



February 24, 2022



**COURT MONITORING TEAM'S PRELIMINARY
ASSESSMENT OF
OFFICE OF PROFESSIONAL STANDARDS
COMPLIANCE WITH THE SETTLEMENT AGREEMENT
BETWEEN THE CITY OF CLEVELAND AND THE U.S.
DEPARTMENT OF JUSTICE**

The Cleveland Consent Decree Monitoring Team is pleased to present this preliminary assessment into the work of Cleveland's Office of Professional Standards (OPS) and the Civilian Police Review Board (CPRB). This assessment also evaluates the impact of the Cleveland Division of Police and Department of Public Safety's actions and impact on the adjudication of community complaints against the police that fall within the jurisdiction and mandate of the OPS/CPRB.

This assessment has been a long time coming. As described herein, it was not until 2018 (three years after the Consent Decree was adopted) that the Monitoring Team identified substantial

improvements as having been made in the OPS program. They included the critically important creation and implementation of an Investigations Manual, among other things. Even after these improvements had been made, the Monitoring Team and the OPS agreed that the OPS needed more time before it would be fully ready for a formal assessment of its work. In late 2020, the Monitoring Team and the OPS agreed that this first assessment should be a limited one, in order for the OPS administration to better understand where the OPS/CPRB program stands with respect to issues of overall compliance with the Consent Decree. It was fully anticipated that the Monitoring Team would identify areas where challenges still exist and that OPS would use the feedback contained within this assessment to achieve full and effective compliance in a future, more comprehensive assessment.

As of the writing of this report, OPS Administrator Roger Smith departed from the OPS to be the first Director of the Office of Accountability and Transparency for the City of Phoenix, with jurisdiction over the Phoenix Police Department. It is hoped that the newly appointed OPS Administrator will use this assessment to further improve the work of the OPS and bring the program into full and effective compliance with the Consent Decree.

This assessment is limited to only those cases received by the OPS after June 1, 2019, where at least one sustained finding was made by the CPRB and where a pre-disciplinary hearing was conducted by the Cleveland Division of Police (CDP) Chief of Police before December 31, 2020.¹ The purpose of this assessment is to evaluate compliance with Consent Decree requirements with respect to civilian complaints, the OPS and the CPRB—and specifically Paragraphs 193 through 239 of the Consent Decree.

1. Methodology

The Monitoring Team, in its role of assessing the status of Consent Decree reforms, developed an assessment tool and methodology for reviewing citizen complaint investigations sustained by the CPRB. The draft tool was reviewed by the DOJ, the OPS Administrator and the former CDP Inspector General. After conferral with these stakeholders, the online tool and methodology were finalized.

The Monitoring Team's review included all cases sustained by the CPRB and adjudicated by the CDP after the new OPS Administrator² had an opportunity to implement the OPS Operations Manual and once the CDP fully staffed its new Case Preparation Unit. It is important to note that the Operations Manual compliant with Consent Decree paragraph 200 was adopted effective

¹ The Monitoring Team and the parties (the DOJ and the City of Cleveland) agreed to the assessment including cases falling within this period to allow recent improvements in case adjudication staffing at the CDP to be considered as they related to the timeliness in the adjudication of community complaints falling within the mandate of the OPS and CPRB.

² Roger Smith was hired in June 2018 as the Administrator of OPS.

February 2017. The Monitoring Team accessed cases through the IA Pro and Evidence.com databases. There was a total of twenty-three (23) cases that met the above-noted criteria.

The Monitoring Team's review coordinator confirmed that the appropriate documents were available to reviewers, including documentation normally uploaded to IA Pro, Wearable Camera Systems (WCS) video, audio and video recordings of CPRB hearings. In addition, the CDP and Department of Public Safety provided transcripts for all Chief's hearings and Director's hearings conducted for the identified cases.

A team of four reviewers examined all case documentation, including watching video recordings of OPS interviews and of relevant portions of CPRB meetings. Each case was randomly assigned to a reviewer. The review coordinator subsequently conducted an independent review of each assessment tool and conferred with the reviewers, as necessary, to ensure consistency amongst the assessments. Ultimately, there were no irreconcilable differences of opinion as to any key issues or conclusions made by the reviewers.

The review considered all parts of the investigation and adjudication processes, to include the underlying OPS investigation and OPS findings, Civilian Police Review Board hearings, findings and recommendations, along with the rationale and disciplinary decisions made during adjudication of cases by the Chief and the Director of Public Safety.

The review specifically evaluated to what extent:

- "OPS investigations of complaints were as thorough as necessary to reach reliable and complete findings that are supported by the preponderance of evidence" as required by paragraph 218 of the Consent Decree;
- "CPRB's recommended dispositions [were] based on a preponderance of the evidence" with the "CPRB set[ting] forth its conclusion and an explanation for its reasons and supporting evidence in writing, including, when applicable, the justification for departing from OPS's recommended discipline," as required by paragraph 237 of the Consent Decree; and,
- The Chief and the Director of Public Safety were compliant with the requirements of paragraphs 240 through 243 of the Consent Decree (relating to Disciplinary Hearings) and paragraphs 245 and 247 of the Consent Decree (relating to Discipline).

2. Background of OPS Compliance Issues

The DOJ's 2014 findings

On December 4, 2014, the U.S. Department of Justice's Civil Rights Division and the United States Attorney's Office for the Northern District of Ohio (DOJ) issued a report detailing their findings from a civil rights investigation into the Cleveland Division of Police. Amongst those findings, the

DOJ detailed numerous deficiencies in carrying out the OPS' mandate to adequately investigate civilian complaints of officer misconduct.

