SUMMARY REPORT OF INVESTIGATION

I. EXECUTIVE SUMMARY

Date of Incident:	November 23-24, 2019
Time of Incident:	10:04 am (November 23) – 7:30 am (November 24)
Location of Incident:	11th District station, 3151 W. Harrison, Chicago, IL
Date of COPA Notification:	November 24, 2019
Time of COPA Notification:	Approximately 7:32 pm

From November 23, 2019, at approximately 10:00 a.m. until November 24, 2019 at approximately 7:30 a.m., the Chicago Police Department ("Department") held [redacted] in the 11th District Lockup related to an arrest on an outstanding warrant. He arrived with frostbite on his feet but was nonetheless admitted into lockup and not provided medical care. On November 24, 2019, as he was leaving lockup, Mr. [redacted] walked with a severe limp and had large stains on the rear of his pants, neither of which were present the day before. He also smelled strongly of feces. He still was not given medical attention; instead, Officers assigned to Central Detention transported Mr. [redacted] to the courthouse at 2650 S. California. When Mr. [redacted] entered the building, he fell to the ground, requiring him to get medical attention. Mr. [redacted] was transported to Mt. Sinai Hospital where he died the evening of November 24, 2019.

II. INVOLVED PARTIES

Involved Member #1:	Alan LASCH, star #1434, employee ID #[redacted], Date of Appointment: June 5, 1995, sergeant, Unit of Assignment: 011, DOB: [redacted], 1971, male, White
Involved Member #2:	Matthew CONWAY, star #2335, employee ID #[redacted], Date of Appointment: October 25, 2004, sergeant, Unit of Assignment: 011, DOB: [redacted], 1979, male, White
Involved Member #3:	Natalie FISCHER, star #1945, employee ID #[redacted], Date of Appointment: July 29, 2002, sergeant, Unit of Assignment: 011, DOB: [redacted], 1972, female, White
Involved Member #4:	Leroy TOLIVER Jr., star #18324, employee ID #[redacted], Date of Appointment: December 7, 1992, police officer, Unit of Assignment: 011, DOB: [redacted], 1963, male, Black

Involved Member #5:	Thomas COON, star #3535, employee ID #[redacted], Date of Appointment: November 16, 2017, police officer, Unit of Assignment: 011, DOB: [redacted], 1989, male, White
Involved Member #6:	Gary COOPER, Star #14217, Employee ID #[redacted], Date of Appointment: July 7, 1997, police officer, Unit of Assignment: 011, DOB: [redacted], 1968, male, Black
Involved Member #7:	Peter VINSON, Star #17066, Employee ID #[redacted], Date of Appointment: December 16, 1991, police officer, Unit of Assignment: 171, DOB: [redacted], 1970, male Black
Involved Member #8:	Gary RILEY, Star #8520, Employee ID #[redacted], Date of Appointment: July 12, 1999, police officer, Unit of Assignment: 171, DOB: [redacted], 1974, male, Black
Involved Member #9:	Rosalyn TEAGUE-BROWN, Employee ID #[redacted], Date of Appointment: January 18, 1994, police officer, Unit of Assignment: 171, DOB: [redacted], 1958, female, Black **(Retired)**[1]
Involved Member #10:	Charles BARRY, Employee ID #[redacted], Date of Appointment: May 1, 1992, detention aide, Unit of Assignment: 011, DOB: [redacted], 1960, male, Black
Involved Member #11:	Keith SPURLIN, Employee ID #[redacted], Date of Appointment: August 1, 1994, detention aide, Unit of Assignment: 011, DOB: [redacted], 1965, male, Black
Involved Member #12:	Andrew MCGUIRE, Employee ID #[redacted], Date of Appointment: July 1, 2014, detention aide, Unit of Assignment: 011, DOB: [redacted], 1985, male, Black
Involved Member #13:	Darius DANIELS, Employee ID #[redacted], Date of Appointment: September 16, 1998, detention aide, Unit of Assignment: 011, DOB: [redacted], 1961, male, Black
Involved Member #14:	Roberto GONZALEZ, Employee ID #[redacted], Date of Appointment: April 2, 2012, detention aide, Unit of Assignment: 011, DOB: [redacted], 1981, male, Hispanic

[1] Officer Teague-Brown retired before being served with allegations and did not provide a statement for this investigation. She is listed here as an involved member but will not be listed in the allegation or analysis sections below.

Involved Member #15:	Kimoni PEALS, Employee ID #[redacted], Date of Appointment: April 1, 2016, detention aide, Unit of Assignment: 011, DOB: [redacted], 1990, male, Black[2]
Involved Individual #1:	[redacted] DOB: [redacted], 1962, male, Black

III. ALLEGATIONS

Pursuant to section 2-78-120(d) of the Chicago Municipal Code, the Civilian Office of Police Accountability ("COPA") has a duty to investigate all incidents, including those in which no allegation of misconduct has been made, where a person dies while in Department custody. As part of its investigation, COPA analyzed the allegations that followed and has made the following findings:

Officer	Allegation	Finding / Recommendation
Sergeant Alan Lasch	1. On or about November 23-24, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Alan Lasch failed to ensure the safety and care of [redacted] (an arrestee in lockup), in violation of Special Order S06-01.	Sustained
	2. On or about November 23-24, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Alan Lasch failed to personally inspect the lockup and prisoners during his tour of duty, in violation of Special Order S06-01.	Sustained
	3. On or about November 23-24, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Alan Lasch failed to record his observations or any noticeable changes in the condition of [redacted] (an arrestee in lockup) in the "Watch Commanders Comments" section of the Automated Arrest Application, in violation of Special Order S06-01-02.	Sustained

[2] Detention Aide Peals is on a leave of absence. He was not served any allegations and did for this investigation. He is listed here as an involved member but will not be listed in the allegation or analysis sections below.

Sergeant Matthew Conway	1. On or about November 23, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Matthew Conway failed to ensure the safety and care of [redacted] (an arrestee in lockup), in violation of Special Order S06-01.	Sustained
	2. On or about November 23, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Matthew Conway failed to personally inspect the lockup and prisoners during his tour of duty, in violation of Special Order S06-01.	Sustained
	3. On or about November 23, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Matthew Conway failed to record his observations or any noticeable changes in the condition of [redacted] (an arrestee in lockup) in the "Watch Commanders Comments" section of the Automated Arrest Application, in violation of Special Order S06-01-02.	Sustained
Sergeant Natalie Fischer	1. On or about November 23-24, 2019, at various times during her shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Natalie Fischer failed to ensure the safety and care of [redacted] (an arrestee in lockup), in violation of Special Order S06-01.	Sustained
	2. On or about November 23-24, 2019, at various times during her shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Natalie Fischer failed to personally inspect the lockup and prisoners during her tour of duty, in violation of Special Order S06-01.	Sustained
	3. On or about November 23-24, 2019, at various times during her shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Natalie Fischer failed to record her observations or any noticeable changes in the	Sustained

	condition of [redacted](an arrestee in lockup) in the "Watch Commanders Comments" section of the Automated Arrest Application, in violation of Special Order S06-01-02.	
Officer Leroy Toliver Jr.	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Leroy Toliver accepted an arrestee into lockup who had injuries requiring medical attention, in violation of S06-01-02.	Sustained
	2. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Leroy Toliver failed to accurately complete the Arrest Processing Report section of [redacted]Arrest Report.	Sustained
	3. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Leroy Toliver failed to provide for the well-being of [redacted](an arrestee in the detention facility).	Sustained
Officer Thomas Coon	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Thomas Coon failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Not Sustained
Officer Gary Cooper	1. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Gary Cooper failed to provide for the well-being of [redacted](an arrestee in the detention facility).	Not Sustained
Officer Peter Vinson	1. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison Street, Officer Peter Vinson failed to search an arrestee ([redacted]prior to transport, in violation of G06-01-02.	Sustained
	2. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison	Sustained

	Street, Officer Peter Vinson failed to ensure the safety and security of an arrestee in your custody ([redacted] in violation of G06-01-01.	
Officer Gary Riley	1. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison Street, Officer Gary Riley failed to search an arrestee ([redacted] prior to transport, in violation of G06-01-02.	Sustained
	2. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison Street, Officer Gary Riley failed to ensure the safety and security of an arrestee in your custody ([redacted] in violation of G06-01-01.	Sustained
Detention Aide Charles Barry	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Charles Barry accepted an arrestee into lockup who had injuries requiring medical attention, in violation of S06-01-02.	Sustained
	2. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Charles Barry failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report.	Sustained
	3. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Charles Barry failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Sustained
	4. On or about January 10, 2020, at approximately 10:31 am, while at 1615 W. Chicago Avenue in Chicago, at the offices of the Civilian Office of Police Accountability (COPA), Detention Aide Charles Barry, during an audio-recorded interview, made one or more false, misleading, incomplete and/or inaccurate statements in his	Sustained

	connection with his awareness of [redacted] (an arrestee in the detention facility) physical condition.	
Detention Aide Keith Spurlin	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Keith Spurlin accepted an arrestee into lockup who had injuries requiring medical attention, in violation of S06-01-02. 2. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Keith Spurlin failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report. 3. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Keith Spurlin failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Sustained Sustained Sustained
Detention Aide Andrew McGuire	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Andrew McGuire failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Not Sustained
Detention Aide Darius Daniels	1. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Darius Daniels failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Not Sustained
Detention Aide Roberto Gonzalez	1. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Roberto Gonzalez failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Not Sustained

IV. APPLICABLE RULES AND LAWS

Rules
1. Rule 2: Any action or conduct which impedes the Department's efforts to achieve its policy and goals or brings discredit upon the Department. 2. Rule 3: Any failure to promote the Department's efforts to implement its policy or accomplish its goals. 3. Rule 5: Failure to perform any duty. 4. Rule 6: Disobedience of an order or directive, whether written or oral. 5. Rule 10: Inattention to duty. 6. Rule 14: Making a false report, written or oral.
General Orders
1. G06-01: Processing Persons Under Department Control (effective June 7, 2002 to February 28, 2020) 2. G06-01-01: Field Arrest Procedures (effective December 8, 2017 to present) 3. G06-01-02: Restraining Arrestees (effective December 8, 2017 to present)
Chicago Police Department Special Orders
1. S06-01: Processing Persons Under Department Control (effective January 29, 2015 to present) 2. S06-01-02: Detention Facilities General Procedures and Responsibilities (effective September 9, 2019 to August 16, 2020)

V. INVESTIGATION

a. Interviews

In separate statements to COPA, dated January 15, 2020, January 21, 2020 and September 17, 2020, Officer Leroy Toliver Jr., #18324, stated that on November 23, 2019, he worked in the lock-up from 5:00 a.m. to 1:30 p.m.[3] Officer Toliver explained that upon Mr. [redacted] entry to lock-up, he asked him the questions on the Lockup Keeper Processing portion of the arrest report. Mr. [redacted] did not say much but said he was fine and that he did not need to go to the hospital and he just wanted to go to his cell. Officer Toliver described Mr. [redacted] as docile, and an older guy who appeared tired, apparently from being homeless. Officer Toliver explained that they have arrestees remove their shoes and socks to ensure that they do not have anything they should not have on them and at that point he saw that Mr. [redacted] had "really bad feet."[4] Officer Toliver further explained that he did not believe that what he saw regarding Mr. [redacted] feet would necessitate him being sent to the hospital as it is something he sees all the time.

