of the Stamford Police Department arrested Jamal Linton¹ on charges arising out of an alleged domestic violence incident. Linton was unable to post the \$150,000 bond that was set by the police. He was held at the Stamford Police Department detention facility pending his arraignment in court on Monday January 27, 2025.

On January 26, 2025, at approximately 5:42 p.m., Linton was found unresponsive in his cell. There was a ligature around his neck suggesting that he had hanged himself. Stamford officers provided medical aid until the arrival of Emergency Medical Services (EMS) and the Stamford Fire Department. He was taken to Stamford Hospital where additional life saving measures were attempted but were unsuccessful. Linton was pronounced dead at 6:26 p.m.

As required by statute,² the Office of Inspector General (OIG) investigated this incustody death. The results of that investigation are set forth in this report. The evidence establishes that the manner of Jamal Linton's death was suicide and was not the result of police use of force or criminal action. The evidence further establishes, however, that the Stamford Police Department did not adhere to its own policies designed to prevent these types of incidents from occurring.

INVESTIGATION

Arrest

On January 26, 2025, at approximately 7:18 a.m., Stamford police officers were dispatched to 30 Southfield Avenue, #215, Stamford, CT on a report of a domestic incident. Upon arrival, officers observed a female in front of the apartment complex. She was yelling something that sounded like, "He's over there." Officer Matthew Harrison saw a black male operating a white sedan attempting to exit the parking lot. When Officer Harrison used his patrol vehicle to block the path of the white sedan, a male exited the vehicle and began to run

¹ Jamal Linton was a black male, age 36, from Brooklyn, New York.

² See General Statutes §51-277a(a)(2)(A) provides in relevant part: "[W]henever a person dies in the custody of a peace officer or law enforcement agency, the Inspector General shall investigate and determine whether physical force was used by a peace officer upon the deceased person, and if so, whether the use of physical force by the peace officer was justifiable under section 53a-22. If the Inspector General determines that the person died as a result of possible criminal action not involving the use of force by a peace officer, the Inspector General shall refer such case to the Division of Criminal Justice for potential prosecution."

toward Southfield Avenue. Officer Harrison was able to tackle the male and place him under arrest. The male was identified as Jamal Linton.

Officers observed that the complainant had a visible laceration on her left arm. She was taken to Stamford Hospital for treatment. At the hospital, officers interviewed the complainant who stated that her boyfriend, Jamal Linton, had returned to her apartment from his restaurant job in Brooklyn, New York at 6:00 a.m. They got into an argument, and the complainant went into the bathroom and locked the door. The complainant stated that Linton kicked down the door, punched her in the face, and then threw her down. She stated that she hit the toilet breaking it apart, which resulted in a laceration to her arm. The complainant further stated that while she was lying next to the toilet, Linton began to choke her.

When the complainant told Linton that she was going to call 911 for help, he took her phone away. He gave it back to her so she could call her job. When she got her phone back, she was able to send her mother a text stating, "Call cops."

Following his arrest, the officers did a record check on Linton and learned that he was the subject of a Full No Contact Protective Order, and the complainant was the protected party. Linton was transported to the Stamford Police Department where he was booked and charged with, inter alia, violation of a protective order in violation of General Statutes §53a-223, interfering with an officer in violation of General Statutes §53a-167a, assault in the second degree in violation of General Statutes §53a-60, criminal mischief in the second degree in violation of General Statutes §53a-116, disorderly conduct in violation of General Statutes §53a-64bb. The police set Linton's bond at \$150,000.

While in booking, and after being advised of his *Miranda* rights, Linton spoke to officers and denied assaulting the complainant. He said that they argued because he had arrived home at 5:00 a.m. and that the argument was strictly verbal. He claimed that the complainant fell while in the bathroom causing her laceration and that her fall was unrelated to the argument.

Booking

Several Stamford officers were involved in the booking process for Linton. The Stamford Police Department's policies make clear that before entry into the holding facility, all prisoners are to be searched. See General Order 5.10 IV D 1. ("All prisoners will be properly searched upon entry into the Stamford holding facility").

General Order 5.10 IV D 3 further provides:

"Any item that could be used to inflict harm to the prisoner or an officer such as medications, shoelaces, **belts**, ties, headbands, matches, sharps, etc. will be removed from the prisoner." (Emphasis added).

Officer Harrison searched Linton twice; once at the time of booking and, again, before he was put into a cell at the Stamford Police Department jail. Although Harrison ran his fingers along the inside of the rear and sides of the waistband of Linton's pants, he did not do so in front. The buckle of Linton's belt can be seen in the photo below.



