SUMMARY REPORT OF INVESTIGATION[1]

I. EXECUTIVE SUMMARY

Date of Incident:	September 2, 2017 and September 3, 2017
Time of Incident:	8:03 pm (September 2, 2017) 6:05 pm (September 3, 2017)
Location of Incident:	[redacted]
Date of IPRA Notification:	September 3, 2018
Time of IPRA Notification:	8:21 pm

On September 2, 2017, [redacted] ("[redacted]") was arrested and transported to the District [redacted] male lock-up. The next day, CPD members working in lock-up discovered [redacted] using the drawstring from his shorts in an attempt to hang himself in his cell. [redacted] was rescued and provided with medical attention. IPRA was notified of the suicide attempt, and an investigation was initiated. The investigation determined that [redacted] was not properly searched when he entered lock-up and that [redacted] was not adequately monitored during the time immediately preceding his suicide attempt.

II. INVOLVED PARTIES

Involved Officer #1:	[redacted];[2] star #[redacted]; employee ID# [redacted]; Date of Appointment [redacted], 2000; Police Officer as Detective; Unit of Assignment [redacted] DOB [redacted], 1976; Male; Hispanic
Involved Officer #2:	[redacted]; star #[redacted]; employee ID# [redacted]; Date of Appointment [redacted], 1991; Police Officer; Unit of Assignment [redacted]; DOB [redacted], 1964; Male; Black
Involved Officer #3:	[redacted];[3] star #[redacted]; employee ID# [redacted]; Date of Appointment [redacted], 2004; Police Officer; Unit of Assignment [redacted]; DOB [redacted], 1964; Male; White

[1] On September 15, 2017, the Civilian Office of Police Accountability (COPA) replaced the Independent Police Review Authority (IPRA) as the civilian oversight agency of the Chicago Police Department. Therefore, this investigation, which began under IPRA, was transferred to COPA on September 15, 2017, and the recommendation(s) set forth herein are the recommendations(s) of COPA.

[2] At the time of the incident under investigation, Detective [redacted] held the rank of Police Officer (star #[redacted]) and was assigned to Unit [redacted] (the [redacted] District). For clarity, Detective [redacted] is referred to by his current rank in this report.

[3] At the time of the incident under investigation, Officer [redacted] was assigned to Unit [redacted].

Involved Officer #4:	[redacted];[4] star #[redacted] employee ID# [redacted] Date of Appointment [redacted], 2014; Police Officer / Field Training Officer; Unit of Assignment [redacted] DOB [redacted], 1989; Male; White
Involved Officer #5:	[redacted]; star #[redacted] employee ID# [redacted] Date of Appointment [redacted], 2001; Sergeant of Police; Unit of Assignment [redacted] DOB [redacted], 1975; Male; White
Involved Individual #1:	[redacted]; DOB [redacted], 1993; Male; Hispanic

III. ALLEGATIONS

Officer	Allegation	Finding / Recommendation
Detective [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 2, 2017, at approximately 8:00 p.m., at or near [redacted] (District [redacted] station), that Detective [redacted], Star #[redacted] committed misconduct through the following acts or omissions, by: failing to properly search arrestee [redacted] resulting in an item that could be used as a ligature, to wit, the drawstring from [redacted] shorts, being accessible to [redacted] while in lockup.	Sustained / 5 Day Suspension
Officer [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 2, 2017, at approximately 8:00 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted] committed misconduct through the following acts or omissions, by: failing to properly search arrestee [redacted] resulting in an item that could be used as a ligature, to wit, the drawstring from [redacted] shorts, being accessible to [redacted] while in lockup.	Unfounded
	2. It is alleged by the Civilian Office of Police Accountability that on or about September 3, 2017, between approximately 5:30 p.m. and	Unfounded

[4] At the time of the incident under investigation, Field Training Officer [redacted] held the rank of Police Officer and was assigned to Unit [redacted]

	approximately 6:05 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted], committed misconduct through the following acts or omissions, by: failing to take necessary precautions to prevent the possible injury or death of arrestee [redacted], to wit, failing to adequately monitor [redacted] while [redacted] attempted to hang himself in a holding cell.	
Officer [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 2, 2017, at approximately 8:00 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted], committed misconduct through the following acts or omissions: by sharing his log-on ID access code for the livescan fingerprint and photograph station in the District [redacted] male lockup with Police Officer [redacted], Star #[redacted].	Sustained / Reprimand
Field Training Officer [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 3, 2017, between approximately 5:30 p.m. and approximately 6:05 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted], committed misconduct through the following acts or omissions, by: failing to take necessary precautions to prevent the possible injury or death of arrestee [redacted], to wit, failing to adequately monitor [redacted] while [redacted] attempted to hang himself in a holding cell.	Sustained / 2 Day Suspension
Sergeant [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 3, 2017, between approximately 5:30 p.m. and approximately 6:05 p.m., at or near [redacted] (District [redacted] station), that Sergeant [redacted], Star #[redacted], committed misconduct through the following acts or omissions, by: failing to properly supervise personnel assigned to the District [redacted] male lockup while an arrestee, [redacted], attempted to hang himself in a holding cell.	Unfounded

IV. APPLICABLE RULES AND LAWS

Rules
1. Rule 5: Failure to perform any duty.
2. Rule 6: Disobedience of an order or directive, whether written or oral.
3. Rule 10: Inattention to duty.
4. Rule 11: Incompetency or inefficiency in the performance of duty.
5. Rule 41: Disseminating, releasing, altering, defacing or removing any Department record or information concerning police matters except as provided by Department orders.

General Orders
1. G06-01-01 Field Arrest Procedures (effective November 12, 2015)[5]
2. G09-01-02 Computer Systems Security (effective September 11, 1998)[6]

Special Orders
1. S03-03-05 District Station Supervisor (effective March 3, 2017)[7]
2. S06-01 Processing Persons Under Department Control (effective January 29, 2015)[8]
3. S06-01-02 Detention Facilities General Procedures and Responsibilities (effective May 20, 2016)[9]
4. S07-01-01 Inventorying Arrestees' Personal Property (effective December 4, 2015)[10]

[5] Attachment 96.
[6] Attachment 97.
[7] Attachment 98.
[8] Attachment 99.
[9] Attachment 100.
[10] Attachment 101.

V. INVESTIGATION[11]

a. Interviews

Sgt. [redacted] was interviewed on November 20, 2019,[12] by COPA investigators. Sgt. [redacted] recalled arresting [redacted] on September 2, 2017, with Officer (now Detective) [redacted] and Officer [redacted],[13] who both worked for Sgt. [redacted] on a robbery/burglary/theft team. After the arrest, they transported [redacted] to the District [redacted] station. Sgt. [redacted] recalled bringing [redacted] from the hallway into the intermediate processing room located between the hallway and the lock-up. Typically, the arresting officer who escorted an arrestee into lock-up would be present when lock-up personnel conducted their own search of the arrestee. But Sgt. [redacted] did not remember who stayed with [redacted] in the processing room until he was brought into lock-up and did not remember who brought [redacted] into lock-up, although it was likely either himself, Detective [redacted], or Officer [redacted]. Sgt. [redacted] claimed no knowledge regarding who searched [redacted] in lock-up nor any knowledge regarding potential errors on [redacted] arrest processing report. Hypothetically, Sgt. [redacted] believed that if an error was discovered, the error could be corrected by making an entry on the Watch Commander Comments section of the report, which can still be amended after the other sections of the report have been finalized.

Detective [redacted] was interviewed on December 2, 2019,[14] by COPA investigators. Detective [redacted], who held the rank of police officer at the time of the incident under investigation, recalled working on September 2, 2017, on a tactical team supervised by Sgt. [redacted]. Detective [redacted], along with Sgt. [redacted] and Officer [redacted], were patrolling together when they encountered [redacted] in a parking lot on Cicero Avenue. The officers arrested [redacted], who was wanted based on an earlier incident, and transported him to District [redacted]. When they arrived at the district, Sgt. [redacted] accompanied [redacted] into the processing room, which is adjacent to lock-up, and Detective [redacted] never saw [redacted] again. After Sgt. [redacted] took [redacted] into the processing room, Detective [redacted] went to the tactical-team office across the hall to complete his paperwork. Detective [redacted] did not recall if Officer [redacted] was with him in the tactical-team office, but he assumed that he was, as it was their practice to sit together while working on reports. Detective [redacted] also assumed that Sgt. [redacted] remained with [redacted] in processing until [redacted] was ready to be brought into lock-up,[15] but Detective [redacted] had no first-hand knowledge regarding who brought [redacted] into lock-up or who searched [redacted] in lock-up.

