

SUMMARY REPORT OF INVESTIGATION¹

I. EXECUTIVE SUMMARY

Date of Incident:	May 15, 2014
Time of Incident:	1:00 PM
Location of Incident:	5 th District Male Lock-up, 727 E. 111 th St.
Date of COPA Notification:	May 15, 2014
Time of COPA Notification:	2:26 PM

On May 15, 2014, [REDACTED] was arrested and taken to the 5th District. While in male lockup, Mr. [REDACTED] attempted suicide via strangulation. Detention Aides Rhone and Kirkland intervened, and Mr. [REDACTED] went to the hospital. On the same date, IPRA requested the surveillance video from the lockup; IPRA received this video footage on May 23, 2014 and determined on May 29, 2014, that Detention Aides Rhone and Kirkland should receive allegations for misconduct.² It was alleged that the detention aides falsified a Department report, left Mr. [REDACTED] unattended after his attempted suicide, and failed to check each arrestee in their custody. It was also alleged that Sergeant Lewis failed to perform supervisory duties. Surveillance footage of the lockup captured the incident.

Available evidence, including accused interviews and lockup surveillance video, revealed that Detention Aide (D.A.) Rhone alone fabricated entries on the Department report, and that all three accused failed to perform their duties.

D.A. Rhone and Sergeant Lewis have both retired from CPD during the pendency of this investigation and, therefore, cannot be disciplined.

II. INVOLVED PARTIES

Involved Member #1:	Keith Kirkland, Employee ID # [REDACTED], Date of Appointment: April 16, 1992, Detention Aide, Unit 171 (Central Detention Unit), Date of Birth: [REDACTED], 1965, Male, Black ³
Involved Member #2:	Maurice Rhone, Employee ID # [REDACTED], Date of Appointment: December 27, 1988, Detention Aide, 5 th

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 recommendation(s) of COPA.

² IPRA converted the log to an EO/CR on June 3, 2014, and sent the requisite Unit II notifications to accused D.A. Rhone and Kirkland. (See Atts. 12, 13, 87). In rebuttals made by SEIU, the defense was raised that IPRA did not comply with Unit II notification requirements. (See Atts. 58, 74).

³ CPD Detention Aides do not have stars.

District, Date of Birth: [REDACTED], 1964, Male, Black, Date of Retirement: June 30, 2019

Involved Member #3: Matt Lewis, Star #1767, Employee ID # [REDACTED], Date of Appointment: April 30, 2001, Sergeant of Police, 5th District, Date of Birth: [REDACTED], 1967, Male, Black, Date of Retirement: September 27, 2019

Involved Individual #1: [REDACTED] Date of Birth: [REDACTED], 1972, Male, Black

III. ALLEGATIONS

Officer	Allegation	Finding / Recommendation
Detention Aide Kirkland	<p>1. Falsified an official departmental report, specifically the 15 minute checklist, in violation of Rule 14.</p> <p>2. Was Inattentive to Duty, in that on May 15, 2014, he left the arrestee unattended in a cell after he attempted to commit suicide, in violation of Rule 6 and Rule 10.</p> <p>3. Was Inattentive to Duty, in that he failed to physically conduct a visual check of each arrestee, in violation of Rules 6, Rule 10, SO 06-01-02(II)(A)(23), and BOPS 10-07(IV)(G)</p>	<p>Unfounded</p> <p>Not Sustained</p> <p>Sustained / 6 Days</p>
Detention Aide Rhone	<p>1. Falsified an official departmental report, specifically the 15 minute checklist, in violation of Rule 14.</p> <p>2. Was Inattentive to Duty, in that on May 15, 2014, he left the arrestee unattended in a cell after he attempted to commit suicide, in violation of Rule 6 and Rule 10</p> <p>3. Was Inattentive to Duty, in that he failed to physically conduct a visual check of each arrestee, in violation of Rules 6, Rule 10, SO 06-01-02(II)(A)(23), and BOPS 10-0710-07(IV)(G).</p>	<p>Sustained</p> <p>Not Sustained</p> <p>Sustained</p>
Sergeant Lewis	<p>1. It is alleged that he was Inattentive to Duty in that on 15 May 2014, he failed to inspect the lock</p>	<p>Sustained</p>

up as directed per SO 06-01-02(II)(B)(2), in violation of Rules 3, 6, and 10.	Sustained
2. It is alleged that he was Inattentive to Duty in that on 15 May 2014, he failed to ensure that lockup keepers effectively monitored and fulfilled their responsibilities, in violation of Rules 3, 6, 10 and SO 06-01-02 (A)(1) and (II)(C).	

