INDEPENDENT POLICE REVIEW AUTHORITY
Log 1078329

INTRODUCTION:

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 the 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. Officer A was carrying a Taser. 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 Subject 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 for Subject 1 to have the Taser probes removed. 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 medical staff and officers by knocking them to the floor and attempting to flee from the hospital. The officers were eventually able to gain control of him, which allowed the medical staff to administer a 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. Subject 1's death in custody 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 the summary report concluding the initial investigation will be published along with this summary report.

On 05 December 2015, IPRA opened a new investigation into what took place during Subject 1's time in police custody to address allegations[1] that the force the officers used on Subject 1 was excessive, and that Department members did not provide Subject 1 with access to medical and/or mental health treatment. This investigative summary includes relevant statements that were given under the original investigation and depositions related to the civil lawsuit.

[1] These allegations were taken from the video in the 005th District lockup and civil suit 12 CV 10061, which was filed by Subject 1's family. That suit was settled prior to the conclusion of this investigation.

ALLEGATIONS:

I. 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:**[2] 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,[3] and General Order G06-01-01.

II. 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,[4] Lt. B,[5] Lt. C ,[6] Sgt. C,[7] and Sgt. A :[8]** 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.

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; 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; and Failed to follow the provisions of General Order G04-09-02 regarding Exposure to Communicable Disease, in violation of Rule 6.

III. 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.

It is alleged that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, **Sgt. C, Sgt. A , Officer A,[9] Officer B,[10] and Officer C :[11]** Used excessive force on

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[2] Sgt. B was a field sergeant who responded to the incident that led to Subject 1's arrest on 12 December 2012.
[3] This Special Order, which was in place at the time of this incident, was rescinded on 30 May 2014 and was replaced with Special Order 04-20-05. The relevant portion can now be found as S04-20-05 II. B. For all other General and Special Orders addressed in this report, the version of the report that was in place on 12-13 December 2012 was the version that was used.
[4] Lt. A was the 005th District station supervisor during third watch on 12 December 2012. Subject 1's arrest occurred during this time.
[5] Lt. B was the 005th District station supervisor during first watch on 13 December 2012, meaning that he was in charge of the station overnight.
[6] Lt. C was a field lieutenant during third watch on 13 December 2012.
[7] Sgt. C was a field sergeant at the time Subject 1Subject 1 was removed from his cell.
[8] Sgt. A is retired from CPD on 07 February 2014. He was the 005th District station supervisor during second watch on 13 December 2012, at the time Subject 1 was removed from his cell.
[9] Officer A Officer A was assigned to the squadrol at the time of this incident. He was present in lockup to drive Subject 1 to court.
[10] Officer B was assigned to lockup at the time of this incident.
[11] Officer C retired from CPD on 16 May 2015. He was assigned to the squadrol with Officer A Officer A at the time of this incident.

Subject 1, in violation of Rules 6 and 8 and General Order G03-02.

It is alleged that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, **Detention Aide A:**[12] 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.

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.

IV. 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:**[13] Used excessive force on Subject 1, in violation of Rules 6 and 8 and General Order G03-02.

[12] Detention Aide A is a civilian and was working in the lockup at the time of this incident.
[13] Officers D and E were assigned to go to Roseland Hospital with Subject 1.

APPLICABLE LAW AND RULES:

Rules

- Rule 2: Prohibits any action or conduct which impedes the Department's efforts to achieve its policy and goals or brings discredit upon the Department.
- Rule 3: Prohibits any failure to promote the Department's efforts to implement its policy or accomplish its goals.
- Rule 6: Prohibits disobedience of an order or direction, whether written or oral.
- Rule 8: Prohibits disrespect to or maltreatment of any person, while on or off duty.
- Rule 22: Failure to report to the Department any violation of Rules and Regulations or any other improper conduct which is contrary to the policy, orders or directives of the Department.

General and Special Orders

- G03-02: Use of Force Guidelines; effective 23 September 2002 – present
- G03-02-02: Force Options; effective 16 May 2012 – 11 March 2015
- G03-02-03: Deadly Force; effective 23 September 2012 – 10 February 2015
- G04-09-02: Post-Exposure Procedures; effective 27 August 1995 – 06 November 2014
- G06-01-01: Field Arrest Procedures; effective 22 August 2012 – 19 December 2012
- G06-04-04: Arrestee and In-Custody Communication; effective 08 May 2012 – 29 January 2015
- S03-02-02:[14] Other Weapon Discharge Incidents; effective 14 June 2012 – 31 October 2014
- S04-20-01:[15] Handling Arrestees in Need of Mental Treatment; effective 06 May 2004 – 30 May 2014
- S06-01: Processing Persons Under Department Control; effective 23 February 2012 – 29 January 2015
- S06-01-02: Detention Facilities General Procedures And Responsibilities; effective 23 February 2012 – 29 January 2015

[14] Now G03-02-07.
[15] Now S04-20-05.

INVESTIGATION:

I. INCIDENT LEADING TO SUBJECT 1'S ARREST

According to **Office of Emergency Management and Communications records**, a man who identified himself as "C" (now known to be Citizen 1 , neighbor of Citizen 2 and Citizen 3, Subject 1's parents) called 911 to report that his neighbor (now known to be Citizen 2) had been beaten by her son, Subject 1 (the victim).[16] The dispatcher then passed this information along to Officers F and G, who responded to the call. After arriving on the scene, Officers F and G requested a sergeant and a squadrol. (Attachments 60-65)

In a deposition taken 07 April 2014, **Citizen 2**, Subject 1's mother, described the physical altercation that led to Subject 1's arrest. According to Citizen 2, on the day of the incident, Subject 1 came into their house and sat down. Citizen 2 noticed that Subject 1 appeared "slumped over"[17] and was crying. Subject 1 then told Citizen 2 that he was hearing voices and he was afraid. Citizen 2 offered to call someone to help him, but Subject 1 suggested that they just sit down and talk. Subject 1 and Citizen 2 sat together, talking and praying for a while. According to Citizen 2, she had never seen Subject 1 act like this before. Then, suddenly, Subject 1 "shot his hand up,"[18] shouted a religious statement, and started jumping up and down and knocking things over. When Citizen 2 tried to calm and console him, Subject 1 knocked her to the floor. It was then that Subject 1 told her that she was not his mother.

After some time, Subject 1 appeared to calm down and he sat down on the floor beside his mother. Citizen 2 continued to encourage Subject 1 to seek help. Then, again suddenly, Subject 1 got up and said he was going to leave. Citizen 2 got up from the floor and tried to discourage Subject 1 from leaving. Then, Subject 1 hit her in the face and she fell back to the floor. Citizen 2 acknowledged that, at that point, she "got scared."[19] Citizen 2 recalled that she stood up and then she and Subject 1 were "tussling."[20] At some point, Citizen 2 hit Subject 1 with a candlestick holder. Citizen 2 believes she hit him in the mouth, because after that he was bleeding. Citizen 2 eventually escaped the melee by running into the bathroom and exiting through a bathroom window. Citizen 2 then went to seek help from a neighbor and walked down the block to the home of Citizen 1.

Citizen 2 recalled that, sometime after the incident, Citizen 1 told her that he and her husband and the other neighbors had tried to tell the police officers that Subject 1 was "having some kind of nervous breakdown or something."[21] They also said, referring to Subject 1, "this wasn't his normal behavior" and that the police had "just kind of ignored the fact." [22]

Initially, Citizen 2 refused medical treatment but was eventually taken to South Metro

[16] For the purposes of clarity, this report will refer to Subject 1 as "Subject 1." His parents will be referred to by full name.
[17] Citizen 2 deposition, Attachment 214, page 32, line 23
[18] Citizen 2 deposition, Attachment 214, page 39, line 14
[19] Citizen 2 deposition, Attachment 214, page 50, line 24
[20] Citizen 2 deposition, Attachment 214, page 52, line 2
[21] Citizen 2 deposition, Attachment 214, page 69, line 13
[22] Citizen 2 deposition, Attachment 214, page 77, line 22-23

hospital by paramedics. Citizen 2 stated that the paramedics that took her to the hospital did not treat her in any way at the scene. At the hospital, Citizen 3 stated that the first ambulance at the scene was only attending to the officers and then when he arrived at the hospital, the officers were being treated before his wife.[23]

Citizen 2 also recalled that one of the police officers, a black female, presented her with a complaint to sign against Subject 1 alleging domestic battery. When Citizen 2 refused to sign the complaint, the officer told her that if she didn't sign the complaint that the officers would have to sign the complaint. But that if Citizen 2 signed the complaint, she could "get it released." Based on this conversation, the officer gave Citizen 2 the impression that, even if she signed the complaint, she could always say that she was not going to press charges against her son, but if the officers signed the complaint the charges would go forward. (Attachment 214).

In a deposition taken 03 February 2014, **Citizen 1**, a neighbor of the Subject 1's family, described his interaction with Citizen 2 on the day of the incident. According to Citizen 1, Citizen 2 came to his home looking disheveled. When he asked her what had happened, she told him "something's wrong"[24] with Subject 1. Citizen 1 recalled being incredulous because he knew Subject 1 to be a "mild-mannered guy."[25] Citizen 1 took Citizen 2 inside where they were joined by his mother. They called 911, Citizen 1's mother speaking first, and Citizen 1 taking over the call. Soon thereafter, they noted fire engines and police arrived.

When Citizen 1 went to leave the house, he was met by Citizen 3, Subject 1's father, who told him that something was wrong with Subject 1. Citizen 1 said that he knew that and then informed Citizen 3 that Citizen 2 was inside the Citizen 1's house. After Citizen 3 checked on his wife, he and Citizen 1 and two police officers left to see about Subject 1.

According to Citizen 1 as he, Citizen 3, and the officers were walking toward the Citizen 2 and 3's residence they saw Subject 1 rolling around in the grass, babbling. Citizen 1 could not decipher what Subject 1 was saying. When Citizen 1 called out to Subject 1, he jumped up and ran towards Citizen 1, Citizen 3 and the officers with his arms extended "like an airplane."[26] According to Citizen 1, Subject 1 did not appear threatening as he approached them in this manner. However, the officers starting commanding Subject 1 to get down on his knees and one of the officers pulled out her firearm. According to Citizen 1, he and Citizen 3 asked the officers to let them talk to Subject 1 to try to calm him. Eventually, Citizen 1, Citizen 3 and the officers were able to gain physical control over Subject 1 and the officers placed him in handcuffs. According to Citizen 1, as this was happening, Subject 1 was continuing to babble and was "talking crazy."[27]

After Subject 1 was placed in handcuffs and while he still remained on the ground,

[23] The failure to treat Citizen 2 immediately is objectionable conduct by a city employee. As a result, the failure to treat Citizen 2 first was directly reported to CFD and the Office of the Inspector General as misconduct by city employees.
[24] Citizen 1 deposition, Attachment 208, page 29, line 5
[25] Citizen 1 deposition, Attachment 208, page 29, line 8
[26] Citizen 1 deposition, Attachment 208, page 44, lines 22-23
[27] Citizen 1 deposition, Attachment 208, page 49, line 22

Citizen 1 saw Subject 1 spit "in the area of the police."[28] Citizen 1 also observed that Subject 1 was spitting out blood.

According to Citizen 1, after the officers had succeeded in getting Subject 1 into the transport vehicle, he asked the supervising officer, who Citizen 1 described as either a sergeant or captain, whether they were going to take him to Jackson Park Hospital.[29] In response, the officer stated "He going to jail. We don't do hospitals. He's going to jail."[30] (Attachment 204)

In a deposition taken on 28 January 2014, **Citizen 3**, Subject 1's father, recounted the events. According to Citizen 3, he returned home from work at approximately 1900-1930 hours to find an ambulance and police car parked on his street, blocking the way to his house. Citizen 3 turned down an alley and heard shouts, so he stopped his car and got out, and encountered Subject 1. Citizen 3 noticed that Subject 1 was not wearing a coat, despite the cold weather. When Citizen 3 approached him, Subject 1 initially put his arm around Citizen 3. But then Subject 1 pushed him away saying, "you not my dad."[31] Subject 1 started cursing in a loud voice and knocked Citizen 3's glasses off. Citizen found Subject 1's behavior to be out of character. When Citizen 3 bent down to pick up his glasses, Subject 1 bent down on his knees as if to pray and started mumbling about the devil and Jesus. Sensing that something was wrong with Subject 1, Citizen 3 got back in his car. After unsuccessfully trying to convince Subject 1 to get in the car, Citizen 3 drove away, but he could see Subject 1 running back and forth in the alley. Citizen 3 drove back to his street and parked. Citizen 3 approached the ambulance to request help from the driver, stating that he thought his son was losing his mind. The driver told Citizen 3 that he was there "for the woman in the house,"[32] referring to the Citizen 1's residence. Not yet knowing that the woman the driver spoke of was Citizen 2, Citizen 3 went to Citizen 1's house. As he started to knock on the door, two police officers, a male and a female, came out of the house. Citizen 3 told them that he thought is son was going crazy and asked for help. One of the police officers asked Citizen 3 if his son's name was "Subject 1," to which he replied that it was. The police officers asked where Subject 1 was, and Citizen 3 directed them down the street to where Citizen 3 had last seen Subject 1.

As Citizen 3 and the officers walked down the street toward the Citizen 2 and 3's residence they encountered Subject 1. According to Citizen 3, Subject 1 was mumbling and talking about Jesus. Subject 1 then lay down in the street and started to move his arms and legs as if to make a "snow angel."[33] Then Subject 1 stood up and starting running at Citizen 3 and the officers. Subject 1 stopped in front of a neighbor's house and asked the officers if they were going to Taser him. The female officer responded, "We don't do Tasers"[34] and, according to Citizen 3, both officers pulled out their firearms. Citizen 3 jumped in front of Subject 1 and implored the officers not to shoot him. According to Citizen 3, the female officer said that's what

[28] Citizen 1 deposition, Attachment 208, page 54, line 12
[29] Special Order 06-08 lists Jackson Park Hospital as a designated mental health intake facility for people in need of mental health treatment services. The same order lists Jackson Park Hospital as an approved comprehensive care hospital.
[30] Citizen 1 deposition, Attachment 208, page 56, lines 45-15
[31] Citizen 3 deposition, Attachment 215, page 84, line 20
[32] Citizen 3 deposition, Attachment 215, page 96, line 24
[33] Citizen 3 deposition, Attachment 215, page 97, line 20
[34] Citizen 3 deposition, Attachment 215, page 98, lines 3-5

they would do if Subject 1 did not follow her instructions.

According to Citizen 3, Citizen 1 helped talk Subject 1 down to having one knee on the ground. Citizen 3 and Citizen 1 then took Subject 1 all the way to the ground. At that time, Citizen 3 could see that Subject 1 was spitting out blood. The female officer then said, "He spitting at us, he spitting at us, I don't play that shit."[35] According to Citizen 3, at that time, Subject 1 was spitting toward the ground, not toward the officers. Citizen 3 and Citizen 1 maintained control over Subject 1 on the ground until the squadrol (police transport vehicle) arrived.

The police squadrol arrived with additional officers who placed shackles on Subject 1. They stood Subject 1 up and the officers started walking with him toward the squadrol. When he got close, Subject 1 refused to get inside stating, "Dad, dad, I'm not going in here, you know how they are, you know how they are."[36] According to Citizen 3, he believed Subject 1 was referring to a recent encounter Citizen 3 had with Riverdale police, where Citizen 3 believed he was unjustly detained.

According to Citizen 3, he asked a sergeant on scene to take his son to Jackson Park Hospital. Based on his experience as a parole officer, Citizen 3 was aware that police officers were permitted to take arrestees with mental health issues to Jackson Park Hospital for treatment or evaluation. According to Citizen 3, the sergeant responded, "We don't do hospitals. We do jail. Your son spit on two officers. He's going to jail."[37]

According to Citizen 3, sometime a little before midnight that evening, he went to the 005th District police station in an attempt to see Subject 1. While there, an officer Citizen 3 believed was either the desk sergeant or watch commander (identified through this investigation as Lt. B) told him that his son was resting quietly. Lt. B refused to allow Citizen 3 to visit his son in lockup.[38] Citizen 3 remained at the station until approximately 0300-0330 hours. During that time, Citizen 3 was interviewed for approximately one hour by a CPD Detective (Detective A) along with an Assistant State's Attorney ("ASA"). Citizen 3 told the Detective A and the ASA that he believed that Subject 1 was having some sort of psychological problem and that he needed to go to the Jackson Park Hospital. Detective A and the ASA told Citizen 3 that there was nothing they could do to get Subject 1 out of jail that night, but that Citizen 3 would have to bail him out the next day and then take him to the hospital.

The next day, Citizen 3 went to the courthouse at 26th and California as the detective and the ASA had suggested, and waited for his son's case to be called. At the conclusion of the court session, at approximately 1300 hours that afternoon, and realizing Subject 1's case had not been called, Citizen 3 tried to phone the detective. Citizen 3 was transferred to someone else at the station who told him that Subject 1 had not gone to court and that he was in the lockup because

[35] Citizen 3 deposition, Attachment 215, page 143, line 23
[36] Citizen 3 deposition, Attachment 215, page 149, lines 16-17
[37] Citizen 3 deposition, Attachment 215, page 154, lines 4-6
[38] Citizen 3 did not provide any further details about his conversation with Lt. B. He was not specifically asked whether he requested that Lt. B send Subject 1 to the hospital.

they were doing some "checks"[39] on him.

Citizen 3 called a friend, Citizen 4, and asked Citizen 4 to go over to the 005th District station to see about Subject 1. After he arrived there, Citizen 4 called Citizen 3 and told him that he had learned that Subject 1 was going to be transferred to Harrison and Kedzie. According to what Citizen 4 had been told by personnel at the station, at that moment, Subject 1 was still at the 005th District, but no one was allowed to see him. Citizen 3 then drove over to the 5th District station and met Citizen 4 there. According to Citizen 4, the personnel at the station had been talking and laughing about "the guy that spit on the policemen"[40] and referring to a file on the front desk that appeared to have Subject 1's name on it. At first, the police personnel at the station were not providing Citizen 3 with any information, but then a lieutenant (Lt. A) came out front and told Citizen 3 that he should go to Roseland Hospital. Lt. A told Citizen 3 that his son had "been acting up today"[41] and that he should go to the hospital to calm him down. No one at the station told Citizen 3 that Subject 1 had been taken to the hospital earlier that morning.

When Citizen 3 arrived at the hospital at approximately 1500 hours, he was allowed in to the emergency room where Subject 1 was being treated. Citizen 3 could see through the curtain to where Subject 1 was being treated and saw that hospital personnel were "working on"[42] Subject 1. He could also hear the sound of the respirator. According to Citizen 3, when he saw Subject 1 through the curtain, he recalled seeing marks on Subject 1's legs and he could see the hospital staff putting ice and stuff on his legs and elsewhere on his body. He also recalled the hospital staff taking about "cleaning him up."[43]

Citizen 3 remained there until approximately 1930 hours, when he got up to leave to get something to eat. As he was leaving the hospital, a police officer came out and told him to come back inside. When he returned, he learned that they staff had called a "code blue"[44] for Subject 1 and that hospital personnel were working on him. At some point later, the hospital personnel informed him that Subject 1 had died. When Citizen 3 returned to the hospital with his wife later than evening to see their son, Subject 1 was covered with a sheet with nothing showing but his head. (Attachment 215)[45]

In a deposition taken 18 March 2014, **Officer F** recounted her involvement in the incident leading to Subject 1's arrest. According to Officer F, she and her partner, Officer G, were assigned to respond to the 911 call made by Citizen 1. When they arrived at his residence, he met them in the street and told the officers that his neighbor had been beaten up by her son. The officers went inside Citizen 1's residence and proceeded to interview Citizen 2. A short time later, Citizen 3 arrived and told the officers that something was wrong with his son, and he asked the officers to follow him to where his son was. The officers and Citizen 1, then followed

[39] Citizen 3 deposition, Attachment 215, page 173, line 7
[40] Citizen 3 deposition, Attachment 215, page 179, line 24
[41] Citizen 3 deposition, Attachment 215, page 182, line 20
[42] Citizen 3 deposition, Attachment 215, page 185, line 11
[43] Citizen 3 deposition, Attachment 215, page 197, line 22
[44] Citizen 3 deposition, Attachment 215, page 188, line 24
[45] Citizen 3 gave a statement to IPRA under Log #1058981 that is consistent with the account he provided in his deposition. That statement is Attachments 134-135.

Citizen 3 outside and down the street. Citizen 3 told them that "his son had gone crazy"[46] and the he didn't know what was wrong with him. The officers then saw Subject 1 first walking in the middle of the street, then rolling around on the ground. According to Officer F, Subject 1 was yelling, but she could not decipher what he was saying. Then Officer F saw Subject 1 get up from the ground and start running toward the officers with his arms extended to the side. The officers stepped apart from each other and Subject 1 ran between them. According to Officer F, in reaction to seeing Subject 1's conduct, she pulled out her O.C. spray, and her partner pulled out his service weapon. Citizen 3 begged the officers not to hurt his son. Officer G reholstered his weapon when Subject 1 obeyed the officers' direction to turn around and show his hands. According to Officer F, Citizen 3 continued to plead with the officers to not hurt his son and to allow Citizen 3 to try to get Subject 1 under control. Eventually, the officers, along with Citizen 3 and Citizen 1, were able to get Subject 1 to the ground and the officers placed handcuffs on him in the front. Officer F explained that they were unable to get him handcuffed behind his back, which is the usual practice.

According to Officer F, she and Officer G called for backup and waited with Subject 1 until other officers arrived. Officer F recalled that, as they waited, Subject 1 started spitting out blood. The officer specifically recalled seeing blood coming from Subject 1's mouth. Officer F also recalled the Subject 1 was screaming profanities. Officer F specifically recalled that Citizen 3 said that his son had gone crazy and that he thought his son needed help. (Attachment 222)

In a deposition taken 18 March 2014, **Officer G** gave an account of the events that was similar to that of Officer F. However, Officer G denied hearing Citizen 3 request help for his son. Officer G acknowledged that she saw that Subject 1 was spitting blood. (Attachment 210)

According to **Sgt. B** in a deposition taken on 21 January 2014, he was working as a field supervisor on 12 December 2012 when he received a call for a supervisor from an officer on the scene of Subject 1's arrest. When Sgt. B arrived, he 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. Sgt. B could not remember what Subject 1 was saying, but he remembered that Subject 1 was coherent rather than irrational. When they got to the squadrol, Subject 1 turned his head and spit at Officer I , striking him on the face. Sgt. B moved next to Officer I and instructed the officers to put Subject 1 in the squadrol because he had just spit. Subject 1 then spit again, striking Sgt. B on the face. Officers then lifted Subject 1 into the squadrol.

Sgt. B recounted that he had a conversation with Citizen 3. According to Sgt. B, Citizen 3 told the sergeant that his son needed to go to the hospital. In response, Sgt. B asked Citizen 3 if his son had ever had any mental health treatment or if he had been on any medication or was he currently seeing a doctor. When asked whether Citizen 3 ever told him that he believed Subject 1 was "having a mental issue,"[47] Sgt. B said that he did not recall. Sgt. B also said he

[46] Officer F deposition, Attachment 244, page 13, line 20
[47] Sgt. B deposition, Attachment 203, page 28, line 14

did not recall Citizen 3 ever using the word "crazy"[48] in reference to Subject 1. Sgt. B acknowledged that it was his decision to transport Subject 1 to the 005th District station rather than to a hospital. Sgt. B also acknowledged that he told Citizen 3 that his son was being taken to jail because he was under arrest for battery to his mother and for aggravated battery to the police officers. Sgt. B also acknowledged that he was aware that Subject 1 was bleeding because he was aware that when he spit, he had spit out blood.