Detective [redacted] did remember having a conversation with Sgt. [redacted] the next day, after they learned that [redacted] had attempted to injure himself in lock-up. In that conversation, Sgt. [redacted] took responsibility for bringing [redacted] to lock-up, telling Detective [redacted], "This is on me. I brought him back there." Detective [redacted] further explained that it was normal practice for

[11] COPA conducted a thorough and complete investigation. The following is a summary of the material evidence gathered and relied upon in our analysis.
[12] Attachments 111, 116.
[13] Officer [redacted] resigned from the Department on November 17, 2018 and was not interviewed as part of this investigation. *See* Personnel Action Request, Attachment 115.
[14] Attachments 112, 117.
[15] Detective [redacted] explained that arrestees would not normally be accepted by lock-up personnel until all of the required paperwork had been completed by the arresting officers.

patrol officers who made an arrest to search the arrestee and remove any strings from their pants, but lock-up personnel were also responsible for conducting their own independent search and removing any dangerous items that the arresting officers had missed. When confronted with Sgt. [redacted] recollection that someone else had taken [redacted] into lock-up, Detective [redacted] could offer no explanation for their differing memories. Detective [redacted] also confirmed that in his experience, the officer working behind the desk in lock-up would enter the name of the officer who searched the prisoner contemporaneously with the search being conducted. Hypothetically, if the wrong officer's name was entered on the report, Detective [redacted] believed that the personnel responsible would notify a supervisor and file a supplemental report explaining the error and identifying the officer who really conducted the search.

Detective [redacted] was interviewed on October 18, 2019,[16] by COPA investigators. Detective [redacted], who is now assigned to Area Central, was working as a police officer in District [redacted] in September of 2017. On the afternoon of September 2, 2017, Detective [redacted] was working in the District [redacted] male lock-up with Officer [redacted] and Officer [redacted]. Detective [redacted] did not remember searching [redacted] and did not remember who had, in fact, conducted the search. Detective [redacted] acknowledged that his name appeared in the "searched by" field of the arrest processing report but explained that his name had been entered in error. Detective [redacted] remembered that on September 3, 2017, he was one of the officers who responded to the call for assistance in lock-up when [redacted] attempted to hang himself. Lt. [redacted], the watch operations lieutenant, also responded to the call for assistance. That day, Lt. [redacted] told Detective [redacted] that he had watched a surveillance video recording from the previous day that depicted [redacted] being searched upon entering the lock-up. Based on that video recording, Lt. [redacted] told Detective [redacted] that "I [Detective [redacted]] was not the one that did the search."[17] Detective [redacted] believed that a report of some kind was generated to document who really conducted the search, but Detective [redacted] was not the author of that report and never saw it. Had Detective [redacted] nducted the search, he "would have written a to-from, or some sort of documentation would have been initiated on my part that says what had happened . . . ."[18] Detective [redacted] was unaware of any efforts to preserve the video recording and never spoke to anyone about this incident after that day.

Based on his knowledge of lock-up procedures, Detective [redacted] elieved that if enough personnel were available, one officer would input arrestee information into the computer, one would search, one would complete inventory reports, and another would fingerprint. If there were not enough personnel, some of these tasks would be done by the same officer. Detective [redacted] remembered that he was the officer who did the inventories on September 2, 2017, and he believed that whoever entered the information in the report erroneously listed him as the searching officer. Detective [redacted] denied the allegation that he failed to properly search [redacted], but he offered a defense for the unknown officer who conducted the search. Detective [redacted] explained that in his experience, when a person is arrested while wearing athletic clothing with a string in the waistband, the searching officer will pull the string as tight as possible and then cut it. Using this method, the officer removes as much of the string as possible, but a short piece could still be attached inside the clothing. Detective [redacted] believed that the searching officer in this case

[16] Attachments 71, 118.
[17] [redacted] Tr. 23:9. Attachment 118.
[18] *Id.* at 23:23–24:2.

pulled the string tight and cut it, leaving only a portion in [redacted] waistband, which [redacted] worked strenuously to remove and use in his suicide attempt the next day.

Officer [redacted] was interviewed on October 23, 2019,[19] by COPA investigators. Officer [redacted] recalled that in September of 2017, he was regularly working both the desk and the lock-up in District [redacted] and had been doing so for several years. On September 2, 2017, Officer [redacted] was working in the male lock-up, and he recalled working on the computer when [redacted] was brought in at about 8:00 pm. Officer [redacted] recalled that Officer (now Detective) [redacted] earched [redacted] on the opposite side of the lockup keeper's desk while he (Officer [redacted] manually entered the identity of the searching officer into the computer so that it would appear on [redacted] arrest processing report. Officer [redacted] did not recall any details about the search of [redacted] and did not recall seeing a drawstring in [redacted] shorts. Officer [redacted] did not enter the identity of the officer who fingerprinted [redacted] into the computer, as that information was recorded automatically based on the identity of the officer who was logged in at the fingerprinting station. When told that Detective [redacted] now claimed that someone else had searched [redacted], Officer [redacted] stated that he believed his report was accurate and that Detective [redacted] had, in fact, conducted the search. Officer [redacted] did not believe he made a mistake and did not believe he could have confused Detective [redacted] for another officer.

Officer [redacted] also recalled working in lock-up the next day, September 3, 2017, when [redacted] attempted to strangle himself in his cell with the drawstring. Officer [redacted] generally recalled conducting visual checks of the arrestees at fifteen-minute intervals and seeing [redacted] either standing at the door of his cell or sitting on the bench. During those checks, Officer [redacted] did not notice anything unusual and did not recall speaking with [redacted]. Later in his shift, Officer [redacted] was dealing with another arrestee when his partner in lock-up that day, Officer [redacted] looked at the surveillance monitor and noticed that [redacted] was "doing something strange" in his cell.[20] Officer [redacted] went to check on [redacted] and quickly yelled for assistance. Officer [redacted] and Officer [redacted] were the only officers working in lock-up that day, so Officer [redacted] had to secure his arrestee in a holding cell near the lock-up keeper's desk before using the station intercom to call for additional assistance and then going back to [redacted] cell to assist Officer [redacted] When Officer [redacted] went to the cell, he saw that [redacted] was sitting on the floor and that Officer [redacted] was struggling with him. Officer [redacted] saw that there was a drawstring attached to the faucet and looped around [redacted] neck, so he freed [redacted] by cutting the loop. The officers then assisted [redacted] onto his side and remained with him while awaiting further assistance. Officer [redacted] did not recall ever speaking about [redacted] with Lt. [redacted].

When confronted with the allegations against him, Officer [redacted] denied responsibility for [redacted] having the drawstring because someone else had searched [redacted]. Officer [redacted] also denied that he failed to adequately monitor [redacted] prior to his suicide attempt, explaining that he had monitored [redacted] throughout his shift and that he was dealing with another prisoner at the moment of the suicide attempt.

[19] Attachments 76, 119.
[20] [redacted] Tr. 53:21–22. Attachment 119.

