About This Work Sample

Excerpts from a Rule 26(a)(2)(B) Expert Report

The pages that follow are excerpted from a 41-page expert witness statement prepared in an active federal civil rights matter brought under 42 U.S.C. § 1983, involving an unlawful seizure, unlawful entry, and involuntary psychiatric detention. All party, officer, clinician, agency, facility, and counsel names have been replaced, and case numbers and record identifiers have been redacted. The analysis, citations, and structure are otherwise as submitted.

This excerpt includes:

- The title page;
- The assignment and scope, and the complete Summary of Principal Opinions;
- Section III, How the Rules Governing Police Conduct Are Established, which describes the layered structure of authority (statute and case law, state training standards, national model policy, and the department's own written manual) against which every incident is measured;
- One complete analysis section (VI.F), showing how each conclusion is tied to an authority and verified against the record, with quotations checked against the source recordings and citations checked against the underlying documents; and
- Appendix B, a timestamped table of each refusal and objection captured on the body-worn camera recordings.

The complete 41-page redacted report is available on request: **bob@policemisconductpro.com**

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EXPERT WITNESS STATEMENT & ANALYSIS

John Doe v. City of [Redacted], et al.

U.S. District Court, [District Redacted]

Case No. [Case No. Redacted]

Filed: [Filing Date]

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42 U.S.C. § 1983 - Civil Rights Claim

Unlawful Seizure, Unlawful Entry, Involuntary Psychiatric Detention

Prepared by: Robert P. Woolverton, Expert Witness

PoliceMisconductPro.com

Date: August 7, 2026

Plaintiff's Attorney: [Retaining Counsel]

I. Assignment and Scope

I was retained by Plaintiff John Doe, witnessed by his counsel [Retaining Counsel], in June 2026. On [Incident Date], [Redacted] Police Department officers and [County] Behavioral Health Services (MCT) personnel responded to Mr. Doe's home. An involuntary psychiatric detention followed. I was asked to analyze whether those actions conformed to four sets of standards: (1) the California statutes governing involuntary detention; (2) the training California peace officers receive through the Commission on Peace Officer Standards and Training (POST); (3) the [Redacted] Police Department's own written policies in force on that date; and (4) generally accepted police practices.

I offer opinions on police practices, training, and policy. I do not offer opinions on ultimate legal questions, which are for the Court and the jury. A complete list of the materials I reviewed appears in Appendix A (p.39). Appendix B sets out, verbatim and with timestamps, each of Mr. Doe's refusals and objections to transport, as captured on the body-worn camera recordings (p.40). My qualifications, compensation, and prior testimony appear in Section VII (p.37).

II. Summary of Principal Opinions

Based on my review of the record and my training and experience, I have reached the following principal opinions, each stated to a reasonable degree of professional certainty and supported in detail in Section VI (p.17):

1. **The wrong statutory mechanism was applied.** Mr. Doe's behavior on [Incident Date], was consistent with acute alcohol intoxication. The California Legislature created a specific mechanism for that situation: civil protective custody under Welfare and Institutions Code section 5170. The section 5150 hold that was used instead requires a mental health disorder as its foundation. No responder identified a mental health disorder. No responder consulted any source that could have; the signed hold application lists a single source for Mr. Doe's history: himself. The diagnostic record assembled after the detention of Mr. Doe is described in detail in Section VI.A (p.17).

2. **The initial report was investigated and not corroborated, yet the detention proceeded.** The 911 call from Ms. Coe provided a legitimate basis to respond and investigate. Standard police practice, POST training, and [Redacted] PD Policy 421.5(a) then required the officers to assess the situation independently. Their investigation did exactly that, for forty minutes. (Officers were present at Mr. Doe's home for a total of 1 hour and 40 minutes. At approximately 40 minutes after their arrival at 20:10:38 officers requested AMR to respond to the scene "for [a] 5150 hold."[1] The 40-minute investigation produced Mr. Doe's direct denials. It produced no observed threats and no observed

[1] CAD INCIDENT REPORT [CAD No.]

