IPRA

INDEPENDENT POLICE REVIEW AUTHORITY

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April 12, 2017

Re: Historical Review of IPRA Officer-involved Shooting Investigations

To the Mayor, Members of the City Council Committee on Public Safety, the City Clerk, the Legislative Reference Bureau, and the citizens of Chicago:

As you may recall, during the Spring of 2016, after spending the first few months of our administration focused on assessing the effectiveness of the Independent Police Review Authority ("IPRA"), we recognized that there were many questions about the manner in which the agency investigated officer-involved shooting incidents. At that time, it was our view that addressing these questions would be essential to the agency's future effectiveness. As such, the agency engaged a law firm, McGuireWoods LLP, to conduct an independent review of shooting investigations and make recommendations regarding how IPRA could improve its investigative processes. As you know, since that time, the City has enacted plans to replace IPRA with a new civilian oversight agency, the Civilian Office of Police Accountability ("COPA"). The build-out of COPA is well underway with a full launch anticipated on or around September 15, 2017. However, because the report on the review conducted by McGuireWoods provides information that is relevant to future COPA operations, we believe it appropriate to release the report, notwithstanding the fact that IPRA will no longer exist after September 30, 2017.

Attached is the report documenting this historical review which summarizes the findings regarding the quality of IPRA's investigative process and analysis of officer-involved shooting incidents as well as recommendations for reform to be considered.

Although we do not necessarily agree with each and every finding and recommendation, we appreciate the thoughtful and well-researched feedback this report has provided. Also attached is our discussion of how we believe the recommendations made in the report are best addressed in the organizational design and operational plans for COPA.

There are a few thoughts that we believe readers of this report should bear in mind, that are not conveyed in the report itself as clearly as we believe appropriate:

1) The timeframe of the investigations reviewed spans the earliest of IPRA's existence through the end of the calendar year of 2015. As such, many of the investigations that were the subject of this review were conducted prior to the implementation of several important reforms put in place by this administration as well as the previous administration;
2) The investigations studied pursuant to this review were not based on a random sample. Rather, the selection methodology (as outlined on pages 19 and 20 of the report), inherently resulted in a sample of the most challenging, problematic investigations;
3) Most of the recommendations made herein have already been incorporated into the policies, procedures, and training plans for the new Civilian Office of Police Accountability;
4) The purpose of the review was not to assess the outcome of specific cases, but rather, to focus on assessing the strengths and weaknesses of the investigative process to identify appropriate reforms; and
5) As outlined in the report, it is important to consider that IPRA, like any organization responsible for police accountability, can only enforce the policies as they exist and as promulgated by the Chicago Police Department itself. It is for this reason, that our leadership team has been proactive in providing feedback to the Chicago Police Department on the policies governing the use of deadly force. Our most recent recommendations have been published along with this report as part of our reporting for Q1 2017.

We hope that this analysis provides helpful insight and perspective on the challenges inherent in effective officer-involved shooting investigations and look forward to continuing to contribute to significant progress being made on this front.

Respectfully,

Sharon R. Fairley
Chief Administrator

RESPONSE TO HISTORICAL REVIEW RECOMMENDATIONS

RECOMMENDATION	RESPONSE
I. STANDARD AND SCOPE OF REVIEW OF OFFICER CONDUCT IN OIS INVESTIGATIONS	
A. Recommendations regarding use of deadly force standard of review	
1. Investigators should be trained on the Chicago Police Department ("CPD") new use of deadly force standard.	COPA Academy curriculum includes training on CPD's new use of deadly force standard.
2. Investigators should investigate and analyze conduct commensurate with all aspects of that new standard.	COPA rules will require that analysis of OIS cases will reflect the new standard, when adopted by CPD.
B. Recommendations regarding scope of review of broader officer conduct	
1. Investigators should investigate officer conduct beginning at the start of the events leading to the incident, not just at the moment of the use of force itself.	This approach will be reflected in COPA Rules and SOP's.
2. Investigators should receive training that extends beyond the evaluation of the use of deadly force. They must have a complete understanding of CPD's training on tactics and judgment in all relevant aspects.	This issue will be reflected in COPA investigator training.
3. There should be a formal mechanism to communicate the information from the OIS oversight investigation and analysis to CPD.	COPA leadership will work with CPD to develop this communication approach and will pursue changes to the applicable CPD directives to the extent necessary to accomplish this.
II. BACKGROUND AND TRAINING OF OIS INVESTIGATORS AND STRUCTURE OF OIS INVESTIGATIVE TEAMS	
1. Considerations for prerequisites for those assigned to OIS cases should include: prior homicide investigation experience, prior shooting investigation experience, prior internal affairs experience, prior experience as a prosecutor, prior experience in law enforcement, and prior investigative experience overall.	Prior law enforcement experience, and specifically prior homicide experience, is relevant and desirable for our investigative staff and these qualifications are reflected in the hiring plans for COPA. However, so long as investigators are provided with relevant training and supervision, maintaining an investigative staff that reflects diverse backgrounds is essential to effective civilian oversight. Because COPA investigative work will be conducted in teams, and with appropriate supervision and legal oversight, this prior law enforcement experience is

	not necessary for each and every investigator. In addition, it is important to acknowledge that our ability to recruit candidates with this background may be limited by the residency requirement, and the fact that the ordinance precludes us from hiring recent (past 5 years) CPD personnel.
2. Each OIS investigative team should have a combination of experience that includes shooting investigation experience. The benefit of internal affairs experience as well should also be considered.	The new structure for the COPA Investigations staff will include working in team structures and our goal is to populate major case specialist teams with individuals with complementary skills and experience.
3. There should be a system established by which investigators in other areas of the organization who wish to become OIS investigators must have, in addition to any classroom training, on-the-job training including evaluation for a substantial period of time, shadowing a significant number of OIS cases from incident to close, and acting as lead investigator in some cases under close supervision.	Under the organization structure for COPA, officer-involved shooting investigations will be conducted by a specific class of investigators titled, Major Case Specialists. COPA will also have a Director of Training to ensure that the investigative staff receives the requisite training and to ensure investigators receive the appropriate ongoing on-the-job training. A combination of classroom and on the job training is appropriate and will be incorporated into COPA's training curriculum.
4. The OIS investigator who is on-scene at the time of the incident should remain on the investigation through its close as the lead investigator whenever possible.	This practice is already in place and will continue under COPA, to the extent feasible depending on staffing levels, caseloads, and team memberships.
5. Each OIS investigative team should have an assigned forensic specialist who remains part of that team from the time of the incident through the close of the case.	COPA will have professional evidence specialists on staff that can be assigned to teams.
6. Each OIS investigative team should have an assigned attorney who remains part of the team from the time of the incident through the close of the case.	This practice is already in place and will continue under COPA.

RESPONSE TO HISTORICAL REVIEW RECOMMENDATIONS

III. CONDUCTING OIS INVESTIGATIONS	
A. Recommendations regarding on-scene investigation	
1. Fully diagram the complete scene. 2. Take complete and detailed measurements at the scene. 3. Conduct trajectory analysis at the scene when appropriate. 4. Take weapons of all officers who were involved in the incident and do not limit to only the officers who state that they fired their weapons. 5. Ensure that all officer weapons that need to be recovered are recovered on-scene. 6. Account for all witnesses at the scene and attempt to interview or obtain contact information. 7. Take independent photos and label for significance and clarity. 8. Take independent scene video and narrate for significance and clarity. 9. Swab subject hands for GSR testing where possible. 10. Preserve subject clothing for GSR testing. 11. Take DNA swabs from subject (within confines of law). 12. Consider if there are instances where taking DNA swabs from officers involved in incident might be beneficial to conducting a credible investigation, e.g., to rule out officer DNA on gun or other object where there are witness statements that an officer planted the gun or object. 13. Properly protect subject body in fatal shooting for evidence. 14. Hold and completely process involved vehicles for recovery of additional projectiles and other evidence.	These requirements are reflected in COPA investigator training and COPA leadership will work to formalize these requirements through CPD directives.

RESPONSE TO HISTORICAL REVIEW RECOMMENDATIONS

B. Recommendations regarding forensic evidence analysis	
1. Analyze any firearm recovered alleged to have been possessed by a subject, as well as all bullets contained within that firearm and magazine, for both the prints of the subject and the prints of involved officers. 2. Analyze any object alleged to have been a mistaken weapon possessed by subject for both prints of subject and prints of involved officers. 3. Request complete ballistics analysis including analyzing any recovered projectile that is not determined to have come from firearm of either subject or shooting officer against firearms of other involved officers. 4. Request DNA analysis on any firearm recovered alleged to have been possessed by subject for both presence of DNA of subject and of involved officers. 5. Request DNA analysis on any object alleged to have been a mistaken weapon possessed by subject for both presence of DNA of subject and of involved officers. 6. Request ATF trace on any firearm recovered. 7. Request GSR analysis on a subject's hands in any case involving an allegation that the subject possessed a firearm. 8. Request GSR analysis on a subject's clothing to determine if there is any evidence of close range firing.	These requirements will be reflected in COPA investigator training and SOP's. In addition, COPA leadership will work to formalize these requirements through CPD directives and collaboration with COPA's forensic analysis partners.
C. Recommendations regarding medical evidence	
1. Request trajectory rod analysis on deceased subjects.	Trajectory analysis is not possible or relevant in all cases, but can be very valuable when it is. COPA leadership will collaborate with the Cook County Medical Examiner regarding protocols for examinations related to COPA investigations.

2. Interview medical examiner in case of fatality at the time of examination for observations and follow up with questions following the receipt of subsequent reports. 3. Interview medical personnel that are treating a subject in the case of non-fatal shooting regarding the subject's injuries, condition, or other issues observed in medical records. 4. Interview medical personnel having contact with a subject in the case of a non-fatal shooting regarding any statements made by the subject.	COPA enhanced investigator training will address these issues.
D. Recommendations regarding OEMC information	
1. Request OEMC to provide all information relevant to the incident in all cases.	COPA leadership will collaborate with OEMC to operationalize this practice.
2. Establish procedures to ensure that all potentially relevant information has been obtained from OEMC.	COPA will address this via enhanced investigator training and/or quality assurance programs.
3. Thoroughly analyze all information received including event queries, PDT transmissions, dispatch recordings, and 911 calls.	COPA will address this with enhanced investigator training and/or quality assurance programs.
E. Recommendations regarding efforts to identify, locate, and interview witnesses	
1. Conduct multiple canvasses as practicable until all witnesses in the area who may have observed shooting have been identified and interviewed. 2. Keep more detailed canvass logs. 3. Interview individuals in positions of authority at each business or building in vicinity to determine if any video may exist and obtain any video that does.	COPA will address this with enhanced investigator training and/or quality assurance programs.
4. Interview all witnesses on-scene.	Ideally, COPA investigators should attempt to interview all witnesses on scene. However, at times, this is not feasible or advisable. In addition, it is important to bear in mind that COPA interviews with witnesses are voluntary and COPA cannot force a witness to agree to be interviewed on-scene. In addition, for incidents in which there is an

	underlying criminal investigation being conducted by CPD, COPA will coordinate witness interviews with CPD to ensure both agencies' investigative needs are met.
5. Locate and interview all individuals identified in CPD reports. 6. Identify, locate, and interview all 911 callers regarding a shooting. 7. Locate and interview any individual identified from an ATF trace as having previously possessed a recovered firearm. 8. Utilize intelligence where able from law enforcement entities to help fully identify witnesses	COPA will address this with enhanced investigator training and/or quality assurance programs.
9. Utilize subpoena power to locate witnesses 10. Utilize subpoenas to interview witnesses unwilling to cooperate.	This practice will be operationalized in COPA Rules and SOP's.
11. Utilize investigative techniques to locate, identify, and interview key witnesses where necessary.	COPA enhanced investigator training will address these issues.
F. Recommendations regarding obtaining additional information	
1. Obtain materials on an ongoing basis that may be generated in any civil or criminal suit related to OIS incidents. 2. Obtain any media footage and articles. 3. Obtain CPD contact cards for subjects	COPA will address this with enhanced investigator training and/or quality assurance programs.
4. Obtain CPD CR histories and files pertaining to each complaint for each involved officer.	COPA will operationalize this practice, to the extent feasible under the collective bargaining agreements.
5. Obtain CPD training records for each involved officer. 6. Obtain CPD firearms qualification records for each shooting officer.	COPA will address this through enhanced investigator training to the extent permissible.
G. Recommendations regarding conducting interviews generally	
1. Ask open-ended questions, not leading ones. 2. Ask follow-up questions to obtain additional details on key points. 3. Ask probing questions to test and challenge the credibility of the interviewee.	COPA will address this with enhanced investigator training and/or quality assurance programs.

4. Raise and challenge the interviewee with any inconsistencies from prior statements. 5. Use aids to help clarify the statements of the interviewee, *e.g.*, maps of the area, diagrams with measurements, video, photos of the location where events occurred, and photos of a vehicle if one is involved. 6. Use evidence gathered during investigation in the interview, particularly evidence that may contradict an account to confront the interviewee and test credibility. 7. Follow up with witnesses and conduct second interviews when new evidence comes to light through additional interviews, videos, results of forensic testing, or otherwise, in order to clarify information obtained in the initial interview or to challenge statements made by the interviewee in the initial interview that may call into question the accuracy or veracity of statements made by the interviewee. 8. Conduct follow-up investigation regarding details learned in interviews. This may involve additional forensic testing or other investigative steps.	
9. Conduct interviews with two interviewers. 10. Conduct all interviews in person unless impossible. If an in-person interview is an impossibility, the investigator should thoroughly document the reasons why a phone interview was the only alternative. 11. Record all interviews unless prohibited by witness (which as noted earlier is specifically required under the current administration).	This practice is currently in place and will continue under COPA
12. Prohibit the turning on and off of the recording device unless needed to accommodate witness needs and	This practice is currently in place and will continue under COPA

prohibit any unrecorded dialogue (which as noted earlier is specifically required under the current administration).	
13. Ensure transcripts are accurate and complete and that statements are fully transcribed where they can be heard instead of transcribing them as "inaudible."	COPA will address this with enhanced investigator training and/or quality assurance programs.
14. Ensure that summaries of interviews (where not recorded or not transcribed) are accurate.	COPA will address this with enhanced investigator training and/or quality assurance programs.
H. Recommendations specific to conducting interviews of civilian witnesses	
1. Any interview conducted on-scene with an individual who has relevant information should have a further interview in a location where a more fulsome interview can be conducted if the witness is willing to do so. 2. Ask detailed questions regarding position and vantage point (*e.g.*, position and obstructions to either sight or ability to hear) and ability to perceive (*e.g.*, lighting, background noise, and quality of vision or hearing) for eyewitnesses.	COPA will address this with enhanced investigator training and/or quality assurance programs.
I. Recommendations specific to interviewing of officers	
1. Interview all officers who were present on-scene.	For some incidents, interviewing all officers present at a scene is not practicable or necessary. Some OIS scenes involve dozens of officers who respond but have no substantive involvement with the on-scene investigation and no specific knowledge of the events. However, it will be the goal of every COPA investigation to identify and interview every on-scene officer with relevant information.
2. Develop and follow checklist of standard topics that should be covered in all officer interviews	COPA will address these issues via enhanced investigator training
3. Consider requesting a non-compelled interview of an officer where concerns exist regarding the potential for criminal prosecution or the	This is neither advisable nor feasible in light of the officer's rights under the collective bargaining agreements.

creation of potential *Garrity* issues that would otherwise delay the interview.	
IV. ANALYSIS OF OIS CASES	
A. Develop a uniform template	
1. Investigators should be able to follow the template with specific instructions as to what is to be included. 2. The template should set forth specific examples demonstrating the level of detail and types of details to be included.	The COPA training curriculum will include a summary report template that incorporates these recommendations.
B. Fact section	
1. Include a detailed recitation of all evidence developed during the investigation 2. Include summaries of each witness's information 3. Include not just the fact that a particular type of evidence was obtained, but the specifics of that evidence 4. Discuss evidence that was not able to be obtained or known with precision	The COPA training curriculum will include a summary report template that incorporates these recommendations and extensive training on report drafting.
C. Analysis section	
1. Approach officers' recitation of events as just one piece of evidence among many in the investigation 2. Identify the key issues in the case that are in dispute and that need to be resolved by a careful examination of the evidence. 3. Discuss all evidence developed in the case and not ignore evidence that does not fit with the officer's version of events. 4. Discuss how each piece of evidence fits together with the other pieces of evidence 5. Discuss multiple statements when	COPA will implement a different procedure for the drafting of summary reports that will involve more robust supervisor and legal oversight. COPA's quality management protocols will also be designed to ensure that COPA summary reports accurately and comprehensively describe and analyze the relevant evidence.

applicable by officers and civilian witnesses and analyze them for inconsistencies and discrepancies 6. Assess and weigh witness credibility. 7. Assess and weigh officer credibility. 8. Contain a detailed discussion of each piece of forensic evidence and what can and cannot be determined	
9. Include a discussion of officer's complaint history and analyze any pattern or absence of pattern of misconduct.	This practice will be operationalized under COPA to the extent feasible under the collective bargaining agreements.
10. Discuss that which cannot be known because certain evidence was unable to be obtained or otherwise. 11. Discuss that which conflicts. 12. Be clear as to the weight given to each piece of evidence and the significance of each in the overall analysis.	The COPA training curriculum includes a summary report template that incorporates these recommendations and extensive training on report drafting.
13. Legally analyze each use of force as its own incident. 14. Legally analyze officer conduct under each potentially applicable prong of use of deadly force policy separately. 15. Identify with precision what factors are being considered in terms of applying the totality of the circumstances to determine whether the use of force is within policy, and identify specific findings of fact that support each factor. 16. Set forth an explanation as to support for the ultimate determination that a use of force was either within or outside of policy. 17. Analyze officers' broader conduct in terms of tactics, judgment, and adherence to training.	These practices were implemented by the present IPRA leadership and will be operationalized under COPA via Rules, SOP's and Summary Report training.
V. SUPERVISION AND CASE MANAGEMENT OF OIS CASES	
A. Recommendations regarding supervision	
1. Hold case review meetings at the outset of the investigation to review	This practice will be operationalized at COPA via SOP's.

evidence and develop the investigative plan. 2. Hold case review meetings at the conclusion of an investigation involving supervisors up to and including the Chief Administrator prior to closing any case.	
3. The immediate supervisor should have weekly meetings with each assigned investigator to review evidence in detail and monitor progress.	The COPA organization structure reduces the ratio of Investigators to Supervising Investigators down to 5:1 which will result in significantly more effective supervision.
4. The assigned attorney should be an integral part of the investigative team and should play a role in the content and drafting of the summary report.	This practice was implemented by the present IPRA leadership and will be operationalized under COPA via SOP's and Summary Report training.
5. The immediate supervisor's review of the summary report should include a detailed memo drafted by the immediate supervisor that sets forth the details of the review.	COPA protocols will require in-depth and substantive review of summary reports by Supervising Investigators.
6. The chain of review in all OIS cases should include review above the immediate supervisor up the review chain and to the Chief Administrator.	This practice was implemented by the present IPRA leadership and will be operationalized under COPA via SOP's.
B. Recommendations regarding case management	
1. Institute a formal system to track the progress of each OIS investigation and have mechanisms in place that will monitor progress. 2. Institute a mechanism to track and address any delays in OIS investigations. 3. Institute a formal review process that tracks the progress of a case once the summary report has been completed by the investigator. 4. Institute policies on case file documentation and retention.	These issues will be addressed under COPA in several ways. COPA is developing a new, independent electronic case management system that will have built-in timeliness checks and balances. COPA will also have quality assurance and audit programs specifically to address timeliness issues. Emphasis on timeliness and effective case management will also be included in COPA's investigator training curriculum.
5. Institute a formal system for regularly keeping the subject, or if subject is deceased then family members of subject	In 2016, IPRA leadership adopted new practices related to information sharing with complainants, victims and families. COPA organizational structure and procedures are being designed to provide more support to involved individuals and family members. In particular, the COPA case

	management system development plans include the creation of an online case tracking system that will allow complainants and officers alike to check on the status of investigations.
VI. INTERACTION WITH OTHER ENTITIES INVOLVED IN CONDUCTING OIS INVESTIGATIONS	
A. Recommendations regarding interaction with CPD	
1. Establish a process for effective communication between investigators handling OIS cases, detectives assigned to investigate any crimes related to OIS cases, and Street Deputies. 2. Establish a process for an initial formal meeting to take place as close in time to the incident as possible with all CPD detective personnel assigned to the investigation.	Revisions to the governing directives are being finalized in collaboration with CPD that will enhance the independence of COPA investigations while continuing to work cooperatively with CPD.
3. Establish a protocol by which investigators have an understanding regarding all documents created by CPD in connection with each particular OIS case.	COPA will address this via enhanced investigator training.
4. Establish a process by which investigators have complete access to all such CPD materials. 5. Establish a memorandum of understanding with CPD requiring that the CPD detective case supplementary report be completed and provided to investigators within 30 days of the incident.	The COPA ordinance requires that CPD provide COPA with access to department records.
6. Establish a process by which investigators will obtain information pertaining to officers. 7. Establish a process by which investigators will obtain access to CPD contact cards for subjects involved in incident.	This practice was implemented by the present IPRA leadership and will be operationalized under COPA via SOP's.
8. Establish a process by which disputes, if any, regarding investigator access to documents or the timeliness in which such documents are being provided can be addressed and	This will be operationalized via COPA SOP's.

resolved.	
9. Document all interactions with CPD in an investigation to include meetings, phone calls, requests for items, and receipt of items.	COPA will address this via enhanced investigator training.
B. Recommendations regarding interaction with SAO	
1. Establish a memorandum of understanding with SAO detailing the role the civilian oversight agency plays in OIS cases. 2. Establish a process by which the investigator has an understanding of all materials created by SAO.	COPA's collaboration with the State's Attorney's Office is ongoing and productive.
3. Document all interactions with SAO in an investigation to include meetings, phone calls, and requests for investigative steps.	COPA will address this via enhanced investigator training.
4. Establish a policy that the timing of SAO decision regarding a declination will not impact or delay resolution of the administrative process.	This practice was implemented by the present IPRA leadership and will be operationalized under COPA via Rules and SOP's.
5. Establish protocols to be followed in the instance that there is an underlying criminal case that is charged in another county for interaction with that county.	COPA will develop an SOP for this situation.
C. Recommendations regarding interaction with ISP	
1. Change the current statute as necessary such that the civilian oversight body can make direct referrals to ISP. 2. Establish agreements concerning complete communication between ISP and the civilian oversight body regarding what testing has been requested. 3. Establish agreements concerning the timing of providing results to testing and mechanisms for communication.	Collaboration with ISP is productive and ongoing.
D. Recommendations regarding interaction with the DOL	
1. Establish a protocol with DOL regarding how investigators and DOL attorneys will coordinate to ensure that investigators have a complete understanding of all of the non-	Protocol is in place.

privileged information that exists in the civil suit file.	
2. Establish guidelines for investigators to follow to best coordinate with attorneys at DOL. 3. Set regular points during an investigation at which investigators are required to make contact with DOL attorneys to check on the status.	This issue will be addressed by COPA via investigator training, SOP's, and quality assurance protocols.
E. Recommendations regarding interaction with FOP	
Ongoing evaluation of the impact of union rules and procedures and of the FOP contract with the City of Chicago on the civilian oversight process.	COPA leadership will provide specific recommendations to the City regarding contractual provisions related to the disciplinary process over which COPA has jurisdiction.

Report from the Independent Audit of the Independent Police Review Authority Officer-Involved Shooting Investigations

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MCGUIREWOODS LLP

MARCH 2, 2017

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EXECUTIVE SUMMARY

A. Introduction

With the concurrence of the City of Chicago, the Independent Police Review Authority (IPRA) engaged McGuireWoods LLP to conduct an independent audit of closed officer-involved shooting (OIS) investigations. Our review team is composed of professionals with significant experience in the criminal justice system, including specifically with police shooting cases as well as development of law enforcement use of force policies and tactics.[1] Our project mandate in general was to assess the following:

1. The quality of IPRA's investigative process;

2. The accuracy of IPRA's legal analysis; and

3. The impact of the Chicago Police Department's (CPD) use of force policy on investigation outcomes.[2]

Our process to accomplish these objectives included the following tasks: (1) review and analysis of documents from IPRA, including documents comprising IPRA's policies and procedures as well as policies and procedures relevant to CPD's "use of deadly force"; (2) interviews of individuals from IPRA, CPD, and the Cook County State's Attorney's Office (SAO) relevant to the process of the investigation of OIS cases; (3) development of selection criteria to select closed OIS cases for in-depth review and a review of 286 summary reports of closed OIS cases for cases meeting the selection criteria; and (4) critical analysis of the 20 OIS cases (the number permitted by our project mandate) selected for an in-depth review.

Our audit of IPRA closed OIS cases, combined with the additional information learned during our review, serves as the foundation for the findings and recommendations set forth in this Final Report. Consistent with what was specifically requested in our mandate, this document:

1. Summarizes relevant findings from our review;

2. Discusses and analyzes common deficiencies in IPRA investigations or legal analysis;

3. Identifies systemic and organizational barriers impairing the quality of the investigations and legal analysis;

4. Identifies possible explanations for the historically low number of cases in which IPRA concluded that officer-involved shootings involved conduct inconsistent with CPD policy;

[1] At Appendix A, we set forth information regarding the review team.

[2] *See* IPRA, Second Quarter Report: April 1, 2016 – June 30, 2016, at 10-11; *see also* Press Release, IPRA, *The Independent Police Review Authority to Conduct Historical Review of Officer-Involved Shooting Investigations* (Mar. 23, 2016). IPRA annual and quarterly reports and press releases are available on IPRA's website at http://www.iprachicago.org/news-publications/publications/.

5. Recommends revisions or additions to IPRA policies and procedures regarding the investigation of officer-involved shootings; and

6. Recommends appropriate changes to CPD use of deadly force policy.

When IPRA announced this review, Chief Administrator Sharon Fairley stated that "[t]he findings of the audit will assist senior leadership at IPRA in identifying ways to bring greater integrity and independence to the investigation of officer-involved shootings."[3] Much work needs to be done to change the OIS review process to meet those objectives. However, we see positive signs towards real change. During the relatively short time period in which we have been engaged, IPRA's new management team has begun to move forward in many respects with significant reform efforts. Additionally, in October 2016, the City enacted an ordinance that will replace IPRA with the Civilian Office of Police Accountability (COPA) in 2017, and CPD released its proposed revised use of force policy. We hope that this Final Report will aid in those efforts in that it will provide a detailed understanding of the problems with past investigations of OIS cases and provide guidance regarding the myriad of ways in which OIS investigations can be improved in the future.

This Final Report proceeds in five parts:

- **Part I** sets forth the methodology we used to obtain information during our review, including the process we followed to select the 20 closed OIS cases for in-depth analysis.

- **Part II** provides background information relevant to our review. We set forth a brief background of IPRA's history, structure, and recent reforms. We also discuss IPRA's key policies and procedures relevant to OIS investigations. IPRA and its practices, including how they have evolved, must be understood before they can be questioned or improved.

- **Part III** sets forth our assessment of CPD's use of deadly force policy on OIS investigation outcomes and makes recommendations regarding the revised draft policy released by CPD in October 2016 as relevant to OIS investigations.

- **Part IV** sets forth in detail the findings from our in-depth review of the selected OIS investigations, including summaries and specific examples of the deficiencies we observed with IPRA's historical investigative process and analysis.

- **Part V** provides a set of recommendations to remediate the identified deficiencies.

B. Overall Assessment Regarding OIS Review

Our work centered on an in-depth review of closed OIS investigations and an analysis of the OIS investigative process. As summarized in this Final Report, we observed significant deficiencies in that investigative process itself and now make numerous recommendations for specific changes

[3] Press Release, IPRA, *The Independent Police Review Authority to Conduct Historical Review of Officer-Involved Shooting Investigations* (Mar. 23, 2016).

going forward. Those findings and recommendations are the heart of our work on this project and are summarized below. As an initial matter, however, before turning to that summary, we set forth some overall points regarding review of OIS cases.

We note two factors that we considered in assessing effective review of OIS cases: (1) effective functioning of the police is an absolute necessity to the system of order through law that does the most possible to protect and preserve human life, both that of officers of the law and the citizens of the community they serve; and (2) police and public confidence in the review and resulting consequences of review in OIS cases is an essential element of effective police functioning. Thus, retrospectively, we examined closely whether IPRA's review of OIS cases provides a basis for confidence in its investigations and analysis of police conduct in those matters.

Our principal term of measurement was the effectiveness of OIS investigations, which entails investigations that are thorough and complete, accomplishing the objective of providing an unbiased analysis of a given incident that obtains all relevant facts and judges the conduct of police fairly under the use of force policy in effect at the time of the incident and related training that has been provided to the involved officers. What constitutes an effective OIS investigation depends greatly on the standard of review by which justification for use of force is measured. In short, if effective OIS review is intended to do more than measure whether the use of force meets simply the legal standards, effective review should also include investigation and analysis of whether a given use of force met standards of police policy and training, which are standards that must be set by the police department.

For any review to be fair, credible, and unbiased, it must have standards of conduct against which to measure the police activity that occurred. Thus, an effective OIS review process requires three interrelated and co-dependent elements: (1) the development and implementation of police use of force policies; (2) use of intensified police training that includes training on tactics used to successfully implement the use of force policies; and (3) a professionalized and transparent OIS review process that examines use of force for both meeting legal standards and conformance with police department policy and procedure on the use of force. A credible OIS review process depends on the first two elements to establish what must be investigated and analyzed and to provide the standards for analyzing whether police conduct was or was not within policy.

Improvement in the quality of the civilian oversight investigative and analytic process will not necessarily change the outcome in many deadly force case reviews where such review simply measures justification for use of force by the legal standard established by the Supreme Court ("the constitutional standard"). An analysis of justification under that standard looks at the moment when deadly force is used rather than a broader analysis of all of the facts of a given incident. A comprehensive review depends on the existence of police policies on the use of deadly force that extend more broadly than the constitutional standard and on the existence of police training on such policies because those will provide the measure by which police conduct is judged in a more comprehensive review.

As a corollary, a more comprehensive use of force policy and tactics will require OIS investigators with the experience and expertise necessary to, for example, analyze whether a given tactical situation called for application of de-escalation and force mitigation techniques and, if so, whether they were employed. A comprehensive assessment of OIS incidents includes a review of not only

the moment that the use of force is deployed but all of the steps leading up to that moment. Both the OIS review of the underlying facts and the resulting analysis will be far more exacting and complex than that required by simple application of the constitutional standard for use of deadly force because a far greater range of factors involved in a given use of force will have to be investigated and analyzed. Likewise, for the same reasons, the analysis of OIS events will be more detailed than OIS determinations of justification for the use of force under the constitutional standard.

Based on the collective experience of our team, including our use of force consultants, we identified certain core elements as ones that will serve the objective of providing an OIS investigation and review process that the public finds credible and one that is fair and just to the officers whose conduct is being examined: (1) a credible investigatory process independent of CPD (as required by Illinois law) conducted by investigators with requisite competence and credibility; (2) objective application of the relevant standards of police practices as required by CPD policy in effect at the time of the occurrence; and (3) a means to effectively coordinate the investigation of OIS cases without impairing timely and effective investigation of any underlying criminal conduct associated with the OIS incident. We believe that for any civilian oversight body to be successful, these core elements must govern its structure and work.

C. Summary Of Findings And Recommendations

Our principal charge was to critically analyze 20 of IPRA's closed OIS investigations in order to assess the quality of IPRA's investigative process and the accuracy of its analysis.[4] The selection process was designed to yield cases that were more complex events in which any lapses in the investigative process were more likely to be observed. Based on the in-depth analysis in these cases, we have concluded that the OIS review process was inadequate and have developed a set of recommendations designed to achieve reform.

It is important to note at the outset that we were not asked to, nor did we, re-conduct investigations in these cases. Thus, while our review enabled us to identify common deficiencies in IPRA's investigations and analysis, it was not our role to opine on the ultimate findings in those cases. Our review, however, disclosed significant investigative shortcomings in IPRA OIS cases.

Findings

IPRA's review process reflected notable deficiencies in three broad categories:

1. Insufficient factual investigation;
2. Inadequate, and in many cases non-existent, analysis of the facts collected; and
3. Substantial and often unexplained problems with timeliness.

While some of the below deficiencies were present in the cases we reviewed with greater prevalence, some were present with lesser prevalence. While some had the potential for serious

[4] The time period of the closed OIS cases were those that had been closed and occurred during the time period between the date of IPRA's inception on September 1, 2007, and December 31, 2015, as at the time our review began there were no OIS cases closed after December 31, 2015.

impact on the investigation, some had the potential for more minimal impact on the investigation. But the deficiencies seen as a whole in these cases evidence a pattern of weak investigations. We summarize herein specific findings for each category.

1. Investigators Failed to Conduct Sufficient and Probing Factual Investigations

Insufficient On-Scene and Follow-Up Investigation

As a threshold matter, it is important to note that historically the on-scene investigation of OIS cases was led by CPD. IPRA relied on and was thus limited to the results of CPD's on-scene investigation and forensics requests based on investigative steps taken on-scene. The investigative deficiencies deriving from those on-scene aspects of the investigation resulted from CPD's decisions regarding investigative steps to be utilized. The failure to obtain other evidence that was not limited by any on-scene investigative decisions by CPD, however, resulted from deficiencies in IPRA's subsequent investigative process. The case files revealed in most instances a failure to collect or obtain one or more of the following types of evidence, which are the result of the limits of CPD's on-scene investigation for some and IPRA's lack of follow-up for others: scene diagrams and scene measurements, trajectory analysis, gunshot residue analysis, fingerprint and DNA analysis, firearms and ballistic evidence, medical evidence, video from businesses or residences in surrounding area, evidence from vehicles, Office of Emergency Management and Communications (OEMC) information such as 911 calls, and information from criminal and civil cases.

Investigators Failed to Conduct Sufficient Interviews of Involved Officers[5]

Comprehensive interviews of officers involved in shootings are essential to a credible review process. This is particularly true where the person who was shot has died, there are few or no other witnesses, and there is little other evidence (whether because it does not exist or was not obtained).

Our review found investigators in nearly all of the cases overall did not conduct interviews in a manner consistent with producing a thorough inquiry. Several areas of deficiency were apparent:

- Failing to follow up in detail on key areas
- Failing to ask probing questions
- Failing to attempt to confront or resolve inconsistencies
- Failing to use aids like photos and scene diagrams to facilitate interviews
- Failing to explain pauses in recordings
- Failing to conduct timely interviews

Officers involved in an OIS matter are obviously critical witnesses. As is true of all witnesses, but especially critical witnesses, their statements in interviews should not simply be accepted at face

[5] Officer and civilian witness interviews are treated separately for purposes of this report because of a number of differences in the way in which they were conducted. For example, the interviews of officers were in person and recorded, while the interviews of civilian witnesses were by and large unrecorded and sometimes conducted by telephone, which had bearing on the depth in which we could analyze the interviews and thus the ability and necessity to make different observations, conclusions, and recommendations.

value but rather should be tested by the use of professional but nonetheless probing interview techniques and by reference to other evidence obtained during the investigation.

Investigators Made Insufficient Efforts to Locate and Interview Civilian Witnesses

Civilian witness interviews, along with forensic and physical evidence, often present critical evidence needed for a comprehensive investigation. Our review, however, identified in most cases numerous areas of deficiency related to investigators' insufficient attempts to locate and interview civilian witnesses, including:

- Failing to take steps to locate or interview relevant identified witnesses
- Failing to conduct a thorough canvass or more than one canvass
- Failing to take more active steps to contact witnesses
- Failing to use subpoenas to compel statements from uncooperative witnesses

Investigators Failed to Conduct Sufficient Interviews of Civilian Witnesses

Even when civilian witnesses were located, investigators did not in most cases sufficiently interview those witnesses. Because most of the interviews were memorialized by summary report rather than recorded (versus IPRA's current practice of regularly recording witness interviews), it has been difficult for us to assess with precision what questions were asked or not asked and what a witness actually said. However, even on this basis, we observed the following problems:

- Failing to follow up in detail on key areas
- Failing to use aids like photos and scene diagrams to facilitate interviews
- Failing to conduct additional interviews after obtaining key information
- Failing to conduct in-person interviews consistently
- Failing to conduct timely interviews

All told, these various deficiencies result in inadequate factual investigations which make it significantly more difficult to reach accurate findings.

2. Investigators Failed to Conduct Any Meaningful Analysis of the Evidence Gathered

Following the gathering of relevant facts and evidence, IPRA investigators document their ultimate findings and recommendations in a summary report. In addition to summarizing the evidence collected, these reports are supposed to analyze that evidence, including how the evidence fits together and whether it corroborates or contradicts an officer's or complainant's version of the events. Investigators should then analyze the evidence in connection with the applicable legal standards and policies, applying a preponderance of the evidence standard, before reaching a reasoned determination regarding the officer's conduct.

All of the summary reports that we reviewed, however, had little or no meaningful analysis. Instead, after reciting the evidence collected, the analysis section almost uniformly consisted of little more than: a recitation of the CPD deadly force policy; a very brief mention of certain evidence, which generally consisted of the officer's version of events; and a summary conclusion

finding the shooting to be within policy. Investigators also inadequately assessed the credibility of witness statements including those of officers. If officers' statements prove to be credible, nonetheless failing to test them and treat them as one piece of evidence to be evaluated along with all of the other evidence in the case adversely affects the credibility of the investigative work product. Similarly, there was no discussion of how other pieces of evidence fit together or the weight to be given to each in reaching the ultimate finding. Nor was there recognition of evidence that was not able to be obtained or questions that remained unanswered and the significance of those information gaps in terms of being able to reach a determination.