Sgt. [redacted] was interviewed on October 17, 2019,[21] by COPA investigators. Sgt. [redacted] recalled working in District [redacted] as the district station supervisor ("DSS") on the afternoon of September 3, 2017, when an arrestee attempted to commit suicide in lock-up. Officers [redacted] and [redacted] were assigned to the lock-up, and Sgt. [redacted] was their immediate supervisor and was responsible for overseeing the lock-up and the welfare of any prisoners. Sgt. [redacted] inspected the lock-up periodically, as required by CPD directives, and recalled seeing [redacted] in his cell during his first inspection at approximately 1:30 pm. Sgt. [redacted] did not recall speaking with [redacted] and did not recall noticing anything unusual. Sgt. [redacted] conducted three additional inspections of the lock-up prior to the suicide attempt, all unremarkable. During each inspection, Sgt. [redacted] looked into each cell and visually checked each prisoner. Later, Sgt. [redacted] was summoned to lock-up, along with the watch operations lieutenant, Lt. [redacted] Sgt. [redacted] could not recall how he was summoned or what he first saw when he entered lock-up, but he did recall supervising the response as medical assistance was requested, officers were assigned to complete a general offense case report, and officers were assigned to accompany [redacted] to the hospital.

After the incident, Officer [redacted] told Sgt. [redacted] that he had observed [redacted] making unusual movements in his cell while looking at the surveillance camera. When Officer [redacted] checked on [redacted], he discovered that [redacted] had attached a string to the faucet in his cell, wrapped the string around his neck, and attempted to commit suicide. Sgt. [redacted] documented the incident by authoring an initiation report and a report of an extraordinary occurrence in lock-up. Sgt. [redacted] explained that he complied with his obligations as the DSS to supervise the lock-up by making all of the required inspections, by checking the log to assure that Officer [redacted] and Officer [redacted] were documenting their prisoner welfare checks, by responding immediately when lock-up personnel requested assistance, and by supervising the response to the suicide attempt and assuring that [redacted] received medical attention. Based on these actions, Sgt. [redacted] denied the allegation that he committed misconduct by failing to supervise lock-up personnel while [redacted] attempted to hang himself.

Officer [redacted] was interviewed on November 19, 2019,[22] by COPA investigators. Officer [redacted] was assigned to District [redacted] in September of 2017, normally working as the watch secretary but occasionally working in lock-up. On September 2, 2017, Officer [redacted] was working in lock-up with Officer [redacted] and Detective [redacted]. Officer [redacted] remembered fingerprinting [redacted] at about 8:00 pm but did not recall who brought [redacted] into lock-up or who searched [redacted]. Typically, the arresting officer or officers would remain in lock-up while lock-up personnel searched the arrestee, but Officer [redacted] did not have a specific recollection regarding [redacted]. Based on who was working, Officer [redacted] was sure that either himself, Detective [redacted], or Officer [redacted] conducted the search. Based on the arrest processing information documented on the arrest report, Officer [redacted] acknowledged that Detective [redacted] was listed as the searching officer. Officer [redacted] believed that the identity of the searching officer would have been entered on the computerized report immediately because the automated system would not allow fingerprints or photographs to be taken until the name of the searching officer was entered. Further, Officer [redacted] acknowledged that Officer [redacted] was listed on the report as the officer who fingerprinted and photographed [redacted], but Officer

[21] Attachments 68, 120.
[22] Attachments 107, 121.

was certain that Officer was not working in lock-up that day. Officer explained that he did not have valid log-in credentials for the automated fingerprint and photograph station, "So Officer gave me his log-in so I could print the people that day."[23] The log-in credentials were either Officer PC number or employee number, plus a unique password. Officer said that officers did not normally share their credentials, but an unusual mix of personnel were working in lock-up that day because it was a holiday weekend.[24] Officer believed that if an error was discovered on an arrest report, a supervisor would be able to amend the report by noting the correct information in the report's "remarks" section, even if they were unable to edit the names listed in the processing section.

Officer was interviewed on November 20, 2019,[25] by COPA investigators. Officer recalled working on September 2, 2017, when he was assigned to the District rategic Decision Support Center (SDSC). Officer had worked in lockup earlier in 2017 and had obtained credentials allowing him to sign in to the automated fingerprinting station in lockup. But on September 2, 2017, Officer was certain that he was not present in lockup when was processed and that he had not witnessed anyone searching . Officer was confronted with the allegation that he had shared his login credentials for the livescan fingerprint and photograph station in the District male lock-up with Officer , and Officer immediately admitted that the allegation was true. Officer also admitted that he was in violation of section III.A.1 of General Order G09-01-02,[26] dealing with the security of CPD computer systems, when he shared his credentials with Officer . Officer explained that he shared his credentials with Officer because Officer did not have valid credentials to use the fingerprint and photograph station. Despite his lack of credentials, Officer new how to use the system and had been assigned to work in lockup during a busy holiday weekend when both of the usual detention aides had taken time off from work.

Officer was interviewed on October 10, 2019,[27] by COPA investigators. Officer now assigned to District as a field training officer, was assigned to District n September of 2017. On September 3, 2017, Officer was working in the District male lock-up with Officer . Officer did not normally work in lock-up and had only worked there once or twice previously. Officer had never been trained in fingerprinting or lock-up procedures, so he was doing the best he could to assist Officer . Officer recalled that Officer was dealing with an arrestee in the processing area, so he stood by at the processing desk, splitting his attention between the surveillance system monitors and his partner. The monitors were split into small squares, each approximately two or three inches wide and tall, allowing officers to monitor each cell in the lock-up.

[23] Tr. 16:8–9. Attachment 121.
[24] Labor Day was on Monday, September 4, 2017, and the incident under investigation took place on Saturday and Sunday, September 2 and 3, 2017.
[25] Attachments 110, 122.
[26] G09-01-12 became effective on September 11, 1998 and was in effect at the time of the incident under investigation. Section III.A.1 of the order requires, "Department members will not share their log-on ID access codes, and will be responsible for the security and integrity of these codes." Attachment 97.
[27] Attachments 57, 123.

As Officer [redacted] watched the monitor, he noticed the prisoner in cell 6, [redacted], acting oddly and standing on top of the toilet. Officer [redacted] noted the odd behavior and began to monitor cell 6 more closely. Looking further at the very small surveillance image, Officer [redacted] saw that [redacted] was lying on the floor, pressed up against the combination toilet/sink fixture, and Officer [redacted] thought there might be something around [redacted] neck. Officer [redacted] could not recall how much time elapsed between first noticing that [redacted] was acting oddly and going to check on [redacted] in person, but immediately after noticing that something might be around [redacted] neck, Officer [redacted] alerted Officer [redacted], grabbed the keys, and ran to the cell. When he opened the cell, Officer [redacted] confirmed that there was a string around [redacted] neck, so he screamed for assistance. Officer [redacted] attempted to loosen the string, but [redacted] began to struggle. Officer [redacted] called for additional assistance, secured the arrestee that he was dealing with, and came to help. An ambulance was summoned, and [redacted] was given medical attention and transported to the hospital.

Officer [redacted] denied committing misconduct by failing to adequately monitor [redacted] during his suicide attempt. After watching a video recording from [redacted] cell on the day of the incident between 5:17 pm and 6:17 pm,[28] Officer [redacted] acknowledged that more time had passed than he previously remembered between [redacted] standing on top of the toilet until Officer [redacted] ran to [redacted] cell. Officer [redacted] also stated that if he had manipulated the surveillance system to enlarge the view of [redacted] cell, he would have had a better perspective on what was happening in the cell and may have discovered the suicide attempt earlier.

Lt. [redacted] was interviewed on November 12, 2019,[29] by COPA investigators. Lt. [redacted] did not recall anything about the processing of [redacted] on September 2, 2017 but did remember responding to the male lock-up in District [redacted] on September 3, 2017, immediately following [redacted] suicide attempt. Lt. [redacted] recalled supervising the initial response, viewing video from [redacted] cell depicting the suicide attempt, and signing off on a report of extraordinary occurrence that was authored by Sgt. [redacted]. Lt. [redacted] recalled assuring that the video recording from September 3, 2017, was bookmarked to prevent it from being over-written, but he did not recall any attempts to view or bookmark any recordings from September 2, 2017. Lt. [redacted] did not recall speaking to Detective [redacted] about who had searched [redacted] on September 2, 2017. Lt. [redacted] said that he was surprised and that it "shocks me, a little bit"[30] that Detective [redacted] now claimed that Lt. [redacted] told him about the events depicted in a video recording from September 2, 2017. Lt. [redacted] was also certain that if he had discovered an error on [redacted] arrest report regarding the identity of the officer who searched [redacted], he would have documented the error on the Initiation Report for the incident. Lt. [redacted] also believed that either himself, the officer who really conducted the search, or both would have authored to-from reports addressed to the district commander documenting the error, and those to-from reports, if they existed, would likely be attached to the Initiation Report.