[3] Attachments 36, 37, 42, 43, 87, 88. There was a technical malfunction with the recorder used for the January 15, 2020, interview that caused the last few minutes to not properly be recorded. The reason for the January 21, 2020, interview was merely to correct that problem and recapture the information provided at the end of that interview.
[4] Attachment 42, page 9, lines 6-9. Officer Toliver stated that Mr. [redacted] feet looked deformed and worn out.

After processing, Mr. [redacted] was placed in a cell. Officer Toliver explained that at this point he watched Mr. [redacted] on the monitors for the 15-minute visual checks. Officer Toliver stated that Mr. [redacted] looked fine during these checks and that about 20 minutes after being placed in the cell he had fallen asleep. Mr. [redacted] made no requests while in his cell, and during a final check done around 1:00 pm, he appeared fine.

Officer Toliver also worked on November 24, 2019, and only had visual contact with Mr. [redacted] as he walked to the transport vehicle. During his shifts on November 23, 2019 and November 24, 2019, Officer Toliver did not have any knowledge of Mr. [redacted] urinating or defecating on himself. He stated that had he been aware of such, he would have tried to provide Mr. [redacted] with a paper garment and ask if he required medical attention. During his statements to COPA on January 15, 2020, and January 21, 2020, Officer Toliver was presented with POD video 8864.[5] Officer Toliver acknowledged that Mr. [redacted] pants appeared to be wet but said they did not appear wet upon Mr. [redacted] entry to lock-up the day prior. When asked about the frequency of lock-up personnel wearing face masks, Officer Toliver explained that it is not routine and added that he was surprised to see Detention Aide Barry wearing a mask on November 24, 2019.

On **September 17, 2020**, COPA presented **Officer Toliver** with allegations listed above. Officer Toliver denied the allegations, stating that Mr. [redacted] did not require medical attention upon entry. Officer Toliver asked Mr. [redacted] if he was okay and if he needed to go to the hospital. According to Officer Toliver, Mr. [redacted] responded by stating, "No… I want to go to my cell and go to sleep."[6] Officer Toliver stated that he did not inaccurately complete the processing section of Mr. [redacted] arrest report, as he did not see any injuries to Mr. [redacted] though he described Mr. [redacted] as having "bad feet."[7] Furthermore, Officer Toliver stated that he did not fail to provide for the wellbeing of Mr. [redacted] He explained that they followed protocol by asking Mr. [redacted] if he needed medical attention, they fed him, and Mr. [redacted] went to sleep in his cell. Officer Toliver did not notice a change in Mr. [redacted] condition during the short interaction Officer Toliver had with him.

In separate statements to COPA, dated January 9, 2020, and June 26, 2020, Detention Aide Keith Spurlin stated that he worked in the lock-up on both November 23, 2019, and November 24, 2019, from 5:00 am to 1:00 pm.[8] Detention Aide Spurlin searched Mr. [redacted] upon his entry to lock-up. The search consisted of having him take everything out of his pockets and physically patting him down. According to Detention Aide Spurlin, when he searched Mr. [redacted] he did notice a smell to him but he hadn't soiled himself.[9] Detention Aide Spurlin stated that he would have provided Mr. [redacted] with a change of clothes had his pants been soiled. He further explained that medical attention is very important to him. If the arrestees can verbalize answers and are able to walk on their own, lock-up personnel will accept them. Mr. [redacted] was

[5] PODs 8863 and 8864 are located in the 11th District lockup and have different views of the front/desk area. Officer Toliver viewed video footage of POD 8864 from November 24, 2019, 7:27 a.m. to 7:28 a.m.
[6] Statement of Officer Toliver, attachment 88, page 7, lines 5-6. Officer Tolliver reported this same statement from Mr. [redacted] in his January 15, 2020, interview. See also attachment 42, page 9, lines 19-20.
[7] Attachment 88, page 9, lines 14-15. Officer Toliver described Mr. [redacted] feet as deformed and in bad shape. He further stated Mr. [redacted] did not have any open wounds that required medical attention.
[8] Attachments 35, 41, 57, 58.
[9] Attachment 41, page 8, lines 8-9.

coherent and followed all verbal direction, including directions to step back, put his hands on the counter, spread his legs, and things of that nature. Mr. [redacted] did not give any indication that anything was wrong, only stating that he was tired. Detention Aide Spurlin believed that Mr. [redacted] feet appeared to be frostbitten due to the brownish color and some blisters coupled with the fact that Mr. [redacted] had indicated that he was homeless and likely out in cold weather.

When Detention Aide Spurlin removed Mr. [redacted] shoes and socks, he noticed that Mr. [redacted] feet were frostbitten. He asked Mr. [redacted] if he was okay and if his feet were all right, to which Mr. [redacted] replied, "Yeah, I'm all right. I'm just tired. I'm trying to go lay down."[10] During processing, Detention Aide Spurlin ascertained that Mr. [redacted] was not in need of medical attention due to the condition of his feet. Mr. [redacted] answered all the required questions and was able to walk under his own strength. He relayed this information to Officer Toliver in order to continue the booking process. Detention Aide Spurlin did not see any signs of Mr. [redacted] being in distress during the 15-minute checks, which are primarily conducted via the monitor.

Detention Aide Spurlin did not have any contact with Mr. [redacted] on November 24, 2019, other than assisting with loading him and other arrestees onto the prisoner vehicle. When presented with lock-up video from that day, Detention Aide Spurlin noted that Mr. [redacted] pants and boxers appeared soiled, which was not how Mr. [redacted] presented on entering lock-up the previous day. Detention Aide Spurlin further stated that it did not appear Mr. [redacted] walked on the side of his foot the day before as he did on the November 24, 2019 video. When asked by COPA personnel if he smelled an odor indicative of someone urinating or defecating, Detention Aide Spurlin explained that the lock-up area normally smells bad, which he attributed to detainees not always flushing their toilets.

Detention Aide Spurlin denied that he failed to accurately complete the arrest processing section of the arrest report because it was the booking officer's responsibility, which was Officer Toliver on the date of incident. Detention Aide Spurlin stated that he did not fail to provide for the well-being of Mr. [redacted] He asked Mr. [redacted] if he needed medical attention, which Mr. [redacted] declined. According to Detention Aide Spurlin, he was not made aware of Mr. [redacted] condition by anyone in lock-up or that Mr. [redacted] needed medical attention. Detention Aide Spurlin did not have any knowledge on either day that Mr. [redacted] had soiled his pants until Mr. [redacted] was being released from lock-up. At that point, Mr. [redacted] had been transferred to the custody of the transport officers. Detention Aide Spurlin stated that the transport officers will search the arrestees and ask them if they need medical attention. Detention Aide Spurlin did not have any conversation with anyone about Mr. [redacted] condition at that point.

In separate **statements**[11] to **COPA,** dated **January 10, 2020,** and **June 25, 2020**, **Detention Aide Charles Barry** stated that on November 23, 2019, he worked from 5:00 a.m. to 1:00 p.m.[12] Detention Aide Barry stated that his only duty on that day was to fingerprint incoming arrestees. Detention Aide Barry recalled fingerprinting Mr. [redacted] but had no recollection of any

[10] Attachment 41, page 12, lines 2-3.
[11] Detention Aide Barry was scheduled to provide a statement on June 22, 2020. At the beginning of the statement, COPA learned that Detention Aide Barry had not had an opportunity to review his previous statement and rescheduled the interview to June 25, 2020. The June 22, 2020, interview is included as Attachments 52 and 53.
[12] Attachments 54, 55, 94, 95

other contact on that day. Detention Aide Barry stated that he also worked the same hours on November 24, 2019, but did not recall having much contact with Mr. [redacted] other than possibly getting him ready to be transported to court.

Detention Aide Barry stated that he may have conducted the 15-minute checks on both dates, which are primarily conducted by viewing the monitors. COPA personnel provided Detention Aide Barry with a copy of the 15-minute checklist and confirmed that he conducted the checks on both dates. According to Detention Aide Barry, although the 15-minute checks are primarily done by viewing the monitors, they also do random physical checks throughout their tour of duty. Detention Aide Barry stated that the monitors provide a view of the cells but explained that if an arrestee requires any type of aid or assistance, they will have to yell, as the monitors do not include audio. Detention Aide Barry did not recall anything occurring on either date that was out of the ordinary. Mr. [redacted] did not request medical attention, nor, according to Detention Aide Barry, did he present in a manner that would have necessitated aid.

On January 10, 2020, COPA personnel presented Detention Aide Barry with POD video from lock-up from November 24, 2019. Detention Aide Barry acknowledged seeing Mr. [redacted] leaving for court in the video. He also described Mr. [redacted] pants as having a stain at the top and agreed that the stain traveled to the bottom of Mr. [redacted] right leg. At one point in the video, where Detention Aide Barry is standing behind Mr. [redacted] COPA personnel asked him what he was wearing on his face. Detention Aide Barry stated that he could not recall, but agreed that the video depicted him wearing a surgical mask. When asked how often he wears a mask while at work, Detention Aide Barry stated that he wears a mask "a lot of times"[13] due to the germs and poor ventilation in lock-up but stated that he did not believe that he wore a mask on November 23, 2019. Additionally, later in the statement, Detention Aide Barry phrased his answer to say he wears a mask "a lot of mornings"[14] or "some days" and in doing so mentioned that some arrestees don't smell well.[15] He denied wearing the mask because Mr. [redacted] smelled of feces, however he stated that he wore the mask on this day because of the smell of all of the prisoners, not just Mr. [redacted] Detention Aide Barry denied smelling anything out of the ordinary, to include urine and feces. Detention Aide Barry stated that had lock-up personnel been informed or become aware that Mr. [redacted] had soiled himself, he should have been sent to the hospital. He was not aware of Mr. [redacted] asking for medical attention, or anyone else in lock-up on November 23-24, 2019, asking on his behalf.