More specifically, throughout all the cases we reviewed, we observed one or more of the following areas of deficiency in investigator analysis and related summary report supervision and case management:

- Failing to analyze witness statements, including those of officers, for discrepancies or inconsistencies against prior statements, against physical evidence, or against other witness statements
- Failing to explore and assess evidence against key issues
- Failing to address the legal standard with specificity
- Failing to analyze officers' broader tactical conduct, judgment, or adherence to training
- Failing to have any apparent meaningful supervisory or specialized input
- Failing to have consistency of assigned investigator
- Failing to keep complete files

Every summary report we reviewed in our view lacked a sufficient depth of analysis.

3. IPRA Investigations Take Too Long

IPRA's investigations take too long. Cases we reviewed lasted on average more than three years from incident date to the date the case was closed. Delays of this length significantly undermine the reliability of investigations.

Also problematic was the fact that IPRA's case files too frequently fail to explain in any detail the cause of numerous and lengthy delays. Without such documentation, it is impossible to definitively assess what caused the passage of time in every individual case. But it is clear that delays occur for various reasons. IPRA cannot control many of these. For example, cases were often held up while investigators awaited forensic reports from the Illinois State Police (ISP), or reports from CPD, or for SAO to issue a declination, or for the resolution of a related criminal or civil case.

But investigations also suffered delays that were not driven by external entities. Numerous cases contained delayed officer and witness interviews with no explanation reflected in the file. We also saw occasions where investigators failed to complete summary reports until long after taking their final investigative step. IPRA has long struggled with insufficient staffing levels and excessive caseloads. These factors undoubtedly play a role in the delays as well. But whatever the cause, the effect in these cases is unacceptable.

Recommendations

Our recommendations pertaining to OIS investigations fall into the following broad categories:

1. The standard and scope of review of officer conduct in OIS investigations
2. Background and training of OIS investigators and the structure of OIS investigative teams
3. Conducting OIS investigations
4. Factual and legal analysis of OIS cases
5. Supervision and case management of OIS cases
6. Interaction with related entities in conducting OIS investigations

We have made numerous detailed recommendations to achieve the highest level of effectiveness and integrity in OIS investigations, which are more thoroughly delineated in Part V of this Final Report.

1. Standard and Scope of Review of Officer Conduct in OIS Investigations

The Use of Deadly Force Standard of Review

What constitutes effective OIS investigations depends largely on the standard of review by which justification for use of force is measured. The use of deadly force standard as set forth in the CPD policy in effect for the period from which the cases we reviewed were drawn was essentially that, if the use of force met the constitutional standard then the use of force is within policy. The standard of review used by IPRA in determining whether or not the use of force was within policy in officer-involved shootings is controlled by the use of force policy in effect at the time of the event being evaluated because it is that standard that dictates policy for use of deadly force by police officers and it is by that standard that their conduct must therefore be evaluated. A use of deadly force policy based on the constitutional standard but which did not include additional factors limited the review and evaluation of police conduct to a certain aspect of a given incident relevant to the use of deadly force.

In our view, a use of force policy that would provide a more complete and thorough standard of review in OIS cases would: require a more comprehensive assessment of OIS incidents to include a review of not only the moment that the use of force is deployed but all of the steps leading up to that moment; involve a review of the underlying facts and the resulting analysis that is far more exacting and complex because a far greater range of factors involved in a given use of force would have to be investigated and analyzed; and result in an explanation for bottom-line determinations of OIS case reviews that is more detailed, including reference to key facts, than assessment of OIS incidents based solely on the constitutional standard. As noted above, in October 2016, CPD released a proposed revised use of deadly force policy. If adopted, the new policy would change the standard in that it specifically requires officers to apply force mitigation principles and to use the least amount of force required under the circumstances. We believe the proposed revised policy provides the basis for change in the standard of review in OIS cases as well and thus for positive change in the OIS review process. We also recommend that CPD consider some additional changes we have outlined in our below discussion of the proposed revised policy, relevant to the standard and parameters under which OIS investigators assess officer conduct, and

which we believe will enhance even further the ability for investigators to provide the basis for meaningful investigation and analysis of OIS cases.

The Scope of Review of Broader Officer Conduct

Our review found that IPRA investigators rarely assessed officer conduct regarding the use of force beyond the narrow moment in time that force is used. As a result, their analysis focused simply on whether that moment justified the use of force. IPRA has articulated a desire to engage in a more holistic review of the events surrounding the use of force, and the current administration has taken steps to do this. The following recommendations are suggested to further the goal of ensuring that officer conduct is not only broadly investigated and analyzed, but that the information learned in the investigation is used to provide opportunities to identify changes to CPD policy and training that can assist in reducing the need for situations involving use of deadly force going forward.

- Investigators should investigate police conduct beginning at the start of the events leading to the incident, not just at the moment of the use of force itself, and investigate that conduct in terms of tactics, judgment, and adherence to training.

- Investigators should receive training beyond the evaluation of the use of deadly force and must have a complete understanding of CPD training on tactics and judgment.

- There should also be a formal mechanism, such as a force review panel (which had been used in the past and was discontinued), to communicate the information from the OIS oversight investigation and analysis to CPD for training and policy purposes and in an effort to reduce situations where force becomes necessary.

2. Background and Training of OIS Investigators and Structure of Investigative Teams

OIS cases demand a higher level of expertise than other police misconduct cases. The ability to conduct these investigations competently stems, at least in part, from having the necessary shooting investigation experience. That experience combined with rigorous training can form the expertise needed for these cases. We have structured the below recommendations to provide our views regarding how to best approach the necessary qualifications and structuring of OIS investigation teams.

- OIS investigators should have experience in one or more of the following areas: homicide investigations, shooting investigations, internal affairs, prosecution, law enforcement, or prior investigative experience overall. Each OIS investigative team should include shooting investigation experience. The benefit of internal affairs experience as well should also be considered.

- Investigators in other areas of the organization who wish to become OIS investigators should have, in addition to any classroom training, on the job training and evaluation for a substantial period of time, including shadowing a significant

number of OIS cases from incident to close as well as assuming the lead role in some cases under close supervision and evaluation. While training and shadowing have been utilized by IPRA in the past as well as present, we encourage a continued critical look at these aspects of developing competent OIS investigators in order to ensure that they are as robust as possible.

- The OIS investigator who is on-scene at the time of the incident should remain on the investigation through its close as the lead investigator whenever possible (as is IPRA's current practice).

- Each OIS investigative team should have an assigned forensic specialist as well as an assigned attorney who remain part of that team throughout the investigation.

3. Conducting OIS Investigations

IPRA's review process reflected substantial deficiencies and the need for additional reform in how investigations are conducted. (The current IPRA administration has made us aware of numerous steps already being made during the time of our review towards instituting change in this area.) We offer the following recommendations in the following categories. More detailed recommendations for each category are set forth in Part V of this Final Report.

On-Scene Investigation

As an initial matter, although not in effect during the time of our closed OIS cases (a time during which CPD led the on-scene investigation in all OIS cases), the current dividing line in terms of which entity is able to lead the investigation under Illinois law is whether a subject is shot fatally or non-fatally.[6] The Illinois Police and Community Relations Improvement Act (PCRIA) effective as of January 1, 2016, as implemented through a CPD general order, requires that the OIS civilian oversight investigative agency now leads the OIS investigation in shooting cases that result in a fatality. The criminal investigation, if any, is conducted by CPD and is conducted concurrently with the OIS investigation. The public safety investigation is conducted by CPD and takes precedence over any other investigation.

Although not in effect during the time of the closed OIS cases we reviewed, we learned through interviews about the current OIS investigation process subsequent to the passage of the new statute. We question whether the division between non-fatal and fatal OIS cases is the most effective approach. All OIS cases, regardless of whether fatal or non-fatal, need to be investigated with the same degree of independence and integrity. (And as a practical matter, we note that an OIS case may initially be non-fatal only to become fatal at some point, leading to a change in the lead role in the middle of an on-scene investigation.) In light of those observations, we suggest that the ideal structure would be one where a civilian oversight agency with seasoned and trained investigators leads the on-scene investigation in all OIS cases, regardless of the question of fatality, while operating in coordination with and without infringing upon any criminal investigation which would in all instances be led by CPD. In our view, continued evaluation of the practical application of the statute as implemented through the CPD general order is warranted and the potential for

[6] Throughout this Final Report, and keeping with the nomenclature used in IPRA summary reports, we refer to a person who was shot as a subject.

revision of the CPD general order to provide that the civilian oversight entity take the lead in non-fatal cases as well should not be foreclosed. It is our understanding that IPRA has proposed revisions to the governing directives to enhance the independence with which they conduct their on-scene investigative efforts.

Regardless of which entity leads the on-scene investigation, it is critical that every effort is made to conduct a thorough and complete investigation and collect, document, and otherwise capture all potentially relevant evidence that includes, but is not limited to, creation of contextual aids such as diagrams and measurements, the collection of biological material and physical evidence that can be analyzed, the recovery of involved weapons, the processing of vehicles used in incidents, and taking steps to identify and interview any and all potential witnesses.

Forensic Evidence

Investigators must ensure that evidence collected from the scene be analyzed, including: biological evidence, recovered and involved firearms (*e.g.*, ballistics testing, ATF firearms trace, fingerprint and DNA testing), presence of gunshot residue on a subject's body or clothing, and the analysis of any object mistaken for a weapon.

Medical Evidence

Investigators should conduct thorough interviews of any relevant medical examiners or medical personnel. They should further request trajectory rod analysis on deceased subjects.

OEMC Information

Procedures should be established to ensure that OEMC provides all information relevant to shooting incidents. Investigators should request and analyze all such information.

Obtaining Additional Information

Investigators should actively seek to obtain and utilize relevant information from other sources, including, for example, civil suits or criminal cases related to the incident; media footage and reports; and CPD contact cards for subjects, which may reflect prior contact with involved officers. In addition, investigators should obtain and review CPD files relevant to involved officers, including complaint register (CR) histories and files pertaining to each complaint, as well as training and firearms qualifications records.

Efforts to Identify, Locate, and Interview Witnesses

Investigators must make all reasonable efforts to identify, locate, and thoroughly interview witnesses, and broadly speaking, should: conduct a sufficient number of canvasses to identify all witnesses; keep detailed canvass logs that detail contacts and results; interview local businesses to obtain videos, if any; locate and interview all individuals identified through CPD reports, 911 calls, ATF tracing, or other sources; use subpoenas to obtain information and compel statements from uncooperative witnesses; and consider other methods for locating and contacting witnesses.

Conducting Interviews

Investigators should follow the guidelines we set forth for the conducting of thorough and probing interviews that: maximize the provision of relevant information; follow up on key points and details; and raise and confront inconsistencies from prior statements and contradictions posed by other evidence.

Additionally, interviews should be conducted in person unless impossible and with two interviewers (which is particularly critical if the interview is not recorded). Investigators should use aids to clarify or challenge statements. Recording devices should be used unless prohibited by the witness to capture all dialogue. They should not be turned on and off (as has been recently mandated under new policy). Transcripts should be complete and accurate. Investigators should also conduct follow-up based on information gained during interviews.

Thorough and prompt interviews should be conducted of all civilian witnesses. Investigators should follow up as necessary to secure complete interviews and should ask detailed questions not only about what the witness saw but about his or her position and ability to perceive the events.

Investigators should interview all officers who were present on-scene, including those not directly involved, as soon as possible. They should use a uniform checklist of standard topics to cover in all officer interviews. Investigators should consider requesting a non-compelled interview where concerns exist regarding the potential for criminal prosecution or the creation of potential *Garrity* issues that would otherwise delay the interview from occurring.[7]

4. Analysis of OIS Cases

Analysis conducted in the historical closed OIS cases we reviewed was woefully inadequate or not properly documented. The summary reports amount to a recitation of evidence obtained without any recognition for how that evidence fits together or its significance. (The current IPRA administration has made us aware of numerous steps already being made during the time of our review towards instituting change in this area.) We offer the following recommendations for improved case analysis. More detailed recommendations for each category are set forth in Part V.

Investigators should have a uniform template that they can follow with specific instructions as to what is to be included in each section and that sets forth specific examples demonstrating the level of detail and types of details to be included.

The fact section should: include a detailed recitation of all evidence developed during the investigation (specifying the source of the evidence and the specifics of it); summarize all interviews and review all key aspects including quotes where appropriate; and discuss evidence that was not able to be obtained or known with precision.

The analysis section should: approach officers' statements as one piece of evidence among many; identify key disputed issues; consider and compare how each piece of evidence fits together or contradicts and how that bears on the disputed issues to be resolved; assess witness and involved

[7] Per *Garrity v. New Jersey*, 385 U.S. 493 (1967), an officer's compelled statement cannot be used against him or her in a criminal case.

officer credibility; and consider what cannot be known. It should also discuss officers' complaint histories and analyze any pattern or absence of pattern of misconduct, within the confines of what is permitted in the Collective Bargaining Agreement (CBA) entered into between the City of Chicago and the Fraternal Order of Police (FOP).

Moreover, the analysis section should set forth a rigorous legal analysis using a preponderance of the evidence standard of each separate use of force as its own incident and should do so under each potentially applicable prong of the applicable use of force policy. The analysis should precisely identify what factors are being considered in looking at the "totality of the circumstances" in determining whether use of force is within policy and should identify the pieces of evidence taken into consideration with respect to each.

In the analysis, investigators should include an explanation as to support for the ultimate determination that a use of force was either within or outside of policy and also include discussion of any credible evidence that may reasonably be viewed as not supporting that determination and why it is not controlling in the analysis.

Finally, investigators should analyze officers' broader conduct in terms of tactics, judgment, and adherence to training.

5. Supervision and Case Management of OIS Cases

There has been a lack of effective supervision and case management, although the current IPRA administration has made us aware of numerous steps that have been made during the time of our review towards instituting change in this area as well as plans that will continue to advance those goals. We offer the following recommendations for improved supervision and case management. More detailed recommendations for each category are set forth in Part V.

Supervision

Supervision needs to be a meaningful and robust part of the OIS review process, both in policy and in practice, and should include the following.

- Hold case review meetings at the outset of the investigation to review evidence and develop the investigative plan. We understand the current administration has established protocols by which case review meetings are held as part of the investigative process at the outset of and throughout an OIS investigation.

- Hold case review meetings involving supervisors up to and including the Chief Administrator prior to closing any case. We understand the current administration has established protocols by which case review meetings are held as part of the review process at the conclusion of an OIS investigation.

- The immediate supervisor should have weekly meetings with each assigned investigator to review evidence in detail and monitor progress.

- Assigned attorneys should be an integral part of the investigative team and should play a role in the content and drafting of the summary report along with the

investigator, including drafting the legal analysis section. We understand the current administration has established protocols by which an attorney is assigned to each case.

- The immediate supervisor summary report review process should include a memo drafted by the supervisor setting forth the details of the review, including: (1) an assessment of the investigative steps taken, including any follow-up steps needed; (2) an assessment of the analysis and follow-up questions regarding that analysis; and (3) an assessment of any unforeseen delays in the case.

- Chain of review in all OIS cases should include review above the immediate supervisor up the review chain and to the Chief Administrator. Comments at each stage of the review should be documented by each reviewer. We understand the current administration has instituted a chain of review that follows this protocol.

Case Management

Better case management should help reduce the length of time historically taken in OIS investigations and should include the following. We understand the current administration has taken steps to improve timeliness and has plans for additional changes for further improvements to meet that objective.

- Institute a formal system to track each step of the investigative process for each OIS investigation and have mechanisms in place that will monitor progress. This should document the timing and reason for any delays. Protocols should also be established to document and address delays caused by third parties (*e.g.*, CPD, SAO, and ISP) as well as internal and external issues pertaining to investigators that cause delays. The timing of summary report drafting and review should be documented as well.

- Supervisors should be required to report monthly on investigation timeliness. Investigators should have a deadline by which to submit a summary report for review following their final investigative step.

- Institute policies on case file documentation and retention, including requiring a complete, thorough, and typed case log to be kept in every case that documents each and every step during the investigation with dates and reference to specific reports if applicable. Policies should also require all material generated to be kept in a well-organized manner. Quality control should be ensured by a checklist for all investigative materials, and investigators should be expected to review material from CPD or other sources as cross-checks to determine if all relevant materials have in fact been obtained.

- Institute a formal system for regularly keeping the subject, or if the subject is deceased then family members of the subject, apprised of the investigation's progress and track the dates, manner, and substance of notifications.

6. Interaction with Other Entities Involved In Conducting OIS Investigations

There have been challenges with the interactions between IPRA and other entities involved in the process of OIS investigations. The current IPRA administration has made us aware of the fact that it has had ongoing communications with these entities aimed towards future improvements. We offer the following recommendations for increased effectiveness in the interactions with the other entities relevant to the process. More detailed recommendations for each category are set forth in Part V.

Interaction with CPD

In order to achieve the highest level of coordination and cooperation with CPD, we make the following recommendations.

- Establish a process for effective communication between investigators handling OIS cases, detectives assigned to investigate crimes related to OIS cases, and the CPD on-scene incident commanders (OCIC or Street Deputies) in order to (1) work out challenges that have arisen on-scene; and (2) provide a forum to include all involved to achieve a level of mutual respect and cooperation that will enhance the effectiveness of on-scene investigations without in any way compromising the independence of OIS investigators.

- Establish a process for an initial meeting to take place as close in time to the incident as possible with all assigned CPD detective personnel, as well as the OCIC, at which CPD will identify all witnesses to whom they have spoken, video obtained and status of obtaining additional video, forensic evidence and testing that will be requested, and any other steps conducted by CPD to ensure the investigator is aware of all information as soon as possible.

- Establish a protocol by which investigators have an understanding regarding all documents created by CPD (not just documents visible in Citizen Law Enforcement Analysis and Reporting or CLEAR), a process by which investigators have complete access to all such materials, and a method for resolving any disputes regarding investigator access to documents or the timeliness of their provision.

- Establish a Memorandum of Understanding (MOU) with CPD requiring that the CPD detective case supplementary report be completed and provided to investigators within 30 days of the incident (providing for more time if there are extenuating circumstances).

- Establish a process by which investigators obtain information including involved officers' CR histories (and related files), as well as training and firearms qualification records.

- Establish a process by which investigators obtain CPD contact cards for subjects.

- Document all interactions with CPD in an investigation to include meetings, phone calls, requests for items, and receipt of items.

Interaction with SAO

In order to achieve the highest level of coordination and cooperation with SAO we recommend: establishing an MOU with SAO detailing the role the civilian oversight agency plays in OIS cases, creating a process by which the investigator has an understanding of all materials created by SAO in the file and a protocol by which all are provided to the investigator (within legal boundaries); documenting all interactions with SAO; and establishing a policy that the timing of a SAO decision regarding a declination will not impact or delay resolution of the administrative process (which will bolster and add to the newly implemented policy that while IPRA may temporarily delay its finding in its administrative case prior to the conclusion of a federal or state criminal investigation, IPRA may also proceed with its administrative action even while the criminal investigation is underway). We likewise recommend establishing protocols to be followed in the instance that there is an underlying criminal case that is charged in another county for interaction with that county.

Interaction with ISP

We are mindful of the fact that there are at times delays in obtaining forensic testing results, that there may be no viable alternatives to having ISP conduct the forensic testing for OIS cases, and that ISP's resource constraints may impact the timing of when such results are provided. We also recognize that current law mandates that only law enforcement entities may refer items to ISP for forensic testing. Finally, we understand that the current administration is in the process of working on a MOU with ISP, and we agree with that approach. We also recommend establishing agreements concerning communication with ISP and timing of the providing of results.

Interaction with the DOL

We understand that the current administration has worked out an agreement with the City of Chicago Department of Law (DOL) by which IPRA will subpoena DOL for relevant non-privileged materials generated in any related civil case, and if IPRA has requests for any subsequently received materials, IPRA will issue subsequent subpoenas. DOL will cooperate and comply fully with subpoenas from IPRA for such information. We agree with this practice and also recommend that additionally the administration: establish protocols with DOL for appropriate communication regarding ongoing civil suits to ensure that the above agreement is adhered to and set regular points at which investigators are required to communicate with DOL attorneys to check on the status of the creation of any new materials documenting their contacts.

Interaction with FOP

We recognize that the parameters guiding the interviews of officers are governed by the CBA entered into between the City of Chicago and FOP. It is beyond the scope of this review to thoroughly analyze and assess the impact of the CBA on the process. But FOP involvement does impact OIS investigations. We recommend ongoing evaluation of the impact of union rules and

procedures and of the FOP contract with the City of Chicago on the civilian oversight process (which we understand the current administration is doing).

PART I – REVIEW METHODOLOGY

This part of the Final Report sets forth the methodology we used to obtain information during our review used to form the basis for our findings and recommendations.

I. INFORMATION GATHERED

A. Documents Obtained

At the outset of our review, we obtained publicly available documents relevant to IPRA and OIS cases, including relevant Illinois statutes, Chicago ordinances, CPD general and special orders, the collective bargaining agreements and arbitration awards between Chicago and FOP and the Policemen's Benevolent & Protective Association, and IPRA's own annual and quarterly reports. We also obtained from IPRA additional documents including documents comprising IPRA policies at various points in time, IPRA budget presentations, documents showing investigator caseloads, and documentation regarding shooting specialist training and experience. These documents helped to provide a basis for foundational information for our investigation.

B. Interviews

As part of our investigation into IPRA functioning, we believed it critical to conduct a number of interviews to understand how IPRA operates and is perceived on a functional level by both its employees and those in other organizations who frequently dealt with IPRA regarding OIS investigations. These interviews helped provide both background and a basis for understanding the IPRA OIS investigation process, as well as challenges IPRA has faced. (Our initial mandate contemplated five interviews. Later in our investigation, it became clear that additional interviews would be useful, and we conducted a total of 16 interviews.)

IPRA interviewees were those identified by IPRA senior management as involved in one or more aspects of OIS investigations whom it would be useful to interview. We also interviewed current Chief Administrator Sharon Fairley. The two prior Chief Administrators declined to be interviewed. We also sought and obtained interviews with individuals at CPD and SAO who had been identified as the individuals most relevant to the OIS process. The current FOP president declined to be interviewed.

C. Research Conducted

We conducted research focused on analyzing the context in which IPRA operates by examining publicly available documents from IPRA, the City of Chicago, CPD, and state statutory sources. In addition, we researched case law to confirm the applicable federal and state law standards for officer use of deadly force.

We also engaged in a review of the use of deadly force policies adopted by the police departments of other major U.S. cities, and we reviewed the practices of selected police agencies that had seemingly successful OIS procedures. This comparative analysis facilitated the identification of differences between CPD policies and those of other metropolitan areas in order to assist us in making recommendations regarding CPD's use of deadly force policy requested as part of our project mandate.

II. INITIAL REVIEW AND SELECTION OF CASES

For our historical in-depth OIS case audit, we used certain criteria to identify cases for review. First, we conducted an initial review of the summary reports for all OIS cases where an individual was hit by a bullet to identify certain criteria whose presence might indicate cases raising particular concern or value for review. Second, we identified OIS cases in which the City of Chicago subsequently paid out a significant settlement or judgment in a civil suit arising from the shooting. Third, we selected certain other cases whose circumstances indicated that review would be valuable.

A. Criteria Review

To identify cases for potential in-depth review, we reviewed the summary reports from all closed OIS cases where at least one individual was hit that took place during IPRA's existence to identify the presence of certain specified criteria.

1. Identification of summary reports

We reviewed all summary reports from OIS cases closed by IPRA as of May 9, 2016 (the date on which they were searched for purposes of this review) where an individual was hit from September 1, 2007, the date on which IPRA replaced its predecessor the Office of Professional Standards (OPS), to December 31, 2015, using the date that IPRA was notified of the shooting.[8] At the time of the commencement of our review, there were no closed OIS investigations for incidents dating after December 31, 2015 and thus all of the cases from which we conducted our review predated the current IPRA administration.

IPRA provided summary reports for our review. Reports were initially provided by referencing the list of reports on IPRA's website, with additional cross-checking through a search of CPD's CLEAR databases. The CLEAR search criterion used the September 1, 2007 to December 31, 2015 date range and was restricted to closed cases. Cases were identified as OIS through a criterion that the investigator and supervisor had contemporaneously designated the case as OIS. IPRA indicated that this criterion was considered more reliable than the category codes that IPRA also tracks. These cases were then cross-checked by IPRA with preliminary results from a City of Chicago Office of Inspector General audit into the completeness and accuracy of IPRA reporting on weapon discharges, which had been shared with IPRA.

We excluded self-inflicted wounds,[9] whether accidental or intentional and cases resolved through mediation. (It is our understanding from IPRA that mediation does not occur in OIS cases where others are hit. In addition, mediated cases would potentially lack sufficiently developed summary reports to be reviewed.) In total, the review of criteria examined the summary reports from 286 IPRA investigations.[10]

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[8] OIS cases that we had previously determined would be included in the in-depth case review were excluded from the review for presence of criteria.

[9] During the review, one case included in the review was discovered to involve a self-inflicted wound and was thereby no longer considered.

[10] In reports, the *Chicago Tribune* has described its review of documents in OIS cases, stating that it has reviewed various numbers of cases including 235 and 435. The *Tribune's* number of cases is not directly comparable to our

2. Selection of criteria

We selected review criteria in consultation with IPRA. The goal was to identify particular fact patterns that raised potentially challenging issues. An additional goal was that the criteria be objective and capable of uniform application, not dependent on subjective evaluation of the circumstances of each case.

We selected eleven criteria to utilize in the review:

- **Unintended Hit** – The officer hit an individual different from the intended target of the shot, regardless of whether the officer also hit the intended target.

- **Secondary Use of Force After Intervening Event** – There was an initial use of force by an officer, followed by a non-force event such as a car or foot chase, and then another use of force by the officer.

- **No Weapon Recovered** – No weapon was found at the scene, regardless of whether any officer or other witness stated that the subject had a weapon.

- **Mistaken Weapon** – The officer stated that he or she mistook another object such as a cellphone or wallet for a weapon.

- **Non-Firearm Weapon** – The only weapon that the subject allegedly had or the only weapon recovered from the scene was something other than a gun, such as a knife or bat.

- **Fleeing Felon Justification** – The officer or IPRA investigator specifically justified the shooting not on the basis of a need to prevent harm to the officer or another, but instead solely as necessary to prevent the subject from fleeing.

- **Continued Shooting After Subject Disabled** – One or more officers continued shooting after the threat of harm from the subject had ceased, *e.g.*, if the subject was on the ground and no longer holding a weapon.

- **Off-Duty Officer** – The involved officer was off-duty.

- **Fatality** – The subject or another individual was fatally injured.

- **Mental Health Issues** – There is an affirmative statement in the report that the subject suffered from some sort of mental health issue.

review. Although the *Tribune's* selection criteria is unclear, it differs from our review in including cases in which no one was hit, uses a shorter period of time, and includes at least some cases in which IPRA has not closed its investigation. *E.g.*, Jeff Coen & Jennifer Smith Richards, *In 14 cases, no gun is found after Chicago police shot someone they said was armed*, CHICAGO TRIBUNE (Sept. 14, 2016); Jennifer Smith Richards et al., *92 deaths, 2,623 bullets: Tracking every Chicago police shooting over 6 years*, CHICAGO TRIBUNE (Aug. 26, 2016).

- **Influence of Drugs/Alcohol** – There is a fact in the report that indicates the subject was under the influence of drugs and/or alcohol.

3. Results

Each criterion was identified in the following number of cases:

Category	***Results***
Unintended Hit	20
Secondary Use of Force After Intervening Event	31
No Weapon Recovered	38
Mistaken Weapon	24
Non-Firearm Weapon	56
Fleeing Felon Justification	0
Continued Shooting After Subject Disabled	3
Off-Duty Officer	41
Fatality	107
Mental Health Issues	15
Influence of Drugs/Alcohol	63

After further consideration, including of the high prevalence of the criterion, the Influence of Drugs/Alcohol criterion was not used in further analysis. We analyzed the remaining criteria and identified the most relevant criteria as (1) Continued Shooting After Subject Disabled, (2) No Weapon Recovered, and (3) Mistaken Weapon, as they raised the most significant questions to be addressed by IPRA investigators. They were used as the starting point for the subsequent case selection process.

B. Civil Payments

In addition to the criteria review, we separately identified OIS cases where the shooting resulted in a civil suit and the City of Chicago eventually settled the suit or had a judgment entered against it.

Cases were identified using an analysis that had been conducted from information from DOL tracking all civil cases filed against CPD from January 1, 2009 to October 16, 2015, against information from IPRA regarding cases where there had been an IPRA investigation. We used these results along with the list of all IPRA OIS cases, discussed above, to identify those OIS cases in which a judgment or settlement was made by Chicago.

From this process, we identified a total of 21 OIS cases investigated by IPRA in which there was a civil settlement or judgment against Chicago. One of those IPRA investigations found the shooting violated policy; the other 20 found the shooting within policy. Seven cases (including the policy violation case) had payouts in excess of $1 million, and an additional six had payouts of $99,000 or more.

The six cases that IPRA found within policy and that later had civil payouts of $1 million or more were all cases involving a fatality. We believed that fatal cases generally raised more challenging

issues than non-fatal cases. However, we also decided to select certain non-fatal cases involving civil payouts because the types of evidence available for each differ in ways significant to an evaluation of IPRA's complete investigative process. In particular, a non-fatal case provided IPRA with the potential opportunity to interview the subject.

C. Other Cases

In addition to the criteria review and analysis of civil suit payments, we additionally identified certain other unusual cases whose circumstances indicated they would be useful additions to review. We included cases identified for us as ones in which there had been a disagreement between the initial investigator and IPRA management as well as a case of which we were aware from media reports involving certain factual disputes.

D. Identification Of Cases For In-Depth Review

Using all three channels of case identification, we developed a group of 20 OIS cases (the number permitted by our project mandate) in which IPRA had not found a policy violation for in-depth review. The selection filters were:

- Cases involving high settlements or judgments including a combination of fatal and non-fatal cases (8)
- The other noted cases discussed above (3)
- All cases identified as having the Fatal criterion and the Continued Shooting After Shooting Disabled criterion (2)
- All cases identified as having the Fatal criterion with the No Weapon Recovered criterion and at least one other criterion that was not Mistaken Weapon or Influence of Drugs and Alcohol (3 within policy cases, not counting cases already included)
- All cases identified as having the Fatal criterion with the Mistaken Weapon criterion and at least one other criterion that was not No Weapon Recovered or Influence of Drugs and Alcohol (4, not counting cases already included)

Subsequent to our selection of the cases for review, IPRA reopened a case that we had selected. In order to keep our focus on the sufficiency of investigations of cases that IPRA had deemed closed, we determined not to review this case. Instead, we identified an additional case through the use of the following filter:

- All cases identified as having the Fatal criterion with the Secondary Use of Force criterion and at least one other criterion that was not Influence of Drugs and Alcohol. (1, not counting cases already included).

The final set of 20 cases comprised 15 fatal and 5 non-fatal cases. All of the criteria identified for our review were represented, in the number set out below:

Criterion	*Results*
Unintended Hit	2
Secondary Use of Force After Intervening Event	6
No Weapon Recovered	5
Mistaken Weapon	6
Non-Firearm Weapon	5
Continued Shooting After Subject Disabled	2
Off-Duty Officer	4
Mental Health Issues	2
Influence of Drugs or Alcohol	6

The 20 cases selected occurred, as shown in the below table, across 7 years from 2007 to 2014. The cases were resolved between 2011 and 2015.

Year	*Year of Shooting*	*Year Case Concluded*
2007	1	
2008	2	
2009	6	
2010	3	
2011	3	2
2012	2	1
2013	1	6
2014	2	7
2015		4

PART II – RELEVANT BACKGROUND INFORMATION

This second part of this Final Report provides a summary of certain of the background information relevant to our review, including a discussion of IPRA's formation, structure, and history, and a review of IPRA's relevant policies and procedures.

I. IPRA'S FORMATION, STRUCTURE, AND HISTORY

A review of IPRA's formation, reform efforts, and challenges provides context for assessing the quality of IPRA's investigative process. To make recommendations likely to result in effective change, it is helpful to understand as background what has impeded IPRA's reforms in the past. We document in this report numerous deficiencies with IPRA's historical internal investigative process. But as discussed in this section, external realities have impeded IPRA's ability to hire and retain a sufficient number of qualified investigators who can timely conduct thorough investigations. The information reported herein is taken from IPRA's own documents, reports, and other publicly available sources.

It is evident to us from this information and other aspects of our review that in addition to its internal challenges, IPRA faced external obstacles and impediments to meeting its responsibilities and objectives. Such external factors affecting IPRA performance need to be considered in assessing that which is needed to improve that performance so as to fulfill IPRA's given mandates and responsibilities for review of OIS cases.

A. Creation, Jurisdiction, And Mission

The City Council created IPRA by ordinance in 2007 to replace OPS, a CPD unit tasked with investigating police misconduct allegations, which had come under intense criticism following the public release of video capturing incidents of misconduct. IPRA is an agency of the City of Chicago, separate from CPD, that receives all allegations of CPD member misconduct and that directly investigates excessive force, domestic violence, bias-based verbal abuse, coercion, and certain other allegations.[11]

IPRA's mandate includes investigating all incidents where a person has died or sustained serious bodily injury while in police custody. Its jurisdiction also includes making findings and recommending disciplinary and non-disciplinary actions pursuant to its investigative findings. IPRA refers misconduct complaints outside its scope of review to CPD's Bureau of Internal Affairs (BIA).[12] IPRA is also empowered by ordinance to "make recommendations to the superintendent, the police board, and the chairman of the city council committee on public safety concerning revisions in policy and operating procedures to increase the efficiency of the department."[13]

[11] IPRA Rules § 1.2 (Mission); *see* MCC § 2-57-40 (Chief Administrator – Powers and duties).
[12] *Id.*
[13] MCC § 2-57-40(i); *see* IPRA Rules § 1.4 (Jurisdiction) ("IPRA is also authorized to make recommendations to the Superintendent regarding the policies, procedures, and programs of the department.").

B. Organization

The Chief Administrator serves as IPRA's chief executive officer.[14] The Mayor, subject to City Council approval, appoints the Chief Administrator for a term of four years or until a replacement is appointed and approved[15]. IPRA has been led by Ilana Rosenzweig (2007–2013), Scott Ando (2013–2015), and current Chief Administrator Sharon Fairley, who was appointed by Mayor Emanuel on December 6, 2015.

IPRA's present staff includes a Chief of Staff, several additional deputy chief administrators, a legal department headed by a General Counsel, a Public Information Officer, a Director of Community Outreach & Engagement, and several teams of investigators, each of whom has a supervisor.[16] "Shooting specialists" are investigators who conduct OIS investigations and are assigned to any one of the several investigator teams. There is no team comprising solely shooting specialists, and specialists carry a caseload of non-OIS cases as well.

C. IPRA's Reform Efforts And Progress Faced Numerous Setbacks

IPRA was born from and into controversy. OPS had been roundly criticized for its alleged failure to recommend disciplinary action against officers, its lack of independence from CPD, and the quality of its investigative process. Since its inception, IPRA has taken steps to address these issues. But budgetary and resource issues inhibited progress, leading IPRA to struggle with staffing issues and large caseloads.

IPRA's backlog of open investigations has long been an issue. In its first two years, IPRA actively worked to reduce it by outsourcing cases to outside attorneys and private investigators, and by hiring new investigators and supervisors.[17] By October 2009, IPRA had closed 2,600 cases in the past year and filled all but one of its investigator vacancies.[18]

IPRA soon, however, faced the same issues as other City agencies in the wake of the financial crisis. Budget-related staffing issues led to increasing caseloads. IPRA's 2009-2010 Annual Report explained that "the results of this shortage of investigators has [sic] been significant," as "IPRA's caseload has grown from 1981 to 2168."[19] Staffing, caseload, and timeliness issues persisted into 2011 and 2012 as well. As IPRA's 2010-2012 Annual Report explained, it had "not operated at full level of personnel in more than two years due to illness and attrition," that it had "vacancies at every level of operations," including multiple investigator vacancies, and that these "resource issues have had a concrete impact on IPRA operations."[20]

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[14] MCC § 2-57-030 (Chief Administrator – Appointment as chief administrative authority).
[15] *Id.*
[16] IPRA's organization has changed over time and has continued to change during the period of our investigation. This description of IPRA's organization represents a summary of information, taken largely from our interviews of IPRA personnel and IPRA historical policies, laying out the general organization of IPRA. Given the historical nature of our review, the description primarily describes the organization of IPRA prior to 2016.
[17] David Heinzmann and Steve Mills, *Cop-case backlog too much; outside help sought*, CHICAGO TRIBUNE (Jan. 16, 2008).
[18] IPRA, Annual Report 2008-2009, at 2, 29.
[19] IPRA, Annual Report 2009-2010, at 10.
[20] IPRA, Annual Report 2010-2012, at 6.

In 2013, Chief Administrator Rosenzweig resigned and Scott Ando became Chief Administrator. During the following two years, IPRA's reports reflected continuing problems with staff vacancies.[21] Despite persistent staff shortages, however, IPRA's caseload fell significantly quarter-over-quarter during the same time period.[22] The declining caseload trend continued in 2015, which was likely aided by additional hires and fewer new investigations, including an all-time low in the number of officer-involved shootings.[23]

On October 20, 2014, CPD officer Jason Van Dyke fired sixteen shots at teenager Laquan McDonald, killing him. When the City released video of the incident more than a year later, it was met with substantial public outcry and demands for widespread reform.