ideation. It revealed a calm, but intoxicated, Mr. Doe. And it produced the officers' own statements to the Reporting Party, Ms. Coe, that Mr. Doe was "not mentioning anything about harming himself or doing anything like that,"[2]. Then when the officer was speaking with Ms. Coe on the phone to verify what she was reporting, the officer said, "So this was all over a phone call; this isn't through text message or anything like that?"[3] "And so he just made comments like, I don't know if I want my life anymore, but nothing of, uh, but nothing more specific, like I'm gonna take my gun and end it, I'm done?"[4] Yet the detention proceeded anyway. See Section VI.B (p.21)

3. **Once consent was revoked and the reported emergency was uncorroborated, standard practices required the officers to leave, and they did not.** Mr. Doe invited the responders into his home voluntarily, and he was free to withdraw that permission. At approximately 19:50 hrs., he did. He told them he would love for them to get out of here.[5] By that point, the officers' own investigation had produced no corroboration of the reported emergency. Officers are trained that staying in a home without a warrant requires consent or a present, articulable emergency. The possibility that an emergency could develop later is not enough. After 19:50 hrs., none of those things existed. Yet officers and MCT personnel remained in the home for approximately eighty additional minutes. See Section VI.C (p.24)

4. **The gravely disabled determination used a definition that was not law in [County] on the incident date.** The MCT clinician wrote that Mr. Doe was unable to keep himself safe due to depressive symptoms and alcohol use disorder. That language comes from Senate Bill 43. [County] had deferred Senate Bill 43 until January 1, 2026.[6] The definition actually in force at the time of this event required inability to provide for food, clothing, or shelter as the result of a mental health disorder. The record contains essentially no evidence of that. The receiving facility's own advisement form left the gravely disabled box unchecked. See Section VI.D (p.25)

5. **The hold was written by a pre-licensed clinician whose authority to do so is unestablished, while the officers abdicated a hold determination they remained responsible for.** The involuntary hold was written by A. Roe, an Associate Marriage and Family Therapist. An AMFT is not a licensed clinician; it is a registration that permits practice only under supervision while the registrant accumulates hours toward licensure. Mr. Roe did not become a licensed marriage and family therapist (LMFT No. [License No.]) until June 5, 2025, 79 days after this incident. Whether the County had designated him to initiate holds under section 5150(a) remains unestablished on this record [formally requested, pending]. The officers summoned MCT. They stood by while

[2] BWC [Camera 1]19:39:33 hrs
[3] BWC [Camera 1] 19:42:26 hrs
[4] BWC [Camera 1] 19:42:35 hrs
[5] BWC [Camera 1] 19:50:17 hrs
[6] [county resolution URL redacted]

clinician A. Roe announced, "So, I, I'm gonna do my due diligence, and I'm gonna write the paperwork. And whether or not you go, that's, that's a whole different story."[7] That announcement made the paperwork independent of Mr. Doe's decision: the hold would be written whether he agreed or not. The voluntary aspect the MCT record later asserts was, by its author's own words on-scene, never actually an option. At transport, Officer B asked the ambulance attendant whether he had received the paperwork, and directed the ambulance attendant to the MCT worker to retrieve it.[8] And the police officers performed none of their own independent assessment and documentation duties even though their department policies required it. See Section VI.E (p.26)

6. **The mandatory advisement was never given, and the stated basis that later appeared on the hold paperwork was factually false.** Section 5150(g) required whoever took Mr. Doe into custody to give him specific information at that moment. He had to be told he was not under criminal arrest. He had to be told he was being taken to a named facility for examination by mental health professionals. No document, recording, or transcript shows this advisement was given. Instead, the trip was framed to him as an emergency room check for alcohol poisoning. The advisement he finally received came the next day, at [Receiving Hospital]. It rested on a report that he had sent suicidal text messages. Ms. Coe's own 911 call establishes the communication was a phone call. No text messages existed. This information was corroborated by Officer A during his phone call with Ms. Coe at 19:42:26 hrs. See Section VI.F (p.29)

7. **The documentation required by law and by the Department's own policy was never created.** [Redacted] PD Policy 412.3.3 required an officer to complete the application for 72-hour detention and retain a copy in the case report. The CAD disposition was "Log Note Only." No case report exists. No officer completed or retained the application. No supervisor response is documented, despite Policy 421.8. See Section VI.G (p.31)

