Lori E. Lightfoot
Mayor

Department of Police · City of Chicago
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David O. Brown
Superintendent of Police

September 24, 2021

Andrea Kersten
Acting Chief Administrator
Civilian Office of Police Accountability
1615 West Chicago Avenue, 4th Floor
Chicago, IL 60622

RE: Superintendent's Partial Concurrence with COPA's proposed findings and penalties
Complaint Register Number: #2019-0004789
Sergeant Alan Lasch #1434, Charles Barry Emp.# [redacted] Sgt. Matthew Conway #2335, Sgt. Natalie Fischer #1945, Officer Leroy Toliver Jr. #18324, Keith Spurlin Emp. #[redacted] Officer Peter Vinson #17066, and Officer Gary Riley #8520

Dear Acting Chief Administrator:

After a careful review of the recommendation made by COPA in this matter, as detailed below the Chicago Police Department (CPD or Department) concurs with certain findings and recommended penalties but does not concur with others.

Facts

Beginning November 23, 2019, at approximately 1000 hours, [redacted] [redacted] was arrested on an outstanding warrant and held in custody at the 11th District Lockup with while exhibiting symptoms of trench foot and what was later determined to be cocaine and opioids in his system. Mr. [redacted] was homeless. On November 24, 2019, Mr. [redacted] collapsed following transport to court at 26th and California. When paramedics arrived they observed Mr. [redacted] to have soiled himself and noted that the skin on his feet was sloughing off. Mr. [redacted] passed away the evening of November 24th.

On November 23, 2019, Officer Leroy Toliver #18324 (Officer Toliver) asked Mr. [redacted] the questions on the Lockup Keeper Processing portion of the arrest report, and described Mr. [redacted] demeanor as docile and tired. Mr. [redacted] denied needing medical care. Officer Toliver had Mr. [redacted] remove his shoes and socks and observed that Mr. [redacted] had "really bad feet" but in Officer Toliver's judgment Mr. [redacted] did not need medical attention. Officer Toliver placed Mr. [redacted] into lockup and noted that after about 20 minutes Mr. [redacted] had fallen asleep. Officer Toliver did the required 15-minute visual checks, and during his final check at around 1300 Officer Toliver observed that Mr. [redacted] appeared to be fine. Office Toliver also worked on November 24, 2019 and had visual contact with Mr. [redacted] as he walked to the transport vehicle to go to court. Officer Toliver said that he did not observe that Mr. [redacted] had soiled himself.

Detention Aide Keith Spurlin (DA Spurlin) searched Mr. [redacted] upon Mr. [redacted] entry into lockup on November 23, 2019. The search consisted of having Mr. [redacted] empty his pockets and physically patting

Mr. [redacted] down. Mr. [redacted] appeared coherent, could follow directions, answered all questions, and did not give an indication that anything was wrong. When DA Spurlin removed Mr. [redacted] shoes and socks he observed that Mr. [redacted] feet were frostbitten. Mr. [redacted] insisted that he did not need medical attention and just wanted to go to sleep. DA Spurlin relayed this information to Officer Toliver to continue the booking process. DA Spurlin did not observe any signs of distress during required 15-minute visual checks up until DA Spurlin's watch ended at 1300 hours. On November 24, 2019, DA Spurlin assisted with loading Mr. [redacted] and other prisoners onto a transport vehicle to go to court. DA Spurlin observed that Mr. [redacted] pants appeared soiled, which is not how he appeared the previous day. Mr. [redacted] was also walking on the sides of his feet, which he did not do the previous day. DA Spurlin recalled a bad smell on November 24, but attributed that to the smell of the lockup and not any one prisoner.

Detention Aide Charles Barry (DA Barry) recalled fingerprinting Mr. [redacted] on November 23, 2019 but had no other contact with Mr. [redacted] that day. He conducted the required 15-minute visual checks. DA Barry stated that Mr. [redacted] did not request medical attention and did not present himself in a manner that would have required aid. On November 24, 2019, DA Barry assisted with loading Mr. [redacted] onto a transport vehicle to go to court. DA Barry was observed on camera wearing a surgical mask. DA Barry observed that Mr. [redacted] pants had a stain that began at the top of his pants and extended to the bottom of the right leg. When asked why he was wearing a surgical mask, DA Barry explained that he did this a lot of times because of germs in the lockup and the absence of ventilation. DA Barry denied wearing the mask because Mr. [redacted] smelled like feces. DA Barry said that the morning of November 24th all the prisoners smelled bad. In a later statement to COPA, DA Barry stated that he couldn't recall why he wore the mask that day, or if it was because of the odor coming from Mr. [redacted] but said that he would normally wear a mask because of odors. COPA reviewed random videos between January 7, 2020 and February 29, 2020 between 0700 and 0800 and was not observed wearing a mask on those videos. In an interview with Detectives following Mr. [redacted] death, DA Barry said that Mr. [redacted] had a strong, unpleasant odor on his person and his clothing.