IV. APPLICABLE RULES AND LAWS

Rules

1. **Rule 3:** Prohibits any failure to promote the Department's efforts to implement its policy or accomplish its goals.
2. **Rule 6:** Prohibits disobedience of an order or directive, whether written or oral.
3. **Rule 10:** Prohibits inattention to duty.
4. **Rule 14:** Prohibits making a false report, written or oral.

Special Orders

1. **S06-01: Processing Persons under Department Control**
(I)(A): This directive: places accountability on station supervisors in charge of detention facilities.
(II)(B): Station supervisors in charge of detention will: **(1)** be held accountable for ensuring the safety and care of all arrestees within police facilities and lockups.
(II)(C): The station supervisor will also be responsible for **(10)** overseeing the conduct of lockup personnel and ensuring they are properly making entries in the Inspection Log by personally inspecting the lockup, prisoners, and the log at least four (4) times during the tour of duty...⁴
2. **S06-01-02(II): Detention Facilities General Procedures and Responsibilities**, requires that **(A)** Lockup personnel will: **(23)** complete a visual check of each arrestee **every 15 minutes**...⁵

Bureau of Patrol Special Orders

1. **BOPS 10-07: Detention Aides**.⁶

⁴ The Processing Persons under Department Control policy referenced in this report was effective from February 23, 2012 until January 29, 2015 (Att. 59).

⁵ Emphasis in original. The Detention Facilities General Procedures and Responsibilities policy referenced in this report was effective from February 23, 2012 until January 29, 2015 (Att. 62).

⁶ The Detention Aide BOPS referenced in this report was effective from February 2010 through July 2015 (Att. 91).

(IV)(G): Detention Aides will “complete a visual check of all arrestees every fifteen (15) minutes to determine their condition and wellbeing [sic]. All observations and times of inspection will be documented in the lockup log.”

V. INVESTIGATION⁷

a. Interviews

Detention Aide (D.A.) Keith Kirkland was interviewed on January 7, 2015.⁸ D.A. Kirkland related that on May 15, 2014, he was working in the 5th District, when D.A. Rhone told him to look at the camera. D.A. Kirkland and his partner could not tell what Mr. ██████ was doing, so D.A. Kirkland approached Mr. ██████ in his cell while D.A. Rhone continued watching the camera. D.A. Kirkland saw clothing tied around Mr. ██████ neck and Mr. ██████ “was just sitting there” on the bench.⁹ D.A. Rhone joined the two men in the cell block, and Mr. ██████ allowed the detention aides to remove the ligature. D.A. Kirkland believed he had to cut the article of clothing off Mr. ██████ neck. The detention aides notified the watch commander and moved Mr. ██████ to Cell B, closer to where they were seated. D.A. Kirkland did not recall leaving Mr. ██████ alone after Mr. ██████ attempted suicide

D.A. Kirkland believed D.A. Rhone’s initials are seen on the 15 Minute Logs from the relevant time frame.¹⁰ Per D.A. Kirkland, during the 15 minute checks, detention aides walk to each cell and ensure that the prisoners are okay. D.A. Kirkland related that, per Att. 20, his only check was at about 6:00 AM, indicated by his initials of “KK.” D.A. Kirkland denied that he was inattentive to duty by failing to conduct a visual check of each arrestee. He explained that the log documented that he was not conducting physical checks. When asked why lockup video showed no one entering the cell block for about 45 minutes, D.A. Kirkland did not recall. When asked for a reason why no detention aides entered the cellblock for at least 45 minutes, D.A. Kirkland reported that there was no reason that he could recall.