[28] Attachment 56.
[29] Attachments 85, 124.
[30] [redacted] Tr. 28:21. Attachment 124.

b. Digital Evidence

Body-Worn Camera video recordings[31] from cameras assigned to Sgt. [redacted] Officer [redacted] and Officer [redacted] depicting the arrest and transport of [redacted] on September 2, 2017, were obtained by COPA. At the time of arrest, [redacted] appears to be wearing the same clothing that he was later observed wearing in lock-up. Sergeant [redacted] recording ends inside the District [redacted] station in a hallway just outside of the prisoner processing room. Officer [redacted] video ends as Officer [redacted] enters the tactical team office, leaving Sgt. [redacted] in the hallway with [redacted] Officer [redacted] video ends as he enters the District [redacted] station. These recordings depict neither the search of [redacted] on September 2, 2017, nor [redacted] suicide attempt on September 3, 2017.

Video recordings[32] depicting the interior of cell 6 in the District [redacted] male lock-up between 5:17 pm and 6:30 pm on September 3, 2017 were obtained by COPA. There is no audio associated with the video recording. At 5:17 pm, the sole prisoner in the cell, [redacted] is seated on a bench. [redacted] attempts to pull a drawstring out from the waistband of his shorts for approximately one minute. Unable to fully remove the drawstring, [redacted] removes his shorts and continues to pull on the string. Still unable to remove the drawstring, [redacted] puts his shorts back on. After sitting still for approximately two minutes, [redacted] begins pulling on the string again, and he succeeds in removing the string at 5:22 pm. [redacted] conceals the string in his hand and walks to the door of the cell, looking out the window. [redacted] then begins pacing in the cell, holding the string and looking at the ceiling. At 5:24 pm, [redacted] quickly looks out the window, then climbs on top of the toilet/sink combination fixture in the cell, reaching towards the ceiling. [redacted] steps down after less than a minute and continues to look up at the ceiling while standing on the floor and holding the string in his hands. At 5:26 pm, [redacted] ties a loop into one end of the string, again glancing out the window. At 5:27 pm, [redacted] stands on top of the toilet/sink fixture and reaches towards the ceiling with the string, apparently succeeding in attaching one end of the string to an unseen object on the ceiling. [redacted] pulls on the string and it immediately comes loose from the ceiling, and [redacted] steps down from the fixture and again looks out the window.

At 5:29 pm, [redacted] attempts to attach one end of the string to the faucet of the sink, but he removes the string after a few seconds and continues to pace and look upwards with the string in his hands. At 5:30 pm, [redacted] again briefly stands on top of the toilet/sink fixture and attempts to attach the string to the ceiling. Unsuccessful, [redacted] sits on the bench, sometimes concealing the string in his hands and other times unfurling the string and stretching it while moving his arms to his sides. At 5:33 pm, still seated, [redacted] momentarily places the loop in the string around his neck before removing it and concealing it in his hands. Between 5:36 pm and 5:38 pm, [redacted] stands, briefly places the loop around his neck, and again looks out the window. At 5:38 pm, [redacted] climbs on top of the toilet/sink fixture and again attempts to attach

[31] Attachment 125.

[32] Attachments 14, 56. IPRA originally requested and obtained a video recording depicting the interior of cell 6 at the District [redacted] male lock-up covering a time period from 5:30 pm to 6:30 pm on September 3, 2017. Attachment 30. COPA later learned that CPD detectives had obtained and preserved a video recording from the same camera covering a time period from 5:17 pm to 6:17 pm. COPA then obtained the video recording that had been preserved by detectives. Attachment 56. The summary that appears in this report covers the entire time period captured by both video recordings: 5:17 pm to 6:30 pm.

the string to the ceiling. [redacted] appears to succeed in attaching the string to an unseen object, and he pulls on the loop, testing the strength or security of the attachment. At 5:39 pm, [redacted] suddenly pulls the string free from the ceiling, jumps down to the floor, and conceals the string in his hands while sitting on the bench. At 5:41 pm, [redacted] stands and walks to the cell door, looking out the window. At 5:44 pm, [redacted] again sits on the bench, concealing the string. [redacted] remains almost stationary on the bench until 5:55 pm, when he lies down briefly and then resumes a seated position, rocking slightly and holding his hands to his head.

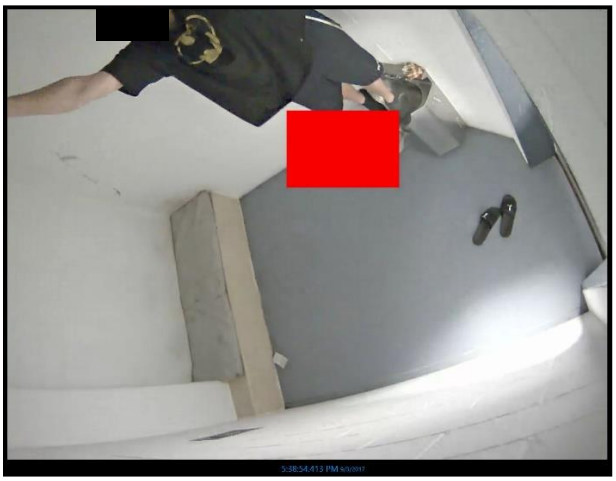

Figure 1. Still frame from video recording of [redacted] standing on the toilet/sink fixture in his cell at 5:39 pm. (The red square covering the toilet is a permanent feature of the video surveillance system for the purpose of preserving the prisoner's privacy.)

At 5:58 pm, [redacted] unfurls the string and stretches it widely between his hands while glancing up at the ceiling. [redacted] again places the loop around his neck and pulls on the free end of the string. [redacted] abruptly removes the loop from his neck and walks to the cell door, looking out the window. At 5:59 pm, [redacted] places the loop around his neck and pulls up on the free end of the string. [redacted] then removes the loop from his neck, places the string in his pocket, and again glances out the window. At 6:03 pm, [redacted] places the loop around his neck and again pulls upwards before removing the loop and placing the string back in his pocket.

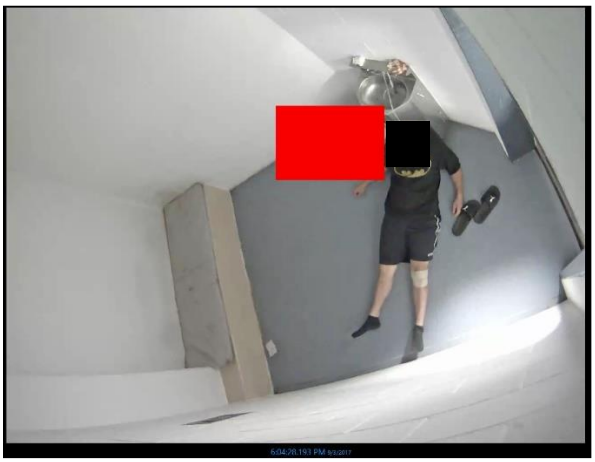

Figure 2. Still frame from video recording of [redacted] sitting on the floor with the drawstring attached to the faucet and looped around his neck at 6:04 pm.

At 6:04 pm, [redacted] places the loop around his neck yet again, this time attaching the free end of the string to the faucet handle and tying a knot. [redacted] then sits on the floor with his back against the toilet/sink fixture, the loop still around his neck. [redacted] remains on the floor for approximately five minutes, occasionally adjusting his position and glancing towards the window. At 6:09 pm, the lights in the cell turn on and [redacted] appears to tighten the loop around his neck, pulling on it with his hands. Approximately 26 seconds after the lights turn on, Officer [redacted] enters the cell and pulls up on [redacted] body, apparently attempting to lessen the pressure on [redacted] neck. Approximately 20 seconds later, Officer [redacted] enters the cell and cuts the string from [redacted] neck. The officers lay [redacted] on the floor, and seven additional officers, including Lt. [redacted] and Detective [redacted] enter the cell. [redacted] is handcuffed and pulled to a seated position against the bench. Officer [redacted] appears to examine the waistline of [redacted] shorts and the drawstring that is attached to the faucet. At 6:18 pm, paramedics enter the cell and begin to examine [redacted]. [redacted] is quickly helped to his feet and then placed on a stretcher. [redacted] is wheeled away from the cell at 6:19 pm, and the cell remains vacant until the recording ends at 6:30 pm.