Sgt. Alan Lasch #1434 (Sgt. Lasch) worked as District Station Supervisor on November 23 and 24, 2019 from 0500-1400 hours. Sgt. Lasch reviewed Mr. [redacted] arrest report, but has no other recollection of incidents happening with him. Sgt. Lasch conducted his required four checks of the lockup during his shifts on both days. Sgt. Lasch had no knowledge of injuries to Mr. [redacted] requiring medical attention or that Mr. [redacted] had soiled himself. Sgt. Lasch later updated the arrest report to indicate that Mr. [redacted] was taken to the hospital.

Sgt. Matthew Conway #2335 (Sgt. Conway) worked on November 23, 2019 from 1300-2200 hours and was not on duty November 24, 2019. Sgt. Conway was not aware of Mr. [redacted] having any condition that required medical attention and was not aware that Mr. [redacted] had soiled himself. Sgt. Conway made the required visual checks by monitor and was not aware of any incidents involving Mr. [redacted]

Sgt. Natalie Fischer #1945 (Sgt. Fischer) worked from 2100 hours on November 23, 2019 to 0600 hours on November 24, 2019. Sgt. Fischer did not recall any interaction with Mr. [redacted] and was not aware of a condition requiring medical attention or that Mr. [redacted] had soiled himself. Sgt. Fischer conducted the required visual checks and did not observe smelling anything out of the ordinary in the lockup or otherwise observe anything to give her cause for concern.

Officer Peter Vinson #17066 (Officer Vinson) worked with Officers Gary Riley and Rosalyn Brown (retired) as a transport officer on November 24, 2019. He was responsible for picking up prisoners and

transporting them to court for bond hearings. Officer Vinson explained that transport officers conduct pat down searches similar to those performed for custodial arrest. Officer Vinson was aware of a bad smell from the holding pen on the morning of November 24, 2019 but could not describe the smell or where it came from. Officer Vinson did not recall searching Mr. [REDACTED] and said that he was not aware that Mr. [REDACTED] had soiled himself. Officer Vinson recalled other prisoners complaining about the odor. Officer Vinson did not recall Mr. [REDACTED] having trouble walking to the transport vehicle, and said that it was not unusual for prisoners to sometimes have trouble walking. A prisoner would still be transported even if having trouble walking or getting into the van, or if the prisoner had soiled himself, unless the prisoner requested medical attention. When Officer Vinson arrived at the court building he lost sight of Mr. [REDACTED] A deputy sheriff advised him that Mr. [REDACTED] had fallen in a stairwell. Officer Vinson went to Mr. [REDACTED] and spoke with him. Mr. [REDACTED] was unable to stand after several attempts. Officer Vinson then called for an ambulance.

Officer Gary Riley #8520 (Officer Riley) was assigned as the driver of the transport vehicle on November 24, 2019. Officer Riley recalled patting Mr. [REDACTED] down, but may not have noticed that Mr. [REDACTED] pants were soiled because he was wearing gloves. Officer Riley was not aware of a condition with Mr. [REDACTED] requiring medical attention. Upon arrival at the court building Officer Riley observed that Mr. [REDACTED] answered all medical questions and was admitted to the next phase of processing. Shortly thereafter a deputy sheriff advised Officer Riley that Mr. [REDACTED] had fallen. Officer Riley told Officer Vinson, and Officer Vinson called for an ambulance.

COPA interviewed Marlon Welton, who shared a cell with Mr. [REDACTED] for approximately 8 hours. Welton relayed that when he entered the cell he could tell that Mr. [REDACTED] had soiled himself. Welton told a detention aide, but nothing was done for Mr. [REDACTED] Mr. [REDACTED] never spoke or complained during his time in the cell with Welton.