Officer Christopher Brown prepared an inventory of the property taken from Linton. That inventory listed the following items:

- 1. Cash money \$1
- 2. 2 Cell phones
- 3. 7 keys
- 4. 1 key fob
- 5. 1 charging cord
- 6. 1 vape
- 7. 2 earrings

- 8. pair of long johns
- 9. black t-shirt
- 10. black sweater
- 11. silver watch
- 12. 1 Discover Card
- 13. 1 Visa
- 14. 1 Mastercard
- 15. 1 diamond chain

The belt that Linton later used as a ligature was not discovered during the two searches and not taken.

In addition to requiring a thorough search of each prisoner, General Order 5.10 mandates that the booking officer evaluate a prisoner for suicide risk before securing him/her in a cell block or holding area. This is accomplished by the completion of a Prisoner Safety Screening Form. Officer Harrison completed such a form for Jamal Linton. Based on the entries on the form, Linton posed little to no risk of suicide. On the form's questions regarding (1) past suicide attempts or (2) comments from the detainee or others about being suicidal, the officer checked the "no" box. A copy of Linton's Prisoner Safety Screening Form is printed in the Appendix.

General Order 5.10 IV H 4 also directs booking officers to be alert for signs of suicidal tendencies that are separate from and possibly inconsistent with the answers given on the form. Such warning signs include depression, sadness and crying, withdrawal or silence, sudden loss or gain in appetite, mood variations, lethargy, intoxication, talking about suicide, previous suicide attempts, history of mental illness, projecting hopelessness or helplessness, speaking unrealistically about the future, severe agitation, paranoid delusions or hallucinations. There is no indication that Linton exhibited any of these signs to Officer Harrison.

Officer Harrison also did a criminal record check for Linton. This criminal background check revealed an August 18, 2024 arrest in Pennsylvania for Aggravated Assault by Vehicle while DUI, Reckless Driving, and related charges. According to a news report, this arrest pertained to an alleged wrong-way DUI crash on I-78 where the other car was cut in half and the driver seriously injured. Linton was due to appear in court in Allentown Pennsylvania on March 13, 2025.

Upon completion of the booking process, Linton was placed into jail cell #8.

Monitoring

Linton was found unresponsive in his cell at approximately 5:42 p.m. At that time, there were four other prisoners in the Stamford Police Department. Two officers were assigned to the jail to manage and monitor these prisoners – Officer Eleni Hatsis and Officer Nicholas Kuhn. General Order 5.10 requires that prisoners be monitored via television and audio monitors. In addition, Order 5.10 requires that a physical check be done every thirty minutes.³ Such physical checks are to be electronically logged by booking officers using their issued fob and the fob readers in the cellblock wings. See General Order 5.10 IV K 2.

Officer Eleni Hatsis

On January 26, 2025, Officer Hatsis was working an overtime shift at the Stamford Police Department holding facility referred to as the "jail." She filed a written report about this incident, which states in relevant part:

"On January 26, 2025, I, Officer Hatsis, arrived at the Jail for my overtime shift at approximately 1501 hours. entering through the sally port entrance. I then walked over to the jailer's area where I relieved Officer Raab and Officer Zoppi from their shift and was briefed on who our prisoners were and if any needed to be sent to the hospital during our shift for medications. At that moment I was informed that a female prisoner was potentially pregnant and would need medical attention as soon as possible. Being the female officer, I reviewed her file and prepared her (informed the desk Seargent) for transport to the hospital. At this time, I was in the jailer's area talking with Officer Raab, and setting up my video surveillance footage of all the prisoners so that Officer Kuhn and I will be able to monitor each cell from our desk area. It should be noted that both Officer Kuhn and I have our own monitors to view the prisoners' live. At approximately 1513-1514 hours. I organized the paperwork located near the intake bench and the processing computer. I then returned to the jailers area where I conversed with Officer Kuhn and Officer Raab.

"Officer Raab, then leaves the jail and Officer Kuhn and I continue talking about various topics while monitoring the cameras that are located directly in front of us. At approximately 1525 hours, Sgt. Landry enters the jailer's area where we update him on who our prisoners are and then talk about various other topics. Throughout our conversation you can see me looking at the large screen camera in front of me various times in which I observed most of the prisoners either talking or laying down on their cell bench. At that point, Linton (cell #8) was observed laying down on his cell bench which assumed he was just sleeping. . . .