The DOJ found that OPS and CDP investigations of civilian complaints were "neither timely nor thorough, that civilians face a variety of barriers to completing the complaint process, and that the system as a whole lacks transparency." Ultimately, the DOJ found that as a result of the deficiencies, "CDP falls woefully short of meeting its obligation to ensure officer accountability and promote community trust."³

The DOJ noted that the problems it identified were not new. At the conclusion of a prior civil rights investigation in 2004, the DOJ had concluded that:

- 1) "OPS was understaffed;
- 2) Investigators were not provided with the guidance and resources to do their jobs effectively;
- 3) Investigations were untimely;
- 4) Civilians' access to the complaint process was limited; and,
- 5) Some complaints that should have been investigated were not."⁴

By 2014, the DOJ found that "these problems remain, and in some cases, have worsened." The DOJ identified:

- 1) "Impossibly high caseloads for investigators,
- 2) The inappropriate and premature rejection of civilians' complaints,
- 3) Substandard investigations,
- 4) Significant delays in completing investigations,
- 5) The failure to document and track outcomes, and
- 6) A troubling pattern of OPS inappropriately rejecting complaints that may have warranted an investigation."⁵

The DOJ report identified "staggering [OPS] caseloads [that] make it impossible to taken even some basic investigative steps such as seeking out witnesses or visiting the scene of the alleged misconduct." The DOJ "saw many complaints that took more than a year to resolve" and "[f]or dozens of complaints" the DOJ saw "no record they were ever resolved."⁶

The DOJ further identified a litany of investigative failures, to include:

- Investigations that consistently lacked basic follow up, such as going to the scene and seeking out witnesses;"

³ DOJ Investigation report, at p. 38.

⁴ *Id.*, at p. 39.

⁵ *Id.*

⁶ *Id.*, at p. 40.

- Complaints involving allegations of serious misconduct where investigations consisted solely of officer statements, the complainant's signed form and recorded interview, and little, if any, additional documentation;" and,
- A systemic failure on the part of the OPS to "interview [] involved officer[s] unless the officer requests an oral interview in lieu of a written response."⁷

The DOJ also found deficiencies in the work of the CPRB, tasked with reviewing OPS investigations and making findings on those complaints. The DOJ found that "[t]he Board's review of these investigations [was] [] inadequate." The DOJ noted that Board files "frequently lack[ed] final dispositions and, when dispositions are included, there is no evidence of the Board's rationale supporting its decisions." The DOJ also noted that when CPRB findings were overturned by the Chief, there was no notice provided to the complainants.⁸

Overall, the DOJ found that the "CDP's civilian complaint system, as a whole is disorganized and ineffective ... with no systems in place to track the performance of OPS and the Police Review Board."⁹

The Monitoring Team's Early Observations:

Up until a change of leadership at the OPS in 2018, the Monitoring Team's reports regarding the state of the OPS-CPRB program were dire.

- In the Monitoring Team's first three Semiannual reports we noted serious failures and found the OPS's situation unacceptable. In June 2017, we found OPS to be non-compliant with 50% of its Consent Decree Requirements.¹⁰
- In our Fourth Semiannual Report (January 2018), and in reference to the above-noted comments from the Third Semiannual Report, the Monitoring Team reported having "remained frustrated by OPS's lack of progress – as well as the increasing likelihood that the systemic failures of OPS in investigating, civilian complaints in a fair, thorough, objective, and timely manner will serve as an anchor that will prevent timely, ultimate compliance with the Consent Decree. Put differently, the OPS-CPRB system is lagging far behind progress made in a number of other areas, which threatens to extend the duration of the reform process." We did note, however, that new leadership at OPS provided the organization with an opportunity "to get on the right track." However, we also commented

⁷ *Id.*

⁸ *Id.*, at 41.

⁹ *Id.*, at 42.

¹⁰ First Semiannual Report, pp. 7 & 47. Located at: [First+Semiannual+Report--2016-06-02--FOR+RELEASE.pdf \(squarespace.com\)](#); Second Semiannual Report, pp. 7 & 8. Located at: [Second+Semiannual+Report--2017-01-10.pdf \(squarespace.com\)](#); Third Semiannual Report, p. 48. Located at: [Third+Semiannual+Report--FINAL--FOR+FILING.pdf \(squarespace.com\)](#).

that “systemic and long-standing problems that have festered over years still require significant time, energy, and resources to make OPS into a functioning and credible oversight agency.”¹¹

Beginning with our Fifth Semiannual Report (August 2018), the Monitoring Team identified a number of areas of improvement at the OPS, to include the completion of OPS and CPRB operations manuals, the creation of a Backlog Reduction Plan, the creation of specific milestones to guide the OPS in achieving Consent Decree compliance, the publication of an OPS annual report, and the creation of additional essential staffing positions within the organization. The Monitoring Team noted that while the lack of a permanent OPS Administrator had contributed to continuing struggles within the organization, a new Administrator began working at the OPS, effective June 4, 2018.¹²

By the time of the publication of the Sixth Semiannual Report (March 2019), we reported having seen “improvements in the quality of OPS investigative practices; however, we still noted that “OPS still need[ed] to make additional progress to address some fundamental investigative deficiencies.”¹³ In our Seventh Semiannual Report (September 2019), we reported concerns that “in some cases, [an OPS] desire for the timely completion of case investigations might have negatively impacted the quality of work in some instances.” We reported that we had “been providing continuing feedback to the OPS administration in an effort to ensure that OPS ha[d] the capacity to appropriately balance the need for both timely and competent investigations.” We also reported on our continuing concerns regarding the apparent lack of timeliness in the final ultimate adjudication of sustained findings recommended by the CPRB on OPS investigations.¹⁴