On June 25, 2020, when presented with allegations of misconduct, Detention Aide Barry stated that since his only role was to fingerprint Mr. [redacted] on November 23, 2019, he did not fill-out any portion of the arrest report. When asked how often he wore a mask in lock-up prior to November 24, 2019, Detention Aide Barry stated that he could not provide an answer. He was asked to provide circumstances in which he would wear a mask, to which he said there is "no special time" and he wears one "whenever [he] felt that [he] need[ed] the mask."[16] He indicated that he wears the mask due to lack of ventilation, and the only specific reason he provided for wearing a mask is if a detainee was spitting. Despite saying he could come up with other reasons

[13] Attachment 55, page 23, lines 11-12.
[14] Attachment 55, page 27, line 20.
[15] Attachment 55, page 28, lines 9-10.
[16] Attachment 95, page 14, lines 1-4.

to wear a mask, that is the only circumstance Detention Aide Barry actually provided in his interview. When asked if he would wear a mask due to an odor, Detention Aide Barry stated, "Normally."[17] Furthermore, Detention Aide Barry stated that he did not recall the reason he wore a mask on November 24, 2019 or if it was because of the odor emanating from Mr. [redacted]

Detention Aide Barry stated that he did not accept an arrestee into lockup with injuries requiring medical attention, as that was the responsibility of the booking and searching officers. He added that he did not fail to accurately complete the arrest processing report section of the arrest report as that was not his responsibility. Detention Aide Barry also denied that he failed to provide for Mr. [redacted] well-being, even though he completed and documented the 15-minute checks throughout his shifts on November 23, 2019, and November 24, 2019, which he stated are primarily done by looking at the monitors. Lastly, Detention Aide Barry denied providing false, incomplete, or inaccurate statements to COPA on January 10, 2020 relating to Mr. [redacted] physical condition.

In a statement to COPA on July 1, 2020, Sergeant Alan Lasch, #1434, stated that on November 23, 2019, and November 24, 2019, he worked as the District Station Supervisor.[18] His work hours were from 5:00 a.m. to 2:00 p.m. Sgt. Lasch stated that other than reviewing Mr. [redacted] arrest report, he had no independent recollection of Mr. [redacted] or any incidents involving him.

Sgt. Lasch stated that during any given workday, he will conduct four checks of the lock-up throughout his shift. He tries to do his first check during the first half hour of his shift, then the remaining checks vary depending on how busy he is. Sgt. Lasch stated that during his checks, he ascertains that the arrestees are okay and that nobody needs anything. Sgt. Lasch explained that the district has cameras in the lock-up that face every cell with monitors by the front desk. He also conducts checks by walking in the hallway for the cells. If a detainee calls him, he will walk down the individual hallway, but otherwise he walks the main cell hallway where he can look down the cell hallways and see each cell.[19]

Sgt. Lasch did not recall having any knowledge that Mr. [redacted] needed any type of aid or had urinated or defecated on himself while in lock-up. According to Sgt. Lasch, had he had knowledge of the occurrence, he would have either sent Mr. [redacted] to the hospital or asked him if he wanted a change of clothes. He added that if Mr. [redacted] had said that he had frostbite, he "very likely" would have sent him to the hospital.[20] If Mr. [redacted] had said he did not want to go, Sgt. Lasch would have sent him anyhow if he believed the Sheriff's Office would require medical clearance.

Sgt. Lasch stated that he did not provide inadequate care to Mr. [redacted] because he conducted video checks and some walk-through checks and no one ever brought to his attention

[17] Attachment 95, page 16, lines 2-3.
[18] Attachments 72, 73.
[19] Attachment 73, page 11, line 19-page 12, line 8. He described that on the male side of lockup there are six corridors of cells with four or five cells in each corridor. There are cameras on the wall which capture two cells at once and allow officers to zoom in on one cell.
[20] Attachment 73, page 28, lines 18-23.

that Mr. [redacted] needed any type of medical attention. Sgt. Lasch stated that the 15-minute log forms show that he completed visual checks as required. Lastly, Sgt. Lasch stated that he updated the arrest report to reflect that Mr. [redacted] was transported to the hospital.

In a statement to COPA on July 2, 2020, Officer Thomas Coon, #3535, stated that on November 23, 2019, he was assigned to the 11th District lock-up from 1:00 pm to 9:00 pm.[21] Officer Coon did not have any independent recollection of Mr. [redacted] He stated when he arrived at work, he conducted a check of the cell blocks. To the best of his recollection, Officer Coon did not believe that Mr. [redacted] or any other arrestee informed him that Mr. [redacted] needed medical attention or that he had soiled himself. Officer Coon stated that in an instance where he would have been informed of such, he would have notified his sergeant and issued Mr. [redacted] a paper gown. Additionally, he did not recall smelling urine or feces when he walked the cellblocks.

In a statement to COPA on June 25, 2020, Detention Aide Andrew McGuire stated that on November 23, 2019, he worked from 1:00 p.m. to 9:00 p.m.[22] Detention Aide McGuire stated that from his recollection, Mr. [redacted] was in a cell when he arrived to work. He explained that his only contact would have been during the 15-minute checks or if Mr. [redacted] asked for something to eat or tissue paper. Detention Aide McGuire explained that on a regular day, his duties as a detention aide include conducting roll call, which consists of walking the cell blocks and calling each arrestee's name for accountability purposes. According to Detention Aide McGuire, either he or one of his partners will walk the cell blocks during the 15-minute checks to make sure everyone is where they need to be but will at times watch the monitors. Detention Aide McGuire added that during the checks, they will ask the arrestees their names to make sure everything is okay.

Detention Aide McGuire recalled Mr. [redacted] declining the offered sandwich during the normal meal time between 5:00 and 6:00 p.m. Detention Aide McGuire stated that Mr. [redacted] slept most of the night but recalled him getting up a couple of times to use the bathroom. Detention Aide McGuire stated that he did not see any injuries to Mr. [redacted] nor did it appear that he required medical attention. Detention Aide McGuire described Mr. [redacted]'s clothing as appearing to fit big on him, given his petite size. Detention Aide McGuire denied that anyone, including Mr. [redacted] ever informed him during his shift that Mr. [redacted] needed aid. Detention Aide McGuire also denied that he recalled ever smelling an odor indicative of Mr. [redacted] urinating or defecating on himself. Detention Aide McGuire stated that if he had knowledge that Mr. [redacted] had urinated or defecated on himself, he would have informed his sergeant and tried to obtain a paper suit for him.

Detention Aide McGuire stated that had he been aware that any arrestee needed help or had to go to the hospital, he would go out of his way to make sure that person obtained the help they needed. He stated that he would also inform his sergeant of such matter and make sure the person got medical attention if needed. According to Detention Aide McGuire, he was not aware that Mr. [redacted] had urinated and defecated on himself. Detention Aide McGuire stated that he learned of Mr. [redacted] dying when a detective later interviewed him.

[21] Attachments 75, 76.
[22] Attachments 66, 67.

In a statement to COPA on August 6, 2020, Sargeant Matthew Conway, #2335, stated that he worked from 1:00 p.m. to 10:00 p.m. on November 23, 2019 and was off on November 24, 2019.[23] Sgt. Conway provided a statement consistent with that of other Department members. He added that he did not have any knowledge of Mr. [redacted] condition. Sgt. Conway stated that he was unaware that Mr. [redacted] needed aid or that he had urinated or defecated on himself.

According to Sgt. Conway, he did not violate any Department orders because he ensured that the arrestees were safe and secure while in the lock-up. Sgt. Conway stated that he conducted the required visual checks, which he did via the monitors, and was not made aware of any incidents. Furthermore, Sgt. Conway stated that had he made any observations or noted any changes to Mr. [redacted] he would have made documentation on the watch commander's section of the arrest report.

In a statement to COPA on July 2, 2020, Officer Gary Cooper, #14217, stated that he worked from 9:00 p.m. on November 23, 2019, to 5:30 a.m. on November 24, 2019.[24] According to Officer Cooper, he did not recall having contact with Mr. [redacted] other than the fact that Mr. [redacted] was inside of a cell when he arrived at work. Officer Cooper stated that he was not informed by anyone during his shift that Mr. [redacted] needed medical attention. Officer Cooper was also unaware that Mr. [redacted] had soiled himself. Officer Cooper stated that he would have made sure Mr. [redacted] obtained medical attention and notified a sergeant had he been made aware of his condition.

In a statement to COPA on June 23, 2020, Detention Aide Darius Daniels stated that he worked from 9:00 p.m. on November 23, 2019, to 5:00 a.m. on November 24, 2019.[25] Detention Aide Daniels provided a statement consistent with that of other Department members interviewed as part of this investigation. After he relieved lock-up personnel from the previous shift, he asked Mr. [redacted] for his name and if he wanted a mat, a sandwich or tissue. Detention Aide Daniels stated that Mr. [redacted] was lying down at the time and sat up when Detention Adie Daniels asked for his name. Mr. [redacted] replied that he did not want any of the offered items and laid back down. Detention Aide Daniels stated that there were no signs that Mr. [redacted] had soiled himself or needed medical attention. Detention Aide Daniels stated that there was another arrestee[26] in the cell with Mr. [redacted] upon his arrival and that person never informed him of Mr. [redacted] condition. Had he been informed of Mr. [redacted] condition, he would have notified a sergeant and asked to have Mr. [redacted] sent to the hospital.

In a statement to COPA on June 23, 2020, Detention Aide Roberto Gonzalez stated that he worked from 9:00 p.m. on November 23, 2019 into the morning of November 24, 2019.[27] Detention Aide Gonzalez provided a statement consistent with other Department members regarding lock-up procedures. Detention Aide Gonzalez stated that he could not recall having any knowledge of Mr. [redacted] soiling himself or needing medical attention. All that Detention Aide

[23] Attachments 90, 91.
[24] Attachments 78, 79.
[25] Attachments 60, 61.
[26] This arrestee was identified as [redacted] Mr. [redacted] entered lock-up at approximately 6:29 p.m. on November 23, 2019 and was released from lock-up at 12:55 p.m. on November 24, 2019.
[27] Attachments 63, 64.

Gonzalez could recall was that November 23, 2019, was a normal night and he did not recall anything out of the ordinary occurring. According to Detention Aide Gonzalez, had he been aware that Mr. [redacted] soiled himself or that he required medical attention, he would have notified a sergeant and had Mr. [redacted] sent to the hospital.

Detention Aide Gonzalez explained that checks of the cells were conducted every 15 minutes via the monitors they have in the lock-up and by walking the cellblocks. According to Detention Aide Gonzalez, he did not recall any smell out of the ordinary and did not recall conducting physical checks of the lock-up on the date of incident.

In a statement to COPA on July 1, 2020, Sergeant Natalie Fischer, #1945, stated that she worked from 9:00 p.m. on November 23, 2019 until 6:00 a.m. on November 24, 2019.[28] Sgt. Fischer provided a statement consistent with that of other Department members. Sgt. Fischer stated that she could not recall any specific interaction with Mr. [redacted] nor did she recall being made aware that he had soiled himself or required medical attention. Sgt. Fischer stated that had she been made aware of Mr. [redacted] soiling himself or needing medical aid, she would have had him sent to the hospital.