"At approximately 1544 hours, Sgt. Landry exits the jail and Officer Kuhn and I continue to monitor the cell block cameras.

³ Physical checks must be performed more frequently if a detainee shows signs of agitation, illness, depression or scores 5 or higher on the prisoner safety screening form. General Order 5.10 IV k 2.d

"At approximately 1547 hours I leave the jailers area and check up on the female prisoner, advising her that we have requested the officer to come and take her to the hospital. At approximately 1548-1552 hours, Officer Leslie and Officer Johnson enter the jailer's area and advise us on how the morning shift went.

"Officer Kuhn and I continue to talk about various topics while monitoring the cell cameras. At this time, Linton was still asleep on his cell bench.

"At approximately 1605 hours, Officer Miranda and Officer Molchanov enter the jail and advise that they were there to pick up the female prisoner. Officer Kuhn and I checked the paperwork on the female prisoner, advise both officers of her mental and health state, and the assisted with searching and cuffing the prisoner. The prisoner walked out into the sally port and both Officer Kuhn and I return to the jailer's area at approximately 1610 hours.

"At approximately 1618 hours, Sgt. Landry enters the jail area and we both walk over to the processing computer where I document the time the female prisoner left the jail area with Officer Miranda and Officer Molchanov. I then update Sgt. Landry on all the other prisoners regarding medication, bonds, etc. Sgt. Landry then leaves the jail.

"I returned to my desk in the jailers' area where I continued to monitor the jail cameras (which are located directly in front of me) in which I observed everyone either moving around, talking or laying down. At this time, Linton (cell #8) was still laying down on the cell bench with his hoodie over his head and arms inside the hoodie.

"At some point after that, I observed Linton getting up to use the bathroom and then moving around in his cell. Multiple camera checks revealed him continuously moving around, using the bathroom again, looking at the cell block phone as though he was going to make a call, and then sitting back down on the bench. As some point I looked up at the cameras again and saw that Linton was sitting on the floor near the jail cell door. At this point I didn't think anything of it since a lot of our prisoners sit on the floor for better heat ventilation.

"At approximately 1718 hours, Officer Kuhn leaves the jailers area and states that he is going to check on the prisoners in the back that are yelling. He returns shortly after at approximately 1720 hours and advises me that the told the prisoner in cell #2 to be a little quieter because there are others around him.

"He then returns and we continue to talk until approximately 1739 hours where I took at the cameras and advise Officer Kuhn that I will do a check of the male area cells since it was approximately at the 30-minute mark from when he walked back there at 1720 hours. At approximately 1740 hours, I walk over to the processing computer to check on the log to see if any prisoner needed medications for the nighttime or any special arrangements for food. I then proceeded to walk back to the male cell area.

"While in the male cell block area, I fobbed in at approximately 1740 hours and then spoke to most of the prisoners where I was able to confirm that they are well and didn't need anything. It should be noted that the cell lights were turned off from the previous shift so looking into the cells to see exactly what each prisoner was doing was difficult. Most prisoners came to the window to ask what time it was, when dinner was coming or if I could get them water. Linton and the male in cell #9 did not come to the window. It should be noted that the

male in cell #9 was intoxicated and we had already advised Sgt. Landry that he might need to go to the hospital at some point for monitoring or medication.

"I then checked the cameras in the jailers area and saw that Linton was still sitting on the floor and no movement was observed. Sitting on the floor was a regular doing by prisoners because heat came from underneath the door as mentioned before but even so, movement or breathing can be somewhat observed through the cell cameras and while watching the cameras I did not observe either.

"I then advised Officer Kuhn that I would wake him up to see if he was okay or needed anything. Upon returning to cell #8, I looked into the cell and saw that Linton was leaning up against the wall but something was attached to the cell block phone (a string or rope like fixture) leading to his neck area, underneath his hoodie. It should be noted that Linton had his hoodie up and even then, it was difficult to see exactly what was going on. I saw that he was not moving, breathing or responding to my questions so I assumed that the string was around his neck, and he had hung himself. I then ran back to the jailers area at approximately 1742 hours where I advised Officer Kuhn that Linton might have hung himself in the cell. At approximately 1742 hours, Officer Kuhn runs back to Lintons cell while I turned on the lights, advised Sgt. Landry about our findings and run back to help Officer Kuhn.