In July 2020, our Eighth Semiannual Report announced our intent to conduct a comprehensive assessment of OPS case investigations and the CPRB review process, using both quantitative and qualitative methodologies.¹⁵

3. Assessment Findings

To achieve compliance with the Consent Decree, OPS investigations must be both competent (e.g., thorough and fair) and timely. Unless and until the OPS is able to achieve both of these objectives, full and effective compliance with the Consent Decree will not be reached. In

¹¹ Fourth Semiannual Report, p. 59. Located at: [Fourth+Semiannual+Report-FILED.pdf \(squarespace.com\)](#).

¹² Fifth Semi-Annual Report, pp. 82-89. Located at: [FINAL+FOR+FILING.pdf \(squarespace.com\)](#).

¹³ Sixth Semi-Annual Report, p. 48. Located at: [Sixth+Semiannual+Report--FINAL.pdf \(squarespace.com\)](#).

¹⁴ Seventh Semi-Annual Report, pp. 47 & 50. Located at: [Seventh+Semiannual+Report+-+FILED.pdf \(squarespace.com\)](#).

¹⁵ Eighth Semi-Annual Report, p. 47. Located at: [FILE_9341.pdf \(squarespace.com\)](#)

addition, the entirety of the complaint adjudication process must be reliable in that it results in the timely imposition of fair and reasonable discipline.

The following findings and observations were made in this initial assessment regarding **Competency**:

- Overall, there have been dramatic improvements in the quality of the work of OPS. The OPS administration should be lauded for taking a program that was clearly broken and ineffectual and making it into a program that can be the subject of legitimate evaluation with specified areas of improvement. There are still, however, important compliance issues that need to be addressed.
- There have also been striking improvements in the CPRB adjudication process for handling community-initiated complaints (to include timeliness of review by the OPS administration, setting cases for review by the CPRB and forwarding sustained finding recommendations to the Chief). In addition, there has been excellent follow-up by the CPRB in those cases where the Chief has departed from their recommendations - a remarkable change given that prior to the Consent Decree no process even existed for the CPRB to pursue appeals to the Director of Public Safety.
- There is a clear and continuing need for more training of OPS investigators to improve the quality of their interviews and a continuing need for formal evaluations of OPS investigators to ensure systemically fair and competent investigations.
- Although the timeliness of reviews by the OPS administration is excellent, OPS administrators sometimes appear to have prioritized timeliness over ensuring the quality of investigations.
- The OPS-CPRB must do more to adequately identify and systemically address training and policy issues (and areas where police services can be improved) outside of the traditional disciplinary process.
- Finally, there is a need for the OPS to ensure that all disposition letters sent to complainants provide sufficient information for them to understand not only the ultimate finding made by the Chief or the Director, but also the rationale provided by the Chief or Director behind that finding.

The following findings and observations were made in this initial assessment regarding **Timeliness**:

- Improvements need to be made with respect to the timeliness of OPS investigations and additional resources are needed to eliminate a recent new backlog of case investigations.

- **With respect to the CDP and the Department of Public Safety, the amount of time it takes the CDP and the Department of Public Safety to impose discipline on sustained community-initiated complaints (approximately one year on average) is far in excess of what is required to be compliant with the Consent Decree.**

A. Evaluation of Competency

Reviewers were asked to rate each OPS investigation according to the following definitions with the following overall results:

Excellent	The investigation complied with all Consent Decree requirements and the OPS manual, and investigators made reasonable attempts to follow all leads and answer all material questions. The investigation was fair, thorough, objective, and timely.	1 case (4%)
Very Good	The investigation complied with most Consent Decree requirements and OPS protocols and investigators made reasonable attempts to follow all leads and answer all material questions.	2 cases (8%)
Good	Although some aspects of the investigation could be improved, the identified flaws did not appear to materially or unduly impact the quality of the overall investigation. The resulting investigation provided sufficient information to evaluate the incident but could be improved.	10 cases (43%)
Fair	Several aspects of the investigation could be improved. Identified flaws materially impacted the quality of the overall investigation, and the resulting file provided insufficient information to evaluate the incident.	5 cases (22%)
Poor	All or nearly all aspects of the investigation could be improved. The investigation failed to establish sufficient information to support an evidence-based evaluation of the incident due to investigative deficiencies, material omissions, or other issues.	5 cases (22%)

In order to achieve full and effective compliance on the quality of investigations, it would be expected that all OPS investigations would fall within the Good to Excellent categories. Unfortunately, OPS achieved this goal in only 55% of its cases. Although the quality of investigations has improved greatly over the past two years, OPS still must make additional improvements to achieve full and effective compliance. OPS must ensure that investigations of all community complaints do not contain flaws that materially or unduly impact the quality of the overall investigation and that those investigations systemically provide sufficient information to evaluate the underlying incident and make reasonable findings.