Sgt. Fischer explained the process of the 15-minute checks and stated that lock-up personnel complete them both by viewing the monitor and by physically walking the cells. Sgt. Fischer stated that lock-up personnel routinely enter the cells for reasons of placing new arrestees in the cells or by feeding and providing mattresses to the arrestees. Furthermore, Sgt. Fischer stated that she conducts four checks throughout her shift by entering the corridor of the cell blocks.

According to Sgt. Fischer, she did not recall observing or smelling anything out of the ordinary in lock-up during her shift. Additionally, Sgt. Fischer stated that she would never put Mr. [redacted] in a position to deny him aid if required. Sgt. Fischer explained that she conducted the lock-up checks and did not find anything that she recalled was a cause for concern. Sgt. Fischer did not recall any kind of concerns with Mr. [redacted] that would require her to document noticeable changes to his condition.

In a statement to COPA on July 21, 2020, Officer Peter Vinson, #17066, stated that on the date of incident, he was assigned to the Central Detention Unit (Unit 171).[29] He worked with Officers Gary Riley, and Rosalyn Brown.[30] According to Officer Vinson, his duties as a transport officer are to pick up arrestees from the district stations and transport them to court for their bond hearings. Officer Vinson explained that upon arrival at a district station, the arrestees are escorted from their cells and taken to a holding pen where they are given an explanation of the process and asked if they are sick, injured or in need of medical attention. The transport officers will pat-down the arrestees, open their pockets and concentrate on the areas most accessible to their hands; similar to a custodial search. The arrestees are then escorted onto the prisoner van and driven to court.

[28] Attachments 69, 70.
[29] Attachments 81, 82.
[30] Officer Rosalyn Teague-Brown retired from the department on February 15, 2020 and thus a statement was not provided to COPA. Refer to attachment 96 for Officer Teague-Brown's Retirement Submission Receipt.

Officer Vinson recalled that on the date of incident, Mr. [redacted] was in the holding pen. Officer Vinson recalled an unpleasant odor in the holding pen but he could not describe the smell or where it came from. According to Officer Vinson, he was not aware that Mr. [redacted] soiled himself, but he heard the arrestees in the cell say that there was a foul smell. Officer Vinson stated that he did not ask questions about the smell because it is not an uncommon occurrence. Officer Vinson could not recall if he specifically searched Mr. [redacted] on the date of incident.

Mr. [redacted] was escorted to the prisoner van and transported to 26th and California. According to Officer Vinson, he did not remember observing anything about Mr. [redacted] gait as he walked to the prisoner van that was cause for concern. Officer Vinson stated that in a situation such as Mr. [redacted] where he soiled his pants and had difficulty walking, if he did not request medical attention and could walk on his own, they would still transport him to court. Officer Vinson stated that it is not uncommon for arrestees to have difficulty walking or getting onto the transport van. In those instances, the officers will assist the arrestees onto the van.

According to Officer Vinson, when they arrived at the court building, the arrestees walked into the receiving area where he lost sight of Mr. [redacted] A deputy sheriff informed him that one of the arrestees, now known to be Mr. [redacted] had fallen in the stairwell. Officer Vinson entered the area and spoke to Mr. [redacted] Officer Vinson stated that he asked Mr. [redacted] if he was okay to stand up. He tried a couple of times to stand Mr. [redacted] up but he failed. With the assistance of a deputy sheriff, Officer Vinson placed Mr. [redacted] on the landing and he called for an ambulance.[31]

In a statement to COPA on July 21, 2020, Officer Gary Riley, #8520, stated that he was assigned as the driver of the transport van on the date of incident.[32] He provided details of his duties consistent with that of Officer Vinson. Officer Riley stated that during Mr. [redacted] pat-down, he may not have noticed his pants to be soiled because he was wearing gloves. Officer Riley stated that he was unaware that Mr. [redacted] had soiled himself. He was also not informed of such or if Mr. [redacted] needed medical attention. Officer Riley stated that had he been made aware of either instance he would have tried to get a change of clothes for Mr. [redacted] and provided medical attention if needed.

According to Officer Riley, once they arrived at the court building, one of the arrestees may have made a statement regarding a foul odor. Officer Riley stated that Mr. [redacted] had answered all medical questions and gone through the court doors to enter the next phase of processing when a sheriff came out to the garage to inform him that Mr. [redacted] had fallen. Officer Riley immediately informed Officer Vinson, who then called for an ambulance.

On December 9, 2019, COPA personnel contacted [redacted] via telephone.[33] Mr. [redacted] stated that he shared a cell with Mr. [redacted] for approximately seven to eight hours.

[31] When asked why Mr. [redacted] name was crossed off on the prisoner manifest form, Officer Vinson said it was due to him not being taking into receiving by the Cook County deputy sheriffs.
[32] Attachments 84, 85.
[33] Attachment 22. Mr. [redacted] declined to provide a formal statement or cooperate any further with the investigation. He informed COPA personnel that he had recently encountered a similar incident but did not provide any further information.

When Mr. [redacted] entered the cell, it was apparent that Mr. [redacted] had soiled himself. Mr. [redacted] informed one of the lock-up staff (an older male with gray hair and glasses) of Mr. [redacted] condition. Mr. [redacted] stated that the male told him to "hang tight"[34] but he never returned. Mr. [redacted] added that during his time in the cell with Mr. [redacted] Mr. [redacted] never spoke or complained.

b. Digital Evidence[35]

POD 8864, located in the 11th District lock-up area, dated November 24, 2019, between 7:00 a.m. and 8:00 a.m., depicts Mr. [redacted] walking towards the area where the arrestees are loaded onto the transport van.[36] Detention Aide Barry is seen walking behind Mr. [redacted][37] Detention Aide Spurlin is also visible on the video near the lock-up desk. Detention Aide Barry is wearing a surgical mask. Mr. [redacted] clothing appears dirty and his pants and boxers appear to be soiled. Additionally, Mr. [redacted] appears to have difficulty walking. He walks much slower than the other arrestees and with a limp. He is walking in a pronated manner, especially with his left foot, which he walks nearly entirely on the inside of the foot. When Detention Aide Barry returns from escorting Mr. [redacted] to the transport van, he removed the surgical mask.[38] The video also shows officers with what appears to be disinfectant spray and an unidentified officer moves a floor fan out of camera view.[39]

COPA ordered and obtained video from POD 8864 and 8863 for various dates ranging from January 7, 2020, through February 29, 2020, between 7:00 a.m. and 8:00 a.m. During those dates and times, COPA personnel did not see Detention Aide Barry wearing a face mask.[40]

c. Physical Evidence

According to the **Chicago Fire Department (CFD) Ambulance Report**, ambulance 34 responded to the Cook County jail, where a 57-year-old male, Mr. [redacted] was found lying at the entrance to the stairs of the lock-up area.[41] No trauma was noted as it was reported that Mr. [redacted] collapsed from a standing position. Mr. [redacted] was found with a bowel movement on him and trench foot on both of his feet. The outer layer of skin of his left foot peeled off as he was being transferred onto the stretcher. Mr. [redacted] appeared confused. No signs of trauma were noted on his head, only an old bruise located near his left eye. Various fingers on his right hand had been amputated. Mr. [redacted] skin appeared dry. His pupils remained dilated despite being exposed to the penlight. After the crew found Mr. [redacted] blood sugar to be low, he was treated with a medication that made him become more active but also restless, moving his arms making an

[34] Attachment 22.
[35] The cameras used to monitor the cells do not record. An additional POD camera located in the cell area was not working at the time of this incident.
[36] Attachment 14.
[37] Attachment 32 @28:24 of the video.
[38] Attachment 32 @29:02 of the video.
[39] Attachment 32 @30:05 and 30:29 of the video.
[40] Attachments 13, 14, 47, 99-116. POD 8863 is located in the 11th District lockup and shows the desk area. COPA attempted to obtain video from these PODs for the time Mr. [redacted] was taken into custody, but the retention period had elapsed before the request was processed.
[41] Attachment 8.

accurate blood pressure/repeat blood sugar unobtainable. Mr. [redacted] was transported to Mt. Sinai Hospital

According to the **medical records received from Mt. Sinai Hospital**, Mr. [redacted] was received into the emergency room for altered mental status.[42] Mr. [redacted] was alert and covered in fecal matter. He also presented with a bruise to his left eye, an open puncture wound to his right palm with no active bleeding, and skin sloth to both feet. Mr. [redacted] mental status was altered, unable to give medical history. Given his altered state, Mr. [redacted] was given multiple doses of Ativan. Mr. [redacted] was also hypoglycemic and was given medication to treat that. Ultimately, Mr. [redacted] was intubated and sent for CT scan, which was unsuccessful. Later, his heart rate became too low and he lost his pulse. The records document that Mr. [redacted] coded three times and was ultimately pronounced deceased. Mr. [redacted] tested positive for cocaine and opiates.[43]

The **Office of the Medical Examiner of Cook County** documented the postmortem examination of [redacted] which was performed on November 25, 2019 at 10:38 a.m., by Doctor [redacted] [redacted][44] Evidence of medical intervention was outlined. Doctor [redacted] determined the cause of death to be combined drug toxicity, probable to be cocaine and opioids. The manner was accident.

The toxicology report documents Mr. [redacted] peripheral blood and urine contained several compounds, to include cocaine and opioids.

d. Documentary Evidence

The **Chicago Police Department Arrest Report** documents that Mr. [redacted] was arrested on an outstanding warrant on November 23, 2019, at 10:04 a.m. and transported to the 11th District for processing.[45] Mr. [redacted] was received in lock-up at 11:06 a.m. According to the lock-up keeper's visual check, Mr. [redacted] did not present any obvious signs of pain, injury or infection. Additionally, the report indicates that Mr. [redacted] was not under the influence of drugs or alcohol.

The **Chicago Police Department Prisoner Log** documents that 15-minute checks were conducted by lock-up personnel from the time Mr. [redacted] entered lock-up, until he was transported out of the 11th District on November 24, 2019.[46] Additionally, the report documents that supervisory personnel also conducted checks during this time.

According to the **Illinois Department of Corrections Report of Extraordinary or Unusual Occurrences**, Mr. [redacted] was arrested on November 23, 2019 at 10:04 a.m.[47] He was held at the 11th District lock-up until he was transported to Mt. Sinai Hospital on November 24,

[42] Attachment 31.
[43] Attachment 31, pages 19-21.
[44] Attachment 98. Photograph taken during the examination showed significant signs of frostbite on Mr. [redacted] feet. There were minor bruises and redness on his arms and torso, but no other significant injuries. See. Attachment 20.
[45] Attachment 1.
[46] Attachment 10. Not all initials are legible, but multiple Officers and Detention Aides signed the book at various times.
[47] Attachment 15.

2019, for an altered mental state. Mr. [redacted] expired at Mt. Sinai Hospital at 7:05 pm. Preliminary findings showed kidney failure and cocaine and opioids in Mr. [redacted] system.