8. **The deficiencies were systemic, not individual improvisation.** The Department's policy manual in force on the incident date was missing every rule this incident needed. It contained no section 5150(g) advisement requirement. It contained no definition of gravely disabled. It contained no protocol of any kind governing MCT co-response, and no reference to section 5170. It affirmatively directed officers to book intoxicated arrestees into jail, contrary to Penal Code section 647(g). POST publishes no training on section 5170. The Department's entire documented MCT co-response training was a briefing of 0.33 hours. One of the two responding officers, hired nine weeks before the incident, never

[7] BWC [Camera 2] 20:09:09 hrs. The final phrase of the quoted statement is partially overlapped by Mr. Doe speaking. Both cameras' independently generated transcriptions concur in rendering the phrase, "that's, that's a whole different story," and my own review of the audio confirms the statement through, "whether or not you go."
[8] BWC [Camera 2] 21:10:01 hrs

received even that. His first crisis intervention course came thirty days after this incident. See Section VI.H (p.32)

9. **The record contradicts the claim that Mr. Doe went voluntarily. What the recordings show is a man given no real choice.** The MCT note states Mr. Doe willingly sat on the gurney to be transported to the hospital. The police bodycam videos show him refusing transport to the hospital at least 26 times, including while he was being placed on the gurney and his objections continued while he was being wheeled into the back of the ambulance. Appendix B lists each refusal, verbatim, with its timestamp. By transport time, six representatives of local government were present in and around his home: two police officers, two MCT team members, and two fire personnel. Officers are trained that presence alone controls behavior. The use-of-force continuum published by the United States Department of Justice places officer presence at its first level: no physical force is needed, because "the mere presence of a law enforcement officer works to deter crime or diffuse a situation."[9] California POST teaches the same principle as "command presence."[10] And the Supreme Court lists "the threatening presence of several officers" first among the circumstances showing that a person has been seized. (United States v. Mendenhall, 446 U.S. 544 (1980))[11]

   Presence is force in its mildest form, and its purpose is exactly what it accomplished here: numbers alone make resistance unrealistic. The responders did not physically force him onto the gurney. They did not need to. They surrounded him, guided him, and left him a single direction to move. His only remaining alternative was physical resistance. That would have been documented as violence, would have retroactively justified the hold as danger to others, and would likely have added criminal charges. Compliance under those conditions is not consent. It is the absence of any other option. See Section VI.I (p.34)

[9] National Institute of Justice, U.S. Department of Justice, The Use-of-Force Continuum (Aug. 3, 2009), https://nij.ojp.gov/topics/articles/use-force-continuum ("Officer Presence - No force is used... The mere presence of a law enforcement officer works to deter crime or diffuse a situation.");
[10] POST Learning Domain 20, Use of Force/De-escalation, Version 6.0, p. 6-4, https://post.ca.gov/portals/0/post_docs/basic_course_resources/workbooks/LD_20-V6.0.pdf
[11]; United States v. Mendenhall, 446 U.S. 544, 554 (1980), https://supreme.justia.com/cases/federal/us/446/544/

III. How the Rules Governing Police Conduct Are Established

Everyone knows that police officers enforce the law. Less understood is where the rules come from that govern how officers enforce the law. This case turns on those rules. So, I begin by describing the framework. Every California officer is trained in that framework, beginning in the police academy.

Some rules are written directly into statute. In some areas, the Legislature has told officers exactly how to act. This case involves two direct examples. California Welfare and Institutions Code section 5150(g) commands that a person taken into custody for psychiatric evaluation "shall" be given a specific advisement at that moment. The advisement includes the officer's name and agency, the fact that the person is not under criminal arrest, and the name of the facility. Penal Code section 647(g) commands that an officer "shall," when reasonably able, place a publicly intoxicated person in civil protective custody rather than book him into jail. These are not suggestions; these are mandates directed by statute.

In my home state of Washington, the legislature wrote the statute on domestic violence that commands police officers that, when there is evidence of an assault and a primary aggressor can be identified, the primary aggressor shall be arrested. When those statutory conditions are met, an arrest is mandatory. Like the previous example in the California Welfare and Institutions Code, they are enforcement instructions written by the Legislature.