B. Specific Concerns Identified:

The most significant concerns identified by the reviewers can be classified as follows:

1. Failure to identify, contact or interview all necessary third-party witnesses	12 cases (52% of cases)
2. Failure to make training and/or policy recommendations	11 cases (48% of cases)
3. Poor interview techniques	9 cases (39% of cases)
4. Failure to download/upload all relevant information/documentation in IA Pro	8 cases (35% of cases)
5. Failure to investigate all potential allegations	7 cases (30% of cases)
6. Disposition letter failed to explain rationale for the ultimate disciplinary decision	6 cases (26% of cases)
7. Insufficient attempts to contact and interview complainant	3 cases (13% of cases)
8. Poor or incomplete investigative report	3 cases (13% of cases)
9. Aggressive presentation by OPS investigator to CPRB	1 case (4% of cases)
10. Failure to record interviews	1 case (4% of cases)

1. Failure to contact and interview all necessary third-party witnesses (52% of cases)

In half of the cases reviewed, OPS investigators failed to attempt to contact and interview relevant third-party witnesses. It is our concern that in its attempt to improve timeliness, the OPS Administration (and the CPRB) have been approving case investigations and making findings on cases that have not been fully investigated. This is a crucial issue that must be resolved by the OPS and CPRB in order to achieve a finding of “full and effective compliance” with the requirements of the Consent Decree.

Comments by reviewers in these cases include:

- “The investigation would have been far more reliable had the second caller (who called 911 under similar circumstances as the complainant) been identified and interviewed.”
- “There was a failure to attempt to locate or interview third-party witness; resulting in a finding of ‘insufficient evidence’ on a harassment allegation.”

- “Additional witnesses were not identified or interviewed, despite at least two people who gave names when calling that night. No attempt was made to canvass the area where incident occurred.”
- “There did not appear to be any effort to interview the manager of the establishment who was present on the night in question.”
- “There was no attempt to contact and interview a 2nd social worker who witnessed much of the initial incident. Also, there was no record of an interview with a third witness whose name was provided by the 1st social worker.”
- “OPS never interviewed the dispatch supervisor who had reviewed the recording of the call in question and opined on its quality.”
- “Relevant testimony was not sought from the officer regarding the potential presence of a second officer at the scene. Nor was the officer asked about his WCS footage. This oversight led to important evidence not being gathered during the investigation.”
- “Additional witnesses would have helped. There was no evidence the OPS investigator attempted to obtain any witness information and he ultimately only interviewed the complainant and the subject officer.”
- “OPS never interviewed the complainant’s girlfriend who made the initial 9-1-1 call. Her comments to a witness officer as heard on WCS were critical to the case.”

2. Failure to make training and/or policy recommendations (48% of cases):

One of the most important tasks for civilian oversight of law enforcement, as it reviews and monitors police conduct, is the identification of policy and training deficiencies that can be used as “lessons learned” to reduce the risk of future police misconduct.

In this area, the Monitoring Team was unable to locate documentation where policy and training issues were, or should have been, identified and passed along to the Department of Public Safety and the CDP for action. As noted by the reviewers:

- “This matter could (and arguably should) have been addressed as a training matter with the subject officer, as opposed to a matter of misconduct.”
- “The core issues of the case related to policy and training versus intentional misconduct or malfeasance. There [was] no indication OPS interviewed personnel from the training section, nor was there a discussion as to whether the subject officer was recently trained in search and seizure law. Also, there was no indication that this issue was referred to the Training Section for CDP wide training on search and seizure.”
- “The OPS could have used this as “a good opportunity to [recommend] general training to all members (lessons learned relating to expectations regarding the use of social media), but there was no evidence this was done.”

The Monitoring Team recommends that the OPS and CPRB create a more formal process, to include a section in all OPS investigative reports to identify policy and training issues and to forward those concerns to the CDP and the Department of Safety. The OPS should then track those recommendations and publicly report on any actions taken (or declined to be taken) by the Division.

3. Poor interview techniques (39% of cases):

The issue of failing to conduct thorough and objective interviews of witnesses has plagued the OPS since the time of the first DOJ investigation. The OPS Administration has explained to the Monitoring Team that they have not been provided with the resources to sit in on or personally review recordings of the vast majority of interviews conducted by OPS staff. As such, they expressed a strong interest in hearing our findings on this issue. The OPS Administrator has also reported that extensive in-house training has been provided to the investigative staff on how to conduct interviews.

Unfortunately, the training provided to OPS does not appear to have been adequate to achieve Consent Decree compliance. As noted by our reviewers:

- “The OPS investigator seemed somewhat inexperienced in asking interview questions of the subject officers and failed to ask deeply probative questions.”
- “The witness interviews relied too heavily on closed questions. Potentially limiting the range of responses from the witness, and potentially contaminating the witnesses’ responses.”
- “The interview of the subject officer was aggressive and confrontational, bordering on an interrogation and was not an advantageous style of interview for this case.” In a second case, it was noted that “the interview of the subject officer was closer to an interrogation than an interview and bordered at times on hostile and aggressive.”¹⁶
- “The investigator spent a lot of time reciting relevant GPO language to the officer and prefacing his questions with lengthy recounting of his interpretation of the law and relevant facts. In some ways, it could have bordered on argumentative but it was a one-sided argument.”
- “The investigator could not control the interview, the complainant was ranting throughout and it was evident that the investigator just wanted to end the call, resulting in the investigator failing to ask important follow-up questions.”