According to Sgt. B, based on the encounter, he never suspected that Subject 1 had "any possible mental problems."[49] (Attachment 203)

In an accused statement for this investigation on 29 June 2016, **Sgt. B** provided essentially the same account of the incident as he provided in his deposition. Sgt. B added that, while he did not observe any injuries on Subject 1, he assumed the blood Subject 1 spit at him came from a cut or injury to Subject 1's mouth. Sgt. B assumed whatever that injury was had been sustained during the fight between Subject 1 and Citizen 2. During Sgt. B's conversation with Citizen 3, Citizen 3 said that he thought Subject 1 was having some sort of mental breakdown because Subject 1 was acting differently than he normally does. Sgt. B asked if Subject 1 had a history of mental illness, if he was on medication, or if he was under a doctor's care. Citizen 3 responded no to all of those questions. Based on Citizen 3's responses, Sgt. B did not believe that Subject 1 was in need of mental health treatment. Sgt. B then informed Citizen 3 that officers were going to transport Subject 1 to the 005th District to be charged with battery to Citizen 2 and to the officers for spitting on them. Sgt. B told Citizen 3 that he could go to the 005th District station and talk to the personnel there if he was concerned about Subject 1's well-being. Sgt. B acknowledged that there was an ambulance on the scene and that he did not ask the paramedics to assess Subject 1 to see if further medical attention was needed. When asked why he did not, Sgt. B stated that Subject 1 himself did not ask for medical treatment and that paramedics could not perform an assessment on someone without their consent. Sgt. B acknowledged that he has been trained that an arrestee who has an injury at the time of arrest should be taken to the hospital for treatment. When asked why Sgt. B did not follow that training during Subject 1's arrest, Sgt. B said that he did not see any visible signs of injury. This is despite the fact that Subject 1 spit blood at Sgt. B, which led Sgt. B to believe that Subject 1 had a cut in his mouth. Sgt. B later saw Citizen 3 at the 005th District station talking to the watch commander. Sgt. B could not remember what time this was or who the watch commander was that Citizen 3 spoke to. Sgt. B did not speak to Citizen 3 at that time. (Attachment 280)

According to the **Arrest Report** dated 12 December 2012 in RD HV-600058, Subject 1's mother (Citizen 2) told the officers that, prior to their arrival, she and Subject 1 were in her home. After Citizen 2 and her son spoke for several hours, Subject 1 kicked Citizen 2, pushed her to the ground, said she was not his mother, and repeatedly punched her on the face. Citizen 2 struck Subject 1 on the mouth during their altercation. Subject 1 then ran from the residence and kicked out the window of his father's vehicle. According to the reporting officers, when CPD arrived, Subject 1 resisted their efforts to take him into custody, but officers were able to gain control of him. As they were escorting Subject 1 to the squadrol, he spit blood at Sgt. B and Officer I. Subject 1's father (Citizen 3) reported Subject 1's behavior as "crazy." The officers

[48] Sgt. B deposition, Attachment 203, page 31, line 1
[49] Sgt. B deposition, Attachment 203, page 47, line 22

transported Subject 1 to the 005th District station. The arresting officers took Subject 1 directly to the lockup facility when they arrived at the station because he was still physically struggling with them and refusing to follow commands. The lockup keeper processing portion of the arrest report documents that Subject 1's fingerprints were taken on 13 December 2012 at 0156 hours. His photographs were taken at 0252 hours.[50] (Attachment 6)

Case Report HV-600058, dated 12 December 2012, authored by Officer F contains an account of Subject 1's arrest consistent with that described in the arrest report. The **Detective Supplementary Report** in HV-600058, dated 03 January 2013, authored by Detective A, includes information obtained through interviews of Subject 1's mother, father, girlfriend, one of Subject 1's Family neighbors, and the arresting officers. Each of these witnesses involved in the incident provided accounts of Subject 1's arrest and the events leading up to it that appear consistent with the arrest and case reports. However, in the Detective Supplementary Report, Subject 1's mother and father added that Subject 1 had been depressed because of a lost job opportunity. Moreover, according to Citizen 2, Subject 1 suddenly attacked her after they had been talking and praying together for hours. (Attachment 8)

Arresting officers Sgt. B and Officer I completed **Tactical Response Reports** related to Subject 1's arrest. Sgt. B's report describes Subject 1 as a passive resister who did not follow directions. He added that he was present when Subject 1 was being escorted to the squadrol. While that was happening, Subject 1 spit blood and "bodily fluids" at Sgt. B's face and upper body. Sgt. B used member presence and verbal commands. Officer I's report describes Subject 1 as an active resister. In addition to not following directions, Subject 1 pulled away and refused to be put in the squadrol. Officer I used member presence, verbal commands, and escort holds. Sgt. B and Officer I also completed **Officer Battery Reports** and **Reports of Exposure to Disease/Hazardous Material** documenting that Subject 1 spit blood at them. Officer H (Officer I's partner) submitted witness reports documenting that he observed Subject 1 spitting at the officers. (Attachments 16-25)

Photographs of Citizen 2, Officer I and Sgt. B were taken by Evidence Technicians. The photographs of Citizen 2 depict injuries to her face and knee. The photographs of Officer I and Sgt. B show various reddish stains on their uniforms. (Attachment 272)

II. SUBJECT 1'S TREATMENT WHILE IN CUSTODY

Video recordings from multiple cameras in the 005th District lockup facility show Subject 1 at various times during his detention at the lockup facility, including when he is in his cell and when he is in the processing area. The cameras are equipped to record video only. The following summarizes some of the pertinent video footage:

At 20:10:29 on 12 December 2012,[51] three officers brought Subject 1 into a cell. The camera recording these images was in place directly across from Subject 1's cell. On the video

[50] The photographs were taken in the female side of the lockup facility because the camera in the male side was not working properly.
[51] All times noted in this section of the report correspond to the time stamp on the video recording. The times are consistent with those listed on related CPD reports.

recordings from this camera, a portion of the area within the cell is not visible because the recording device intentionally masks the area directly around the toilet within the cell for privacy purposes. In the video recording, this privacy effect appears on the screen as an opaque white rectangle superimposed over the recorded images.

- 20:10:34: Four officers carried Subject 1 into the cell on a sheet and placed him on the floor. A detention aide and two additional officers stand at the entrance of the cell.
- 20:10:44: Subject 1 is still on the floor of the cell with officers surrounding him. Because of the way the officers are positioned, Subject 1 is not in view. A few seconds later, two officers bend down near Subject 1's feet and legs and carry him further into the cell.
- 20:11:07: Subject 1 remains on the cell floor. It is clear that he begins to struggle with the officers that are kneeling around him. While you cannot see Subject 1, the officers who are attempting to un-cuff him are struggling and moving as they hold onto him.
- 20:12:03: Three officers remain in the cell and kneeling around Subject 1.
- 20:12:36: Subject 1 appears again to struggle against the officers. The officers' body movements indicate that they are holding onto a person who is moving and difficult to control.
- 20:14:06: The officers are still struggling with Subject 1 on the floor; another officer is seen bending down to hold his legs or feet.
- 20:14:26: The officers finally un-cuff Subject 1 and leave the cell. From 20:14:36 until approximately 20:44:36, Subject 1 appears to be very agitated. He continually paces back and forth in his cell and appears to be talking or yelling. Multiple times he walks to the cell door and appears to be talking and gesturing towards someone who is not in view. At one point, Subject 1 jumps up on the bench in the cell and paces back and forth, while moving his arms and talking.
- 20:24:51: Subject 1 appears to be speaking heatedly with someone outside of his cell.
- 20:26:29: Subject 1 resumes pacing around the cell; based on his body movements, he still appears to be agitated. Finally, Subject 1 lies down on the bench.
- 21:41: Subject 1 stands back up and again begins to pace around the cell. He also raises both hands and appears to be talking. Subject 1 lies back down till about 00:58 on 13 December 2012, when he is seen sitting up briefly.
- 01:52: Subject 1's cell door is opened and he follows officers out of the cell. Subject 1 is not handcuffed at that point and walks on his own.

Video recorded by a camera in the area where male arrestees are processed shows that, at approximately 01:53, Subject 1 appeared to be talking to the lockup personnel and other Department members as they took his fingerprints. Initially, Subject 1 appeared to be cooperating with his processing, moving his hand to the fingerprint machine as directed by the lockup staff. However, during that process, Subject 1 suddenly stopped moving his hand to the fingerprint machine. He stood still and would not move his hand when the lockup keeper tried to pull it forward. Several Department members put their hands on Subject 1's back and back of his head, apparently to move him forward. They were able to finish taking the fingerprints and

returned him to his cell.

The camera outside Subject 1's cell shows four officers returning him to his cell at 02:02:01. Subject 1 was not handcuffed and appeared to be walking on his own with the officers guiding him. One officer is on each side of Subject 1 holding his arms and two additional officers guide Subject 1 from behind. Once he is in the cell, Subject 1 sits on the bench and then lies down. He remained in the cell until approximately 02:46:13, when officers enter the cell. At that time Subject 1's pants were fully on. The officers talk to Subject 1 for about 20-30 seconds while Subject 1 remains seated on the bench. Then, officers physically remove him from the bench and place him on the floor. The officer's movements and Subject 1 are partially blocked by the privacy box, but it appears the officers are attempting to place Subject 1 in handcuffs. At 02:48:19, Subject 1 is lifted off the floor and walk out of his cell. An officer is on either side of Subject 1 and they hold him by the arms to escort him out of the cell. Subject 1 leaves the frame at 02:48:22; his body is only visible from the waist up because of the number of officers that are around him as he is walked out of the cell.

Video recordings show that, at approximately 02:48:36, Subject 1 was brought through the male processing area. There are officers on either side of him holding his arms as they escort him. Subject 1 is barefoot and is wearing a t-shirt, jeans, basketball shorts, and boxers. As he is being escorted through the processing area, his jeans have fallen around his knees. His basketball shorts and boxers have also slipped slightly below his waist, exposing his buttocks. Multiple officers surround Subject 1 as he stops briefly. Subject 1 resumes walking and is out of view at 02:48:50.

At 02:48:56, a camera in the area where female arrestee's are processed shows that Subject 1 was brought to that area of the lockup facility to be photographed.[52] At this point, Subject 1's basketball shorts are on, but his jeans are still around his ankles. The jeans fall off of Subject 1's legs completely as he walks across the area captured by the video recording.[53] As he is being brought through the area, because his shorts and boxers have fallen below his waist, his buttocks are visible to the video camera. Subject 1 is out of the frame as he is being photographed from the front. He comes back into the camera's view as they photograph his profile. One of the male officers held Subject 1 in place while the photographs were taken. Subject 1 did not appear to be in distress or unable to stand; it appears that Department members are attempting to hold him in place so he would not move away from the camera. At approximately 02:50:03, Subject 1 is seen being removed from the woman's lockup area. His jeans are no longer around his ankles at this point.

At approximately 02:50:18, Subject 1 is being brought down the hallway back to his cell. At this point, Subject 1 is still being escorted by the two officers who are holding him by the arms. His boxers are fully over his waist and covering his buttocks but his basketball shorts are now down around his ankles. Subject 1 is out of sight at 02:50:29. At 02:50:33 Subject 1 is placed back in his cell. The same officers that had him in the escort hold since 02:48:22 hold him against the wall as other officers attempt to take off his handcuffs. The video is not clear, but the

[52] CPD reports reveal that the camera on the male side of lockup was not working, which required Subject 1 to be photographed on the female side.
[53] Lt. B is on screen for portions of this video, but he was not in the room when Subject 1's jeans fell off of him.

officers appear to have difficulty in removing the handcuffs. Subject 1 is then laid on the floor, where his handcuffs were removed. The officers leave the cell at 02:51:53. Subject 1 is now only in his boxers but his private areas are completely covered. Subject 1 lies on the floor till 03:08:20, when he moves to the bench. Subject 1 remains lying on the bench until 0611 hours when he sits up. Subject 1 appears visibility agitated and is either talking or yelling. At 0614 hours, Subject 1 lies back down and remains there until officers come to take him out of his cell at 0725 hours for court. (Attachments 66-67)

Subject 1's **Central Booking photographs** show that a black male officer has his hand on the back of Subject 1's neck during the photographs. Subject 1 did not have any obvious injuries in the photographs. (Attachment 7)

According to **IPRA Inv. 1** in a report dated 14 December 2012, she and IPRA Inv. 2 went to the 005th District station on 13 December 2012 to obtain information about Officer A's Taser deployment in the lockup facility. The investigators spoke to Lt. A , Sgt. A, and Sgt. C and learned about the basic facts of Subject 1's arrest and processing, including the Taser deployments in lockup and at the hospital. Inv. 1 and Inv.2 asked whether Subject 1 had been under the influence of drugs or alcohol during his initial arrest. The department members said that he did not, but that he appeared to be "crazy." The investigators asked why officers hadn't taken Subject 1 directly to Jackson Park Hospital for a psychiatric evaluation. According to the report, Lt. A responded that CPD would have lost physical custody of Subject 1 if he had been admitted to a psychiatric hospital, which would have compromised CPD's power to bring charges against Subject 1 for battering the officers during his arrest. According to the report, Lt. A also wanted to make sure that blood was drawn from Subject 1 so it could be tested for any communicable diseases. According to the report, Sgt. A informed the investigators that Subject 1 was shouting profanities and religious comments while he was in lockup. (Attachment 268)

According to **Lt. A** in a deposition provided on 21 January 2014, he was working as a lieutenant[54] on 12 December 2012 and learned about the circumstances of Subject 1's arrest. Lt. A did not recall who notified him about the incident, but he learned, via either radio or telephone, that an arrestee (Subject 1) had battered two officers during his arrest. Because of this, the officers who were transporting Subject 1 asked for, and received, permission to bring him straight to the lockup facility when they arrived at the station. The normal procedure is for officers to have an arrestee wait in the processing area while they complete the related reports. After the reports are completed, the officers bring the arrestee to lockup so they can be processed there. In this instance, the officers wanted to bring Subject 1 straight to lockup so that there would be no further commotion. Lt. A was informed that paramedics had seen Subject 1 on the scene and that Subject 1 was okay and only had a small cut in his mouth. There were no reports that Subject 1 was not acting rationally. When Subject 1 arrived at the station, Lt. A saw two officers escort him to lockup. Lt. A was at the station's front desk at the time and he could see the officers walk down the hallway toward lockup. Lt. A did not get a close look at Subject 1, but he saw that Subject 1 was handcuffed and did not appear to be resisting the officer's attempts to escort him to lockup. At some point after Subject 1 arrived in lockup, Lt. A entered the lockup for his normal check. Lt. A asked the lockup staff how Subject 1 was acting and learned that

[54] Lt. A did not specify what his assignment was. CPD records reveal that he was the third watch station supervisor on 12 December 2012.

Subject 1 was calm. Lt. A used the monitor to observe Subject 1 in his cell and noticed that Subject 1 appeared to be calm. Lt. A later went to the hospital to talk to Sgt. B and Officer I, who received treatment there. Lt. A also talked to Officer H, who was at the hospital with them. They told Lt. A that Subject 1 had beaten his mother. As officers were placing him in the squadrol, Subject 1 spit blood in the eyes of Sgt. B and Officer I. None of the officers involved in the arrest mentioned anything about Subject 1 making comments about Satan or the devil. Sgt. B told Lt. A that he asked Subject 1's father whether Subject 1 had a history of mental illness, who responded that he did not.

When Lt. A arrived at the station for his work shift the following day, Sgt. A informed him that Subject 1 had refused to go to court and a Taser had been discharged at him in lockup. Lt. A also learned that Subject 1 had been taken to Roseland Hospital, where an officer discharged a Taser at him again. As far as he was aware, at the time Lt. A arrived at work, Subject 1 was still being treated at Roseland Hospital. A detective and state's attorney[55] arrived at the 005th District and requested to see the video of what happened with Subject 1 in lockup. The detective, state's attorney and Lt. A went to the lockup facility and viewed the recording from the camera showing Subject 1's cell. Lt. A described what he remembered from the video, which is that officers entered Subject 1's cell and had a conversation with him. At some point, Subject 1 jumped up from where he was sitting and Officer A deployed a Taser at him. He did not see Subject 1 kick, strike, or spit on anyone. According to Lt. A, he could not determine why Officer A used his Taser on Subject 1 because the camera's angle did not provide a view of what the officers in the cell could see. Either Sgt. A or Officer A informed Lt. A that Officer A used the Taser because Subject 1 became an assailant. Officer A was trying to prevent Subject 1 from battering anyone.

Lt. A later was present when IPRA Inv.1 and Inv. 2 were in the watch commander's office. Sgt. A and Sgt. C were also present in the office. Lt. A did not recall everything that was discussed, but he remembered telling the IPRA investigators about what happened during Subject 1's arrest. Lt. A did not say anything about Subject 1 appearing to be crazy. When asked why Inv. 1's report said the Department members referred to Subject 1 as crazy, Lt. A did not know who would have said that. He said that the word "crazy" was actually used by Inv. 1 herself. Lt. A had not had any interaction with Subject 1 that would allow him to determine that, and he did not believe that Sgt. C had enough interaction to make such an assessment. Lt. A 's brief glimpse of Subject 1 as officers were escorting Subject 1 to lockup did not provide him enough time to determine whether Subject 1 was under the influence of drugs or alcohol. None of the Department members who arrested and/or processed Subject 1 reported that they believed he was under such influence. Lt. A denied that he told Inv. 1 that he did not want CPD to lose physical custody of Subject 1 or that bringing Subject 1 to a psychiatric hospital would have prevented prosecution of battery charges. According to Lt. A, Inv. 1 proposed a hypothetical question about what would happen if Subject 1 had gone to Jackson Park Hospital. One of the answers Lt. A provided was that CPD would no longer have physical custody of him in that case. Lt. A did not consider this to be a "concern" but merely a "fact."[56] According to Lt. A, that Inv. 1's report is not an accurate representation of the questions he and the sergeants were asked and the answers they provided. He noted that some comments he made were "packaged together

[55] Lt. A did not remember the names of the detective and state's attorney with whom he spoke.
[56] Lt. A deposition, Attachment 211, page 61, lines 7-8

completely wrong,"[57] giving the impression that he said things he did not actually say.

According to Lt. A, if Subject 1 displayed symptoms of someone who suffers from mental illness that would not necessarily mean that he needs to go to the hospital. If such an arrestee becomes a danger to themselves or others, that would require them to go to the hospital. Although Subject 1 was a danger to others when he battered his mother, he calmed down when he was in custody and was no longer a danger. Lt. A noted that Subject 1 was indeed taken to Roseland Hospital after he lost control when the officers tried to take him to court. The assumption was that the hospital staff would assess Subject 1 and determine what treatment he needed, including mental health treatment. Lt. A previously worked with people with mental illness through his assignment with CAPS. In those instances, Lt. A would assist family members when someone stopped taking their prescribed medication. Lt. A did not ever assist in a situation where an individual with no history of mental illness was acting in a scary or irrational manner. (Attachment 211)

In an accused statement for this investigation on 13 July 2016, **Lt. A** provided essentially the same account of his involvement in this incident as in his deposition. Lt. A added that he believed Sgt. B was the one who called him from the scene of Subject 1's arrest. Sgt. B informed Lt. A that Subject 1 had spit blood on him and another officer. This led Lt. A to believe that Subject 1 had a cut in his mouth. Lt. A was aware that there were ambulances on the scene of Subject 1's arrest for Citizen 2 and for the officers. The paramedics visually saw Subject 1. Lt. A assumed that the paramedics would have called for another ambulance to treat Subject 1 if he had any visible signs of injury.

Lt. A was at the front desk when Subject 1 arrived at the station. Lt. A briefly saw Subject 1 as officers escorted him to lockup. Lt. A described that officers were on each side of Subject 1 and holding onto his arms. The officers were guiding Subject 1 to the lockup because he did not appear to be walking on his own will. Lt. A later went into lockup to check on Subject 1. The lockup staff informed Lt. A that Subject 1 was sitting in his cell and was calming down. Lt. A looked on the monitor that displayed a view of Subject 1's cell and observed that Subject 1 was sitting still and not doing unusual. Lt. A was satisfied that Subject 1 was calming down and that the officers could proceed with processing him. The lockup staff reported that Subject 1 was making religious comments against them. Lt. A explained that he did not find this to be alarming because it is not unusual for arrestees to make comments like that.

Once Lt. B arrived to relieve Lt. A as the station supervisor for the next shift, Lt. A went to the hospital to check on Sgt. B and Officer I. Lt. A also asked about Citizen 2 and learned that she had been beaten up. Lt. A made sure that an Evidence Technician was going to photograph Citizen 2 's injuries and that the officers were going to complete the necessary paperwork for Subject 1's arrest. At that point, Lt. A finished his shift for the night.

On 13 December 2012, Lt. A was at the 005th District station for the start of his shift. He had already been informed that Subject 1 was taken to the hospital and was in medical distress due to the medication that was given to him there. Someone told Lt. A that Citizen 3 was at the station looking for Subject 1. Lt. A informed Citizen 3 that Subject 1 was at Roseland Hospital

[57] Lt. A deposition, Attachment 211, page 62, line 19

and that Citizen 3 should get there immediately because Subject 1 was very ill. Lt. A then called the officers who were guarding Subject 1 at the hospital and instructed them to allow Citizen 3 to see his son.

Upon being asked about the conversation with IPRA Inv. 1 and Inv. 2, Lt. A stated that he did not say that Subject 1 was "crazy." According to Lt. A, the conversation was about whether Subject 1 was drunk, high, crazy, angry, or what. At the time, no one knew what was wrong with him. They wondered if Subject 1 had a drug overdose because he appeared to be physically healthy but had coded, meaning that he was in grave condition, when he got to the hospital. It was not until much later that Lt. A learned that Subject 1 had coded in response to medication provided by the hospital. Lt. A explained that, to him, the word "crazy" is a broad term that encompasses many different types of behavior. Lt. A considers people who batter their family members to be "crazy" because they are exhibiting abnormal anti-social behavior. Whether or not someone who needs to be evaluated for mental health purposes, however, depends on whether that person is a danger to themselves or others. Lt. A explained that Subject 1 did not fall into that category because Subject 1 was sitting calmly in his cell and did not appear to be in any distress during Lt. A 's shift. Lt. A added that, as a watch commander or station supervisor, he does not have to approve whether someone gets medical and/or mental health treatment if needed. Any CPD member who believes an arrestee needs such treatment can call an ambulance to come to the station, they just need to inform the supervisor that they have done so. Lt. A stated that he would have made sure that Subject 1 received a mental health evaluation if it appeared that he needed one. (Attachment 284)

According to **Lt. B** in a deposition provided on 31 January 2014, he was working as the station supervisor during first watch on 13 December 2012. His shift started at 2030 hours on 12 December 2012 and ended at 0500 hours the next morning. When Lt. B arrived at the station to start his shift, Lt. A informed him that there was a combative arrestee (Subject 1) in lockup. Subject 1 had been taken straight to lockup when he arrived at the station and had not yet been fingerprinted. Lt. A also said that two officers (Sgt. B and Officer I) were at the hospital because Subject 1 had spit blood at them during his arrest, which was for Domestic Battery. Sgt. B and Officer I were going to complete TRRs when they returned from the hospital, which Lt. B would have to approve.

When the first watch lockup staff started their shifts at 2200 hours and conducted their first check of the lockup cells, they discovered that Subject 1 had a sheet in his cell. According to Lt. B, this is not the normal practice. For safety reasons, Lt. B prefers that arrestees not have sheets with them in their cells. Lt. B went to Subject 1's cell. Subject 1 complied with Lt. B's directions to get up and to put his hands on the wall while Lt. B entered the cell and removed the sheet. Knowing he would have to eventually approve Sgt. B and Officer I's TRRs, Lt. B asked Subject 1 if he wanted to talk about what happened during his arrest but Subject 1 declined. Lt. B next saw Subject 1 when Lt. B accompanied Detective A to lockup to see if Subject 1 wanted to make a statement. Lt. B did not interact with Subject 1 at that point but merely stood out of the way while the detective talked to him. Subject 1 again declined to make a statement, saying that he wanted to talk to an attorney first. Lt. B and Detective A then left lockup.