The **Detective file,** which includes the **Original Case Incident Report**, the **Detective Supplementary Reports**, as well as other documents detail information consistent with the information COPA obtained throughout the investigation.[48] The supplementary reports detail additional information and interviews conducted by detectives assigned to the investigation.

The Progress Violent (Scene) Supplementary Report documents interviews taken by detectives assigned the investigation. Information obtained by detectives was consistent with the interviews conducted by COPA personnel. Additional interviews documented by detective are as follows.

Detectives interviewed Detention Aide Charles Barry on November 25 at 5:05 a.m. Detectives reported that Detention Aide Barry told them that he recalled Mr. [redacted] having a "strong unpleasant odor on his person and his clothing."[49]

Officer Derrick McDonald, #9080, was also interviewed. He stated that he started his shift at 5:00 a.m. on November 24, 2019. When he arrived to work, Mr. [redacted] was in his cell. When the prisoner transport van arrived, Officer McDonald observed Mr. [redacted] walk out from the cell block, appearing to be coherent and following instructions given by the transport officers. Similarly, Detention Aide Kimoni Peals[50] informed detectives that he worked from 1:00 p.m. to 9 p.m. on November 23, 2019. Detention Aide Peals stated Mr. [redacted] was in cell #D2 and was responsive and made no complaints. According to Detention Aide Peals, Mr. [redacted] was offered food but he refused.

Arresting Officers Kartik Ramakrishnan, #17572 and Shaun Susnis, #3178 were also interviewed. Both officers provided essentially the same account of their contact with Mr. [redacted] The officers stated that they were assigned to Unit 311 (Area Central Gang Enforcement) on the date of Mr. [redacted] arrest. The officers stated that they were aware that Mr. [redacted] had an outstanding arrest warrant. They recognized him while they were on patrol. After verifying that warrant to still be active, they placed him under arrest and transported him to the 11th District. Officer Ramakrishnan stated that while Mr. [redacted] was being processed, he was coughing quite a bit and was offered medical attention, which he refused.

COPA conducted a search of the **Court Dockets** for the Northern District of Illinois and Cook County Circuit Court on April 13, 2021 and located no lawsuits related to this incident. The Department of Law confirmed via email that they had no record of a lawsuit.

[48] Attachment 97.
[49] Attachment 97, pages 26 and 78.
[50] Detention Aide Peals is on extended leave from the Department and therefore COPA personnel are unable to interview him.

VI. LEGAL STANDARD

A. Detention Facilities Procedure and Processing Persons Under Department Control.

The Department states that it is its policy to provide secure detention for persons in custody and to maintain its lockups in a safe and sanitary condition.[51] To implement that policy, Department members assigned to a lockup facility must adhere to Department procedures and "will be alert to any problems or conditions that may compromise the security or safety of detained" persons.[52]

Lockup facility procedures are detailed in several Department orders. These orders assign general responsibilities for Department members processing arrestees and lockup personnel. Ultimately, these orders hold station supervisors accountable for ensuring the safety and care of all arrested persons.

1. Station Supervisor Duties.

Department Special Order S06-01-02, entitled 'Detention Facilities General Procedures and Responsibilities," provides that station supervisors are responsible for:

- personally conducting an independent thorough inspection of lockup and arrestees at least four times during their tour of duty and noting conditions found;
- recording noticeable changes in the conditions of arrestees in the Watch Commander Comments section of the arrest report;
- ensuring that lockup personnel effectively monitor and fulfil their responsibilities; and
- ensuring that Chicago Fire Department paramedics are called should an arrestee be exhibiting signs of medical distress.[53]

Special Order S06-01similarly requires that station supervisors personally inspect lockup and prisoners at least four times during their tour of duty and to note the conditions they find.

2. Lockup Personnel Duties.

a) Arrestee Screening.

Department Special Order S06-01-02 dictates non-supervisory lockup personnel duties. Lockup personnel are responsible for conducting an initial inspection of an arrestee, prior to accepting them, following the Guidelines for Arrestee Screening and Monitoring (the "Screening and Monitoring Guidelines").[54] Lockup personnel may not accept any arrestee into the lockup if they have injuries or illnesses that may require hospitalization or the immediate attention of a healthcare professional. The Screening and Monitoring Guidelines provide examples of signs of injury,

[51] General Order G06-01, "Processing Persons Under Department Control."
[52] General Order G06-01, "Processing Persons Under Department Control."
[53] See also General Order G06-01-01, "Field Arrest Procedures," section 2.G.3 (stating that "station supervisors will be responsible for the safety and security of arrestees brought to their facility. During their tour of duty, station supervisors will verify the arrestee's well-being by independently conducting thorough inspections to visually observe arrestees . . . .").
[54] Attached here as Appendix 1.

illness, and other distress such as sleepiness, unsteady gait, and sores. If an arrested person exhibits symptoms of sickness or injury, Department members are directed to notify supervisors and send the arrested person to the nearest approved hospital. If an arrested person is under the influence of drugs, Department members are directed to monitor the arrested person and to keep the individual within sight and sound when possible. If an arrested person shows signs of infection or disease, Department members are required to isolate the individual. The Screening and Monitoring Guidelines provide that Department members may employ standard operating procedure *only* where the arrested person shows no signs of distress.

b) Complete Arrest Report.

Lockup personnel must also complete intake screening questions on the arrest report using the Screening and Monitoring Guidelines. Directives order them to "pay particular attention" to the Visual Check of Arrestee section.[55] Questions included in the Visual Check of Arrestee section include:

- Is there obvious sign of pain or injury? (Yes/No)
- Is there obvious sign of infection? (Yes/No)
- Under the influence of drugs/alcohol? (Yes/No)

c) Visual Checks and Monitoring.

Lockup personnel are directed to "complete a visual check of each arrestee every 15 minutes" following the Screening and Monitoring Guidelines.[56] Personnel must record the time of each inspection, a concise statement of conditions found, notable occurrences, actions taken, if any, and the initial and employee identification number on the Daily Prisoner Log record.[57] They must also "maintain security and provide for the well-being of all arrestees while in the detention facility."[58]

d) Arrestee Search.

Department General Order G06-01-01, entitled "Field Arrest Procedures," requires that Department members taking an individual into custody from other members will perform a thorough search of persons they take into custody.[59] Department members are also directed that they are responsible for the safety and security of the arrested person.[60]

General Order G06-01-02, entitled "Restraining Arrestees," reiterates Department policy that members are responsible for the safety and security of arrested persons.[61] Accordingly, Department members are directed to search all arrestees prior to transport.[62]

[55] Special Order S06-01-02, section III.A.20.
[56] Special Order S06-01-02, section III.A.28.
[57] Special Order S06-01-02, section III.A.28.
[58] Special Order S06-01-02, section III.A.35.
[59] General Order S06-01-01, section II.A.
[60] General Order S06-01-01, section II.A.
[61] General Order S06-01-01, section II.
[62] General Order G06-01-02, section II.

e) False or Misleading Statements.

Department members have a duty to always act with honesty and integrity and completely report their observations.

> Rule 14 of the Department Rules of Conduct prohibits Department members from making a false report, whether it be written or oral.[63] "An officer's responsibility to tell the truth is at the heart of Rule 14 and at the heart of community trust in the police."[64] To find that a Department member has violated Rule 14, COPA must establish that (1) the Department member willfully made a false statement and (2) the false statement was made about a fact material to the incident under investigation.[65] A "material fact" is a fact that is "crucial . . . to the determination of an issue at hand."[66] A false statement is made "willfully" if it is done intentionally.[67]

Department Rules of Conduct 2 and 3 also serve the principal that Department members are held to standard of truthfulness:

> Department Rule 2 and 3 require that Chicago police officers provide a complete and accurate accounting of what they observe while on duty. Officers may not offer misleading statements which emphasize certain facts to the exclusion of others. And they are not permitted to pick and choose facts to support a pre-determined conclusion.[68]

Conduct inconsistent with these rules is antithetical to that expected and required of law enforcement personnel.[69]

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[63] Police Board of Chicago, *From the Rules and Regulations of the Chicago Police Department Adopted and Published by the Police Board, Article V: Rules of Conduct*, *available at https://www.chicago.gov/dam/city/depts/cpb/PoliceDiscipline/RulesofConduct.pdf* (last accessed April 23, 2021).
[64] *In re Franko et al.*, 16 PB 2909-2912, Findings and Decisions, July 18, 2019, at p. 39.
[65] The elements of a Rule 14 violation are set forth in the Collective Bargaining agreement between the Fraternal Order of Police Chicago Lodge No. 7 (police officers) and the City of Chicago, effective as of July 1, 2012 (the "FOP CBA"), at p. 5; *available at http://www.chicagofop.org/contract* (last accessed April 20, 2021). Department detention aides are party to a different collective bargaining agreement between the City of Chicago and the Public Safety Employees Union Unit II, effective as of January 1, 2018, *available at https://www.chicago.gov/content/dam/city/depts/dol/Collective%20Bargaining%20Agreement3/UNIT%20II%20CBA%20%201.1.2018-6.30.2022%20Final%20and%20Fully%20Executed.pdf* (last accessed April 20, 2021). However, COPA here uses the elements of a Rule 14 violation as set forth in the FOP CBA for sake of consistency.
[66] Black's Law Dictionary, (Online, 2nd Edition, accessed April 13, 2021), *available at https://thelawdictionary.org/material-fact/.*
[67] Black's Law Dictionary, (Online, 2nd Edition, Accessed April 26, 2021), *available at https:/thelawdictionary.org/willfully/.*
[68] *In re Franko et al.*, 16 PB 2909-2912, Findings and Decisions, July 18, 2019, at pp. 5-6.
[69] *Id.* at 42.

B. Standard of Proof.

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 is described as evidence indicating that it is more likely than not that the conduct reviewed complied with Department policy.[70] If the evidence COPA gathers 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.[71] Clear and convincing evidence 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."[72]

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[70] *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").
[71] *See e.g., People v. Coan, 2016 IL App (2d) 151036 (2016).*
[72] *Id.* at ¶ 28.

VI. LEGAL ANALYSIS

a. Findings of Fact[73]

COPA finds that certain Department members, as discussed more fully below, neglected their duty to ensure the safety and security of Mr. [redacted] while he was in Department custody. Mr. [redacted] was in Department custody for a little more than one day. During that time, eight Department members failed to obtain medical care for Mr. [redacted] despite evidence of injury and illness and despite several opportunities to do so. Department members could have obtained care for Mr. [redacted] based on any of the following circumstances:

- when Mr. [redacted] arrived in lockup with visible signs of trench foot (which one Department member believed to be frost bite);
- when Mr. [redacted] defecated in his clothing while in a lockup cell;
- when Mr. [redacted] showed visible signs of difficulty walking; and
- when Mr. [redacted] was loaded onto a Department transport vehicle with visible signs of having soiled his pants.