D.A. Maurice Rhone was interviewed on January 7, 2015.¹¹ D.A. Rhone recalled that on May 15, 2014, he saw Mr. ██████ via video monitor, tying clothing around his neck. D.A. Rhone notified D.A. Kirkland, who went to Mr. ██████ cell. D.A. Rhone followed, and they removed the shirt from Mr. ██████ neck. D.A. Rhone could not recall if they immediately moved Mr. ██████ to a different cell, or if they notified supervisors and then moved Mr. ██████. D.A. Rhone could not recall how long he had been watching the monitor before noticing Mr. ██████ actions. After reviewing the lockup video, D.A. Rhone did not know why he and D.A. Kirkland failed to intervene after Mr. ██████ initial attempts to strangle himself and asserted they may have been busy. Per D.A. Rhone, he did not believe he performed checks during this time, because he did not see himself in the surveillance video. When asked why they left Mr.

⁷ COPA conducted a thorough and complete investigation. The following is a summary of the material evidence gathered and relied upon in our analysis.

⁸ Atts. 35, 42

⁹ Approximately 7:58 minute mark of Att. 35

¹⁰ Att. 20

¹¹ Atts. 40, 41

██████████ in the cell for two – three minutes after removing the ligature from his neck, D.A. Rhone asserted Mr. ██████████ was in a secure area with the threat removed. The detention aides then notified superiors and moved Mr. ██████████ to a cell nearer to them.

D.A. Rhone acknowledged his initials of “MR” were seen on the Lockup 15 Minute Log from about 6:15 AM until 1:30 PM.¹² Per D.A. Rhone, “You know I, to be perfectly honest I couldn’t say yes I did do every single check. It’s a 15 minute log and, and sometimes we get busy [...] [a]nd you don’t get a chance to actually do a check.”¹³ D.A. Rhone later related, “[...] per the video it shows clearly that I didn’t do the checks [...] So if you’re looking at every 15 minutes check then yeah that would be considered I guess falsified document.”¹⁴

Sergeant Matt Lewis was interviewed on March 4, 2015.¹⁵ On May 15, 2014, Sergeant Lewis was working as the District Station Supervisor, but he did not recall Mr. ██████████ attempted suicide. Sergeant Lewis asserted that on this date, he had walked through lockup and based on documentation, he believed this occurred one time, at about 7:55 AM.¹⁶ Sergeant Lewis related, “I did check lockup at least once that day and I can only assume some sort of activity or occurrence prevented me from bein’ [*sic*] able to check the lockup on more than one occasion [...] on that day.”¹⁷

b. Digital Evidence

Lockup video was obtained of Mr. ██████████ attempted suicide in the 5th District on May 15, 2014.^{18 19}

1st Angle²⁰

The video began with Mr. ██████████ standing inside a cell. At approximately the 22:49 minute mark, Mr. ██████████ removed his sweatshirt. At roughly the 23:40 minute mark, Mr. ██████████ tied one of the sweatshirt’s arms to the cell bars. However, his actions were partially obscured by the privacy box blocking view of the commode. Mr. ██████████ proceeded to manipulate the sweatshirt, in an apparent attempt to strangle himself, until about the 26:43 minute mark. Then, Mr. ██████████ went to the ground, with the sweatshirt presumably around his neck, until approximately the 29:50 minute mark, when Mr. ██████████ stood up.²¹ Mr. ██████████ actions were then mostly obscured by the privacy square.

At roughly the 32:00 minute mark, Mr. ██████████ proceeded to the bench, with the sweatshirt arm still around his neck. He remained at the bench, with occasional adjustments to the

¹² Att. 20

¹³ Att. 41: Page 18, Lines 26 – 29 & Page 19, Lines 1 – 2.

¹⁴ Att. 41: Page 27, Lines 31 – 32 & Page 28, Lines 3 – 5.

¹⁵ Atts. 48, 55

¹⁶ Att. 20

¹⁷ Att. 55: Page 9, Lines 22 – 26.