At some point after that, Citizen 3 approached Lt. B in the 005th District lockup.

Detective A was also nearby during this conversation but did not participate in it. Citizen 3 asked if his son was okay. Lt. B informed Citizen 3 that he had just seen Subject 1, who was sitting on the bench in his cell and appeared to be fine. Citizen 3 asked if he could go to lockup to see Subject 1 but Lt. B would not allow it. According to Lt. B, the reason he denied the request was that Subject 1 had been charged with battering his mother, who was Citizen 3's wife, and that Subject 1 had broken the window of Citizen 3's vehicle. Lt. B did not know what precipitated that incident and did not want to allow another family in to speak to Subject 1. Lt. B stated that he would never allow a family member who had been involved in a domestic altercation to go into lockup to talk to someone who had been arrested during that altercation. Lt. B acknowledged there is a CPD policy that says arrestees should be allowed a visit from a family member,[58] but pointed out that the policy also says that this should not be allowed if extenuating circumstances can affect the safety of the arrestee or visiting family member. Lt. B said that he did know enough about what caused the altercation to know whether it would continue if Citizen 3 was allowed into lockup, but he did not want to take any chances. Lt. B told Citizen 3 that he would "keep an eye" on Subject 1 for the remainder of his shift.[59] According to Lt. B, this conversation with Citizen 3 was brief and only lasted one or two minutes. Lt. B did not have any further interaction with Citizen 3.

When it was time for Subject 1's fingerprints to be taken, Lt. B went to lockup to make sure that the process went smoothly. Detective A was with Lt. B in lockup, as well as the three CPD members who were assigned to the lockup during that shift. One of the lockup staff told Subject 1 to exit his cell so they could bring him to the front and take his fingerprints. Subject 1 complied with their direction and walked to the fingerprint machine in the processing area. Subject 1 was not handcuffed at this point. Subject 1 initially continued to obey directions and cooperated with the fingerprinting. Partway through the process, Subject 1 suddenly tensed his arm and would not allow the detention aide to put his hand on the fingerprint machine. Lt. B did not recall Subject 1 saying anything at that point, he just would not move his arm. Lt. B explained that the fingerprint system only requires seven or eight fingers to be placed on the machine. They only needed one or two more fingers at that point to finish Subject 1's fingerprints. Lt. B stepped forward and placed his hand on the back of Subject 1's neck while the lockup staff tried to get Subject 1's hand to the machine. Other officers had their hands on Subject 1 at the same time, in an effort to prevent him from moving away from the machine. They were able to get enough of his fingers scanned so the machine could register it. According to Lt. B , he did not recall Subject 1 yelling or saying anything during this process. After it was done, the lockup staff escorted Subject 1 back to his cell. Again, he was not handcuffed. Lt. B and Detective A went with them to the cell. Subject 1 did not resist anyone as they placed him back in his cell.

The next time Lt. B interacted with Subject 1 was when they took him to be photographed. The normal process is for an arrestee to be photographed immediately after being fingerprinted. They waited in this case because Subject 1 had not been compliant with the fingerprinting process. Lt. B explained that the fingerprint system would not allow any other

[58] Special Order 06-01 II.B.12. requires that station supervisors "allow the arrestees a reasonable number of visitations by an attorney of their choice and/or a member of their family unless there is an imminent danger of escape."
[59] Lt. B deposition, Attachment 251, page 29, line 18

arrestees to be processed until Subject 1's photographs were taken.[60] Lt. B therefore decided that they should take Subject 1's photographs so that incoming arrestees could be processed. When Lt. B went to Subject 1's cell, he brought other officers who were in the station on unrelated matters. Because Subject 1 had become uncooperative during fingerprinting, and because they would have to use the camera in the female side of lockup, Lt. B wanted to make sure there were enough officers present to escort Subject 1 to be photographed. When they arrived at Subject 1's cell, someone handcuffed him. Officers accompanied Subject 1 as he exited his cell on his own. Once he reached the hallway, however, he stopped walking and tried to stand still. The officers who were escorting him continued to walk, so Subject 1 walked with them. The only thing Lt. B remembered Subject 1 saying was to call out to Jesus for help. Once they reached the photograph area on the female side of the lockup facility, Subject 1 tried to turn and walk away from the officers. One of the officers held Subject 1 by the shoulder area in order to keep him still for the photographs. An officer also lifted Subject 1's head because Subject 1 kept trying to turn away from the camera. The first photograph had to be discarded because Subject 1 moved out of frame while it was being taken. Ordinarily, officers will take photographs of any scars or tattoos of a compliant arrestee. Because Subject 1 was not cooperating with them, they decided that it would be too difficult to take the extra photographs. Officers then returned Subject 1 to his cell. Subject 1 walked slowly as the officers brought him back to his cell. According to Lt. B, he did not realize at the time that Subject 1's pants had fallen off during the process of photographing him. Lt. B noticed this for the first time when he watched the video prior to his deposition. He also saw that one of the detention aides retrieved the pants and returned them to Subject 1 in his cell. When asked why Subject 1 was not allowed to have his pants pulled up to the normal position, Lt. B said that it appeared as if the pants being down were not hindering Subject 1's ability to walk.[61] Subject 1 remained in handcuffs until he was back in his cell, at which point the officers removed the handcuffs. Lt. B recalled that Subject 1 was on the floor in his cell at some point when he returned, possibly when the handcuffs were being removed. Lt. B did not see any of the CPD members force Subject 1 to the floor, and no one reported that they performed a takedown of any kind. Lt. B stated that Subject 1 was conscious throughout this interaction, and that Subject 1 always appeared to be completely rational in Lt. B's presence.

At the end of his shift, Lt. B was relieved by Sgt. A, who was the district station supervisor for second watch. Lt. B informed Sgt. A about Subject 1, saying that there was a combative arrestee in lockup who had already been fingerprinted and photographed.

According to Lt. B, it is his understanding that what to do with an arrestee who is in custody and needs a mental health evaluation or treatment depends on what their charges are. It is Lt. B's belief that the station supervisor has the discretion to send an arrestee to the hospital, but they would consult with the ASA and detective assigned to the case if necessary. According to Lt. B's understanding of the relevant policies, if an arrestee is charged with a bondable offense, meaning that the arrestee does not have to go to bond court, the arrestee will either be bonded out at the station or released without charges and the victim will be advised to seek a warrant at a later date. The arrestee would then be brought to the hospital. If it is not a bondable offense, as in this case, the officers would have to take the arrestee to the hospital and stay with

[60] In his subsequent statement to IPRA, Lt. B explained that he later learned there was a way to bypass this in the system.
[61] Lt. B deposition, Attachment 251, page 98, lines 9-10

them. If doctors determined that the arrestee needed to be admitted, a guard detail would be established so that officers would remain with the arrestee until custody was transferred to Cook County Sheriff's officers. Lt. B reiterated that he did not believe that Subject 1 was irrational or in need of a mental health evaluation. He noted that the fact that an arrestee is combative and uncooperative does not necessarily mean that they are in need of a mental health evaluation. (Attachment 251)

In an accused statement for this investigation on 11 August 2016, **Lt. B** provided essentially the same account of his involvement in this incident as in his deposition. Lt. B added that Lt. A informed him that there was a combative arrestee (Subject 1) who was brought directly to lockup when he arrived at the station and had not yet been processed. Lt. B did not recall whether he knew specifically how Subject 1 had been combative, just that it happened during his arrest. The first contact Lt. B recalled having with Subject 1 was when Lt. B entered the cell to retrieve the sheet that the lockup staff reported they found. Lt. B described Subject 1 as calm and compliant at that point and said that Subject 1 followed directions to stand up and put his hands on the wall as the lieutenant entered the cell to retrieve the sheet.

The next encounter Lt. B recalled having with Subject 1 was when he went to lockup to oversee the fingerprinting process. Lt. B explained that he did this because of the reports that Subject 1 was combative during his arrest. Lt. B just wanted to make sure that everything was okay. Lt. B described Subject 1 as initially cooperative but that he suddenly stopped cooperating midway through the process and tensed his arms. Lt. B did not recall the specific conversation that was occurring when Subject 1 tensed his arms. There were several people talking to Subject 1 off-and-on at that point and Lt. B did not pay attention to what people were saying. After the fingerprints were done, Lt. B had officers return Subject 1 to his cell before having him photographed. According to Lt. B, he previously experienced arrestees who would not initially cooperate with processing but who later did comply after having a chance to calm down. Lt. B thought that would work with Subject 1.

When Lt. B returned to have Subject 1's photographs taken, he brought additional officers with him because they had to bring Subject 1 to the female side of the lockup facility to use the functioning camera located there. Lt. B wanted to be prepared with extra officers in case Subject 1 became combative as he had done during his arrest. Although Subject 1 did not become combative, but he was uncooperative as they took his photographs. Two officers had to hold Subject 1 in place so the photographs could be taken. One of the lockup personnel told Lt. B that incoming arrestees could not be processed until Subject 1's processing was finished. He later learned that there may have been a way to bypass Subject 1's place in the queue so that other arrestees could be processed, but Lt. B was unaware of that capability at the time of the incident. Subject 1 yelled out occasionally while this was happening, including yelling for Jesus to help him. Lt. B did not find these comments to be out of the ordinary.

Lt. B did not remember Subject 1's pants falling down. He saw the video recording from lockup that showed the pants falling down, but he had no independent recollection of that happening. Lt. B surmised that he may not have been looking down at that time so he would not have seen it. He was aware that one of the lockup personnel picked up the pants at some point.

After the photographs were done, the officers brought Subject 1 back to his cell. They placed him on the floor of the cell to remove the handcuffs. Lt. B explained that this is the easiest way to remove handcuffs from an arrestee who is not compliant. Lt. B did not recall having any further contact with Subject 1, although he may have seen him during his further checks of the lockup.

According to Lt. B, in his experience, most arrestees cooperate with the lockup processing. However, there occasionally are arrestees who realize the severity of their situation once they reach lockup and refuse to cooperate. Lt. B likened Subject 1's behavior to that previous experience. According to Lt. B, there was nothing that Subject 1 was doing or saying that was alarming to Lt. B or that indicated to him that Subject 1 was in need of mental health treatment. Lt. B did not believe that he ever asked if Subject 1 wanted to go to the hospital, and he added that Subject 1 never asked to go to the hospital.

Lt. B had a conversation with Citizen 3 at some point during the night. He did not remember at what point during his shift this conversation happened. Lt. B did not recall Citizen 3 saying anything specific about Subject 1's behavior. Citizen 3 asked if Subject 1 was okay and asked to go to lockup to see his son. Lt. B did not recall Citizen 3 saying that Subject 1 was having a mental breakdown, or that he was acting out of the ordinary, or that he needed to go to the hospital. Lt. B's understanding of CPD policy is that whether or not an arrestee should be allowed to see a family member was up to the station supervisor's discretion. Upon reviewing the relevant portion of Special Order S06-01,[62] Lt. B acknowledged that the order did leave the decision up to the station supervisor's discretion. According to Lt. B, he based his decision on the fact that Subject 1 had been charged with battering his mother, who is Citizen 3's wife. During the incident preceding his arrest, Subject 1 also broke the windows of Citizen 3's car. Although Citizen 3 did not pursue charges against Subject 1 for breaking the windows, Lt. B did not want to incite any negative reaction from Subject 1 that would cause the officers to have to physically bring him back to his cell. Lt. B acknowledged that there are rooms in the 005th District station where arrestees can speak to their attorneys. When asked whether one of those rooms would have been available for Citizen 3 to talk to Subject 1 without entering Citizen 3 lockup, Lt. B said that he did not know. According to Lt. B, he did not recall ever having the parent of an adult arrestee asking to see their child and he did not know what the best way to facilitate such a meeting.

Lt. B acknowledged that he completed the Report of Exposure to Communicable Disease/Hazardous Material related to Subject 1 spitting at Sgt. B, although he did not have any independent recollection of completing the report.[63] According to Lt. B, the normal practice in completing these reports is to get an account of the incident from the involved member and to

[62] Section II.B.12 says that station supervisors in charge of detention facilities will "allow the arrestees a reasonable number of visitations by an attorney of their choice and/or a member of their family unless there is imminent danger of escape. Such visits will be permitted in accordance with the Department directive entitled 'Arrestees' Communications.'" The Arrestees' Communications directive, which is now titled "Arrestee and In-Custody Communications," is General Order G06-01-04. That order reiterates that such visitations will be allowed unless there is a danger of escape, however, Section III.C.2 says that visitation may be denied if, "in the judgment of the station supervisor, it would not be prudent to do so at that time. In this case, the station supervisor must have a sound, articulable justification for denying the visitation request."
[63] See Attachment 24.

write that on the report. Upon review of the relevant section of General Order G04-09-02,[64] Lt. B stated that he did not recall attempting to have Subject 1 tested for any communicable diseases. This testing would be done at the hospital rather than at the station. Lt. B did not recall any specific training he received regarding this testing. He did not know what the process was for the testing to take place, or whether there was a separate form that was required to do so. Lt. B noted that Subject 1's information was on the report but did not recall whether he forwarded the report to the Office of Legal Affairs as required by the General Order. (Attachment 288)

According to **Detective A** in a deposition taken on 12 March 2014, he was assigned to investigate the domestic altercation between Subject 1 and his mother, Citizen 2, and what happened during Subject 1's arrest. Detective A went to Metro South Hospital and interviewed Citizen 2. In telling Detective A what happened, Citizen 2 said that Subject 1 had been crying and that he had a "breakdown."[65] Detective A also interviewed Sgt. B and Officer I at the hospital. Detective A returned to the 005th District and spoke to Officer F, who reported that Citizen 3 had told her that Subject 1 was "acting crazy."[66] Detective A then entered the lockup facility to talk to Subject 1. Detective A introduced himself and asked if Subject 1 knew why he was there. Subject 1 responded, "I can only be judged by God."[67] Subject 1 would not answer any of Detective Connolly's questions, which were general in nature about who Subject 1 was, where he lived, and if he knew why he was in lockup. According to Detective A, he was trying to determine whether he could interview Subject 1 about the incident between him and Citizen 2 . Detective A determined that such an interview would not be productive at that time and left the lockup. He described the interaction as being brief, only one or two minutes. According to Detective A, he did not form any opinion as to Subject 1's mental status at that point; he only determined that an interview would not be productive.

After attempting to interview Subject 1 in lockup, Detective A had a telephone conversation with Citizen 3. At some point after that, Citizen 3 arrived at the 005th District station. Detective A met him in the station's lobby and spoke to him there. Citizen 3 aid that he wanted the officers to take Subject 1 to the hospital because he believed that Subject 1 was having a "breakdown"[68] Detective A brought Citizen 3 to the lobby desk where Citizen 3 spoke to Lt. B . Citizen 3 told Lt. B that there was something wrong with Subject 1 and that he did not want Subject 1 to be charged with a crime. Citizen 3 wanted Subject 1 to be brought to the hospital instead. Lt. B denied the request to bring Subject 1 to the hospital and explained that Subject 1 would be going to bond court in the morning. In denying the request to bring Subject 1 to the hospital, Lt. B explained that Subject 1 was calm in lockup. Citizen 3 said that he would help the officers bring Subject 1 to the hospital and asked to be allowed into lockup in order to do so. Lt. B denied that request and said they (apparently meaning CPD) could not allow it.

After the brief conversation between Citizen 3 and Lt. B, Detective A brought Citizen 3 upstairs to the detectives' area.[69] Detective A interviewed Citizen 3 about the incident leading up

[64] Section II.C.3 says that "in cases where the source has not been tested, an attempt will be made to obtain the source individual's written informed consent for testing.
[65] Detective A deposition, Attachment 216, page 12, line 3
[66] Detective A deposition, Attachment 216, page 17, lines 14-15
[67] Detective A deposition, Attachment 216, page 14, lines 5-6
[68] Detective A deposition, Attachment 216, page 21, line 8
[69] Area South Detective Division shares a building with the 005th District but is a separate unit. The CPD members

to Subject 1's arrest. During the interview, Citizen 3 again expressed his concern for Subject 1's mental health. According to Detective Connolly, Citizen 3 said that he had never seen his son act in that manner. Citizen 3 later repeated this same concern when speaking to the Assistant State's Attorney who interviewed him. After the interviews were over, Citizen 3 remained at the station to learn what Subject 1's charges would be. Detective A explained the charges to him and provided the information regarding Subject 1's bond hearing.

At the ASA's request, Detective A returned to the lockup facility a second time to see if Subject 1 would agree to be interviewed. Lt. B was with him when he talked to Subject 1. Detective A asked if Subject 1 wanted to talk to a lawyer, and Subject 1 said yes. While Detective A was in lockup, the lockup staff brought Subject 1 to be fingerprinted. Subject 1 voluntarily left his cell and was not handcuffed. Subject 1 was initially cooperative with the fingerprinting process, but then he stiffed his arm to prevent the staff from taking his fingerprints. Subject 1 was yelling something that Detective A could not remember. Detective A tried to calm Subject 1 by saying that no one was going to hurt him. Detective A was unable to determine what caused Subject 1 to become upset; there appeared to be no apparent reason for it. Detective A could not remember whether any of the lockup staff pushed Subject 1 toward the fingerprint machine, and he did not know whether the lockup staff were able to complete the fingerprint process. The CPD members who were present escorted Subject 1 back to his cell. Detective A stated that he may have put his hand on Subject 1 to guide him back to the cell. Detective A did not see Subject 1 again after he was placed back in his cell. According to Detective Connolly, he had not formed any opinion about Subject 1's mental state after that interaction.

Detective A testified about each of the interviews he conducted in his investigation. Detective A explained that Citizen 2, Citizen 3, Citizen 1, and Citizen 5 (Subject 1's girlfriend) all described that Subject 1 was having some sort of breakdown and was not acting like he normally does. They said that Subject 1 had been depressed recently about not being able to find a job, but that his behavior before his arrest was something that they had never seen. (Attachment 216)

According to **Lt. C** in a deposition taken on 06 February 2014, he was scheduled to start work at 1330 hours on 13 December 2012. Earlier in the day, Lt. A telephoned him and said that there had been an incident where an arrestee (Subject 1) was taken to the hospital where he "crashed"[70] after being administered medication. Lt. A asked Lt. C to start his shift early to help with the paperwork related to the incident. Sgt. A was the station supervisor at the time and someone of a higher rank was needed to approve reports. Lt. C arrived at the 005th District station at approximately 1100 hours. Subject 1 was at Roseland Hospital by the time Lt. C arrived at the station. Lt. C did not have any contact with Subject 1 at any point.

Lt. C spoke to Sgt. A and Sgt. C about what happened. He did not recall if he talked to them separately or together. Sgt. A told Lt. C that Subject 1 had refused to exit his cell to go to court and became combative with the officers. An officer (Officer A) deployed his Taser at

assigned to the detective division do not have any control over the 005th District station operations, including the lockup facility.

[70] Lt. C deposition, Attachment 245, page 10, line 9

Subject 1 after Subject 1 crouched down into a "combative stance."[71] An ambulance then brought Subject 1 to Roseland Hospital. Sgt. C told Lt. C that Subject 1 attacked doctors and nurses at the hospital and needed to be restrained. Sgt. C reported that he was present at the hospital when this happened.

Lt. C approved several Tactical Response Reports and Officer Battery Reports related to this incident. Lt. C testified that, except for Sgt. C, he did not speak directly to any of the officers who completed the reports and did not check the veracity of what each report contained. He spoke to Sgt. C , who had already reviewed the reports and talked to each of the reporting officers. According to Lt. C , he does several things when he reviews the reports to be approved: he checks to see whether the officers' actions followed the CPD use of force guidelines; he compares what was included in the reports with the accounts provided to him by Sgt. C; and he looks for inconsistencies between the reports themselves. If he had found any discrepancies between what Sgt. C told him and what was in the reports, Lt. C would have talked to the reporting officers directly. Likewise, if the officers had described Subject 1's actions in different ways (i.e., if one called him a passive resistor and another called him an assailant), Lt. C would have spoken to the officer and the supervisor to figure out why the discrepancy existed. None of these discrepancies occurred in this case.

According to Lt. C, neither Sgt. A nor Sgt. C said anything to him about Subject 1's mental status. They said he "went crazy"[72] at the hospital but did not say anything about suspecting that he might have a mental illness. (Attachment 245)

III. INCIDENT LEADING TO REMOVAL FROM LOCKUP

A **video recording** from the 005th District lockup facility captured some of the contact between Department members and Subject 1 while he was in his cell. A camera directly across from his cell reveals that six Department members (now known to be Sgt. A, Sgt. C, Officer A, Officer C, Officer B, and Detention Aide A entered Subject 1's cell on 13 December 2012 at approximately 0726 hours. This video recording was captured by the camera that was positioned directly across from Subject 1's cell as described above, and also includes the privacy effect. The recording shows that Subject 1 was sitting on the bench in his cell when the Department members entered. Although it does not capture what was said, the video recording shows there was a verbal dialogue between the Department members and Subject 1 that lasted approximately one-and-a-half minutes. The video recording shows that an officer, now known to be Officer A, had a Taser in his hand while this verbal dialogue was taking place.

After approximately one-and-a-half minutes of conversation with the officers, Subject 1 moved from or on the bench. The exact nature of his movement is not visible in the video recording because it takes place in the area of the cell that is masked by the privacy effect. The video then shows that Officer A deployed the Taser at Subject 1 and the other Department members moved toward Subject 1, surrounding him. Sgt. A was behind Subject 1 and put his hands or arms on or near Subject 1's shoulders/neck/upper body area. Sgt. A appeared to pull Subject 1 toward himself. It is not clear whether Sgt. A's hands or arms reached Subject 1's

[71] Lt. C deposition, Attachment 245, page 14, line 7
[72] Lt. C deposition, Attachment 245, page 21, line 9

throat in a way that would restrict airflow.[73] The subsequent actions of the Department members and Subject 1 are not clearly visible because the view of the camera is obscured. At approximately 0729 hours, Subject 1 is shown lying face-up on the floor. According to CPD reports and officer statements, Subject 1 had been restrained by handcuffs and leg shackles at that point, but that is not clear on the video. The video shows that Detention Aide A grabbed Subject 1 by the hands or handcuffs and dragged Subject 1 out of the cell with his body dragging behind. A video recording from another camera in the lockup facility shows that, once they emerged from the cell, Detention Aide A dragged Subject 1 down the hallway of the lockup facility. The video also shows Sgt. A, Officer A, and Officer B walking behind and watching Detention Aide A as he drags Subject 1 down the hallway. Sgt. C and Officer C walked behind Sgt. A, Officer A, and Officer B, in a position to see at least part of how Detention Aide A dragged Subject 1. (Attachments 66-67)

Tactical Response Reports from each of the six Department members involved in the lockup incident describe Subject 1 as an Assailant.

According to Sgt. A's report, Subject 1 did not follow direction, stiffened his body, kicked his feet, and attacked without a weapon. Subject 1 also refused to be handcuffed so he could be transferred to court. Sgt. A responded with member presence, verbal commands, and by holding Subject 1's arms. Sgt. A noted that Subject 1 was making religious comments and that a Taser was deployed.

According to Sgt. C's report, Subject 1 did not follow directions, stiffened his body, pulled away, stood and advanced on the officers, prepared to spit at them, and attacked without a weapon. Sgt. C responded with member presence and takedown/emergency handcuffing.