Photographs[33] taken by CPD evidence technicians depict a pair of blue-and-white shorts with a damaged waistband, an empty plastic bag, and various views of cell 6 in the District [redacted] male lock-up. The lock-up photographs also depict a clothing draw-string tied to the cell's toilet/faucet combination fixture, with close-up views of the knot at the faucet end of the draw-string, along with the opposite end of the string, which appears to have tied into a loop and then cut. The aglets at both ends of the draw-string are visible and remain attached to the draw-string. The photographs also depict [redacted] lying on a hospital gurney with a breathing tube in his mouth, along with apparent red bruising around his throat. Additional photographs depict the Prisoner's Receipt from a Personal Property Form listing 3 traffic tickets as the only items of personal property taken from [redacted] in lockup. The receipt is signed by Officer [redacted] (Star #[redacted] and dated September 2, 2017.

[33] Attachment 12.

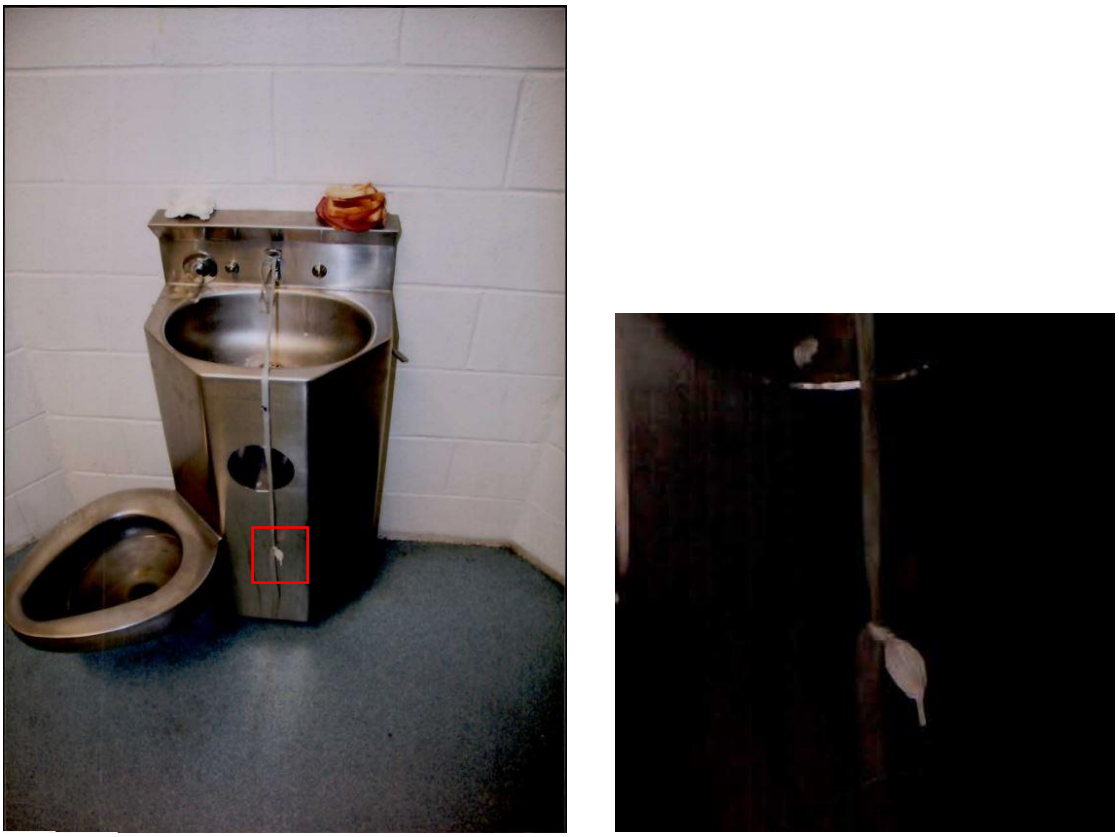

Figure 3. Photograph of toilet/sink fixture in Cell 6 with draw-string attached to faucet. The aglet at the far end of the draw-string, near the floor, is visible.

Figure 4. Close-up photograph of the draw-string attached to the faucet with aglet intact.

c. Physical Evidence

Medical records[34] obtained from Stroger Hospital document that [redacted] was admitted on September 3, 2017, at 6:42 pm.[35] [redacted] was alert, but apparently unable to speak, when he was admitted. Paramedics told hospital staff that [redacted] had been found in a lock-up facility attempting to commit suicide by kneeling forward with a rope around his neck, attached to a sink. [redacted] was wheezing when he arrived at the hospital, and he was then sedated and given a breathing tube. Bruising to the skin around [redacted] neck was observed with a rope-like pattern. [redacted] was discharged from the hospital on September 5, 2017, after regaining consciousness and having his breathing tube removed. At the time of discharge, [redacted] denied having any suicidal or homicidal thoughts.

Crime Scene Processing Reports[36] document CPD evidence technicians photographing cell 6 at the District [redacted] male lock-up on September 3, 2017, including photographs of a gray waistband clothing string attached to a faucet in the cell. The waistband clothing string was also recovered from the faucet and placed in inventory. [redacted] shorts were photographed and placed in inventory. Photographs were also taken at Stroger Hospital depicting ligature marks on [redacted] neck.

Inventory sheets[37] document that the following evidence was collected and placed in inventory by CPD evidence technicians and detectives: District [redacted] arrestee property log for September 3, 2017; District [redacted] desk officer work queue for September 3, 2017; District [redacted] daily prisoner logs for the second and third watch on September 3, 2017; gray waistband clothing string recovered from the faucet in cell 6 at the District [redacted] lock-up; torn blue and silver shorts and a plastic bag that previously contained the shorts; and a video recording from September 3, 2017.

d. Documentary Evidence

An **Initiation Report**[38] signed by Sgt. [redacted] and dated September 3, 2017, documents that Officer [redacted] observed a prisoner, [redacted], making unusual movements inside his cell. Officer [redacted] walked to the cell and then saw that [redacted] was lying on the floor with a string attached to both his neck and the faucet.

An **Original Case Incident Report**[39] documents that on September 3, 2017, at 6:05 pm, a detainee in cell 6 in the District [redacted] lock-up attempted to commit suicide by wrapping a string around his neck and then attached the string to a faucet. The detainee, [redacted], was taken by ambulance to Stroger Hospital at 6:19 pm, where he was reported to be in stable condition.

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[34] Attachment 11.
[35] The hospital records are consistent with Chicago Fire Department run sheet documenting [redacted] transport (Attachments 23, 24) and a supplemental report filed by officers who accompanied [redacted] to the hospital (Attachment 128).
[36] Attachment 16.
[37] Attachments 43–47.
[38] Attachment 28.
[39] Records Division No. [redacted] Attachment 5. *See also* **Event Query Reports** documenting the police, evidence technician, and ambulance response to this incident, which are consistent with the Original Case Incident Report. Attachments 48–51.

Detectives and evidence technicians were summoned to both the District [redacted] station and the hospital.

A **Report of Extraordinary or Unusual Occurrences,**[40] authored by Sgt. [redacted] and approved by Lt. [redacted], dated September 3, 2017, documents that Officer [redacted] while assigned to the District [redacted] lock-up, observed arrestee [redacted] making unusual movements near the toilet area in his cell. Officer [redacted] first observed the unusual movements while monitoring a surveillance camera and then approached [redacted] cell to investigate further. When Officer [redacted] arrived at the cell, he observed [redacted] on the floor with a string wrapped around his neck and attached to the faucet.[41]

Daily Prisoner Log Records[42] indicate that Officer [redacted] conducted prisoner welfare checks in the District [redacted] male lock-up at 15-minute intervals between 1:45 pm and 7:00 pm on September 3, 2017. The log also indicates that a notable occurrence happened at 6:15 pm.