COPA interviewed Officer Thomas Coon #3535 (Officer Coon) who was assigned to the 11th District lockup on November 23, 2019 from 1300-2100 hours. Officer Coon did not recall Mr. [REDACTED] needing medical attention or soiling himself, or any other arrestee bringing such a condition to his attention. Officer Coon did not recall smelling urine or feces when he walked the cell blocks.

COPA interviewed Officer Gary Cooper #14217 (Officer Cooper) who was assigned to the 11th District lockup on November 23, 2019, from 2100 hours until November 24, 2019 at 0530 hours. Officer Cooper was aware that Mr. [REDACTED] was inside a cell when he arrived. Officer Cooper was not informed by anyone that Mr. [REDACTED] had a condition requiring medical attention and was unaware that Mr. [REDACTED] had soiled himself.

COPA interviewed Detention Aide Darius Daniels (DA Daniels) who worked in the 11th District lockup on November 23, 2019 from 2100 hours until November 24, 2019 at 0500 hours. DA Daniels asked Mr. [REDACTED] for his name, and asked if Mr. [REDACTED] wanted a mat, a sandwich, or a tissue. Mr. [REDACTED] sat up, said no to all items offered, and laid back down. DA Daniels said there was no indication that Mr. [REDACTED] had a condition needing medical attention or that Mr. [REDACTED] had soiled himself. There was another arrestee in the cell with Mr. [REDACTED] who did not advise DA Daniels of Mr. [REDACTED] condition or that Mr. [REDACTED] had soiled himself.

COPA interviewed Detention Aide Roberto Gonzalez (DA Gonzalez) who worked in the 11th District lockup on November 23, 2019 from 2100 hours until November 24, 2019 "in the morning." DA Gonzalez had

no knowledge of Mr. [redacted] having a condition that required medical attention or that Mr. [redacted] had soiled himself. During his walks of the cell block he did not smell anything out of the ordinary.

COPA interviewed Detention Aide Andrew McGuire (DA McGuire) who worked from 1300-2100 hours on November 23, 2019. DA McGuire made the required 15-minute checks. DA McGuire recalled Mr. [redacted] declining the offered sandwich at evening meal time. DA McGuire recalled that Mr. [redacted] slept most of his shift, but got up to use the restroom a few times. No one advised DA McGuire that Mr. [redacted] had a condition requiring medical assistance and did not recall smelling urine or feces when he walked the cell blocks.

COPA found that there was insufficient evidence to sustain the allegations against Detention Aides McGuire, Daniels, and Gonzalez, as well as Officers Coon and Cooper.

Superintendent's Penalty Analysis

Sergeant Alan Lasch

CPD concurs with the sustained finding for Allegation #2 – that Sergeant Lasch failed to personally inspect the lockup and prisoners during his tour of duty in violation of S06-01. The Department disagrees with the findings concerning Allegations #1 and #3, as well as the proposed penalty of 180 days up to separation.

COPA proved by a preponderance of the evidence Allegation #2 – that Sgt. Lasch failed to personally inspect the lockup and prisoners during his tour of duty in violation of S06-01. While Sgt. Lasch testified that he did personally conduct his required four inspections of the lockup and prisoners, he also stated that his check involved walking the main hallway for the cells instead of walking down each individual hallway. Sgt. Lasch said that he would not walk down the individual hallways unless called by a detainee. This does not fulfill the requirements of S06-01 – that the DSS personally inspect the lockup and prisoners. By Sgt. Lasch's own admission, he did not fulfill his obligations under S06-01, and therefore COPA has proven Allegation #2 by a preponderance of the evidence.

COPA failed to prove by a preponderance of the evidence, Allegation #1 – that Sgt. Lasch failed to ensure [redacted] safety and care while in the Department's custody in violation of S06-01. COPA's argument is that Sgt. Lasch's failed to uncover that Mr. [redacted] had a condition that required medical intervention. Sgt. Lasch relied on Officer Toliver and DA Spurlin to determine whether Mr. [redacted] had a condition requiring medical assistance before they allowed Mr. [redacted] to enter the lockup. However, it defies any reasonable explanation that a District Station Supervisor would be required to conduct the same thorough examination as that conducted by Officer Toliver and DA Spurlin of each prisoner four times during each tour of duty. As was corroborated by COPA's interviews of every Department member, Mr. [redacted] spent most of his time in lockup sleeping or using the restroom. Mr. [redacted] responded when asked if he wanted food, a sleeping mat, or a tissue. Mr. [redacted] was observed using the restroom several times. With the exception of Mr. [redacted] trench foot, which only Officer Toliver and DA Spurlin observed, Mr. [redacted] presented himself no differently than any other prisoner in the lockup on November 23-24, 2019. Since neither Officer Toliver nor DA Spurlin brought [redacted] injuries to Sgt. Lasch's attention, and did not otherwise record the existence of these injuries in a place where Sgt. Lasch would have observed them, Sgt. Lasch cannot be held responsible for failing to ensure the safety and care of Mr. [redacted] As such, COPA has not sustained its burden as to Allegation #1.