IPRA responded to widespread criticism through new management and reforms. Although our review of closed OIS cases is retrospective in nature, we nonetheless briefly summarize IPRA's recent efforts to remediate historical issues because some of these efforts bear on our findings and recommendations.[24]

Since Mayor Emanuel appointed Sharon Fairley as IPRA's new Chief Administrator on December 6, 2015, IPRA has hired new staff (such as a new General Counsel, a First Deputy Chief of Investigations, legal staff, and a policy and legal affairs analyst); enacted new rules, regulations, and quality control measures related to investigative processes; implemented a new transparency policy mandating the public release of recordings and reports; created a new training curriculum; and engaged in other reform efforts.[25] IPRA also recommended changes to CPD's Deadly Force policy, as discussed below in Part III.[26]

These changes, however, have affected the closing of open investigations. As IPRA's 2016 quarterly reports confirm, the implementation of new policies and procedures, as well as staff attrition in the wake of the City's announcement that it would replace IPRA with a new agency, have contributed to declines in IPRA's quarterly case closure rates.[27]

Although IPRA's caseload has increased while investigators adjusted to reforms and underwent additional training, the agency closed more cases with a finding of a non-justified shooting in 2016 than in the prior eight years of its existence. In June, IPRA announced that it concluded that an officer violated CPD policy in a 2011 shooting.[28] More recently, IPRA found three additional shootings, involving four officers in total, to violate policy. In total, in 2016 IPRA closed seventeen OIS cases, finding policy violations by five officers involved in four separate

[21] *See generally* IPRA Quarterly Reports 2013-2015.
[22] IPRA Quarterly Report, October 1, 2014 – December 31, 2014, at 4.
[23] *See generally* IPRA Quarterly Reports, 2015.
[24] We address certain reforms more specifically where appropriate within our discussion of findings and recommendations below.
[25] *See generally* IPRA, Quarterly Report January 1, 2016 – March 30, 2016 (published Apr. 15, 2016), at 3; Second Quarter Report, April 1, 2016 – June 30, 2016 (published July 14, 2016), at 6-8.
[26] IPRA, Second Quarter Report, April 1, 2016 – June 30, 2016 (published July 14, 2016), at 20-25.
[27] IPRA, Quarterly Report January 1, 2016 – March 30, 2016 (published Apr. 15, 2016), at 3; Second Quarter Report, April 1, 2016 – June 30, 2016 (published July 14, 2016), at 6–8; Third Quarter Report, July 1, 2016 – September 30, 2016 (published October 14, 2016), at 8–13.
[28] Dan Hinkel, *Chicago cop faulted for fatal shooting – 10 months after he resigned*, CHICAGO TRIBUNE (June 10, 2016).

shootings.[29] The involved officer in one of those cases has been indicted on federal civil rights charges.[30] Although assessment of current cases is not a focus of our investigation, recent publicly available summary reports show more detailed consideration of the facts and analysis, particularly when compared to the findings of the historical review discussed below.

D. Civilian Office Of Police Accountability

In May 2016, Mayor Emanuel announced a plan to replace IPRA with a new civilian agency to be afforded greater independence and resources.[31] After hearings and public discussion, the Mayor's plan to create the Civilian Office of Police Accountability was set out in a draft ordinance on August 30, 2016.[32] On October 5, 2016, the Chicago City Council approved the new ordinance.[33] Under the terms of the ordinance, COPA must be implemented by January 1, 2017, and IPRA's empowering ordinance will be repealed as soon as COPA is able to take up IPRA's responsibilities.[34] COPA will similarly investigate OIS cases as well as other complaints, but has broader investigative jurisdiction than IPRA.[35] COPA similarly has greater ability to recommend revisions to CPD policies and conduct pattern and practice investigations.[36]

II. IPRA POLICIES, PROCEDURES, AND PRACTICES RELATED TO OIS INVESTIGATIONS

IPRA's policies and procedures related to OIS investigations should serve as the framework for the quality of its investigations, findings, and ultimate recommendations. A basic understanding of what IPRA policies and procedures have existed in the past and what policies exist today is important to understanding how the policies and procedures have affected IPRA's OIS investigations over time and what policy revisions are needed moving forward.

Historically, based upon interviews of IPRA personnel and what we could ascertain from the documents made available to us by IPRA, it appears that IPRA relied on the OPS Standard Operating Procedure Manual for many years while creating or revising policies informally and *ad hoc*. From the documents made available to us, we observe that there was a formal IPRA Standard Operating Procedure Manual (SOP) as of at least January 1, 2015. In addition to the SOP, there are numerous loose documents that appear to memorialize policies *ad hoc* in 2015 and early 2016.

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[29] Illinois statute requires that IPRA's determinations in OIS cases be made public if criminal charges are not filed against the officer. 50 ILCS 727/1-10(e). IPRA's newly adopted rules require publishing of redacted summary reports within 30 days of closing a case. Given this, it is possible that IPRA has closed additional cases that are not yet publicly available.

[30] Jeremy Gorner & Dan Hinkel, *Chicago cop indicted in 2013 shooting captured on video*, CHICAGO TRIBUNE (Sept. 16, 2016).

[31] Editorial, Mayor Rahm Emanuel, *Our next steps on road to police reform*, CHICAGO SUN-TIMES (May 13, 2016).

[32] *See* Press Release, Office of the Mayor, City of Chicago, *Mayor Emanuel Statement on Police Accountability Ordinance* (Aug. 30, 2016); Office of the Mayor, City of Chicago, *Fact Sheet on the Police Accountability Ordinance* (Aug. 30, 2016), available at: http://www.cityofchicago.org/content/dam/city/depts/mayor/Press%20Room/Press%20Releases/2016/August/8.30.16PoliceAccountabilityOrdinanceFactSheet.pdf.

[33] John Byrne & Hal Dardick, *Police reform advances; But Emanuel faces rough course carrying out changes to oversight*, CHICAGO TRIBUNE (October 6, 2016).

[34] An Ordinance in Relation to Police Oversight §§ 2, 9 (October 5, 2016).

[35] Ordinance § 2-78-120(c), (f) (Office and Chief Administrator – Power and Duties).

[36] Ordinance §2-78-120(m), (n) (Office and Chief Administrator – Power and Duties).

Anecdotally, it is clear that IPRA policies were not widely disseminated to or known among IPRA personnel historically, and among those who did receive the policies, it was understood that many of them were outdated and wholly inapplicable. For the first time, as of June 28, 2016, IPRA released a set of policies and procedures (the Rules) that are accessible not only by IPRA personnel but also by the public.[37]

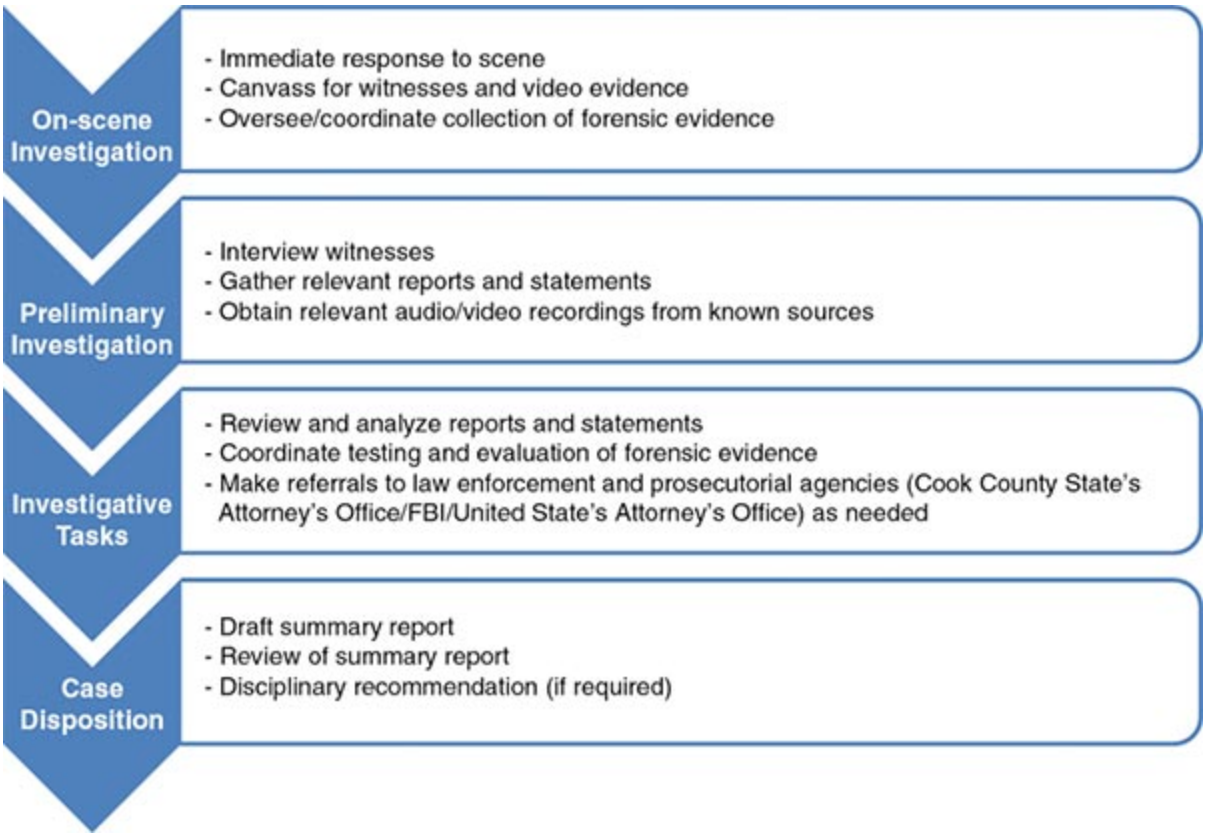
A. IPRA Case Intake

IPRA receives notification of firearm discharges (as well as certain other incidents) from CPD.[38] By Chicago ordinance, IPRA investigates all police shootings without need for any complainant or sworn affidavit.[39] IPRA accordingly does not require an affidavit, but automatically responds to OIS cases.[40] Historical IPRA policies as of January 1, 2015 classified all OIS cases as "U#" cases. U# cases could later be converted and assigned CR designation if an allegation of misconduct was made. Officers involved in OIS cases would not be classified as "Accused" unless the case had been converted to a CR. Anecdotally, from our interviews of IPRA personnel, we understand that such an allegation of misconduct can include a formal complaint or a witness statement that can be construed as a complaint. For example, a witness statement contradicting an officer's statement could be grounds for converting the case to a CR. An IPRA finding that the shooting was not within CPD policy would also result in conversion to a CR case.

B. IPRA's Investigation – Process For OIS Investigations

For officer-involved shootings, IPRA's current investigative process is set forth as follows:[41]

[37] Notably, only those policies and procedures that are most relevant to OIS investigations are discussed in this section. For example, because OIS cases are unlikely to be mediated, a discussion of the policies related to mediation is not included.
[38] IPRA, *Investigative Process, Step 1: Intake & Classification Process*, available at: http://www.iprachicago.org/investigative-process/.
[39] MCC § 2-57-040(c) (Chief administrator – powers and duties).
[40] IPRA, Investigative Process, *Step 2: IPRA Investigative Process*, available at: http://www.iprachicago.org/investigative-process/
[41] IPRA, Investigative Process, *Step 2: IPRA Investigative Process*, available at: http://www.iprachicago.org/investigative-process/



C. Initial Response To And Preservation Of The OIS Scene

Historically, there was an absence of policies and procedures addressing the specifics of IPRA's initial response to and preservation of an OIS scene. The historical policies only generally required IPRA to protect the integrity of the crime scene and identify evidence that it found pertinent to its investigation.

Currently, IPRA personnel immediately respond to the scene of any officer-involved death incident and routinely respond immediately to officer-involved shooting scenes where a non-Department member has been injured.[42] Per current Rules, IPRA's response team typically includes a Deputy Chief Administrator, a Supervising Investigator, two IPRA "shooting specialists," and two additional investigators.[43] In addition, current Chief Administrator Sharon Fairley has responded to most of the OIS scenes during her tenure.

OIS scenes often involve concurrent investigations, and the on-scene facts and circumstances will determine which department or agency has investigative priority. For example, CPD conducts any public safety investigation, which takes precedence over other investigations.[44] CPD's investigation of any underlying criminal offense and IPRA's investigation of the officer-involved

[42] IPRA Rules § 5.2 (Response to the Scene). The Chief Administrator has discretion regarding whether IPRA personnel will respond immediately to a scene of an officer-involved shooting that has resulted in no injuries to a non-Department member. *Id.*
[43] *Id.*
[44] *Id.*

shooting are conducted concurrently.[45] The Rules require coordination between the assigned Street Deputy, the appropriate Bureau of Detectives Area Commander, and the responding IPRA personnel with regard to how to conduct the investigation at the scene.[46]

While on-scene, investigators will, among other things:

- Canvass the scene to identify witnesses and available video recordings;
- Coordinate with CPD Forensic Services Evidence Technicians regarding collection of physical evidence and documentation of the scene via photographs and video; and
- Interview available witnesses either at the scene or at the closest Bureau of Detectives Area facility.[47]

In addition to these newly implemented Rules, IPRA, CPD, SAO, and ISP are working together to establish certain policies and procedures relating to the initial response to, and investigation of, OIS scenes under PCRIA. Pursuant to PCRIA and the implementing CPD general order, in the case of a fatal shooting, IPRA now leads the OIS investigation. IPRA, CPD, and SAO have agreed that when an OIS has resulted in the death of a civilian person:

- CPD will address the immediate needs of the crime scene, including seeking medical attention for the injured and securing the scene.
- CPD will also continue to undertake any and all necessary investigative activity necessary to investigate any underlying criminal offense connected to the shooting, while IPRA will conduct all investigative activity at the scene relating to the shooting itself.
- CPD will continue to conduct the evidence collection and processing and will transport civilian witnesses to the appropriate CPD area headquarters for the purpose of conducting interviews.
- IPRA will advise SAO if and when witnesses are available at CPD area headquarters for interviews, and the three agencies will jointly determine the appropriate order in which witnesses will be interviewed by each agency.

D. Collection And Analysis Of Physical And Other Evidence

The historical 2015 IPRA policies set forth a detailed policy with regard to physical evidence, which listed types of evidence that investigators should collect, discussed the importance of each category of physical evidence, and discussed ways in which to collect the evidence.

[45] *Id.*
[46] *Id.*
[47] *Id.*

The current IPRA Rules state that within the first 48 hours following an OIS incident, the IPRA investigative team will develop an investigation plan, seek to obtain all relevant department reports related to the incident, and seek to obtain all available audio and documentation from OEMC related to the incident.[48] Within 96 hours following an incident, the IPRA investigative team confers with ISP regarding the analysis and testing of physical and forensic evidence including, but not limited to, fingerprint recovery and analysis, ballistic testing and analysis, and DNA or other biological testing and analysis.[49]

E. Interviews Of Civilian Witnesses

1. Identification of relevant witnesses

The identification of relevant witnesses is a crucial first step in any OIS investigation. Historically, IPRA would delay its canvass until some point after its initial response to the OIS scene. For example, the January 2015 SOP provides that a canvass was to occur within 72 hours of the incident, and the May 2015 Intake and Rapid Response Manual requires that a canvass be conducted within 24 hours of the incident. Pursuant to the current Rules, IPRA will conduct a canvass immediately at the OIS scene.[50] We were also told in interviews that IPRA now requires two canvasses for OIS cases.

Historical IPRA policies also required investigators to record all attempts made to contact individuals, including dates, times, person contacted, and the manner in which contact was made or attempted. The Rules generally require investigators to document all investigative activities in a timely, accurate, and complete manner in case files.[51]

2. Subpoenas

Historical policies required subpoenas to be served on all non-cooperative witnesses who could have information material to the investigation. But as discussed below, the case files we reviewed show almost a complete absence of subpoena use, even when the IPRA policy technically required it. It is our understanding, however, that the current administration has renewed emphasis on the use of subpoenas for non-cooperative witnesses.

3. Audio recording of interviews

Historical IPRA policies required that interviews with non-CPD complainants, victims, and witnesses be audio-recorded unless the interviewee declined consent or other extenuating circumstances made recording technically impossible. The policies also required that if any breaks were taken during the recording that the investigator state that he/she was taking a break and the time at which the break starts and ends.

[48] IPRA Rules § 5.3 (Initial Investigative Activities).
[49] *Id.*
[50] Rules § 5.2 (Response to the Scene).
[51] Rules § 3.5 (IPRA Case File Maintenance).

The current IPRA Rules likewise require that all interviews be recorded, either via audio or video, unless the interviewee refuses consent.[52] A policy circulated by Chief Administrator Fairley via e-mail in 2016 requires the recording of the entirety of any interview and prohibits any unrecorded dialogue. The policy further states that once a recording has started, there should only be a break in the recording to accommodate witness needs.

4. Phone interviews

Historical IPRA policies, at least as of January 1, 2015, required that formal in-person statements be taken of all complainants, victims, or witnesses who could provide information that could impact the outcome of the investigation. Phone interviews were only permissible where an in-person interview was impossible or impractical and a phone interview would not undermine the quality of the investigation. Phone interviews required supervisory approval.

5. Substance of interviews

Historical IPRA policies, at least as of January 1, 2015, set forth requirements for the substance of witness interviews. These requirements included:

- Names and contact information for all potential witnesses;
- Detailed information regarding any alleged injuries; and
- Detailed information about the accused officers.

6. Transcription of interviews

Historical policies, at least as of January 1, 2015, required that every recorded interview be either transcribed or summarized. The policies stated that an interview should be transcribed when it would add material value to the investigation and assist the investigator in reaching a sound conclusion, a determination which would be made on a case-by-case basis. Any interviews not transcribed were required to be summarized in a To/From Report.

F. Officer Interviews

1. Compulsory interviews

CPD officers no longer provide voluntary statements to IPRA, so all officer statements are compelled.[53] This compulsion raises Fifth Amendment concerns, meaning that, per *Garrity*, the officer's compelled statement cannot be used against him or her in a criminal proceeding.[54] Such compelled statements inhibit IPRA's role in providing SAO with information to make charging decisions, because SAO cannot consider the statement or information gained through further investigation precipitated by the statement. It is possible for IPRA to use so-called "taint" or "clean" teams (individuals who do not have the officer statement) to continue the investigation

[52] IPRA Rules § 3.8.2 (Recording of Interviews).
[53] IPRA, Annual Report 2010-2012, at 22–23 (discussing "Limitations on Interviewing Involved Officers" in OIS investigations). CPD officers used to provide voluntary statements at a post-incident "Roundtable" attended by CPD, IPRA, and SAO personnel, but since the Roundtable process ceased, officers began to provide only compelled testimony to IPRA. *See id.* at 23.
[54] *Id.* (discussing *Garrity v. New Jersey*, 385 U.S. 493 (1967)).

and work with SAO. Such a process is complex, and IPRA employees reported that such procedures have in the past been usually avoided in favor of simply waiting for SAO to make a determination before interviewing officers. Under historical IPRA policies as of January 1, 2015, a supervisor had to approve the taking of all interviews of CPD members (both accused and witness) in cases referred to SAO before they occurred in order to avoid potential taint to the criminal prosecution.

2. Restrictions and policies regarding interviews

For officer interviews, IPRA must abide by the CBA as well as applicable CPD general orders.[55] The CBA provides a number of restrictions on officer interviews.

3. Timing of interviews

The CBA provides that in shooting cases, witness officer interviews can be postponed no more than two hours, but it does not expressly set out a time period for involved officer interviews.[56] At one point, prior to the current CBA but under similar provisions, IPRA took the position that involved officers were witness officers under the CBA and accordingly were not permitted to postpone interviews more than two hours after the shooting.[57] In a 2011 grievance, an arbitrator determined that IPRA's practice of requiring such interviews of involved officers violated the then-current CBA, but left the remedy to negotiations between Chicago and the FOP.[58] The results of those negotiations do not appear to be public, but a CPD general order enacted after the arbitration contained limitations on involved officer interviews. Interviews are not permitted until 24 hours after the shooting and must occur between 6 am and 6 pm.[59] As a consequence of the dual limitations, interviews in some cases may not take place until as much as 36 hours after the shooting.[60]

The CBA further requires that the length of the interview must be reasonable, with reasonable interruptions permitted for personal necessities, meals, telephone calls, and rest.[61] IPRA can require an officer to provide an audio recorded statement, provided all requirements of the CBA are met.[62]

Anecdotally we were told that IPRA, beginning a few years ago, now interviews witness officers within 48 hours and involved officers within 72 hours of the shooting instead of trying to interview them more quickly. As discussed elsewhere in this report, nearly all of the cases we reviewed took well more than a year and in most cases several years to complete. Although IPRA interviewed

[55] IPRA Rules § 5.6.2 (Interviews of Department Members).
[56] CBA § 6.1(E).
[57] *In re City of Chicago & Fraternal Order of Police, Chicago Lodge No. 7*, Grv. No. 129-10-033/341 at 13–15 (Mar. 25, 2011), available at http://www.chicagofop.org/arbitration-awards/.
[58] *Id.* at 48–54.
[59] CPD General Order 08-01-01, Section III(C), (D) (Department Member's Bill of Rights); *see* IPRA Rules § 5.6.2 (Interviews of Department Members).
[60] IPRA, Annual Report 2010–2012, at 22–23.
[61] CBA §§ 6.1(F), 6.2(G).
[62] *Id.* §§ 6.1(K), 6.2(H).

involved officers promptly in some cases, it just as often took months or even years before it interviewed officers in other cases.

4. Questioning

Under the CBA, every officer has the right to be represented by counsel or a representative of the FOP, and such counsel or representation shall be present at all times during questioning.[63] Prior to questioning an officer, the officer shall be:

- Provided the identities of the: (1) person in charge of investigation; (2) designated primary interrogation officer; (3) designated secondary interrogation officer; and (4) all persons present during the interrogation;[64]

- For cases in which there is a complaint, accused officers must be informed of the nature of the complaint and the names of all complainants in writing;[65]

- Advised as to whether the interview will be audio recorded and must be given the appropriate rights (statutory or criminal);[66] and

- Given a copy of any previous statements and of the portion of any official report purportedly summarizing a prior statement.[67]

No more than two members of IPRA can be present in the interview room during the questioning. Questions must be asked by a designated primary interrogator. A secondary interrogator may participate in the interview, provided that he or she is present for the entire interrogation. The secondary interrogator is not allowed to ask any questions until the primary interrogator has finished asking questions. The primary interrogator is then not allowed to ask questions until the secondary interrogator has finished.[68] Within 72 hours of when the interview concludes, the officer shall be provided a copy of any and all statements he or she has made that were audio recorded or in writing.[69]

It is in IPRA's discretion whether to advise the officer that it, CPD, or BIA may be in possession of video or audio evidence relevant to the matter under investigation. It has the same discretion regarding whether to allow the officer to view evidence. But if the officer is not allowed to review the video or audio evidence prior to giving a statement, the officer cannot be charged with making a false statement unless the officer has been presented with the video or audio evidence and given the opportunity to clarify and amend the officer's original statement.[70] Regardless, the officer will not be charged with making a false statement unless it has determined that: (1) the officer willfully

[63] *Id.* §§ 6.1(J), 6.2(E).
[64] *Id.* §§ 6.1(C), 6.2(C).
[65] *Id.* § 6.1(E).
[66] *Id.* § 6.1(C), (I), 6.2(C).
[67] *Id.* §§ 6.1(H), (L), 6.2(D), (L).
[68] *Id.* §§ 6.1(C), 6.2(C).
[69] *Id.* §§ 6.1(H), 6.2(D).
[70] An officer's false oral or written statement is sometimes referred to as a Rule 14 violation, after CPD Rule of Conduct 14 which prohibits such false statements.

made a false statement; and (2) the false statement was made about a fact that was material to the incident under investigation.[71]

Historical policies, as well as the current IPRA Rules, mirror the CBA with regards to the requirements for questioning officers. We were told in interviews that as of the last few years, IPRA now requires that two shooting specialists attend every officer interview.

Historical IPRA policies, at least as of January 1, 2015, required that the CPD member be scheduled for an additional interview if the investigation uncovered evidence or information requiring further information.

G. Referrals To SAO And Interactions With Other Agencies

IPRA's current Rules state that, as a matter of course, IPRA refers all OIS matters to SAO.[72] The Rules further state this referral is usually achieved within the initial two to three weeks following the incident, and that IPRA may conduct additional investigative steps at the request of SAO.[73]

IPRA may also "temporarily delay making findings in its administrative case" against a department member where there is a pending federal or state criminal investigation.[74] Finally, "unless there are countervailing needs to do so, IPRA will generally defer issuing findings until all relevant forensic testing has been completed and analyzed."[75]

H. Case Files

1. General organization

Current IPRA Rules require that all investigative activities be documented in the appropriate IPRA case file in a timely, accurate, and complete manner consistent with IPRA policies and procedures.[76] They further require that IPRA promulgate policies and procedures for the maintenance of case files and shall implement a quality control procedure to ensure case files are maintained properly.[77]

2. Investigator's case log

The investigator case log is a particularly important document. If the log is missing or is illegible, it is nearly impossible to piece together exactly how IPRA's investigation unfolded.

At least one historical policy, effective January 1, 2015, set forth detailed requirements for the case log. These requirements included, among other things, that the log:

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[71] CBA §§ 6.1(M), 6.2(J).
[72] IPRA Rules § 5.5 (Law Enforcement Referrals).
[73] *Id.*
[74] IPRA Rules § 5.6.1 (Pre-requisites to Issuing Findings).
[75] *Id.*
[76] Rules § 3.5 (IPRA Case File Maintenance).
[77] *Id.*

- Be kept in the file; the entries be succinct, legible, and accurate;
- Contain entries that are entered immediately upon completion of every investigative activity in case;
- Include information that would explain any delay in the investigation (including civil litigation);
- Include the date of referral to any agency (*e.g.*, SAO), the date of any decision from the agency, and the dates for conclusion of any initiated proceedings;
- Include the date of any information learned about any complainant, witness, or officer unavailability;
- Include the dates that requests were made to outside agencies for transcripts or evidence; and
- Note any instances in which the investigator was required to work on another case.

3. To/From Reports

The To/From Report appears to be the main vehicle through which IPRA investigators document investigative steps. The January 2015 SOP set forth at least minimal guidance for preparing these reports.

I. IPRA's Analysis Of Use Of Force – Ultimate Findings And Recommendations As Documented In Summary Reports

At the conclusion of its investigation, IPRA evaluates the evidence gathered against applicable legal standards (discussed further in the next section) to determine whether the officer or officers' conduct was reasonable and within policy. IPRA's investigation into the officer-involved shooting "will seek to determine if, based on the circumstances, the officer's use of deadly force was objectively reasonable and within policy as defined by the CPD's Use of Force Model and the General Orders governing the Use of Deadly Force."[78] As noted in the next section, CPD proposed revised use of force policies in October 2016.

Following Supreme Court and other precedent regarding the reasonableness of the use of force (discussed in detail in the next section), IPRA judges the use of deadly force "from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight" and accounts "for the fact that police officers are often forced to make split-second decisions in circumstances that are tense, uncertain and rapidly evolving."[79] As memorialized in the current IPRA Rules, reasonableness depends on the totality of the circumstances, and IPRA considers the following circumstances leading up to and including the use of force:

[78] IPRA Rules § 5.6.4 (Legal Standard).
[79] IPRA Rules § 5.6.4 (Legal Standard) (discussing reasonableness standard grounded in *Graham v. Connor*, 490 U.S. 386 (1989)).

- The seriousness of the crime or suspected offense;
- The level of threat or resistance presented by the subject;
- Whether the subject was posing an immediate threat to officers or a danger to the community;
- The potential for injury to citizens, officers, or subjects;
- The risk or apparent attempt by the subject to escape;
- The conduct of the subject being confronted (as reasonably perceived by the officer at the time);
- The time available to an officer to make a decision;
- The availability of other resources;
- The training and experience of the officer;
- The proximity or access of weapons to the subject;
- The characteristics of the officer or group of involved officers relative to those of the subject including, but not limited to, age, size, relative strength, skill level, injury/exhaustion, and number; and
- The environmental factors and/or other exigent circumstances.[80]

Following consideration of the applicable legal standards and policies, the IPRA investigator must recommend whether the use of force was within policy.[81] This analysis and the resulting findings are documented in a summary report.

J. Summary Reports

1. Form and substance of summary reports

Summary Reports document IPRA's ultimate findings and recommendations in each file.

Historical policies, at least beginning on January 1, 2015, detailed the requirements for each of the five required sections of the report: cover form, allegations section, investigation section, conclusion, and findings section. These policies required that the report, among other things, explain the investigation in a logical sequence and summarize witness statements and physical (and other) evidence. They also required that the conclusion section articulate the specific evidence that supports the findings, and in doing so, address evidence which corroborated and

[80] *Id.*
[81] *Id.*; IPRA Rules § 5.6.5 (IPRA Findings in Officer-involved Death Investigations).

contradicted both the complainant's and officer's version of events as well as the investigator's conclusion.

Current IPRA Rules require that each summary report:

- Outline the allegations;
- Identify the department rule or order alleged to have been violated;
- Summarize and analyze the relevant evidence, including evidence that is contrary to the recommended findings, if any; and
- Conclude with the recommended disposition of the case.[82]

Under the current IPRA Rules, IPRA investigators are also required to assess whether:

- The conduct in question complied with department training;
- A better outcome might have been achieved had the officer's conduct been different;
- The officer's conduct indicates a need for specific additional training; and
- The conduct in question reflects gaps or other deficiencies in department policies or training.[83]

2. Consideration of pattern analysis

One historical IPRA policy, dated October 20, 2015, required IPRA to "make every effort possible to attempt to identify and address patterns of misconduct on the part of officers, both individually and collectively." In an effort to do so, the supervising investigator was to review a report for each accused officer, which contained a seven-year complaint history for the department member, and identify any similar patterns of complaints made against the department member that could lend credence to the substance of the complaint in the instant investigation. This included complaints with a finding of Not Sustained, but where, by the nature of the similarity of the allegations, or the sheer number of allegations within a specific time frame, the pattern causes sufficient concerns to believe the matter should be referred through the IPRA chain of command.

3. Supervisory review and approval of summary reports

Historical policies memorialized a formal supervisory review and approval process for summary reports. Generally, the policies required that, once an investigator completed a summary report, it was forwarded to the investigator's supervisor. The supervisor was to suggest any necessary changes or edits. Once the investigator incorporated the suggested edits, the summary report was submitted back to the supervisor for final approval. Once received, the summary report would

[82] IPRA Rules § 4.2 (Investigative Reports).
[83] IPRA Rules § 4.1 (Investigative Findings).

follow the same process all the way up the review chain. A summary report was considered final only when it was approved by the Chief Administrator.

K. Other Relevant Policies

1. Related litigation

IPRA's governing ordinance empowers IPRA to "review all cases settled by the department of law in which a complaint register was filed against a member of the department, and if, in the opinion of the chief administrator, further investigation is warranted, to conduct such investigation."[84]

IPRA's current administration has instituted policies requiring investigators to consider potential evidence available in both criminal and civil proceedings. Investigators must address the status of these proceedings in draft summary reports.

2. Timeliness of investigations

Although there is an absence of historical policies addressing the timeliness of IPRA investigations, the current IPRA Rules state that, pursuant to MCC §2-57-070, if IPRA does not conclude an investigation within six months after its initiation, the Chief Administrator shall notify the Mayor's office, the City Council Committee on Public Safety, the complainant, and the department member named in the complaint or that department member's attorney of the general nature of the complaint or information giving rise to the investigation and the reasons for failing to complete the investigation within six months.[85] The Rules also state that IPRA supervising investigators are responsible for ensuring that investigations are conducted in an efficient, yet effective manner, and are concluded expeditiously.[86] The current administration has developed certain reports to assist in timeliness.

[84] MCC § 2-57-040(e) (Chief administrator – Powers and duties).
[85] Rules § 3.3 (Timeliness of Investigations).
[86] *Id.*

PART III – CPD USE OF DEADLY FORCE POLICY

This part of our Final Report, as requested by our mandate, evaluates the potential impact of CPD's use of deadly force policy on investigations and makes recommendations regarding CPD's draft revised policy. The CPD use of deadly force policy sets forth the standard by which investigators evaluate officer conduct as to whether such conduct was within or outside of policy. Thus, it is the foundation for determining whether officer conduct in officer-involved shooting cases is deemed acceptable under policy.

We note at the outset that as the investigations we reviewed and analyzed spanned the period during which IPRA has existed, CPD policies relevant to OIS cases have changed during that time. Most recently, in October 2016, CPD released in draft form a revised use of force policy for public comment. Because our charge has asked us to make recommendations to CPD's use of deadly force policy, we do so by assessing the proposed revised policy released by CPD in light of what we learned during our in-depth analysis of closed OIS cases, remaining mindful that the closed OIS cases we reviewed were investigated under the existing use of deadly force policy in effect at the time of the investigations. We have also reviewed and incorporated, where appropriate, IPRA's own use of force recommendations.[87]

Below we do three things: (1) set forth a summary of the law relevant to the use of deadly force; (2) summarize the recently released draft revised CPD use of deadly force policy; and (3) discuss points relevant to the CPD use of deadly force policy, as reflected in the proposed revised use of force policy, in light of observations made regarding the analysis of closed OIS investigations and our recommendations for changes to consider making to the draft revised use of deadly force policy as it relates to OIS investigations.

I. RELEVANT LAW

A review of law relevant to the use of deadly force is instructive.

A. Federal Law

The legal standard applicable to use of force rests on two seminal U.S. Supreme Court cases, *Tennessee v. Garner* and *Graham v. Connor*.

In *Tennessee v. Garner*, the Supreme Court established the principle that a police officer could use deadly force on a fleeing suspect if the officer had probable cause to believe that the suspect posed significant threat of death or injury to the officer or others.[88] The case involved a civil rights claim (brought under 42 U.S.C. § 1983) stemming from the shooting and death of an unarmed man fleeing arrest. The Court held that a Tennessee statute was unconstitutional insofar as it authorized the use of deadly force against an apparently unarmed, non-dangerous fleeing suspect, but further

[87] IPRA, Second Quarter Report, April 1, 2016 – June 30, 2016 (published July 14, 2016), at 20–25; IPRA, Use of Deadly Force Policy Analysis & Recommendations (Nov. 3, 2016), *available at* http://www.iprachicago.org/use-of-force-policy-recommendations-november-2016/.
[88] *Tennessee v. Garner*, 471 U.S. 1, 11 (1985).

held that deadly force could be used in certain circumstances involving the threat of serious physical harm:

> Where the officer has probable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is not constitutionally unreasonable to prevent escape by using deadly force. Thus, if the suspect threatens the officer with a weapon or there is probable cause to believe that he has committed a crime involving the infliction or threatened infliction of serious physical harm, deadly force may be used if necessary to prevent escape, and if, where feasible, some warning has been given.[89]

Four years later, in *Graham v. Connor*, the Court established that all excessive force cases must be analyzed under the Fourth Amendment's "objective reasonableness" standard and that the prevailing question in each case was "whether the officers' actions are 'objectively reasonable' in light of the facts and circumstances confronting them, without regard to their underlying intent or motivation."[90] Graham sought to recover damages for injuries allegedly sustained when law enforcement officers used physical force against him during the course of an investigatory stop. In analyzing Graham's § 1983 claim, the Court explained that the reasonableness of law enforcement's use of force is fact dependent:

> Because the test of reasonableness under the Fourth Amendment is not capable of precise definition or mechanical application, however, its proper application requires careful attention to the facts and circumstances of each particular case, including the severity of the crime at issue, whether the suspect poses an immediate threat to the safety of the officers or others, and whether he is actively resisting arrest or attempting to evade arrest by flight.[91]

The Court further held that the "reasonableness" of a particular use of force must be judged from the "perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight."[92] The Court also stressed that the "calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving—about the amount of force that is necessary in a particular situation."[93]

B. State Law

In addition to the federal law discussed above, Illinois law also governs the legal standards applicable to use of force.

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[89] *Id.* at 11–12.
[90] *Graham v. Connor*, 490 U.S. 386, 397 (1989).
[91] *Id.* at 396 (internal citation omitted).
[92] *Id.*
[93] *Id.* at 396–97.

1. Use of force in making arrest

Illinois law does not require an officer to retreat or desist from efforts to make a lawful arrest because of resistance or threatened resistance to an arrest.[94] An officer "is justified in the use of any force which he reasonably believes to be necessary to effect the arrest and of any force which he reasonably believes to be necessary to defend himself or another from bodily harm while making the arrest."[95] The statute continues:

> However, he is justified in using force likely to cause death or great bodily harm only when he reasonably believes that such force is necessary to prevent death or great bodily harm to himself or such other person, or when he reasonably believes both that:
>
> (1) Such force is necessary to prevent the arrest from being defeated by resistance or escape; and
>
> (2) The person to be arrested has committed or attempted a forcible felony which involves the infliction or threatened infliction of great bodily harm is or is attempting to escape by use of a deadly weapon, or otherwise indicates that he will endanger human life or infliction great bodily harm unless arrested without delay.[96]

2. Resisting arrest

Pursuant to Illinois statute, a "person is not authorized to use force to resist arrest which he knows is being made either by a peace officer or by a private person summoned and directed by a peace officer to make the arrest, even if he believes that the arrest is unlawful and the arrest in fact is unlawful."[97]

3. Deadly force

Force likely to cause death or great bodily harm includes: "(1) the firing of a firearm in the direction of the person to be arrested, even though no intent exists to kill or inflict great bodily harm; and (2) the firing of a firearm at a vehicle in which the person to be arrested is riding."[98]

4. Use of force to prevent escape

Pursuant to Illinois statute, a "peace officer or other person who has an arrested person in his custody is justified in the use of such force to prevent the escape of the arrested person from custody as he would be justified in using if he were arresting such person."[99]

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[94] 720 ILCS 5/7-5.
[95] *Id.*
[96] *Id.*
[97] 720 ILCS 5/7-7
[98] 720 ILCS 5/7-8.
[99] 720 ILCS 5/7-9.