The **Watch Incident Log**[43] for the third watch at District [redacted] on September 3, 2017, signed by Sgt. [redacted], documents that an attempted suicide in lockup occurred, with references to the Original Case Incident Report and the log number for this investigation.

A **Case Supplementary Report**[44] submitted on November 17, 2017, by Detective [redacted] documents the CPD's investigation of [redacted] attempted suicide while in police custody on September 3, 2017. Per the report, detectives responded to the district and viewed a video-recording of [redacted] attempting to hang himself in his cell. The detectives also interviewed involved CPD members and two other prisoners who were in the male lock-up at the time of the suicide attempt. Detectives also interviewed [redacted] the next day (September 4, 2017) while he was recovering in the hospital.[45]

Officer [redacted] told detectives that he was working in lock-up and periodically checking the surveillance cameras to see what the prisoners were doing in their cells. There were only three prisoners at the time of the attempted suicide. Officer [redacted] noticed that [redacted] was walking back and forth in his cell while Officer [redacted] escorted another prisoner to the telephone. Officer [redacted] went to conduct a welfare check on [redacted] and noticed that [redacted] was on the floor with a string around his neck. Officer [redacted] called out for Officer [redacted] to assist and opened the cell door. Officer [redacted] held [redacted] up until Officer [redacted] arrived and cut the string. Paramedics were then summoned to provide medical assistance.

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[40] Attachment 29.

[41] The Report of Extraordinary or Unusual Occurrences was transmitted to IPRA with attached copies of [redacted] arrest report; the Event Query Report documenting the ambulance response; the Unit [redacted] 3rd Watch Arrestee Property Log from September 3, 2017; the District [redacted] Desk Officer Work Queue for September 3, 2017; and Daily Prisoner Log Records for the District [redacted] male lock-up for September 3, 2017. These documents, where relevant, are summarized and discussed elsewhere in this summary report.

[42] Attachment 26.

[43] Attachment 89.

[44] Attachment 95.

[45] The Case Supplementary Report also documents the efforts of evidence technicians, CPD members who responded to this incident after the fact, and medical personnel involved in [redacted] treatment. This information is consistent with medical records and crime scene processing reports documented elsewhere in this summary report.

Officer [redacted] told detectives that he was assigned to lock-up and that he conducted and documented all of the required welfare checks on the three arrestees, including [redacted], who were in lock-up. Officer [redacted]s confirmed that he had been escorting one of the other arrestees to the telephone at the time of the suicide attempt, and that he secured the arrestee and called for help over the district's intercom system before going to [redacted] cell to assist Officer [redacted] When Officer [redacted] arrived at the cell, he was able to cut the string that [redacted] had attached to his neck, and paramedics arrived shortly after.

Lt. [redacted] told detectives that he heard a call over the intercom for assistance in the male lock-up. The lieutenant, along with other officers, went to cell 6 and saw [redacted] lying on the floor. [redacted] was on his side, awake, and gasping.

Sgt. [redacted] told detectives that he arrested [redacted] on September 2, 2017, and transported [redacted] to District [redacted]. [redacted] was searched at the scene of arrest and then searched again by Sgt. [redacted] in the District [redacted] processing area. Likewise, **Officer** [redacted] told detectives about [redacted] arrest and transportation to District [redacted].

Two detainees, [redacted] and [redacted], were also interviewed by detectives. [redacted] recalled being in his own cell during the incident, and he saw and heard nothing unusual. [redacted] recalled being near the lock-up keeper's desk making a telephone call when he heard officers say that the person in cell 6 was attempting suicide. [redacted] saw paramedics enter the lock-up and take [redacted].

The next day, [redacted] told detectives that he began thinking about suicide after he realized that he was being charged with felonies and after his girlfriend told him that their relationship was over because of his arrest. [redacted] recalled removing his shorts and pulling out the stitching so that he could remove the drawstring. [redacted] secured one end of the string to the faucet in his cell and secured the other end around his neck in a noose. [redacted] had second thoughts about ending his life but decided to go through with it after he saw an officer looking into his cell through the window.

VI. LEGAL STANDARD

For each Allegation COPA must make one of the following findings:

1. Sustained - where it is determined the allegation is supported by a preponderance of the evidence;

2. Not Sustained - where it is determined there is insufficient evidence to prove the allegations by a preponderance of the evidence;

3. Unfounded - where it is determined by clear and convincing evidence that an allegation is false or not factual; or

4. Exonerated - where it is determined by clear and convincing evidence that the conduct descried in the allegation occurred, but it is lawful and proper.

A **preponderance of evidence** can be described as evidence indicating that it is **more likely than not** that the conduct reviewed complied with Department policy. *See Avery v. State Farm Mutual Automobile Insurance Co.*, 216 Ill. 2d 100, 191 (2005) ("A proposition proved by a preponderance of the evidence is one that has been found to be more probably true than not true."). If the evidence gathered in an investigation establishes that it is more likely that the conduct complied with Department policy than that it did not, even if by a narrow margin, then the preponderance of the evidence standard is met.

Clear and convincing evidence is a higher standard than a preponderance of the evidence but lower than the "beyond-a-reasonable doubt" standard required to convict a person of a criminal offense. *See, e.g., People v. Coan,* 2016 IL App (2d) 151036 (2016). Clear and Convincing can be defined as a "degree of proof, which, considering all the evidence in the case, produces the firm and abiding belief that it is highly probable that the proposition . . . is true." *Id.* ¶ 28.

VII. ANALYSIS

Officer [redacted] violated CPD policy when he provided Officer [redacted] his credentials for the livescan fingerprint station. To safeguard Department software, reports, data, and files, CPD directives require that Department members not share their log-on ID access codes.[46] Officer [redacted] admitted that on September 2, 2017, he shared his log-in credentials for the livescan fingerprint and photograph station with Officer [redacted], and Officer [redacted] admitted that, in doing so, he violated General Order G09-01-02. Because Officer [redacted] shared his log-in credentials with Officer [redacted], the wrong officer's name was recorded on [redacted] arrest report and the wrong officer was initially identified as a potential witness in this investigation. COPA finds by a preponderance of evidence that Officer [redacted] violated Rule 6, which prohibits CPD members from disobeying an order or directive, and also violated Rule 41, which prohibits CPD members from altering any Department record or information concerning police matters, except as provided by Department orders. COPA therefore finds that **Allegation 1 against Officer [redacted] is Sustained.**

Detective [redacted] failed to search [redacted] properly in violation of CPD policy. CPD members working in lock-up facilities must immediately search each arrestee brought into lock-up and must remove any potentially hazardous clothing from each detainee.[47] Also, "An arrestee's shoelaces, tie, belt, scarf, or anything that could be used as a ligature" must be taken by lock-up personnel upon the arrestee's entry into lock-up.[48] Further, Detective [redacted] conceded that whoever searched [redacted] in lock-up was obliged to search for and to remove the drawstring. Detective [redacted] also admits that he was working in lock-up when [redacted] was processed and that he completed the inventory of [redacted] personal property. But Detective [redacted] insists that, contrary to the facts documented in [redacted] arrest processing report, someone else searched [redacted]. Based on the evidence reviewed, COPA does not find Detective [redacted] version of the events credible.

[46] General Order G09-01-02, Computer Systems Security § II.A.1 (Sept. 11, 1998).
[47] *See* Special Order S06-01-02, Detention Facilities General Procedures and Responsibilities §§ II.B, III.A.12 (May 20, 2016).
[48] Special Order S07-01-01, Inventorying Arrestees' Personal Property § II.C (Dec. 4, 2015).