Despite these signs of medical distress, Department members did not send Mr. [redacted] to a hospital, keep Mr. [redacted] within sight and sound, isolate Mr. [redacted] or take any other steps outlined in the Screening and Monitoring Guidelines to ensure Mr. [redacted] safety.

1. Officer Toliver and Detention Aides Barry and Spurlin should not have accepted Mr. [redacted] into lockup.

COPA finds that the preponderance of the evidence establishes that Mr. [redacted] had visible injuries to his feet when he arrived at lockup and he therefore should have been directed to a hospital for care.[74] Detention Aide Spurlin, who had closest contact with Mr. [redacted] admitted that he believed Mr. [redacted] had frostbitten feet based on visible discoloration and blisters. Officer Tolliver confirmed that he also observed Mr. [redacted] having "bad feet."

[73] COPA makes the following findings regarding the relevant times worked that involved officers worked:

- That on November 23, 2019, Officer Tolliver, Detention Aide Barry, and Detention Aide Spurlin were assigned to lockup from 5:00 a.m. to 1:30 p.m., and their supervisor was Sergeant Lasch from 5:00 a.m. to 2:00 p.m.
- That when Mr. [redacted] arrived, Officer Tolliver was the booking officer who asked him questions and inserted required information into the computer and arrest report; Detention Aide Spurlin searched Mr. [redacted] and Detention Aide Barry fingerprinted him.
- That from 1:00 p.m. to 9:00 p.m. on November 23, Officer Coon, and Detention Aide McGuire were assigned to lockup, and their supervisor was Sergeant Conway from 1:00 p.m. to 10:00 p.m.
- That from 9:00 p.m. until 5:30 a.m. on November 24th, Officer Cooper, Detention Aide Daniels, and Detention Aide Gonzalez were assigned to lockup, and their supervisor was Sergeant Natalie Fischer from 9:00 p.m. until 6:00 a.m.
- That from 5:00 a.m. on November 24th through the time that Mr. [redacted] was taken to the transport vehicle, Officer Tolliver, Detention Aide Barry, and Detention Aide Spurlin were once again assigned to lockup, with Sgt. Lasch as their supervisor.

[74] The presence of cocaine and opioids in Mr. [redacted] system over 24 hours after he entered lockup also suggests that Mr. [redacted] was under the influence of drugs when he entered lockup. The Screening and Monitoring Guidelines require that Department members keep arrestees under the influence of drugs within sight and sound.

Ambulance and hospital personnel both diagnosed the injury as trench foot the next day and noted that it was apparent on both feet. According to the Center for Disease Control ("CDC") website, trench foot, also known as immersion foot, occurs when the feet are wet for long periods of time.[75] Symptoms of trench foot include blisters that can be followed by skin and tissue falling off.[76] The CDC directs that persons suffering from trench foot obtain medical assistance as soon as possible.[77]

Even if Department members were unfamiliar with the signs and symptoms of trench foot, the CDC also tells anyone suffering from frostbite: "don't wait – take action." The CDC says those with frostbite should promptly seek medical attention.[78] As noted above, Detention Aide Spurlin believed Mr. [redacted] had frostbite but did not send Mr. [redacted] for medical attention.

Officer Toliver and Detention Aide Spurlin claimed that Mr. [redacted] did not need medical care because he denied help and was able to walk. COPA does not find these claims reasonable or persuasive. Mr. [redacted] autopsy photos show that his foot injuries were severe. The skin on Mr. [redacted] right foot appears blackened. Further, Mr. [redacted] left foot had deteriorated so badly that skin peeled off in the presence of ambulance personnel shortly after he left Department custody, strongly suggesting Mr. [redacted] arrived at lockup in that state. COPA finds that it was or should have been apparent to Officer Toliver and Detention Aide Spurlin that Mr. [redacted] feet needed medical attention despite Mr. [redacted] denials. The Screening and Monitoring Guidelines provide that such injuries should have been treated as a serious injury, requiring that Mr. [redacted] to be taken to a hospital. Those guidelines and the Department directives do not provide an exception for arrestees that decline care. Rather, Department directives unequivocally prohibit Department members from accepting an arrestee into lockup if they have any injury that requires immediate attention of a healthcare professional.

Detention Aide Barry claimed that he was not responsible for accepting Mr. [redacted] into lockup up because he believed that to be the duty of booking and arresting officers. Detention Aide Barry further stated that he had limited contact with Mr. [redacted] when he arrived at lockup because he only fingerprinted Mr. [redacted] COPA does not find these claims reasonable. Department directive S06-01-02 places a duty on all lockup personnel, regardless of the role they might fulfill, to screen arrestees and to deny any arrestee with injuries needing medical attention.[79]

For these reasons, COPA finds that:

- Officer Toliver violated S06-01-02 by accepting Mr. [redacted] into lockup and therefore SUSTAINS Allegation #1 against Officer Toliver;
- Detention Aide Spurlin violated S06-01-02 by accepting Mr. [redacted] into lockup and therefore SUSTAINS Allegation #1 against Detention Aide Spurlin; and

[75] *See* "Trench Foot or Immersion Foot: Disaster Recovery Fact Sheet," Centers for Disease Control, https://www.cdc.gov/disasters/trenchfoot.html (last accessed April 18, 2021).
[76] *Id.*
[77] *Id.*
[78] "Prevent Hypothermia and Frostbite," Centers for Disease Control, https://www.cdc.gov/disasters/winter/staysafe/hypothermia.html (last accessed April 18, 2021).
[79] Special Order S06-01-02, section III.A.8, 10.

- Detention Aide Barry violated S06-01-02 by accepting Mr. [redacted] into lockup and therefore SUSTAINS Allegation #1 against Detention Aide Barry.

2. Officer Toliver and Detention Aides Spurlin and Barry failed to document Mr. [redacted] injuries in the Arrest Report.

COPA finds that the preponderance of the evidence establishes that Officer Toliver, Detention Aide Spurlin, and Detention Aide Barry failed to accurately document Mr. [redacted] injuries in Mr. [redacted] arrest report.[80] Under the Arrest Processing Report section, the report indicates "No" for "Is there obvious pain or injury?". As discussed above, Mr. [redacted] foot injury was evident or should have been evident to lockup personnel. Therefore, lockup personnel should have answered this question with "Yes."[81]

Detention Aide Barry attempted to avoid responsibility for improperly admitting Mr. [redacted] and failing to document his injuries because he was only responsible for fingerprinting Mr. [redacted] Department directives, however, place the responsibility on all lockup personnel to complete intake screening questions following the Screening and Monitoring Guidelines. Detention Aide Barry was working as lockup personnel on the date and time that Mr. [redacted] arrived at lockup. Detention Aide Barry therefore was also responsible for following Department orders regarding arrestee screening and reporting.

For these reasons, COPA finds that:

2. Officer Toliver failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report and therefore SUSTAINS Allegation #2 against Officer Toliver;
   - Detention Aide Barry failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report and therefore SUSTAINS Allegation #2 against Detention Aide Barry; and
   - Detention Aide Spurlin failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report and therefore SUSTAINS Allegation #2 against Detention Aide Spurlin.

3. Department members failed to provide for Mr. [redacted] well-being and committed other misconduct.

a. Officer Toliver and Detention Aides Barry and Spurlin failed to obtain medical care for Mr. [redacted]

COPA finds that, as discussed above, Detention Aides Spurlin and Barry and Officer Toliver knew or should have known that Mr. [redacted] was in medical distress and failed to provide for his well-being as soon as he arrived at lockup. The preponderance of the evidence also

[80] As noted above, Officer Toliver was the booking officer and primarily responsible for completing the Arrest Report. Detention Aide Spurlin was responsible for searching Mr. [redacted] upon arrival to lockup. Detention Aide Barry was responsible for fingerprinting Mr. [redacted] upon his arrival to lockup.

[81] Lockup personnel arguably should also have answered "Yes" to the question regarding signs of infection and whether Mr. [redacted] was under the influence of drugs.

establishes that Mr. [redacted] condition worsened while he was in lockup. COPA further finds that Officer Toliver and Detention Aides Barry and Spurlin failed to take any action despite signs of Mr. [redacted] worsening condition.

Video and other evidence establishes that Mr. [redacted] defecated in his pants prior to being discharged from lockup. Ambulance records reported that he had feces in his pants when they arrived at the courthouse. Video from lockup shows that Mr. [redacted] pants had a visible dark stain on the rear of his pants. Detention Aide Spurlin also stated that he noticed on November 24 that Mr. [redacted] appeared to have soiled himself. Rather than obtain medical assistance for Mr. [redacted] Detention Aide Spurlin told COPA that he took no action to get help for Mr. [redacted] on November 24 because Mr. [redacted] had been transferred to another Department member's custody.

In addition, evidence establishes that the condition of Mr. [redacted] feet worsened while he was in lockup. Video from lockup depicts Mr. [redacted] walking with a severe limp on the date he left lockup. No officer indicated that he was walking like that when he arrived at lockup. Detention Aide Spurlin stated that Mr. [redacted] was not walking in that manner when he arrived at lockup on November 23. Despite this sign that Mr. [redacted] medical condition was deteriorating, Department members did not obtain medical attention for Mr. [redacted] or otherwise provide for his well-being.[82]

Department directives place the duty on lockup personnel to care for the well-being of arrestees in Department detention facilities. Officer Toliver's and Detention Aide Barry and Spurlin's treatment violated their duty as lockup personnel to care for Mr. [redacted] well-being.

For these reasons, COPA finds that:

- Officer Toliver failed to provide for the well-being of [redacted] and therefore SUSTAINS Allegation #3 against Officer Toliver;
- Detention Aide Barry failed to provide for the well-being of [redacted] and therefore SUSTAINS Allegation # 3 against Detention Aide Barry; and
- Detention Aide Spurlin failed to provide for the well-being of [redacted] and therefore SUSTAINS Allegation #3 against Detention Aide Spurlin.

b. Officers Vinson and Riley failed to ensure the safety and security of an arrestee and failed to search or to thoroughly search Mr. [redacted]

COPA finds that transport Officers Vinson and Riley knew or should have known that Mr. [redacted] needed medical attention but failed to obtain medical care. Officers Vinson and Riley encountered Mr. [redacted] on November 24 when loading and driving Mr. [redacted] from lockup in a Department transport vehicle.

Officer Vinson admitted to smelling an unpleasant odor and stated other arrestees commented on the odor. Officer Vinson, however, also stated that he did not know the source of the smell. He therefore denied knowing Mr. [redacted] had soiled his pants. Officer Vinson also

[82] Officer Toliver and Detention Aides Barry and Spurlin also failed to notify their supervisor or the lockup personnel who relieved them of duty on the evening of November 23 that Mr. [redacted] had visible injuries.

denied any knowledge of injuries to Mr. [redacted] feet despite Mr. [redacted] trouble walking. He stated that it was not uncommon to have arrestees to have difficulty walking. Officer Vinson could not specifically recall searching Mr. [redacted] on November 24.