COPA also failed to prove by a preponderance of the evidence Allegation #3 – that Sgt. Lasch failed to record his observations or any noticeable changes in the condition of Mr. in the "Watch Commanders Comments" section of the Automated Arrest Application in violation of S06-01-02. Sgt. Lasch explained that he observed the lockup both through video connections and by conducting the required personal inspections, and he observed no change in Mr. condition during his watch. During that time, neither Mr. nor other prisoners in lockup, nor anyone on shift brought a change in Mr. condition to Sgt. Lasch's attention. Again, as noted above, Mr. did not outwardly present himself any differently than other prisoners in the lockup on November 23-24, 2019. Sgt. Lasch had no change in condition to record. As such, COPA has not proven Allegation #3 by a preponderance of the evidence.

For the foregoing reasons, CPD concurs with COPA's finding concerning Allegation #2 and disagrees with COPA's findings concerning Allegations #1 and #3. Considering Sgt. Lasch's exemplary complimentary and disciplinary history, CPD disagrees with the recommended penalty of a suspension of 180 days up to separation and instead recommends that Sgt. Lasch be suspended for 30 days. CPD believes that a 30 day suspension is a more appropriate penalty given COPA's prior recommendation in 2019-1719 in which a Lieutenant was suspended for 5 days for (1) failing to timely document or ensure the proper documentation was completed for the incident in lockup per Special Order S06-01- 07; (2) failing to complete or ensure an initiation report was completed that Officer Delgado Fernandez used excessive force; (3) failing to make or ensure proper notifications were made; and (4) failing to provide or ensure Damien Stewart was provided medical assistance.

Sergeant Matthew Conway

CPD concurs with the sustained finding for Allegation #2 – that Sergeant Conway failed to personally inspect the lockup and prisoners during his tour of duty in violation of S06-01. The Department disagrees with the findings concerning Allegations #1 and #3, as well as the proposed penalty of 180 days up to separation.

COPA proved by a preponderance of the evidence Allegation #2 – that Sgt. Conway failed to personally inspect the lockup and prisoners during his tour of duty in violation of S06-01. Sgt. Conway testified that he conducted the required inspections of the lockup and prisoners by video monitors. This does not fulfill the requirements of S06-01 – that the DSS personally inspect the lockup and prisoners. By Sgt. Conway's own admission, he did not fulfill his obligations under S06-01, and therefore COPA has proven Allegation #2 by a preponderance of the evidence.

COPA failed to prove, by a preponderance of the evidence, Allegation #1 – that Sgt. Conway failed to ensure safety and care while in the Department's custody in violation of S06-01. was brought into custody before Sgt. Conway began his role as District Station Supervisor. Officer Toliver and DA Spurlin both observed foot, yet failed to seek medical care for However, Sgt. Conway was not on duty at the time that entered the lockup and could not have been aware of these injuries. As was corroborated by COPA's interviews of every Department member, Mr. spent most of his time in lockup sleeping or using the restroom. Mr. responded when asked if he wanted food, a sleeping mat, or a tissue. Mr. was observed using the restroom several times. With the exception of Mr. trench foot, which only Officer Toliver and DA Spurlin observed, Mr. presented himself no differently than any other prisoner in the lockup on November 23-24, 2019. Sgt. Conway cannot be held responsible for failing to discover Mr. trench foot, which was an injury concealed from his observation in the absence of

making Mr. [redacted] remove his shoes and socks. As such, COPA failed to prove Allegation #1 by a preponderance of the evidence.