"While in the cell, Officer Kuhn and I entered and saw that there was a string-like fixture around the corner of the cell block phone wedged in there tightly. We attempted to lift Linton up and get it off him or cut it, but eventually Officer Kuhn was able to rip it out of the wedging. After detaching him from the phone, Officer Kuhn and I placed him on the floor, and I advised him to start CPR while I grabbed the AED. . . . "

Officer Nicholas Kuhn

On January 26, 2025, Officer Kuhn was assigned to the jail with Officer Hatsis. He began his shift at 3:04 p.m. He filed a written report, which states in relevant part:

"I arrived at the Jail at 1504 hours to begin the assigned shift for the evening, relieving Officer Raab. Upon my arrival I logged into the jailer computer and viewed the corresponding cameras to ensure all the prisoner cells were visible. I was advised by Officer Hatsis the we had several individuals in lockup and that the one female we had in the female lockup, needed to go to Stamford hospital to receive medication. Officer Hatsis advised Sgt. Landry and requested Officers for transport from Stamford Police Dispatch.

"At 1522 hours I reviewed the prisoner logbook and then returned to the jailers area. During the next period of time I was engaged in conversation with Officer Hatsis and Sgt. Landry but continually checked the cameras on all of the prisoners.

"At 1605 Officer Molchanov and Officer Miranda arrived to take the female prisoner to the hospital and I assisted them before returning to the Jailers area.

"At this time, I was engaged in conversation with Officer Hatsis and was periodically checking the cameras on all the prisoners that were currently still in lockup. During this time, I

observed the male in Cell #8, later identified to be Jamal Linton, appear to be talking on the phone. ⁴

"At 1719 hours, I began to hear loud yelling coming from the male cell block. When I turned to the camera to see what was occurring, I observed the male in Cell #2 was being very animated and believe it to be him. I went back to the cell corridor and spoke with the male in that cell. I asked him if everything was ok or if he needed anything, he explained, he was just talking on the phone and apologized for yelling so loudly.

"At that time, I did not walk the entire cell block and check on any other prisoners. I instead returned to the jailer area. ⁵

"While engaged in conversation with Officer Hatsis, we noticed on the cameras that, two (2) prisoners were now sitting on the floor. In the Jail, this is a common occurrence due to the floor being warmer than the metal bench.

"At 1740 hours, Officer Hatsis advised me she is going to conduct a security check of the prisoners. At 1742 hours, I observed Officer Hatsis running towards the Jailer area and she explained the male in Cell 8 was not responding.

"At this time, I grabbed the Cell key from the wall and ran to Cell 8. I unlocked and opened the cell door. I observed Linton sitting up with his back against the cell wall directly under the phone box. Linton had his hood up with his arms down by his side. His left leg was hinged inward towards his right leg creating a 45-degree angle. His right leg was extended straight out towards the toilet. I observed a thin black string stretched behind the phone box and down towards Linton's body where it disappeared into his hood. I observed foam bubbling out from the corner of his mouth and both of his hands curled inward.

"I followed the string with my hand towards Linton's neck while removing it from behind the phone box with my other hand. I then slip Linton down in the supine position while loosening the string around his neck and attempting to check for a pulse. I was unable to locate a pulse and immediately began to conduct CPR."

Electronic Log

The Stamford Police Department maintains an electronic log that records each time an officer fobs into the cellblock area of the jail. The electronic prisoner monitoring log for January 26, 2025 shows that, prior to Officers Hatsis and Kuhn starting their shift as jailers at 3:00 p.m., a cellblock check was made at 1:15 p.m. by Officer Joseph Joppi. The next log entry is a cellblock check by Officer Hatsis at 5:41 p.m. According to the log, there were no documented cellblock checks from 3:00 p.m. to 5:41 p.m. As discussed later, Linton hanged himself between 4:56 p.m. and 5:07 p.m.

⁴ Stamford Police Department has no record of any phone call being made from cell #8 on January 26, 2025.

⁵ According to the video for cell #8, by 5:19 p.m., Linton had already hanged himself.