II. CPD USE OF DEADLY FORCE POLICY[100]

CPD General Order 03-02 sets forth the proposed revised Department policy regarding the use of force, including within it guidance on use of deadly force.[101] Below we summarize the several aspects of the policy most relevant to OIS investigations.

The guidelines under the proposed revised policy for use of deadly force by an officer are as follows: "A sworn member is justified in using force likely to cause death or great bodily harm only when, taking into account the totality of the circumstances, he or she reasonably believes that such force is necessary to prevent: (a) death or great bodily harm from an immediate threat posed to the sworn member or another person[;] (b) an arrest from being defeated by the resistance or escape and the sworn member reasonably believes that the person to be arrested poses an immediate threat of death or great bodily harm to a sworn member or another person unless arrested without delay."[102]

The proposed revised department policy specifically requires that officers follow a standard for use of force beyond simply what is required by law under *Graham v. Connor*, stating: "While the legal standard allows for force only to the degree that is objectively reasonable, necessary under the circumstances, and proportional to the threat or resistance of a subject (*Graham v. Connor*, 490 U.S. 386, 1989) Department members are also required to follow the Department policy on the use of force which extends beyond what the law requires."[103] The policy further specifies that "Department members will use the least amount of force reasonably necessary based on the totality of the circumstances to perform a lawful task, effect an arrest, overcome resistance, control a subject, or protect themselves or others from injury."[104]

The policy provides further guidance on use of deadly force stating that "use of deadly force must be objectively reasonable, necessary, and proportional."[105] The proposed revised use of force policy provides specific definitions for each of these terms:

- "Objectively reasonable" is defined to look to reasonableness "based on the totality of the circumstances known by the officer at the time of the use of force" and "judged from the perspective of the reasonable officer on-scene, rather than with the benefit of hindsight."[106] It uses an "objective" standard, *i.e.*, "whether the Department member's actions are objectively reasonable in light of the facts and circumstances confronting him or her, without regard to the member's underlying intent or motivation."[107] The policy notes that "[r]easonableness is not capable of precise definition or mechanical application" and "must allow for the fact that Department members are often forced to make split second decisions—in circumstances that are tense, uncertain, dynamic, and

[100] All cites to CPD General Order G03-02, Use of Force Guidelines, are to the proposed revised policy released in and dated October 2016.
[101] CPD, General Order G03-02, Section II(E).
[102] *Id.* at Section II(F)(4).
[103] *Id.* at Section II(E).
[104] *Id.* at Section II(E)(1).
[105] *Id.* at Section II(F)(2).
[106] *Id.* at Section II(E)(2).
[107] *Id.*

rapidly evolving—about the amount of force that is necessary in a particular situation."[108]

- "Necessary" mandates that "Department members will use physical force only when no reasonably effective alternative appears to exist" and that they "are required to employ strategies and tactics designed to provide members more response options, including creating more time and distance within which to exercise those options."[109]

- "Proportional" requires officers to "employ force in proportional response to the threat, actions, and level of resistance offered by a subject."[110]

The proposed revised use of deadly force policy also specifically requires that "Department members will apply the force mitigation principles and use the least amount of force under the circumstances."[111] The use of force policy states that even when it is necessary to use force, officers will do the following: "use the least amount of force required under the circumstances"; "de-escalate as soon as practicable"; and "determine if the seriousness of the situation requires an immediate response or whether the member can employ other reasonable alternatives."[112] It also incorporates by reference the detailed guidance on de-escalation and force mitigation set forth in the separate Response Options policy.[113]

There are also specific prohibitions in the use of deadly force policy on the use of firearms in certain instances, including (with limited exceptions for each) firing at subjects whose actions are only a threat to themselves; firing into crowds; firing into buildings or through doors, windows or other openings when the person lawfully fired at is not clearly visible; and firing at or into a moving vehicle when the vehicle is the only force used against the sworn member or another person.[114]

III. RECOMMENDATIONS REGARDING CPD USE OF DEADLY FORCE POLICY

In the time during which we were engaged to conduct the review and analysis of closed OIS cases, we studied the existing CPD use of deadly force policy for which we had been asked to make recommendations relevant to OIS cases and our review. As part of our study, we focused on what we learned in our case review as well as drew from an analysis we conducted of the use of deadly force policies of other large police departments. Based upon that work and through the expertise of the use of force consultants on our team, we developed observations and recommendations for consideration for changes to the existing use of deadly force policy as it pertains to OIS investigations.

However, as noted above, CPD in October 2016 released its proposed revised use of force policy for public comment. We have studied the proposed revised policy and observe that it reflects changes that comport with many of our own independent observations and recommendations for

[108] *Id.*
[109] *Id.* at Section II(F)(3).
[110] *Id.* at Section II(F)(4).
[111] *Id.* at Section II(F)(2).
[112] *Id.* at Section II(G)(1)-(3).
[113] *Id.* at Section II(G)(4) (referencing CPD General Order G03-02-01, Response Options, released in and dated October 2016).
[114] *Id.* at Section II(F)(6).

changes to the existing use of deadly force policy as it pertains to OIS investigations. The CPD proposed revised use of force policy incorporates the following concepts, which in our work to assess and evaluate the existing use of deadly force policy we likewise had previously concluded should be added, and thus agree with CPD's decision to propose such revisions: imposition of a use of force standard beyond the constitutional standard permitted under *Graham v. Connor*; a clear sanctity of human life provision; a medical attention provision; detailed guidance regarding the term "reasonableness"; a requirement that officers articulate specific facts to support a decision to use force; incorporation of immediacy language into the use of deadly force guidelines; incorporation of a specific directive that officers will use the least amount of force necessary; and an expanded duty to intervene provision.

Accordingly, based on our work prior to the release of the proposed revised policy and our analysis of it as it pertains to OIS investigations, the proposed revised use of deadly force policy is consistent with observations and recommendations previously made during the course of our work, and we believe the proposed revised use of deadly force policy can support more effective OIS investigations.

Specifically, what constitutes effective OIS investigations depends largely on the standard of review by which justification of use of force is measured. As discussed above, the use of deadly force standard under the CPD proposed revised policy holds officer conduct to a standard where policy is not only violated when a use of deadly force violates the constitutional standard but also when use of force is employed in contradiction to other considerations as well. We agree with the changes that are encompassed in the proposed revised policy and believe those changes take significant steps to provide a broader basis upon which investigators will evaluate officer conduct in an OIS case and from which investigators will be able to determine whether that conduct was within or outside of policy. We do, however, have additional recommended changes relevant to the standard by and parameters under which OIS investigators assess officer conduct, which we set forth below for consideration. We believe that the following are additional areas that should be considered to further enhance the standard that forms the basis for OIS investigations.

List of Factors for Totality of the Circumstances

- Include a specific non-exhaustive list of factors to consider in looking at whether under the totality of the circumstances the officer had a reasonable belief that deadly force was necessary.

The proposed revised CPD use of force policy states that the use of deadly force is justified "when, taking into account the totality of the circumstances," the officer "reasonably believes such force is necessary to prevent" death or great bodily harm from an immediate threat posed to the sworn member or another person or an arrest from being defeated by resistance or escape when those circumstances are present.[115] It further states that reasonableness is "based on the totality of circumstances known by the officer at the time of the use of force" and is "not capable of precise definition or mechanical application."[116]

However, CPD may want to consider adding a non-exhaustive list of factors to consider regarding the "totality of the circumstances" from which to assess the officer's reasonable belief. We note

[115] CPD General Order G03-02, Section II(F)(4).
[116] CPD General Order G03-02, Section II(E)(2).

that in its Second Quarter 2016 Report, IPRA recommended that the policy explicitly articulate the factors that are considered in determining whether an officer's use of deadly force was objectively reasonable.[117] IPRA explained that an explicit list will enhance the effectiveness of the policy and will provide officers clarity regarding the criteria by which their conduct will be evaluated. It will also help to ensure that this information will be incorporated into training. IPRA noted that the most common factors include: the seriousness of the crime or suspected offense; the level of threat or resistance presented by the subject; whether the subject was posing an immediate threat to the officers or a danger to the community; the risk of escape by the subject; the conduct of the subject being confronted (as reasonably perceived by the officer at the time); the time available to an officer to make a decision; the availability of other resources; the training and experience of the officer; the proximity or access of weapons to the subject; officer versus subject factors, such as age, size, relative strength, skill level, injury or exhaustion and number of officer versus subjects; and the environmental factors and/or other exigent circumstances.[118]

Many police departments' use of force policies incorporate a compilation of factors that are to be considered when the officer is determining whether to apply force or when evaluating whether an officer has used reasonable force. In our extensive review of the policies of other police departments, factors we observed included:

- the nature and seriousness of the suspected offense or reason for contact with the individual;
- the immediacy and severity of threat to officers or others;
- officer factors (*e.g.*, relative size and stature of the officer, officer's age, the relative capabilities of the officer, training and experience of officer, level of exhaustion or fatigue);
- subject factors (*e.g.*, relative size and stature of the subject; subject's age; injuries sustained; level of exhaustion or fatigue; the subject's behavior including verbal dialogue, physical restrictive actions, and aggressive acts; whether the subject is violent; whether the individual is armed; the degree to which the subject has been effectively restrained and his or her ability to resist despite being restrained; the relative capabilities of the subject including tactical or martial arts training; any disability of the subject; whether the person appears to be resisting, attempting to evade arrest by flight, or is attacking the officer; the subject's known or apparent mental state or capacity; the effects of drugs or alcohol; and any prior contacts with the subject or awareness of any propensity for violence);
- the availability of officers and resources to de-escalate the situation;
- the number of officers in comparison to the number of suspects;

[117] In IPRA's Second Quarter 2016 Report, IPRA focused its attention on the policy governing CPD's use of deadly force. IPRA reviewed policies governing the use of deadly force for several other large, urban police departments and other published literature on the topic, and identified several areas of potential improvement to CPD's use of deadly force policy. IPRA, Second Quarter Report, April 1, 2016 – June 30, 2016 (published July 14, 2016), at 20–25. IPRA published a report this month discussing which of its previous recommendations had been incorporated by the new proposed revised CPD policy. IPRA, Use of Deadly Force Policy Analysis & Recommendations (Nov. 3, 2016), at 14–18.

[118] IPRA included this list of factors in its June 28, 2016 Rules as factors that IPRA would consider in evaluating whether an officer's use of force was reasonable. IPRA Rules § 5.6.4 (Legal Standard).

- the actions of third parties or bystanders;
- the duration of resistance;
- the proximity of weapons or dangerous improvised devices;
- the risk and reasonably foreseeable consequences of escape;
- the apparent need for immediate control of the subject or a prompt resolution of the situation;
- whether the officer intentionally or unnecessarily instigated the use of force;
- the feasibility, availability, and effectiveness of alternative action;
- the time available to an officer to make a decision;
- the environmental or terrain factors, such as whether the incident is near a busy street;
- other exigent circumstances.

We believe that adding a non-exhaustive list of factors to consider regarding the "totality of the circumstances" from which to assess the officer's reasonable belief would provide guidance to investigators to aid in their review and some overarching consistency to the analysis of officer conduct in OIS cases.

Provision Regarding Actions Leading Up to Use of Force

- Include a provision in the use of force policy setting out the concept that an officer's actions leading up to the use of force, including deadly force, will be considered when assessing whether the conduct was in violation of the use of force policy.

The proposed revised CPD use of deadly force policy deadly force provision specifically directs that officers will apply force mitigation principles, which necessarily include an officer's conduct leading up to a use of deadly force.[119] However, in addition, CPD may want to consider adding a provision that specifically states that, while in some instances deadly force may be justified at the moment the force is administered, the officer's actions leading up to the use of deadly force may be in violation of the department's training or policies and will be assessed as part of the use of deadly force analysis. We note that in IPRA's Second Quarter 2016 Report and its subsequent Use of Force Policy Report, IPRA recommended that the CPD policy be revised to reflect that the context of the situation will be considered in evaluating the propriety of the officer's conduct, specifically to make clear that the officer's conduct leading up to the use of deadly force is an important consideration when evaluating a use of deadly force incident.[120]

Some departments acknowledge that in some instances force may be legally justified at the moment the force is administered, but the officer's actions leading up to the use of force may be in violation of the Department's training or policies. For example, the Charlotte-Mecklenburg Police Department's use of force policy prohibits officers from intentionally or unnecessarily instigating a use of force in that an officer who taunts, verbally baits, or initiates needless or

[119] CPD General Order G03-02, Section II(F)(2).
[120] IPRA, Second Quarter Report, April 1, 2016 – June 30, 2016 (published July 14, 2016), at 23; Use of Deadly Force Policy Analysis & Recommendations (Nov. 3, 2016), at 15–16.

unnecessary physical contact with a subject and then is forced to apply force immediately afterwards will be in violation of the use of force policy.[121]

We believe adding the type of provision we suggest would give investigators in OIS cases the ability to have the most appropriate base under policy from which to assess an officer's conduct in that it would specifically incorporate the conduct leading up to the use of force into an evaluation of the use of force incident.

Provision Regarding Use of Deadly Force as a Last Resort

- Include a provision that specifically conditions the use of deadly force on the officers exhausting all reasonable alternatives and expressly state that deadly force will be used as a last resort.

The proposed revised CPD use of force policy directs officers to use the least amount of force reasonably necessary based on the totality of the circumstances.[122] However, in addition, CPD may want to consider adding, specifically in the subsection of the policy addressing use of deadly force, that deadly force only be used when all reasonable alternatives have been exhausted and as a last resort.

Many departments include language expressly conditioning the use of deadly force on the officers exhausting all reasonable alternatives or only being used as a last resort, for example: officers may resort to the use of deadly force, "only when there is no less drastic means available to defend oneself or another"[123]; officers may use deadly force when there is "no viable alternative by which the threat can be removed or reduced"[124]; "In no instance will deadly force be used other than as a last resort"[125]; and "deadly force is utilized as a last resort when other measures are not practical under the existing circumstances"[126]

We believe adding a specific provision along these lines would give investigators in OIS cases the ability to have the most appropriate base under policy from which to assess an officer's conduct in that it would make clear that no other reasonable alternative may exist when deadly force is used.

Provision Regarding Use of Deadly Force in Connection With Bystanders

- Include a provision that specifically addresses use of deadly force in connection with bystanders.

The proposed revised CPD policy provision addressing use of deadly force includes in the prohibitions on the use of firearms section certain prohibitions that are relevant to situations involving bystanders (with limited exceptions to where such force is reasonably necessary to prevent imminent death or great bodily harm to the sworn member or to another person), *e.g.*,

[121] Charlotte-Mecklenburg Police Dept., Use of Less Lethal Force 600-019, II, at 1.
[122] CPD General Order G03-02, Section II(E)(1).
[123] Boston Police Department, Rule 303, Section 6.
[124] Lexington Police Department, General Order, 1991-021, III(D), at 7.
[125] Corpus Christi Police Department, Policy 200.4(2), at 63.
[126] Phoenix Police Department, Operations Order 1.5(H), at 12.

prohibitions on firing into crowds; firing into buildings or through doors, windows or other openings when the person lawfully fired at is not clearly visible; and firing at or into a moving vehicle.[127] In addition to these specific prohibitions in certain instances that may involve bystanders, CPD may want to consider also adding a general provision that directs officers to consider the presence and potential for injury of bystanders. Many departments include provisions specifically discussing the use of deadly force in connection with the possibility of bystanders.

Some policies define reasonableness to include consideration of the presence of bystanders and their safety, for example: providing that when there is a potential for deadly force, an officer "must plan ahead and use reasonable alternatives if time and opportunities permit," and the reasonableness of the action is based on time available, opportunity of performing the action, and facts apparent to employee—this *includes the presence of innocent third persons*[128]; or stating that officers will consider their immediate surroundings and the safety of uninvolved citizens before using deadly force.[129]

Other policies stated that any necessity of deadly force could be outweighed if there were a probability of injuring bystanders, for example: providing that the use of deadly force by sworn personnel should not create a danger to the public that outweighs the benefits of its use[130]; stating that deadly force shall not be used when there is a likelihood of serious injury being inflicted upon persons other than the individual against whom the member is authorized to use deadly force and that the safeguarding of other human lives shall outweigh all other considerations[131]; or directing that even when deadly force is permissible, officers should assess whether the use of deadly force creates a danger to third parties that outweighs the likely benefits of its use.[132]

Policies also emphasized the need to minimize the risk of harm to bystanders, for example: making clear that every effort will be made to minimize the risk of harm to innocent persons[133]; stating that the safety of hostages, innocent persons, and officers takes priority over the safety of subjects engaged in criminal or suicidal behavior[134]; and providing that when discharging a firearm for any reason, officers must exercise caution in order to avoid unnecessarily endangering the lives of bystanders and that unless there are extenuating circumstances, officers shall give consideration to the backdrop, bystanders, and location.[135]

Finally, some policies stated that deadly force could only be used when there was no risk to bystanders, for example: providing that officers who find it necessary to discharge firearms shall exercise "due care for the safety of persons and property in the area and shall fire only when reasonably certain that there is no substantial risk to bystanders"[136]; stating that members shall not use force that may injure bystanders or hostages, except to preserve life or prevent serious bodily

[127] CPD General Order G03-02, Section II(F)(6).
[128] Arlington, Texas Police Department, 401.04(A)(3)
[129] Houston Police Department, General Order 600-17(4).
[130] Columbus Police Division Directive, Use of Force, 2.01, II(B)(6).
[131] Orlando Police Department, Policy and Procedure, 1128.13(3).
[132] Toledo, Directive 103.2, III(7.1.1).
[133] Metropolitan Nashville Police Department, Use of Force Policy, 11.10.150(B)(4).
[134] Fresno Police Department, Policy Manual, Force Options, 308.1.2.
[135] Consolidated City of Jacksonville, General Order LXXII.6, V(B)(4).
[136] Boston Police Department, Rule 303, Section 6(C).

injury[137]; making clear that any force used shall not create a substantial risk of injury to innocent persons[138]; providing that to the extent an officer has reasonable time for consideration, he "shall never use deadly force which creates a greater risk of death or serious bodily injury to themselves or others than if they did not use such force"[139]; and stating that use of deadly force is only authorized when bystanders are not in jeopardy.[140]

We believe this will give investigators in OIS cases the ability to have the most appropriate base under policy from which to assess an officer's conduct in that it would make clear that in any circumstance involving bystanders consideration must be given to their presence and the potential for injury.

[137] Cleveland Division of Police, Use of Force Policy, 2.1.01, at 1.
[138] Newark Police Department, General Order 63-2, IV(F)(9).
[139] Corpus Christi Police Department, Policy 200.4.2(f).
[140] Detroit Police Department, Directive Number 304.2-4.2(1)(a).

PART IV – FINDINGS

This fourth part of our Final Report identifies issues and deficiencies in IPRA's investigative process and its subsequent legal analysis that we observed in our review and analysis of 20 closed OIS cases.

We believe it is important to stress that we were not asked to, nor did we, re-conduct investigations in these cases. Thus, while our review enabled us to identify common deficiencies in IPRA's investigations and analysis, it was not our role to opine on the ultimate findings in those cases.

Through our review, we were able to discern numerous issues with IPRA's historic review of OIS incidents. Some were present in the cases we reviewed with greater prevalence and some with lesser prevalence. Some had the potential for serious impact on the investigation and some had the potential for more minimal impact on the investigation. Taken together the deficiencies in these cases evidence a pattern of weak investigations and collectively undermine the confidence in their ultimate findings. Below we set forth our findings regarding the deficiencies we found, supporting them with examples drawn across our sample of cases, and then we provide recommendations for improvement in the section that follows.

This section is divided into the following three parts: (1) findings related to investigation; (2) findings related to analysis; and (3) findings related to length of time of investigations.

I. FINDINGS RELATED TO INVESTIGATION

A. Insufficient On-Scene Investigative Steps And Follow-Up Investigation

We identified significant deficiencies in the investigation done on-scene and resulting follow-up. As noted above, during the time of the investigations of the OIS cases we reviewed, the on-scene investigation of OIS cases was led by CPD. IPRA relied on and was thus limited by the results of CPD's on-scene investigation and forensics requests based on investigative steps taken on-scene. Although the investigative deficiencies deriving from those on-scene aspects of the investigation resulted from CPD's decisions regarding investigative steps to be utilized, the failure to obtain other evidence, which was not limited by the results of on-scene investigation decisions by CPD, resulted from IPRA's subsequent investigative process. But regardless of whether the deficiency resulted from decisions made by CPD or by IPRA, the fact remains that, as discussed in detail below, there are numerous areas of specific deficiencies in on-scene investigations. We observe that not only did these deficiencies result in the inability to obtain evidence as a deficiency in and of itself, but the issues created by failing to effectively obtain all evidence were compounded in cases where the majority of the available evidence is the officers' account of events which can go virtually unchallenged unless sufficient forensic evidence is collected. We noted the following areas of deficiencies in the cases we reviewed and for each, set forth examples we found.

1. Failing to obtain detailed scene diagrams and measurements

Scene diagrams and measurements provide a complete and accurate depiction of the scene and the distance between key points or pieces of evidence. There were no detailed scene diagrams or on-scene measurements. During the time of the OIS investigations we reviewed, for which the on-

scene investigation was led by CPD, these steps would have been handled by CPD. The decision not to obtain sufficiently detailed scene diagrams with measurements inhibited more fulsome analysis of what occurred during an incident and where it occurred. We found this deficiency in most of the cases we reviewed. The below examples illustrate the significance.

- Failing to create a scene diagram and take measurements in case involving multiple separate use of force incidents in multiple locations by multiple officers during a foot chase of a fleeing subject that spanned city blocks, parking lots, alleys, gangways, and a residential backyard. This would have assisted the investigator (who was not the investigator on-scene) in understanding the flight path of the subject and where each use of force incident occurred and could also have been used to test details provided by the involved officers, particularly when used along with video that only captured portions of the chase and significantly revealed that the fleeing subject did not have a weapon in his hands at the moments on video.

- Failing to create a scene diagram or take measurements in case involving an officer who shot the subject in a residential backyard and CPD recovered a BB gun in an adjacent yard. A scene diagram with measurements would have permitted an evaluation of the officer's statements by assessing whether the fleeing subject could have thrown a weapon that distance.

- Failing to create a scene diagram and take measurements in case involving officers who parked in front of and perpendicular to a subject's vehicle in parking lot in which officer stated the subject tried to drive around the officers' car, striking one officer and the car. A scene diagram with measurements would have facilitated a better understanding of the subject's movements and provided the investigator the ability to probe the officer's account of events.

- Failing to create a scene diagram and take measurements in case involving a subject running in a path leaving a blood trail that covered multiple blocks after being shot by an officer. A scene diagram with measurements would have assisted the investigator (who was not present on-scene) and could have been used with witnesses who gave varying accounts of when and where shots were fired.

- Failing to create a scene diagram and take measurements in case involving an officer who fired shots that hit multiple individuals, projectiles recovered in numerous locations, and bullet holes identified in multiple places on a porch and in a residence. A scene diagram with measurements would have assisted the investigator (who was not present on-scene), allowed the investigator to connect pieces of evidence together, and provided context for the location of each aspect of the events.

2. Failing to obtain trajectory analysis

Trajectory analysis where possible is done through taking measurements on-scene and permits the investigator to determine the distance, position, and firing direction of the shooting officer and the subject in the case where a subject has fired shots. Trajectory analysis is not always possible, for

example, in instances where there are no bullet holes from which to measure. Among the cases we reviewed, there was no trajectory analysis conducted. During the time of the OIS investigations we reviewed, for which the on-scene investigation was led by CPD, these steps would have been handled by CPD. Trajectory analysis might have provided useful information to understand if the recitation of events by officers or witnesses was supported by additional evidence. We found this deficiency in many of the cases we reviewed. The below examples illustrate the significance.

- Failing to conduct trajectory analysis in case in which there was a key factual question to be resolved regarding the direction of fire of shooting officer where there were recovered projectiles and bullet holes in door frame of nearby residence. Trajectory analysis would have assisted the investigator in determining whether the subject was standing squared up on officer when officer fired as officer had stated, or had turned and was fleeing at the time shots were fired.

- Failing to conduct trajectory analysis in case in which officer who fired shots that hit multiple individuals, projectiles recovered in numerous locations, and bullet holes identified in multiple places on a porch and in a residence. Trajectory analysis would have assisted the investigator in determining the position and distance of the officer at the time of firing including whether the officer may have been able from that position to see the bystander individuals.

3. Failing to obtain gunshot residue analysis

Gunshot residue (GSR) analysis tests for the presence and pattern of gunshot residue. When tested on an individual's hands, where possible, it can provide information regarding whether that person may have discharged a firearm. When tested on an individual's clothing, it can provide information regarding whether the individual may have been shot at close range. During the time of the OIS investigations we reviewed, for which the on-scene investigation was led by CPD, these steps would have been handled by CPD. We found this deficiency in many of the cases we reviewed for which it was relevant. We observed in our review multiple instances in which the circumstances warranted such testing because either there was an allegation that the subject discharged a firearm (warranting GSR testing on the subject's hands) or there was an allegation that the subject was shot at close range (warranting GSR testing on the subject's clothing), but no such testing was done. The below examples illustrate the significance.

- Failing to conduct GSR testing on subject's clothing in a case where witness stated that she observed officers shoot a subject as he lay on the ground. GSR testing would have potentially either corroborated or contradicted the witness's statement.

- Failing to conduct GSR testing on subject's hands in a case where key issue was whether subject had a gun, as officers stated, or not, as multiple witnesses said that they did not see a gun. GSR testing would have potentially corroborated or contradicted the officers.

- Failing to conduct GSR testing in case in which shooting officer stated that he had heard shots fired, possibly by the subject, and a weapon was recovered close to the subject. GSR testing on the subject as well as other witnesses who may have been

with the subject just prior to the shooting would potentially have been evidence relevant to determining whether the subject or another witness might have fired the gun.

- Failing to conduct GSR on subject's clothing in a case where shooting officer stated that he backed away from a subject four feet before firing multiple shots. GSR testing would have potentially corroborated or contradicted the officer.

4. Failing to obtain complete fingerprint or DNA analysis

Fingerprint analysis to test for the presence of any latent prints of value that can be compared to the prints of an individual can provide evidence as to whether that individual touched an object. (It should be noted that fingerprints are rarely able to be recovered from firearms due to the smooth surface from which a print is more susceptible to be smeared or not otherwise readily preserved in a manner from which it can be effectively tested.) DNA analysis to test for the presence of DNA that can be compared to the DNA of an individual can provide evidence as to whether that individual has touched an object. We found this deficiency in many of the cases we reviewed for which it was relevant. There were multiple instances in which the circumstances warranted such testing that was not done or more extensive testing than was conducted. The below examples illustrate the significance.

- Failing to analyze for DNA or fingerprints in a case where recovered item was the object stated by shooting officer to have been possessed by subject at time shooting officer fired.

- Failing to process subject's alleged firearm for latent fingerprints.

5. Failing to effectively analyze ballistics evidence

Ballistics analysis to determine if a gun is in firing condition and whether it was the source of any recovered casings or bullets provides evidence as to whether a gun was able to be fired and whether it fired recovered projectiles. We found a few cases involving potentially insufficient analysis or follow-up. The below example illustrates the significance.

- Failing to further analyze casing and jacket fragments that had not come from the shooting officer's weapon in a case where witnesses alleged that a second officer had fired at subject.

6. Failing to obtain medical evidence

Medical information can be critical evidence, particularly evidence that provides information regarding the position of the subject's body in relation to the shooter. In a fatal shooting, information can be obtained from the medical examiner's report as to the location of entry and exit wounds (where applicable) but also from a trajectory rod analysis if done. In a non-fatal shooting, information can be obtained from medical records regarding entry and exit wounds (where applicable). We found this deficiency in many of the cases we reviewed. There were instances where certain medical information was not obtained that could have had significant evidentiary value. The below examples illustrate the significance.

- Failing to obtain trajectory rod analysis by medical examiner in instance where subject suffered wounds in particular finger and lower back that would have provided additional evidence against which to evaluate officer's statements regarding subject's position at the time officer fired, and which could have been particularly valuable as the officer had initially not stated that the subject had turned away but later made a different statement regarding that aspect of the incident.

- Failing to analyze medical examiner's trajectory analysis of path of bullet in subject's body for potential information on body position at the time shots were fired in case in which multiple witnesses stated that officers fired at the subject while he was lying on the ground.

- Failing to attempt to obtain or analyze medical records or mental health history of a subject involved in attempted suicide by officer where there was clear evidence he suffered from mental health issues and substance abuse.

- Failing to analyze medical examiner's bullet wound trajectory analysis to aid in determining whether subject was turning towards or falling away from officer when he was shot.

7. Failing to obtain other types of evidence

There are numerous other instances in our review of information that investigators failed to obtain. Such evidence would have provided additional information relevant to the investigation. The below examples illustrate the significance.

- Video: We observed instances where investigators failed to take thorough and persistent steps to obtain video from businesses or residences in surrounding areas. We found this deficiency in a few of the cases we reviewed. We observed one instance where the investigator failed to obtain transit authority video that may have corroborated or contradicted the officer's statement that the subject turned and pointed a weapon at the officer.

- ATF Trace: We observed instances in which an ATF trace was never requested regarding a gun recovered, which the shooting officer stated had been possessed by subject. Such information, which provides an ownership history of a firearm, may provide information that could corroborate the officer's account if it traced to the subject or someone connected to the subject and contradict assertions that the gun was planted by police. We found this deficiency in many of the cases we reviewed.

- Vehicle Evidence: We observed instances where evidence that can be obtained from a vehicle involved in the incident was not obtained. These included: failing to process the vehicle in any detail to recover all projectiles or other evidence; failing to conduct trajectory rod analysis to provide evidence regarding the position of the shooting officer at the time of firing; and failing to view and assess various aspects of the vehicle to see if they are consistent with or contradict the shooting

officer's statements. We found this deficiency in a few of the cases we reviewed but note that many others did not involve vehicles.

- OEMC Evidence: We observed at least one instance where there was no indication that investigators ever requested information from OEMC. Such information can be critical as there may be among other things 911 calls that provide relevant witness information and dispatch recordings that provide details and timing of events.

- Information from Related Civil and Criminal Cases: We observed instances where related civil and criminal cases existed during the pendency of the investigation and investigators failed to obtain information generated by those matters. Such cases may provide critical information not developed or obtained during the course of the investigation and can include materials such as deposition testimony of officers, witnesses, and surviving subjects; medical and other records; additional forensic testing; materials not obtained from CPD; or trial testimony of officers or witnesses. We found this deficiency in most of the cases we reviewed.

8. Failing to take additional steps on-scene

There are numerous other failings that occurred on-scene that bear mentioning. The below illustrate those additional points.

- Officer weapons: We saw instances where involved-officer weapons were either not secured properly or failed to be secured. These steps would have been handled by CPD. We found this deficiency in a few of the cases we reviewed. These instances included securing a shooting officer's weapon at the station rather than on-scene. They also included a failure to recover the weapon from a second officer despite the fact that witnesses said they saw the second officer fire his weapon.

- Witnesses on-scene: We saw at least one instance where it did not appear that potential witnesses were properly accounted for on-scene or that reasonable attempts were made to hold witnesses at the scene. These steps would have been handled by CPD. In that case involving a large number of witnesses at a residence, there was no attempt to do a head count of all individuals present or to ensure that each individual had been interviewed before they left, including an individual with a visible minor injury who did not appear to have been identified or treated.

- Detail follow-up: We saw instances where investigators did not appear to follow up on small details that could corroborate or contradict officer or witness statements. We found this deficiency in many of the cases we reviewed. Such examples included: (1) failing to follow up to determine if an insurance card was recovered in case in which officers stated that the subject handed over an insurance card as part of the events leading up to the shooting incident; (2) failing to attempt to determine if a buzzer was working in case in which a witness said the subject had called prior to the subject encountering the police because a building's buzzer was not working; (3) failing to attempt to find a receipt of purchase where witness said

the subject had gone to the store to make a purchase prior to encountering police; (4) failing to attempt to verify the level of window tinting on the subject's vehicle even though such information was disputed and relevant to what the officers could see; and (5) failing to attempt to determine if subject was left or right-handed in case in which officer stated the subject held the weapon in a particular hand.

B. Insufficient Interviews Of Involved Officers

Thorough and probing interviews of involved officers are essential to the credibility of an OIS review process. This is particularly so when there are few or no other witnesses, the subject is deceased or has not made a statement, and where there is little forensic or other evidence to challenge what the officer says happened. IPRA's involved officer interviews were generally of insufficient quality and depth.

The officer interviews in almost every instance were audio recorded thus providing us the ability to conduct a detailed analysis of the interviews.[141] Interviewers often asked the involved officers to simply recite their version of events, used ineffective leading questions, or appeared to be essentially using a script. Without challenging or probing the answers with pointed follow-up questions, and without testing officers' statements against the available forensic evidence or the contradictory or corroborating statements of other witnesses, officer interviews did not rise to the standard necessary for a credible OIS review process.

We noted the following areas of deficiencies in the cases we reviewed.

- Failing to follow up in detail on key areas;
- Failing to ask probing questions;
- Failing to attempt to confront or resolve inconsistencies;
- Failing to use aids to facilitate interview;
- Failing to prohibit unexplained pauses in recording; and
- Failing to conduct timely interviews.

1. Failing to follow up on key details

Investigators frequently failed to ask follow-up questions or seek additional details regarding key areas. We found this deficiency in nearly all of the cases we reviewed. The below examples illustrate the significance.

- Failing to question officer regarding witness statements that shots had been fired after the subject had been handcuffed.

- Failing to question officer who had previously stated to CPD that he never lost sight of the subject as to whether he saw subject throw a weapon in a case involving

[141] As previously noted, officer and civilian witness interviews are treated separately for purposes of this report because of a number of differences in the way in which they were conducted, including the recording of officer interviews and lack of recording of civilian interviews, which had bearing on the depth in which we could analyze the interviews.

subject who did not have a weapon when shot but where a weapon was recovered from adjacent yard.

- Failing to ask officer whether he saw the subject drop a weapon during a chase and before the officer fired in a case where the weapon was recovered near where the subject reportedly fired at the officer and not where the subject was shot.

- Failing to question officer regarding the view he had of a subject who had a gun in his pocket that may not have been visible or whether he saw the gun fall out of the subject's pocket.

- Failing to question shooting officer about prior contacts with subject in a case in which shooting officer stated that he recognized subject from prior arrest where such questioning would have enabled investigators to ascertain information as to what prior views shooting officer may have had regarding subject.

- Failing to ask shooting officer detailed questions about the subject's behavior including whether subject's hands were visible in a case in which the officer alleged that the subject stopped and turned towards the officer.

2. Failing to ask probing questions

Investigators failed to ask probing questions. We found this deficiency in nearly all of the cases we reviewed. The below examples illustrate the significance.

- Failing to ask shooting officer questions about his statement that he dropped from climbing a fence, unholstered his weapon, and fired a shot from 30 feet that struck a subject in the back of the head, even though the officer stated the subject had squared up on him.

- Failing to question shooting officer about reason for location of entry wound on the subject's back as set forth in medical examiner report.

- Failing to ask shooting officer detailed questions about description of gun officer stated he saw, how it could have been thrown by subject some distance away from where he was shot, whether the subject could have been holding his pants up when he reached to his waistband, and why his partner had re-holstered his weapon at the time of the fatal shot.

- Failing to ask shooting officer questions regarding reason for firing weapon, questions pertaining to whether firearm was fully loaded or not and number of bullets held in firearm, or questions pertaining to witness statement that officers had fired at subject while he was handcuffed.

- Failing to ask shooting officer questions regarding the effectiveness of the officer's identification of the subject as the shooter in an altercation among a large group of

people; why the officer, who was off-duty, did not call 911 during his vehicular pursuit of the subject; and the feasibility of the recovered weapon landing on a roof.

- Failing to do more than ask officer to recount a narrative of the events with minor follow-up questioning.

3. Failing to raise inconsistencies

Investigators failed to raise inconsistencies. We found this deficiency in nearly all of the cases we reviewed. The below examples illustrate the significance.

- Failing to question officer regarding inconsistencies where officer stated in interview that the subject got out of the rear of a car but prior reports stated that the subject was the car's driver.

- Failing to question officer regarding inconsistencies in multiple statements including (1) prior statement that officer saw the subject shoot at another individual as contrasted with later statement that he was dialing his phone at the time and only heard the shot; (2) prior statement to 911 dispatcher that the subject had thrown a weapon as contrasted with later statement that the location he directed dispatch to was the last place he observed the subject with the weapon; (3) prior statement that the subject turned towards him and raised his weapon as contrasted with later statement that the subject pointed the gun right at him.

- Failing to question shooting officer, who stated that his body was inside the almost completely open car window of the vehicle that the subject was driving, regarding photographs of the vehicle that were inconsistent with that claim.

- Failing to question shooting officer about inconsistent statements regarding whether anyone was present with the subject around the time of the shooting where officer had previously maintained that multiple people were present but later stated that only one person was present despite the fact the officer also claimed to have heard an individual ask a question, which would have indicated the presence of two people.