COPA also failed to prove by a preponderance of the evidence Allegation #3 – that Sgt. Conway failed to record his observations or any noticeable changes in the condition of [redacted] Mr. [redacted] in the "Watch Commanders Comments" section of the Automated Arrest Application in violation of S06-01-02. Sgt. Conway explained that he observed the lockup by conducting the required personal inspections, and he observed no change in Mr. [redacted] condition during his watch. During that time, neither Mr. [redacted] nor other prisoners in lockup, nor anyone on shift brought a change in Mr. [redacted] condition to Sgt. Conway's attention. Again, as noted above, Mr. [redacted] did not outwardly present himself any differently than other prisoners in the lockup on November 23-24, 2019. Sgt. Conway had no change in condition to record. As such, COPA has not proven Allegation #3 by a preponderance of the evidence.

For the foregoing reasons, CPD concurs with COPA's finding concerning Allegation #2 and disagrees with COPA's findings concerning Allegations #1 and #3. Considering Sgt. Conway's exemplary complimentary and disciplinary history, CPD disagrees with the recommended penalty of a suspension of 180 days up to separation and instead recommends that Sgt. Conway be suspended for 30 days. As with Sgt. Lasch, the Department relies on Log No. 2019-1719 to support a significantly decreased penalty.

Sergeant Natalie Fischer

CPD concurs with the sustained finding for Allegation #2 – that Sergeant Fischer failed to personally inspect the lockup and prisoners during her tour of duty in violation of S06-01. The Department disagrees with the findings concerning Allegations #1 and #3, as well as the proposed penalty of 180 days up to separation.

COPA proved by a preponderance of the evidence Allegation #2 – that Sgt. Fischer failed to personally inspect the lockup and prisoners during her tour of duty in violation of S06-01. Sgt. Fischer testified that she conducts the four required checks by entering the corridor of the cell blocks four times during her shift. This does not fulfill the requirements of S06-01 – that the DSS personally inspect the lockup and prisoners. By Sgt. Fischer's own admission, she did not fulfill her obligations under S06-01, and therefore COPA has proven Allegation #2 by a preponderance of the evidence.

COPA failed to prove, by a preponderance of the evidence, Allegation #1 – that Sgt. Fischer failed to ensure [redacted] safety and care while in the Department's custody in violation of S06-01. [redacted] was brought into custody before Sgt. Fischer began her role as District Station Supervisor. Officer Toliver and DA Spurlin, both observed Mr. [redacted] foot, yet failed to seek medical care for [redacted] However, Sgt. Fischer was not on duty at the time that Mr. [redacted] entered the lockup and could not have been aware of these injuries. As was corroborated by COPA's interviews of every Department member, Mr. [redacted] spent most of his time in lockup sleeping or using the restroom. Mr. [redacted] responded when asked if he wanted food, a sleeping mat, or a tissue. Mr. [redacted] was observed using the restroom several times. With the exception of Mr. [redacted] trench foot, which only Officer Toliver and DA Spurlin observed, Mr. [redacted] presented himself no differently than any other prisoner in the lockup on November 23-24, 2019. Sgt. Fischer cannot be held responsible for failing to discover Mr. [redacted] trench foot, which was an injury concealed from his observation in the absence of making Mr. [redacted] remove his shoes and socks. As such, COPA failed to prove Allegation #1 by a preponderance of the evidence.

COPA also failed to prove by a preponderance of the evidence Allegation #3 – that Sgt. Fischer failed to record her observations or any noticeable changes in the condition of [REDACTED] Mr. [REDACTED] in the "Watch Commanders Comments" section of the Automated Arrest Application in violation of S06-01-02. Sgt. Fischer explained that she observed the lockup by conducting the required personal inspections, and she observed no change in Mr. [REDACTED] condition during his watch. During that time, neither Mr. [REDACTED] nor other prisoners in lockup, nor anyone on shift brought a change in Mr. [REDACTED] condition to Sgt. Fischer's attention. Again, as noted above, Mr. [REDACTED] did not outwardly present himself any differently than other prisoners in the lockup on November 23-24, 2019. Sgt. Fischer had no change in condition to record. As such, COPA has not proven Allegation #3 by a preponderance of the evidence.

For the foregoing reasons, CPD concurs with COPA's finding concerning Allegation #2 and disagrees with COPA's findings concerning Allegations #1 and #3. Considering Sgt. Fischer's exemplary complimentary and disciplinary history, CPD disagrees with the recommended penalty of a suspension of 180 days up to separation and instead recommends that Sgt. Fischer be suspended for 30 days. As with Sgt. Lasch, the Department relies on Log No. 2019-1719 to support a significantly decreased penalty.