Cell Video

Cell #8 had a camera installed in the upper corner of the cell door wall. The camera's field included the cell bench and phone box area. The camera recorded the activity of Jamal Linton while in the cell on January 26, 2025. As relevant to this investigation, the camera recorded the following:

Time

16:55 (4:55 p.m.)	Linton is standing near the phone box
16:56 (4:56 p.m.)	Linton is holding something
16:58 (4:58 p.m.)	Linton is putting an item onto the phone box
16:59 (4:59 p.m.)	Linton is attaching an item to the phone box
16:59:34 (4:59 p.m.)	Linton is holding the attached cord with a loop (a ligature)
17:00 (5:00 p.m.)	Linton is holding the ligature
17:01 (5:01 p.m.)	Linton has his hood up and is holding the ligature
17:04 (5:04 p.m.)	Linton appears to have the ligature around his neck
17:04:37 (5:04 p.m.)	Linton moves to a kneeling position
17:05:36 (5:05 p.m.)	Linton is on the floor
17:06:23 (5:06 p.m.)	Linton is struggling on the floor
17:06:43 (5:06 p.m.)	Linton has his fists clenched
17:06:52 (5:06 p.m.)	Linton's arms are moving
17:09:34 (5:09 p.m.)	Linton stops moving – remains motionless.

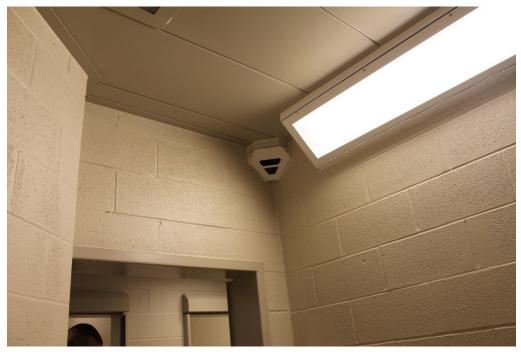
To view this portion of the cell #8 video, click here. [Warning: This video may be disturbing to many viewers.]

Scene

The scene consisted of cell #8 at the Stamford Police Department Jail. OIG inspectors took photographs of the cell:



[Cell Door]



[Camera]



[Phone Box]



[Phone Box]



[Corner of Phone Box]



[Gap between Phone Box and Wall]



[Gap between Phone Box and Wall]

At the hospital, the Stamford Police Department seized Linton's clothing and the ligature as evidence. Linton's pants were made of a lightweight synthetic material, color blue. Along the inside of the waistband was a sleeve to accommodate a belt.



[Photo of Pants]

The ligature was a belt approximately ¾" wide made of synthetic material. At one end was a "male" end of a black plastic clasp designed to be inserted into a "female" end. The female end was not present. The belt was knotted and had been cut from around Linton's neck.



[Photo of Ligature]



[Photo of Pants with Ligature]

Linton used the phone box as an anchor point for the ligature. He apparently wedged the belt behind the box such that the black clasp held it securely. After placing the ligature around his neck and concealing it under his hoodie, he then slid down the wall cutting off his air supply.

Medical Records

Linton was taken to Stamford Hospital arriving at 6:08 p.m. He presented at the Emergency Department in cardiac arrest. The hospital record noted the following:

"EMS reported that they had done compressions and that the patient had received multiple rounds of epinephrine but remained PEA." The hospital staff continued lifesaving efforts, but "the patient remained in PEA with cardiac standstill. . . . Patient was pronounced dead at 6:26 p.m.

"A loose cord draped around the patient's neck on arrival. It was removed with shears. A subtle ligature mark was observed around the right side of the patient's neck. EMS reported that the patient was found with a small black cord hanging around his neck in jail.

"Impression

Primary Impression
Asphyxiation by hanging

Additional Impression

Cardiac arrest."

Office of the Chief Medical Examiner

Associate Medical Examiner Melissa Pasquale-Styles, M.D. performed an autopsy on the body of Jamal Linton on January 27, 2025. The doctor's report lists the cause of death as "HANGING" and the manner of death as "SUICIDE (HANGED SELF IN JAIL)."

The Injuries section of the report notes that "a circumferential dried, abraded, linear, red-brown ligature furrow is around the neck." This furrow was 17%" in length and ranges from %" to %" in width. The police sent the ligature to the medical examiner's office for inspection. The autopsy report describes the ligature as follows: "A black strap ligature with multiple knots and an attached black plastic buckle/clasp . . . The ligature is %" in width and is a total of 28" in length, not including the plastic buckle."

⁶ PEA is an acronym for "pulseless electrical activity." It describes a medical condition where the heart shows electrical activity but fails to pump effectively resulting in a lack of pulse and blood circulation.

In addition to the ligature furrow around the neck, the report details other injuries indicative of death by hanging. Specifically, petechiae and hemorrhages were noted on the white part of the eyes, a fracture of the thyroid cartilage, and a discoloration of the brain due to hypoxic change.