Constitutional case law supplies most of the remaining rules. The Fourth Amendment prohibits unreasonable searches and seizures. The courts, case by case, define what is reasonable. Those precedents provide legal instruction to every police officer. A well-known example illustrates how this works in practice. In Arizona v. Gant, 556 U.S. 332 (2009),[12] the United States Supreme Court addressed when officers may search the interior of a vehicle after arresting one of its occupants. The Court held that officers may search the passenger compartment in that situation only in two circumstances: if the arrestee is unsecured and within reaching distance of the passenger compartment at the time of the search, or if it is reasonable to believe the vehicle contains evidence of the offense of arrest. No statute contains that rule. It comes entirely from case law. Yet from the day it was decided, it governed every vehicle search incident to arrest in the country. It was promptly incorporated into police training and department policies nationwide. That is the ordinary path by which the rules of police work are made. The courts announce the standard. Officers are trained on it and expected to apply it. The same path produced the standard governing this case. For involuntary psychiatric detentions, the California courts held in People v. Triplett (1983) that an officer needs probable cause built on "specific and articulable facts," that the person, as a result of a mental disorder, is a danger to himself or others or gravely disabled. The federal Ninth Circuit adopted the same standard. An officer is expected to know and apply these standards whether or not any department policy repeats them.

[12] https://supreme.justia.com/cases/federal/us/556/332/

POST translates the law into training. The Commission on Peace Officer Standards and Training certifies the academy curriculum every California officer must complete. Learning Domain 37[13] devotes a chapter to section 5150. It covers the criteria, the probable cause standard, and the mandatory advisements. POST's field guide for mental health response quotes the Triplett standard directly. When I state what officers are trained to know, I cite these materials.

Departments translate the law and training into policy. Individual departments adopt written policy manuals that give officers day-to-day guidance. These are sometimes built on the Lexipol platform. (Lexipol is a commercial company that drafts model policy manuals for police departments across the country. Each department subscribes to the service, adapts the model policies to its own needs, and adopts them as its own. The result is the department's official policy manual.) The [Redacted] Police Department subscribes to the Lexipol platform for its policy manual. [Redacted] PD Policy 412 governs mental illness commitments. Policy 421 governs crisis intervention incidents. Policy is where a department demonstrates how it expects its officers to apply the law. Gaps in policy are gaps in guidance.

Even absent a specific policy, the officer remains obligated. Where a department's manual is silent, the statute and the case law still govern. Officers are trained that they must stay current on ever-changing case law and be bound by the directions provided within that case law. The [Redacted] Police Department's own policy manual is very explicit in this regard. Its Search and Seizure policy states: "Because case law regarding search and seizure is constantly changing and subject to interpretation by the courts, each member of this department is expected to act in each situation according to current training and his/her familiarity with clearly established rights as determined by case law."[14] The manual's preface makes the same commitment: the manual is based on "current, relevant, and applicable federal law, state law, legal precedent, and the best practices within the law enforcement profession," and members are expected to familiarize themselves with its content, "including updates." (Chief's Preface, p. 1.) [Redacted] PD's own Policy 421.5 reminds officers that mental health crises alone are not criminal offenses. It directs officers to assess situations independently of reported information. The absence of a policy on a subject does not excuse noncompliance with the law on that subject. Although that does not excuse the officer, it raises a separate question about the department itself: why was there no written direction on the very subjects this incident required - the mandatory advisement, the handling of intoxicated people, how to work alongside the County's crisis team? Section VI.H (p.32) offers in-depth analysis to that question.

[13] https://post.ca.gov/portals/0/post_docs/basic_course_resources/workbooks/LD_37-V7.0.pdf

[14] [Redacted] PD Policy Manual, Policy 311, p. 130

MCT documentation never mentions: their own call with Ms. Coe, establishing the report was a phone call with nothing specific (not a text message with suicidal threats).

The vacuum that made this possible. No MOU, protocol, bulletin, or training document governing MCT co-response has been produced by either agency [confirmation requested, pending]. The Department's entire documented MCT training was a twenty-minute briefing in March 2024. One of the two responding officers never received it. Policy 421.4 directed the Department to develop a response protocol with mental health professionals. No evidence shows it did. When no rule assigns responsibility, the predictable result is what this record shows. Each participant assumed the other held the duty. No one performed it.