- Failing to question the shooting officer regarding evidence that the subject's weapon was recovered in slide-lock position against the officer's statement that he saw the subject point the weapon at him out of slide-lock position.

4. Failing to use aids to facilitate interview

Investigators failed to use maps, diagrams, photographs, video, or similar aids to facilitate a clearer discussion of the events surrounding the shooting or to probe the officers' statements. We found this deficiency in most of the cases we reviewed for which it was relevant. The below examples illustrate the significance.

- Area maps, photographs, and diagrams with measurements: We observed that in most cases maps, photographs, and diagrams were not used and would have aided the interview in facilitating more effective questioning of the officer. These instances included cases where the subject may have fled on foot over a period of distance or cases involving a vehicle pursuit.

- Scene photographs: We observed that in most cases, photographs of key aspects of the scene were not used and would have aided the interview in facilitating more effective questioning of the officer. For example, we observed one instance where the position of a door was relevant to what the shooting officer could have been able to see regarding the presence of bystanders, the shooting officer inaccurately reported the direction the door swung, and the investigator did not confront the officer with photographs contradicting that statement or use photographs to elicit further information regarding the position of the screen door. We observed another instance in a case where an involved officer placed himself on the driver's side of a vehicle and stated that he had not fired his weapon, and the investigator in the interview did not utilize photographs showing bullet holes on the driver's side of the vehicle.

- Video of events: We observed that in cases that had video evidence, the video was not used in the interview and would have aided the interview in facilitating more effective questioning of the officer. We observed one instance, for example, where although surveillance footage and the in-car camera from the shooting officer's vehicle captured the shooting on video, the investigator failed to use videos in the interview of the shooting officer. In another instance, although CPD's report stated that CTA surveillance footage was obtained, IPRA failed to use the footage in the officers' interviews to corroborate their version of events.

5. Failing to explain pauses in the recording

Recordings of officer interviews contained unexplained pausing of the audio-recorder, particularly at key moments of the interviews. We found this deficiency in a few of the cases we reviewed.

6. Failing to timely conduct officer interviews

Investigators failed to conduct timely interviews of officers in some cases, although in other cases officers were interviewed promptly. The delay in conducting officer interviews was in some instances months or even years. While we note the potential for a criminal prosecution and the *Garrity* issues presented by taking compelled statements in light of that issue, in many cases the delay in the officer interviews appears to have no relation to that matter since lengthy delays persisted even after SAO had declined criminal prosecution. We found this deficiency in many of the cases we reviewed. The below examples illustrate the significance.

- Failing to interview multiple officers until between one-and-one-half years and three-and-one-half years after the incident despite fact that SAO declination came eight months after incident.

- Failing to interview shooting officer until more than two years after incident and over two years after SAO declination.

- Failing to interview involved officer until 18 months after incident despite fact that SAO declined to prosecute 9 months after incident.

- Failing to interview involved officers until almost two years after the incident and a witness officer who recovered the subject's weapon was not interviewed until three-and-one-half years after the incident.

- Failing to interview involved officers until more than three years after the incident.

C. Insufficient Efforts To Locate And Interview Civilian Witnesses

We identified numerous deficiencies regarding investigators' minimal or insufficient attempts to locate and interview civilian witnesses to the incident. We noted the following areas of deficiencies in the cases we reviewed: (1) failing to take steps to locate or interview relevant identified witnesses; (2) failing to conduct a thorough canvass or more than one canvass; (3) failing to take most active steps to contact witnesses; and (4) failing to use subpoenas to compel statements from uncooperative witnesses.

1. Failing to take steps to locate or interview relevant identified witnesses

Investigators frequently failed to even attempt to locate or interview witnesses that had been previously identified. We found this deficiency in most of the cases we reviewed. The below examples illustrate the significance.

- Failing to identify or locate the passenger of a carjacked vehicle who ran from the scene even though he was depicted on a video and a victim had seen all of the individuals who got in the car.

- Failing to adequately follow up with witnesses identified in CPD reports or 911 callers who made statements raising questions as to whether involved officers fired additional rounds after a pause in the shooting or shot subject while he was on ground.

- Failing to follow up with any of 20 witnesses identified in a CPD report who heard but did not see a shooting.

- Failing to interview seven of nine witnesses identified in CPD reports including a witness who had heard an individual make statements instructing another individual not to move because he was going to shoot.

- Failing to interview employees who would have been working at the time of the incident, but were not working at the time investigator attempted to conduct interviews at business.

- Failing to interview seven relevant witnesses, two of whom were officers.

- Failing to interview key individual residing at known location and identified in CPD reports as having been present with the subject around the time of the shooting, and who could have thus potentially confirmed whether the subject in fact had a gun that he pointed at the officer.

- Failing to take steps to attempt to fully identify and locate key individual who, according to other witnesses, saw the shooting and had said that the subject had a gun in his possession.

- Failing to conduct adequate follow-up to locate and secure cooperation of individuals who had called 911 with relevant information.

2. Failing to conduct a thorough canvass or more than one canvass

A canvass is the technique by which an investigator can most readily identify individuals not present and identified on-scene but who may have been in the vicinity by virtue of their residence or place of business and thus may have been in a position to see or hear something relevant to the incident or otherwise have significant information. Investigators in many instances conducted only one canvass or a less than thorough canvass. This is significant because a single canvass is likely to miss individuals with information who are not present at the time the investigator is canvassing, even if the canvass is done at the same time of day as the incident occurred. We found this deficiency in most of the cases we reviewed. A few featured no canvass at all.

3. Minimal efforts to contact witnesses

Investigators took delayed, minimal, and ineffectual steps to locate witnesses. We found this deficiency in most of the cases we reviewed. The below examples illustrate the significance.

- Failing to attempt to contact multiple individuals identified in CPD report until almost two years after the incident and then simply sending letters or leaving business cards. This included one witness who had a cell phone number identified by CPD and as reflected in the CPD report had eyewitness information regarding the shooting.

- Failing to attempt to contact numerous individuals identified in CPD reports who heard or witnessed some part of the shooting or to interview half of the officers present at the scene during the incident.

- Failing to contact two witnesses until over two years after the incident who had stated to CPD that they heard the subject, who did not have a weapon, tell the officers he did not have a weapon in response to their commands to drop the gun before he was shot.

- Failing to interview individual present at the scene who had stated to CPD that he witnessed the subject holding a towel around what could have been a gun, and failing to follow up with witness on-scene who stated that she was willing to provide a statement at a later date.

4. Failing to use subpoenas

Investigators failed to use subpoenas. IPRA is empowered by ordinance to issue subpoenas for testimony or the production of relevant information. We found this deficiency in nearly all of the cases we reviewed. In almost every instance, investigators declined to use this powerful tool as leverage with reluctant or uncooperative witnesses. In the limited instances in which a subpoena was used with witnesses, efforts to use it effectively were minimal. Moreover, subpoenas were likewise rarely used to obtain relevant information. The below examples illustrate the significance.

- Failing to use a subpoena where a witness had told CPD that she saw officers shoot a subject after he was already lying on the ground but declined to be interviewed when contacted by investigators.

- Failing to use a subpoena to secure cooperation of individual who had called 911 with relevant information but was uncooperative when contacted by investigators.

- Failing to use more than one attempt to serve subpoenas on nine witnesses where only one was successfully served.

- Failing to use subpoena power to subpoena phone company for address of 911 caller who stated he witnessed the shooting.

D. Insufficient Interviews Of Civilian Witnesses

Investigator interviews of civilian witnesses also suffered from serious deficiencies. However, because on many occasions the civilian witness interviews were not audio-recorded and memorialized only by summary reports, we had less of an ability to analyze the details of the interview than with the audio-recorded officer interviews. We were able, however, to observe a number of issues that impacted the ability to obtain information from civilian witnesses.

We noted the following areas of deficiencies in the cases we reviewed: (1) failing to follow up in detail on key areas; (2) failing to conduct additional interviews after obtaining key information; (3) failing to use aids to facilitate interview; (4) failing to conduct in-person interviews consistently; and (5) failing to conduct timely interviews.

1. Failing to follow up in detail on key areas

Investigator interviews of civilian witnesses generally lacked any detailed follow-up questioning. We found this deficiency in most of the cases we reviewed for which it was relevant. For example, we observed an instance involving a store robbery in which the witness was not questioned about her observations of the positions and movements of the subject or the officer while she was attempting to contact 911 or about the timing of the shooting, which she heard. We observed in another instance in which the investigator failed to ask multiple witnesses who saw some or all of the incident whether or not the subject had a weapon, or about their vantage point or lighting or other ability to perceive the events. The investigator also failed to ask a witness believed, based on phone records, to have been on the phone with the subject during the events what he heard on the call.

We also observed that investigators in many instances where relevant failed to use detailed questioning to address inconsistencies between the witness's account given in the interview as compared to that witness's previous statements or as compared to the accounts of other witnesses or other evidence. Interviews of key witnesses conducted on-scene at the time of the incident may have benefited from attempting to bring the interviewee back to the station for a more detailed and thorough debriefing in a less chaotic environment than the scene of the incident. In one instance, the investigator interviewed a witness on-scene who provided a detailed account of key observations including seeing the subject being shot in the back that may have benefitted from additional detailed questioning in a different environment if possible to better parse out the details in relation to other evidence and assess the witness's ability to perceive events.

2. Failing to use aids to facilitate interviews

Investigators used no aids in interviews of civilian witnesses. We found this deficiency in many of the cases we reviewed for which it was relevant. Area maps, photographs, and diagrams with measurements would have provided critical assistance to investigators effectively eliciting detailed information from civilian witnesses. Scene photographs of key aspects or video of events would have likewise aided the investigator to assess the witness's statements against significant pieces of evidence.

3. Failing to conduct additional interviews after obtaining key additional information

Investigators failed to conduct additional interviews with witnesses after obtaining key additional information that may have been inconsistent with the witness's statements or warranted further clarification. We found this deficiency in a few of the cases we reviewed for which it was relevant, however, in other instances related deficiencies rendered it difficult to determine whether additional follow-up was warranted. In one case, a carjacking victim's description of the weapon used did not match the mistaken weapon found, and investigators did not question the victim about the dissimilarity or ask him to identify whether the recovered mistaken weapon was the one used by the carjacker. In another case, investigators failed to attempt to reconcile statements from three witnesses, one of whom said the subject was not holding a weapon, one who said he thought there was something in the subject's hand, and the third who was positive the subject pointed a gun at the officer after the officer ordered him to drop the gun.

4. Failing to conduct interviews in person consistently

Investigators conducted some witness interviews solely by phone. Phone interviews are inferior to in-person interviews as there is no ability to connect with the witness in a meaningful way, assess credibility, or conduct the most thorough interview possible. We found this deficiency in a few of the cases we reviewed for which it was relevant. In the instances in which a phone interview was used, it was not evident that a phone interview was the only option available. We observed in one instance, for example, that investigators conducted a single phone interview where the witness contradicted officer's statements regarding the events in that she stated that she was hiding in a position close to the shooting and saw the subject lying on the ground but did not see a weapon.

5. Failing to conduct timely interviews

Investigators failed to conduct timely interviews of civilian witnesses in some cases. With respect to civilian witness interviews, there are not the same issues presented by *Garrity* providing potentially some basis for the delay. We found this deficiency in a few of the cases we reviewed for which it was relevant. The below examples illustrate the significance.

- Failing to interview the last two civilian witnesses until one and two years post-incident with no information in the file explaining the reason for the delay, where four other civilian witnesses were interviewed within the first month.

- Failing to interview two civilian witnesses until four years post-incident with no information in the file explaining the reason for the delay.

II. FINDINGS RELATED TO ANALYSIS

Investigators' summary reports lacked any meaningful analysis of the evidence gathered during the investigation. Rather, following a brief formulaic discussion of evidence in the fact section, the analysis section of the report consisted of little more than the CPD deadly force or other applicable policy; a very brief mention of certain evidence, which generally consisted of the officer's version of events; and a summary conclusion finding the shooting to be within policy. There was no discussion of how various pieces of evidence fit together and the weight to be given to each in assessing the significance in terms of the ultimate finding. There was no assessment of witness credibility. There was also no recognition of evidence that was not obtained or questions that remained unanswered and the significance of unanswered questions in terms of being able to reach a determination. Every summary report we reviewed lacked this depth of analysis.

We noted the following areas of deficiencies in the cases we reviewed.

- Failing to analyze witness statements for discrepancies and inconsistencies;
- Failing to analyze witness statements against physical evidence;
- Failing to analyze witness statements against other witness statements;
- Failing to explore and assess evidence against key issues;
- Failing to address legal standard with specificity;
- Failing to analyze officers' broader tactical conduct, judgment, or adherence to training;
- Failing to have any apparent meaningful supervisory or specialized input;
- Failing to have consistency of assigned investigator; and
- Failing to keep complete files.

A. Failing To Analyze Officer Statements For Discrepancies Or Inconsistencies

Investigators failed to acknowledge, or meaningfully address, discrepancies or inconsistencies between and among multiple statements by an officer. We observed this in almost every case. The below examples illustrate the significance.

- Failing to analyze for potential inconsistencies when summarizing officer's subsequent statement the same way as it summarized the statement he made one-and-one-half years earlier without taking into account the differences in responses or the different questions posed.

- Failing to analyze inconsistencies among the shooting officer's multiple statements in order to attempt to reconcile the differing accounts or discuss the effect those inconsistencies had on the ultimate finding.

- Failing to analyze shooting officer's inconsistent statements and their impact on the ultimate finding in case involving question of whether the officer knew the subject tossed his weapon and the officer stated that he saw the subject make a throwing motion, which would provide some evidence the subject had thrown a weapon, but later stated only that he saw the subject flailing his arms.

B. Failing To Analyze Officer Statements Against Physical Evidence

Investigators failed to analyze officer statements against physical evidence relevant to determining the truth or accuracy of the officer's recounting of the incident. We observed this in almost every case. The below examples illustrate the significance.

1. Failing to consider photographs and video

- Failing to analyze scene photographs showing blood smears on a hallway wall which could have been used to assess the credibility or accuracy of contradictory statements about the subject's movements before and after being shot.

- Failing to analyze photographs of vehicle documenting the position of a car window that conflicted with the shooting officer's statement about the window in which he had placed his body.

- Failing to analyze photographs of vehicle depicting bullet holes on the driver's side of a car against an involved officer's statement that while on driver's side of vehicle he did not fire weapon (which was never examined).

- Failing to analyze whether video that showed the subject did not have a weapon in hand during the portion of the foot chase captured by the cameras was consistent with the involved officers' statements.

2. Failing to consider medical records

- Failing to analyze medical records of an injured shooting officer who stated that he fired at the driver of a vehicle because his body was in the car window to see if the medical records of officer injuries were consistent with his statement.

- Failing to analyze medical examiner's report findings reflecting wounds to the subject's back against officers' statements that subject was in vehicle when shot.

- Failing to analyze medical examiner's report findings reflecting entry wounds to the subject's back and finger raising issues as to whether the subject was running away from the officer rather than facing him or possibly turning at the time of the shooting as shooting officer stated.

- Failing to analyze whether the gunshot wound to the subject's left hand, evidenced in the medical records, would have potentially affected his ability to manipulate his weapon in the manner described by officers or to return it to his pants pocket at the end of the chase as officers stated.

3. Failing to consider OEMC information

- Failing to consider dispatch tape that contradicted officer's statement that shooting officer radioed "gun, gun."

- Failing to consider 911 call from witness stating officer killed subject "for no reason."

- Failing to consider 911 caller statement that he heard shots and then a pause and then more shots in light of witness accounts that subject was shot after he was handcuffed and/or on the ground.

C. Failing To Analyze Officer Statements Against Witness Statements

Investigators also failed to assess officer statements against statements made by witnesses. We observed this in almost every case. In certain instances, the analysis included statements or other evidence consistent with the officer's statements while excluding any reference to statements or other evidence contradicting the officer's statements. The below examples illustrate the significance.

- Failing to discuss witness statement that witness saw the subject get shot in the back, portion of another witness statement that witness did not see the subject turn towards the officer, and medical examiner finding of gunshot wound to upper left back but, by contrast, including another witness's statement that the subject fired at the officer.

- Failing to discuss witness statement that witness did not see a gun while including reference to the recovery of a weapon on-scene and a witness statement reporting that the subject had a gun.

D. Failing To Explore And Assess Key Issues

Investigators failed to explore and assess key issues in light of the evidence. We observed this in almost every case. The below examples illustrate the significance.

- Failing to analyze evidence in light of key issue regarding whether officer who stated area was dark could see the subject throw his weapon in case in which photographs of the scene reveal that there was a light mounted on a pole that could

illuminate the area, and witnesses indicated that the motion sensor light was activated when police entered the area.

- Failing to analyze evidence in light of key issue regarding whether shooting officer who stated that she saw an object in the subject's hand had in fact seen such an object and investigator summarily concluded that item recovered at the scene was the item the officer saw without analyzing whether the subject would have been able to hold onto that object after being involved in a car crash, climbing out of the vehicle, being hit by another car, climbing out from under that car, struggling with officers, repelling officers' attempts to subdue him, and then breaking free and fleeing.

- Failing to analyze evidence including video evidence of shooting in light of key issue regarding whether subject may have been fleeing or falling at the moment of shooting instead of turning towards officer as officer stated.

- Failing to analyze evidence in light of key issue regarding whether subject pointed a weapon at the officer as opposed to disposing of it when the subject had been disposing of multiple weapons when the officer approached.

- Failing to analyze evidence in light of key issues arising from the chain of events that led up to the shooting including (1) the basis stated by officer for the officer's decision to insert his body into vehicle; (2) the description officer gave as to how the officer was positioned within the car, including whether he could have disengaged from the car; and (3) whether the evidence supported the officer's claim that he fired because he was going to be seriously injured if the vehicle struck his own car or another car in the street.

E. Failing To Address Legal Standard With Specificity

Investigators failed to include any meaningful discussion of the facts as applied to the legal preponderance of the evidence standard. We observed this in almost every case. In many instances, the legal analysis simply parroted the officer's version couched in the boilerplate legal language from the policy—*i.e.*, that the officer believed that deadly force was necessary to prevent death or great bodily harm to him or herself or another. This *pro forma* analysis sometimes failed to even clarify which portion of CPD policy justified the shooting. For example, in a case where it would have been particularly relevant involving a subject who was believed to have just engaged in a drug transaction and who was attempting to continue driving with the officer inside the window, while the investigator concluded that the subject was using the vehicle as a deadly weapon, there was no specific analysis regarding under which prong the use of force was justified—*i.e.*, (1) to prevent death or great bodily harm to the officer or another, or (2) to prevent the arrest to be defeated by a fleeing felon who was attempting to escape by use of a deadly weapon.

F. Failing To Analyze And Assess Broader Tactical Conduct, Judgment, And Adherence To Training

Investigators failed to analyze and assess broader tactical conduct, judgment, and adherence to legal standards. In so doing, investigators failed to fulfill the mandate of IPRA to recommend policy revisions to CPD that might enhance the efficiency of the department or improve the training of its officers. While a given shooting might have been within policy, that shooting may nevertheless reflect questionable tactics and judgment by officers. We observed this in a number of cases and saw concerning patterns in certain areas with police tactics and judgment from the cases we reviewed. The below examples illustrate the significance.

1. No consideration of whether officers should have sought cover or awaited back-up

Investigators failed to assess whether officers should have taken cover or awaited back-up before engaging with subjects.

- Failing to assess, in a case involving multiple officers approaching a vehicle believed to have been involved in an armed carjacking, whether officers could have controlled the situation from a position of cover.

- Failing to assess whether officers should have waited for supervisors to arrive on the scene of an apartment containing an armed subject, particularly given that enough officers were on-scene to secure the apartment rather than immediately entering it.

- Failing to assess whether off-duty officer walking in on a robbery-in-progress could have taken cover before interacting with the subject.

- Failing to assess, in a case involving suicidal subject possessing two items believed to be guns whether other options were available to the responding officers, such as taking cover and using time as a tactic, or whether a trained Crisis Intervention Training officer should have been summoned to the scene.

- Failing to assess, in a case involving stop of vehicle, whether the shooting officer could have taken cover behind his own vehicle, which was one of the vehicles blocking in the subject's car and which would have protected him.

2. Excessive shooting

Investigators failed to assess whether officers engaged in excessive shooting, particularly in instances where there was no return fire from subject.

- Failing to assess, in a case where an apparently mentally ill subject possessed two guns (later determined although not known at the time to be toys), whether multiple officers, some with a level of cover, firing almost 40 rounds constituted an excessive shooting.

- Failing to assess whether there was excessive shooting in case where 21 rounds were fired at occupant of car who was allegedly reaching for a weapon.

- Failing to assess, in a case where subject approached officers with kitchen knife and fell to floor after being shot, whether eight rounds was excessive shooting, particularly in light of witness testimony that officers continued to shoot after subject was incapacitated.

3. Vehicle cases

Investigators failed to assess whether officers employed reasonable tactics and judgment with respect to vehicles.

- Failing to assess tactics of officer who had his left hand on the steering wheel, raised his weapon with his right hand, leaned out the window, and fired at an armed subject who was running on foot and according to officer turned and pointed his weapon at the officer.

- Failing to assess tactics of officer who inserted himself into the passenger window of the subject's fleeing car with weapon drawn and who fired at the driver holding gun with one hand.

- Failing to assess tactics of officer who inserted himself into the window of the car while the subject was attempting to flee and officer's partner fired shots past the officer in window, killing the driver.

- Failing to analyze the judgment of officer to reach into stopped vehicle to try to extricate the subject driver, particularly when the subject vehicle was boxed in by multiple officer vehicles.

4. Potential danger to bystanders or fellow officers

Investigators failed to assess whether officers conduct endangered bystanders or other officers.

- Failing to analyze, in case involving multiple individuals present at residence, whether the officer was aware of bystanders who also ended up being hit by the officer who was shooting from outside of the residence.

- Failing to analyze, in case involving officers on either side of vehicle, whether officers were in a potential cross-fire situation.

- Failing to analyze, in case involving multiple officers approaching vehicle believed to have been involved in an armed carjacking, the decisions by officers who fired multiple times after the vehicle came to a stop despite the fact that they acknowledged not knowing the positions of their fellow officers.

5. Failing to remain at scene

Investigators failed to assess officers' conduct in leaving the scene.

- Failing to analyze judgment of involved officer to leave immediate scene following shooting to attempt to apprehend an individual suspected of having just made a user-quantity purchase of drugs from the subject.

6. Failing of effective protocols or supervision

Investigators failed to assess whether proper protocols were followed or supervision was effective.

- Failing to analyze fully supervisory and OEMC management of the vehicle pursuit that resulted in close to 50 officers being involved, most of whom failed to notify OEMC of their intent to pursue the subject.

- Failing to analyze supervisory management of situation occurring in transit station where lieutenant had directed responding officers not to approach the subject and whether that direction was successfully communicated to the officers on-scene, or why that direction if heard was not followed.

G. Failing To Have Any Meaningful Supervisory Or Specialized Input

The files of the investigators reflect little to no supervisory or specialized input. It is possible that the investigations received more supervisory involvement than what is reflected in the files. But that is not demonstrated by the files themselves. There is, in almost all instances, nothing in the files such as notes of meetings with supervisors that reflects ongoing supervision during the investigation. There is, in almost all instances, nothing in the files that indicates any meaningful supervisory review of the summary report. Some cases have nothing indicating that a supervisor conducted any review. Other cases contain some indication of review but then lack documentation on whether issues raised by the supervisor were ever addressed. There are still other instances where an ultimate determination was changed by a supervisor and there is no documentation as to the reasons for the decision or the discussions with the investigator. In addition to a general lack of supervisory input, we observed a lack of information in the files that reflected any consultation or input from either staff attorneys or those on staff with forensic evidence expertise.

H. Failing To Have Consistency Of Assigned Investigator

Investigations often lacked a consistent lead investigator. In many instances, the lead investigator on a case was not the investigator who responded to the shooting scene, meaning that the lead investigator had no first-hand observations of the shooting scene, had no observation of the collection of forensic and other evidence, and had not conducted initial interviews. Additionally, lead investigators sometimes changed over time. While this can be a common occurrence in any investigative agency due to attrition, extended leaves, or other circumstances, the length of time of these investigations can exacerbate turnover.

I. Failing To Keep Complete Files

Investigators appeared to keep incomplete investigative files, as all in one aspect or another lacked documentation we would have expected to see. The files lacked the type of handwritten notes that would be expected to be found from meetings, phone calls, or interviews that took place during the investigation. The files lacked in most instances marked up drafts of summary reports that one would expect to see from a supervisory review.

Investigator case logs were likewise incomplete and often contained only minimal information and lacked details about investigative actions taken. We observed in one case that there was a one-page case log for a four-year investigation and in another there was no case log at all. The investigative logs also frequently lacked information regarding when IPRA requested or received information from third parties, often failing to indicate when a report was requested or when it was received noting only the date on which it had been printed.

There were also instances in which the case files appeared to be missing materials that seem to have been created during the investigation. These included cases where the following items which should have likely existed based on references elsewhere in the file or otherwise but were not found in the file: witness statements, scene photos, plats of scenes, scene video, lab reports, and recordings of interviews.

III. FINDINGS RELATED TO LENGTH OF TIME OF INVESTIGATIONS

A. Timelines

In order to analyze how each investigation unfolded, we created timelines that documented the dates upon which all significant investigative steps were taken in each reviewed case file. The information that populated each timeline was compiled from the documents that were made available to us in each individual case file, including, but not limited to, the investigator's case log, To/From Reports, Summary Reports, transcripts, request forms, and third party documents (*e.g.*, medical examiner reports or medical records, CPD reports, ISP reports, OEMC reports, and SAO declinations). We then categorized the timeline entries into ten categories that would reflect the most significant investigative steps. These categories include:

(1) Incident: Date of OIS.

(2) IPRA Witness Interviews: Dates of all witness interviews that resulted in substantive statements regarding the incident. Contacts with individuals that did not result in substantive statements were not included in this category. For example, this category does not reflect a canvass in which no substantive statement was taken from any witness. Similarly, this category does not reflect an investigator's attempt to contact a potential witness or a call with a potential witness regarding only scheduling.

(3) IPRA Officer Interviews: Dates of officer interviews. This category includes interviews of witness, involved, and shooting officers.

(4) Report Generated: Dates significant reports were generated by third parties, including CPD reports, medical examiner reports, ISP reports, and medical records. The dates documented in this category were taken from the third party reports themselves, where

possible. If it was not possible to ascertain a date for a specific document, that document is not reflected in the timeline. Internal IPRA reports, including To/From Reports, are not reflected in this category.

(5) Information Requested: Dates IPRA requested information from third-parties.

(6) Information Received: Dates IPRA received information from third parties. In cases in which the case file failed to document the date upon which a document was received and there was a "printed on" date on the document, we used the print date as the date of receipt. If there was no indication in the case file as to when a document was received, that document is not reflected in the timeline.

(7) Contact with SAO: Dates of any contact with SAO, including IPRA referrals and SAO declinations. If there was no indication in the file as to when the case was referred, the timeline does not reflect the referral. If there is no indication as to when SAO issued a declination (*e.g.*, the declination is undated and no declination date on case log), the declination is not reflected in the timeline.

(8) Civil Litigation: Dates that the investigator received or was informed of any information related to a pending related civil suit.

(9) Summary Report: Dates of all draft and final Summary Reports. If a Summary Report was not dated and there was no other indication in the file as to when the Summary Report was written, the Summary Report is not reflected in the timeline.

(10) Case Closed: Date the case was closed pursuant to the CR Summary.

The categorized entries were then converted into a corresponding graphic in order to aid in understanding the timeline of each case. Those graphic timelines are attached hereto as Appendix B. Notably, we were only able to document that information which was clear from the case files. For this reason, to the extent any information in the case file was undocumented, unclear, or inaccurate, the timelines necessarily would similarly reflect those deficiencies.

B. Analysis Of Timelines Generally

As noted above, IPRA's investigations take too long. And quite often, the files fail to explain in any detail the cause of numerous and lengthy delays. These delays significantly undermine the reliability and completeness of investigations. Indeed, based upon the compiled timelines, the mean length of each investigation from the date of the incident to the date the case was closed was over three years (39 months).[142]

To the extent we could ascertain how the investigations unfolded from the documentation in the case files, it appears that the majority of witness interviews were completed within the first two months after the incident. Although the timing of officer interviews tended to vary substantially (ranging from 1 month to 40 months post-incident), when averaged, the majority of those interviews were completed within the first year of the investigation. The majority of the relevant

[142] All means were estimated based upon the timelines.

reports (including CPD, medical examiner, and ISP) were generated, on average, within the first three months of the investigation, and the investigators received the majority of the key information in each investigation within the first eight months. Thus, on average, the vast majority of IPRA's investigative steps appear to be completed within the first eight months. However, in almost every case, there are sporadic and often inexplicable delays between the initial flurry of investigative steps in those first eight months and the closing of the case years later.

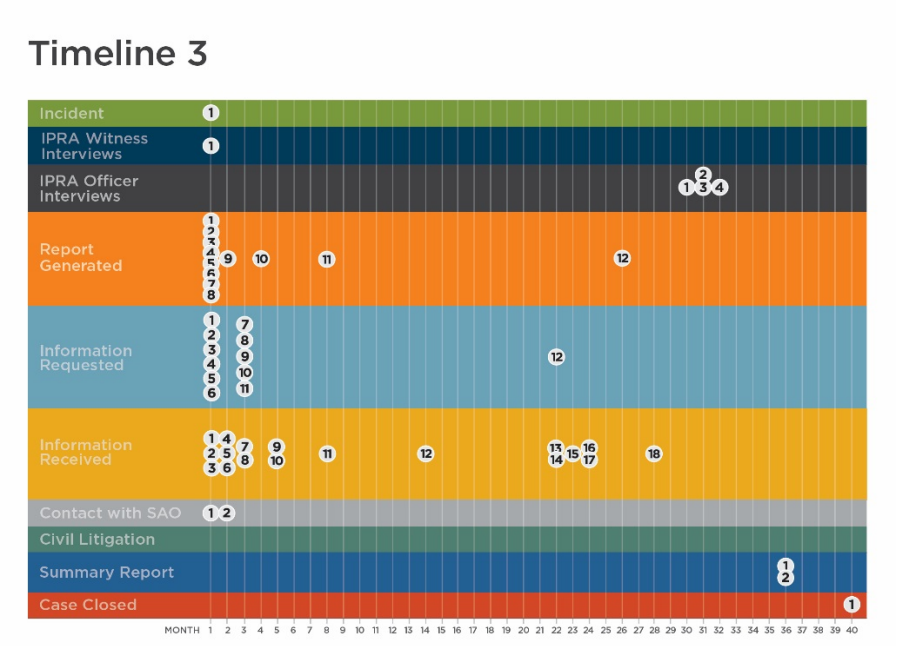
C. Analysis Of Delay Drivers

1. ISP reports

Investigations are sometimes delayed while IPRA waits on ISP reports. On average, the last ISP Report in the reviewed case files was generated almost eleven months post-incident. However, in several cases, the last ISP report was not generated until much later. For example:

- Timeline 1: Last ISP report generated 15 months post-incident.
- Timeline 4: Last ISP report generated 21 months post-incident.
- Timeline 7: Last ISP report generated 17 months post-incident.
- Timeline 13: Last ISP report generated 18 months post-incident.
- Timeline 15: Last ISP report generated 15 months post-incident.

To put this in context visually, below is Timeline 3. As indicated by the dot numbered 12 in the orange "Report Generated" category, the last ISP Report was not generated until 26 months post-incident.



2. SAO declinations

In some cases, IPRA's investigations stall while IPRA waits on a SAO declination in order to avoid any possible taint to a potential criminal prosecution. In those case files that documented both the date of IPRA's referral and date of SAO declination, it took, on average, six-and-one-half months for SAO to issue a declination. The date upon which SAO issued its declination was, on average, just under seven months from the date of incident. Although six-and-one-half months is still a significant delay, it does not appear from the timelines that SAO declination was the driver of the most notable and significant delays in the reviewed case files. For example:

- Timeline 1: SAO declination issued three months after referral. Unexplained 5-month delay in issuing Summary Report and 14 month delay closing case after declination, during which time no additional investigative steps were taken.

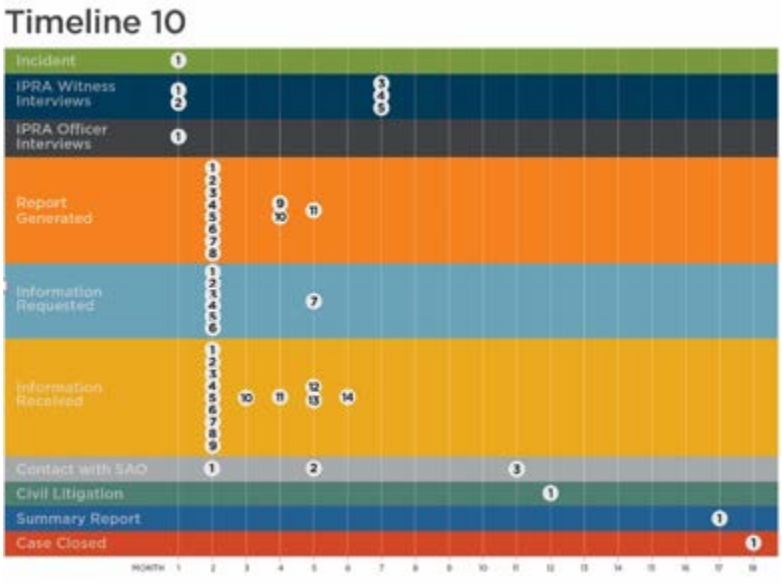
- Timeline 3: SAO declination issued one month after referral. Summary Report not generated until 36 months post-incident, and case closed 40 months post-incident.

- Timeline 7: SAO declination issued two months post-incident. 29-month delay before Summary Report issued and case closed.

- Timeline 9: SAO declination issued three months post-incident. Summary Report and case not closed until 33 months post-incident.

- Timeline 15: Eight-month delay between referral and SAO declination, during which time IPRA continued to take significant investigative steps. Case closed over three years after SAO declination.

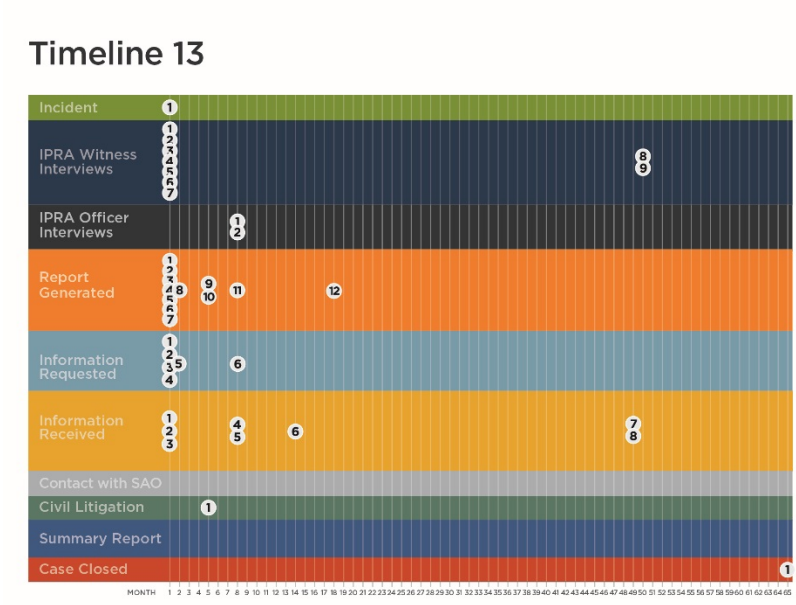
To put this in context visually, below is Timeline 10. As indicated by the dots numbered 1 and 2 in the grey "Contact with SAO" category, IPRA referred the case to SAO two months post-incident and submitted additional documentation five months post-incident. SAO issued its declination nine months after the initial referral, as indicated by the dot numbered 3 in the same category. During the nine months between the initial referral and the declination, IPRA continued to take significant investigative steps, including witness interviews. There is an unexplained six-month delay in issuing the final Summary Report after SAO declination, during which time no investigative steps were taken.



3. Civil suits

Twelve case files documented the existence of a related pending civil suit. On average, the first indication of a civil suit in those case files occurred just under nine months after the incident. Only one case file documented the resolution of the civil suit. In that case, the suit settled 28 months after the incident, and IPRA's case was closed 3 months later. Because there is no documentation in the remaining case files as to when the related civil suits were resolved, we were unable to analyze whether related pending civil suits are a driver for investigative delays.

To put this in context visually, below is Timeline 13. As indicated by the dot numbered 1 in the green "Civil Litigation" category, the complaint in the related civil suit was filed five months post-incident. There is no additional information regarding this suit in the case file. The case was closed 65 months post-incident.