¹⁸ Att. 85

¹⁹ The lockup video referenced in this report did not include timestamps.

²⁰ This video file is named “005_15May14_a.asf” on the disc labeled Att. 85 in the investigative file.

²¹ While ██████████ primarily stayed on the ground, he occasionally adjusted his body positioning and the sweatshirt.

sweatshirt. At about the 43:20 minute mark, Mr. ██████ seemingly attempted to remove the sweatshirt arm from around his neck. Mr. ██████ struggled with the item around his neck until approximately the 45:02 minute mark. It is unclear if Mr. ██████ was trying to strangle himself during this time.

At roughly the 50:25 minute mark, Mr. ██████ returned to the cell bars and again tied the loose sleeve to the bars, with the other sleeve still around his neck. Mr. ██████ proceeded to sit with his back to bars, presumably making the sweatshirt tight around his neck. Mr. ██████ remained in this position, making occasional adjustments, until about the 58:27 minute mark. At this point, Mr. ██████ got to his feet and returned to the bench.

Mr. ██████ continued sitting on the bench until the roughly 1:05:04 minute mark, at which point D.A. Kirkland approached his cell. D.A. Kirkland apparently spoke to Mr. ██████ and Mr. ██████ approached the bars. D.A. Kirkland touched the clothing around Mr. ██████ neck. Then, at about the 1:06:04 minute mark, D.A. Rhone joined his partner and the detention aides entered the cell and touched the object around Mr. ██████ neck. Then, at approximately the 1:06:40 minute mark, they removed the sweatshirt, exited, and closed the cell. D.A. Kirkland held the sweatshirt as they walked off. Mr. ██████ remained seated on the bench and, at about the 1:09:57 minute mark, the detention aides returned and escorted Mr. ██████ out of the cell.

*Second Angle*²²

Video began with Mr. ██████ already in a cell. At about the 22:51 minute mark, Mr. ██████ was seen removing his sweatshirt. About one minute later, he tied one sweatshirt sleeve around the cell bars. At approximately 24:46 minute mark, Mr. ██████ tied the other sleeve around his neck. Mr. ██████ proceeded to seemingly adjust the sweatshirt and test the tension. Then, at roughly the 26:47 minute mark, Mr. ██████ got on the ground in an apparent attempt to strangle himself. This continued, with Mr. ██████ re-positioning his body and adjusting the sweatshirt, until approximately the 32:00 minute mark, when Mr. ██████ removed the sweatshirt from the bars and walked off screen.

At about the 50:30 minute mark, Mr. ██████ returned to the bars with his sweatshirt. He again tied one sleeve to the bars, with the other sleeve around his neck. At roughly the 51:32-minute mark, Mr. ██████ sat on the ground, seemingly in an effort to strangle himself with the sweatshirt. This went on, with Mr. ██████ occasionally making adjustments, until about the 59:27-minute mark, when Mr. ██████ again went off screen. At roughly the 56:48 minute mark, a detention aide, believed to be D.A. Kirkland, entered the cell block, took a mattress out of the first cell, then left the cell block after about ten seconds. He never went past the first cell and, therefore, never approached or looked in the cell containing Mr. ██████

At approximately the 1:05:01 minute mark, D.A. Kirkland again entered the cell block and approached Mr. ██████ cell. D.A. Kirkland appeared to be speaking with Mr. ██████ who approached D.A. Kirkland at the bars at roughly the 1:05:25 minute mark. D.A. Kirkland reached his arm through the bars and touch the sweatshirt tied around Mr. ██████ neck. D.A. Rhone joined his partner at about the 1:06:02 minute mark. The detention aides unlocked and entered the

²² This video file is named "005_15May14.asf" on the disc labeled Att. 85 in the investigative file.

cell. D.A. Kirkland was seemingly removing the sweatshirt from Mr. [REDACTED] neck, but the three men were not clearly visible. At approximately the 1:06:50 minute mark, D.A. Kirkland left the cell with sweatshirt in hand, followed by D.A. Rhone. The detention aides closed the cell and left the cell block at about the 1:07:15 minute mark. D.A. Kirkland returned to the cell block at approximately the 1:09:57 minute mark, unlocked Mr. [REDACTED] cell, and escorted Mr. [REDACTED] out of the cell block.