Officer [redacted], who completed the arrest processing report, told COPA investigators that he was present when Detective [redacted] searched [redacted] and that he typed Detective [redacted] name into the report contemporaneously with the search. Each officer and supervisor involved in this investigation who was asked how arrest processing reports are completed agreed that the lock-up keeper inputs the name of the searching officer contemporaneously with the search. There were only three officers working in lock-up at the time of the search, and it is undisputed that Officer [redacted] was sitting behind the desk at the computer work-station and that Officer [redacted] fingerprinted and photographed [redacted], leaving the remaining officer, Detective [redacted], to both search [redacted] and inventory [redacted] property.

Additionaly, Detective [redacted] told investigators that he spoke with Lt. [redacted] on September 3, 2017 – the day after [redacted] was searched upon entering lock-up – and that Lt. [redacted] told him that he had viewed a video recording of the search and that someone other than Detective [redacted] had searched [redacted]; yet Lt. [redacted] denies ever viewing a video of the search and does not remember having the conversation described by Detective [redacted]. Additionally, the officers and supervisors involved in this incident agree that if a mistake was discovered as to the identity of the officer who searched [redacted], the mistake would have been documented in writing, yet no such document has been found.[49] Given that CPD members would regularly document the discovery of a mistake in an arrest processing report and that no such record appears to exist, it is logical to conclude that the events described by Detective [redacted] involving Lt. [redacted] supposed discovery of the mistake did not occur.

In sum, while Detective [redacted] denied that he searched [redacted], his partner officers provided versions of the event that impeach Detective [redacted] Specifically, Officer [redacted] and

[49] While the CPD members interviewed in this investigation agreed that a mistake as to the identity of the searching officer would be corrected in writing, they did not agree as to the form such a writing would take. Detective [redacted] believed that the member who conducted the search would have been ordered to write a to-from-subject report or some other type of report. Sgt. [redacted] believed that the error, if discovered, would have been documented in the "Watch Commander Comments" section of [redacted] arrest report. Likewise, Officer [redacted] believed that a supervisor would be able to amend the arrest report by making a note in the "remarks" section. Detective [redacted] believed that the responsible officer would have filed a supplemental report explaining the error. Lt. [redacted] told investigators that if he had discovered this type of error, he would have assured that the error was documented in a to-from-subject report addressed to the district commander, and the to-from-subject report would likely be appended to the related initiation report. It is apparent that no corrections were made in the lockup keeper comments nor the watch commander comments to [redacted] arrest report, even though the latest comment regarding transferring custody was made on September 5, 2017 – two days after [redacted] attempted suicide. (Attachment 13, p. 5). No "to-from-subject" reports were attached to the copies of the Initiation Report nor the Report of Extraordinary or Unusual Occurrences that were transmitted to IPRA on September 3 and September 6, 2017, even though various other documents related to [redacted] attempted suicide were attached to these reports. (Attachments 28, 29). COPA requested that the District [redacted] commander search her records for any documents, reports, or recordings related to the processing of [redacted] on September 2, 2017, or [redacted] suicide attempt on September 3, 2017, but no additional records were found. (Attachments 81, 88). COPA subpoenaed the Department of Law for any records in that department's possession related to [redacted] processing or suicide attempt with a return date of November 19, 2019. As of December 27, 2019, the Department of Law has not responded to this subpoena. Should a subsequent response to the subpoena produce any material evidence and/or information, COPA will seek to re-open the investigation to incorporate same. (Attachment 82). COPA also requested that the CPD's Bureau of Technical Services conduct a new search for any relevant video recordings, but no new recordings were found. (Attachments 80, 113, 114). CPD records available to COPA also indicate that no electronic requests were made to retrieve District [redacted] lock-up video from September 2, 2017. (Attachment 126).

[redacted], the only two other officers in lock-up that day, offer that [redacted] was the searching officer and the report reflects what occurred that day. Officer [redacted] detailed his participation in processing [redacted] while admitting to his own misconduct in using another officer's log-in. Officer [redacted] specifically stated that [redacted] conducted the search and he observed it, then noted it on the report. Further, Detective [redacted] detailed that Lt. [redacted] discovered that he had not searched [redacted] after viewing the video from September 2, 2017 and gave Detective [redacted] the impression that a correction to the report would be documented. However, Lt. [redacted] specifically denied both viewing the September 2, 2017 video and having that conversation with Detective [redacted] Finally, no department member made any attempt to amend or correct the report.

Based on the evidence described above, COPA finds by a preponderance of evidence that Detective [redacted] searched [redacted] upon his entry into lock-up and failed to discover and remove the drawstring from [redacted] shorts. In failing to properly search [redacted], Detective [redacted] violated Special Order S06-01-02 and Special Order S07-01-01, which required him to conduct the search and remove the drawstring. Thus, Detective [redacted] violated Rule 5 (failure to perform any duty), Rule 6 (disobedience of an order or directive), Rule 10 (inattention to duty), and Rule 11 (incompetency or inefficiency in the performance of duty). COPA therefore finds that **Allegation 1 against Detective [redacted] is Sustained.** Likewise, because COPA finds that Detective [redacted] conducted the search, and because all known evidence indicates that Officer [redacted] did not conduct the search, COPA finds by clear and convincing evidence that **Allegation 1 against Officer [redacted] is Unfounded.**

CPD members working in lock-up facilities must provide for the well-being of all arrestees in the lock-up and must complete a visual check of each arrestee every 15 minutes.[50] District station supervisors are responsible for the safety and security of arrestees brought to their facility, for supervising subordinates working in lock-up, and for conducting periodic inspections of lock-up to visually observe arrestees.[51] Officer [redacted] told COPA investigators that on September 3, 2017, either he or his partner, Officer [redacted] performed the required visual checks of arrestee [redacted] and documented those checks on the required form. During the time immediately preceding [redacted] suicide attempt, both Officer [redacted] and Officer [redacted] agree that Officer [redacted] was dealing with the needs of another arrestee and that Officer [redacted] was monitoring [redacted]. The available video recording from the surveillance camera in [redacted] cell shows that [redacted] moved towards the window in the cell door and looked out approximately every 15 minutes, providing circumstantial evidence that one of the officers was walking the corridor and checking the arrestees. Also, arrestee [redacted] statement to detectives following [redacted] suicide attempt, describing how he was at the lock-up desk while officers allowed him to make a telephone call, corroborates the officers' assertion that Officer [redacted] was dealing with another arrestee immediately before the suicide attempt. Further, COPA has found no evidence that [redacted] made any statements or exhibited any behaviors indicating that he might

[50] *See* Special Order S06-01-02, Detention Facilities General Procedures and Responsibilities § III.A.28, 35 (May 20, 2016).
[51] *See* General Order G06-01-01, Field Arrest Procedures § II.F.2.a (Nov. 12, 2015); Special Order S03-03-05, District Station Supervisor § II.J, U (Mar. 2, 2017); Special Order S06-01, Processing Persons Under Department Control § II.B (Jan. 29, 2015); Special Order S06-01-02, Detention Facilities General Procedures and Responsibilities § III.A.28, B.8 (May 20, 2016).

harm himself prior to 5:17 pm on the day of his suicide attempt. Likewise, the available documentary and testimonial evidence shows that Sgt. [redacted] conducted all of his required lock-up inspections on the date of [redacted] suicide attempt and that Sgt. [redacted] reacted appropriately upon learning of the suicide attempt by responding immediately to lock-up, assuring paramedics were summoned, and timely documenting the incident. COPA therefore finds, by clear and convincing evidence, that **Allegation 2 against Officer [redacted] is Unfounded** and that **Allegation 1 against Sgt. [redacted] is Unfounded.**