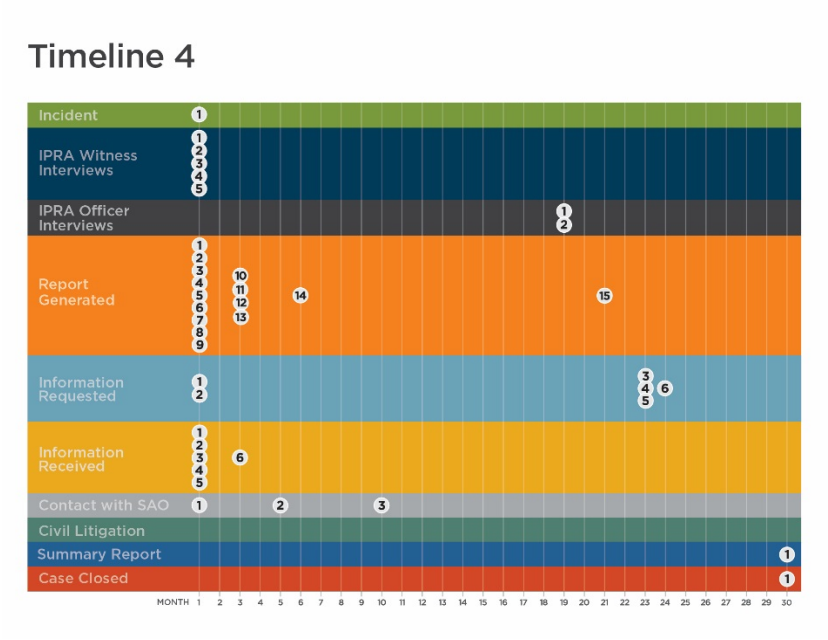


4. Officer interviews

IPRA appears to have in the past delayed officer interviews (which may or may not include the shooting officer) without any explanation provided in the file. In the reviewed case files, the last officer interview was not completed, on average, until 16 months post-incident. In several case files, the officer interviews were not taken until years after the incident. For example:

- Timeline 2: 12-month delay in interviewing shooting officer, no significant investigative steps were taken in preceding 7 months.
- Timeline 3: Shooting officer interviewed two-and-one-half years after incident and over two years after SAO declination.
- Timeline 7: Officer interviews taken 29 and 30 months post-incident.
- Timeline 8: Six officers were not interviewed until more than three years after the incident.
- Timeline 14: Officer not interviewed until over two years after incident.
- Timeline 15: Four officers were interviewed between one-and-one-half years and three-and-one-half years after the incident. SAO declination came eight months after incident.
- Timeline 16: Involved/accused officers were not interviewed until almost two years after the incident, and a witness officer who recovered the subject's weapon was not interviewed until three-and-one-half years after the incident.
- Timeline 20: Last officer interview not completed until 18 months after incident.

To put this in context visually, below is Timeline 4. As indicated by the dots in the brown "IPRA Officer Interviews" category, the involved officers were not interviewed until 19 months post-incident, 9 months after SAO issued its declination, and over a year since the last significant investigative step.



5. Summary reports

There were, on average, roughly 31 months between the date of the incident and the date of IPRA's final Summary Report in the reviewed case files. Many times, there was an unexplained delay between the last investigative step and the final Summary Report. For example:

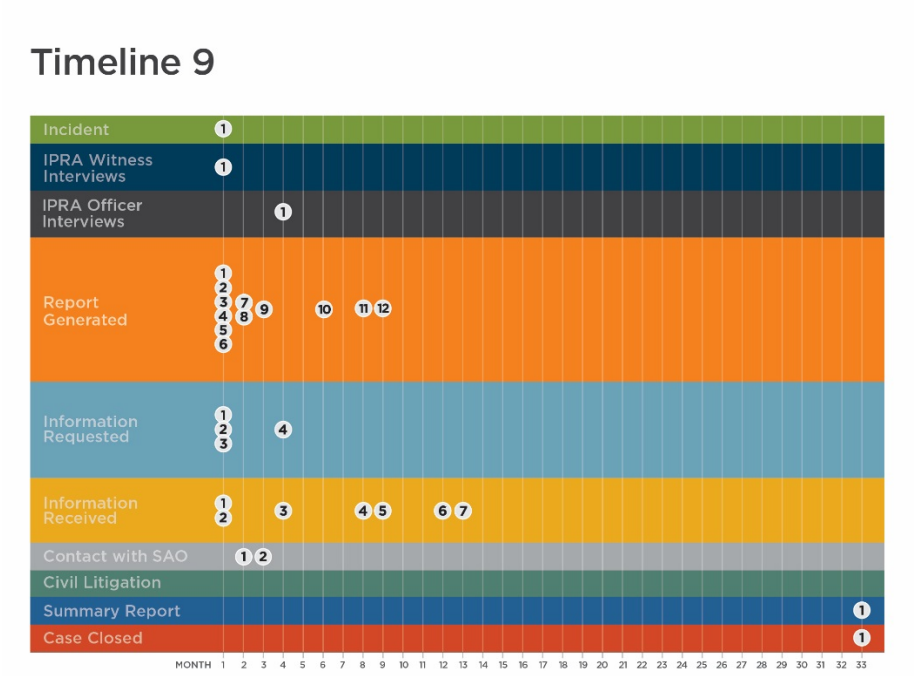
- Timeline 1: SAO declination issued three months after referral. Unexplained five-month delay in issuing Summary Report after SAO declination, during which time no additional investigative steps were taken.

- Timeline 4: Six-month delay between last significant investigative step and Summary Report.

- Timeline 8: Summary Report not issued until 65 months post-incident, almost 2 years after last significant investigative step.

- Timeline 10: Summary Report not issued until six months after SAO declination, during which time no significant investigative steps were taken.

To put this in context visually, below is Timeline 9. As indicated by the dot in the blue "Summary Report" category, the final Summary Report was not issued until 33 months post-incident, 20 months after the last significant investigative step.



6. Unexplained delays

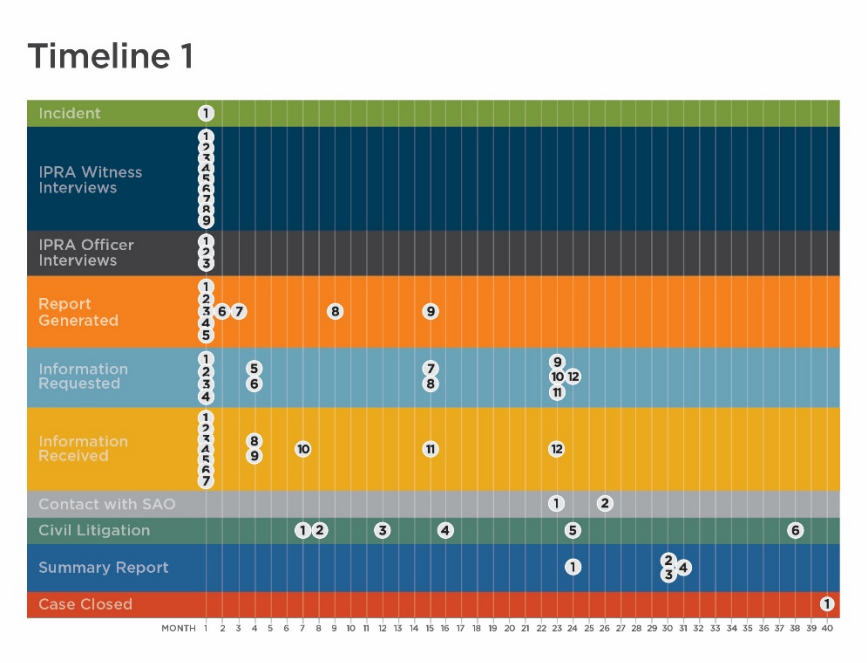
Even though many of IPRA's investigative delays may be the result of factors outside the control of IPRA, they do not appear to be consistently driven by any single suspected driver (*e.g.*, SAO declinations or ISP reports). There remains significant and unexplained delays in the case files not attributable to the suspected drivers listed above (though the insufficient staffing and excessive caseloads with which IPRA has historically operated undoubtedly have played a role in these delays). For example:

- Timeline 4: Failure to request pertinent medical records until 23 months post-incident.
- Timeline 5: Unexplained ten-month delay between final Summary Report and time case was closed.
- Timeline 6: Failure to request CPD reports until 18 months post-incident and failing to request relevant medical records until 34 months post-incident.
- Timeline 8: Unexplained 22-month delay where no investigative steps appear to be taken. Case not closed until 69 months post-incident.
- Timeline 9: Unexplained 20-month delay between last significant investigative step and issuance of Summary Report and closing of case.
- Timeline 13: 16 months during which no significant investigative steps were taken.
- Timeline 14: Unexplained 26-month delay between the time the Summary Report was issued and the date the case was closed.

- Timeline 17: Delay of more than one year between date of Summary Report and date the case was closed.

- Timeline 18: Failure to request medical examiner report until 20 months post-incident.

To put this in context visually, below is Timeline 1. As indicated by the dots numbered 9-12 in the light blue "Information Requested" category, there is an unexplained two-year delay in requesting pertinent medical records. In addition, there is an unexplained 5-month delay in issuing the final Summary Report and a 14-month delay in closing the case after SAO declination, during which time no additional investigative steps were taken.



PART V – RECOMMENDATIONS

This fifth part of our Final Report makes recommendations regarding OIS investigations. Our recommendations should be viewed in the overall context of what we see as the primary objectives of a well-functioning OIS review process. It is important that the investigation, analysis, and conclusions that result from that process be seen by both the police and the public— in equal measure—as fair, objective, thorough, and credible. There must be both public and police confidence in the process in order for it to succeed. It is in the nature of police work that force sometimes must be used in the legitimate exercise of police authority, including sometimes deadly force as necessary to protect officer and/or civilian life. An inadequate review process does neither the police nor the public a service for many reasons, including that it contributes to public distrust of police policy and tactics and also fails to instill confidence in police that their actions will be investigated objectively and fairly. We have endeavored to recognize these factors and take them into account in creating and forming the below recommendations.

Our recommendations pertaining to OIS investigations fall into six main categories regarding the following: (1) standard and scope of review of officer conduct in OIS investigations; (2) background and training of OIS investigators and structure of OIS investigative teams; (3) conduct of OIS investigations; (4) factual and legal analysis of OIS cases; (5) supervision and case management of OIS cases; (6) interaction with related entities in conducting OIS investigations.

Some of our recommendations are being made to address specific procedural deficiencies. Others are intended to introduce best practices or improve upon policies already in place. As noted elsewhere in this report, the current administration during the time of this review has made significant efforts to memorialize additional points into policy (as reflected in the Rules issued June 28, 2016) and has likewise made even greater strides forward by implementing training in a variety of areas. Some of the below recommendations may already have begun to be put into practice by current IPRA investigators during the time of our review.

Below we have made extensive recommendations to achieve the highest level of effectiveness and integrity in OIS investigations.

I. STANDARD AND SCOPE OF REVIEW OF OFFICER CONDUCT IN OIS INVESTIGATIONS

A. Recommendations Regarding Use Of Deadly Force Standard Of Review

What constitutes effective OIS investigations depends largely on the standard of review by which justification for use of force is measured. The use of deadly force standard as set forth in the CPD policy in effect for the period from which the cases we reviewed were drawn was essentially that, if the use of force met the constitutional standard then the use of force is within policy. The standard of review used by IPRA in determining whether or not the use of force was within policy in officer-involved shootings is controlled by the use of force policy in effect at the time of the event being evaluated because it is that standard that dictates policy for use of deadly force by police officers and it is by that standard that their conduct must therefore be evaluated. A use of deadly force policy based on the constitutional standard but which does not include any additional

factors limited the review and evaluation of police conduct to a certain aspect of a given incident relevant to the use of deadly force.

In our view, a use of force policy that would provide a more complete and thorough standard of review in OIS cases would: require a more comprehensive assessment of OIS incidents to include a review of not only the moment that the use of force is deployed but all of the steps leading up to that moment; involve a review of the underlying facts and the resulting analysis that is far more exacting and complex because a far greater range of factors involved in a given use of force would have to be investigated and analyzed; and result in an explanation for bottom-line determinations of OIS case reviews that is more detailed, including reference to key facts, than assessment of OIS incidents based solely on the constitutional standard as set forth by the Supreme Court. As discussed previously, in October 2016, CPD released a proposed revised use of deadly force policy. If adopted, the new policy would change the standard in that it specifically requires officers to "apply the force mitigation principles and to use the least amount of force required under the circumstances."[143] We believe the draft proposed revised policy provides the basis for change in the standard of review in OIS cases as well and thus for positive change in the OIS review process. Additionally, if adopted, in order for the new policy to have a meaningful impact on the investigation of OIS cases, we make the following recommendations.

1. Investigators should be trained on CPD's new use of deadly force standard, if the proposed revised use of force policy is adopted. They must have a complete understanding of how CPD is trained on the standard and should go through the actual training program. They should also receive in-house training as to how to investigate and analyze cases under that new standard.

2. Investigators should investigate and analyze conduct commensurate with all aspects of that new standard. This will necessarily involve a far more complex analysis with many facets. The investigation will have to collect evidence pertaining to each aspect of the use of force policy. Investigators will need to analyze that evidence in accordance with each distinct point under the new use of deadly force standard.

B. Recommendations Regarding Scope Of Review Of Broader Officer Conduct

Our review has shown that there is virtually no assessment by investigators of officer conduct involving the use of force beyond the narrow moment in time of that use of force. The analysis has focused simply on looking at whether that moment justified the use of force. It is critical that this change. IPRA has at times in the past articulated a desire to engage in a more holistic review of the events surrounding the use of force, and during the time of our review, as noted above, the current IPRA administration has taken steps to change this.

The following recommendations further the goal of ensuring that officer conduct involving use of force in OIS cases is not only broadly investigated and analyzed, but that information is also utilized in a way to best effect change in officer conduct so as to minimize the need for situations

[143] CPD General Order 03-02, Section II(F)(2).

involving use of deadly force going forward. We believe that all of these recommended changes to process should be memorialized in policies and procedures for the oversight agency.

1. Investigators should investigate officer conduct beginning at the start of the events leading to the incident, not just at the moment of the use of force itself (which as noted above is the subject of recent reform), and investigate that conduct in terms of tactics, judgment, and adherence to training. This includes focusing on events like the response to the scene, vehicle pursuits, foot chases, entries into residences or vehicles, the method by which officers approach subjects, and how officers interact with subjects. Examples of evidence to be analyzed for these events include: POD cameras, dash cameras, body cameras or other video of the steps taken before the use of force; OEMC recordings and event queries; and witnesses who observed conduct leading up to the use of force

2. Investigators should receive training that extends beyond the evaluation of the use of deadly force. They must have a complete understanding of CPD's training on tactics and judgment in all relevant aspects and need to go through that training so that they have a working knowledge. As CPD officers receive new training, investigators must go through that training as well.

3. There should be a formal mechanism to communicate the information from the OIS oversight investigation and analysis to CPD. Utilizing a Force Review Panel that is presented with and evaluates the outcome of the investigation for information and training purposes, not just pertaining to the involved officers, but more broadly for training and policy purposes, is the key to most thoroughly leveraging the work done in the OIS investigations to begin to reduce situations in which use of force may become necessary in the first place.

II. BACKGROUND AND TRAINING OF OIS INVESTIGATORS AND STRUCTURE OF OIS INVESTIGATIVE TEAMS

Based upon our observations regarding the closed OIS cases we analyzed and the expertise that our review team brings to this assessment, we provide our views on the collective qualities we believe are necessary for an investigative team and on the team structure needed to conduct effective OIS investigations. OIS cases demand a higher level of expertise than other police misconduct cases. The ability to conduct these investigations competently—which are the most serious investigations conducted by a civilian oversight agency—stems at least in part from having the necessary shooting investigation experience. That experience, combined with training, will form the expertise needed for these cases.

Accordingly, we have structured the below recommendations to provide our views regarding the necessary qualifications and structuring of its OIS investigation teams. We believe that all of these recommended changes to process should be memorialized in policies and procedures for the oversight agency.

1. Considerations for prerequisites for those assigned to OIS cases should include prior homicide investigation experience, prior shooting investigation experience, prior internal affairs experience, prior experience as a prosecutor, prior experience in law enforcement, and prior investigative experience overall.

2. Each OIS investigative team should have a combination of experience that includes shooting investigation experience. The benefit of internal affairs experience as well should also be considered.

3. There should be a system established by which investigators in other areas of the organization who wish to become OIS investigators must have, in addition to any classroom training, on-the-job training including evaluation for a substantial period of time, shadowing a significant number of OIS cases from incident to close, and acting as lead investigator in some cases under close supervision. While training and shadowing have been utilized by IPRA in the past as well as present, we encourage a continued critical look at these aspects of developing competent OIS investigators in order to ensure that they are as robust as possible.

4. The OIS investigator who is on-scene at the time of the incident should remain on the investigation through its close as the lead investigator whenever possible (as is IPRA's current practice).

5. Each OIS investigative team should have an assigned forensic specialist who remains part of that team from the time of the incident through the close of the case. The forensic specialist should be on-scene at the time of the incident and should be actively involved in decisions regarding requests made for the preservation of evidence and forensic testing.

6. Each OIS investigative team should have an assigned attorney who remains part of the team from the time of the incident through the close of the case. The attorney should play an active role in determining what investigative steps need to be taken and in assessing the evidence as it is gathered during the course of the investigation.

III. CONDUCTING OIS INVESTIGATIONS

As set forth in detail above, IPRA's historical process for investigating OIS incidents reflected numerous and substantial deficiencies and the need for significant reform. Our recommendations are driven by the deficiencies observed in the closed OIS cases we reviewed.
During the time of our review, the current IPRA administration has made us aware of numerous steps towards instituting change in this area. We recognize these changes of which we have been made aware, whether implemented or planned, below where applicable.

We divide our recommendations below into the following areas: (1) recommendations regarding on-scene investigations; (2) recommendations regarding forensic evidence; (3) recommendations regarding medical evidence; (4) recommendations regarding OEMC information; (5)

recommendations regarding efforts to identify, locate, and interview witnesses; (6) recommendations regarding obtaining additional information; (7) recommendations regarding conducting interviews generally; (8) recommendations specific to conducting interviews of civilian witnesses; and (9) recommendations specific to interviewing of officers. We believe that all of these recommended changes to process should be memorialized in policies and procedures for the civilian oversight agency.

A. Recommendations Regarding On-Scene Investigation

As noted above, during the time of the OIS investigations we reviewed, on-scene investigative steps were led by CPD in all cases. However, in 2016 following the enactment of PCRIA and CPD issuing policy implementing PCRIA and introducing the procedures for investigating officer-involved deaths, that has changed.[144] Accordingly, because the changes have altered the practices regarding on-scene investigations, in order to make recommendations regarding steps we recommend being taken on-scene, we do so in light of the current CPD policy regarding OIS investigations.

A summary of the relevant policy, which sets forth the respective responsibilities of CPD and IPRA in the investigation, is as follows.[145] Under current policy, the Deputy Chief assigned to the Street Operations Unit, Office of the First Deputy Superintendent (who as noted above is referred to as the Street Deputy or OCIC) will coordinate the Department's on-scene investigations into the incident and underlying criminal events.[146] CPD will conduct all necessary investigative activity into the incident as it relates to: (1) the public safety investigation of the incident; (2) any underlying criminal offenses associated with the officer-involved death consistent with its existing policies; (3) traffic crashes involving department members resulting in an officer-involved death—in coordination with the on-scene IPRA investigative personnel; and (4) the Department's internal investigation in situations involving life-threatening injuries to one or more members of the public that resulted directly from an action or intentional omission of a Department member who was on-duty or otherwise acting within the scope of his or her employment—this last investigation will not interfere with the investigation conducted by IPRA.[147] IPRA will conduct the officer-involved death investigation consistent with PCRIA. The on-scene IPRA personnel will coordinate and direct any investigative activity that is pursued at the scene that relates to the actual officer-involved death. If there are multiple concurrent investigations, CPD's public safety investigation takes priority. CPD's investigation of any underlying offense is conducted concurrently with IPRA's investigation of the officer-involved death. CPD's internal investigation will be led by CPD but will not interfere with IPRA's investigation.[148] To ensure proper coordination, the Street Deputy, the Bureau of Detectives Area Commander, and responding IPRA personnel will confer on-scene about the conduct of the investigations.[149] With regard to evidence, CPD forensic technicians continue to collect evidence, but do so with IPRA personnel on-scene and observing. An IPRA investigator is required to be present for the collection and examination of firearms at

[144] CPD, General Order G03-06.
[145] *Id.* at Section III.
[146] *Id.* at Section III(A).
[147] *Id.*
[148] *Id.* at Section III(B), (C).
[149] *Id.* at Section III(D).

the scene when practicable.[150] If CPD and IPRA have concurrent investigations of an underlying crime and the OIS, witnesses are interviewed concurrently. The Street Deputy and IPRA are required to confer regarding whether interviews will be joint or separate.[151]

In short, pursuant to PCRIA and as implemented by a CPD general order, the current dividing line in terms of which entity is able to lead the on-scene OIS investigation under Illinois law is whether a subject is shot fatally or non-fatally. The civilian oversight agency leads the OIS on-scene investigation in the case of a fatal shooting. CPD leads the OIS on-scene investigation in the case of a non-fatal shooting. CPD leads the criminal investigation, if any, which is to be worked concurrently with the OIS investigation. CPD also leads the public safety investigation which takes precedence over all other investigations.

As a threshold matter, we note our concerns from what we have observed regarding the current policy. While we recognize that there are multiple investigative needs and inherent challenges in designing a system that can effectively meet all needs, we question whether the division between non-fatal and fatal OIS cases is the most effective approach. All OIS cases, regardless of whether fatal or non-fatal, need to be investigated with the same degree of independence and integrity. (And as a practical matter, we note that an OIS case may initially be non-fatal only to become fatal at some point, leading to a change in the lead role in the middle of an on-scene investigation.) In light of those observations, we suggest that the ideal structure would be one where a civilian oversight agency with seasoned and trained investigators leads the on-scene investigation in all OIS cases, regardless of the question of fatality, but operating in coordination with and without infringing upon any criminal investigation, which would in all instances be led by CPD. In our view, continued evaluation of the practical application of the statute as implemented through the CPD general order is warranted and the potential for revision of the CPD general order to provide that the civilian oversight entity take the lead in non-fatal cases as well should not be foreclosed.

Also, as previously noted, currently, when IPRA is taking the lead in the on-scene investigation, the investigative steps at the scene are largely being executed by CPD evidence technicians done at the direction of IPRA. Recently, IPRA has also called on ISP to execute certain investigative techniques at the scene, including LEICA scans and trajectory analysis. (It is our understanding that while CPD has the requisite equipment for these techniques, they rarely have been used in investigations of any kind, and thus CPD does not currently have the personnel with the expertise to utilize them effectively.) Whether or not a civilian oversight entity should have its own evidence technicians along with all of the related capabilities (*i.e.*, equipment and evidence storage) is an open question. It may make more sense from a resources and cost standpoint to enable it to use resources that already exist. But regardless of who actually conducts the collection of the evidence, it must be done in a manner to support an effective and thorough investigation.

Below we set forth our recommendations regarding on-scene investigation based on the deficiencies we observed in our review of closed OIS cases. These apply regardless of whether the on-scene investigation is led by an OIS oversight body or CPD and regardless of what entity

[150] *Id.* at Section V(F).
[151] *Id.* at Section V(G).

is actually doing the collection. This area in general has been one of change under the current administration.

1. Fully diagram the complete scene.

2. Take complete and detailed measurements at the scene.

3. Conduct trajectory analysis at the scene when appropriate.

4. Take weapons of all officers who were involved in the incident and do not limit to only the officers who state that they fired their weapons.

5. Ensure that all officer weapons that need to be recovered are recovered on-scene.

6. Account for all witnesses at the scene and attempt to interview or obtain contact information.

7. Take independent photos and label for significance and clarity.

8. Take independent scene video and narrate for significance and clarity.

9. Swab subject hands for GSR testing where possible.

10. Preserve subject clothing for GSR testing.

11. Take DNA swabs from subject (within confines of law).

12. Consider if there are instances where taking DNA swabs from officers involved in the incident might be beneficial to conducting a credible investigation, *e.g.*, to rule out officer DNA on gun or other object where there are witness statements that an officer planted the gun or object.

13. Properly protect subject body in fatal shooting for evidence.

14. Hold and completely process involved vehicles for recovery of additional projectiles and other evidence.

B. Recommendations Regarding Forensic Evidence Analysis

1. Analyze any firearm recovered alleged to have been possessed by a subject, as well as all bullets contained within that firearm and magazine, for both the prints of the subject and the prints of involved officers.

2. Analyze any object alleged to have been a mistaken weapon possessed by subject for both prints of subject and prints of involved officers.

3. Request complete ballistics analysis including analyzing any recovered projectile that is not determined to have come from firearm of either subject or shooting officer against firearms of other involved officers.

4. Request DNA analysis on any firearm recovered alleged to have been possessed by subject for both presence of DNA of subject and of involved officers.

5. Request DNA analysis on any object alleged to have been a mistaken weapon possessed by subject for both presence of DNA of subject and of involved officers.

6. Request ATF trace on any firearm recovered.

7. Request GSR analysis on a subject's hands in any case involving an allegation that the subject possessed a firearm.

8. Request GSR analysis on a subject's clothing to determine if there is any evidence of close range firing.

C. Recommendations Regarding Medical Evidence

1. Request trajectory rod analysis on deceased subjects.

2. Interview medical examiner in case of fatality at the time of examination for observations and follow up with questions following the receipt of subsequent reports.

3. Interview medical personnel that are treating a subject in the case of non-fatal shooting regarding the subject's injuries, condition, or other issues observed in medical records. Such interviews may require either the consent of the subject or the issuance of a subpoena so that the provider may comply with federal regulations implementing the Health Insurance Portability and Accountability Act of 1996.[152]

4. Interview medical personnel having contact with a subject in the case of a non-fatal shooting regarding any statements made by the subject. Such interviews may similarly require either the consent of the subject or the issuance of a subpoena so that the provider may comply with federal regulations implementing the Health Insurance Portability and Accountability Act of 1996.

D. Recommendations Regarding OEMC Information

1. Request OEMC to provide all information relevant to incident in all cases.

[152] 45 C.F.R. § 164.512(f).

2. Establish procedures to ensure that all potentially relevant information has been obtained from OEMC.

3. Thoroughly analyze all information received including event queries, PDT transmissions, dispatch recordings, and 911 calls.

E. Recommendations Regarding Efforts To Identify, Locate, And Interview Witnesses

1. Conduct multiple canvasses as practicable until all witnesses in the area who may have observed shooting have been identified and interviewed.

2. Keep a more detailed canvass log which: (1) lists all businesses and residences in the area that may have witnesses or video; (2) sets forth each attempt at finding witnesses at each residence or business by date, time, details of approach, and planned next step; and (3) details the ultimate result for canvasses done for each residence or business, *e.g.*, "interviewed all individuals at residence which are documented in the audio recording and accompanying summaries of interviews of the following individuals," or "six canvass attempts made at the dates and times documented, and residence is believed to be abandoned based on statements made by neighbors and observations of exterior of residence as documented in accompanying memo."

3. Interview individuals in positions of authority at each business or building in vicinity to determine if any video may exist and obtain any video that does.

4. Interview all witnesses on-scene.

5. Locate and interview all individuals identified in CPD reports.

6. Identify, locate, and interview all 911 callers regarding a shooting.

7. Locate and interview any individual identified from an ATF trace as having previously possessed a recovered firearm.

8. Utilize intelligence where available from law enforcement entities to help fully identify witnesses, *e.g.*, where an eyewitness or other key witness may be identified only by nickname or first name or description, IPRA investigators should leverage the street knowledge of law enforcement entities with specific historical knowledge of the area or related individuals to assist in identification.

9. Utilize subpoena power to locate witnesses, *e.g.*, in instances where investigators have a phone number from a 911 call and have been unsuccessful in efforts to reach the caller, they should use a subpoena to obtain the address associated with that phone number and locate the caller.

10. Utilize subpoenas to interview witnesses unwilling to cooperate.

11. Utilize investigative techniques to locate, identify, and interview key witnesses where necessary.

F. Recommendations Regarding Obtaining Additional Information

1. Obtain materials on an ongoing basis that may be generated in any civil or criminal suit related to OIS incidents. This can include discovery materials, such as depositions or additional forensic testing, or trial material if a matter progresses to trial during the pendency of the investigation. The investigator should also obtain a list of all items provided by CPD or other related entities to the parties to any related matter, as there may be documents or other evidence that was created at the outset and not initially provided to the investigator. A formal protocol is needed to ensure that the investigator has access to, and has reviewed, all evidence obtained in any other relevant legal proceeding. This area has been one of reform under the current administration.

2. Obtain any media footage and articles. There may be additional individuals and details identified in media reports.

3. Obtain CPD contact cards for subjects, which may reflect prior contact with any involved officers.

4. Obtain CPD CR histories and files pertaining to each complaint for each involved officer. This area has been one of reform under the current administration.

5. Obtain CPD training records for each involved officer.

6. Obtain CPD firearms qualification records for each shooting officer. This area has been one of reform under the current administration.

G. Recommendations Regarding Conducting Interviews Generally

The following recommendations reflect standard guidelines for the conducting of interviews. Investigators in the cases we reviewed frequently failed to follow these basic principles. This area has been the subject of increased training under the current administration.

1. Ask open-ended questions, not leading ones.

2. Ask follow-up questions to obtain additional details on key points.

3. Ask probing questions to test and challenge the credibility of the interviewee.

4. Raise and challenge the interviewee with any inconsistencies from prior statements.

5. Use aids to help clarify the statements of the interviewee, *e.g.*, maps of the area, diagrams with measurements, video, photos of the location where events occurred, and photos of a vehicle if one is involved.

6. Use evidence gathered during investigation in the interview, particularly evidence that may contradict an account to confront the interviewee and test credibility.

7. Follow up with witnesses and conduct second interviews when new evidence comes to light through additional interviews, videos, results of forensic testing, or otherwise, in order to clarify information obtained in the initial interview or to challenge statements made by the interviewee in the initial interview that may call into question the accuracy or veracity of statements made by the interviewee.

8. Conduct follow-up investigation regarding details learned in interviews. This may involve additional forensic testing or other investigative steps.

9. Conduct interviews with two interviewers.

10. Conduct all interviews in person unless impossible. If an in-person interview is an impossibility, the investigator should thoroughly document the reasons why a phone interview was the only alternative.

11. Record all interviews unless prohibited by witness (which as noted earlier is specifically required under current administration policy).

12. Minimize the turning on and off of the recording device and explain any reason for doing so on the recording. Prohibit any unrecorded dialogue. This is required by the current administration.

13. Ensure transcripts are accurate and complete and that statements are fully transcribed where they can be heard instead of transcribing them as "inaudible."

14. Ensure that summaries of interviews (where not recorded or not transcribed) are accurate.

H. Recommendations Specific To Conducting Interviews Of Civilian Witnesses

1. Any interview conducted on-scene with an individual who has relevant information should have a further interview in a location where a more fulsome interview can be conducted if the witness is willing to do so.

2. Ask detailed questions regarding position and vantage point (*e.g.*, position and obstructions to either sight or ability to hear) and ability to perceive (*e.g.*, lighting, background noise, and quality of vision or hearing) for eyewitnesses.

I. Recommendations Specific To Interviewing Of Officers

1. Interview all officers who were present on-scene when practicable. Officers who may not have been directly involved in the incident may still have relevant evidence through observations they may have made or details that may not be raised by involved officers. The shooting officer or other involved officers may have made statements to other officers who arrived at the scene that may be of significance. The current administration has begun following this protocol.

2. Develop and follow checklist of standard topics that should be covered in all officer interviews, *e.g.*, whether officer has had prior contact with subject and the length of time that the officer has worked with other involved officers and in what capacity.

3. Consider requesting a non-compelled interview of an officer where concerns exist regarding the potential for criminal prosecution or the creation of potential *Garrity* issues that would otherwise delay the interview.

IV. ANALYSIS OF OIS CASES

As discussed above, the analysis that has been conducted in OIS cases has been woefully inadequate or not properly documented. The summary reports for the closed cases we reviewed amounted to a recitation of evidence obtained, largely by CPD, without any recognition for how that evidence fits together or its significance. However, we observe that during the time of our historical review, the current administration has made significant strides to change this deficiency through increased training and supervisory review.

The recommendations set forth below address multiple aspects of the analysis of OIS cases. We believe that all of these recommended changes to the factual and legal analysis of OIS cases should be memorialized in policies and procedures for the oversight agency.

A. Develop A Uniform Template

1. Investigators should be able to follow the template with specific instructions as to what is to be included.

2. The template should set forth specific examples demonstrating the level of detail and types of details to be included.

B. Fact Section

1. Include a detailed recitation of all evidence developed during the investigation, specifying the source of the evidence, *e.g.*, if it is a witness interviewed by CPD who was not located by the investigator, the substance of the witness's information should be included and the source specified.

2. Include summaries of each witness's information, reviewing all key aspects specifically, and including quotes where appropriate.

3. Include not just the fact that a particular type of evidence was obtained, but the specifics of that evidence, *e.g.*, setting forth not just that there was a 911 caller, but the specific details of that call.

4. Discuss evidence that was not able to be obtained or known with precision, *e.g.*, witnesses who could not be located, the fact that no latent prints of value were recovered from firearm, that aspects of the events were not captured on video.

C. Analysis Section

1. Approach officers' recitation of events as just one piece of evidence among many in the investigation, rather than as the accurate statement of events unless disproven by other pieces of evidence.

2. Identify the key issues in the case that are in dispute and that need to be resolved by a careful examination of the evidence. Each piece of evidence should be discussed in terms of the impact it has on these key issues.

3. Discuss all evidence developed in the case and do not ignore evidence that does not fit with the officer's version of events.

4. Discuss how each piece of evidence fits together with the other pieces of evidence and discuss the significance of each piece of evidence in terms of the key issues identified.

5. Discuss multiple statements when applicable by officers and civilian witnesses and analyze them for inconsistencies and discrepancies, including assessing the reason an officer or civilian witness might have changed the statement from one interview to the next.

6. Assess and weigh civilian witness credibility.

7. Assess and weigh officer credibility.

8. Include a detailed discussion of each piece of forensic evidence and both what can and cannot be determined in terms of the key issues from that evidence.

9. Include a discussion of officer's complaint history and analyze any pattern or absence of pattern of misconduct within the confines of what is permitted in the CBA entered into between the City of Chicago and the FOP.

10. Discuss that which cannot be known because certain evidence was unable to be obtained or otherwise.

11. Discuss that which conflicts, *e.g.*, two civilian witnesses relating differing versions of events, and specify the impact the conflict has on the overall evidence or how the investigator is resolving such conflicts.

12. Be clear as to the weight given to each piece of evidence and the significance of each in the overall analysis.

13. Legally analyze each use of force as its own incident, *e.g.*, if an officer fires a set of shots at a subject and then chases the subject, and then fires another set of shots, those are two distinct use of force events each requiring separate analysis.

14. Legally analyze officer conduct under each potentially applicable prong of use of deadly force policy separately.

15. Identify with precision what factors are being considered in terms of applying the totality of the circumstances to determine whether the use of force is within policy, and identify specific findings of fact that support each factor.

16. Set forth an explanation to support the ultimate determination that a use of force was either within or outside of policy and also include discussion of any credible evidence that may reasonably be viewed as not supporting that determination and why it is not controlling in the analysis.

17. Analyze officers' broader conduct in terms of tactics, judgment, and adherence to training.

V. SUPERVISION AND CASE MANAGEMENT OF OIS CASES

The recommendations set forth below address increased supervision and more effective case management of OIS cases. We believe that all of these recommended changes to process should be memorialized in policies and procedures for the oversight agency.

A. Recommendations Regarding Supervision

We understand from the current administration that it has taken steps to increase supervision.

1. Hold case review meetings at the outset of the investigation to review evidence and develop the investigative plan. We understand the current administration has established protocols by which case review meetings are

held as part of the investigative process at the outset of and throughout an OIS investigation.

2. Hold case review meetings at the conclusion of an investigation involving supervisors up to and including the Chief Administrator prior to closing any case. We understand the current administration has established protocols for major case review meetings in which a draft summary report is submitted to a group consisting of supervisors and management including the Chief Administrator and the draft report analysis is reviewed for, among other things, identification of additional investigative steps that are required. This process typically results in several rounds of revisions to the report.

3. The immediate supervisor should have weekly meetings with each assigned investigator to review evidence in detail and monitor progress.

4. The assigned attorney should be an integral part of the investigative team and should play a role in the content and drafting of the summary report along with the investigator, including drafting the legal analysis section. We understand the current administration has established protocols by which an attorney is assigned to each case.

5. The immediate supervisor's review of the summary report should include a detailed memo drafted by the immediate supervisor that sets forth the details of the review including: (1) an assessment of the investigative steps taken, including any follow-up steps needed; (2) an assessment of the analysis and follow-up questions regarding that analysis; and (3) an assessment of any unforeseen delays in the case.

6. The chain of review in all OIS cases should include review above the immediate supervisor up the review chain and to the Chief Administrator. We understand the current administration has instituted a chain of review that follows this protocol. Comments at each stage of the review should be documented by each reviewer.

B. Recommendations Regarding Case Management

As discussed above, the length of time it has taken IPRA to conduct these investigations has been significant. Not only are these delays detrimental to the public having any confidence in the oversight process and in the entity charged with conducting the investigations, they are also detrimental to the investigations themselves, particularly when individuals, including officers as well as civilian witnesses are interviewed sometimes years after the incident occurred.
We understand from the current administration that it has taken steps to improve timeliness and has plans for additional changes to meet the same objective. We offer the following case management recommendations for improving investigation timeliness.

1. Institute a formal system to track the progress of each OIS investigation and have mechanisms in place that will monitor progress.

a. Document dates for each step of investigative process in the system, *e.g.*, completion of officer interviews, completion of civilian interviews, receipt of forensic results, and decision by SAO.

b. Require supervisors to report monthly on the specifics of the timing of each investigation, including the length of time an investigation has been underway, the investigative steps conducted to date, and the remaining investigative steps to be taken including the timing of each.

c. Permit a maximum of 14 days (unless intervening circumstances prohibit that timeline from being met in which case those circumstances should be documented) from the time that the final investigative step is taken in an investigation to the time the investigator must submit an initial summary report to a supervisor for review.