Officer Riley similarly denied knowing that Mr. [redacted] had feces in his pants. Officer Riley said he might not have noticed this when he searched Mr. [redacted] because he wore gloves during the search.

COPA does not find Officer Vinson or Officer Riley to be credible. As previously discussed, the evidence establishes Mr. [redacted] debilitated condition at the time of transport. Video evidence establishes that Mr. [redacted] was visibly limping and that his pants were stained. Ambulance personnel found Mr. [redacted] with a bowel movement on him and trench foot on both feet shortly after Officers Vinson and Riley transported him to court. COPA doubts that Officer Vinson or Riley did not notice that Mr. [redacted] had feces in his pants and could not walk without difficulty.

Officer Vinson and Riley's failure to search or properly search Mr. [redacted] is not a shield to their duty to provide for the safety and security of persons in custody. For the reasons noted in the preceding paragraph, COPA finds that Officers Vinson and Riley either failed to search or to thoroughly search Mr. [redacted] before taking custody of him. Officers Vinson and Riley searched Mr. [redacted] would have been better positioned to ensure Mr. [redacted] safety and security had they searched him properly.

For these reasons, COPA finds that:

- Officer Vinson failed to search Mr. [redacted] prior to transport in violation of G06-01-02 and therefore SUSTAINS Allegation #1 against Officer Vinson;
- Officer Vinson failed to ensure the safety and security of an arrestee in custody in violation of G06-01-01 and therefore SUSTAINS Allegation #2 against Officer Vinson;
- Officer Riley failed to search Mr. [redacted] prior to transport in violation of G06-01-02 and therefore SUSTAINS Allegation #1 against Officer Vinson;
- Officer Riley failed to ensure the safety and security of an arrestee in custody in violation of G06-01-01 and therefore SUSTAINS Allegation #2 against Officer Riley.

c. Sergeants Lasch, Conway, and Fischer failed to ensure Mr. [redacted] safety and security and committed other misconduct.

Department directives hold station supervisors accountable for the safety and care of all arrestees within lockup. Supervisors are specifically required to personally inspect prisoners at least for times a day and to note conditions found. COPA could detect Mr. [redacted] ailments from lockup video footage. Sergeants Lasch, Conway, and Fischer were each on duty when Mr. [redacted] was in lockup. Each indicated that they completed the required checks by either viewing video monitors and/or by physically walking the cells to inspect arrestees. Yet each denied knowledge of Mr. [redacted] condition. COPA does not find these statements credible given the conspicuous nature of Mr. [redacted] problems. COPA concludes that a preponderance of the evidence shows that Sergeants Lasch, Conway, and Fischer either did not inspect or improperly inspected persons

in their custody. Because of these deficiencies, Sergeants Lasch, Conway, and Fischer could not ensure Mr. [redacted] safety and security.

For these reasons, COPA finds that:

- Sergeant Lasch failed to ensure the safety and care of [redacted] in violation of S06-01 and therefore SUSTAINS Allegation #1 against Sergeant Lasch;
- Sergeant Lasch failed to personally inspect the lockup and prisoners during his tour of duty in violation of S06-01 and therefore SUSTAINS Allegation #2 against Sergeant Lasch;
- Sergeant Conway failed to ensure the safety and care of [redacted] in violation of S06-01 and therefore SUSTAINS Allegation #1 against Sergeant Conway;
- Sergeant Conway failed to personally inspect the lockup and prisoners during his tour of duty in violation of S06-01 and therefore SUSTAINS Allegation #2 against Sergeant Conway;
- Sergeant Fischer failed to ensure the safety and care of [redacted] in violation of S06-01 and therefore SUSTAINS Allegation #1 against Sergeant Fischer; and
- Sergeant Fischer failed to personally inspect the lockup and prisoners during his tour of duty in violation of S06-01 and therefore SUSTAINS Allegation #2 against Sergeant Fischer.

d. COPA cannot find Sergeants Lasch, Conway, and Fischer failed to note Mr. [redacted] condition because they each failed to inspect Mr. [redacted] as required.

Sergeants Lasch, Conway, and Fischer each failed to notice Mr. [redacted] worsening medical status because they did not personally or thoroughly inspect Mr. [redacted] while he remained in their custody. They therefore did not record their observations or changes in his condition as required by Special Order S06-01-02.

For these reasons, COPA finds that:

- Allegation #3 against Sergeant Lasch is SUSTAINED;
- Allegation #3 against Sergeant Conway is SUSTAINED; and
- Allegation #3 against Sergeant Fischer is SUSTAINED.

4. COPA does not have sufficient evidence to sustain allegations against Detention Aides McGuire, Daniels, and Gonzalez because other Department members failed in their duties.

COPA finds there is insufficient evidence to sustain allegations against Detention Aides McGuire, and Gonzalez. COPA reaches this conclusion based on the failure of other Department members to flag Mr. [redacted] medical condition. These officers arrived after Mr. [redacted] was accepted into lockup and left before Mr. [redacted] departed lockup the next day. Unlike station supervisors, detention aides are not required to *personally* inspect prisoners. They are required to complete a *visual* check of arrestees every 15 minutes. Department members told COPA that those visual checks are typically completed by viewing video monitors that do not have sound.

Department members stated it was their usual practice to physically walk through the cell blow at some points during their shifts.

Detention Aide McGuire stated that he typically conducted his checks in person and recalled Mr. [redacted] declining food during his shift. He stated, however, that he did not know that Mr. [redacted] required medical assistance. He further stated he had no indication Mr. [redacted] defecated in his clothing.

Detention Aide Gonzalez provided similar statements. He stated he typically would conduct his checks both by checking video monitors and by physically walking past cells. He could not specifically recall whether he physically walked the cell block during his shift from November 23 to November 24. He also stated he did not know of Mr. [redacted] soiling himself or needing medical care.

Detention Aide Daniels also provided similar statements. He did remember Mr. [redacted] declining food but noted that Mr. [redacted] sat up from his bed to speak to him. He also stated that he did not know that Mr. [redacted] needed medical assistance or that he was in distress.

COPA cannot find that Detention Aides McGuire, Daniels, or Gonzalez committed misconduct based on these facts and lack of other evidence suggesting these involved officers were or should have been aware of Mr. [redacted] condition.

For these reasons, COPA finds that:

- Allegation #1 against Detention Aide McGuire is NOT SUSTAINED;
- Allegation #1 against Detention Aide Daniels is NOT SUSTAINED; and
- Allegation #1 against Detention Aide Gonzalez is NOT SUSTAINED.

5. Detention Aide Charles Barry knowingly provided materially false or misleading information during his statements to COPA.

Department members are prohibited from making false statements. COPA finds that Detention Aide Barry intentionally made false or misleading statements to COPA during his initial statement on January 10, 2020. Detention Aide denied knowing Mr. [redacted] smelled of feces or that anything appeared out of the ordinary during his shift on November 24th. He also told COPA that he wears a mask "a lot" at work and that wearing a mask in Mr. [redacted] presence was not related to Mr. [redacted] condition

Specifically, Detention Aide Barry made the following statements to COPA:

Q: Were you aware that Mr. [redacted] had soiled himself?
A: No.[83]

Q. Was there anything out of the ordinary that you saw with Mr. Barry [sic]?
A. [redacted]

[83] Attachment 55, page 17, lines 3-7.

Q. I mean Mr. [redacted] I'm sorry.
A. No.
Q. Nothing?
A. Nothing.
Q. Okay. You didn't smell anything out of the ordinary as if he had defecated himself?
A. No.[84]

A: I wear a mask back there a lot of times. There's a lot of germs back in lockup. We don't have windows, ma'am. We have no ventilation there.[85]

Q: Is it possible that you were wearing that mask because Mr. [redacted] reeked of urine?
A: No. I wear a mask a lot of morning because we – depends on how many prisoners we have. Because I'm saying not just him. It's prisoners, period, that don't smell that well a lot of the time.
Q: And were you wearing that mask as you were walking behind Mr. [redacted] because he smells of feces?
A: No.[86]

Q: Were you wearing that mask as you were walking behind Mr. [redacted] because he smells of feces?
A: No. I wore the mask because all of them, not just him.
Q: On this particular day?
A: On that particular day.
Q: But you don't wear a mask every day?
A: No. Some days.[87]

COPA finds that the preponderance of the evidence establishes that these statements were false or misleading.

Detention Aide Barry told Department Detective Frank Szwedo on November 25th (the day after Mr. [redacted] left lockup) that Mr. [redacted] had a strong, unpleasant odor. Furthermore, ambulance personnel noted on November 24th that Mr. [redacted] had feces in his pants. Video from lockup also shows stains on Mr. [redacted] pants consistent with him having soiled himself. COPA does not find Detention Aide Barry's denial of knowledge of Mr. [redacted] condition credible based on this contradictory evidence.

Detention Aide Barry did not provide credible explanations regarding the reasons for his face mask wearing. He initially told COPA on January 10, 2020 that he frequently wore masks because of germs in lockup. When COPA personnel pressed him, he then admitted he may have worn a mask on November 24th based on Mr. [redacted] odor. He then stated that he wore masks because of the smell from all arrestees, not just Mr. [redacted] When interviewed again on June 25, 2020, and confronted with these inconsistencies, Detention Aide Barry said he wore masks when

[84] *Id.* at page 22, lines 7-16
[85] *Id.* at page 23, lines 11-14.
[86] *Id.* at page 27, lines 17-24.
[87] *Id.* at page 28, lines 1-10.

detainees spit on officers. He never stated this was an issue during the time Mr. [redacted] was in custody in November 2019. Detention Aide Barry then again claimed that he wore the mask because the group smelled and that he could not identify Mr. [redacted] as the source.

Detention Aide Barry also did not provide credible statements regarding the frequency of his mask wearing. On January 10, 2020, Detention Aide Barry told COPA that he could not remember why he wore a face mask when standing near Mr. [redacted] He then said he frequently wears masks in lockup. On June 25, 2020, Detention Aide Barry stated he could not answer how often he wore a face mask.

Detention Aide Barry's inability to consistently describe why or when he wears at face mask at work suggests his statements are false or misleading. Other evidence establishes the falsity of his statements. First, Detention Aide Spurlin told COPA that he was "surprised" when he saw Detention Aide Barry wearing a mask in lockup video. He explained that lockup personnel did not routinely wear facemasks. Second, COPA corroborated Detention Aide Spurlin's statement by reviewing video from lockup for various dates ranging from January 7, 2020 through February 29, 2020 and during the times Detention Aide Barry was working. COPA personnel did not see Detention Aide Barry wearing a face mask in any of those videos. COPA accordingly finds that the preponderance of the evidence establishes that Detention Aide Barry does not have a practice of wearing a mask. COPA concludes Detention Aide Barry more likely than not wore a face mask on November 24, 2019 because of Mr. [redacted] physical condition. His statements to COPA stating otherwise were false or misleading.