According to Officer A's report, Subject 1 did not follow directions, stiffened his body, pulled away, posed an imminent threat of battery, attacked without a weapon, and used force likely to cause death or great bodily harm.[74] Officer A responded with member presence, verbal commands, and by using a Taser by laser targeting and probe deployment.

According to Officer C's report, Subject 1 did not follow directions, stiffened his body, pulled away, posed an imminent threat of battery, attacked without a weapon, and used force likely to cause death or great bodily harm.[75] Officer C responded with member presence, verbal commands, escort holds, open hand strike[76] and takedown/emergency handcuffing. Officer C noted that Subject 1 appeared to be irrational.

[73] Watching this portion of the video at slower speeds does not provide clarity.
[74] According to Officer A Officer A in his statement to IPRA, he marked this action because he believed that Subject 1Subject 1 was going to punch one of the officers, which may have caused them great bodily harm.
[75] In his statement to IPRA, Officer C reported that he did not recall to which specific action he was referring when he indicated that Subject 1Subject 1 used force likely to cause death or great bodily harm.
[76] In his statement to IPRA and in his deposition for the civil suit, Officer C reported that the open hand strike was incorrect. He did not know if there was a computer error or if he accidentally selected that option when he completed his TRR, but he did not perform an open hand strike. Sgt. A also acknowledged this error in his own deposition.

According to Officer B's report, Subject 1 did not follow directions, stiffened his body, pulled away, attempted to spit blood, posed an imminent threat of battery, and attacked without a weapon. He responded with member presence, verbal commands, and takedown/emergency handcuffing. He noted that another officer on the scene discharged a Taser.

According to Detention Aide A's report, Subject 1 did not follow directions, stiffened his body, pulled away, kicked his legs, posed an imminent threat of battery, and attacked without a weapon. Detention Aide A responded with member presence, verbal commands, takedown/emergency handcuffing, and by restraining Subject 1's leg. (Attachments 26-34)

The **Taser download report** for Officer A's Taser reveals that there were three trigger pulls, each one for five seconds.[77] (Attachment 45)

According to now-retired **Sgt. A** in a deposition on 16 January 2014, the only information he received about the people who were in custody when he started his shift was that an arrestee had refused to have his fingerprints taken during the previous shift and had to be made to do so. Sgt. A later learned that person was Subject 1. Soon after he started his shift, the lockup staff informed him that Subject 1 was refusing to go to court.[78] Upon learning this information, Sgt. A went to Subject 1's cell to talk to him. Subject 1 was sitting on the bench. Sgt. A asked why Subject 1 didn't want to go to court. Subject 1 replied with a comment about Satan. According to Sgt. A, the comment about Satan was abnormal, but he had no other reason to believe that there was anything wrong with Subject 1.[79] Because Subject 1 had already declared that he did not want to go to court, Sgt. A believed that Subject 1 was faking that there was something wrong with him so he would not have to go. Sgt. A informed the lockup staff that they would send Subject 1 to court with the 005th District squadrol rather than the standard prisoner transport that collects arrestees from several district lockup facilities. Sgt. A left the lockup area and returned to the station supervisor office in the front of the station.

Sgt. A next saw Subject 1 when the squadrol was ready to take him to court. Sgt. A asked Sgt. C to help because Subject 1 was large and Sgt. A did not want anyone to get hurt while dealing with him. Sgt. A also had the transport officers (Officers A and C) and Detention Aide A with him. (Sgt. A did not specifically remember Officer B being present, but said that he may have been.) Sgt. A did not remember specifically what happened when he first entered the cell. The first action he remembered was directing Officer A to deploy his Taser.[80] Sgt. A did not remember any discussion with Officer A before they went in the cell about using the Taser.

[77] The Taser download report only registers trigger pulls, not whether electricity was actually flowing through the wires to the probes. Each pull of a Taser trigger should send electricity down the wires to the probes for five seconds. The Taser can be turned off during that five-second burst, which results in the electricity being conducted for a shorter time span. In this instance, the three trigger pulls do not correspond to three bursts of electricity. Officer A Officer A reported that the first trigger pull deployed the probes but did not result in electricity actually being conducted. He then pulled the trigger a second time, which appeared to be effective. It is not clear whether the third trigger pull documented on the download report resulted in any electricity being conducted.

[78] This happened when the main transport arrived to bring the arrestees to court. Subject 1 would not get out of his cell to get ready for that group.

[79] According to Sgt. A, he received training about what to do with an arrestee who is in need of mental health treatment, but no training about how to determine whether such treatment is needed.

[80] It should be noted that Subject 1Subject 1 was a passive resistor at this point. Had Officer A Officer A deployed his Taser when Sgt. A first told him to do so, it would have been excessive.

According to Sgt. A, he would only order Officer A to use his Taser if Subject 1 was not cooperating with the Department members. However, Sgt. A did not remember what, if any, commands were given to Subject 1 prior to him giving the order to deploy the Taser. Officer A did not follow Sgt. A's first direction to use the Taser. Officer A did not say anything about it; he just did not deploy the Taser as ordered. Sgt. A said that he preferred to use a Taser in such a situation because it is a good way to gain control and avoid a big fight. Subject 1 stood up at some point after that. Sgt. A did not remember specifically what Subject 1 did but believed that he may have kicked his legs at that point. Subject 1 also pursed his lips as if he was going to spit. Officer A deployed his Taser after Subject 1 got to his feet. Subject 1 then fell back onto the bench. Sgt. A grabbed Subject 1's right arm while other Department members grabbed his legs and other arm. Sgt. A's attention was not directed on Subject 1's legs so he was unable to see whether Subject 1 was kicking them. They were able to get handcuffs and leg shackles on Subject 1.

Once Subject 1 was restrained and lying on the floor, Detention Aide A pulled him out of the cell and brought him to the front of lockup. Subject 1 appeared to be conscious at this point. Sgt. A claimed he did not know why Detention Aide A pulled Subject 1 out of the cell by dragging him on the floor. According to Sgt. A, it was Detention Aide A who made that decision. Sgt. A acknowledged that Detention Aide A was acting under Sgt. A's direct supervision and that he could have taken action if he felt that Detention Aide A's actions were improper. According to Sgt. A, the Department members could have carried Subject 1 out of the cell and to the front of lockup, and they also could have brought him to his feet and had him walk there. According to Sgt. A, he had never witnessed someone being carried out of a cell. When he has experienced an arrestee being carried in lockup, they are usually being carried into a cell, not out of a cell. This is usually due to them fighting, and the goal was to get a combative arrestee to the cell so they could be left there. Subject 1 was removed from the cell at that point because they were going to send him to the hospital. Paramedics arrived, assessed Subject 1, and removed him from the facility to go to Roseland Hospital. (Attachment 204)

According to **Sgt. C** in a witness statement to IPRA on 27 May 2014 under Log #1058981, Sgt. C was assigned as a patrol sergeant on 13 December 2012. According to Sgt. C, Sgt. A asked for assistance getting Subject 1 ready to be transported to court because Subject 1 had been combative during his arrest the day before. Sgt. C was in the station for the start of his shift when Sgt. A asked him for assistance. Soon after that conversation, Sgt. C went to the lockup facility where he assembled along with Sgt. A, Officer A, Officer C, Officer B, and Detention Aide A. Sgt. C did not remember any specific details that Sgt. A gave him about Subject 1's behavior other than that he had been combative. According to Sgt. C, the plan was to enter Subject 1's cell and try to convince him to go to court in a cooperative manner. If that did not work, they would do a "cell extraction." According to Sgt. C, a cell extraction involves handcuffing the arrestee, putting on leg shackles if necessary, removing the arrestee from the cell, and putting the arrestee in a vehicle to be transported to court.

According to Sgt. C, when the six Department members entered Subject 1's cell, he was lying on the bench. Subject 1 gave no response when Sgt. A directed him to stand up, turn around, and put his hands on the wall so they could get him ready to go to court. The other officers also gave Subject 1 the same directions, but he ignored them. Subject 1 continued to sit

on the bench. Subject 1 moved his jaws. Sgt. C recalled having been told that Subject 1 had spit on officers during his arrest the night before and thought that Subject 1 was moving his jaws so he could spit at them. Sgt. C observed Subject 1 clench his fists and put them on the bench beside him. To Sgt. C, this indicated that Subject 1 intended to raise himself off the bench in an aggressive manner. Sgt. C moved to Subject 1's feet and put a shackle on one of his legs. Sgt. C was initially unable to shackle the other leg because Subject 1 was kicking his legs.

Sgt. C recalls that one of the Department members gave a warning about a Taser and directed Subject 1 to cooperate, to which he failed to comply. According to Sgt. C, Officer A deployed the Taser at Subject 1 as Subject 1 rose from the bench. One of the probes struck Subject 1, but the other wire wrapped around the legs of Sgt. C and Subject 1. Subject 1 continued to display an aggressive attitude toward the officers in the way he looked at them, but he sat back on the bench. Sgt. C was then able to shackle Subject 1's other leg. According to Sgt. C , at that point, Subject 1 stopped physically struggling with the officers, but remained passively resistant, refusing to stand or walk on his own. The officers brought him to the front receiving area of lockup, where they waited for the ambulance to arrive. Officers D and E went to Roseland Hospital with Subject 1.[81] (Attachments 193-194)

In an accused statement to IPRA on 14 April 2016 for this investigation, **Sgt. C** reiterated the sequence of events that he detailed in his statement of 27 May 2014 and provided further information about what happened during the incident. Sgt. C became a sergeant in September 2012. He did not remember whether he had been assigned as the district station supervisor between the time of his promotion and this incident three months later. His normal assignment during that time was 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. A did not ask Sgt. C to do anything specific other than to assist in getting Subject 1 out of the cell if he refused to voluntarily get ready for court. There was no specific plan in place to remove Subject 1 from the cell. According to Sgt. C, the purpose in having six Department members go to the cell was for "member presence and member safety."[82] Sgt. C explained that officers can sometimes gain compliance from an uncooperative subject merely by showing that there are other officers available to assist if the subject continues to resist. Sgt. C did not remember ever using this tactic in lockup before, but he has used it effectively in other situations as a police officer and a supervisor. Sgt. C further described the cell extraction that he referenced in his earlier statement as simply removing an arrestee from a cell. Sgt. C never received any specific training from CPD about cell extractions. He received general training about using handcuffs and leg restraints as necessary but was not trained on physically removing someone from a cell.[83] According to Sgt. C , it was Sgt. A's plan to forcibly remove Subject 1 from his cell if he did not cooperate with going to court. Sgt. A did not seek any advice from Sgt. C in determining what to do. Sgt. C had

[81] Sgt. C later responded to the hospital to assist the officers. That portion of his statement is summarized below in the section about the incident at the hospital.
[82] Sgt. C transcribed statement, Attachment 199, page 11, line 2
[83] Prior to his employment with CPD, Sgt. C worked at the Cook County Department of Corrections. He did not receive any training about cell extractions there because he was not part of the specialized team that performed those tasks.

not previously experienced an arrestee who refused to go to court. He was not aware whether Sgt. A considered leaving Subject 1 in the cell for another day. Sgt. C was not aware of Subject 1 making any specific comments about Satan, either based on his own observations or what the other Department members told him. Sgt. C did not observe Subject 1 to be in need of medical or mental health treatment, nor did any of the other Department members report such a need to him.

When the Department members were in the cell that morning, Sgt. C was in direct alignment with Subject 1's legs, so that's where his attention was focused. Sgt. C was also closer to Subject 1's legs than the other Department members. When Subject 1 stood up in a way that Sgt. C found to be aggressive, the other Department members moved back to distance themselves from him. Sgt. A directed Officer A to deploy the Taser after Subject 1 made that movement. Sgt. C's leg made contact with the Taser wire, and from the reaction that Sgt. C observed, he believed that Subject 1 felt the effect of the Taser. Sgt. C then backed away and put his hand on the rear wall for a moment before returning to complete putting the shackles on Subject 1's legs. Other officers were able to handcuff Subject 1. Subject 1 was then lying on the floor. Subject 1 continued to passively resist the officer's direction by refusing to stand up. No one brought Subject 1 to his feet or attempted to help him up. Sgt. C was in the back of the cell and the other Department members blocked his access to the doorway. Sgt. C acknowledged that he observed Detention Aide A remove Subject 1 from the cell by dragging him on the floor. Sgt. C had never before seen anyone remove an arrestee from a cell in that way. Sgt. C has not received specific training on how to move an arrestee who is handcuffed and shackled. However, in Sgt. C's view, that is typically done by using escort holds. Sgt. C was one of the last people to leave the cell. When he left, he could see the backs of Sgt. A, Officer A, and Officer B, who were directly in front of him. Detention Aide A and Subject 1 were in front of them. Sgt. C could not fully see those two, but he saw Subject 1's legs moving along the floor and assumed that Detention Aide A was continuing to drag him. According to Sgt. C, he did nothing to intervene because, in his view, Sgt. A was responsible for supervising the situation. Sgt. C did not hear Sgt. A or any of the officers say anything about Detention Aide A's actions. Sgt. C did not have a good vantage point to see what Subject 1 was doing while he was being dragged, but he did not hear Subject 1 screaming or complaining about the action.

When asked whether he believed Detention Aide A's actions to be proper, Sgt. C acknowledged that the situation could have been handled differently and that Subject 1 could have been moved to the front of lockup in a different manner. He did not step in and say anything because Detention Aide A's direct supervisor was present during the action. 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. After assessing whether he himself was okay after feeling the Taser effects, Sgt. C's focus was on making sure that someone called paramedics to deal with Subject 1 having been hit by a Taser. At the end of his statement, Sgt. C added that he felt bad about the situation and said that there was no intention to harm Subject 1 or treat him with disrespect. He was present in lockup to help in getting Subject 1 to court as quickly and as safely as possible. Sgt. C was eager for further training opportunities both for himself and for the officers under his command. (Attachments 198-199)[84]

[84] Sgt. C's deposition, which is Attachment 242, is consistent with his statements to IPRA.

According to **Officer A** in a witness statement to IPRA on 20 May 2014 under Log #1058981, he was assigned to the squadrol on 13 December 2012 with Officer C. One of his duties with the second watch squadrol is to transport arrestees to court in the morning. He encountered Subject 1 in the 005th District lockup at approximately 0730 hours. According to Officer A , Sgt. A had previously notified 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 them that Subject 1 was "not in his right mind."[85] According to Officer A, the normal procedure for preparing detainees for transport to court is for lockup personnel to assemble the detainees at the front of the lockup facility so that they can be placed into the squadrol when it arrives. Officer A understood that, based on Subject 1's past combativeness, Sgt. A anticipated that Subject 1 might be uncooperative and was preparing to have additional officers to be present to prepare Subject 1 for transport. Officer A observed Sgt. A enter Subject 1's cell. Officer A watched Sgt. A's interaction with Subject 1 over the video monitor, which does not have an audio feed. According to Officer A, he observed Subject 1 sitting on the bench while Sgt. A was talking to him. Although Officer A could not hear what was being discussed, from the body language and demeanor of the two men, Officer A believed that Subject 1 was continuing to be uncooperative. Sgt. A returned to the main area of the lockup facility and met with Officer A, Officer C , Sgt. C , Officer B, and Detention Aide A. They came up with a plan to get Subject 1 to leave the cell and go to court by trying to convince him to do so. Officer A had a Taser to use to gain control if Subject 1 became combative.

According to Officer A, Subject 1 was lying down in his cell, but he sat up on the bench when the six Department members entered the cell. Several of them tried to convince Subject 1 to get ready to go to court. According to Officer A, 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.

According to Officer A, the officers stood around Subject 1 in a horseshoe pattern; Officer A was in the middle. Officer A had his Taser in his hand when he entered the cell. Officer A purposefully turned the Taser off and on, which illuminates the light, so that Subject 1 could see that he had it. According to Officer A, Subject 1 did not react to the presence of the Taser[86] and continued to disobey the officers' commands. Subject 1 then became agitated, rose to his feet, and clenched his fists. Officer A took that to mean that Subject 1 was taking a combative stance. According to Officer A, Subject 1 then made a movement toward the officers. In response, Officer A deployed his Taser at Subject 1 and saw that the probes struck his left thigh. Subject 1 moved back and sat on the bench. Officer A believed that his use of the Taser was appropriate because a physical fight could cause injury to Subject 1 or one of the Department members in the cell. Officer A monitored the counter on the Taser[87] to make sure that it was working while the other officers attempted to restrain Subject 1. As the Department members tried to do so, Subject 1 became combative by flailing his arms and kicking his legs. Based on Subject 1's continued active resistance, Officer A believed that the Taser did not have the full

[85] Officer A transcribed statement, Attachment 187, page 8, lines 6-7
[86] It is not known whether Subject 1 actually saw the Taser or knew what it was.
[87] During both of his statements, Officer A explained that the Taser has a digital readout on the back that counts down five seconds that the electricity is conducted through the wires.

effect on Subject 1. As Sgt. C attempted to put shackles on Subject 1's legs, the wire from the Taser got wrapped around the sergeant and the electricity emanating from the Taser was conducted through the metal of the shackles to Sgt. C. Officer A observed that Sgt. C was feeling the effect of the Taser, so he turned the Taser off before the end of the five-second cycle. Officers were then able to finish putting the shackles on Subject 1. According to Officer A, his attention was mostly focused on the Taser, so he did not see the entirety of the struggle to handcuff Subject 1. Officer A did not see anyone punch or kick Subject 1 at any point. The only physical contact he saw any of the Department members have with Subject 1 was to grab his arms and legs in an effort to gain control.

According to Officer A, he did not believe that the Department members had placed handcuffs on Subject 1 because he was restrained by the leg shackles and the handcuffs would have to be removed for the paramedics to treat Subject 1 as a result of the Taser discharge.

Officer A observed that Subject 1 continued to passively resist, describing Subject 1 as "playing possum."[88] Officer A described that Subject 1 was lying still and would not respond to the Department members, but his eyes were flickering. Officer A acknowledged that he observed the officers[89] drag Subject 1 out of the cell and to the front of lockup. Shortly thereafter, the paramedics arrived and assessed Subject 1. The Taser probes were still attached to the Taser through the wires. According to Officer A, when he disconnected the Taser wires, Subject 1 opened his eyes and sat up. According to Officer A, this led further credence to his belief that Subject 1 was "playing possum." The paramedics then took Subject 1 to the hospital. (Attachments 186-187)

In an accused statement to IPRA on 12 April 2016, for this investigation, **Officer A** reiterated the sequence of events detailed in his statement of 20 May 2014 and provided further information about what happened during the incident. According to Officer A, he had a Taser with him when he entered lockup that morning because he routinely carried one when he worked. He had been issued the Taser at the start of his shift that day. According to Officer A, he had never received any training specifically about the use of a Taser in a lockup facility. Officer A described the training he received regarding Taser use as focusing on the type of subjects and situations in which Taser use is permitted pursuant to CPD policy. Officer A also noted that he had previously served as a lockup keeper for seven years. Officer A described the procedures that he had observed regarding the handling of detainees who refuse to go to court. According to Officer A, when he served as a lockup keeper, if a detainee refused to go to court, the lockup staff would notify the desk sergeant, who would then try to convince the arrestee to go to court. If that failed, the sergeant would notify the watch commander. The watch commander then would talk to the arrestee and try to convince them to cooperate and go to court. Officer A did not recall any incident where a detainee was forcibly removed from a cell for the sole purpose of getting the detainee to court. As a lockup keeper, Officer A also recalled situations where an arrestee would be held back from going to court to go the next day instead. Officer A was unaware whether anyone involved considered holding off on sending Subject 1 to court due to his uncooperative, combative demeanor that morning. In Officer A's view, that decision would be made by Sgt. A. In Officer A's experience, the only time someone did not go to court on their

[88] Officer A transcribed statement, Attachment 187, page 19, line 14
[89] Officer A did not specifically identify in this statement which CPD member dragged Subject 1.

first day in custody was if that person was getting medical attention. Officer A did not remember whether there was any discussion about bringing Subject 1 to a hospital for medical treatment and/or a mental health evaluation.

According to Officer A, the plan before the group of Department members entered Subject 1's cell was to try to convince him to go to court. There was no specific plan for Officer A to use the Taser, except that he should do so if Subject 1 became combative with them. According to Officer A , the objective for sending six Department members into Subject 1's cell was for officer safety. It was Officer A's understanding that officer safety was a concern based on Subject 1's behavior during his arrest, during which he fought with the arresting officers.

As they entered the cell, Officer A turned his Taser on and off specifically so Subject 1 would notice the Taser. According to Officer A, he usually gains compliance from a subject when he does this to show them he has a Taser. However, this had no effect on Subject 1, who continued to ignore Department member commands to get ready for court. When Subject 1 suddenly got to his feet and clenched his fist, Officer A considered him as an assailant who was putting the officers in fear of receiving a battery. When Subject 1 started, moving toward the officers, Officer A deployed his Taser. The Taser did not initially appear to affect Subject 1. In Officer A's experience, a standing subject who is hit by a Taser usually falls straight to the ground. Subject 1, however, sat back on the bench and appeared to still have his strength. When Officer A checked the digital readout on the Taser, it was blank, leading him to believe the unit was not functioning properly. Normally the digital readout displays a countdown of the time during which electricity is being conducted through the wires to the probes. Believing that the first discharge did not properly transmit, Officer A pulled the trigger a second time and saw that the counter was working properly. According to Officer A, it appeared that the Taser discharge had not been fully effective on Subject 1, because although he reacted to the charge, he was still able to flail his arms and kick his legs. Officer A stated that he interrupted the five-second cycle of the Taser when he saw that Sgt. C was being affected by the Taser. The other Department members in the cell were eventually able to get the leg shackles on Subject 1. Officer A did not remember the officers putting handcuffs on him.

According to Officer A, after Subject 1 was restrained, he was lying limply on the floor but was opening and shutting his eyes. At that point, Officer A described Subject 1 as a passive resister. Officer A observed Detention Aide A drag Subject 1 out of the cell and through the hallway to the front of lockup. Officer A has never seen another Department member remove someone from a cell in that manner. When Officer A has had to physically remove someone from a cell in the past, he has used arm bars and wrist locks. He has never received any training about how to remove someone from a cell, but that is how he has been able to do it in the past. Officer A has never experienced an arrestee who was unable to walk out of a cell and to the front of lockup on their own. Officer A did not say anything to Detention Aide A or to either of the sergeants about Detention Aide A dragging Subject 1. Officer A did not remember them having any conversation about bringing Subject 1 to his feet and giving him the opportunity to walk on his own. Subject 1 was not still struggling with the officers but was merely lying on the floor as a passive resister. The Taser was still attached to Subject 1 at this point and Officer A was monitoring it. Officer A believed Detention Aide A's action of dragging Subject 1 was proper because Subject 1 was an active resister and there was no other way to bring him to the front of

lockup. When asked if the other Department members could have assisted Detention Aide A in carrying Subject 1, Officer A acknowledged that they could have and added that one of the sergeants who were present would have made that decision. (Attachments 191-192)[90]

According to **Officer C** in a witness statement to IPRA on 10 July 2014 under Log #1058981, he was working with Officer A in the squadrol on 13 December 2012. When they arrived at lockup facility at the 005th District station to transport arrestees to court, Sgt. A and Sgt. C instructed Officers A and C to go to Subject 1's cell because he was refusing to go to court. According to Officer C, detainees are usually assembled and waiting for the transport officers in the holding cell at the front of lockup. Officer C recalls that he and Officer A entered Subject 1's cell with the two sergeants and Detention Aide A to try to convince Subject 1 to go with them.[91] Officer A had a Taser with him as he does every day. One of the sergeants told Officer A to bring the Taser with him into the lockup facility. According to Officer C, there was no specific plan in place other than to try to convince Subject 1 to go to court. When they arrived at his cell, Subject 1 was sitting on the bench and making mumbled comments about the devil. Subject 1 refused to exit the cell and did not even acknowledge that the officers were there. Subject 1 refused the officers' directions to stand up and be handcuffed. Suddenly, Subject 1 rose to his feet and clenched his fists in what Officer C referred to as a "boxer stance."[92] At Sgt. A's direction, Officer A deployed the Taser at Subject 1. Subject 1 then fell either back onto the bench or onto the floor. The other officers grabbed Subject 1 and struggled to handcuff him. Subject 1 stiffened his arms and pulled away while they were doing so which made it difficult to handcuff him, but they were eventually able to do so. Sgt. C also put shackles on Subject 1's legs. Officer C acknowledged that, after Subject 1 was restrained, he observed Detention Aide A drag him out of the cell. Subject 1 appeared to be alert at the time, but he did not say anything to anyone. Paramedics arrived and transported Subject 1 to Roseland Hospital. (Attachments 161-162)

In a deposition on 13 January 2014, **Officer C** provided a consistent account of the incident as he provided in his statement to IPRA under Log #1058981. Officer C added that Sgt. A directed him to assist with getting Subject 1 ready for court because Subject 1 was refusing to leave his cell. The only thing Officer C knew about Subject 1's arrest the night before was that it was domestic-related. Officer C was not aware that Subject 1 had spit blood on any officers during his arrest. When Officer C arrived at Subject 1's cell with the rest of the Department members, Subject 1 was sitting on the bench, talking to himself. Subject 1 was saying things about Satan and, "Don't touch me." Officer C could not say whether Subject 1 was having mental problems, but he did think that Subject 1 was acting abnormally. Sgt. A talked to Subject 1 for approximately five to seven minutes and tried to convince him to get ready for court. When this had no effect, the rest of the Department members entered the cell behind Sgt. A. The only plan Officer C remembered receiving from Sgt. A was that they should be careful and that Officer A should use his Taser if necessary.