FINDINGS

The investigation supports the following findings of material fact:

- 1. On Sunday January 26, 2025, at approximately 7:34 a.m., Stamford police officers arrested Jamal Linton on a variety of charges arising out of an alleged domestic violence incident. The police set his bond at \$150,000. He was unable to post this bond and was held at the Stamford Police Department Jail pending his court arraignment for Monday January 27, 2025.
- 2. During the booking process at the police department, Officer Harrison searched Linton and fifteen items were taken from him. The belt from the inner waistband sleeve of his pants that he later used as a ligature was not taken.
- 3. As part of the booking process, Officer Harrison completed a Prisoner Safety Screening Form. This screening form is designed to identify subjects who might be at risk to commit suicide. Linton gave no answers that placed him at an increased risk of suicide.
- 4. Linton had no record of convictions, but he did have a pending case in Pennsylvania on a charge of "Aggravated Assault by Vehicle While DUI" with a court date of March 13, 2025.
- 5. Linton was held in cell #8. Prior to being placed in that cell, Officer Harrison searched him a second time. Nothing was discovered. At some time prior to 4:55 p.m., Linton likely removed the belt from the inner waistband sleeve of his pants.
- 6. At approximately 4:59 p.m., Linton wedged one end of the belt around the phone box that was affixed to the wall of cell #8. He fashioned the other end of the string into a loop that he placed around his neck and under the hood of his hoodie sweatshirt. Linton then sat down on the floor and asphyxiated himself.
- 7. The camera located in the upper corner of cell #8 recorded the following:

Time

16:55 (4:55 p.m.) Linton is standing near the phone box 16:56 (4:56 p.m.) Linton is holding something

```
16:58 (4:58 p.m.)
                      Linton is putting an item onto the phone box
16:59 (4:59 p.m.)
                      Linton is attaching an item to the phone box
16:59:34 (4:59 p.m.)
                      Linton is holding the attached belt with a loop
17:00 (5:00 p.m.)
                      Linton is holding the ligature
17:01 (5:01 p.m.)
                      Linton has his hood up and is holding the ligature
17:04 (5:04 p.m.)
                      Linton appears to have the ligature around his neck
17:04:37 (5:04 p.m.)
                     Linton moves to a kneeling position
17:05:36 (5:05 p.m.) Linton is on the floor
17:06:23 (5:06 p.m.) Linton is struggling on the floor
17:06:43 (5:06 p.m.) Linton has his fists clenched
17:06:52 (5:06 p.m.) Linton's arms are moving
17:09:43 (5:09 p.m.) Linton stops moving – remains motionless.
```

- 8. At the time of Linton's suicide, the prisoners held in the Stamford Police Department Jail were being monitored by Officer Eleni Hatsis and Officer Nicholas Kuhn. They began their shift at 3:00 p.m. Despite the requirement that physical checks of each cell be made every thirty minutes, they did not check on cell #8 until at approximately 5:42 p.m., when they discovered Linton sitting on the floor of his cell with a belt wrapped around his neck. He was motionless and had no pulse. They commenced medical aid and summoned EMS and the Stamford Fire Department. Linton was taken to Stamford Hospital where further aid was attempted. He was pronounced deceased at 6:26 p.m.
- 9. The Office of the Chief Medical Examiner performed an autopsy of Linton on January 27, 2025. The medical examiner noted a ligature mark on Linton's neck and other injuries consistent with hanging. The autopsy report states the cause of death to be "HANGING" and the manner of death to be "SUICIDE (HANGED SELF IN JAIL)."

LEGAL STANDARD

Under Connecticut law, the Office of Inspector General is charged with, inter alia, investigating the death of persons who die while in the custody of a peace officer or law enforcement agency. Specifically, the Inspector General shall determine whether physical force was used by a peace officer upon the deceased person and, if so, whether the use of physical force by the peace officer was justifiable under § 53a-22. In addition, if the person's death was not due to a peace officer's use of force but from some criminal action, the Inspector General is to refer the matter for potential prosecution. The version of that statute in effect on January 26, 2025, in relevant part, provides: "[W]henever a person dies in the custody of a peace officer or law enforcement agency, the Inspector General shall investigate and determine whether physical force was used by a peace officer upon the deceased person, and if so, whether the use of physical force by the peace officer was justifiable under section 53a-22. If

the Inspector General determines that the person died as a result of possible criminal action not involving the use of force by a peace officer, the Inspector General shall refer such case to the Division of Criminal Justice for potential prosecution." General Statutes §51-277a(a)(2)(A).

