Eddie T. Johnson
Superintendent
Chicago Police Department
3510 S. Michigan Avenue
Chicago, Illinois

August 16, 2016

Re: Log#1078329
Disciplinary and Policy Recommendations

Dear Superintendent Johnson:

This outlines disciplinary and policy recommendations arising from the above-captioned investigation:

I. BACKGROUND

On 12 December 2012, Subject 1 was arrested following a physical altercation with his mother. Despite the fact that he had been injured during this altercation and was exhibiting strange behavior, the responding officers took him to the 005th District station. Over the next twelve hours he spent within the lockup facility, Subject 1's behavior was, at times, erratic and uncooperative. On the morning of 13 December 2012, Subject 1 refused to cooperate with Department members when they tried to get him ready to go to court. Sgt. A, who was the District Station Supervisor, enlisted the assistance of five additional Department members in an attempt to obtain Subject 1's cooperation from a "display of force." All six Department members entered the cell where Subject 1 was being detained. The officers' verbal attempts to convince Subject 1 to cooperate were unsuccessful. At Sgt. A's request, Officer A discharged his Taser at Subject 1. Then the group of officers used physical force to take Subject 1 to the floor and restrain him in handcuffs and leg shackles. Detention Aide A then removed Subject 1 from the cell by pulling the handcuffs and allowing 1's body to be dragged behind his hands. While the other Department members followed behind and watched, Detention Aide A continued to drag Subject 1 down a hallway to the front of the lockup facility. Pursuant to Department policy, Detention Aide A called for medical support to have the Taser probes removed from Subject 1.

Paramedics arrived and took Subject 1 to Roseland Hospital. Officers D and E accompanied Subject 1 to the hospital. Once they arrived at the hospital, Subject 1 struggled violently with the officers and the medical staff and attempted to flee from the hospital room. The officers, ambulance crew and hospital staff members were eventually able to gain control of Subject 1, which allowed the medical staff to administered sedative to Subject 1. According to the medical examiner's report, Subject 1 had a negative reaction to the drug, which caused his death later that day. The death in custody of Subject 1 was initially investigated by the Independent Police Review Authority under Log #1058981. In that investigation, IPRA did not present allegations of misconduct to any Department members involved in Subject 1's custody. A copy of that summary report will be made publicly available along with the summary report resulting from the conclusion of this re-investigation.

II. INVESTIGATIVE ALLEGATIONS AND FINDINGS

A. Incident Leading to Subject 1's Arrest

It is alleged that on 12 December 2012, at approximately 1930 hours, at 12828 S. Morgan, **Sgt. B:** knew Subject 1 needed medical and/or mental health treatment and refused to make it available for him, in violation of Rule 6, Special Order S04-20-01, and General Order G06-01-01. This allegation is **Sustained.**

B. Subject 1's Treatment While in Custody

It is alleged that at various times between 12 December 2012 at approximately 1945 hours and 13 December 2012 at approximately 0745 hours, at 727 E. 111th Street, **Lt. A, Lt. B, Lt. C, Sgt. C, and Sgt. A:** Failed to make medical and/or mental health treatment available for Subject 1, in violation of Rule 6 and Special Orders S04-20-01 and S06-01. This allegation as to Lt. B is **Sustained.**

It is also alleged that **Lt. B:** Maltreated Subject 1 by allowing him to walk around the lockup area with his pants down, in violation of Rule 8. This allegation is **Not Sustained**.

It is also alleged that **Lt. B**: failed to follow the provisions of Special Order S06-01 by not allowing Citizen 3 to see his son, Subject 1, while Subject 1 was in custody, in violation of Rule 6. This allegation is **Exonerated**.

It is also alleged that **Lt. B**: failed to follow the provisions of General Order G04-09-02 regarding Exposure to Communicable Disease, in violation of Rule 6. This allegation is **Sustained.**

C. Incident Leading to Removal from Cell

It is alleged that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, **Sgt. A:** Instructed Officer A to bring a Taser into lockup, in violation of Rule 6 and Special Order S06-01-02. This allegation is **Sustained.**

It is alleged that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, **Sgt. C, Sgt. A, Officer A, Officer B, and Officer C:** Used excessive force on Subject 1 in violation of Rules 6 and 8 and General Order G03-02. This allegation is **Not Sustained**.