After they entered the cell, Sgt. A continued to direct Subject 1 to stand up, turn around, and put his hands on the wall; directions which Subject 1 continued to refuse to obey. After

[90] Officer A deposition, which is Attachment 224, is consistent with his statements to IPRA.
[91] Officer C did not mention that Officer B was also present.
[92] Officer C transcribed statement, Attachment 162, page 13, line 24

several minutes of Sgt. A trying to convince Subject 1 to cooperate, Subject 1 suddenly got to his feet and took a "boxing stance"[93] with his fists clenched, which Officer C described to be threatening. Sgt. A then directed Officer A to deploy his Taser, which he did. After being struck with the Taser probes, Subject 1's body went limp. In Officer C's experience, this is not the normal effect of someone who is the subject of an effective Taser discharge. Ordinarily, someone will shake upon being receiving a Taser discharge. Subject 1 sat back on the bench. The Department members in the cell then moved forward to restrain Subject 1. Officer C had a pair of leg shackles and tried to put them on Subject 1.[94] Subject 1 resisted Officer C's efforts by moving his legs. The Department members were finally able to place handcuffs and leg shackles on Subject 1. Officer C did not recall Subject 1 saying anything after that point.

After Subject 1 was restrained with handcuffs and leg shackles, he was removed from his cell. According to Officer C, he did not remember which Department member brought Subject 1 out of the cell and to the front of lockup. He did not remember seeing Detention Aide A remove Subject 1 by holding his handcuffs. (Attachments 205)

According to **Officer B** in a witness statement to IPRA on 21 May 2014 under Log #1058981, he started his shift at 0500 hours on 13 December 2012. Officer B was assigned to the 005th District male lockup. Officer B usually worked as a patrol officer, but he had worked in the lockup two or three times each year[95] when needed. When Officer B started his shift, the detention aide[96] who had worked the previous watch gave Officer B a brief synopsis of what was going on at the lockup facility that morning. This synopsis included that there was a combative arrestee currently in the lockup facility who had spit in an officer's face. Soon after he started his shift, Officer B did a check of the lockup facility to make sure that the detainees there were in good health. According to Officer B, he observed Subject 1 merely sitting in his cell. According to Officer B, during the routine checks he conducted over the next few hours he observed Subject 1 continuing to sit in his cell without incident. Officer B did not have any verbal interaction with Subject 1 during those checks.

Anticipating that the van that transports detainees to court arrives at approximately 0700 hours, Officer B asked Subject 1 to leave the cell and get ready to go to court at 26th and California. Subject 1 gave no response to this request; he did not say anything and remained seated. Officer B informed Detention Aide A, who was the only other Department member working in the male lockup facility that morning, that Subject 1 was not responding to the request that he get ready to go to court. Detention Aide A then went to the cell and demanded that Subject 1 get ready for court. Again, Subject 1 failed to respond. Detention Aide A notified Sgt. A that Subject 1 would not respond to their directions. Sgt. A went to the cell and received the same lack of response from Subject 1.

According to Officer B, Sgt. A enlisted the assistance of Sgt. C, Officer A , and Officer C . These officers, along with Officer B and Detention Aide A, entered Subject 1's cell. Officer B

[93] Officer C deposition, Attachment 205, page 29, line 1
[94] According to Officer C, putting leg shackles on an arrestee is his normal practice when he transports someone to court.
[95] Officer B did not specify how long he had occasionally worked in lockup. He started with CPD in July 1999.
[96] Officer B did not remember which detention aide provided this information.

understood that the purpose of assembling this group of officers was to convince Subject 1 to cooperate. Sgt. A did not give any specific instructions other than that the goal was to get Subject 1 to go to court. Officer B did not have any specific information about Subject 1's prior behavior other than what the detention aide from the prior watch had told him. When the group of six Department members approached Subject 1's cell, one of them[97] asked Subject 1 to come out of the cell, but he again ignored the request. The six Department members then entered the cell, where they again attempted to persuade Subject 1 to go to court. Subject 1 continued to sit on the bench and not respond to them. Then suddenly Subject 1 jumped to his feet. According to Officer B, Subject 1 "came off of the bench faster than the normal average person would have."[98] Officer B described Subject 1 as acting more "aggressive" and "surprising" than simply rising to his feet.[99]. According to Officer B, after Subject 1 made this aggressive movement, Officer B viewed him as an assailant. When Subject 1 jumped to his feet, Officer A deployed his Taser at him. According to Officer B, he believes the officers discharged the Taser to avoid getting into a physical altercation with Subject 1. Subject 1 fell backward in response to the Taser discharge which allowed the officers to grab him and take him to the floor to handcuff him. After Subject 1 was taken to the floor, Officer B, who was kneeling on the bench above, tried to grab Subject 1's arms. Subject 1 was stiffening and moving his arms to preclude the officers from being able to secure the handcuffs on him. Eventually, Officer B was able to hold Subject 1 so the other officers could handcuff him.[100] Officer B recalled that leg shackles were placed on Subject 1 as well. Everyone left the cell and went to the front of lockup, where Detention Aide A called for an ambulance. The paramedics arrived, placed Subject 1 on a chair, and left with him. Subject 1 did not verbally respond to them but he was looking around and breathing and appeared to be alert.

According to Officer B, he did not observe any of the Department members punch or kick Subject 1. According to Officer B, the only physical interaction he observed between Subject 1 and the Department members in the cell was after Officer A deployed the Taser and the other officers were attempting to restrain him.

After reviewing the Tactical Response Report he completed, Officer B said that the physical actions he took of holding Subject 1 down would be considered an emergency takedown. According to Officer B, the Taser appeared to have the desired effect on Subject 1 in that it gave the officers the opportunity to grab him and start handcuffing him. Officer B estimated that it took approximately 30 seconds for them to complete the handcuffing once they started. He did not know how long they were in the cell before Subject 1 jumped off the bench but believed it may have been "a few minutes."[101] (Attachments 179-180)

In an accused statement to IPRA on 31 March 2016 for this investigation, **Officer B** reiterated the sequence of events that he detailed in his statement of 21 May 2014 and provided further information about what happened during the incident. Officer B had never before experienced an arrestee who refused to go to court. Because he only worked in lockup a few times per year, he was unaware of all of the lockup procedures, including what to do with an

[97] Officer B did not remember which person gave this direction.
[98] Officer B transcribed statement, Attachment 180, page 18, lines 6-8
[99] Officer B transcribed statement, Attachment 180, page 18, lines 12 and 13
[100] Officer B did not remember specifically which officer(s) applied the handcuffs.
[101] Officer B transcribed statement, Attachment 182, page 30, line 22

arrestee who does not cooperate with court procedures. When the group of Department members went to Subject 1's cell, the only plan was to get him out of the cell to go to court. According to Officer B, the Department members anticipated that, because Subject 1 was being uncooperative, his removal from the cell might have to be accomplished physically. According to Officer B, he had never received any training about cell extractions and he was unaware of any CPD policies about them. After Officer A deployed his Taser at Subject 1, the officers performed a takedown to bring Subject 1 to the floor. According to Officer B, he kneeled on the bench as they all tried to handcuff Subject 1 because that was the best place where he could position himself in the small area.

During this second statement given to IPRA, Officer B did not remember whether they were able to put the leg shackles on Subject 1. However, he acknowledged that he said the leg shackles were on during his previous statement, but added that a lot of time had passed and he could no longer recall. According to Officer B, none of the officers punched or kicked Subject 1 during the struggle to handcuff him and he described the incident as "uneventful."[102]

Officer B acknowledged that he observed Detention Aide A drag Subject 1 out of the cell by holding either his hands or the handcuffs. Officer B believed that Subject 1 was handcuffed in front. 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 did not recall hearing any of the Department members direct Subject 1 to do so. Nor did Officer B instruct Subject 1 to stand up and walk.

According to Officer B, he has never seen anyone drag someone out of a cell while they were restrained. When he saw Detention Aide A do this, he did not say anything to him or intervene in any way. According to Officer B, he was trying to regain his composure after the intense struggle in the cell, which he described as intense. There were two sergeants present who could have said something if Detention Aide A's behavior was incorrect. Officer B did not remember hearing Sgt. A or Sgt. C say anything to Detention Aide A about what he was doing. When Detention Aide A proceeded to drag Subject 1 to the front of lockup, Officer B watched Subject 1 to make sure he was okay after receiving the Taser discharge. According to Officer B, Subject 1 was conscious, breathing, and looking around. He did not verbally respond to the officers. According to Officer B, after everything was over, the sergeants told the officers that they had done a great job in handling the situation.

In addressing the allegations against him, Officer B said that he did not feel that he needed to report the incident to any supervisor because the station supervisor and his field sergeant were both present when Detention Aide A dragged Subject 1. He did not prevent Detention Aide A from dragging Subject 1 because he believed that Detention Aide A was using the appropriate amount of force in dealing with an arrestee who was resisting them. Officer B added that Detention Aide A had more knowledge about lockup procedures than he himself did, so he assumed that Detention Aide A was following those procedures. According to Officer B, none of the involved Department members tried to hurt Subject 1. It was unfortunate what happened, but, according to Officer B, the involved Department members used the force they

[102] Officer B transcribed statement, Attachment 185, page 9, line 20

believed was necessary at the time. (Attachments 184-185)[103]

According to **Detention Aide A** in a witness statement to IPRA on 22 May 2014 under Log #1058981, he started his shift in the 005th District male lockup at 0600 hours on 13 December 2012. When he arrived, his partner, Officer B, informed him that Subject 1 would not go to court. Subject 1 was sitting in his cell. Detention Aide A attempted to talk to Subject 1, who was sitting in his cell and responded only by saying things that Detention Aide A either could not hear or did not understand. Detention Aide A informed his immediate supervisor, Sgt. A, that Subject 1 would not go to court. Sgt. A told Detention Aide A that they were going to send Subject 1 to court in a squadrol. According to Detention Aide A, a group of Department members assembled which included: Sgt. C, Officer B, Officer A , and Officer C . Detention Aide A did not recall any specific discussion amongst the group to plan their approach before entering Subject 1's cell. According to Detention Aide A, the normal procedure if an arrestee refuses to go to court is to handcuff them and escort them from the cell. Arrestees "usually go to court" after that. [104]

When the group entered the cell, Subject 1 was sitting on the bench. Sgt. A directed Subject 1 to get ready to be handcuffed for court. According to Detention Aide A, Subject 1 cursed at the officers and told them not to touch him. Subject 1 then lunged forward and everyone grabbed him to restrain him. Detention Aide A grabbed one of Subject 1's legs and Sgt. C grabbed the other. According to Detention Aide A, Subject 1 flailed his arms and kicked with his legs, apparently to prevent the officers from restraining him with handcuffs and shackles. Officer A deployed his Taser at Subject 1. According to Detention Aide A, when Officer A discharged the Taser, Detention Aide A was trying to put a shackle on Subject 1's leg. When Detention Aide A felt the effect of the Taser he released Subject 1's leg. Detention Aide A believes that Sgt. C was also shocked by the Taser. Other officers were able to place handcuffs on Subject 1. Detention Aide A did not recall whether anyone finished securing the leg shackles. Detention Aide A pulled Subject 1 out of the cell and called an ambulance. According to Detention Aide A, Subject 1 was awake and looking at the Department members while they waited for the ambulance, but he did not say anything. Detention Aide A did not observe any injuries on Subject 1. (Attachments 172-173)

In an accused statement to IPRA on 30 March 2016 for this investigation, **Detention Aide A** reiterated the sequence of events that he detailed in his statement of 22 May 2014 and provided further information about what happened during the incident. According to Detention Aide A, after he informed Sgt. A that Subject 1 was refusing to go to court, Sgt. A decided what to do about the situation. The only plan that was discussed before the group of Department members entered Subject 1's cell was that they were going place restraints on him and take him to court. According to Detention Aide A, Subject 1 was kicking his legs while Detention Aide A was trying to apply the leg shackles. Detention Aide A was down by Subject 1's feet and was unable to see whether Subject 1 was moving his arms. Detention Aide A dropped the leg shackle when he felt the effect of the Taser and he did not believe that they were ever able to put the shackles on Subject 1's feet.

[103] Officer B's deposition, which is Attachment 241, is consistent with his statements to IPRA.
[104] Detention Aide A, transcribed statement, Attachment 173, page 11, line 6

According to Detention Aide A, at the end of the struggle in the cell, Subject 1 was lying on his back with his hands placed in handcuffs in front of his body. Detention Aide A did not know which Department member secured the handcuffs on Subject 1. According to Detention Aide A, the other officers were unable to exit the cell because Subject 1 was lying in the path of the doorway. Detention Aide A was closest to Subject 1, so he grabbed the handcuffs and pulled him out of the cell. According to Detention Aide A, he was worried that Subject 1 was going to start kicking at them again, so he felt this was the safest way to move Subject 1 out of the cell. Detention Aide A initially said that he did not remember if Subject 1 was still kicking at anyone at that point because things were happening very quickly. Detention Aide A acknowledged that Subject 1 was not fighting with anyone while Detention Aide A was dragging him. Detention Aide A believed that Subject 1 had enough time to stand and exit the cell on his own, which he did not do. Detention Aide A did not remember whether anyone gave Subject 1 directions to do so at that point. Detention Aide A then dragged Subject 1 down the hallway to the front of the lockup in the same manner that he dragged Subject 1 out of the cell. According to Detention Aide A, he did this for the same reason, because he did not want Subject 1 to start fighting with them again. None of the Department members, including Detention Aide A, gave Subject 1 directions to stand and walk with them. None of the other Department members assisted Detention Aide A in moving Subject 1, even though the hallway is wider than the door to the cell. Detention Aide A did not ask anyone for assistance. He did not believe that he was doing anything wrong. Everyone else was in the same area and did not step in to help, which caused Detention Aide A to think that they also thought he was not doing anything wrong. Detention Aide A had not had to physically remove someone from a cell or physically bring them to the front of lockup prior to this incident and he did not receive any training on how to do so. In Detention Aide A's previous experience, any arrestee who needed to be moved would walk with them.

Although Detention Aide A was intending to place Subject 1 in an observation cell while they waited for an ambulance, he did not actually do so. Detention Aide A stopped near the front desk to call an ambulance and waited there with Subject 1. Paramedics would have been able to reach Subject 1 in his cell.

According to Detention Aide A, a detainee needing medical attention would be moved to the observation cell in the front of lockup so that the paramedics could treat them there. When asked why they did not simply leave Subject 1 in the cell for the paramedics to take him from there, Detention Aide A again stated that he thought it was safer to move Subject 1. According to Detention Aide A, they had just finished struggling with Subject 1. He was concerned that leaving Subject 1 in the cell would mean that they would have to struggle with him again once the paramedics arrived. Detention Aide A added that whether or not to leave Subject 1 in the cell was Sgt. A's decision. The only direction he received from Sgt. A was when they initially went to the cell, which was that the plan was to remove Subject 1 from the cell and get him to court. According to Detention Aide A, because Sgt. A did not provide further direction to the contrary, he assumed that removing Subject 1 from the cell was still the goal.

After the paramedics arrived, they put Subject 1 on a chair and left with him. Sgt. A then told everyone that they did a good job ensuring that no one was injured. Detention Aide A did not see Subject 1 again and learned the next day that he had died at the hospital. Detention Aide

A denied the allegations against him and added that he did not intend to harm Subject 1 during this incident but was merely trying to do his job under the direction of his supervisor, Sgt. A. (Attachments 177-178)[105]

The **Chicago Fire Department ("CFD") ambulance report** related to the paramedic service (Incident number 123480363) documents that Paramedics 1 and 2 responded to the lockup facility. The report lists the incident type as "Taser#." A narrative in the report states as follows:

> UPON OUR ARRIVAL WE FOUND THIS PATIENT/S UNCONSCIOUS BUT BREATHING @ THIS TIME … THIS PATIENT/S WAS POSSIBLY A TASER VICTIM BY POLICE A.L.S. CARE SEE NOTES … UPON OUR ARRIVAL TO HOSPITAL THIS PATIENT/S BEGAN TO VERBALLY & PHYSICALLY ASSAULT POLICE & AMBULENCE CREW WITH PUNCHES, SPITTING …..EXPOSED TO BLOOD & BODY FLUIDS.

There are no physical injuries noted on the report (Att. 56).

According to **Paramedic 1** in a statement to IPRA on 14 January 2013 under Log #1058981, he and Paramedic 2 went to the 005th District lockup because they received a call about an arrestee who had been the subject of Taser discharge. When they arrived, Subject 1 was lying on the floor. They did not initially know whether Subject 1 was conscious because he was not talking to them, which is why the report indicates that Subject 1 was "unconscious." However, according to Paramedic 1, Subject 1 started talking "like nothing happened."[106] Moreover, according to Paramedic 1, "he didn't appear to have anything extraneous done to him other than the amount of force required to restrain for that – for their particular incident. He had no other apparent marks; he didn't have anything." [107] According to Paramedic 1, Subject 1 got into the transport chair when the paramedics asked him to do so. Subject 1 complied with the paramedics as they put him in the ambulance. (Attachments 139-140)

In a deposition taken 05 December 2014, **Paramedic 1** stated that, on 13 December 2012, he responded to a call at the CPD lockup facility where he encountered Subject 1. When the paramedics arrived, they found Subject 1 handcuffed from behind with his eyes closed. Subject 1 was breathing normally but was not moving. According to Paramedic 1, Subject 1 appeared to be asleep. According to Paramedic 1, Subject 1 responded to direction and helped the paramedics get him into a transport chair. According to Paramedic 1, they transported Subject 1 to Roseland Hospital because that was the closest hospital. (Attachment 229)

In a deposition taken 13 May 2014, **CFD Paramedic 2** provided an account of the events that was similar to that of Paramedic 1. When asked about the notation of "unconscious" in the CFD report, Paramedic 2 explained that unconscious could also mean "unresponsive" and that the term could be used to describe "eyes closed, no movement."[108] Paramedic 2 recalled that

[105] Detention Aide A deposition, which is Attachment 237, is consistent with his statements to IPRA.
[106] Paramedic 1 transcribed statement, Attachment 140, page 10, line 12
[107] Paramedic 1 transcribed statement, Attachment 140, page 10, line 18
[108] Paramedic 2 deposition, Attachment 236, page 22, lines 6-8

while en route to the hospital, Subject 1 opened his eyes and asked where he was. Paramedic 1 told him that he was in the back of an ambulance, after which he closed his eyes again. (Attachment 236)

IV. INCIDENT AT ROSELAND HOSPITAL[109]

An **E.M.S. Incident Case Report** dated 13 December 2012, documents that CFD Paramedics 1 and 2 were involved in an "assault & battery" incident at 45 W. 111th Street. According to the report, the paramedics were called to the CPD lockup facility where they found a patient who appeared to have been the subject of a Taser discharge. The paramedics provided initial care and transported the patient to Roseland Community Hospital. The report documents that the patient became "enrage [sic], combative verbally and physically abusive to police and ambulance crew." The narrative of the report further states:

> Patient/s had Officer D in what appeared to be a increasingly desperate defensive posture, patient/s continued assault on crew of ambulance 60, then turned again his attention to Officer D, who by this time had time to discharge his taser to no effect, patient/s continued his assault … patient attempted to escape & elude police where patient continued to spit, bite, fight at which time he was given Ativan/Haldol mix upon doctors [sic]order (Doctor 1) by hospital staff.

(Attachment 57)

According to **Paramedic 1** in a statement to IPRA on 14 January 2013 under Log #1058981, Subject 1 was compliant until they turned the corner in the ER toward Room 11, at which time Subject 1 raised up off the gurney and made a comment about Satan. Once in Room 11, Subject 1 spat at Paramedic 1 and the others and lunged off the gurney, causing it to tip over. Subject 1 lunged at Officer D and backed Officer D into a corner. Officer D pulled out his Taser and attempted to use it on Subject 1 but the Taser did not work. Paramedic 1 heard the Taser cycling repeatedly but it still did not work. Officer D pulled the trigger a third time and announced that the Taser was not working. Subject 1 kept fighting. Paramedic 1 stated that he is 280 pounds but that Subject 1 threw him as if he were a doll. Officer D's partner, Officer E, struck Subject 1 with his baton but Subject 1 kept fighting. According to Paramedic 1, everyone was fighting with Subject 1 and trying to gain control of him. Subject 1, who was still shackled and handcuffed, charged past Officer E and ran into the main ER. Officer E called for backup while Paramedic 1, Paramedic 2, Officer D and Roseland Hospital security staff held Subject 1 down. Subject 1 remained combative until a nurse gave him a sedative. Paramedic 1 and the others held Subject 1 down for several minutes until the medication took effect. (Attachments 139-140)[110]

According to **CFD Paramedic 2** in a statement to IPRA on 14 January 2013 under Log #1058981, he and his partner, Paramedic 1, responded to a request to treat the subject of a Taser

[109] Five CPD members, two CFD paramedics, and fourteen employees of Roseland Hospital were interviewed about what happened with Subject 1 at the hospital for Log #1058981. Those statements were also made a part of this investigation.
[110] Paramedic 1's deposition, which is Attachment 229, is consistent with his statements to IPRA.

discharge at the 005th District station, Subject 1. Paramedic 2 and Paramedic 1 performed an initial assessment of Subject 1 and then placed him into the ambulance without incident. A police officer, now known as Officer D, rode with Subject 1 in the back of the ambulance. Officer D's partner, Officer E, also accompanied them to the hospital. When they arrived at Roseland Hospital, the paramedics and officers transported Subject 1 by gurney to treatment Room 11 in the ER. According to Paramedic 2, Subject 1, rose up off the gurney even though he was handcuffed, shackled, and strapped to it. Once inside Room 11, Paramedic 1 removed the gurney straps from Subject 1 to transfer him to the bed. Subject 1 then leaned forward and tried to escape from the room. Paramedic 1 and Officer E tried to restrain Subject 1 but he broke loose. Officer D deployed his Taser at Subject 1, but Subject 1 charged at him and backed him into a corner. Officer D again tried to use his Taser but yelled out that it was not working.