Contrary considerations. If the County produces a valid designation for Mr. Roe, the authority question resolves. But the officers' deference problem remains. Designation authorizes a clinician to initiate a hold. It does not relieve officers of their independent assessment, documentation, and advisement duties. If Mr. Darien held a valid designation, he used an improper 5150 involuntary hold for an intoxicated subject, and used a legal definition of "gravely disabled" that had not been authorized yet. Conversely, if no designation existed, then no person on that scene held lawful authority to initiate the hold except the officers themselves. And they made no independent determination of their own. On either branch, the practices I observe in this record deviated from the standards.

Conclusion. It is my opinion that the handoff of the hold decision to MCT deviated from generally accepted police practices and from the Department's own policy. No protocol governed it. And the officers' independent duties went unperformed.

VI.F. The advisement that never happened and the false basis

Opinion. In my opinion, to a reasonable degree of professional certainty, the advisement that California law required at the moment of custody was never given. The purpose of the detention was affirmatively misdescribed to Mr. Doe. And the factual basis recorded on his hold paperwork was false. It described text messages that never existed.

The advisement duty. Section 5150(g) requires that a person taken into custody be told specific things, at that time, by the person taking him into custody. He must be told the officer's name and agency. He must be told he is not under criminal arrest, but is being taken for examination by mental health professionals. He must be told the name of the facility. If taken from his residence, he must also be told he may bring personal items, make a phone call, and leave a note. The Legislature wrote this advisement for a reason. A person subjected to one of the most serious intrusions short of arrest should understand what is actually happening to him.

What happened instead. No recording, transcript, or document shows any part of the section 5150(g) advisement being given. The only advisement-adjacent statement on the bodycam is “You're not under arrest, John.”[46] What Mr. Doe was told, repeatedly, was that he

[46] BWC [Camera 1] 19:59:06 hrs

was going to the emergency room for an alcohol check. At 20:37:40 hrs, Clinician Roe specifically said, "It's about checking your blood alcohol content, making sure you're not gonna overdose."[47] This was 27 minutes after Clinician Roe had already decided he was going to implement a 5150 hold, and the AMR ambulance had been summoned. They were still selling Mr. Doe on a medical emergency room visit almost half an hour after the involuntary psychiatric commitment was already in motion. Mr. Doe's stated objection was the cost of an emergency room visit. He was never told, in any recorded moment, that he was being taken for an involuntary psychiatric commitment. That misdescription is precisely the harm the advisement statute exists to prevent.

The advisement he ultimately received came the next day, at a second facility, from a nurse as recorded on form DHCS 1802.[48] The signed application itself, DHCS Form 1801, underscores the failure in its own advisement block. It records, "Complete Advisement," at [Incident Date], 9:08 p.m.[49] That is the moment of transport, not the moment of custody; police body cam video confirms the advisement was not given at that date and time. And it names the destination facility as "Any LPS designated facility." That is not the name of a facility as required by law.

The paperwork chain did not end with the advisement forms. The [Receiving Hospital] record also contains a Certification Review Hearing form under Welfare and Institutions Code section 5250, the mechanism for extending an involuntary hold up to 14 days of intensive treatment. The form reflects that [Receiving Hospital] initiated certification and that a probable cause hearing was held on March 21, 2025, the day Mr. Doe was discharged. The hearing officer determined that probable cause **did not exist** to continue the detention, and Mr. Doe went home that day.[50] That outcome completes the arc of this record: a hold written on a false factual basis, executed without the required advisement, survived only until the first moment a neutral decision-maker examined it.

The false basis. The next-day advisement form, the DHCS 1802 completed at [Receiving Hospital], states the basis for his hold: "It was reported you sent text messages expressing suicidal thoughts." No text messages existed. Ms. Coe's own recorded 911 call describes a phone call. The officers confirmed as much on scene: "So this is all over a phone call? This isn't through text messages or anything like that?" The origin of the false version is on tape.