Officer Leroy Toliver

COPA proved, by a preponderance of the evidence, all three allegations against Officer Toliver. Officer Toliver and DA Spurlin both observed Mr. [REDACTED] feet, which exhibited symptoms of trench foot and Officer Toliver described as "really bad feet". Rather than seeking medical attention for Mr. [REDACTED] or even bringing the condition of Mr. [REDACTED] feet to the attention of the DSS, Officer Toliver exercised poor judgment by ignoring the problem and allowing Mr. [REDACTED] to enter the lockup. Officer Toliver chose not to record Mr. [REDACTED] condition in the Arrest Processing Report section of the Arrest Report. Officer Toliver's actions resulted in Mr. [REDACTED] not receiving medical care, which may have uncovered the cocaine and opiates in Mr. [REDACTED] body that ultimately caused Mr. [REDACTED] death. Moreover, Officer Toliver more likely than not observed that Mr. [REDACTED] had soiled himself the morning of November 24, 2019. COPA has sustained its burden of proving, by a preponderance of the evidence, all three allegations brought against Officer Toliver.

For the foregoing reasons and considering Officer Toliver's complimentary and disciplinary history, CPD concurs with COPA's findings concerning Allegations #1-#3, and COPA's recommendation that Officer Toliver be suspended for 365 days.

Officer Peter Vinson

COPA proved, by a preponderance of the evidence, both allegations against Officer Vinson. Officers Vinson and Riley were tasked with transporting prisoners to court on the morning of November 24, 2019. G06-01-01(II)(A) requires a Department member accepting custody from another member to not only ensure the safety and security of the arrestee, but to conduct a thorough search of the arrestee in accordance with established Department procedures. Mr. [REDACTED] presented to Officers Vinson and Riley with a pronounced limp, an odor so bad that a detention aide was wearing a mask and other arrestees were complaining about it, and visible stains running the length of his pants. Notwithstanding, neither Officer Vinson nor Officer Riley were able to discern that Mr. [REDACTED] soiled himself during their search. Mr. [REDACTED] soiled condition, combined with his limp, should have triggered further inquiry into whether Mr. [REDACTED] required medical attention. At a minimum, protecting the sanctity of human life should have caused

these officers to return Mr. to the lockup to, at a minimum, receive clean clothes. These officers' failure to consider Mr. weakened condition was further borne out by how quickly Mr. collapsed on arrival at the court building and his inability to get up, even with assistance. COPA sustained its burden, by a preponderance of the evidence, on both allegations brought against Officer Vinson.

For the foregoing reasons and considering Officer Vinson's complimentary and disciplinary history, CPD concurs with COPA's findings concerning Allegations #1 and #2, and with COPA's recommendation that Officer Vinson be suspended for 180 days.

Officer Gary Riley

COPA proved, by a preponderance of the evidence, both allegations against Officer Riley. Officers Vinson and Riley were tasked with transporting prisoners to court on the morning of November 24, 2019. G06-01-01(II)(A) requires a Department member accepting custody from another member to not only ensure the safety and security of the arrestee, but to conduct a thorough search of the arrestee in accordance with established Department procedures. Mr. presented to Officers Vinson and Riley with a pronounced limp, an odor so bad that a detention aide was wearing a mask and other arrestees were complaining about it, and visible stains running the length of his pants. Notwithstanding, neither Officer Vinson nor Officer Riley were able to discern that Mr. soiled himself during their search. Mr. soiled condition, combined with his limp, should have triggered further inquiry into whether Mr. required medical attention. At a minimum, protecting the sanctity of human life should have caused these officers to return Mr. to the lockup to, at a minimum, receive clean clothes. These officers' failure to consider Mr. weakened condition was further borne out by how quickly Mr. collapsed on arrival at the court building and his inability to get up, even with assistance. COPA sustained its burden, by a preponderance of the evidence, for both allegations brought against Officer Riley.

For the foregoing reasons and considering Officer Riley's complimentary and disciplinary history, CPD concurs with COPA's findings concerning Allegations #1 and #2. However CPD disagrees with COPA's recommendation that Officer Riley be suspended for 180 days up to and including separation, and instead recommends that Officer Riley be suspended for 30 days.