Paramedic 1 pulled Subject 1 off of Officer D. Paramedic 1 and Subject 1 fell on top of the gurney. Officer E pulled out his baton and told Subject 1 to stop moving. When Subject 1 kept moving, Officer E swung his baton at Subject 1's legs. Officer E blocked the doorway to Room 11 and told Subject 1 to stop moving. Subject 1 then charged past Officer E and ran out into the hallway. Officer D, Officer E, and Paramedic 1 subdued Subject 1 and held him down until backup officers arrived. The paramedics left the room after additional officers arrived.[111] (Attachment 137)[112]

Tactical Response Reports from the first two officers who were with Subject 1 at Roseland Hospital describe him as a battery assailant. According to Officer D's report, Subject 1 did not follow verbal direction, pulled away, displayed an imminent threat of battery, and attacked without weapon. In response, Officer D used member presence and verbal commands, and deployed his Taser at Subject 1 using probe discharge and contact stuns. According to Officer E's report, Subject 1 displayed an imminent threat of battery and attacked without weapon. In response, Officer E used member presence, verbal commands, and his baton to try to subdue Subject 1.

Additional Department members arrived after Officers D and E and the hospital staff struggled with Subject 1.[113] According to Sgt. C's report from the Roseland Hospital incident, Subject 1 did not follow verbal direction, stiffened, pulled away, displayed an imminent threat of battery, and attacked without weapon. Sgt. C performed a take down/emergency handcuffing and restrained Subject 1's legs. According to Officer K's report, Subject 1 did not follow verbal direction, stiffened his body, and pulled away. Officer K responded with member presence, verbal commands, and a shoulder restraint. According to Officer L's report, Subject 1 stiffened his body and pulled away. Officer L responded with escort holds. According to Officer J's report, Subject 1 did not follow verbal direction, stiffened, pulled away, and flailed his arms. Officer J responded with member presence, verbal commands, and by holding Subject 1's right arm. (Attachments 36-43)

[111] Paramedic 2 did not report anything about the medication that was given to Subject 1. It is not clear whether or not he was in the room when that was administered.
[112] Paramedic 2's deposition, which is Attachment 236, is consistent with his statements to IPRA.
[113] There are some minor differences in the way these officers described Subject 1's actions. They arrived at the hospital at different times and saw different portions of the incident.

The **Taser download report** for Officer D's Taser reveals that there were 13 trigger pulls over the course of 4 minutes. The bursts vary from 5 seconds to 11 seconds for a total of 81 seconds.[114] (Attachment 46)

In his statement to IPRA on 27 May 2014 under Log #1058981, **Sgt. C** also spoke about the incident at Roseland Hospital. Sgt. C responded to the hospital when Officers D and E called for assistance.[115] When Sgt. C made his way to the room where Subject 1 was being treated, he saw Officers D and E, Roseland security guards, and the paramedics struggling on the floor with Subject 1. Sgt. C assisted by grabbing Subject 1's legs and holding him until the one of the medical staff could administer a sedative. Sgt. C then left the hospital. Sgt. C was not present when Officer D deployed his Taser at Subject 1 or when Officer E struck Subject 1 with a baton. Sgt. C later learned that Subject 1 had passed away. (Attachments 193-194)

According to **Officer E** in a witness[116] statement to IPRA on 21 May 2014 under Log #1058981, he first encountered Subject 1 after Sgt. A called him to the station to accompany the paramedics and Officer D to transport a combative prisoner to Roseland Hospital. When Officer E arrived at the station, Subject 1 was lying on a gurney, handcuffed and shackled. Officer D rode in the ambulance with Subject 1, and Officer E followed in his vehicle. When they arrived at the hospital, the emergency room ("ER") staff directed the officers and paramedics to take Subject 1 to Room 11. As they walked through the ER, Subject 1 started ranting and quoting religious phrases. When they entered Room 11, Subject 1, still shackled and handcuffed in the front, started kicking and flailing his arms. As the officers tried to subdue Subject 1, the gurney flipped over. Officer D deployed his Taser at Subject 1. Subject 1 paused briefly, but then ran toward Officer D and tried to disarm him of the Taser. Officer E struck Subject 1 on the legs with his baton. Officers E and D tried to subdue Subject 1 on the floor but he kept getting up. As Officer E blocked the doorway of Room 11, Subject 1 looked at him and said, "Here I come."[117] Subject 1 then ran past Officer E and into the hallway. Officer E struck Subject 1 with his baton several more times. Once Subject 1 went down to the floor, Officer E stepped on Subject 1's shackles to prevent him from getting up. The officers, paramedics, and hospital security personnel held Subject 1 on the floor. Subject 1 yelled excerpts from the bible and kept trying to get loose. A nurse eventually gave Subject 1 a sedative. When other officers arrived, Officer E sought medical attention for his knuckle which was injured during the struggle. (Attachments 151-152)[118]

[114] The Taser download report only registers trigger pulls, not whether electricity was actually flowing through the wires to the probes. In this instance, the 13 trigger pulls do not correspond to 13 bursts of electricity. Officer D reported to IPRA that Subject 1 broke the Taser probes and struggled with him over control over the device. Officer D attempted to make the Taser operational by pulling the trigger but it did not work.
[115] Sgt. C did not specify when he went to the hospital. CPD reports reveal that it was a little over one hour after the incident in lockup.
[116] Officers E and D did not receive allegations under Log #1058981. The allegations against these officers that are addressed in this report were raised in the civil suit that Subject 1's estate filed. Because the evidence shows that the force used by Officers E and D was proper given the totality of the circumstances, they did not provide additional statements as accused officers under this investigation.
[117] Officer E transcribed statement, page 11, line 20
[118] Officer E's deposition, which is Attachment 244, is consistent with his statement to IPRA.

According to **Officer D** in a witness statement to IPRA on 29 May 2014 under Log #1058981, Sgt. A assigned Officers D and E to escort Subject 1 and the paramedics to Roseland Hospital. Sgt. A informed the officers that Subject 1 had been the subject of a Taser discharge. Officer D did not know what happened during Subject 1's arrest and did not know Subject 1's state of mind. Paramedics were strapping Subject 1 to the gurney when Officer D first saw him. Subject 1 was quiet but appeared to be alert. Officer D rode in the ambulance with Subject 1 while Officer E followed in a squad car. When they arrived at the hospital, the paramedics removed Subject 1 out of the ambulance and rolled him into the emergency room. Officer E got out of his car and joined Officer D in following the paramedics and Subject 1 into the hospital.

When they got to the nurse's station in the emergency room, Subject 1 started yelling and talking about the devil. One of the nurses directed them to move Subject 1 into Room 11 so he would not disturb the other patients. After they moved him, the paramedics reached over to remove the restraint from the gurney. As they did, Subject 1 elbowed one of them and spit in his face. Officer D removed his Taser and yelled a warning about the Taser. Subject 1, who was still handcuffed in front of him at this point, was swinging his arms around. Officer D ordered Subject 1 to stop his actions, which Subject 1 did not do. Officer D then deployed the Taser at Subject 1. Officer D was standing approximately one foot away from where Subject 1 was sitting on the gurney when he deployed the Taser.[119] The Taser discharge did not have any apparent effect on Subject 1. The gurney flipped over and Subject 1 fell to the floor. As Officer Egot on his radio to report the Taser discharge, Subject 1 looked at Officer D and threatened to kill him. Subject 1 then jumped up, broke the Taser probes, and tried to take the Taser from Officer D. Officer D pushed Subject 1 off of him. As Officer D and Subject 1 struggled over the Taser, Officer D repeatedly squeezed the Taser's trigger in order to make it work. Officer D did not recall how many times he squeezed the trigger. Once Subject 1 broke the probes, however, the Taser malfunctioned and it had no effect. Officer D believed that the Taser further malfunctioned after Subject 1 tried to take it from him.

Subject 1 then lunged at Officer E. Officer E hit Subject 1 on the legs with his baton to try to get Subject 1 to the floor. Officer D and the paramedics also grabbed Subject 1 to bring him down. They were finally able to get him on the floor. Subject 1 continued to struggle and spit. Additional CPD officers and hospital security guards arrived after Subject 1 was restrained on the floor. One of the security guards tried to help the officers hold Subject 1 on the floor, but he backed away after Subject 1 spit at him. Subject 1 remained combative until hospital staff administered him a sedative. It took several minutes for Subject 1 to calm down after that. Hospital staff and CPD officers moved Subject 1 to a gurney. The hospital staff then brought him to another room. Officer D did not see Subject 1 again. (Attachments 155-156)[120]

According to **Officer K** in a witness statement to IPRA on 21 May 2014 under Log #1058981, he responded to a request for officer assistance at Roseland Hospital. When he arrived, he observed Sgt. C, two police officers whose names he did not know, and Fire Department personnel restraining Subject 1 on the floor. Subject 1 flinched as he lay on the

[119] It should be noted that the Taser will not be effective if the probes are fewer than four inches apart from each other. CPD officers are trained to fire a Taser from a distance of 7-15 feet from the target in order for the probes to reach the minimum spread distance.
[120] Officer D's deposition, which is Attachment 230, is consistent with his statement to IPRA.

floor. Officer Hill relieved Sgt. C by placing his hand on Subject 1's shoulder to help the other two officers hold Subject 1 down. A nurse administered a sedative and Subject 1 eventually stopped moving. A short time later, Officer K urged the doctor to take a look at Subject 1. Hospital staff then placed Subject 1 on a gurney, and brought him to a treatment room. Officer K was not present when Officer D deployed the Taser. (Attachments 153-154)

According to **Officer L** in a statement to IPRA on 06 June 2014 under Log #1058981, he responded to a request for officer assistance at Roseland Hospital. When he arrived, he saw officers restraining Subject 1 on the floor in the treatment area of the emergency room. Specifically, Officer D was holding Subject 1's shoulder and Sgt. C was holding Subject 1's legs. Officer E was in the corner of the room, apparently out of breath. Officer J arrived around the same time as Officer L. Subject 1 was struggling with the officers by kicking his legs and moving his arms and torso. Officer L assisted Officer D in restraining Subject 1's shoulder. Officer L learned that one of the hospital staff administered medication to Subject 1, but he did not see that happen because he was focused on restraining Subject 1. Subject 1 eventually stopped struggling. The officers placed Subject 1 onto a gurney and handcuffed him to it. Hospital staff wheeled the gurney into another area. Officer L did not follow them and did not have any further contact with Subject 1. Officer L was not present when Officer D deployed the Taser. (Attachments 157-158) [121]

According to **Officer J** in a statement to IPRA on 17 June 2014 under Log #1058981, once he arrived at Roseland Hospital in response to a request for officer assistance, the situation was mostly under control. Subject 1 was on the floor squirming and trying to get up; he was being restrained by two paramedics. Officers D and E were present but were standing away from Subject 1. Officer J assisted the paramedics in restraining Subject 1. Once Subject 1 stopped struggling, he was placed on a gurney and hospital security applied their restraints. Officer J left the hospital once Subject 1 was brought to a treatment room. Officer J was not present when Officer D deployed the Taser. (Attachments 159-160)

According to Security Guard 1 in a statement to IPRA under Log #1058981 on 19 December 2012, she received a call from her supervisor, Security Guard 2, who requested that she come to the ER. Security Guard 1 stated that her supervisor got a call because a patient was "beating up" paramedics and police officers.[122] After about five minutes, Security Guard 1 stated she was requested to go back to the ER area because it was "getting wild."[123] When she arrived, she saw three police officers and her co-worker, Security Guard 4, struggling to hold Subject 1 down on the floor. Security Guard 1 described Subject 1 as combative and stated that he pushed the officers off him, kicked at them, and repeatedly tried to stand up. Security Guard 1 stated that she did not help the other security guards hold Subject 1 down because once she saw how strong he was as he pushed the other security guards off of him, and she could only imagine what Subject 1 was capable of doing to her. Security Guard 1 stated that the officers involved tried to keep him calm but it would not work. She stated she heard Officer E tell Subject 1 to calm down and "we are trying to help you."[124] Security Guard 1 saw Officer D deploy his Taser

[121] Officer L's deposition, which is Attachment 206, is consistent with his statement to IPRA.
[122] Statement of Security Guard 1, Attachment 77, page 8, lines 20-24
[123] Statement of Security Guard 1, Attachment 77, page 10, lines 7-11
[124] Statement of Security Guard 1, Attachment 77, page 5, lines 7-12

at Subject 1. Officer E struck Subject 1 with a baton. They also gave him verbal commands to be still and stay down, but Subject 1 did not comply. Other officers arrived to help subdue Subject 1. Subject 1 did not calm down until after a nurse gave him a sedative. (Attachments 76-77)

According to **Security Guard 2** in a statement to IPRA under Log #1058981 on 19 December 2012, he was sitting at the front desk when he received an urgent phone call from Security Guard 3 requesting security in the ER. Security Guard 2 approached Room 11 in the ER and observed the police and a paramedic with Subject 1. Security Guard 2 and members of his security staff, Security Guard 3 and Security Guard 5, attempted to enter Room 11 but Officer E, who was in Room 11, told them to step back. As Security Guard 2 stood in the ER hallway, Subject 1 broke through the door. CPD Officer E grabbed him, took him to the floor, and struck him with a baton. Security Guard 2 returned to the front desk and left two of his security guards, Security Guard 4 and Security Guard 1, with Subject 1, the police, and the paramedics. (Attachments 80-81)

According to **Roseland Hospital Doctor 1** in a statement to IPRA under Log #1058981 on 19 December 2012, CPD officers and paramedics brought Subject 1 through the back entrance of the ER. As the group passed Doctor 1, Subject 1 was ranting and verbally abusive. Five to ten minutes later, Doctor 1 heard a commotion in the back. Someone told Doctor 1 that a patient broke loose and was fighting with officers and hospital staff. When Doctor 1 went to the back, Subject 1 was fighting with the officers, paramedics, and medical staff. The officers held Subject 1 down on the floor. Subject 1 moved around, tried to get up, and spat at the officers. Doctor 1 ordered the nurses to give Subject 1 medication to sedate him. Doctor 1 stated that approximately fifteen minutes later, he was notified that Subject 1 coded. Doctor 1 performed CPR and stabilized Subject 1. Doctor 1's shift ended at 2:00 p.m. and Doctor 2 relieved him. When Doctor 1 returned to work two days later, he learned that Subject 1 passed away. (Attachments 84-85)[125]

According to **Roseland Hospital Security Guard 4** in a statement to IPRA under Log #1058981 on 19 December 2012, he received a call from a co-worker, Tommy Harris, telling him to report to Bed 11 as soon as possible. As Security Guard 4 neared Room 11, he heard a "big scuffle" and the sound of a Taser being deployed. Security Guard 4 approached the room and saw two police officers, who he now knows as Officer E and Officer D, and two EMS workers in the room trying to restrain Subject 1. Officer E ordered Subject 1 to get down and stop resisting. Subject 1, who was handcuffed in the front and had shackles on his ankle, flipped over a gurney and fell to the floor. Subject 1 jumped up and removed the Taser probes from his body. He then tried to take the Taser from Officer D. Subject 1 looked at Officer E, who was standing in the doorway, and said, "Here I come." Subject 1 then charged at Officer E. The tussle spilled out of Room 11 and into the hallway near Room 8. Subject 1 was resilient and kept fighting. He swung his arms while Security Guard 4 and the officers tried to get him down. Officer E struck Subject 1 on his legs with a baton but Subject 1 refused to go down. It took approximately five people to get Subject 1 to the floor, yet Subject 1 kept fighting. Subject 1 spit blood onto Security Guard 4's vest and neck. Officer D performed a Drive Stun with the Taser. More CPD officers arrived and subdued Subject 1. Security Guard 4 described Subject 1's

[125] Doctor 1's deposition, which is Attachment 234, is consistent with his statement to IPRA.

demeanor as "chaotic"[126] and he believed his actions to be threatening the safety of the hospital staff, patients, and himself. Security Guard 4 stated that he was required to take excessive force classes as training for "situations like this"[127] and that the officers' actions in light of Subject 1's behavior were not excessive or abusive. A nurse administered a shot to Subject 1; shortly thereafter, Subject 1 stopped struggling. (Attachments 89-91)

According to **Roseland Hospital Nurse 1** in a statement to IPRA under Log #1058981 on 19 December 2012, once CFD paramedics and CPD officers brought Subject 1 to Room 11, they asked Subject 1 to move from the gurney to the bed but he did not comply. When the officers tried to escort Subject 1 from the gurney to the bed, he became loud and aggressive. The officers and paramedics unsuccessfully tried to calm Subject 1. Subject 1 was combative and aggressive toward the officers and appeared to be out of control. Subject 1 then asked Officer E if he was ready because he (Subject 1) was coming. Officer E told the hospital staff in the area to move back. Nurse 1 stated they scattered in fear of being attacked. In Nurse 1's deposition, she testified that she heard Subject 1 threatening Officer E while he was in Room 11 by saying, "Are you ready, I'm coming."[128] Nurse 1 testified that Subject 1 charged at Officer E and that Subject 1 was hit by Officer E approximately eight times near the knees but that it had no effect on Subject 1. Nurse 1 also testified that after hitting Subject 1 in the legs, Officer E directed baton hits to Subject 1's abdomen or rib cage. Nurse 1 stated that the baton hits to the abdomen did not have any effect on Subject 1. Nurse 1 testified that it was her belief that Officer E did the right thing. (Attachments 94-95) [129]

According to **Roseland Hospital Nurse 2** in a statement to IPRA under Log #1058981 on 19 December 2012, Subject 1 rushed or ran into Officer E with his head and shoulders. She stated Subject 1's behavior was scary and she ran to the other side of the ER. The remainder of her statement was consistent with the other statements from the witnesses at Roseland Hospital. (Attachments 98-99)

According to **Roseland Hospital Doctor 2** in a statement to IPRA under Log #1058981 on 27 December 2012, he started work at 1400 hours on 13 December 2012 and relieved Doctor 1 in the ER. When Doctor 2's shift started, Subject 1 was already on life support; he died a short time later. (Attachments 102-103)[130]

According to **Roseland Hospital Nurse 3** in a statement to IPRA under Log #1058981 on 27 December 2012, **,** Subject 1 was enraged and made references to the devil as officers and paramedics wheeled him into Room 11. Subject 1 fought with the officers and "threw" a 400 pound security guard as if he was a much smaller person. Subject 1 came toward Nurse 3 and she and a couple other nurses ran into the mailroom. The doctor told the nurses to get some medication for Subject 1. Nurse 3 stayed in the mailroom for approximately two minutes. When she came out of the mailroom, Subject 1 was still fighting and wrestling with the officers. Nurse

[126] Statement of Security Guard 4, Attachment 91, page 32, line 6
[127] Statement of Security Guard 4, Attachment 91, page 31, line 24
[128] Statement of Nurse 1, Attachment 95, page 20, lines 10-11
[129] Nurse 1's deposition, which is Attachment 233, is consistent with her statement to IPRA.
[130] Doctor 2's deposition, which is Attachment 243, is consistent with his statement to IPRA.

4 administered the medication to Subject 1. Approximately four to five minutes after receiving the medication, Subject 1 stopped struggling. (Attachments 106-107)

According to **Roseland Hospital Nurse 5** in a statement to IPRA under Log #1058981 on 27 December 2012, Subject 1 was erratic, irate, and very strong. Nurse 5 expressed relief that officers were present at the hospital to deal with Subject 1. Most of the nurses were in the mailroom during the incident because they were afraid of what he was going to do. The hospital security staff assisted the police and paramedics, but Subject 1 overpowered them. The hospital security staff was not strong enough to handle Subject 1 and they were also afraid of him. The remainder of her statement was generally consistent with the other statements from the witnesses at Roseland Hospital. (Attachments 110-111)[131]

According to **Roseland Hospital Nurse 6** in a statement to IPRA under Log #1058981 on 27 December 2012, a nursing supervisor paged her to come to the ER during the incident. When Nurse 6 arrived to the ER, the police were kneeling on the floor next to Subject 1 and everything was under control. A short time later, the police picked Subject 1 up and took him to Room 4. Nurse 6 stated that she did not witness much else of substance. (Attachments 114-115)[132]

According to **Roseland Hospital Security Guard 5** in a statement to IPRA under Log #1058981 on 27 December 2012, he was patrolling the parking lot when he received a call requesting his help in the ER. When Security Guard 5 arrived at the ER, the police had Subject 1 detained on the floor outside a treatment room. Security Guard 5 stated he did not witness any other contact between the police and Subject 1. (Attachments 118-119)

According to **Roseland Hospital Emergency Room Technician 1** in a statement to IPRA under Log #1058981 on 19 December 2012, Subject 1 was belligerent and resistant to the paramedics and police officers. The officers wrestled with Subject 1 after he refused to move from the gurney to the bed in Room 11. One officer struck Subject 1 with a baton, and another officer deployed a Taser at Subject 1, but neither action appeared to affect Subject 1. ER Technician 1 noted that Subject 1 was very strong and had a lot of energy. ER Technician 1 added that the police and paramedics were out of breath from trying to subdue Subject 1. (Attachments 122-123)[133]

According to **Roseland Hospital Nurse 4** in a statement to IPRA under Log #1058981 on 19 December 2012, Subject 1 was violent and had an unbelievable amount of strength. An officer struck Subject 1 with a baton, but that did not stop him so a doctor gave the order to medicate Subject 1. Nurse 4 administered the medication via intramuscular injection. The officers held Subject 1 down on the floor for approximately twenty minutes before the medicine took affect and he calmed down. Subject 1 was then brought to Room 4. (Attachments 126-127)[134]

[131] Nurse 5' deposition, which is Attachment 227, is consistent with her statement to IPRA.
[132] Nurse 6's deposition, which is Attachment 247, is consistent with her statement to IPRA.
[133] ER Technician 1's deposition, which is Attachment 256, is consistent with his statement to IPRA.
[134] Nurse 4's deposition, which is Attachment 257, is consistent with her statement to IPRA.