COPA concludes that Detention Aide Barry knew his statements were false or misleading and made them intending to avoid knowledge of Mr. [redacted] need for medical attention. Presumably Detention Aide Barry would know why and how often he wore face masks at work. Detention Aide Barry would also have known that he told Department detectives that Mr. [redacted] had a "strong and unpleasant odor on his person and clothing" the day after Mr. [redacted] passed away.[88] His contradictory statements to COPA could only have been made to avoid responsibility for Mr. [redacted] well-being.

Detention Aide Barry's false and misleading statements were about a matter that was material to the investigations. A fact is material when it is "crucial . . . to the determination of an issue at hand."[89] The purpose of the January 10, 2020 interview was to determine what Detention Aide Barry, and the other officers, knew and/or observed about Mr. [redacted] condition and whether they knew or should have known that Mr. [redacted] was in distress. It was integral to the investigation to determine whether Detention Aide Barry was aware that Mr. [redacted] had soiled himself at the time they led him to be transported. Likewise, it was integral to know if, and how frequently, he wore a mask while escorting arrestees to determine the credibility of his statement that he was not wearing the mask due to Mr. [redacted] odor. These determinations were not only material, but the issues upon which the entire investigation revolved.

[88] Attachment 97, pages 26 & 78.

[89] Black's Law Dictionary, (Online, 2nd Edition, accessed April 13, 2021), *available at https://thelawdictionary.org/material-fact/.*

The evidence demonstrates that Detention Aide Barry's statements are so inconsistent with the facts that they reflect willful materially false statements about the incident for the purposes of protecting himself.

For these reasons, COPA finds that: Detention Aide Barry made false or misleading statements to COPA and therefore SUSTAINS Allegation #4 against Detention Aide Barry

VII. RECOMMENDED DISCIPLINE FOR SUSTAINED ALLEGATIONS

a. Sergeant Alan Lasch, #1434

i. Complimentary and Disciplinary History

Sgt. Lasch has been with CPD since June 5, 1995. In that time, he has received 42 honorable mentions, 2 department commendations, and 1 complimentary letter. In the last five years, he received a reprimand for Operation/Personnel Violations Neglect of Duty.

ii. **Recommended Penalty:** 180-Day Suspension up to and including Separation.

b. Sergeant Matthew Conway, #2335

i. Complimentary and Disciplinary History

Sgt. Conway has been with CPD since October 25, 2004. In that time, he has received 111 honorable mentions, 7 complimentary letters, 3 department commendations, 1 honorable mention ribbon award, 1 joint operations award, 1 life-saving award, and 1 police officer of the month award. In the last five years, he has not received any discipline.

ii. **Recommended Penalty:** 180-Day Suspension up to and including Separation.

c. Sergeant Natalie Fischer, #1945

i. Complimentary and Disciplinary History

Sgt. Fischer has been with CPD since July 29. 2002. In that time, she has received 53 honorable mentions, 7 complimentary letters, and 2 department commendations. In the last five years, she has not received any discipline.

i. **Recommended Penalty:** 180-Day Suspension up to and including Separation.

Officer Leroy Tolliver, #18324

ii. Complimentary and Disciplinary History

Officer Tolliver has been with CPD since December 7, 1992. In that time, he has received 20 honorable mentions, 3 complimentary letters, and 3 department commendations. In the last five years, he has not received any discipline.

i. **Recommended Penalty:** 180-Day Suspension up to and including Separation.

d. Officer Peter Vinson, #17066

i. Complimentary and Disciplinary History

Officer Vinson has been with CPD since December 16, 1991. In that time, he has received 22 honorable mentions, 5 complimentary letters, and 1 department commendation. In the last five years, he has not received any discipline.

i. **Recommended Penalty:** 180-Day Suspension up to and including Separation.

e. Officer Gary Riley, #8520

i. Complimentary and Disciplinary History

Officer Riley has been with CPD since July 12, 1999. In that time, he has received 15 honorable mentions and 1 department commendation. In the last five years, he has not received any discipline.

i. **Recommended Penalty:** 180-Day Suspension up to and including Separation.

For the allegations that Officer Riley failed to search Mr. [redacted] prior to transport and failed to ensure the safety and security of Mr. [redacted]

f. Detention Aide Charles Barry, Employee #49970

i. Complimentary and Disciplinary History

Detention Aide Barry has been with CPD since May 1, 1992. In that time, he has received 1 complimentary letter and 1 honorable mention. In the last five years, he has not received any discipline.

ii. **Recommended Penalty:** Separation

g. Detention Aide Keith Spurlin, Employee #36932

i. Complimentary and Disciplinary History

Detention Aide Spurlin has been with CPD since August 1, 1994. In that time, he has received 2 honorable mentions and 1 complimentary letter. In the last five years, he has not received any discipline.

i. **Recommended Penalty:** 180-Day Suspension up to and including Separation.

The Chicago Police Department holds the sanctity of human life among its highest priorities. All CPD members must perceive all individuals as having inherent worth. By taking Mr. [redacted] into custody, the Department and those Department members involved with Mr. [redacted] chain-of-custody assumed direct responsibility for Mr. [redacted] life, safety, and overall welfare. Despite the apparent degraded physical condition of Mr. [redacted] not a single involved Department member displayed the requisite regard for the preservation of Mr. [redacted] well-being and safety. This failure was protracted and evolved Department supervisors, police officers and detention aides. Such an exhibited disregard towards Mr. [redacted] is at odds with the culture the Department strives to achieve. Accordingly, COPA finds penalties up to an including separation are arguably warranted for all involved members.

VIII. CONCLUSION

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

Officer	Allegation	Finding
Sergeant Alan Lasch	1. On or about November 23-24, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Alan Lasch failed to ensure the safety and care of [redacted] (an arrestee in lockup), in violation of Special Order S06-01.	Sustained
	2. On or about November 23-24, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Alan Lasch failed to personally inspect the lockup and prisoners during his tour of duty, in violation of Special Order S06-01.	Sustained
	3. On or about November 23-24, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Alan Lasch failed to record his observations or any noticeable changes in the condition of [redacted] (an arrestee in lockup) in	Sustained

	the "Watch Commanders Comments" section of the Automated Arrest Application, in violation of Special Order S06-01-02.	
Sergeant Matthew Conway	1. On or about November 23, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Matthew Conway failed to ensure the safety and care of [redacted] (an arrestee in lockup), in violation of Special Order S06-01.	Sustained
	2. On or about November 23, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Matthew Conway failed to personally inspect the lockup and prisoners during his tour of duty, in violation of Special Order S06-01.	Sustained
	3. On or about November 23, 2019, at various times during his shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Matthew Conway failed to record his observations or any noticeable changes in the condition of [redacted] (an arrestee in lockup) in the "Watch Commanders Comments" section of the Automated Arrest Application, in violation of Special Order S06-06-02.	Sustained
Sergeant Natalie Fischer	1. On or about November 23-24, 2019, at various times during her shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Natalie Fischer failed to ensure the safety and care of [redacted] (an arrestee in lockup), in violation of Special Order S06-01.	Sustained

	2. On or about November 23-24, 2019, at various times during her shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Natalie Fischer failed to personally inspect the lockup and prisoners during her tour of duty, in violation of Special Order S06-01.	Sustained
	3. On or about November 23-24, 2019, at various times during her shift at the 11th District, located at 3151 W. Harrison Street, Sgt. Natalie Fischer failed to record her observations or any noticeable changes in the condition of [redacted] (an arrestee in lockup) in the "Watch Commanders Comments" section of the Automated Arrest Application, in violation of Special Order S06-01-02.	Sustained
Officer Leroy Toliver	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Leroy Toliver accepted an arrestee into lockup who had injuries requiring medical attention, in violation of S06-01-02.	Sustained
	2. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Leroy Toliver failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report.	Sustained
	3. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Leroy Toliver failed to provide for the well-being of	Not Sustained

	[redacted](an arrestee in the detention facility).	
Officer Thomas Coon	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Thomas Coon failed to provide for the well-being of [redacted](an arrestee in the detention facility).	Not Sustained
Officer Gary Cooper	1. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Officer Gary Cooper failed to provide for the well-being of [redacted](an arrestee in the detention facility).	Not Sustained
Officer Peter Vinson	1. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison Street, Officer Peter Vinson failed to search an arrestee ([redacted]prior to transport, in violation of G06-01-02. 2. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison Street, Officer Peter Vinson failed to ensure the safety and security of an arrestee in your custody ([redacted]in violation of G06-01-01.	Sustained Sustained
Officer Gary Riley	1. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison Street, Officer Gary Riley failed to search an arrestee ([redacted]prior to transport, in violation of G06-01-02. 2. On or about November 24, 2019, at approximately 7:30 am, at 3151 W. Harrison Street, Officer Gary Riley failed to ensure the safety and security of an arrestee in your	Sustained Sustained

	custody ([redacted] in violation of G06-01-01.	
Detention Aide Charles Barry	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Charles Barry accepted an arrestee into lockup who had injuries requiring medical attention, in violation of S06-01-02.	Sustained
	2. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Charles Barry failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report.	Sustained
	3. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Charles Barry failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Sustained
	4. On or about January 10, 2020, at approximately 10:31 am, while at 1615 W. Chicago Avenue in Chicago, at the offices of the Civilian Office of Police Accountability (COPA), Detention Aide Charles Barry, during an audio-recorded interview, made one or more false, misleading, incomplete and/or inaccurate statements in his connection with his awareness of [redacted] (an arrestee in the detention facility) physical condition.	Sustained
Detention Aide Keith Spurlin	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street,	Sustained

	Detention Aide Keith Spurlin accepted an arrestee into lockup who had injuries requiring medical attention, in violation of S06-01-02.	
	2. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Keith Spurlin failed to accurately complete the Arrest Processing Report section of [redacted] Arrest Report.	Sustained
	3. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Keith Spurlin failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Sustained
Detention Aide Andrew McGuire	1. On or about November 23, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Andrew McGuire failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Not Sustained
Detention Aide Darius Daniels	1. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Darius Daniels failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Not Sustained
Detention Aide Roberto Gonzalez	1. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Roberto Gonzalez failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	Not Sustained

Detention Aide Kimoni Peals	1. On or about November 23-24, 2019, while at the 11th District, located at 3151 W. Harrison Street, Detention Aide Kimoni Peals failed to provide for the well-being of [redacted] (an arrestee in the detention facility).	On LOA

[redacted]

Matthew Haynam
Deputy Chief Investigator

6/23/2021
Date

[redacted]

Andrea Kersten
Interim Chief Administrator

6/23/2021
Date

Appendix A

Assigned Investigative Staff

Squad#:	One
Major Case Specialist:	Chantall Morley
Supervising Investigator:	Shannon Hayes
Deputy Chief Administrator:	Matthew Haynam