Officer [redacted] admits that he was monitoring the arrestees via the video surveillance system immediately before [redacted] suicide attempt. Officer [redacted] also admits that he noticed [redacted] acting strangely prior to the attempt. One specific behavior that Officer [redacted] noticed was [redacted] standing on top of the toilet/sink fixture in his cell. The video recording from [redacted] cell shows that [redacted] last stood on top of the toilet/sink fixture at 5:39 pm; [redacted] began his suicide attempt in earnest at 6:04 pm (25 minutes later), and Officer [redacted] entered the cell at 6:09 pm (30 minutes later). Had Officer [redacted] investigated [redacted] strange behavior sooner, he may have discovered the drawstring and prevented the suicide attempt, or at least would have had the opportunity to do so. And while it is undisputed that Officer [redacted] partner in lock-up, Officer [redacted], was dealing with another arrestee at the time in question, nothing would have prevented Officer [redacted] from alerting Officer [redacted] to [redacted] strange behavior. Had Officer [redacted] done so, Officer [redacted] could have temporarily secured the other arrestee and allowed Officer [redacted] to check on [redacted]. While COPA finds that Officers [redacted] and [redacted] were periodically walking past [redacted] cell and making some efforts to monitor [redacted] welfare, it is apparent that Officer [redacted] was not diligent in investigating the strange behavior that he admits he observed. COPA finds, by a preponderance of evidence, that Officer [redacted] violated Special Order S06-01-02, which makes lock-up personnel responsible for the well-being of all arrestees while in lock-up.[52] In violating this directive, Officer [redacted] also violated Rule 5 (failure to perform any duty), Rule 6 (disobedience of an order or directive), Rule 10 (inattention to duty), and Rule 11 (incompetency or inefficiency in the performance of duty). COPA therefore finds that **Allegation 1 against Officer [redacted] is Sustained.**

VIII. RECOMMENDED DISCIPLINE FOR SUSTAINED ALLEGATIONS

a. Detective [redacted]

i. Complimentary and Disciplinary History

Detective [redacted] complimentary record consists of 122 awards, including 1 special commendation, 1 police officer of the month award, 4 Department commendations, 87 honorable mentions, and 5 complimentary letters. Detective [redacted] disciplinary record consists of two sustained SPARs resulting in a reprimand and a one-day suspension, one for failure to perform any duty and one for a back-in-service violation, both occurring in 2019. Other than the SPARs, Detective [redacted] has no sustained complaints on his disciplinary history.

[52] *See* Special Order S06-01-02, Detention Facilities General Procedures and Responsibilities § III.A.35 (May 20, 2016).

ii. Recommended Penalty, by Allegation

1. Allegation No. 1

COPA has found that Detective [redacted] failed to properly search [redacted]; this failure resulted in [redacted] having access to a drawstring while he was confined in lock-up, and [redacted] ultimately used the drawstring in a suicide attempt. Had Detective [redacted] conducted a thorough search, he would have discovered and removed the drawstring upon [redacted] entering lock-up, thereby precluding this method of suicide. Thorough searches of arrestees are also necessary for the safety and security of sworn and civilian CPD members who work in lock-up, as these members could be harmed by weapons or other contraband that are not discovered. Here, the suicide attempt was discovered while [redacted] was alive, and [redacted] ultimately survived the incident. Also, COPA has no reason to believe that Detective [redacted] oversight was willful or malicious. However, Detective [redacted] has not taken responsibility for his mistake and has instead attempted to shift the blame to an unknown officer that he has been unable to identify. In light of Detective [redacted] record of service and the factors discussed above, COPA finds that a 5-day suspension is the appropriate penalty to impose in this case.

b. Police Officer [redacted]

i. Complimentary and Disciplinary History

Officer [redacted] complimentary record consists of 29 awards, including 2 Department commendations, 8 honorable mentions, and 1 complimentary letter. Officer [redacted] has no sustained complaints on his disciplinary history.

ii. Recommended Penalty, by Allegation

1. Allegation No. 1

COPA has found that Officer [redacted] shared his log-on credentials for the livescan fingerprint and photograph station with another officer, contrary to CPD's computer systems security directive. Maintaining the security of log-on user names and passwords is essential to the integrity of computer-based records, particularly when those records are relied upon by other CPD members, by oversight agencies, and by the courts. All of the available evidence indicates that Officer [redacted] was trying to be helpful and to allow the lock-up to operate smoothly on a holiday weekend when an atypical grouping of officers were working in lock-up. Also, there is no evidence to indicate the Officer [redacted] acted with the intent to falsify Department records, even though his actions ultimately resulted in a false record being created. Further, Officer [redacted] immediately took responsibility for his actions and did not seek to deflect blame to anyone else. In light of both the seriousness of the violation and the mitigating evidence discussed above, as well as Officer [redacted] record of service, COPA finds that a reprimand is the appropriate penalty to impose in this case.

c. Police Officer / Field Training Officer [redacted]

i. Complimentary and Disciplinary History

Officer [redacted] complimentary record consists of 8 awards, including the annual bureau award of recognition, the military service award, and four honorable mentions. Officer [redacted] has one sustained complaint on his disciplinary history where he was found to have assaulted a fellow CPD member while on duty, resulting in a 2-day suspension that he served in 2018.

ii. Recommended Penalty, by Allegation

1. Allegation No. 1

COPA has found that Officer [redacted] was not appropriately attentive to his duties while in lock-up, thereby allowing [redacted] to commence his suicide attempt. While this is the case, there are mitigating factors: first, Officer [redacted] had only worked in lock-up a handful of times and had limited experience and training in lock-up procedures and operation of the lock-up surveillance system; and second, when Officer [redacted] realized what [redacted] was doing, he reacted immediately and appropriately, likely saving [redacted] life. In light of both the seriousness of the violation and the mitigating evidence discussed above, and in light of Officer [redacted] record of service, COPA finds that a 2-day suspension is the appropriate penalty to impose in this case.

IX. CONCLUSION

Based on the analysis set forth above, COPA makes the following findings:

Officer	Allegation	Finding / Recommendation
Detective [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 2, 2017, at approximately 8:00 p.m., at or near [redacted] (District [redacted] station), that Detective [redacted], Star #[redacted] committed misconduct through the following acts or omissions, by: failing to properly search arrestee [redacted], resulting in an item that could be used as a ligature, to wit, the drawstring from [redacted] shorts, being accessible to [redacted] while in lockup, in violation of Rules 5, 6, 10, and 11.	Sustained / 5 Day Suspension
Officer [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 2, 2017, at approximately 8:00 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted] committed misconduct through the following acts or omissions, by: failing to properly search arrestee [redacted], resulting in an item that could be used as a	Unfounded

	ligature, to wit, the drawstring from [redacted] shorts, being accessible to [redacted] while in lockup. 2. It is alleged by the Civilian Office of Police Accountability that on or about September 3, 2017, between approximately 5:30 p.m. and approximately 6:05 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted], committed misconduct through the following acts or omissions, by: failing to take necessary precautions to prevent the possible injury or death of arrestee [redacted], to wit, failing to adequately monitor [redacted] while [redacted] attempted to hang himself in a holding cell.	Unfounded
Officer [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 2, 2017, at approximately 8:00 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted], committed misconduct through the following acts or omissions: by sharing his log-on ID access code for the livescan fingerprint and photograph station in the District [redacted] male lockup with Police Officer [redacted] Star #[redacted], in violation of Rules 6 and 41.	Sustained / Reprimand
Officer [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 3, 2017, between approximately 5:30 p.m. and approximately 6:05 p.m., at or near [redacted] (District [redacted] station), that Officer [redacted], Star #[redacted], committed misconduct through the following acts or omissions, by: failing to take necessary precautions to prevent the possible injury or death of arrestee [redacted], to wit, failing to adequately monitor [redacted] while [redacted] attempted to hang himself in a holding cell, in violation of Rules 5, 6, 10, and 11.	Sustained / 2 Day Suspension
Sergeant [redacted]	1. It is alleged by the Civilian Office of Police Accountability that on or about September 3, 2017, between approximately 5:30 p.m. and approximately 6:05 p.m., at or near [redacted]	Unfounded

	[redacted] (District [redacted] station), that Sergeant [redacted], Star #[redacted], committed misconduct through the following acts or omissions, by: failing to properly supervise personnel assigned to the District [redacted] male lockup while an arrestee, [redacted], attempted to hang himself in a holding cell.	

Approved:

[redacted]

December 29, 2019

Andrea Kersten
Deputy Chief Administrator – Chief Investigator

Date

Appendix A

Assigned Investigative Staff

Squad#:	[redacted]
Investigator:	[redacted]
Supervising Investigator:	[redacted]
Deputy Chief Administrator:	Andrea Kersten