c. Physical Evidence

Mr. [REDACTED] **Medical Records** were obtained from **Jackson Park Hospital**.²³ ²⁴ Mr. [REDACTED] arrived at the Emergency Room with an admitting complaint of depression and in police custody. Mr. [REDACTED] reportedly attempted suicide by trying to hang himself. Mr. [REDACTED] was transferred to Cermak Health Services for further psychiatric evaluation.²⁵

d. Documentary Evidence

[REDACTED] **Arrest Report** for **RD #HX226852** reported that he was arrested on May 15, 2014 for felony violation of his sex offender registration.^{26, 27, 28} Mr. [REDACTED] was received at 5th District Male Lockup at approximately 10:26 AM. Lieutenant Michelle McCartney related that at approximately 1:00 PM, [REDACTED] “tied his shirt around his neck and it had to be cut off,” before Mr. [REDACTED] was taken “to Jackson Park Hospital for mental health treatment.” At roughly 2:54 PM, Mr. [REDACTED] reportedly went to St. Bernard Hospital for a mental evaluation and returned to lockup at approximately 5:14 PM. Then, at about 5:15 PM, it was reported that Mr. [REDACTED] was going to Jackson Park Hospital for a mental evaluation. On May 16, 2014, at approximately 2:16 AM, it was reported that Mr. [REDACTED] returned from the hospital and was a suicidal prisoner. On May 16, 2014, at about 3:12 AM, the lockup keeper, Paul Sauseda, reported that Mr. [REDACTED] was placed in a cell for close observation. He was released from lockup on May 16, 2014, at roughly 4:25 AM.

Case Reports were located for **RD #HX262846**, related to Mr. [REDACTED] attempted suicide on May 15, 2014.²⁹ While working in 5th District Male Lockup, D.A. Rhone and D.A. Kirkland, “observed [REDACTED] [...] tie his shirt tightly around his neck.” The detention aides proceeded to the cell and “cut the shirt from around” Mr. [REDACTED] neck. Mr. [REDACTED] had “no visible injuries” and was taken “to Jackson Park Hospital [...] for a mental health evaluation.”

²³ Att. 56

²⁴ While [REDACTED] Arrest Report stated he initially went to St. Bernard Hospital, this hospital reported having no records for [REDACTED] (Atts. 29, 30, 31). Additional reports from CPD, including Lieutenant McCartney’s Report, suggest that [REDACTED] only went to Jackson Park Hospital.

²⁵ Cermak Health Services is a division of the Cook County Jail, which “provides healthcare to the detainees at the Cook County Department of Corrections.” Source: <https://cookcountyhealth.org/locations/cermak-health-services-of-cook-county/>.

²⁶ Att. 4

²⁷ The RD# listed on Mr. Matthew’s May 15, 2014 Arrest Report is HX225852, which records a completely unrelated incident/parties/date. COPA believes this is a typographical error, and that the correct RD # is HX226852.

²⁸ Additional documents under RD #HX225852 are related to Matthew’s lapsed sex offender registration, which lead to his arrest on May 15, 2014 (Atts. 78, 79, 80).

²⁹ Att. 5, 82

The Lock-up **15 Minute Check Log** from May 15, 2014 was obtained from CPD.³⁰ The initials “MR” are written every 15 minutes between 10:00 AM until 1:00 PM. At 1:00 PM, it was written that [REDACTED] had a t-shirt “around his neck” and he was “moved to holding cell B for closer observation.” The initials “KK” are written once, at 6:00 AM.