2. Institute a mechanism to track and address any delays in OIS investigations.

a. The timing and reason for each period of delay without investigative steps having been taken in excess of two weeks must be documented and reported to supervisor.

b. Establish a protocol to address anything inherent in the facts of the case that may be leading to delay, *e.g.*, if there were numerous officers on-scene and multiple potential tangential policy violations pertaining to those officers that are unrelated directly to the use of force, and provide additional investigator resources to focus on that aspect of the case in order to allow the primary investigator to proceed with completing the investigation of the use of deadly force in a timely manner.

c. Establish protocols to track and address delays by outside entities such as ISP, SAO, or CPD by having a formal process in place for involvement at a supervisory level to resolve any external issues delaying the progress of an OIS investigation or resolution.

d. Establish a protocol to document and address any delays regarding the timing of officer interviews and the reason for such delays.

e. Establish a protocol to address any internal issues pertaining to the investigator causing delay, *e.g.*, issues with overall workload that may be detracting from the ability to further and complete the investigation of an OIS case in a timely manner.

f. Establish a protocol to address any external issues pertaining to the investigator causing delay, *e.g.*, illness or extended leave that may

be detracting from the ability to further and complete the investigation of an OIS case in a timely manner.

3. Institute a formal review process that tracks the progress of a case once the summary report has been completed by the investigator.

    a. Utilize a form that tracks the date on which the summary report was submitted to each supervisor in the review chain and the date at which the review was completed by the supervisor and whether it was submitted back to the investigator for additional work or whether it was submitted to the next supervisor in the chain.

4. Institute policies on case file documentation and retention.

    a. Require a complete and thorough case log to be kept in every case. The case log should document each and every step during investigation with dates and reference to specific reports if applicable. Modify the case log format to provide the ability to give detailed descriptions. Require the case log to be kept in a typed format for easy review by supervisors.

    b. Enact requirements setting forth specifics of the To/From report to include the form, substance, timing and use of such reports. Require periodic review of such reports by supervisors to ensure that the reports meet standards.

    c. Enact requirements that set forth with detail how case files are to be kept and organized. Include a checklist for all investigative materials and quality control measures for ensuring that case files contain all investigative materials.

    d. Require all material generated to be kept as a part of the case file. This should include, among other things: (1) notes from interviews; (2) notes from meetings with supervisors; (3) notes from calls or meetings with SAO, CPD, ISP, or others; (4) notes taken while analyzing evidence; (5) drafts of summary reports that were submitted for review; and (6) emails.

    e. Require investigators to review material from CPD or otherwise as a cross check to determine if all material has been obtained, *e.g.*, references in a CPD detective case supplementary report to the existence of the creation of witness statements, and document that they have done so.

5. Institute a formal system for regularly keeping the subject, or if subject is deceased then family members of subject, apprised of the investigation's progress and track the dates, manner, and substance of notifications. This system should also track whether the efforts to provide information

successfully reach the subject or family members, and IPRA should make adjustments accordingly.

VI. INTERACTION WITH OTHER ENTITIES INVOLVED IN CONDUCTING OIS INVESTIGATIONS

The recommendations set forth below address more effective interaction with other entities related to the conducting of OIS investigations. We believe that all of these recommended changes to process should be memorialized in policies and procedures for the oversight agency.

A. Recommendations Regarding Interaction With CPD

1. Establish a process for effective communication between investigators handling OIS cases, detectives assigned to investigate any crimes related to OIS cases, and Street Deputies. It is important that the communication not just involve supervisors at each respective entity, but also the individuals at each who are working on-scene and conducting investigations. The purposes of this would be twofold: (1) to work out challenges that have arisen on-scene with two sets of investigators and come to agreements regarding how to navigate issues that have arisen going forward; and (2) to provide a forum for investigators and CPD detectives and Street Deputies to achieve a level of mutual respect and cooperation to enhance the effectiveness of on-scene investigations without in any way compromising the independence of OIS investigators.

2. Establish a process for an initial formal meeting to take place as close in time to the incident as possible with all CPD detective personnel assigned to the investigation, as well as the Street Deputy, at which CPD will identify for the IPRA investigator all witnesses with whom CPD spoke, video obtained and status of obtaining any additional video, forensic evidence and testing that will be requested, and any other steps conducted on-scene or following by CPD. This is critically important in the non-fatal cases where CPD has taken the lead on the on-scene investigation, but it is likewise important in fatal cases in which CPD may have also developed evidence on-scene. The goal of the meeting is to ensure that the investigator is made aware of all information as close in time to the event as possible rather than learning about information, *e.g.*, the existence of a witness, months later when the CPD detective case supplemental report is completed and reviewed by the investigator.

3. Establish a protocol by which investigators have an understanding regarding all documents created by CPD in connection with each particular OIS case, not just the documents that are visible in the CLEAR system. These include documents that CPD considers to be internal in nature as well as notes created by officers either on-scene or in interviews.

4. Establish a process by which investigators have complete access to all such CPD materials. These should include files associated with the CPD RD number created for the OIS case as well as the CPD RD number created for any related criminal case. These should also include notes taken by CPD either on-scene or in interviews as well as internal CPD memos.

5. Establish a MOU with CPD requiring that the CPD detective case supplementary report be completed and provided to investigators within 30 days of the incident, with provisions for a lengthier period if there are extenuating circumstances, *e.g.*, key forensic results that remain pending.

6. Establish a process by which investigators will obtain information pertaining to officers: (1) CR history and files for each CR for each involved officer; (2) information regarding CPD training for each involved officer; and (3) information regarding firearms qualifications for each shooting officer.

7. Establish a process by which investigators will obtain access to CPD contact cards for subjects involved in the incident.

8. Establish a process by which disputes, if any, regarding investigator access to documents or the timeliness in which such documents are being provided can be addressed and resolved.

9. Document all interactions with CPD in an investigation including meetings, phone calls, requests for items, and receipt of items.

B. Recommendations Regarding Interaction With SAO

1. Establish a MOU with SAO detailing the role the civilian oversight agency plays in OIS cases. This should include, for example, the process that is to be followed for interaction between the two entities and details regarding the process to be followed to best navigate the issues presented by *Garrity*.

2. Establish a process by which the investigator has an understanding of all materials created by SAO in the file and a protocol by which all are provided to the investigator (within legal boundaries) and a mechanism for resolving any disputes about what should be provided.

3. Document all interactions with SAO in an investigation to include meetings, phone calls, and requests for investigative steps.

4. Establish a policy that the timing of SAO decision regarding a declination will not impact or delay resolution of the administrative process (which will bolster and add to the newly implemented policy that while IPRA may temporarily delay its finding in its administrative case prior to the conclusion of a federal or state criminal investigation, IPRA may also

proceed with its administrative action even while the criminal investigation is underway).

5. Establish protocols to be followed in the instance that there is an underlying criminal case that is charged in another county for interaction with that county, *e.g.*, in the instance where there is a vehicle chase that ends in an adjacent county and results in criminal charges based on conduct occurring in that county.

C. Recommendations Regarding Interaction With ISP

We are mindful of the fact that although as discussed above there are at times delays in obtaining forensic testing results, there may be no viable alternatives to having ISP conduct the forensic testing for OIS cases, as well as the resource constraints ISP may face that impact the timing of when such results are provided. We also recognize that the Civil Administrative Code of Illinois requires ISP's Division of Forensic Services to assist "law enforcement" and that this is understood to mean that only law enforcement entities may refer items for forensic testing, excluding a civilian oversight body from doing so. We further understand that the current administration is in the process of working on a MOU with ISP and agree with that approach. We provide the following recommendations in light of the above current realities.

1. Pursue amendments to the governing code as necessary such that the civilian oversight agency can make direct referrals to ISP without needing to use a law enforcement entity as a pass through to request forensic testing.

2. Establish agreements concerning complete communication between ISP and the civilian oversight agency regarding what testing has been requested (in the case where testing may have been requested by CPD).

3. Establish agreements concerning goals for the timing of providing results to testing and mechanisms for communication regarding circumstances necessitating exceptions to that timing and a recognition of the seriousness of OIS cases warranting appropriately prioritized and timely results. These should apply in an OIS case regardless of whether the request is made by the civilian oversight agency or by CPD.

D. Recommendations Regarding Interaction With DOL

We understand that the current administration has worked out an agreement with the City of Chicago Department of Law (DOL) by which IPRA will subpoena DOL for relevant non-privileged materials generated in any related civil case, and if IPRA has requests for any subsequently received materials, IPRA will issue subsequent subpoenas. DOL will cooperate and comply fully with subpoenas from IPRA for such information. We agree with this practice and note the below additional recommendations to ensure it is carried out most effectively and efficiently.

1. Establish guidelines for investigators to follow to best coordinate with attorneys at DOL and ensure appropriate communication regarding ongoing related civil suits and adherence to the above described agreement.

2. Set regular points during an investigation at which investigators are required to make contact with DOL attorneys to check on the status of the creation of any non-privileged new materials and obtain those materials by following the agreement discussed above. Require investigators to document the contacts and the result of those contacts.

E. Recommendations Regarding Interaction With FOP

We recognize that the parameters guiding the interviews of officers are governed by the CBA entered into between the City of Chicago and the FOP. It is beyond the scope of this review to thoroughly analyze and assess the impact of the CBA on the process. But FOP involvement does impact OIS investigations. We recommend ongoing evaluation of the impact of union rules and procedures and of the FOP contract with the City of Chicago on the civilian oversight process.

CONCLUSION

It is to the benefit of all in the City of Chicago that there is a credible OIS process in place. To be credible, that process must be one that the community and the police believe investigates officer-involved shootings thoroughly and effectively and analyzes those shootings accurately. It must be one in which everyone, the police and the community, can have confidence in the outcomes. There is much work to be done, and we hope that this report will give an increased understanding of the problems with past investigations of OIS cases and provide guidance for the ways in which those investigations can be improved upon in the future.

APPENDIX A

MCGUIREWOODS PARTNERS

George J. Terwilliger III

George Terwilliger served for 15 years in the United States Department of Justice (DOJ), culminating in his service for 2 years as the Deputy Attorney General and serving as Acting Attorney General. He was also the United States Attorney for the District of Vermont and spent eight years as an Assistant United States Attorney in the District of Columbia and in Vermont. As the DOJ Deputy Attorney General, he chaired an interagency working group that unified the federal law enforcement deadly force policy and supervised major federal law enforcement operational incidents where the use of deadly force was authorized and contemplated. As an Assistant United States Attorney, he handled numerous police shooting or excessive use of force cases and worked extensively on a matter in which DEA agents killed one of three individuals who posed as police officers while robbing the agents. He has led "process reviews," whereby a multidisciplinary group looks into a process or processes that may have led to an undesired incident or result or otherwise represent a material risk in operations. His current practice includes leading corporate internal investigations, an area in which he is widely recognized. He currently serves as a co-chair of the firm's Government Investigations and White Collar Group and leads the Strategic Risk and Crisis Management team.

Christina M. Egan

Christina Egan served as an Assistant United States Attorney for the Northern District of Illinois for ten years, including four years as a Deputy Chief. As an Assistant United States Attorney, she led a police corruption investigation and trial involving robberies by police officers and was involved in investigations and trials involving shootings and murders. Her current practice focuses on conducting corporate internal investigations and compliance reviews.

Patrick J. Rowan

Pat Rowan served as an attorney for the DOJ for 18 years, including service as the Assistant Attorney General for National Security, leading the National Security Division. During his tenure at DOJ, he also spent ten years as an Assistant United States Attorney in the District of Columbia. As an Assistant United States Attorney, he investigated several officer-involved shootings and investigated and tried a number of police corruption cases, including matters involving bribery or robbery by police officers. As the Assistant Attorney General for National Security, he supervised the federal investigation and prosecution of five Blackwater guards for a shooting in Nisour Square, Baghdad in which 17 Iraqis were killed and 20 more were wounded. His current practice includes conducting internal investigations and providing compliance counseling in a number of practice areas.

Howard C. "Toby" Vick Jr.

Toby Vick served as an Assistant United States Attorney for nine years in the United States Attorney's Offices for the Southern District of Florida and the Eastern District of Virginia. He

also served for eight years as the elected Commonwealth's Attorney in Henrico County, Virginia, during which time he conducted a full review of more than a dozen police shootings and made charging decisions based upon his findings. He has represented an FBI agent involved in a police shooting and was retained by the FBI Agents Association for that engagement. He led a review of evidence handling procedures of a local police department and provided findings and recommendations. His current practice includes a focus on conducting internal investigations and audits and providing counsel on compliance. He currently also serves as a co-chair of the firm's Government Investigations and White Collar Group.

Colon C. Willoughby

Colon Willoughby served as the elected District Attorney of Wake County, North Carolina for 27 years. As the District Attorney for Wake County, he oversaw the State Bureau of Investigation's handling of the investigation of more than 20 police shootings and more than two dozen excessive force and death in custody cases and made charging decisions in those matters. He has organized and presented evidence to state grand juries reviewing officer misconduct cases involving use of force in corruption matters and has prosecuted and tried cases involving excessive force and corruption by law enforcement and public officials. His current practice includes all aspects of white collar work.

USE OF FORCE CONSULTANTS

Ann Marie Doherty

Ann Marie Doherty was employed with the Boston Police Department for 26 years. During that time period she attained every rank, retiring as Superintendent. She held command positions included Internal Investigation and Professional Development. Currently, she serves as a Police Practices Expert on the Independent Monitoring Team for the Virgin Islands Police Department. Prior to this, served as a Police Practices Expert on the Independent Monitoring Team for the District of Columbia Metropolitan Police Department. These roles necessitated providing technical assistance and continual assessment of the Departments' progress towards achieving substantial compliance with the full range of requirements and reforms identified in the consent decrees each Department had reached with the Department of Justice.

Robert Harrington

Bob Harrington is a 33-year law enforcement veteran, the bulk of his service has been spent in various investigative capacities. He has investigated almost every type of crime and spent 11 years as a supervisor in the Boston Police Homicide Unit where he developed and served as the lead investigator for the department's Firearm Discharge Investigation Team.
He also served as Commander of the Special Investigations Unit which focused on major drug and fraud cases as well as organized crime. Upon promotion to Superintendent at the Boston Police Department he was named as the Chief of the Bureau of Internal Investigations and subsequently a newly established Bureau of Professional Standards and Development, overseeing all internal affairs, anti-corruption, and training activities. He has served for many years as adjunct faculty in criminal justice at the University of Massachusetts (Lowell) and Boston University. He is a

member of the Massachusetts and Federal bars and currently serves as a member of the senior staff at the Harvard University Police Department.

Robert Stewart

Bob Stewart had a 40-year career as a law enforcement professional. He has held positions of increasing rank and responsibility in the Washington, D.C. Metropolitan Police Department, retiring at the rank of captain. He continued his active career as a major in the Tallahassee Police Department and concluded his active service following five years as the police chief in Ormond Beach, Florida. He continued with active employment as the Training Director of the Louisville Metro Police Department and interim Police Director at Rutgers-Newark University and Camden, New Jersey. As the Executive Director of the National Organization of Black Law Enforcement Executives (NOBLE), he played a role in the establishment of early understanding of biased-based policing. He has worked on the monitoring team attached to the ongoing Department of Justice Consent Decree with the U.S. Virgin Islands Police Department. He is also on the monitoring team attached to the Department of Justice Consent Decree with the Newark, New Jersey Police Department. He is the CEO of a Consulting and Training Company engaged in a wide array of law enforcement related subjects.

MCGUIREWOODS ASSOCIATES

Benjamin J. Christenson

Rachel J. Freyman

Amy Starinieri Gilbert

Nicholas B. Lewis

Kathleen Cunniff Ori

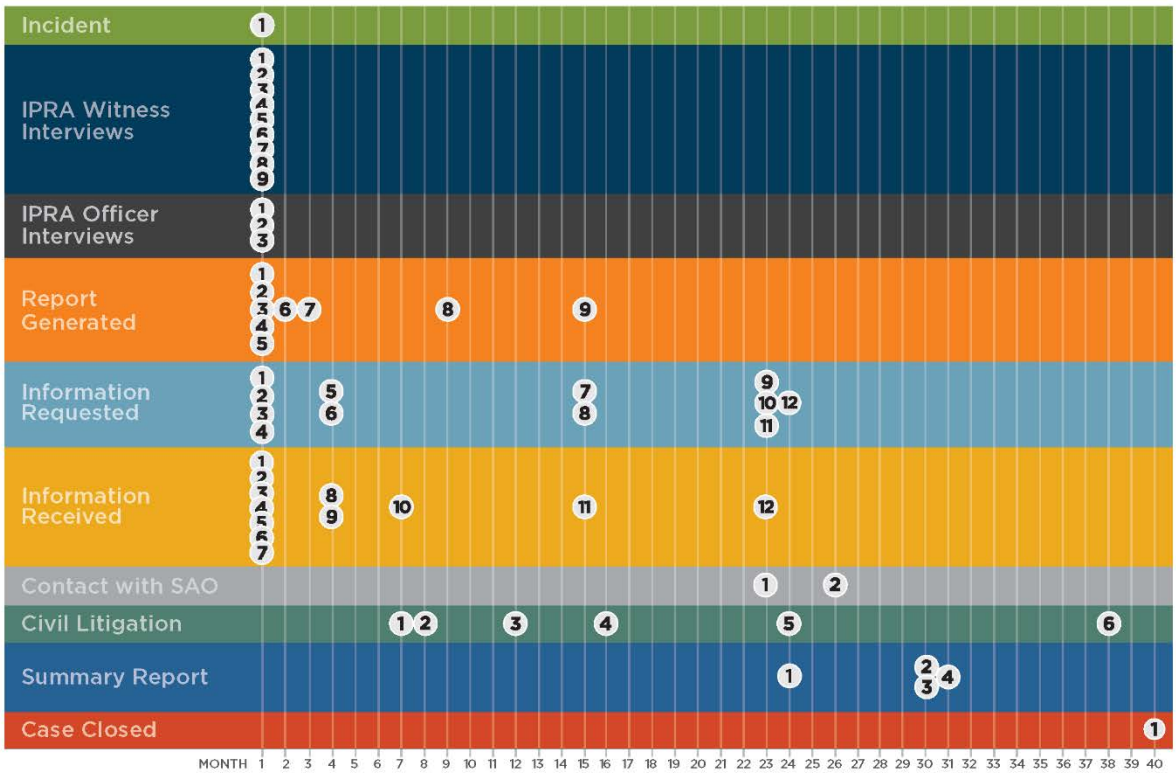
Erin Dine – Summer Associate

MCGUIREWOODS PARALEGAL

Lawrence M. Corridon

TIMELINES

Timeline 1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IPRA Officer Interviews
Report Generated
Information Requested
Information Received
Contact with SAO
Civil Litigation
Summary Report
Case Closed
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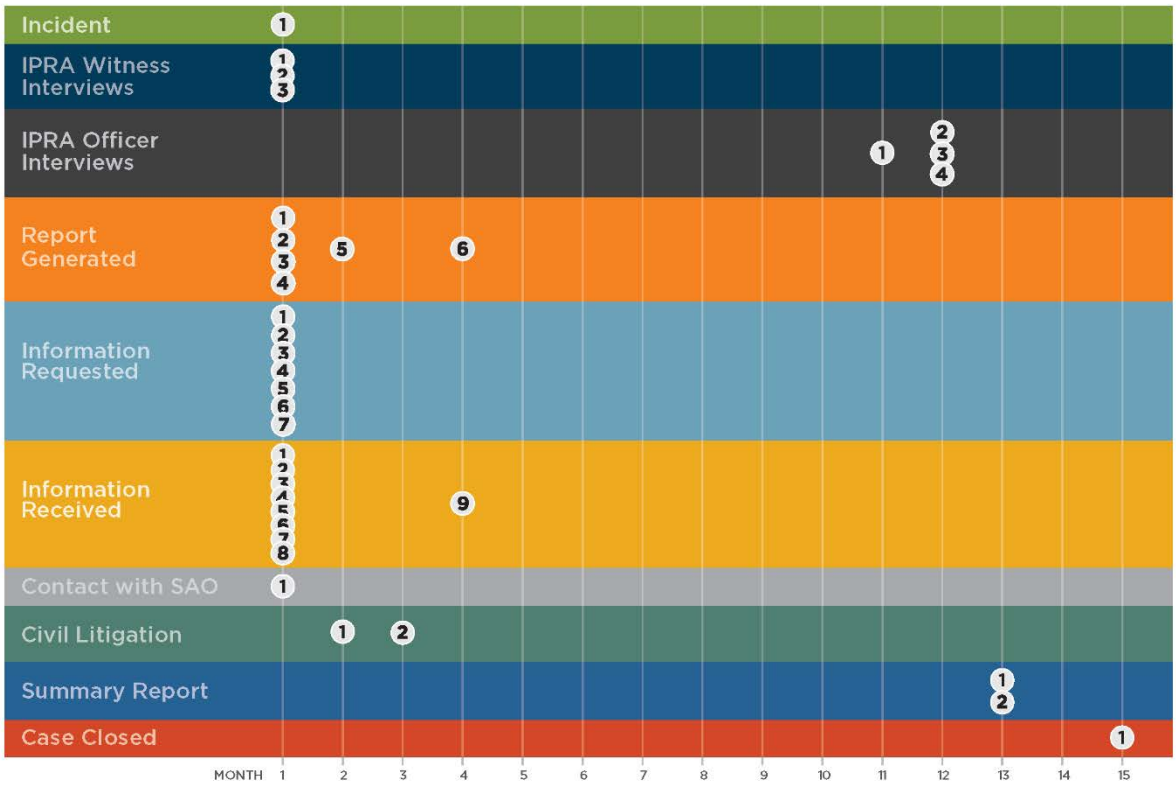
Timeline 2


Incident
IPRA Witness Interviews
IPRA Officer Interviews
Report Generated
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Information Received
Contact with SAO
Civil Litigation
Summary Report
Case Closed
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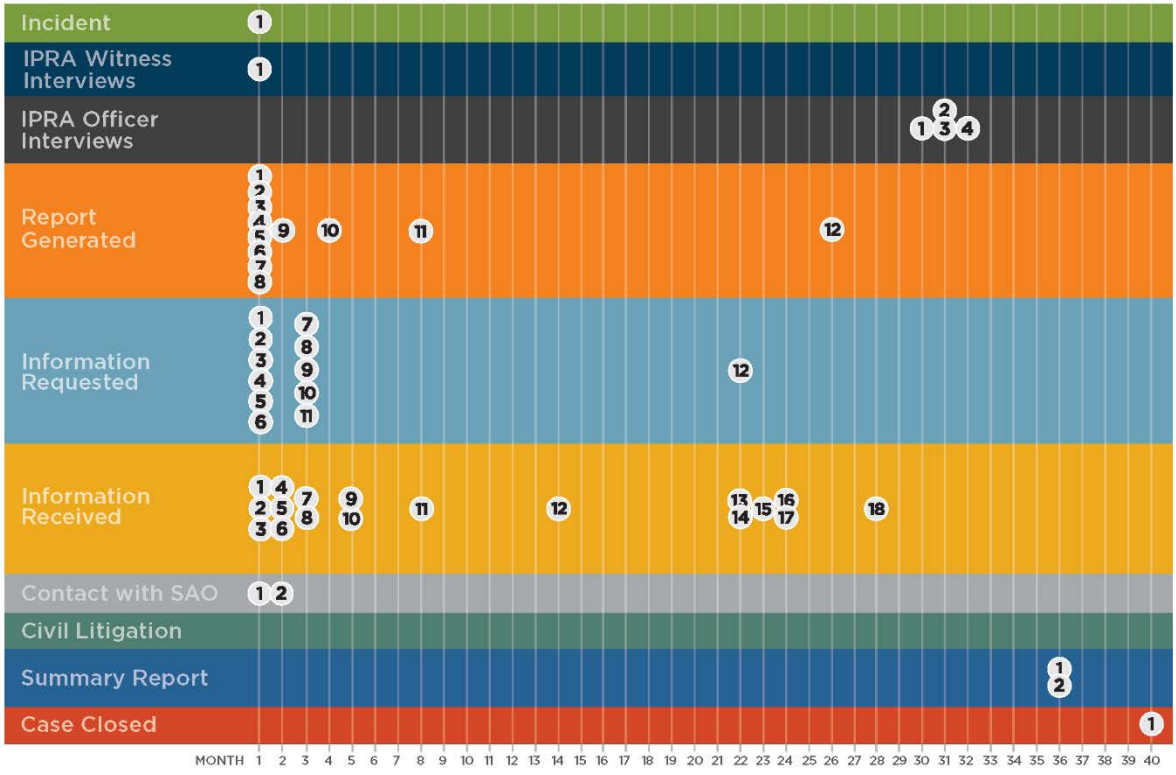
Timeline 3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IPRA Officer Interviews
Report Generated
Information Requested
Information Received
Contact with SAO
Civil Litigation
Summary Report
Case Closed
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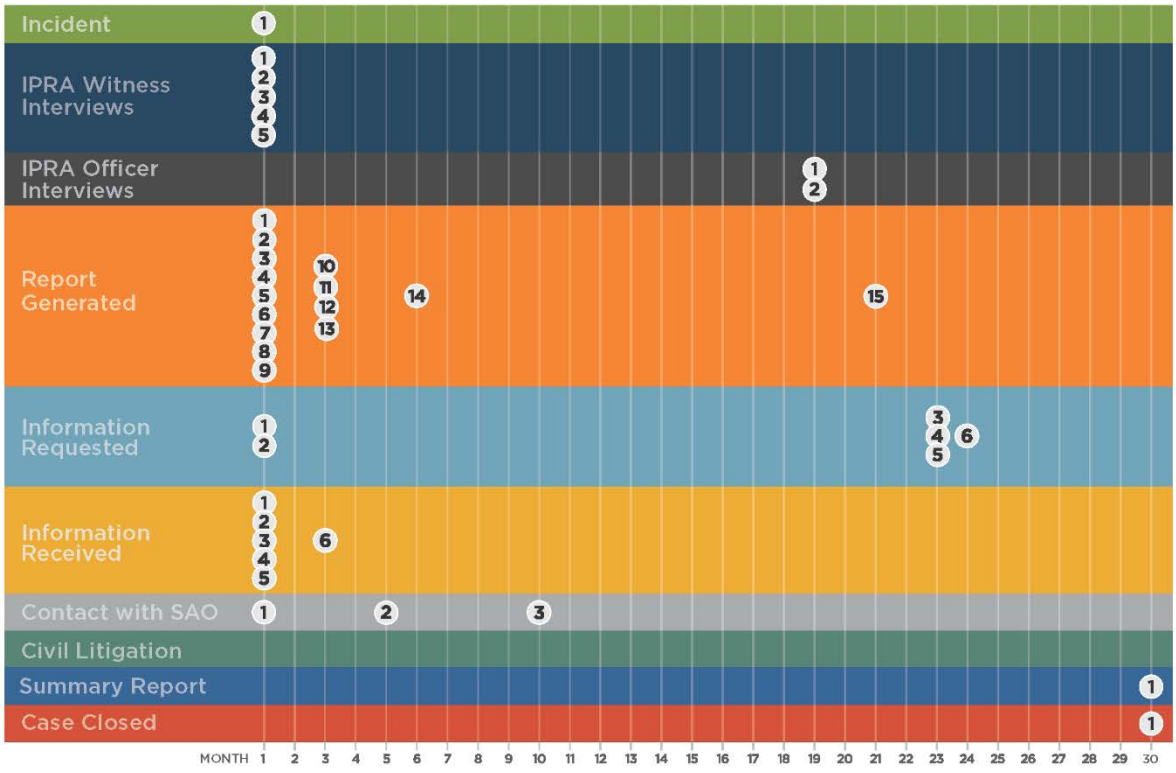
Timeline 4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15
Information Requested
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Information Received
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2
3
4
5
6
Contact with SAO
1
2
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Case Closed
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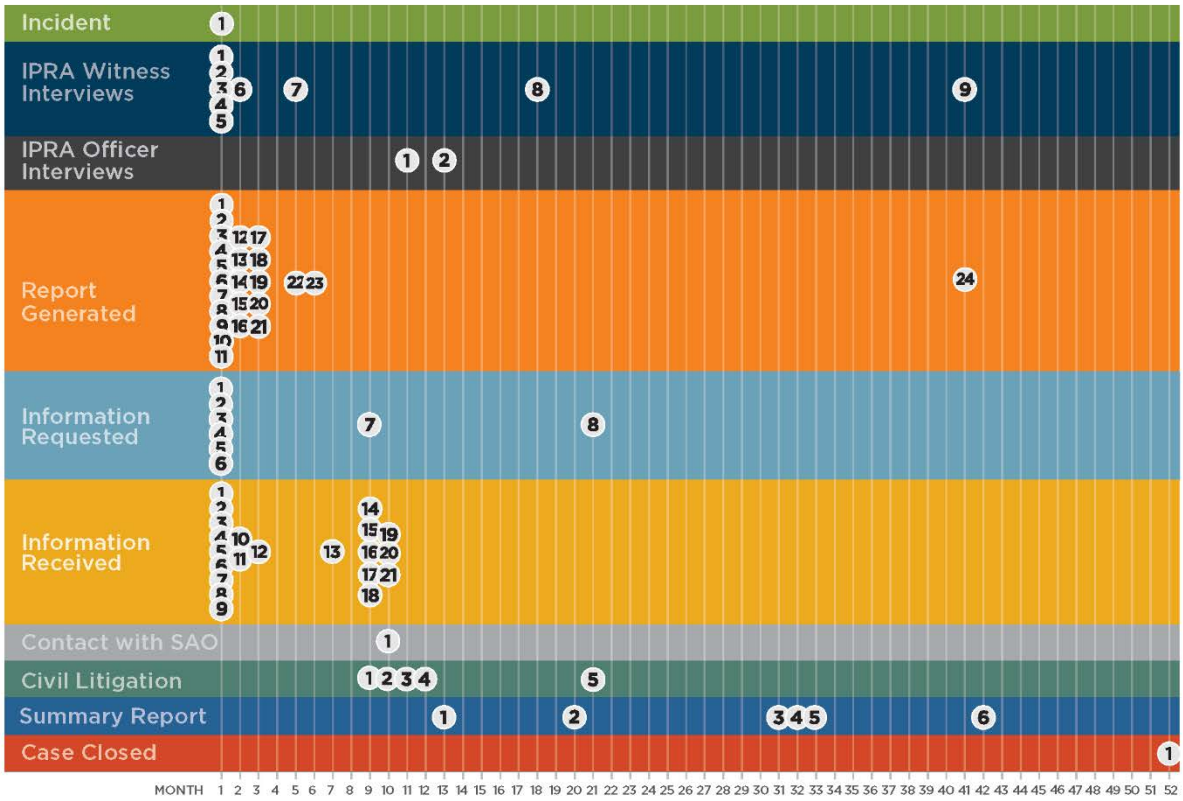
Timeline 5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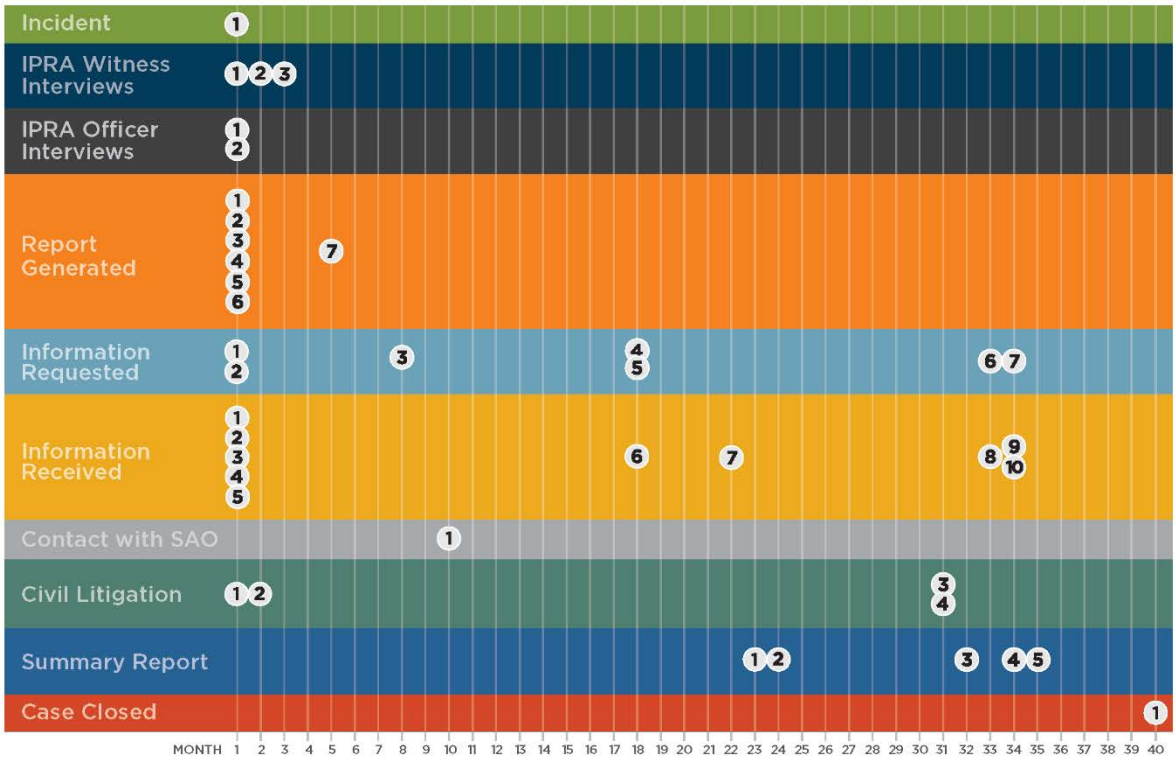
Timeline 6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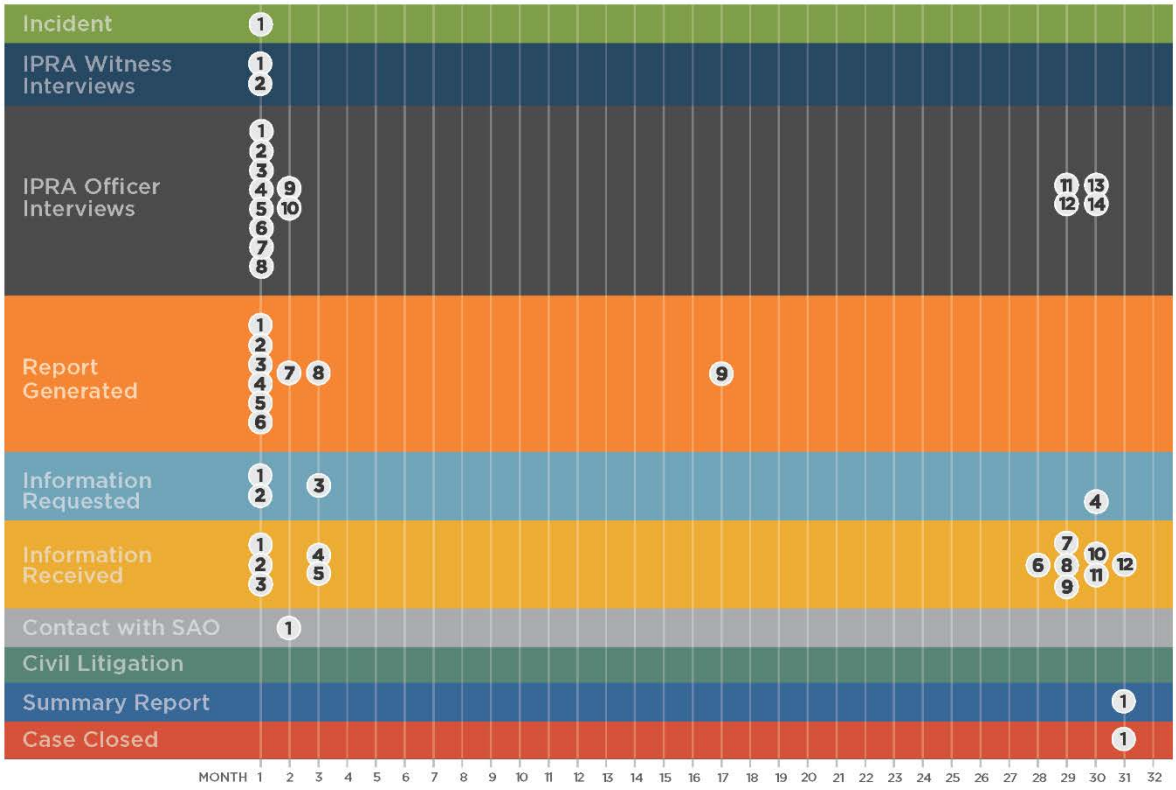
Timeline 7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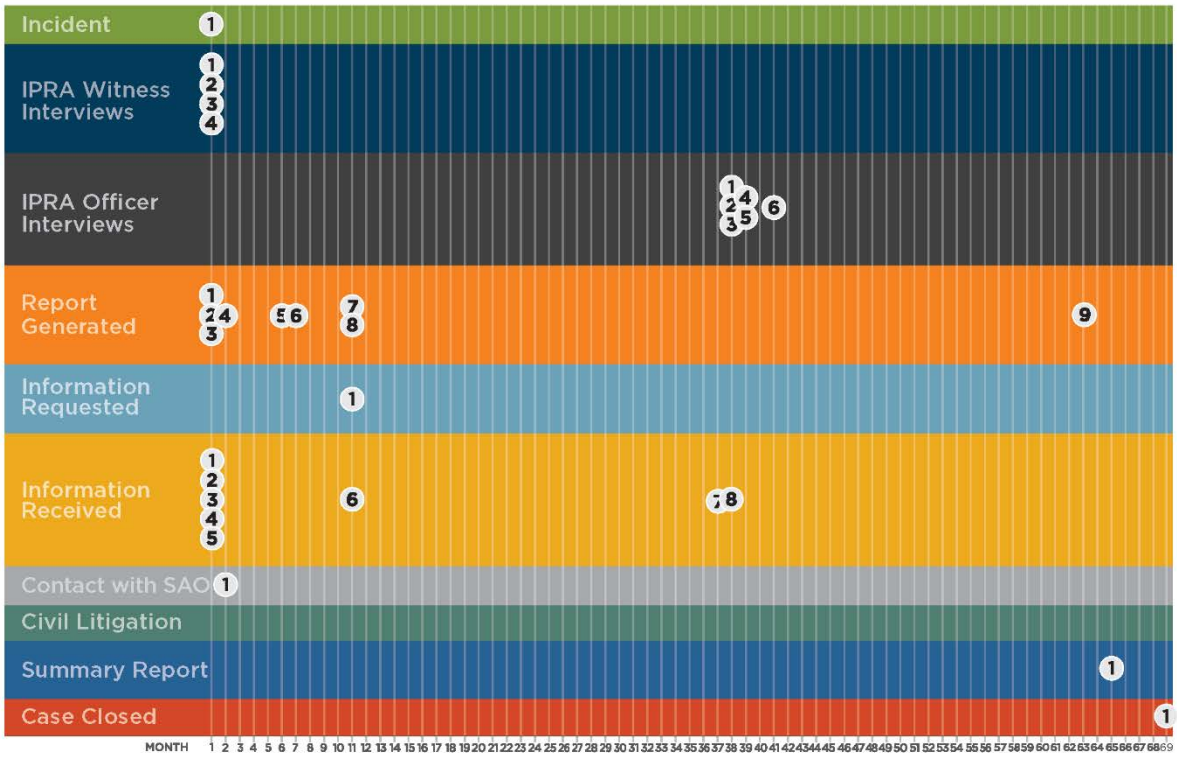
Timeline 8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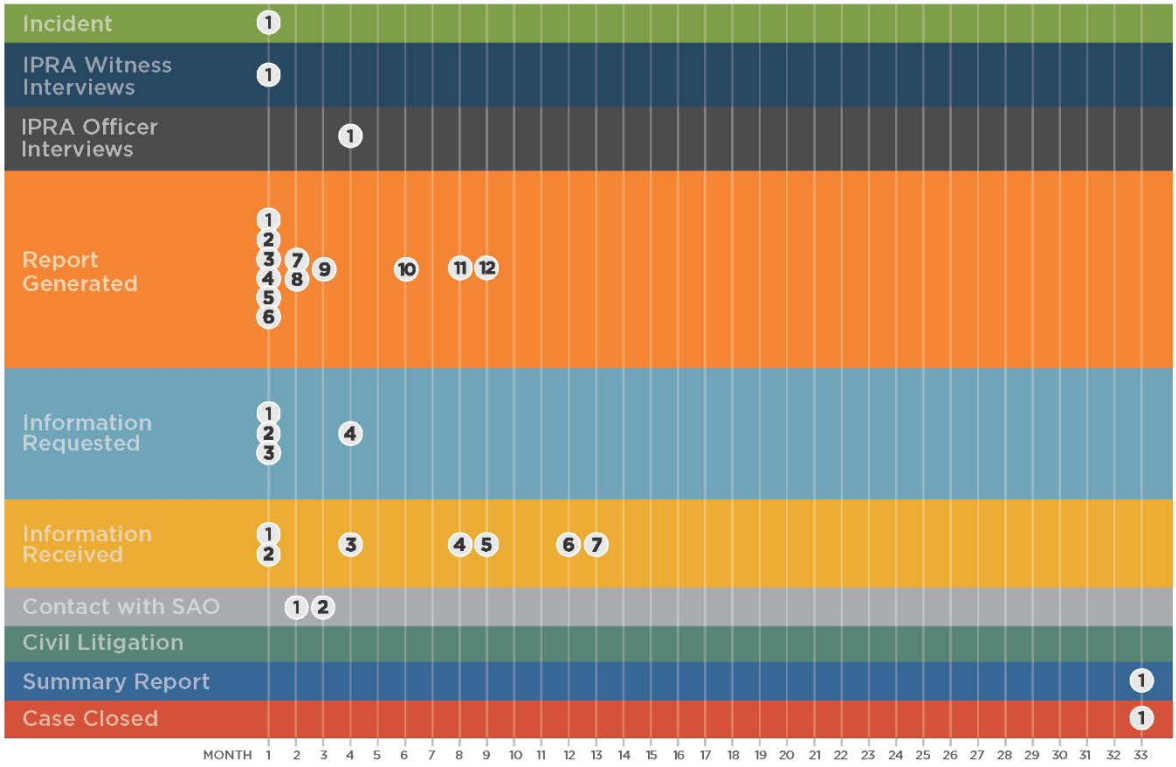
Summary Report
Case Closed
MONTH