It is alleged that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, **Detention Aide A:** Physically maltreated Subject 1 by dragging him from his cell while he was handcuffed and shackled, in violation of Rules 6 and 8 and General Order G03-02; Physically maltreated Subject 1 by dragging him down the hallway while he was handcuffed and shackled, in violation of Rules 6 and 8 and General Order G03-02; and Brought discredit upon the Department, in violation of Rule 2. This allegation is **Sustained**.

It is alleged that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, **Sgt. C, Sgt. A, Officer A, Officer B, and Officer C:** Failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled, in violation of Rules 3, 6, and 8, General Order G06-01-01, and Special Order S06-01; and Observed misconduct and failed to report it when Detention Aide A dragged Subject 1 from his cell and down the hallway while he was handcuffed and shackled, in violation of Rule 22. This allegation is **Sustained** as to Sgts. C and A and Officers A and B.

D. Incident at Roseland Hospital

It is alleged that on 13 December 2012, at approximately 0819 hours, at 45 W. 111th Street, **Officer D and Officer E:** Used excessive force on Subject 1, in violation of Rules 6 and 8 and General Order G03-02. This allegation is **Not Sustained**.

III. DISCIPLINARY RECOMMENDATIONS

Sergeant B: 120 Day Suspension

Sgt. B responded to the scene of Subject 1'sarrest in response to a request for a supervisor. When he arrived, Sgt. B saw a group of officers standing around Subject 1, who was on the ground and in handcuffs. The officers told Subject 1 that he was in custody following a domestic incident with his mother. Sgt. B and the officers then informed Subject 1 that they were going to escort him to the squadrol. Subject 1 got up from the ground with the officers' assistance. Officers H and I escorted Subject 1 to the squadrol so they could transport him. Subject 1 did not willingly walk with the officers but he tensed his body. According to Sgt. B, Subject 1 was talking, but not in an irrational manner. When they got to the squadrol, Subject 1 turned his head and spat at Officer I, striking him on the face. According to Sgt. B, he moved

next to Officer I and instructed the officers to put Subject 1 in the squadrol because he had just spat at an officer. According to Sgt. B, Subject 1 then spat again, striking Sgt. B on the face.

As they were preparing to take Subject 1 to jail, his father, Citizen 3, told Sgt. B that his son was acting strangely and needed to be hospitalized rather than taken to jail. Sgt. B acknowledged that Subject 1 father suggested that he needed mental help. According to Sgt. B, he concluded that mental health evaluation was not necessary or appropriate because Citizen 3 stated that Subject 1 had not previously had mental health issues. However, Sgt. B knew that Subject 1 was bleeding, and therefore, in need of medical attention, because the sergeant had Subject 1's blood-stained spit on his clothing. Sgt. B has admitted that he told Citizen 3 that he was taking his son to jail because he had spit at the officers. Both Citizen 3 and neighbor Citizen 1 recall the specific words Sgt. B used, "we don't do hospitals, we do jail."

There is a reasonable inference from the evidence in this case that Sgt. B's conduct was retaliatory. No one likes being spat upon. It is not only an insulting gesture, it is an act that places an officer at risk of harm through the spread of communicable diseases, and is, in fact, a criminal offense. It is understandable that Sgt. B and the other officers who perceived themselves to have been spat upon would be more than displeased. But displeasure does not excuse an officer's duty to provide police service in a manner that is consistent with the Department values.

After reviewing Sgt. B's complimentary history and disciplinary history, and given the aggravated circumstances of the conduct, the appropriate sanction for Sgt. B's failure to provide medical treatment or mental health evaluation, in violation of Rule 6 and Special Order 04-20-01, is 120 days' suspension.

Lt. B: 28 Day suspension

According to Detective A, Lt. B had a face-to-face conversation with Citizen 3 during which Citizen 3 informed Lt. B that he believed his son was in need of mental health treatment. In addition, Lt. B was aware of the strange behavior Subject 1 had exhibited while in lockup because he had personally interacted with Subject 1 during various aspects of his processing.

Lt. B's failure to follow the required protocol for exposure to communicable diseases also delayed Subject 1's receipt of medical care. Lt. B's explanation for this lapse was his lack of awareness of the policy/directive. Ignorance of the rules is no excuse and senior Department members are held accountable for their knowledge of the rules. Based on the totality of the conduct at issue, and reviewing Lt. B's complimentary history and disciplinary history, a sanction of 28days' suspension is warranted.