According to **Roseland Hospital Security Guard 3** in a statement to IPRA under Log #1058981 on 27 December 2012, he had just finished his shift and was walking through the ER to leave when he observed the police and paramedics bring Subject 1 in on a gurney. Subject 1 yelled obscene language and was very combative. Subject 1 also thrashed around and tried to get off the gurney. Security Guard 3 picked up the phone and called his superiors to the ER. The police and Fire Department took Subject 1 to Room 11. Security Guard 3 heard a commotion but could not see inside the room. Once Security Guard 2 and Security Guard 4 arrived, Security Guard 3 stepped away and went to Security Guard 2's post at the main entrance to relieve him until he returned. (Attachments130-131)

The **Postmortem Examination Report** prepared by Dr. 3 documents that Subject 1 had multiple bruises and abrasions about his body as well as a fractured rib. The medical examiner noted both external and internal evidence of injury that was substantial, including bruises and abrasions about the face, arms, legs and torso. Regarding the external evidence of injury, the report documents two bruises and nine abrasions about the face and head; approximately eleven bruises and five abrasions about the arms; two bruises and one abrasion on the hands; approximately seventeen bruises and eight abrasions about the legs; and approximately two bruises and two abrasions on the back. Regarding internal evidence of injury, the report documents approximately seven subcutaneous bruises about the legs; approximately four subcutaneous bruises about the arms; approximately three subcutaneous bruises about the chest area; and two subgaleal hemorrhages under the scalp near the right and left temporal bones.[135]

The Medical Examiner ruled that Subject 1 died of Neuroleptic Malignant Syndrome[136] due to Haloperidol (Haldol)[137] administration. The manner of death was ruled an accident. Toxicology Reports revealed the presence of Diphenhydramine (Benadryl) in Subject 1's system, but no other positive findings of toxicological significance. (Attachment 58)

According to **IPRA Inv. 2** in a report dated 20 December 2012, she went to the Cook County Medical Examiner's Office and observed the postmortem examination of Subject 1. Dr. 3 conducted the examination, and Dr. 4 was also present for at least a portion of it. Inv. 2's observations during the examination are consistent with Dr. 3's final report described above. Inv. 2 noted multiple abrasions, bruises, scrapes, and discoloration to Subject 1's body. Dr. 3 and Dr. 4 both noted that the bruises on Subject 1's legs, arms, ankles, and the left side of his upper back were consistent with being struck by a baton. Dr. 4 specifically noted the "train track" pattern found in the bruises on Subject 1's back that is consistent with a strike from an expandable baton like an ASP. Dr. 3 attributed the indentations on Subject 1's wrists and ankles to the binding that hospitals put on bodies when they are transported to the Medical Examiner's office. (Attachment 291)

Civil Suit

Subject 1's estate filed **Civil Suit 12 CV 10061**, which alleged that CPD supervisors

[135] The temporal bones are on both sides of the head at the lower part of the skull around the ears.
[136] A life-threatening neurological disorder most often caused by an adverse reaction to neuroleptic or antipsychotic drugs. *The National Institute of Neurological Disorders*. (www.nih.gov).
[137] An antipsychotic medication. *Ibid.*

knew that Subject 1 was in need of medical and/or mental health treatment and refused to make it available for him, and that officers used excessive force on Subject 1 at the station and at the hospital. On 14 December 2015, Judge Matthew Kennelly issued an order of partial summary judgment for Subject 1's estate regarding two of the claims made in the suit: that Detention Aide A used excessive force when he dragged Subject 1 while he was restrained, and that Sgt. A was present for this action but failed to intervene. The case was later settled out of court. The City Council approved the settlement on 13 April 2016. (Attachments 10, 200-202)

ANALYSIS and FINDINGS:

I. INCIDENT LEADING TO SUBJECT 1'S ARREST

It is alleged that Sgt. B failed to provide Subject 1 with access to medical care and mental health evaluation subsequent to his arrest. Pursuant to General Order G06-01-01, Section X(A), "[i]n the event that an arrestee requires immediate medical care, the arrestee will be transported to the nearest approved emergency room." Moreover, pursuant to Special Order S04-20-01, Sections III(A) and (B), which was in place at the time of this incident,[138] "[a]rrestees charged with any offense requiring a judge's bond and in need of mental health evaluation, treatment, or hospitalization" … "will be transported to the nearest designated mental health intake facility for evaluation." In this case, Subject 1 was arrested based on charges of domestic battery and aggravated battery, offenses that would require a judge's bond. It is undisputed that, at the time of the arrest, Subject 1 had an injury that required immediate medical care – he was bleeding from his mouth. Yet, Sgt. B made the decision to transport Subject 1 to the lockup facility for processing rather than to a hospital for immediate medical care. The evidence suggests that Sgt. B did so because he was angry at having been spat upon by Subject 1. Sgt. B's conduct was clearly in violation of Special Order S04-20-01.

Moreover, there is more than a preponderance of evidence that Subject 1 was in need of a mental health evaluation. Sgt. B's assertion that he did not consider Subject 1's conduct to reflect a need for mental health evaluation is simply not credible. Citizen 3 pleaded with Sgt. B and the other officers to have Subject 1 taken for "help" rather than to jail because there was something clearly wrong with his son. The totality of Subject 1's behavior clearly establishes that he was having some kind of mental crisis, which could have been related to mental health issues or substance abuse. Subject 1 suddenly attacked his mother, he was yelling indecipherably, he spat at the officers, he had been rolling around on the ground, and he ran at the officers with his arms extended like an airplane. Sgt. B's explanation for his decision was based on the fact that Subject 1 told him that Subject 1 had not had mental health issues before and was not currently undergoing mental health treatment. This was insufficient grounds to ignore the clearly abnormal behavior that Subject 1 had exhibited that evening. Based on the totality of the circumstances and the evidence in the record, there was a failure to provide Subject 1 access to medical care and mental health evaluation subsequent to the arrest. Therefore, this allegation as to Sergeant B is **Sustained**.

II. SUBJECT 1'S TREATMENT WHILE IN CUSTODY

A. Failure to Provide Medical/Mental Health Treatment

It is alleged that Lt. A , Lt. B , Sgt. A , Sgt. C , and Lt. C knew Subject 1 needed medical and/or mental health treatment and refused to make it available to him. According to Special Order S04-20-01 II. B., which was in place at the time of this incident,[139] an arrestee in need of mental health evaluation, treatment, or hospitalization "will be transported to the nearest designated mental health intake facility for evaluation."

[138] These duties are currently detailed in S04-20-05 III. A. and B.
[139] This duty is currently detailed in S04-20-05 II. B.

Because each of the accused Department members had different interactions with Subject 1 and different knowledge of his situation, they will be discussed separately.

Lieutenant A

Lt. A was the station supervisor at the time of Subject 1's arrest. He was not present for the arrest and did not receive any information that Subject 1 was acting irrationally. The only information Lt. A had about Subject 1 was that he had been combative during his arrest and spit blood on two officers. Lt. A was told that there were paramedics on the scene of the arrest who had seen Subject 1. It was Lt. A's belief that the paramedics would have either treated Subject 1 or gotten additional paramedics on the scene to do so if he been in need of medical treatment. Once Subject 1 was at the station, Lt. A did not have any direct contact with him. He observed Subject 1 via the lockup monitor and noted that Subject 1 appeared to be calm. This behavior was echoed by the lockup staff, who reported that Subject 1 was calm. The video recording from lockup reveals that Subject 1 appeared to be agitated at times, but there were also times where he remained calmly seated or laying in his cell. As Lt. A explained in his statement to IPRA, in his view, the term "crazy" is a broad one that pertains to a large variety of behaviors; only a small subset of people who fit that term are in actual need of mental health treatment. According to Lt. A , he believes that CPD policies and training requires officers to observe a subject's specific behavior to determine whether they are a danger to themselves or others. According to Lt. A, during his shift, he observed Subject 1 merely sitting calmly in his cell. In Lt. A's view, this behavior was not indicative of someone who posed a threat to themselves or others. Lt. A had heard reports that Subject 1 had been making religious comments. However, in his experience, this is not an unusual thing for a person in police custody to do.

Due to his limited role in Subject 1's detention, Lt. A did not have enough information to determine that Subject 1 needed a mental health evaluation or treatment. Therefore, the allegation that Lt. A knew Subject 1 needed medical and/or mental health treatment and refused to make it available to him is **Unfounded**.

Lieutenant B

Lt. B took over from Lt. A as station supervisor for the following shift. Unlike Lt. A , Lt. B had several interactions with Subject 1 throughout the first watch shift and was present when Subject 1 was uncooperative during his processing in lockup. Citizen 3 reported that he had a conversation with a supervisor, identified by Detective A as Lt. B, about his son's behavior. Citizen 3 testified that he told Detective A about his concerns about Subject 1's mental health and that he needed to go to the hospital, but he did not testify about telling Lt. B the same concerns.[140] According to Detective A in his deposition, he was present when Citizen 3 informed Lt. B that he believed his son was acting out of character and needed mental health treatment. While this information, on its own, is not enough to warrant bringing Subject 1 for mental treatment, it did provide context for Subject 1's behavior in lockup. In his deposition and IPRA statement, Lt. B repeatedly stated that he did not find Subject 1's behavior to be irrational or alarming. However, the bizarre behavior that Lt. B personally observed, when combined with the knowledge that Subject 1's father reported he was acting abnormally and needed to go to the hospital, *should* have been prompted Lt. B to more seriously consider this issue. Therefore, the

[140] Citizen 3 was not specifically asked about this in his deposition or in his statement to IPRA.

allegation that Lt. B knew Subject 1 needed medical and/or mental health treatment and refused to make it available to him is **Sustained**.

Sergeant A

Sgt. A was the second watch station supervisor during Subject 1's period of detention, including when Subject 1 was finally removed from his cell to go to court. Under normal circumstances, arrestees are usually taken to court during the early hours of second watch. Sgt. A directed Officers A, C, and B, and Detention Aide A to remove Subject 1 from his cell to take him to court. He also enlisted Sgt. C's assistance in doing so, apparently believing that the presence of several Department members would encourage Subject 1 to cooperate. The evidence suggests that Sergeant A was well aware that Subject 1 was exhibiting behavior that indicated he was in need of mental health treatment or evaluation, but that Sergeant A was determined to send him to court anyway.

In his deposition, Sgt. A testified that he believed Subject 1 was faking that there was something wrong with him so that he would not have to go to court. However, in his initial statement to IPRA, Officer A reported that Sgt. A had warned him that Subject 1 "was not in his right mind."[141] Officer A himself believed that there was something wrong with Subject 1. When he reported that to Sgt. A, Sgt. A said that they needed to bring Subject 1 to court.[142] These reports refute Sgt. A's statement that he thought Subject 1 was faking.

Sgt. A attempted to explain his lapse by claiming that he lacked sufficient training on how to assess whether an arrestee is in need of mental health treatment. However, the fact that Sgt. A felt the need to warn Officer A that Subject 1 was not in his right mind indicates that Sgt. A had enough information to know that Subject 1 needed a mental health evaluation. Therefore, the allegation that Sgt. A knew Subject 1 needed mental health treatment and failed to make it available to him is **Sustained**.

Sergeant C

Sgt. C was also present when Subject 1 was removed from his cell and taken to court. The evidence is clear that Sgt. C was not participating in the cell extraction in his capacity as a supervisor, but rather as another Department member intended to establish an impressive member presence so as to encourage cooperation out of Subject 1. Sgt. C had no prior contact with Subject 1 and had limited knowledge of what his conduct had been during his time in police custody. Once Sgt. C did have contact with Subject 1 and could observe his behavior, there was no time for him to change course from the plan to bring Subject 1 out of his cell for court because the physical interaction in the cell and removal from it was over within a few minutes. Sgt. C did not know that Subject 1 needed mental health treatment and was not in a position that he should have known this. Therefore, this allegation against Sgt. C is **Unfounded**.

Lieutenant C

Lt. C's involvement in this incident was less than any other accused member. He testified that he started his shift early to help approve the reports related to the incident. Lt. C never had any contact with Subject 1, who was already at Roseland Hospital by the time Lt. C became

[141] Statement of Officer A , Attachment 187, page 8, lines 6-7
[142] Statement of Officer A , Attachment 187, page 5, lines 7-9

aware of the situation. Therefore, the allegation that Lt. C knew Subject 1 needed mental health treatment and failed to make it available to him is **Unfounded**.

B. Maltreatment While in Lockup

It is further alleged that Lt. B maltreated Subject 1 by allowing him to walk around the lockup area with his pants down. For safety purposes, arrestees in lockup are not allowed to keep belts with them. It seems clear that Subject 1's pants fell down because they were not sufficiently tightened while he was moving through the lockup area to have his fingerprints and photographs taken. According to Lt. B, he had no recollection of seeing Subject 1's pants down while he was in lockup. Lt. B was only aware this happened because he later watched a portion of the lockup video. The video shows that Lt. B was not present in the room when Subject 1's pants fell to his ankles, but it is not clear on the video whether Lt. B had a clear view of Subject 1 during the following period when Subject 1's pants were off. This allegation against Lt. B is also **Not Sustained**.

C. Failure to Allow Family Visit

It is alleged that Lt. B violated two different policies related to Subject 1's detention. First, it is alleged that he failed to follow the provisions of Special Order S06-01 by not allowing Citizen 3 to see Subject 1 while Subject 1 was in custody. That order requires that station supervisors in charge of detention facilities will "allow the arrestees a reasonable number of visitations by an attorney of their choice and/or a member of their family unless there is imminent danger of escape." Lt. B's rationale for refusing to allow Citizen 3 to see his son is that he did not know what effect such an interaction would have on Subject 1. Subject 1was charged with battering his mother. Subject 1 also broke the windows in Citizen 3's car, although he was charged with the damage to property. Lt. B did not know what precipitated the actions that led to Subject 1's arrest, and he did not know if any interaction between Subject 1 and his father would cause further problems. While the Special Order only lists "imminent danger of escape" as an exception to allowing visitation with a family member, it does say that such visitations should be done in accordance with General Order G06-01-04. That General Order allows the station supervisor to deny a family visit where the station supervisor has a "sound, articulable justification for denying the request" on the grounds that it would not be prudent. Lt. B's explanation, that he feared further escalation of the domestic altercation, was reasonable in light of the fact that Subject 1 had been arrested on a signed complaint by his mother as the result of an altercation that also involved a violent act against his father. Therefore, the allegation that Lt. B failed to follow the provisions of Special Order S06-01 is **Exonerated**.

D. Failure to Follow Protocol for Exposure to Communicable Diseases

It is further alleged that Lt. B failed to follow the provisions of General Order G04-09-02 regarding Exposure to Communicable Disease. That order requires that the supervisor conducting a preliminary investigation into a Department member's exposure to communicable disease should attempt to have the source individual consent to be tested for disease. As the supervisor who completed the Report of Exposure to Communicable Disease/Hazardous Material, this was Lt. B's responsibility. Lt. B did not know whether he asked Subject 1 if he would consent to such testing. Lt. B also did not know whether he sent the report to the Office of Legal Affairs as further required by the General Order. Lt. B did not recall receiving any specific training regarding this practice. Lt. B did not know how such written consent should be recorded if it was obtained. His lack of knowledge about this policy is insignificant. If Lt. B did not know what the procedure was, he should have found out. It is clear that Lt. B did not follow the requirements of General Order G04-09-02. This allegation is therefore **Sustained**.

III. INCIDENT LEADING TO REMOVAL FROM CELL

A. Member Presence

It is alleged that Sgt. C, Sgt. A, Officer A , Officer B, and Officer C used excessive force on Subject 1 in his cell. Before the Department members used any physical force, however, they entered Subject 1's cell with Detention Aide A. According to the involved members, the reason they went to the cell together was to convince Subject 1 to cooperate with their efforts to bring him to court. One of the lowest police actions listed on the CPD Use of Force Model is "member presence." It is listed along with "verbal commands" as one of the actions that is appropriate for even a cooperative subject. The member presence involved in this case is that six Department members, including two sergeants, entered Subject 1's cell and reported that the reason they did so was to try to convince Subject 1 to go to court. Sgt. A, Officer B, and Detention Aide A had all tried to talk to Subject 1 one-on-one, but Subject 1 ignored them, which resulted in Subject 1 being classified by the officers as a passive resistor. The Department members who were present explained that the reason that six officers entered the cell was to show Subject 1 that there was a group of officers ready in the event Subject 1 decided to be combative like Subject 1 had been during his arrest. The CPD General Order on Force Options notes that "Social control/police presence is established through identification of authority and proximity to the subject. Police presence may result in conforming behavior."[143] Applying CPD's policy to the plan used to enter the cell with six officers may appear to be a reasonable progression in dealing with an arrestee who refused to cooperate with several individual Department members and had previously exhibited combativeness toward his arresting officers; however such an application of policy should be seriously questioned when applied to an otherwise quiet and non-threatening arrestee who refused to attend his court hearing.

Based on the circumstances here, although bringing six members into the lockup cell to create a strong member presence may have been a tactic that caused the situation to escalate into the need to for the use of physical force, it was not necessarily outside of CPD policy.

[143] G03-02-02 IV.A.1.a.

B. Use of a Taser

One aspect of physical force that was used in the cell against Subject 1 was Officer A's discharge of a Taser. There is insufficient evidence to prove by a preponderance that Officer A's discharge of a Taser at Subject 1 in lockup was an unreasonable use of force based on the totality of the circumstances.

Prior to entering Subject 1's cell, Officer A had learned the Subject 1 had been combative during his arrest and, for this reason, Sgt. A, who had supervisory authority over the conduct of officers within the lockup facility, had found it necessary and appropriate to produce a "show of force" of six Department members in an attempt to secure Subject 1's cooperation. Sgt. A instructed Officer A to have the Taser ready and available in case Subject 1 became combative with them. Sergeant A's directive to Officer A to bring the Taser into the lockup cell was in violation of Special Order S06-01-02, which prohibits bringing weapons into a lockup cell unless there is an emergency. Despite urging to do so by Sgt. A, Officer A did not discharge the Taser until Subject 1 exhibited what he believed was aggressive behavior: Subject 1 clenched his fists and, in a sudden movement, jumped or stood up from the bench. A reasonable officer in Officer A's position and with his knowledge at that time would perceive Subject 1 as transforming from a passive resister to a low-level aggressor. Pursuant to General Order G03-02-02 and the Use of Force Model, discharge of a Taser is permissible in such a situation.

The fact that Officer A considered Subject 1 a low-level aggressor warranting the Taser discharge is credible. First, Subject 1's sudden movement up and off the bench is visible in the video recording. Second, this movement on the part of Subject 1 is described similarly by all other involved officers. Moreover, these events took place within a relatively confined space thereby increasing the potential for harm to Subject 1 and the officers. The fact that Subject 1 had exhibited aggressive behavior during and since his arrest is also probative as to whether Subject 1's behavior in the cell at that moment appeared aggressive to Officer A and the other officers.

Officer A did not discharge the Taser until Subject 1 became a low level assailant when he suddenly jumped to his feet as depicted in the video, clenched his fists as was reported by the officers, and moved toward the officers. The video does not fully show the movement that Subject 1 took, but it does not contradict the officers' assertion that he moved in their direction. Sgt. A had already informed Officer A that Subject 1 had been combative during his arrest and fought with his arresting officers. According to Officer A, Sgt. A had already warned him that they may experience similar behavior. That warning, coupled with Subject 1's sudden movement into what Officer A perceived to be an aggressive stance, put Officer A in reasonable expectation that Subject 1 might batter him or one of the other officers. According to Officer A, after deploying the Taser, Officer A noticed that the digital readout on the Taser was not counting down as it normally does. He understood that to mean that no electrical current was being transmitted to the probes that were attached to Subject 1, making the Taser ineffective. Subject 1 was also not exhibiting behavior that showed that he was affected by the Taser. Instead, according to the Department members in the cell, he flailed his arms and kicked his legs when the other officers tried to restrain him put handcuffs and leg shackles on him. Officer A then pulled the Taser trigger a second time to send a burst of electricity to the probes. This time the

Taser appeared to be working and appeared to have an impact on Subject 1. Based on the totality of the circumstances, there is insufficient evidence to prove that Officer A's use of the Taser was unreasonable.

As part of Officer A's use of a Taser, it is alleged that Sgt. A violated Special Order S06-01-02 in instructing Officer A to bring the Taser into lockup in the first place. That order prohibits lockup staff from carrying or keeping any weapons in lockup or permitting other Department members from doing so. There is an exception in this prohibition for emergency situations. Prior to the officers entering Subject 1's cell, however, no emergency existed. According to Officer A, Sgt. A directed him to use the Taser if Subject 1 became combative. Although Subject 1 had been described as combative during his arrest, and he did not fully cooperate with the first watch staff during processing, there was no reason to believe that an emergency allowing for the presence of a Taser in the lockup. Therefore, this allegation against Sgt. A is **Sustained**.

C. Grabbing, Takedown, etc.

Aside from Officer A's use of a Taser, the other physical force that was used on Subject 1 in the cell was the officers' performing a takedown by grabbing Subject 1's arms and legs so that they could place restraints on them. The officers who were present at the time of the incident described that Subject 1 was flailing his arms and kicking his legs in order to prevent the Department members from securing the handcuffs and leg shackles on him. To be sure, Subject 1's resistance continued even after Officer A deployed the Taser and the physical struggle between Subject 1 and the officers ensued. Although the video does not provide an unfettered view of the altercation, it clearly shows that a struggle occurred. A takedown is permitted for a subject who is an active resistor, which includes someone who moves to avoid physical control. Based on what is visible in the lockup video, Subject 1's actions appear to fit that category. In addition, the fact that Subject 1 was uncooperative at various times during his stay in the lockup over the course of that night and into the morning hours is probative as to the fact that Subject 1 was uncooperative during the incident in his cell. Although there are allegations that the officers who went into the cell used excessive force against Subject 1, the video evidence is inconclusive on this issue. Because the video images are obscured by the privacy screen, it is not possible to see exactly what transpired in the cell that morning. What can be seen is consistent with the accounts of the officers, that they were attempting to gain control over an uncooperative subject. Moreover, the reports and statements from the ambulance personnel bear no documentation of visible external injury to Subject 1. According to Paramedic 1, Subject 1 "didn't appear to have anything extraneous done to him other than the amount of force required to restrain for that – for their particular incident. He had no other apparent marks; he didn't have anything." The available evidence is insufficient to prove by a preponderance whether or not the force the officers involved in the lockup incident used against Subject 1 was excessive. Therefore this allegation as to Sergeants A and C and Officers A, B and C is **Not Sustained**.

D. Dragging Subject 1 (Detention Aide A)

It is alleged that Detention Aide A physically maltreated Subject 1 by dragging him from his cell and down the hallway while Subject 1 was handcuffed and shackled. There is more than

a preponderance of evidence showing that Detention Aide A's dragging Subject 1 out of the cell and down the hallway of the lockup facility was an unreasonable use of force based on the totality of the circumstances. Detention Aide A's conduct was a violation of Section III of General Order G03-02 which states:

> (A) When a Department member engages a member of the public, the member will do so in such a manner which affords that person the respect and dignity to which all persons are entitled.
> (B) Department members will use an amount of force reasonably necessary based on the totality of the circumstances to perform a lawful task, effect an arrest, overcome resistance, control a subject, or protect themselves or others from injury.

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. According to Detention Aide A, he did not recall that the shackles had been secured on Subject 1's legs. Nonetheless, by all accounts, by this point Subject 1 had been subdued. Subject 1 was no longer fighting with the Department members and was, in fact, fully restrained at the point that Detention Aide A dragged Subject 1. Therefore, there was no lawful task to be accomplished by dragging Subject 1 out of the cell and down the hallway.

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. If Subject 1 was not given an opportunity to walk, dragging an arrestee who was already restrained by the hands and feet was not the only option. There were five other Department members present who could have assisted Detention Aide A in carrying Subject 1 to the front. Alternatively, they could have left Subject 1 in his cell until the paramedics arrived. According to Detention Aide A, he did not want to do that because he thought it would require the officers to again struggle to get Subject 1 to leave the cell once the paramedics arrived. This makes no sense; if Subject 1 was going to struggle, he would just as easily have struggled upfront as in the cell. Detention Aide A also argued that he needed to move Subject 1 so that the other Department members could exit the cell. This argument is not valid for the dragging that continued through the walk down the hallway toward the front of lockup, which he acknowledged was wide. Moreover, pursuant to S03-02-02, because Subject 1 had been the subject of a Taser discharge, Detention Aide A knew that he would have to be seen by paramedics to have the Taser probes removed.[144] Therefore there was no exigent need to remove Subject 1 from the lockup cell, because he would not be transported to court before being seen by paramedics for this purpose.[145]

[144] S03-02-02, which was in effect at the time of this incident but is now labeled as G03-02-07, requires that a member who discharged a Taser immediately notify OEMC and request assignment of emergency medical personnel when either the Taser probes were discharged and penetrated a subject's skin or an electrical current from the Taser was applied to the subject's body.
[145] At this time, Subject 1 had only been in custody for approximately 12 hours, well within the 48 hour threshold limit within which a detainee must be seen in court.

Lastly, in addition to representing an unreasonable use of force by dragging Subject 1 out of the cell and down the hallway, Detention Aide A failed to provide Subject 1 with the respect and dignity to which all members of the public are entitled. Therefore, this allegation as to Detention Aide A is **Sustained**.