In the only case reviewed involving a complainant who had limited English speaking proficiency, the reviewer commented that “it was unclear from the recording or the electronic file whether the

¹⁶ It must be noted, however, that the Monitoring Team has identified significant improvements in this area. In the past, overly aggressive interviewing techniques were common amongst certain OPS investigators; at the current time, this type of conduct appears to be more of an aberration than a continuing course of conduct.

investigator established that the complainant was proficient in English for the interview to be conducted without an interpreter. The investigator also asked a few unnecessary leading questions but this may have been due to the discomfort caused by some of the communication difficulties.”¹⁷

The OPS Administrator has informed the Monitoring Team that a number of the issues identified in this assessment were previously identified by OPS Administration and have already been addressed with OPS staff. OPS Administration was specifically aware that a few of its investigators had occasionally engaged in overly aggressive interview techniques and that these investigators had already been counselled about their performance.

The new OPS Administrator will need to review OPS training that has previously been provided in this area and determine to what extent additional training will be needed to ensure compliance. As previously suggested by the Monitoring Team, it appears that ongoing monitoring or reviews of interviews in support of a formal performance review process will be required for the OPS to achieve full and effective compliance in this area.

4. Failure to download/upload all relevant information/documentation in IA Pro (35% of cases):

The importance of documenting all aspects of investigations cannot be overstated. The old axiom of “if it’s not documented, it didn’t happen” must be applied to the OPS when it conducts its investigations and uploads information into its Management Information System. In addition, without full documentation, reviewing bodies such as the Monitoring Team or the Inspector General are unable to effectively evaluate the progress of the OPS and CPRB as to Consent Decree compliance and overall competence.

In a full one-third of the cases reviewed, there was information missing from IA Pro. In these cases, we found examples of the following: no documentation of investigative plans, missing recordings of interviews, missing correspondence from the Chief’s Office, and lack of documentation as to notice provided to complainants and officers. In one case, there was no documentation of when a case was returned to OPS from CDP Internal Affairs. Finally, the Monitoring Team was unable to find any documentation of CPRB decision-making with respect to agreements or disagreements with the Chief and the Director of Public Safety regarding their departures from recommendations made by the CPRB.¹⁸

¹⁷ It should be noted that Under Title VI (and the Safe Streets Act), the City is required to provide Limited English Proficient individuals with meaningful access to their programs and services. Providing “meaningful access” will generally involve some combination of services for oral interpretation and written translation of vital documents. See, ([Civil Rights | Limited English Proficient \(LEP\) | Office of Justice Programs \(ojp.gov\)](#)).

¹⁸ The only way the Monitoring Team was able to identify the CPRB conclusions in this regard involved a labor-intensive process of accessing and then listening to CPRB meetings conducted after the Chief sent notice of his departure to the OPS and CPRB.

5. Failure to investigate all potential allegations (26% of cases):

Another important component of the community complaint adjudication process is the need for the investigative and reviewing bodies to identify and fully investigate all significant allegations of misconduct. In 30% of the cases reviewed, however, we noted failures on the part of the OPS and the CPRB to identify areas where serious misconduct may have occurred and to fully investigate those acts or omissions.

In one case, the OPS failed to allege or investigate a “Failure to Supervise” allegation brought up by the complainant. In an additional three cases, the OPS failed to initiate false statement allegations against subject officers who made statements during the course of the OPS investigation that appeared to have been (or had the potential to be) provably false. In yet another case, the reviewer noted that the OPS failed to look into the complainant’s allegation that an officer failed to submit a complete report on an incident, instead focusing on the allegation that the officer failed to cite the driver of the vehicle that collided with the complainant.

Ultimately, the responsibility for ensuring that all potential instances of officer misconduct are fully investigated and adjudicated falls on every stakeholder in the adjudication process, starting with the OPS investigator, and including the OPS Administration, the CPRB and the Chief and/or Director of Public Safety. In none of these cases was there any intervention on the part of any of these stakeholders.

The failure to fully identify and investigate all potential allegations should be a rare occurrence. The various stakeholders in the community complaint adjudication process will need to be more attuned to this issue, and act accordingly, before Consent Decree compliance can be achieved.

6. Failure of disposition letters to explain the rationale for ultimate disciplinary decision (26% of cases):

It is important for an oversight agency to be transparent and provide civilian complainants with explanations of rationales for decision-making. This is particularly important when complaints are not sustained. The CPRB manual has specific provisions in that regard. Specifically, in cases where the Chief or the Director of Public Safety has decided to depart from the Board’s adjudication and/or recommended discipline and the Board has decided not to appeal or formally disagree with that decision, pursuant to CPRB Policy Manual Section L.3, the OPS is required to provide notice to the complainant to “include the Board’s reasoning for not reconsidering the Chief’s determination.” In addition, that same Manual Section requires that “[i]n all cases adjudicated by the Board,” the OPS shall “provide a timely written explanation to the complainant and the subject employee(s) *outlining the reasoning* behind the Board’s decision to issue findings of “insufficient evidence,” “unfounded” or “exonerated.” (Emphasis added).

In a number of cases, however, the current processes used by the OPS and the CDP do not appear to provide complainants with the information they would need to understand the rationale behind the decisions made by the Division, the Director or, sometimes, the CPRB.

In one case, the reviewer noted that “OPS’ final disposition letter to the complainant did not provide any notice of Chief’s departure from PRB recommendations or the history of decision-making. It only stated that PRB sustained and the Chief issued a written reprimand.” In another case, it was noted that although the OPS disposition letter to the complainant did outline the course of events, it did not explicitly state whether or not the CPRB publicly challenged the decision-making of the Public Safety Director. In yet another case, there was no indication of any letter to the complainant advising her of a dismissal by the Chief - instead, the last letter sent by the OPS only advised her of sustained findings having been recommended by the CPRB.