Sergeant C: 28 day Suspension

Sgt. C became a sergeant a few months before the incident, in September 2012. Sgt. C's normal assignment at the time of the incident was serving as a field sergeant. Sgt. C recalled that Sgt. A asked him to assist with Subject 1 not because he was a supervisor, rather, because he wanted another Department member present as a show of force. Sgt. A did not initially tell Sgt. C that Subject 1 was refusing to go to court. Sgt. C did not learn that until he was actually in the lockup.

Sgt. C acknowledged that the situation in the lockup cell could have been handled differently and that Subject 1 could have been moved to the front of lockup in a different manner. According to Sgt. C, he did not intervene while watching Detention Aide A dragging Subject 1 out of the cell because Detention Aide A's direct supervisor was present during the action. According to Sgt. C, he did not report Detention Aide A's actions to any other supervisor because he assumed that Sgt. A, who had a better view of it, would make whatever report he needed to make. Sgt. C referred to the situation as a dynamic series of events that unfolded in a short amount of time.

Sgt. C defends his failure to intervene and failure to report on the basis that the involved member's direct supervisor was present for the misconduct at issue. Although this may be a mitigating factor, it does not excuse Sgt. A's failure here. A Department member's duty to intervene and duty to report misconduct are not negated when there is someone else available to intervene and report. In fact, as a supervisor, Sgt. C is meant to set an example for junior officers.

Based on Sgt. C's complimentary history and disciplinary history, the appropriate sanction for Sgt. C's violation of Rules 3, 6, 8, and 22, and General Order 06-01-01, and Special Order 06-01 is a 28 day suspension.

Officer A: 28 day suspension

On the date of the incident, Officer A was assigned to a squadrol and one of his duties was to transport arrestees to court in the morning. According to Officer A, on the morning in question, Sgt. A told Officer A and his partner that Subject 1 had been combative with officers during a domestic-related arrest the night before. Sgt. A also informed the officers that Subject 1 was "not in his right mind." Sgt. A asked Officer A to join in the group that was going to try to extract Subject 1 from the cell. According to Officer A, after they got inside the cell, Subject 1 was saying things about Satan, which gave Officer A the impression that Subject 1 may have had mental health issues. Based on Subject 1's demeanor and the strength, Officer A also wondered if Subject 1 was on drugs.

Knowing that Department rules prohibit officers from taking weapons into a cell unless there is an emergency, but having been directed by Sgt. A to do so, Officer A entered the cell with his Taser. There was no emergency requiring the immediate need to remove Subject 1 from the cell. Officer A threatened Subject 1 with the Taser by visibly turning it on and off. Yet Subject 1 remained uncooperative. Officer A ignored Sgt. A's first request that he discharge the Taser at Subject 1. However, ultimately, Officer A discharged the Taser at Subject 1 in reaction

to seeing his rise from the bench in an aggressive manner. Officer A then stood by and watched as Detention Aide A dragged Subject 1 out of the cell.

Based on Officer A's complimentary history and lack of disciplinary history, the appropriate sanction for Officer A's failure to intervene and failure to report the misconduct of Detention Aide A is a 28 day suspension.

Officer B: 28 day suspension

According to Officer B, he had only worked in lockup a few times per year, he was unfamiliar with all of the lockup procedures, including what to do with an arrestee who does not cooperate with court procedures. According to Officer B, he believed Detention Aide A dragged Subject 1 out of the cell because Subject 1 continued to refuse to get up and leave the cell on his own power. However, Officer B acknowledged that none of the Department members directed Subject 1 to do so. Nor did Officer B instruct Subject 1 to stand up and walk.

Based on Officer B's complimentary history and disciplinary history, the appropriate sanction for Officer B's failure to intervene and failure to report the misconduct of Detention Aide A is a 28 day suspension.