Neither General Statutes Chapter 886, nor the penal code define the terms "physical force" or "criminal action." For purposes of this report, I apply such terms in accord with their ordinary meanings.

ANALYSIS

Jamal Linton's death was not the result of police use of force against him nor any other type of criminal action. The evidence clearly supports the medical examiner's finding that Linton committed suicide by hanging. This finding, however, raises two related issues: (1) was Linton's suicide predictable, and (2) was his suicide preventable.

Stamford Police Department policy mandates the use of a Prisoner Safety Screening Form to identify people who may pose a risk of suicide. Variations of this form are used by most law enforcement agencies and correction departments for this purpose. The form is considered to be is effective in predicting suicide risk as long as the individual honestly answers the questions. In some cases, however, like the present case, an individual who harbors suicidal thoughts will give answers intended to hide that fact. That is why the Stamford PD Form and policy directs officers to look beyond the arrestee's answers to see if, notwithstanding the answers, the individual's state of mind or other circumstances suggest a suicide risk.

Jamal Linton answered the questions at 7:51 a.m. on January 26th in a manner that did not suggest a risk of self-harm. Nevertheless, nine hours later, he hanged himself. It is difficult to imagine the depths of despair that motivated him to do that. Perhaps he feared a lengthy incarceration. His despair may have been driven by the felony charges he faced in Stamford or the serious crime for which he had been charged in Pennsylvania. It may have been something else. My investigation has not revealed the "why?", and I cannot fault the officers of the Stamford Police Department for failing to perceive a suicide risk that was far from evident.

The preventability of Linton's suicide is another story. The preventability of this tragedy, at least in part, turns on the lack of internal compliance with the Stamford Police Department's own policies designed to ensure prisoner safety – including preventing self-harm. In two regards, those policies were not followed. First, a thorough search of Linton at booking and again when he was placed in a cell should have found the belt that he ultimately used as a ligature. He never should have been placed into a cell with the ability to retrieve that item from his pants. Belts must be taken from prisoners under the express terms of Stamford's General

Order 5.10 IV D 3. Without access to the belt, Linton would have lacked the means to commit suicide.⁷

Second, the officers who were tasked on January 26th to monitor and ensure the safety of the prisoners, including Linton, did not competently do their jobs. They began their shift at 3:00 p.m. and Linton was discovered at 5:42 p.m. In that interval, according to Stamford policy, four physical checks of the cells at thirty (30) minute intervals should have occurred. See General Order 5.10 IV K 2. The electronic log reflects that they performed one cell check, but not until 5:42 p.m. when Linton likely was already dead. The physical presence of the officers in the cellblock and their interaction with the prisoners might have discouraged Linton from connecting the belt to the phone box for fear of being discovered. I cannot know for sure; what I do know is that Linton never confronted that risk of discovery because no physical checks were made. Moreover, the officers' monitoring of the cell video feed was deficient. Finally, the officers' statement that they regularly checked the monitors does not seem reliable because Linton's actions in committing suicide, beginning when he can be seen holding something and ending when he stopped moving, lasted almost ten minutes. Yet, this activity was not observed.

CONCLUSION

The investigation establishes that the in-custody death of Jamal Linton was not the result of either police use of force or criminal action. The Office of Inspector General will take no further action in this matter.

December 9, 2025

ELIOT D. PRESCOTT INSPECTOR GENERAL

⁷ Wisely, the Stamford Police Department has taken remedial steps, including the use of caulking and other means to reduce or eliminate the possibility that the phone box and other cell items can be used to anchor a ligature. See Appendix.

APPENDIX

Substitute Clothing

In other reports issued by the Office of Inspector General, it has been recommended that law enforcement agencies consider issuing substitute clothing to arrested persons who cannot make bond and are held in a police lockup until they are taken to court. This practice would reduce the chances of the arrestee having access to drugs that might be concealed in their street clothes. It might also reduce the ability of the arrestee to use features of their street clothes to facilitate a suicide attempt as was done in the present case.

The idea would be to provide the person with suitable substitute clothing to wear while they are held the police lockup. Prior to being transported to court, the individual could be permitted to change into his or her street clothes.

Prisoner Safety Screening Form



Stamford Police Department Prisoner Safety Screening

Procedure

- 1. EVERY incoming prisoner MUST be screened using this form.
- 2. The completed form MUST be given to the Desk Supervisor <u>BEFORE</u> the prisoner enters the cell.
- 3. <u>FIVE</u> (5) or more <u>YES</u> answers or a <u>YES</u> to Questions 13 or 14 <u>MAY</u> require close supervision. <u>ALERT THE DESK SUPERVISOR</u> and refer to General Order 5.10 for guidance.
- 4. The medical screening starts with Box 18.