Just as important as advising complainants of why the CPRB declined to sustain an allegation, is the need to be transparent as to the ultimate findings when the Chief or the Director do not follow CPRB recommendations as to findings and/or discipline. In all but one case, the Chief provided rationale for his departures¹⁹ and there is no apparent reason why the OPS did not pass along that rationale to the complainant in all cases.

7. Insufficient efforts to contact and interview complainant (13% of cases):

The OPS Manual is very clear on what is required regarding OPS investigators’ efforts to contact complainants. Section 403 of the Manual provides specific detail for procedures for contacting and/or interviewing complainants. This Manual Section was created specifically to deal with a prior history where the OPS systemically failed to take appropriate efforts to contact and interview complainants. The Manual includes a requirement that OPS investigators go to the complainant’s last known address “after three unsuccessful attempts to contact the complainant.”

In two different cases reviewed, however, the complainant was not located or interviewed and there was no documentation of any OPS investigator attempt to visit the complainant’s last known address. In a third case, even though the first OPS investigator promised a complainant a subsequent “full blown” interview, a second investigator failed to follow through on that promise.

8. Poor or incomplete investigative reports (13% of cases)

In the past, the Monitoring Team observed systemically poor report writing on the part of OPS investigators. This no longer appears to be a systemic issue. However, in one of the cases reviewed, it was noted that the “overall report was a cliff notes type report more than a comprehensive investigative report.” In another case, it was reported that although the interview of the complainant was conducted in a “very respectful and compassionate way,” and the interview was

¹⁹ In one case, the Chief’s explanation was purely conclusory. There was no documentation, however, of any attempt by the OPS or the PRB to obtain a more robust rationale from the Chief.

“thorough and produced very detailed information,” the OPS investigative report did not include some critical information from the interview. In a third case, it was reported that the investigative report contained no documentation about why witnesses were unable to be identified.

9. Singular Case Issues:

In singular cases, issues of concern were identified by reviewers that warrant comment herein:

A. Aggressive presentation by OPS investigator to Board or at pre-disciplinary hearing

In the past, the Monitoring Team noted overaggressive presentations to the CPRB or at pre-disciplinary hearings. In all but one case that was reviewed, such behavior no longer appears to occur. However, in one notable case, the OPS investigator was noted to have been “over-zealous and even interrupted Board members during their deliberations.” The Monitoring Team understands that OPS Administration has been cognizant of this issue and addresses it as necessary with OPS staff. The Monitoring Team believes that the new OPS administration will need to address any future issues in this regard, to include overly aggressive interview techniques, on a more formal basis, through a formal performance review process.

B. Failure to record interviews

In the past, OPS investigators, more often than not, failed to record their interviews. This appears to be no longer the case. However, in one case, it was noted that although the OPS investigator appropriately conducted “non-evidentiary interviews” with CDP personnel for technical advice, the investigator failed to record the interviews.

10. Additional Issue of Concern: Video recordings of subject officers:

Finally, in two cases, the reviewer noted the poor quality of WCS video recordings of OPS interviews with subject officers which highlighted a continuing need for more adequate video recording technology to be provided in the OPS interview room.

In addition, in one instance, the subject officer video interview shut off at a midway point without explanation or documentation thereof.

C. Evaluation of Timeliness

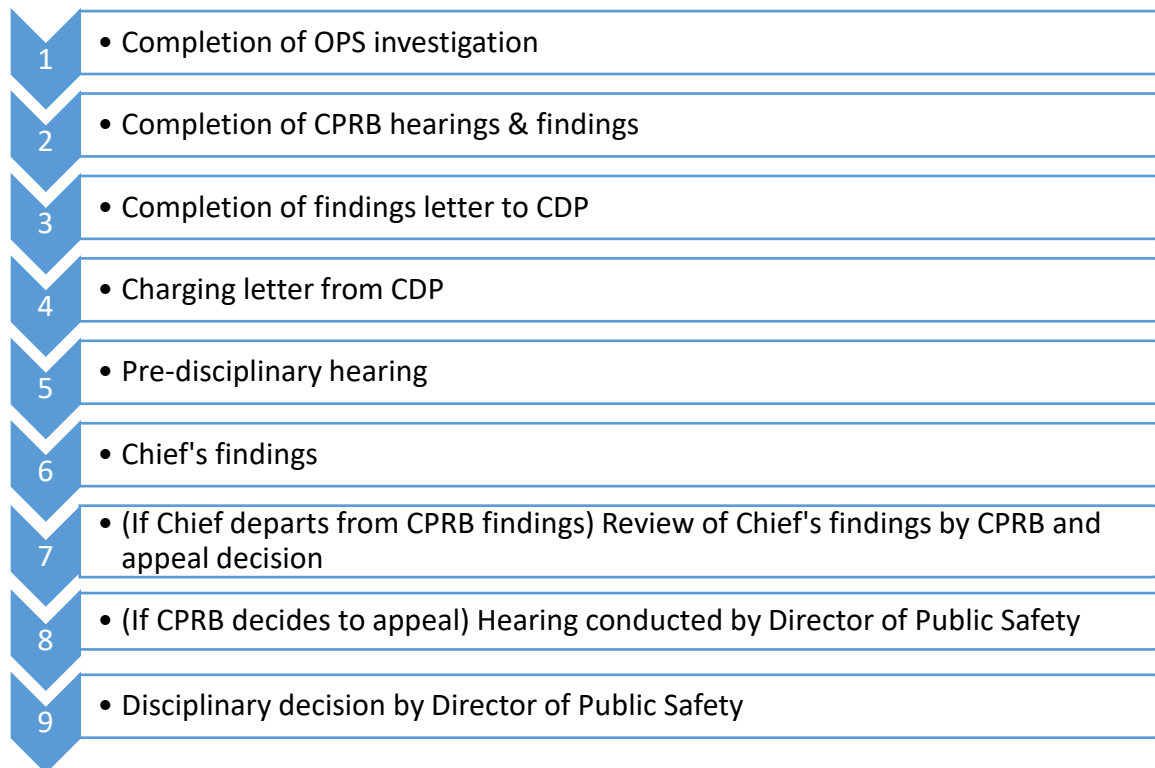
1. Full Adjudication of OPS Cases:

As previously stated, even if an OPS investigation is thorough, fair and professional, if the investigation or the adjudication of a complaint is not timely, the community and the police are not well served. Untimely investigations undercut the efficacy of any police accountability systems. In addition, such delays also lead to procedural injustice for both the community and the

involved officers. Of the 23 cases that were assessed, the Monitoring Team noted that only one case was fully adjudicated in a timely fashion. (That case was adjudicated in 152 days (approximately 5 months from the time the complaint was received by OPS until the time a disciplinary decision was made)).

The overall time for the full adjudication of OPS-PRB cases was on average, approximately one year from the date the complaint was received by OPS. (Average time was 361.2 days, with a median of 363 days). The case that took the longest amount of time to resolve, took 567 days (approximately 19 months). That case ultimately included a CPRB appeal of the Chief's departure from their disciplinary recommendation.

The stages of adjudicating a complaint, include:



Each stage takes time and is an integral part of the overall process of attempting to ensure officers and complainants receive fair treatment and due process. However, as the Monitoring Team has repeatedly noted, and as this review has established, it is impossible to ensure the overall timely

adjudication of complaints (as envisioned by the Consent Decree),²⁰ without creating and monitoring timeliness goals for each and every stage of the process.²¹

The Monitoring Team has concluded that Consent Decree compliance will not be possible in this important area of police accountability until the City establishes such timeliness goals and ensures all stakeholders work towards achieving each and every goal.

2. Timeliness of Various Stages of OPS Adjudication Process:

Stage 1: OPS Investigation Timeliness.

With respect to the first stage of the investigation/adjudication process, Consent Decree paragraph 216 requires that “[i]nvestigation of complaints assigned to the standard track will be completed within 45 days” and “[i]nvestigation of complaints assigned to the complex track will be completed within 90 days during the first 6 months following the Effective Date and within 75 days thereafter.”

Only 52% (n=12) of the cases reviewed were completed within the required 90-day period. Of those cases completed within 90 days, the average time of completion was 38 days (median between 38 and 47 days). Of those cases not completed within 90 days, the average time of completion was 205 days (217 days median).

The time for completion of investigations ranged from 11 days to 377 days. Two cases took over one year (366 & 377 days), but seven cases (30%) took more than 6 months to complete.

Current issues with timeliness of OPS investigations:

Unfortunately, the number of open cases at the OPS has been trending upwards over the course of 2021. This trend appears to be based, in large part, on an increase in the number of OPS complaints currently being received. The number of OPS complaints received in the first 9 months of each year hit a low of 151 in 2018. As of September 28, 2021, however, the number of complaints received was reported by the OPS to be 237, an increase of 57% over the last three years

²⁰ See paragraph 177 requiring CDP Internal Affairs to conduct “objective, comprehensive, and timely investigations of all internal allegations of officer misconduct;” paragraph 194 requiring the City to hire an OPS administrator with the ability to manage, amongst other things the “timely, and objective investigation of complaints;” paragraph 253 requiring the Inspector General to “analyze investigations conducted by OPS to determine whether they are timely, complete, [and] thorough...”; and, paragraph 320, requiring the City to create a police staffing plan that will ensure, among other things, “a sufficient number of well-trained staff and resources to conduct timely misconduct investigations.”

²¹ With the passage of Issue 24, it appears that additional stages to the disciplinary process may need to be added; as such, this issue may be of increasing importance in the upcoming future.

As a result, over the course of 2021, the number of pending investigations overall has significantly increased. This has led to an increase in the average OPS investigator's caseload. At the beginning of 2021, the OPS reported a total of **169** active investigations, assigned amongst a total of nine investigators, showing an average caseload of 18.7 cases per investigator. As of the end of October 2021, the OPS reported a total of **237** active case investigations amongst eleven investigators, resulting in an increase in average caseload from 18.7 to 21.5, even with the addition of two new investigators.²²

In addition, as of the end of October 2021, the OPS reported having a total of **52** case investigations that are over one year old and not yet completed. This is a dramatic increase over the number of year-old case investigations reported at the beginning of 2021 wherein the OPS reported a total of **18** cases that were over a year old and still pending the completion of an OPS investigation.

The City must act quickly and provide additional resources to the OPS in order to attend to this significant increase in workload. Only in this way will the City be able to eliminate this unacceptable workload that will negatively impact the OPS' ability to achieve full and effective compliance with the Consent Decree.

Stage 2: Assignment of Cases to CPRB / Completion of CPRB hearing.

With respect to the reviewed cases, it took the OPS-CPRB, on average, almost two months (57.5 days average; median = 49 days), from the time an investigation was completed to the time that the CPRB adjudicated the case. It does appear that a large part of any delays in this stage of the process can be attributed to the CPRB meeting only once a month.²³

In sixteen (70%) of the cases, the CPRB was able to hear the case within a two-month period. In seven cases, however, it took between 75 and 141 days for the CPRB to adjudicate an OPS investigation (average of 101 days; median of 82 days).