Lieutenant McCartney wrote a **Report**, dated 14 May 2014, relating that at approximately 1:15 PM, D.A. Rhone called her and reported that he and D.A. Kirkland saw Mr. [REDACTED] “tie his outer shirt around his neck and sit on the bench in his cell.”³¹ The Detention Aides entered the cell and “had to cut the shirt from around [REDACTED] neck.” Mr. [REDACTED] showed no signs of injury and “was transported to Jackson Park Hospital for a mental health evaluation.” Lieutenant McCartney authored a **second report** on July 15, 2014, relating that she “directed the Detention Aides to move [REDACTED] to the front of the lockup in one of the holding cells for closer observation until he could be transported to the hospital.”³² Lieutenant McCartney, “did not observe any other prisoners in the same cell block as [REDACTED]”

A **Report of Extraordinary or Unusual Occurrences** was authored by D.A. Kirkland for the Illinois Department of Corrections.³³ Per this report, Mr. [REDACTED] “was observed on camera to tie shirt around neck,” so D.A. Kirkland and D.A. Rhone, “went into cell block and removed shirt from arrestee’s neck and placed arrestee in cell B to be observed.” The detention aides also notified a supervisor. For recommendations to prevent future occurrences, D.A. Kirkland wrote, “make routine checks and observe prisoner while locked up in cells.”

e. Additional Evidence

Personnel Exit Interview Reports were obtained for Sergeant Lewis and D.A. Rhone.³⁴ Sergeant Lewis retired on September 24, 2019. D.A. Rhone retired on June 30, 2019.

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

³⁰ Atts. 11, 20

³¹ Att. 6; the report was erroneously dated 14 May 2014, given that both Mr. [REDACTED] arrest and suicide attempt occurred on 15 May 2014.

³² Att. 24

³³ Att. 14

³⁴ Atts. 83, 84

4. Exonerated - where it is determined by clear and convincing evidence that the conduct described 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 occurred and violated Department policy. See *Avery v. State Farm Mutual Automobile Insurance Co.*, 216 Ill. 2d 100, 191 (2005), (a proposition is proved by a preponderance of the evidence when it has found to be more probably true than not). If the evidence gathered in an investigation establishes that it is more likely that the misconduct occurred, 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.* at ¶ 28.

VII. ANALYSIS

Detention Aide Keith Kirkland

COPA finds that **Allegation 1** against D.A. Kirkland, that he falsified an official departmental report, specifically the 15 minute checklist, in violation of Rule 14 is **Unfounded**. Both D.A. Rhone and D.A. Kirkland asserted that only D.A. Rhone's initials were seen on the 15 Minute Log during the relevant time frame. The 15 Minute Log confirmed that only one set of initials, attributed to D.A. Rhone, were written during the time of Mr. ██████ detention on May 15, 2014. Therefore, this allegation against D.A. Kirkland is unfounded.

COPA finds **Allegation 2** against **D.A. Kirkland**, that he was Inattentive to Duty, in that on May 15, 2014, he left the arrestee unattended in a cell after he attempted to commit suicide, in violation of Rules 6 and 10 and CPD S06-01-02, is **Not Sustained**. Per CPD S06-01-02, when an "arrestee has been identified as a present danger to themselves (i.e. attempt suicide, caused harm to self, despondent)," lockup personnel is required to, "place the subject in a cell closet [*sic*] to the lockup keeper and will place another arrestee in the cell [...]." Once the detention aides entered Mr. ██████ cell, they saw ligature around his neck and removed it. Mr. ██████ was not left alone until the sweatshirt was taken off his neck and removed from the cell. The detention aides then left Mr. ██████ alone for roughly three minutes. While it may have been best practice not to leave Mr. ██████ alone at this point, CPD directives did not specifically prohibit leaving a suicidal arrestee alone or require the individual to be moved within a certain time frame. However, this same special order also requires lockup personnel to maintain safe conditions, and leaving a suicidal arrestee alone, even for three minutes, could potentially be dangerous. Since the policy is unclear, COPA cannot sustain this allegation.