Detention Aide Charles Barry

COPA proved, by a preponderance of the evidence, all four allegations against DA Barry. DA Barry was one of the detention aides responsible for processing incoming arrestees. He should have been aware of injuries, noted those injuries on the appropriate forms, and sought appropriate medical care. Rather than seeking medical attention for Mr. or even bringing the condition of Mr. feet to the attention of the DSS, DA Barry exercised poor judgment by ignoring the problem and allowing Mr. to enter the lockup. DA Barry failed to record Mr. condition in the Arrest Processing Report section of the Arrest Report. DA Barry's actions resulted in Mr. not receiving medical care, which may have uncovered the cocaine and opiates in Mr. body that ultimately caused Mr. death. Moreover, DA Barry more likely than not observed that Mr. had soiled himself the morning of November 24, 2019. COPA has sustained its burden of proving, by a preponderance of the evidence, all three allegations brought against DA Barry.

COPA proved by a preponderance of the evidence that DA Barry knowingly made a materially false or misleading statement during his interviews with COPA. The morning of November 24, 2019, DA Barry was wearing a surgical mask while assisting with the transfer of arrestees to the transport vehicle. When COPA asked why he was wearing a mask, DA Barry claimed to wear a mask "a lot" because of germs in lockup and the absence of windows or ventilation. DA Barry denied that he was wearing a mask because of how bad Mr. ███████ smelled after he soiled himself. DA Barry went on to state that he wears a mask in the lockup "a lot of times" and then offered an alternate reason for wearing the mask that morning – that it was the smell of all the prisoners that that caused him to wear a mask. DA Barry denied smelling anything out of the ordinary concerning Mr. ███████ including the smell of Mr. ███████ defacating on himself. DA Barry's claim to wear a mask frequently was further belied by the statement of DA Spurlin, who said he was surprised to see DA Barry wearing a mask that morning. Taken as a whole, it is clear that DA Barry was attempting to conceal that he knew Mr. ███████ had soiled himself and was wearing a mask as a result of the odor.

The threshold to charge a rule 14 violation requires: 1) willfulness; and 2) the false statement must be material to the incident under investigation. *See In the Matter of Charges Filed Against Police Officer Raoul Mosqueda, Star No. 13662, Department of Police, City of Chicago (No. 17 PB 2935) page 12.* Willful is defined as "of an immoral or illegal act or omission; intentional; deliberate." In this case, the statements were willful in that DA Barry was deliberate in his efforts to conceal that he knew that Mr. ███████ had soiled himself. The statements were material in that DA Barry was attempting to conceal that he placed an arrestee in a transport vehicle knowing that the arrestee had soiled himself – a symptom of other medical conditions.

DA Barry's false statements meet the threshold of a Rule 14 violation in that the statements were willful and were material to the incident under investigation. As such, COPA has carried its burden by demonstrating, by a preponderance of the evidence, that DA Barry made false and misleading statements.

For the foregoing reasons and taking into account DA Barry's complimentary and disciplinary history, CPD concurs with COPA's findings on Allegations #1-#4 and its recommendation of separation for DA Barry.

Detention Aide Keith Spurlin

COPA proved, by a preponderance of the evidence, all three allegations against DA Spurlin. DA Spurlin and Officer Toliver both observed Mr. ███████ feet, which exhibited symptoms of trench foot and DA Spurlin mistakenly thought was frost bite. Rather than seeking medical attention for Mr. ███████ or even bringing the condition of Mr. ███████ feet to the attention of the DSS, DA Spurlin exercised poor judgment by ignoring the problem and allowing Mr. ███████ to enter the lockup. DA Spurlin chose not to record Mr. ███████ condition in the Arrest Processing Report section of the Arrest Report. DA Spurlin's actions resulted in Mr. ███████ not receiving medical care, which may have uncovered the cocaine and opiates in Mr. ███████ body that ultimately caused Mr. ███████ death. Moreover, DA Spurlin more likely than not observed that Mr. ███████ had soiled himself the morning of November 24, 2019. COPA has sustained its burden of proving, by a preponderance of the evidence, all three allegations brought against DA Spurlin.

For the foregoing reasons and considering DA Spurlin's complimentary and disciplinary history, CPD concurs with COPA's findings concerning Allegations #1-#3, and COPA's recommendation that DA Spurlin be suspended for 365 days.

CPD looks forward to discussing this matter with you pursuant to MCC-2-78-130(a)(iii).

David O. Brown
Superintendent of Police
Chicago Police Department