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[47] BWC [Camera 2] 20:37:40 hrs

[48] DHCS Form 1802, Involuntary Patient Advisement, [Receiving Hospital], 3/19/2025 (produced by plaintiff's counsel as an image file; no Bates number assigned; not contained in the [Receiving Hospital] records produced at COM (Doe) 000964 to 001173).

[49] DHCS Form 1801, Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment, COM (Doe) 001101 to 001102 (advisement block at 001101), signed A. Roe, AMFT, [Incident Date] 9:08 p.m.

[50] Certification Review Hearing form, W&I Code section 5250, [Receiving Hospital], hearing date 3/21/2025, scanned into the record 3/24/2025, COM (Doe) 001118. Discharge date per [Receiving Hospital] Discharge Summary, COM (Doe) 000974. See also the Leave Hospital Against Advice forms of 3/21/2025, COM (Doe) 001113 to 001114.

Appendix B. Mr. Doe's Refusals and Objections to [Discharge RN]sport, by Timestamp

The table below lists twenty-nine timestamped statements in which Mr. Doe refused or objected to being transported, identified in my review of both body-worn camera recordings. Times are the camera clock. Quotations are as heard on my review of the video. Where a statement answered a specific request, the request is noted. The list is conservative: it excludes nonverbal resistance and borderline statements. The figure of at least 26 refusals used in the body of this statement is therefore an understatement of the record.

No.	Time	Camera (BWC)	Mr. Doe's statement
1	20:09:06 hrs	[Camera 1]	"No God damn way I'm going to the hospital."
2	20:30:30 hrs	[Camera 2]	"Oh, no, I'm not going."
3	20:30:34 hrs	[Camera 2]	"I'm not going, baby."
4	20:30:52 hrs	[Camera 2]	"I'm not going, boys."
5	20:37:19 hrs	[Camera 1]	In response to the AMR attendant's "Why don't we take you to the ER, bro, and just have them check you out real quick?": "I don't want to go to the ER."
6	20:38:46 hrs	[Camera 1]	In response to Officer A' "Come on, Zack, let's get on the gurney, man. Can we do this?": "No, I'm not going."
7	20:38:58 hrs	[Camera 1]	"No, I'm never leaving."
8	20:40:26 hrs	[Camera 2]	"I'm not going."
9	20:40:35 hrs	[Camera 2]	"I'm not going."
10	20:41:26 hrs	[Camera 2]	"I'm not going."
11	20:46:16 hrs	[Camera 2]	"No! No!"
12	20:47:06 hrs	[Camera 2]	"No, I'm not going."
13	20:47:51 hrs	[Camera 2]	"I'm not going on a gurney."
14	20:48:23 hrs	[Camera 2]	"I'm not leaving!"
15	20:48:40 hrs	[Camera 2]	"No!"
16	20:50:50 hrs	[Camera 2]	"I'm not going to the hospital because they'll charge me $4,000."
17	20:54:28 hrs	[Camera 2]	"I'm not getting on the gurney."
18	20:55:12 hrs	[Camera 2]	"I'm not getting on the gurney."

No.	Time	Camera (BWC)	Mr. Doe's statement
19	20:55:32 hrs	[Camera 2]	"There's no way I'm getting into an ambulance."
20	20:58:56 hrs	[Camera 2]	"I'm not going. I'm not going. I'm backing out."
21	21:02:24 hrs	[Camera 2]	"Oh no, I'm not going."
22	21:04:46 hrs	[Camera 2]	"I'm not getting on there."
23	21:05:10 hrs	[Camera 2]	"Oh, I can't go. No, I can't go. I can't go. I'm sorry, but I can't go."
24	21:05:36 hrs	[Camera 2]	"No, I'm not leaving."
25	21:06:33 hrs	[Camera 2]	"I'm not going. I really don't want to go, boys."
26	21:08:08 hrs	[Camera 2]	"I really don't want to go, boys."
27	21:09:15 hrs	[Camera 2]	"Guys, No. No."
28	21:09:25 hrs	[Camera 2]	"Guys. Guys, Guys. Bring me back in. Just wheel me up to my bed."
29	21:10:08 hrs	[Camera 2]	"I want to know how much this costs before I go because I'm not paying."