Timeline 9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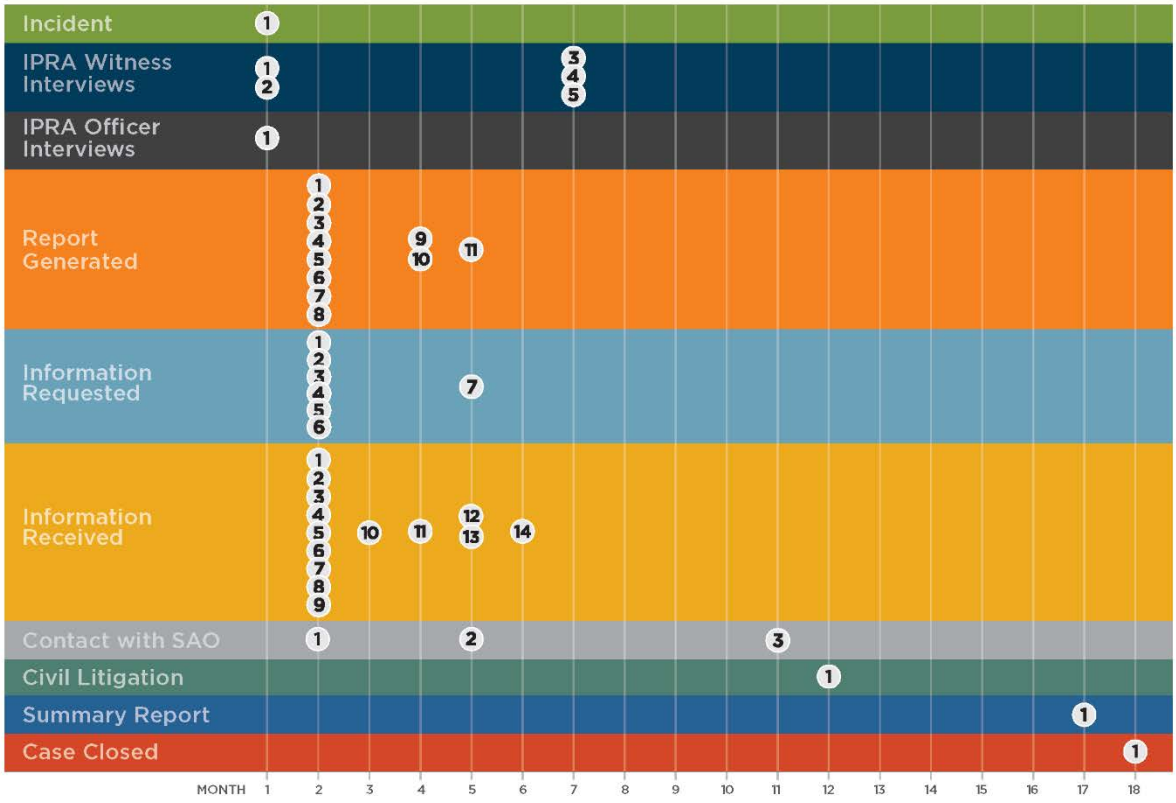
Timeline 10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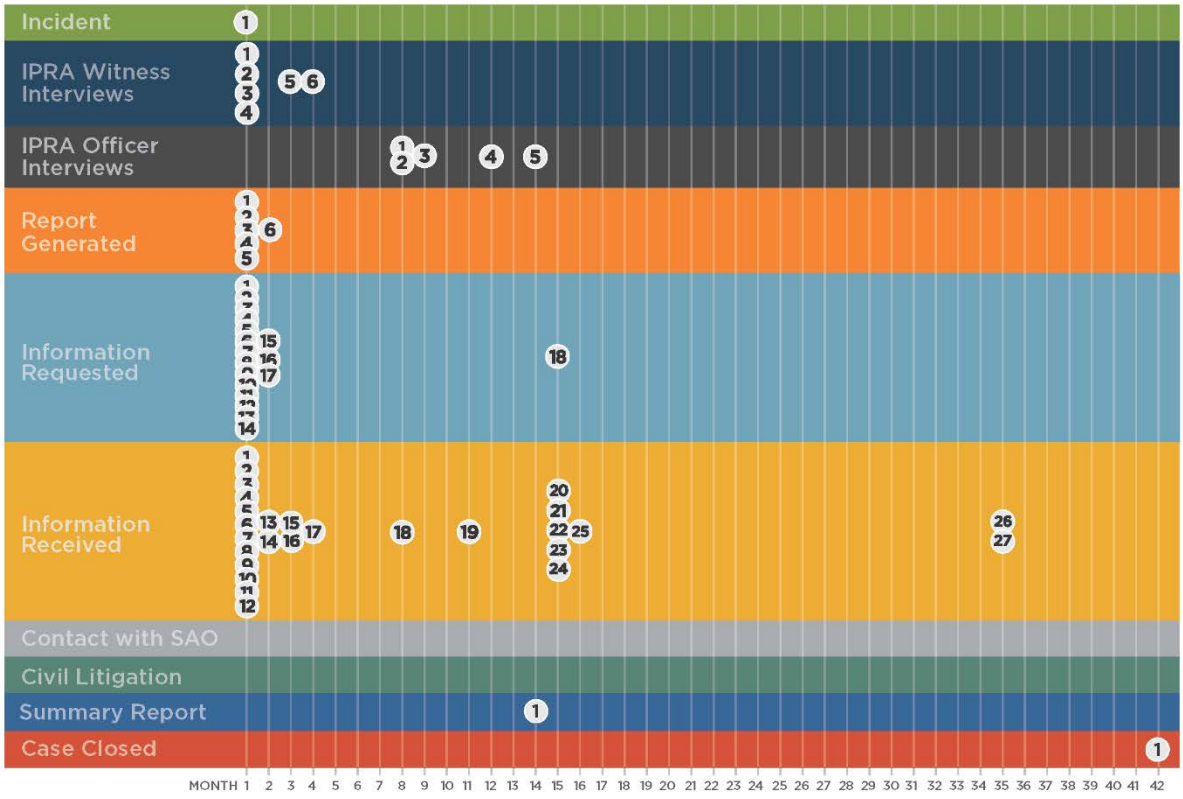
Timeline 11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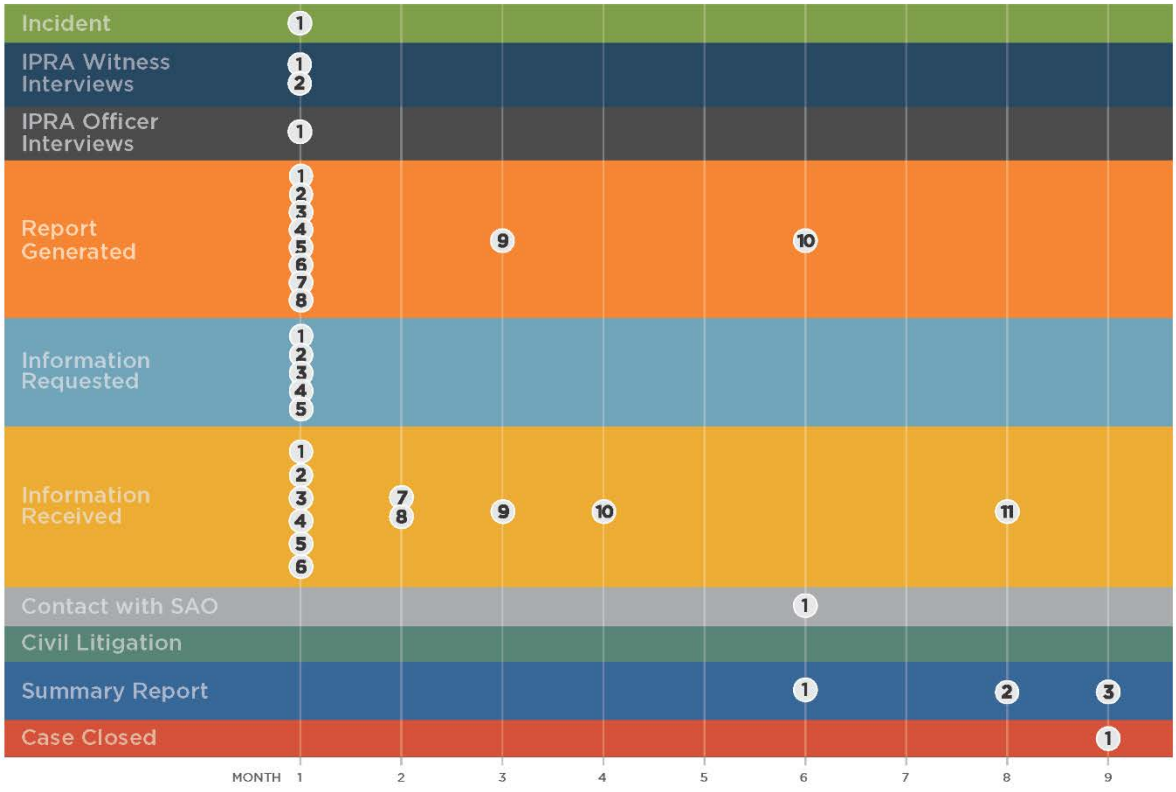
Timeline 12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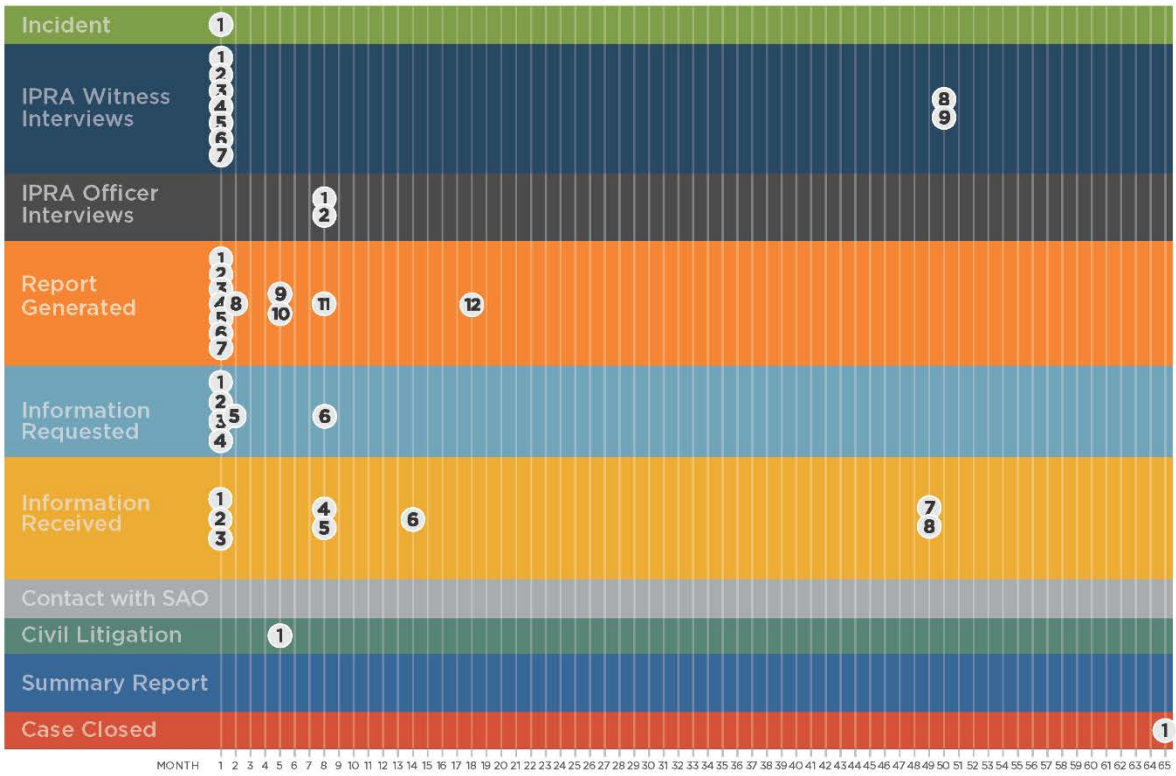
Timeline 13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Case Closed
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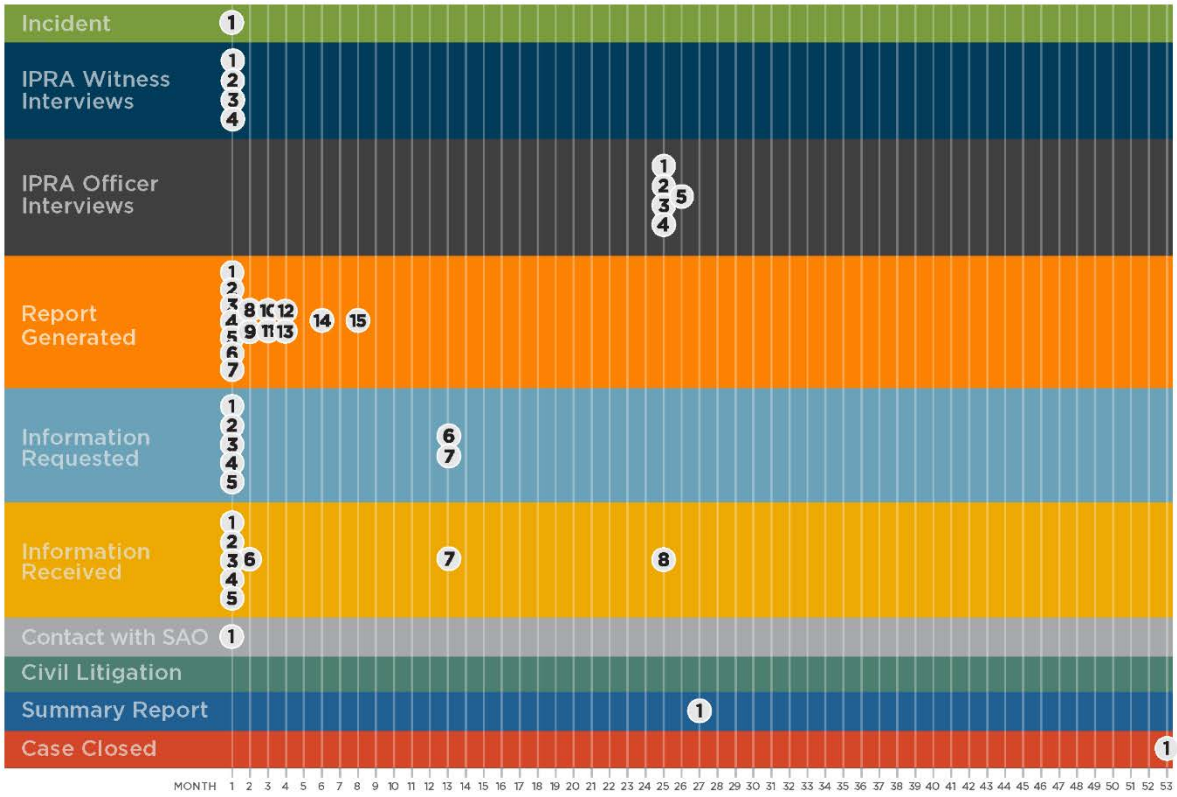
Timeline 14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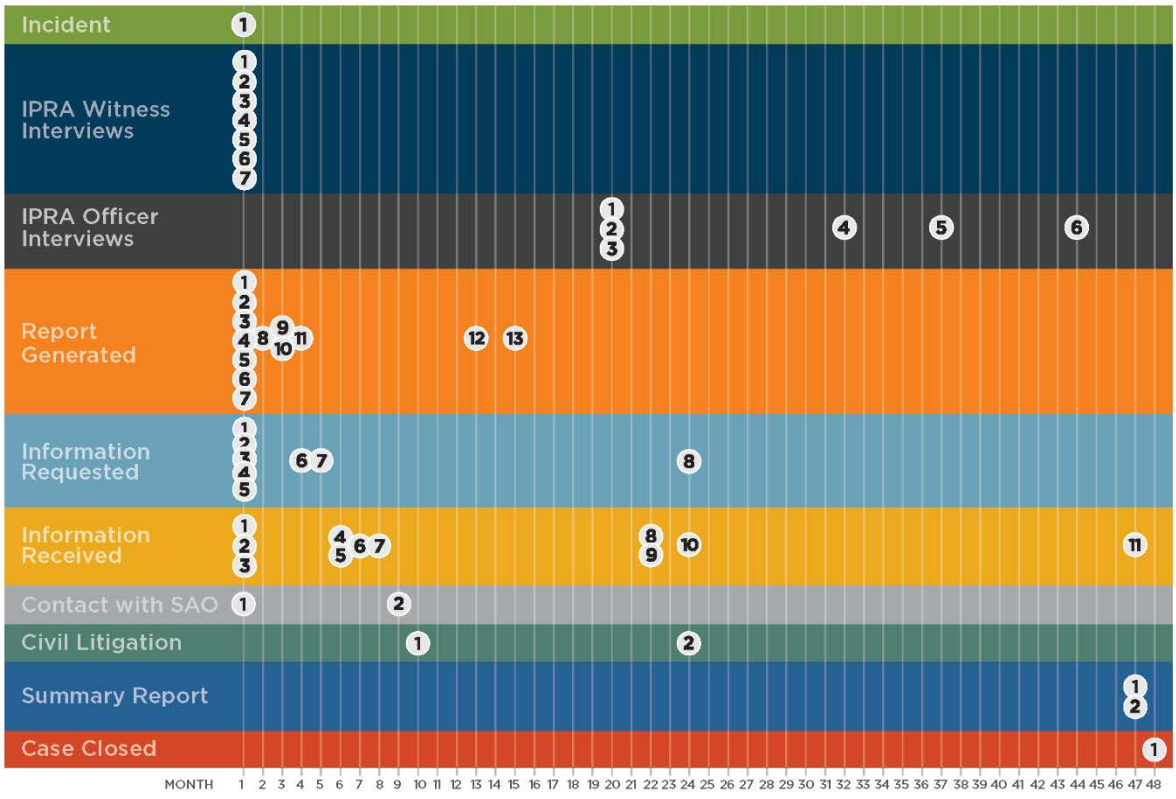
Timeline 15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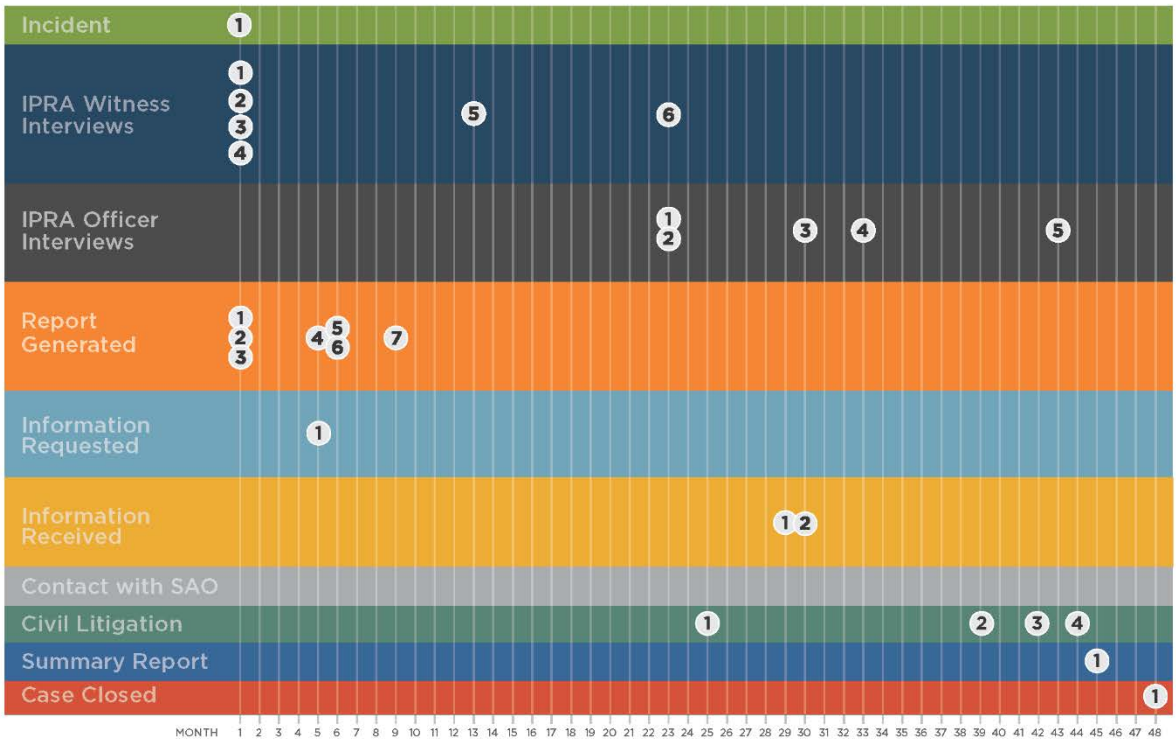
Timeline 16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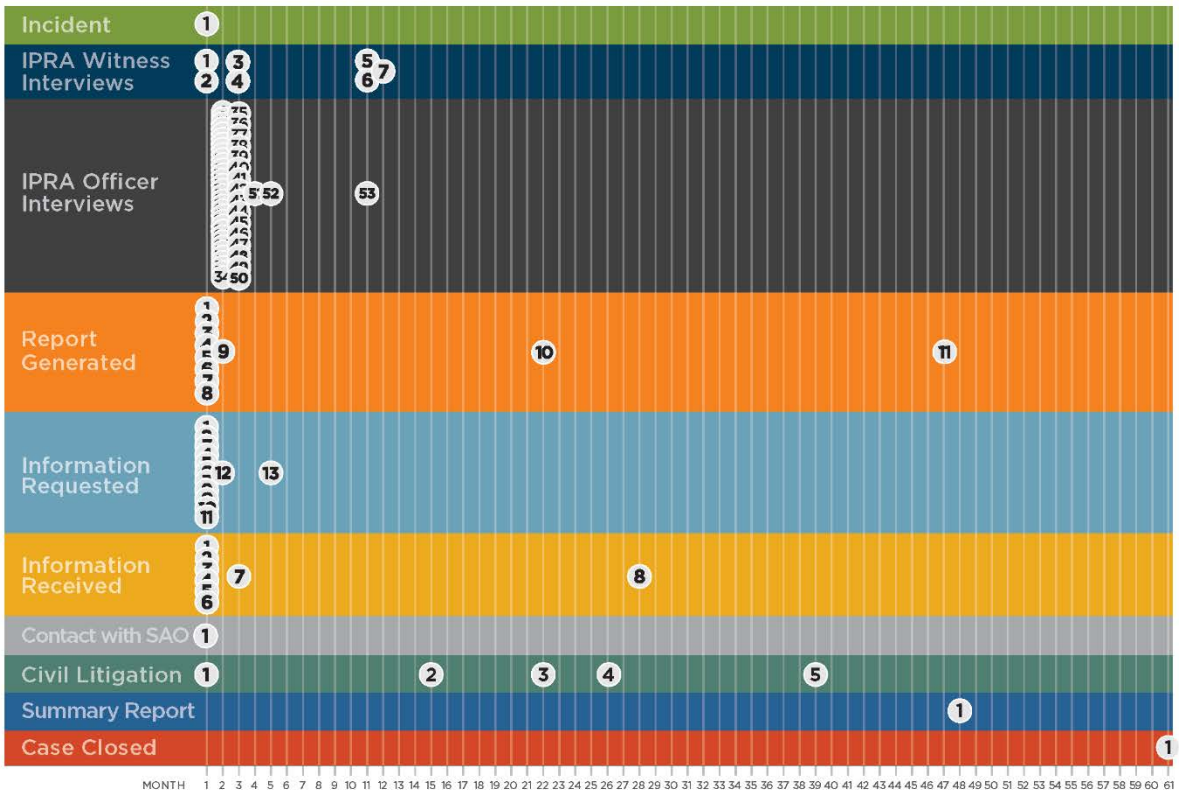
Timeline 17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Summary Report
Case Closed
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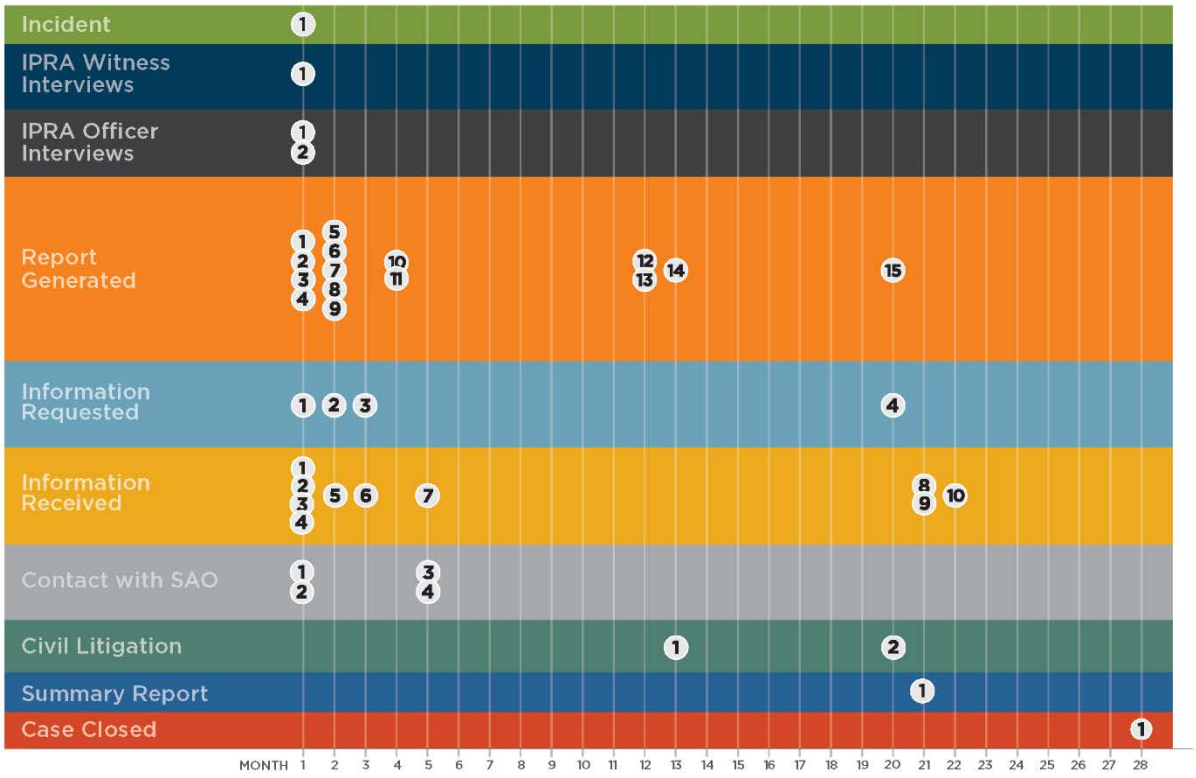
Timeline 18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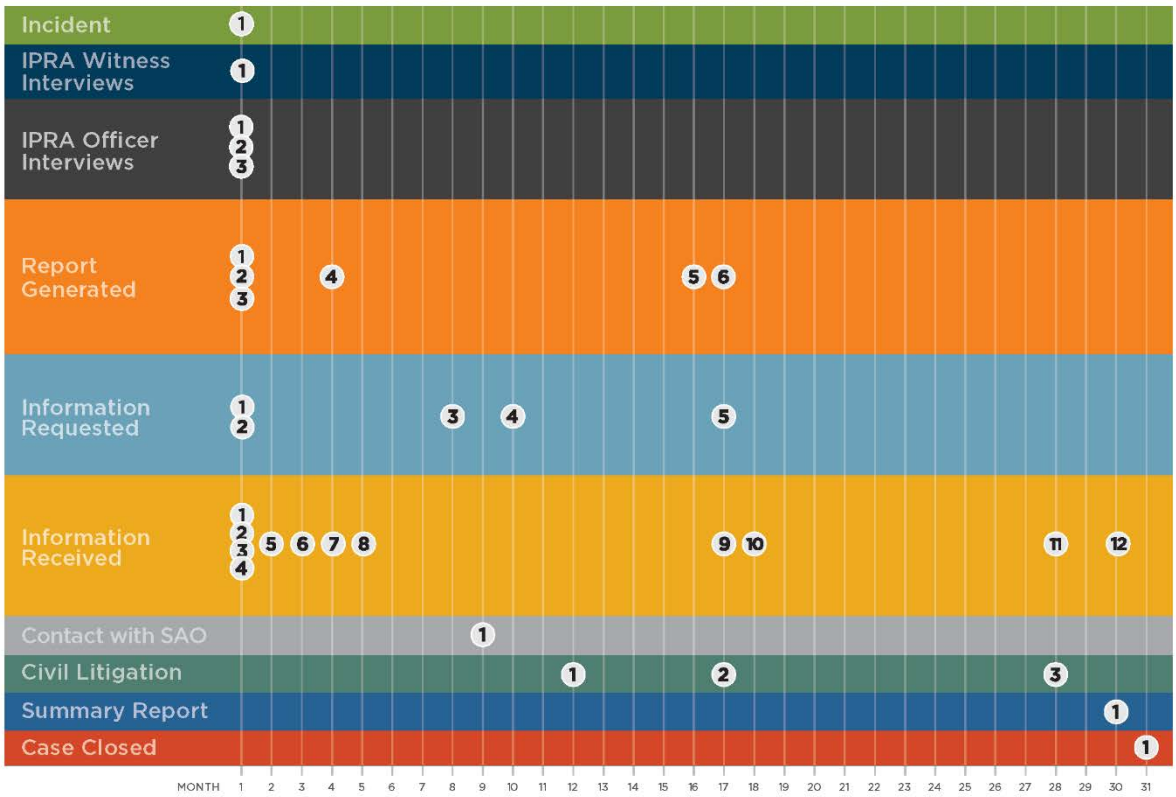
Timeline 19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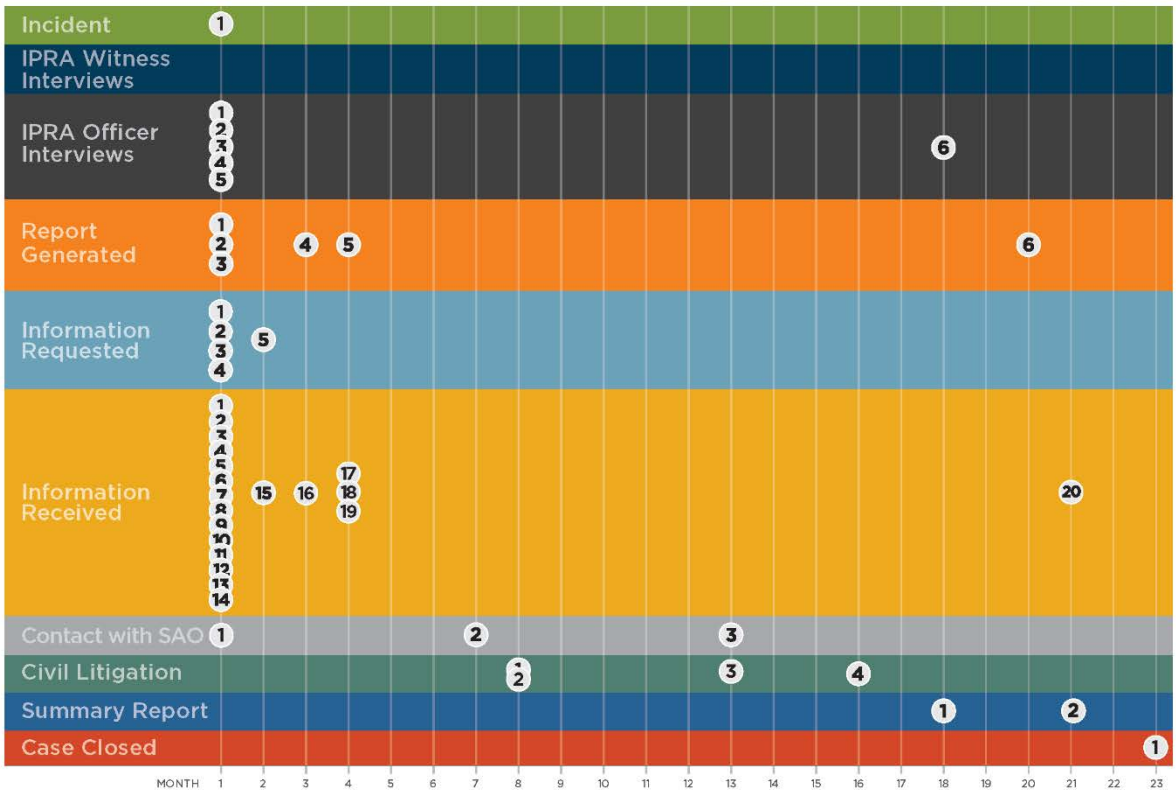
Timeline 20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