Detention Aide A: 90 day suspension

Detention Aide A physically maltreated Subject 1 by dragging him from his cell and down the hallway while Subject 1 was handcuffed and shackled. According to Detention Aide A, he pulled Subject 1 out of the cell and down the hallway because he was worried that Subject 1 would start fighting with him and the officers again if he did not immediately move him out of the area. This explanation lacks credibility. There is no indication that Subject 1 was combative after he was restrained by the handcuffs and shackles. Detention Aide A admitted that neither he, nor any of the other involved Department members, gave Subject 1 any commands to rise to his feet to walk on his own, nor did they give him any opportunity to do so. Detention Aide A's maltreatment of Subject 1 was inappropriate and unnecessary, particularly in light of the fact that, by then, it had most likely become clear to all of the Department members involved, that Subject 1 was in need of mental health treatment.

Based on Detention Aide A's complimentary history and disciplinary history, the appropriate sanction is a 90 day suspension.

Sergeant A: Placement on Do Not Hire List

The evidence in this investigation suggests that Sgt. A's treatment of Subject 1 at the lockup facility was outside of Department policy in several respects: (1) Sgt. A knew Subject 1 was exhibiting behavior indicative of the need for mental health treatment or evaluation and he failed to provide such; (2) Sgt. A unnecessarily caused the incident in the lockup by his attempts to force Subject 1 out of the lockup cell that morning; (3) Sgt. A directed Officer A to bring a

Taser into the lockup cell against Department policy; and (4) Sgt. A failed to intervene when Detention Aide A dragged Subject 1 out of the cell.

Sgt. A retired from the Department on 07 February 2014. As such, IPRA was not able to present him with all of these allegations, and at this time, the Department is unable impose discipline upon him. If Sgt. A were still employed by the Department, we would have recommended Separation. As such, we are asking the Department to include this report in Sgt. A's personnel file, and to take any and all possible action to prevent him from future employment with the City of Chicago.

Lastly, we recommend that all officers involved in the arrest and lockup incidents attend Crisis Intervention Training, if they have not done so already.

IV. POLICY DISCUSSION AND RECOMMENDATIONS

This investigation has revealed concerning behavior committed by members at all levels within the Department who came in contact with Subject 1 that we believe are a result of gaps in both policy and training.

A. Dealing with Persons In Mental Health Crisis

The Department continues to struggle with the manner in which members address the needs of individuals in mental health crisis. This investigation has revealed a lack of sufficient direction from the Department and a lack of understanding, among members at all levels of the Department, of the policies and procedures that do exist related to the treatment of individuals in crisis.

1) Incorporate questions into OEMC protocol to identify mental health issues involved in incoming calls requesting police service for "domestic incidents."

First, we reiterate one of the recommendations that we proposed in our Crisis Intervention Policy Review published earlier this year -- that OEMC incorporate into their call intake protocol, additional questions to callers requesting police assistance for "domestic" incidents. Additional questions could attempt to identify those calls in which the domestic incident involves an individual in mental health crisis or otherwise in need of mental health evaluation. This can be accomplished by simply adding one or two questions to the battery that is asked when incoming callers identify a domestic incident as the basis for their request for police assistance. In this case, the Citizen 2 and Citizen 3's neighbor called 911 to request police assistance on behalf of Subject 1's mother following a violent domestic incident. At that moment, it was clear to Citizen 2 and the neighbor that Subject 1 was acting out in an unusual way. If the 911 call intake staff member had been prompted to ask whether anyone involved in the domestic incident appeared to be in mental health crisis or in need of mental health evaluation, that call could have been flagged for response by a CIT-certified officer. This is not meant to imply that the outcome of this incident would necessarily have been different had a

CIT-certified officer been dispatched. However, it is possible that a CIT-certified officer might have more readily recognized that Subject 1 was in need of mental health evaluation.

2) Accelerate crisis intervention training for *all* supervisory Department members and lockup personnel, including detention aides.

In this investigation, at least four involved supervisory members demonstrated a fundamental lack of understanding of and sensitivity to individuals in mental health crisis. Had Sergeant B received more substantial crisis intervention training, his decision-making regarding whether Subject 1 should have been transported to jail or to a hospital would have been informed by better knowledge and tools to evaluate the situation. Similarly, the failure of Sgt. A and Lt. B act on Subject 1's evident need for mental health evaluation may also have been based on a lack of training.

3) Amend applicable directives or create new directives regarding the handling of uncooperative detainees, in general, and those in need of mental health treatment or evaluation, in particular. In addition, provide improved officer training on the treatment of uncooperative detainees.