E. Failure to Intervene

It is alleged that 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. According to General Order G06-01-01 II. A., Department "members will be responsible for the safety and security of the arrestee." Sgt. A, Sgt. C, Officer A, Officer C, and Officer B were all present when Detention Aide A dragged Subject 1 along the floor while Subject 1 was restrained. These Department members failed to ensure Subject 1's safety and security by not intervening when Detention Aide A did this.

Additionally, according to Special Order SO 06-01, station supervisors in charge of detention facilities will be held accountable for ensuring the safety and care of all arrestees within police facilities and lockups. Sgt A was Detention Aide A's direct supervisor and was directly responsible for the care of detainees in the 005th District Lockup facility. Sgt. A's failure to intervene when Detention Aide A dragged Subject 1 out of the cell and down the hall was in violation of SO-06-01.

Sgt. A

Sgt. A's failure to intervene was also problematic because it gave the other involved officers the impression that Detention Aide A's conduct was acceptable. Officers A and B both stated that they did not stop Detention Aide A from dragging Subject 1 because their sergeants were present and did not do or say anything to stop it. Detention Aide A himself said that he thought his actions were proper because his sergeant did not stop him from taking them. Sgt. A's silence in the presence of this display of excessive force amounted to tacit approval of it. Sgt. A was Detention Aide A's direct supervisor at the time of this incident. He had a duty and responsibility to immediately address Detention Aide A's conduct. Because Sgt. A did not do so, Detention Aide A continued his actions in dragging Subject 1 to the front of lockup rather than giving Subject 1 the opportunity to walk or having other officers assist him in carrying Subject 1. Therefore, this allegation as to Sergeant A is **Sustained**.

Sgt. C

Sgt. C was also present when Detention Aide A dragged Subject 1. According to Sgt. C , he was one of the last people to leave the cell because he was recovering from being hit by the Taser discharge. The video evidence from lockup corroborates that Sgt. C was slightly behind several of the other Department members as they exited the cell area. However, by his own admission, Sgt. C could see Subject 1's feet and could see that Detention Aide A was dragging him down the hall. Sgt. C acknowledged that the incident could have been handled differently. Even though Sgt. A was present, Sgt. C could and should have stepped forward and stopped Detention Aide A from using excessive force by dragging Subject 1. Therefore, this allegation as to Sgt. C is **Sustained**.

Officers B and A

According to Officers B and A, they relied on the fact that the sergeants did not intervene to present Detention Aide A's excessive use of force on Subject 1. The fact that superior officers were present did not absolve these officers' duty to intervene. Rule 3 of the Rules and Regulations Governing the Chicago Police Department (the "Department Rules") prohibits the "failure to promote the Department's efforts to implement its policy or accomplish its goals." The Comment associated with this rule clearly states that the rule encompasses an omission or failure to act by any member of the Department which act "would be required by the stated policy, goals, rules, regulations, orders and directives of the Department." Here, the stated policy or goal of the Department is expressed in Article I(B)(7) of the Rules, which states "[t]he use of excessive and unwarranted force or brutality will not be tolerated under any circumstances," and which policy is further outlined in General Order G03-02, et seq.

Moreover, neither Officer A, nor Officer B stepped forward to assist Detention Aide A in moving Subject 1. If they had offered to help, they could have carried Subject 1 to the front rather than allowing Detention Aide A to drag him. Even though the sergeants present did not direct them to intervene, Officers B and A should have taken it upon themselves to provide a different solution to the problem of moving Subject 1. Therefore, this allegation as to Officers B and A is **Sustained**.

Officer C

Sgt. C identified himself and Officer C as the last two people to leave Subject 1's cell after Detention Aide A dragged Subject 1 out of it. This is supported by the video, which shows them behind the other Department members in the cell and hallway. In his deposition, Officer C reported that he did not remember seeing Detention Aide A drag Subject 1. He also did not mention the removal in his statement to IPRA under Log #1058981. It is not clear whether he would have had an opportunity to see Detention Aide A dragging Subject 1. Because it is not known whether Officer C was in a position to see this, the allegation that he failed to intervene is **Not Sustained**.

F. Failure to Report

It is alleged that Sgt. C, Sgt. A, Officer A , Officer B, and Officer C 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. According to Officers B and A, they did not report this incident to a supervisor because their supervisors were present when it occurred. Because Sgt. A and Sgt. C were both present when Detention Aide A dragged Subject 1, neither Officer B nor Officer A would have had to report the incident to anyone else. Officer B said that he did not believe that Detention Aide A's actions amounted to misconduct because Sgt. A was present and did not say anything. According to Officer B, he then assumed that Detention Aide A was doing the right thing. This is a flawed argument. Detention Aide A's behavior was so excessive that Officers A and B should have known that it was the wrong thing to do. They had a duty to report this misconduct. Rule 22 of the Rules and Regulations of the Chicago Police Department is unequivocally proscribes the "failure to report to the Department any violation of Rules and Regulations or any other improper conduct which is contrary to the policy, orders or

directives of the Department." This rule is not qualified in any manner to indicate that the rule does not apply where a superior officer is present and appears to condone the misconduct. Officer A and B's failure to report Detention Aide A's misconduct represents a violation of Rule 22, notwithstanding, the presence of the two superior officers. If the supervisors who were present did not stop Detention Aide A's action, they should have reported it to the next supervisor in their chain of command. The allegation that Sgt. C, Sgt. A, Officer A, and Officer B failed to report Detention Aide A's misconduct is therefore **Sustained**.

For Officer C, however, as with the allegation that he failed to intervene, it is not know whether he was in a position to see that Detention Aide A was dragging Subject 1 out of the cell and down the hall. This allegation against Officer C is therefore **Not Sustained.**

G. Brought Discredit Upon the Department

It is alleged that Detention Aide A brought discredit upon the Department. Moreover, Detention Aide A's acts represented a violation of Rule 2, which prohibits "[a]ny action or conduct which impedes the Department's efforts to achieve its policy and goals or brings discredit upon the Department." Detention Aide A's callous and disrespectful treatment of Subject 1 was inconsistent with core department values and brought discredit upon the Department. Therefore, this allegation as to Detention Aide A is **Sustained**.

IV. INCIDENT AT ROSELAND HOSPITAL

It is alleged that Officers D and E used excessive force on Subject 1 at Roseland Hospital. The excessive force allegation includes the use of a Taser by Officer D and the use of a baton by Officer E.

The medical examiner's report clearly outlines that the level of force used against Subject 1 at the hospital was more than extensive. Based on the number and severity of the injuries he sustained, the force used against him was quite violent.

The use of force by Department members is governed by General Orders G03-02 and G03-02-02, and Special Order S03-02-02.[146] The appropriate use of force is determined based on whether a subject is cooperative, resister or an assailant. A resister is categorized as either passive or active. Pursuant to General Order G03-02-02 that was effective at the time of this incident, an active resister is:

> a person whose actions attempt to create distance between that person and the member's reach with the intent to avoid physical control and/or defeat the arrest. This type of resistance includes gestures ranging from evasive movement of the arm, through flailing arms, to full flight by running.

Pursuant to the same General Order, an assailant is a "subject who is using or threatening the imminent use of force against himself/herself or another person." More specifically, the General Order states that an assailant is one whose "actions are aggressively offensive without

[146] Now G03-02-07.

weapons." The General Order further states:

> This type of assailant is one who places a member in fear of battery and includes the advancing on the member in a threatening manner or closing the distance between the assailant and the member, thereby reducing the member's reaction time.

Under the applicable General Orders, the discharge of a Taser is a permissible use of force against an active resister or an assailant. The use of an impact weapon, such as a baton, is a permissible use of force against an assailant.

An assessment of the reasonableness of a given use-of-force is judged from the perspective of a "reasonable officer on scene, rather than with the 20/20 vision of hindsight." When judging an officer's acts, the reviewer should allow "for the fact that police officers are often forced to make split-second judgments – in circumstances that are tense, uncertain, and rapidly evolving – about the amount of force that is necessary in a particular situation."

Here, the evidence shows that Subject 1's conduct was sufficiently elusive and combative that a reasonable officer would have perceived him to be an assailant.

Fourteen employees of Roseland Hospital provided statements to IPRA regarding the interaction between Subject 1 and the officers at the hospital. This is in addition to the statements from the involved CPD officers. The statements to IPRA and the depositions of the medical and security staff at Roseland Hospital are consistent in their description of Subject 1's behavior. A review of the various statements and depositions has revealed no evidence to suggest that that the hospital staff involved in the incident exaggerated or fabricated the events that occurred. The hospital staff was very consistent in their statements when they characterized Subject 1's actions as violent and chaotic as he struggled with hospital staff, paramedics, and the officers. Several of the hospital staff members reported that they ran out of the area because they were in fear of Subject 1. Nurse 3 described Subject 1 as very "violent".[147] Nurse 3, Security Guard 4 and Security Guard 1 also described Subject 1 as being exceptionally strong. At one point, Subject 1 was able to use such force to lift a security guard off his feet and "throw" him towards the wall.[148]

Paramedics 1 and 2 also corroborated the hospital staff's accounts of Subject 1's behavior. Before Officer D deployed the Taser, Paramedic 1 described Subject 1 as actively fighting the paramedics attempting to transfer him from the ambulance stretcher to the hospital gurney.[149] The paramedics removed Subject 1's handcuffs in order to transfer him. Subject 1 then became irate; kicking, spitting, and punching.[150] In struggling with the paramedics, Subject 1 either tipped the gurney over or fell from the gurney and headed towards Officer D.[151] With

[147] Deposition of Nurse 3, Attachment 223, page. 48, lines 13-17.
[148] Deposition of Nurse 3, Attachment 223, pages 18-19, lines 19-22; Statement of Security Guard 4, Attachment 87, page 7; Statement of Security Guard 1, Attachment 77, pages 4-5.
[149] Deposition of Paramedic 1, Attachment 229, page 41, lines 2-22; page 44, lines 8-18.
[150] Deposition of Paramedic 2, Attachment 236, page 44, lines 16-18.
[151] Deposition of Paramedic 2, Attachment 236, page 47, line 20-24; Deposition of Paramedic 1, Attachment 229, page 44, lines 6-21.

regards to the deployment of the Taser by Officer D, the Taser download report indicates that the trigger was pulled thirteen times. While this appears to be excessive, the accounts from Paramedic 1 and 2 corroborate Officer D's assertion that the Taser did not actually function because Subject 1 broke the probes after the initial discharge.[152] Additionally, Paramedics 1 and 2 corroborate the officers' account that when the Taser malfunctioned, Subject 1 had cornered Officer D or was actively still advancing on Officer D.[153] Finally, Paramedic 1 stated that he physically struggled with Subject 1 in an attempt to prevent him from reaching Officer D.[154]

Statements from hospital staff and the paramedics verify that Officer E used his baton multiple times on Subject 1. Nurse 4, Security Guard 4, and Paramedics 1 and 2 all stated that Subject 1 charged Officer E and made statements to the effect of "I'm coming out" or "here I come" before Officer E used his baton.[155] After making this statement, Subject 1 charged through the doorway of his assigned room and the struggle continued in the hallway of the emergency room. At the time Officer E hit Subject 1, his legs were shackled. Those who witnessed Officer E strike Subject 1 stated that, at least initially, the strikes were aimed at Subject 1's legs. According to Officer E, he used his baton to try to gain control of Subject 1 and get him to stop fighting with them. Officer E stated that he struck Subject 1 on the legs and hips.[156] Officer E is trained not to strike "vital areas."[157] Officer D stated that Officer E hit Subject 1 in legs and lower body but he never saw him hit Subject 1 above the waist.[158] Nurse 1 testified that she observed Subject 1 being stuck more than once in the abdomen and rib cage, however, Nurse 1 also testified that the leg hits to Subject 1 had no effect to his actions.[159] Subject 1 continued to struggle, even as additional officers arrived to provide assistance. Ultimately, officers and hospital staff were able to gain control of Subject 1 after the sedative was administered.

Subject 1 suffered extensive injuries during this incident. The medical examiner's report details multiple severe abrasions and bruises. In fact, Subject 1 sustained so much bruising that it was difficult for the doctor who performed the autopsy to discuss every single bruise and abrasion.[160] Specifically, the left side of Subject 1's body contained the following: multiple abrasions, bruises, scrapes and discoloration throughout the left arm on the inside, outside, and elbow area; bruising on the thigh and above the calf and ankles; the entire left leg had extensive bruising in a concentrated area; the entire knee area was bruised.[161] Additionally, the right side of the body contained the following: large bruise and scrapes on the right elbow; bruising on the

[152] Deposition of Paramedic 1, Attachment 229, pages 47-88, lines 18-4; Deposition of Paramedic 2, Attachment 236, page 50, lines 5-10.
[153] Deposition of Paramedic 1, Attachment 229, page 49, lines 17-21; Deposition of Paramedic 2, Attachment 236, page 51, lines 6-11
[154] Deposition of Paramedic 1, Attachment 229, page 48, lines 16-24
[155] Deposition of Nurse 4, Attachment 257, page 14, lines 5-24; Deposition of Paramedic 2, Attachment 236, page 55, lines 9-19; Deposition of Paramedic 1, Attachment 229, page 54, lines 6-24; Statement of Security Guard 4, Attachment 87, page 13-14, lines 24-14
[156] Deposition of Officer E, Attachment 244, pages 24-25, lines 14-4
[157] Deposition of Officer E, Attachment 244, page 28, lines 3-9
[158] Deposition of Officer D, Attachment 230, pages 32-33; lines 12-4
[159] Deposition of Nurse 1, Attachment 233, page 18, lines 5-15
[160] Attachment 291
[161] Attachment 58

right forearm; extensive abrasions and multiple bruises on the knee.[162] Of particular note was the internal bruising of Subject 1's body; this occurred behind the head, on the side of the head, in front of both ears in the temporal region, and on his back. The autopsy confirmed additional internal bruising to the mid chest wall and the left clavicle as well as a fractured anterior rib. After reflecting the scalp it was revealed that Subject 1 suffered bruising to his right and left temporal regions. Additionally, after reflecting the back, a number of internal bruises were discovered on the upper and mid back.[163] The bruises on the back were not apparent externally to the doctor who performed the autopsy.[164]

Dr. 4, who was present at the postmortem examination, described a large number of Subject 1's bruising to be consistent with someone being struck with an ASP or baton, including bruises on Subject 1's legs and back.[165] Most of the bruising Dr. 4 attributed to the baton was found on Subject 1's legs, but there were bruises on the upper back that also were verbally attributed to the baton during the examination. Dr. 4 specifically referred to the distinctive pattern of those bruises, which is similar to a "train track," as being indicative of an ASP expandable baton. However, Officer E, the only officer who used a baton of any kind, used a wooden baton rather than an ASP. Because a wooden baton does not leave the same distinctive pattern as an ASP, which is created by the ASP's ridges, it is not clear what caused these specific bruises found on Subject 1's back. Dr. 3, who performed the examination, made no conclusive opinion that the internal bruising on Subject 1's back or head and the external bruising to the arms was the result of a baton. Only one of the witnesses, Nurse 1, recalled seeing the officers use a baton to Subject 1's torso, specifically the rib cage and abdomen area. Nurse 1 also reported that the strikes to the legs were ineffective. Officer E's description of striking Subject 1 on the hips and Nurse 1's report of seeing strikes to the abdomen/rib cage area are likely the same action being described in two different ways. Because of the dynamic situation, it is possible that Officer E's baton made contact with Subject 1's torso, despite Officer E's attempts to only strike Subject 1's legs. The final post mortem report, however, does not detail any external injury to Subject 1's torso or abdomen.[166] The medical examiner also opined that the internal bruising on the back was consistent with applied pressure from a knee.[167] This injury may have been caused by one of the officers or other persons using a knee to hold Subject 1 on the floor. Although not explicitly addressed by the medical examiner, the fracture to the anterior rib might also have been caused by such a restraint action.

All witness statements about the altercation at the hospital are quite consistent that the struggle with the paramedics and officers was violent in nature, which could have reasonably contributed to the extensive injuries.

Officer E's use of the baton against Subject 1's torso, if intentionally so directed, could be considered use of "deadly force." According to General Order G03-02-03, a sworn member is "justified in using force likely to cause death or great bodily harm only when he or she

[162] Attachment 58
[163] Attachment 58
[164] Deposition of Dr. 3, Attachment 249, pages 23-25; lines 24-5.
[165] Attachment 291
[166] Attachment 58
[167] Deposition of Dr. 3, Attachment 249, page 74, lines 4-15.

reasonably believes that such force is necessary to prevent death or great bodily harm to the sworn member or to another person." In this situation, there is insufficient evidence to prove that Officer E was unreasonable in his belief that Subject 1 presented an imminent threat of death or great bodily harm to the sworn members as well as the hospital employees and patrons. All witnesses to the incident describe a completely violent encounter during which Subject 1 exhibited violent and threatening behavior to the officers and the ambulance and hospital personnel who were attempting to detain him.

General Order G03-02-03 also provides that a sworn member is justified in using deadly force when he or she reasonably believes that such force is necessary to prevent an escape by a person "who will endanger human life or inflict great bodily harm unless arrested without delay." In this situation, there is insufficient evidence to support that Officer E was unreasonable in his belief that Subject 1 could endanger human life or inflict great bodily harm unless he was arrested without delay. Subject 1 was exhibiting seriously violent behavior in the emergency room of a hospital, therefore, a setting with many potential vulnerable victims had Subject 1 been successful at making good the escape he did, in fact, attempt.

Based on the totality of circumstances, although Subject 1's injuries were substantial and the force used against him seemingly quite severe, there is insufficient evidence to prove by a preponderance that the officer's use of force was excessive in light of Subject 1's combative, violent conduct and the resulting risk of injury to the officers, ambulance personnel, and hospital staff who restrained him as well as the potential risk of harm to hospital patrons had he escaped. Therefore, allegations of excessive force against Officers D and E based on their conduct at Roseland Hospital are **Not Sustained**.

FINDINGS:

Accused #1 **Sgt. B, Unit 008**

Allegation #1 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 12 December 2012, at approximately 1945 hours, at 12828 S. Morgan, Sgt. B, Unit 008, failed to follow the provisions of Special Order S04-20-01 and General Order G06-01-01 when he failed to bring Subject 1 for medical and/or mental health treatment.

Accused #2 **Lt. B Unit 012**

Allegation #1 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 12 December 2012 at approximately 2230 hours through 13 December 2012 at approximately 0530 hours, at 727 E. 111th Street, Lt. B, Unit 012, failed to follow the provisions of Special Orders S04-20-01 and S06-01 when he failed to make medical and/or mental health treatment available for Subject 1.

Allegation #2 **Not Sustained**

Allegation #3 **Exonerated**

Allegation #4 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that at an unknown time on 13 December 2012, at 727 E. 111th Street, Lt. B Unit 012, failed to follow the provisions of General Order G04-09-02 regarding Exposure to Communicable Disease.

Accused #3 **Lt. A , Unit 001**

Allegation #1 **Unfounded**

Accused #4 **Lt. C, Unit 008**

Allegation #1 **Unfounded**

Accused #5 **Sgt. C, Unit 004**

Allegation #1 **Unfounded**

Allegation #2 **Not Sustained**

Allegation #3 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. C, Unit 004, failed to follow the provisions of General Order G06-01-01 when he failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Sustained – Violation of Rule 3, "Any failure to promote the Department's efforts to implement its policy or accomplish its goals," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. C, Unit 004, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Sustained – Violation of Rule 8, "Disrespect or Maltreatment of any person, while on or off duty," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. C , #1003, Unit 004, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Allegation #4 **Sustained** – Violation of Rule 22, "Failure to report to the Department any violation of Rules and Regulations or any other improper conduct which is contrary to the policy, orders or directives of the Department," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. C, Unit 004, 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.

Accused #6 **Sgt. A, Employee**

Allegation #1 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. A, failed to follow the provisions of Special Orders S04-20-01 and S06-01 when he failed to make medical and/or mental health treatment available for Subject 1 .

Allegation #2 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. A, failed to follow the provisions of Special Order S06-01-02 when he instructed Officer A to bring a Taser into the lockup facility.

Allegation #3 **Not Sustained**

Allegation #4 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. A, failed to follow the provisions of General Order G06-01-01 and Special Order S06-01 when he failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Sustained – Violation of Rule 3, "Any failure to promote the Department's efforts to implement its policy or accomplish its goals," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. A, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Sustained – Violation of Rule 8, "Disrespect or Maltreatment of any person, while on or off duty," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. A , Employee #46287, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Allegation #5 **Sustained** – Violation of Rule 22, "Failure to report to the Department any violation of Rules and Regulations or any other improper conduct which is contrary to the policy, orders or directives of the Department," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Sgt. A, 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.

Accused #7 **Officer A , Unit 050**

Allegation #1 **Not Sustained**

Allegation #2 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer A, Unit 050, failed to follow the provisions of General Order G06-01-01 when he failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Sustained – Violation of Rule 3, "Any failure to promote the Department's efforts to implement its policy or accomplish its goals," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer A , Unit 050, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed

and shackled.

Sustained – Violation of Rule 8, "Disrespect or Maltreatment of any person, while on or off duty," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer A , Unit 050, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Allegation #3 **Sustained** – Violation of Rule 22, "Failure to report to the Department any violation of Rules and Regulations or any other improper conduct which is contrary to the policy, orders or directives of the Department," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer A, Unit 050, 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.

Accused #8 **Officer B, Unit 050**

Allegation #1 **Not Sustained**

Allegation #2 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer B, Unit 050, failed to follow the provisions of General Order G06-01-01 when he failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Sustained – Violation of Rule 3, "Any failure to promote the Department's efforts to implement its policy or accomplish its goals," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer B, Unit 050, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Sustained – Violation of Rule 8, "Disrespect or Maltreatment of any person, while on or off duty," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer B, Unit 050, failed to intervene when Detention Aide A physically maltreated Subject 1 by dragging him while he was handcuffed and shackled.

Allegation #3 **Sustained** – Violation of Rule 22, "Failure to report to the Department any violation of Rules and Regulations or any other improper conduct which is contrary to the policy, orders or directives of the Department," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Officer B Unit 050, 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.

Accused #9 **Officer C, Employee**

Allegation #1 **Not Sustained**

Allegation #2 **Not Sustained**

Allegation #3 **Not Sustained**

Accused #10 **Detention Aide A, Employee, Unit 005**

Allegation #1 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Detention Aide A, Employee #57170, Unit 005, failed to follow the provisions of General Order G03-02 when he physically maltreated Subject 1 by dragging him from his cell while he was handcuffed and shackled.

Sustained – Violation of Rule 8, "Disrespect to or maltreatment of any person, while on or off duty," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Detention Aide A, Unit 005, physically maltreated Subject 1 by dragging him from his cell while he was handcuffed and shackled.

Allegation #2 **Sustained** – Violation of Rule 6, "Disobedience of an order or directive, whether written or oral," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Detention Aide A, Unit 005, failed to follow the provisions of General Order G03-02 when he physically maltreated Subject 1 by dragging him down the hallway while he was handcuffed and shackled.

Sustained – Violation of Rule 8, "Disrespect to or maltreatment of any person, while on or off duty," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Detention Aide A, Unit 005, physically maltreated Subject 1 by dragging him down the hallway while he was handcuffed and shackled.

Allegation #3 **Sustained** – Violation of Rule 2, "Any action or conduct which impedes the Department's efforts to achieve its policy and goals or brings discredit upon the Department," in that on 13 December 2012, at approximately 0745 hours, at 727 E. 111th Street, Detention Aide A, Unit 005, by his overall actions and conduct did bring discredit upon the Department.

Accused #11 **Officer D, Unit 002**

Allegation #1 **Not Sustained**

Accused #12 **Officer E, Unit 005**

Allegation #1 **Not Sustained**