	This is Page	1 of 2			
Detainees name (Last, First)		Date of Birth		Case Number	
Linton , Jama		9/21/88	-	250126001	
Date	Sex	Time		Name of Screening Officer	
1/26/25	Male	0751		Harrison	
. '				YES	NO
1) Has the detainee been arre	sted for a nonviole	ent offense	T		\/
(motor vehicle, misdemeanor					V
2) Has the detainee sustained loved one)?	a recent loss (fam	ily member or		<u>.</u>	V
3) Does the detainee have a p	sychiatric history?				V
4) Does the detainee have a h	istory of drug or a	lcohol abuse?			2
5) Does the detainee hold a po and is the alleged crime shock		the communit	y		V .
6) Is this the detainees first ti	me arrested?				V
7) Does the detainee have a te	rminal illness?				V
8) Does the detainee appear to ashamed or afraid?	feel unusually en	barrassed,		•	• 1/
9) Is the detainee acting or tal	king in a strange	nanner?			~
1.1		1 1	- 1		

Updated 12-29-2023



Stamford Police Department

Prisoner Safety Screening

This is Page 2 of 2 10) Is the detainee currently under the influence of drugs or alcohol? 11) Does the detainee show signs of depression? 12) Has the detainee recently lost or been fired from a job? 13) Are officers aware of any past suicide attempts (SPD suicide alerts, check arrestee wrists, etc.)? If YES explain below.	YES	NO / / / /
alcohol? 11) Does the detainee show signs of depression? 12) Has the detainee recently lost or been fired from a job? 13) Are officers aware of any past suicide attempts (SPD suicide	-	\(\sqrt{\sq}}}}}}\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{\sq}}}}}}}\sqrt{\sqrt{\sqrt{\sq}}}}}}}\signtimes\sintitita}\signtiftita}\signtifta}\signtifta}\signtifta\sintititit{\sintitita}\sintititit{\sintitita}\sintititit{\sintiin}}\signtifta\sintititit{\sintiin}}\signtifta\sintitititit{\sintiin}\sintitititititititititititititititititit
12) Has the detainee recently lost or been fired from a job? 13) Are officers aware of any past suicide attempts (SPD suicide	-	V V
13) Are officers aware of any past suicide attempts (SPD suicide		V
		V
13A) Explain:		7.77
14) Has the detainee, or anyone else, made comments to officers about the detainee being suicidal? If YES explain below.		V
14A) Explain;		
15) Does the detainee have martial problems (divorce / separation) or relationship problems?		
16) Detainee appears overly anxious, afraid or angry?		V
17) Does the detainee lack close family in the community?	V	
18) List any of the detainee's medical health conditions below or write NONE.		; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;
18A) NONE		
19) List any of the detainee's medications below or write NONE.	and the state of t	es ef - mail Es ef - mail
19A) NONE		
20) Conduct a visual screen for and list any: body deformities, trauma markings, bruises, lesions, jaundice or write NONE.		
20A) NONE	e	
21) Conduct an assessment for and list any physical, ease of movement and mental health conditions or write NONE.		
NONE		

If necessary, notify the Desk Supervisor of any existing injuries, body deformities, trauma markings, bruises, lesions, jaundice, etc. upon admission. This is so photographs may be taken of the detainee to protect the officers from any accusations of wrongdoing during detention.

Updated 12-29-2023

Remedial Actions taken by the Stamford Police Department

After Jamal Linton's suicide, the following changes were made to enhance prisoner monitoring at Stamford Police Department jail:

- Caulk was added around all phones sealing the gaps between the phone and the walls, as well as around toilets, vents, and any other potential gaps.
- Two additional monitors were added, and an existing monitor was replaced with a larger one in the Jailer's office.
- Four new monitors were added to both the police aid workstation and the duty desk sergeant's workstation.
- A second monitor was added to the prisoner processing/mug shot area.
- A large monitor was installed in the fingerprint area.
- HQ Lieutenant's Office was moved to the first floor between the jail and Front Desk.
- Jail monitoring system added to HQ Lieutenant's office computer.
- "30-minute Cellblock Checks" signs were added.
- "Cellblock Check Point Swipe Required" signs were added above each fob station.
- HQ Lieutenant runs a fob report on all cellblock checks, which is then sent to all supervisors weekly to confirm required checks are being made.