COPA finds **Allegation 3** against **D.A. Kirkland**, that he was Inattentive to Duty, in that he failed to physically conduct a visual check of each arrestee, in violation of Rules 6, 10 and S06-01-02(II)(A)(23) is **Sustained**. Special Order S06-01-02 and BOPS 10-07 required that lockup

personnel, “complete a visual check of each arrestee **every 15 minutes.**”³⁵ Based on lockup video, the detention aides never approached Mr. ██████████ cell for almost an hour, when they should have checked on him three - four times. Mr. ██████████ attempted suicide is a glaring example of why the 15 minute checks are required, as he was able to continue his attempts at suicide for over 30 minutes. D.A. Rhone admitted to IPRA that, “per the video it shows clearly that I didn’t do the checks.” D.A. Kirkland denied the allegation. The video evidence is clear that neither detention aide conducted the requisite 15-minute observations of Mr. ██████████ therefore, both detention aides violated S06-01-02, this allegation is Sustained.

Detention Aide Maurice Rhone

COPA finds that **Allegation 1** against D.A. Rhone, that he falsified an official departmental report, specifically the 15 minute checklist, in violation of Rule 14, is **Sustained for D.A. Rhone**. D.A. Rhone and D.A. Kirkland both asserted that only D.A. Rhone’s initials were seen on the 15 Minute Log during the relevant time frame. The 15 Minute Log confirmed that only one set of initials, attributed to D.A. Rhone, were written during the relevant watch on May 15, 2014. Neither Detention Aide believed they conducted the checks, based on lockup video. Since D.A. Rhone documented making arrestee checks that he admitted never occurred, this allegation is Sustained.

COPA finds **Allegation 2** against **D.A. Rhone**, that he was Inattentive to Duty, in that on May 15, 2014, he left the arrestee unattended in a cell after he attempted to commit suicide, in violation of Rules 6 and 10 and PDC S06-01-02, is **Not Sustained**. Per CPD S06-01-02, when an “arrestee has been identified as a present danger to themselves (i.e attempt suicide, caused harm to self, despondent),” lockup personnel is required to, “place the subject in a cell closet [*sic*] to the lockup keeper and will place another arrestee in the cell [...]” Once the detention aides entered Mr. ██████████ cell, they saw ligature around his neck and removed it. Mr. ██████████ was not left alone until the sweatshirt was taken off his neck and removed from the cell. The detention aides then left Mr. ██████████ alone for roughly three minutes. While it may have been best practice not to leave Mr. ██████████ alone at this point, CPD directives did not specifically prohibit leaving a suicidal arrestee alone or require the individual to be moved within a certain time frame. However, this same special order also requires lockup personnel to maintain safe conditions, and leaving a suicidal arrestee alone, even for three minutes, could potentially be dangerous. Since the policy is unclear, COPA cannot sustain this allegation.

COPA finds **Allegation 3** against **D.A. Rhone**, that he was Inattentive to Duty, in that he failed to physically conduct a visual check of each arrestee, in violation of Rules 6, 10 and S06-01-02(II)(A)(23) is **Sustained**. Special Order S06-01-02 and BOPS 10-07 required that lockup personnel, “complete a visual check of each arrestee **every 15 minutes.**”³⁶ Based on lockup video, the detention aides never approached Mr. ██████████ cell for almost an hour, when they should have checked on him three - four times. Mr. ██████████ attempted suicide is a glaring example of why the 15 minute checks are required, as he was able to continue his attempts at suicide for over 30 minutes. D.A. Rhone admitted to IPRA that, “per the video it shows clearly that I didn’t do the checks.” D.A. Kirkland denied the allegation. The video evidence is clear that neither detention

³⁵ Emphasis in the original.

³⁶ Emphasis in the original.

aide conducted the requisite 15-minute observations of Mr. [REDACTED] therefore, both detention aides violated S06-01-02, this allegation is Sustained.

Sergeant Matt Lewis

Allegation 1 against **Sergeant Lewis**, that he was Inattentive to Duty in that on 15 May 2014, he failed to inspect the lock up, in violation of Rules 3, 6, 10 and SO 06-01-02(II)(B)(2), is **Sustained**. Based on CPD documentation and Sergeant Lewis' own admission, he only checked lockup one time on May 15, 2014, instead of the minimum required four times. Because he was in violation of the referenced directive, this allegation is Sustained.