There does not appear to be a policy or directive that explicitly addresses how to handle passive resisters – those individuals who are uncooperative, but not necessarily violent – in lockup facilities. In this incident, absent such a policy, the Department members present were left to devise a plan about how to proceed with Subject 1 as he repeatedly refused to cooperate with the officers' requests for him to get ready for court. S06-01 dictates that a station supervisor in charge of a detention facility will ensure the Duty Judge procedures are initiated consistent with the Department directive entitled "Duty Judge Procedures" whenever a charged arrestee will not be able to appear at the next regularly scheduled court call for which the case is normally returnable within 48 hours from the time of arrest. This rule clearly anticipates that there will be occasions on which a detainee will be unable to appear at the next regularly scheduled court call. By its terms, S06-01appears to focus on those situations in which an arrestee is sent for medical treatment or is otherwise unable to be physically present in court, rather than the situation at issue here, where a detainee refuses to go to court. Outside of being up against the 48 hour deadline, there is usually no exigent need to get a detainee out of his cell for transport to court. Subject 1 had only been in custody for approximately twelve hours prior to the decision to remove him from the lockup facility. There was no exigent need for him to be transported to court for the scheduled court call that morning. We recognize that the movement of detainees cannot be dictated by their degree of cooperation. Allowing an arrestee to dictate whether he or she will go to court by acting out is not a workable policy. Under normal circumstances, a person in custody should not be able to decide whether they go to court. In exceptional cases like this, however, where the involved officers had enough information to indicate that mental health evaluation might be warranted. Had there been a protocol in place to do so, the officers could have called a CIT-trained officer to assist in evaluating the situation. Improved CPD policy and training could better inform the decisions officers are required to make in these situations.

We also understand that individuals that are detained following arrest are often combative and uncooperative and that lockup personnel are often responsible for handling extremely difficult and potentially dangerous detainees. Without appropriate training and direction, it is extremely difficult for Department members to distinguish between behavior that is merely combative or uncooperative from behavior that signals a need for mental health treatment. This series of events shows the need to revise the current relevant directives or create new directives that inform Department members regarding the appropriate means by which to handle uncooperative detainees in lockup facilities, and, in particular, those in need of mental health treatment or evaluation. In addition, the Department should provide improved or enhanced training on the treatment of uncooperative detainees that emphasizes the use of de-escalation techniques when and where appropriate.

4) Create a protocol that allows for lockup personnel to request assistance from CPD's Critical Response Unit (CIT Trainers and other highly experienced CIT officers).

The Department should also consider creating a protocol that would allow for lockup personnel to request Critical Response Unit officers to respond to lockup facilities to assist in assessing detainees that may need mental health treatment or evaluation and/or assist in the movement or processing of detainees who are exhibiting behavior indicative of the need for mental health evaluation or treatment.

B. Courtesy and Core Department Values When Dealing with Citizens

1) Incorporate language into the Department standards of conduct that clearly convey that acting out against a member of the public in retaliation for an actual or perceived slight is inconsistent with the Department's values. Also, clearly convey that misconduct that appears retaliatory will be punished more severely.

As outlined above, we believe that this investigation revealed misconduct that was, at least in part, driven out of spite – the officers were resentful of Subject 1 because he spat at them or their colleagues. We ask that you consider revising the standards of conduct to prohibit retributive and retaliatory treatment of citizens, and that you revise the disciplinary protocols to include increased sanctions where it appears that an officer acted, or failed to act where there was a duty to do so, in retaliation for something the citizen did.

2) Revise policies and training related to lockup facility procedures to more clearly state that detainees as well as family members and attorneys who seek information about them should be treated fairly and with dignity.

The Department's treatment of Subject 1 and his father was unnecessarily callous and insensitive, and not in keeping the Department's core values. The directives governing lockup facilities should more clearly state that individuals in the care and keeping of Department

members should be treated with dignity and respect. We understand that Department members who manage these facilities often deal with difficult, obstructive, and even dangerous individuals and that the efficiency of operations and the safety of Department members are paramount. However, we also have to remind Department members that they serve the citizens of Chicago and that each and every citizen should be treated fairly and with the appropriate due care.

We sincerely hope you will give serious consideration to these issues and concerns.

Respectfully,

Sharon R. Fairley
Chief Administrator