Allegation 2 against **Sergeant Lewis**, that he was Inattentive to Duty in that on 15 May 2014, he failed to ensure that lockup keepers effectively monitored and fulfilled their responsibilities, in violation of Rules 3, 6, 10 and SO 06-01-02(I)(A) and (II)(C) is **Sustained**. This directive clearly places accountability on the station supervisor. Sergeant Lewis, however, was not even aware that Mr. [REDACTED] had made multiple suicide attempts over the course of an hour. Sergeant Lewis failed to properly supervise and direct his staff, enabling the detention aides to shirk their duty to checking arrestees every 15 minutes. Because Sergeant Lewis failed to meet the requirements of Special Order S06-01, this allegation is Sustained.

VIII. RECOMMENDED DISCIPLINE FOR SUSTAINED ALLEGATIONS³⁷

a. Detention Aide Keith Kirkland

i. Complimentary and Disciplinary History

1. Complimentary History

- 1 Democratic National Convention Award
- 1 Presidential Election Deployment Award 2008
- 1 Complimentary Letter
- 1 NATO Summit Service Award
- 1 2009 Crime Reduction Award

2. Disciplinary History

90 Day suspension served November 16, 2017 – February 15, 2018 under Log #1078329 for physically maltreating an arrestee.

ii. Recommended Penalty, by Allegation

- 1. Allegation No. 3:** Was Inattentive to Duty, in that he failed to physically conduct a visual check of each arrestee.

³⁷ No discipline can be recommended for D.A. Rhone or Sergeant Lewis, as both men have retired from CPD.

D.A. Keith Kirkland was Inattentive to Duty in that he failed to physically conduct a visual check of each arrestee. COPA finds a six (6) day penalty appropriate.

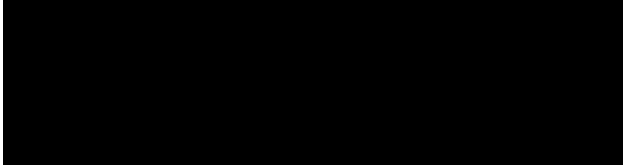
IX. CONCLUSION

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

Officer	Allegation	Finding / Recommendation
Detention Aide Kirkland	1. Falsified an official departmental report, specifically the 15 minute checklist, in violation of Rule 14. 2. Was Inattentive to Duty, in that on May 15, 2014, he left the arrestee unattended in a cell after he attempted to commit suicide, in violation of Rule 6 and Rule 10. 3. Was Inattentive to Duty, in that he failed to physically conduct a visual check of each arrestee, in violation of Rule 6 Rule 10, SO 06-01-02(II)(A)(23), and BOPS 10-07(IV)(G).	Unfounded Not Sustained Sustained / 6 Days
Detention Aide Rhone	1. Falsified an official departmental report, specifically the 15 minute checklist, in violation of Rule 14. 2. Was Inattentive to Duty, in that on May 15, 2014, he left the arrestee unattended in a cell after he attempted to commit suicide, in violation of Rule 6 and Rule 10. 3. Was Inattentive to Duty, in that he failed to physically conduct a visual check of each arrestee, in violation of Rule 6 Rule 10, SO 06-01-02(II)(A)(23), and BOPS 10-07(IV)(G)	Sustained Not Sustained Sustained
Sergeant Lewis	1. It is alleged that he was Inattentive to Duty in that on 15 May 2014, he failed to inspect the lock up as directed per SO 06-01-02 II, B 2, in violation of Rule 3, Rule 6, and Rule 10. 2. It is alleged that he was Inattentive to Duty in that on 15 May 2014, he failed to ensure that lockup keepers effectively monitored and fulfilled their	Sustained Sustained

responsibilities, in violation of Rule 3, Rule 6, and Rule 10.

Approved:



12-2-19

Angela Hearts-Glass
Deputy Chief Administrator – Chief Investigator

Date

Appendix A

Assigned Investigative Staff

Squad#:	Two
Investigator:	Kelsey Fitzpatrick, #61
Supervising Investigator:	Shery Daun, #13
Deputy Chief Administrator:	Angela Hearts-Glass