Prior to our next evaluation, the City, the OPS and the CPRB should further examine this issue to determine to what extent case adjudication times can be shortened. In a best-case scenario, all

²² One case was assigned to the Supervising Investigator, reducing the caseload from 237 to 236 cases, split amongst eleven investigators. One temporary investigator was added onto the OPS Bi-weekly report as of June 22, 2021; a second temporary investigator was added onto the OPS Bi-weekly report as of July 6, 2021. The caseloads for these new investigators started small, with each investigator only being assigned one case each and then increased over time with each new investigator being assigned 8 to 9 cases as of the end of October, 2021. As of the end of October, neither of the new investigators were carrying a full caseload, resulting in the permanent investigators carrying an actual average caseload of 24.4 cases each.

²³ The issue of how often the CPRB should meet was the subject of significant discussion in the early stages of Consent Decree implementation (2017-2018). CPRB workload is substantial and meeting more than once a month was considered to be too great a burden on the CPRB membership, who receive only small stipends from the city for their work.

community complaints should be able to be adjudicated by the CPRB within 30-45 days of the completion of an OPS investigation.

Stage 3: Preparation of Findings Letters to Chief.

OPS Manual Section 802 requires the OPS Administrator to prepare a letter to the complainant, explaining CPRB findings within 15 days of a CPRB meeting (and “promptly direct that a findings letter be delivered to the Chief of Police requesting that a charging document be issued”). For the 23 cases reviewed, the longest it took the Administrator to send such a letter was 24 days (on four occasions) and the average number of days to send a findings letter was 17 days (median = 17 days). Although OPS was generally compliant with this OPS Manual requirement, the 15-day requirement was not met in a majority of the cases.

Stage 4: Preparation of Charge Letters.

In prior public reports, the Monitoring Team has identified a lack of timeliness in the scheduling of OPS case-related pre-disciplinary hearings by the Chief of Police to be an issue of significant concern (although we have noted that some of those delays were the result of the COVID-19 pandemic, which resulted in the inability of the Division to conduct any pre-disciplinary hearings from March through May, 2020).²⁴ Over the past few reporting periods, the Chief’s Office increased staffing to the “Case Prep Unit” to address the Division’s need to handle discipline in a more timely and effective manner. In fact, immediately prior to conducting this assessment, the Monitoring Team updated the population of cases to be reviewed to allow this assessment to evaluate impact of the increase in the Case Prep Unit’s staffing.

Out of 24 charge letters created²⁵ – it took the Division 78 days, on average [median between 58 and 66 days], to produce a letter to the subject officer(s) advising them of the charges against them. This stage of the disciplinary process should take no longer than 30 days, except in unusual circumstances (such as where an OPS case needs to be combined with other pending internal allegations).

²⁴ See, Third Semiannual Report, at p. 48 [discussing OPS failure to refer cases to Chief’s Office]; Seventh Semiannual Report, at p. 50 [regarding the reported inability of the CDP to schedule timely OPS pre-disciplinary hearings]; Eighth Semiannual Report, at p. 49 [recommending that the CDP establish timeliness goals for the completion of Chief’s Hearings; and, Ninth Semiannual Report, at p. 93 [noting challenges posed by COVID-19 pandemic on timeliness of Chief’s Hearings].

²⁵ Due to a number of factors, not every case involved the issuance of a charge letter and some cases involved the creation of more than one charge letter.

Stage 5: Completion of pre-disciplinary hearing.

On average, it took the Division 22 days to conduct pre-disciplinary hearings from the date of the charge letter (median = 21 days].

As such, this was the one stage of the adjudication process where it appears that timeliness has been achieved.

Stage 6: Chief's Findings.

This part of the adjudication process involves the amount of time that the Chief took to decide and impose discipline after completing a pre-disciplinary hearing.

The population included twenty-five (25) individual disciplinary decisions made by the Chief.²⁶ The average amount of time it took the Chief to issue discipline was thirty-nine (39) days from the date of the pre-disciplinary hearing (with a median of 36 days). The Chief issued eleven (11) decisions in less than 30 days (46%), and a total of 22 decisions in 60 days or less (92%). In one case, however, involving a letter of reprimand, without a pre-disciplinary hearing, it took the Chief one hundred and fifteen (115) days to issue his decision.

Although the Monitoring Team has witnessed impressive improvements in timeliness in this area, more needs to be done. In order to ensure procedural justice for both the community and the involved officers, except in the most exceptional cases, it should take the Chief no longer than 30 days to issue discipline and that, in most cases, discipline should be imposed within 15 days of a pre-disciplinary hearing.

Stage 7: CPRB reviews cases involving departures from the Chief of CPRB recommendations.

The Monitoring Team found that the OPS-CPRB has created a robust process by which the CPRB considers departures by the Chief from its disciplinary recommendations at the next available hearing. This is an excellent process improvement given that, in the past, there was no record of the CPRB even considering appealing a departure by the Chief to the Director of Public Safety.

*Stage 8: [If CPRB decides to appeal] – hearing conducted by Director of Public Safety, and,
Stage 9: Disciplinary Decision by Director of Public Safety.*

Only four of the cases reviewed involved instances where the Chief departed from CPRB disciplinary recommendations and the CPRB chose to appeal the Chief's decision to the Director

²⁶ In some cases, the Chief issued more than one disciplinary decision, in other cases, the Director of Public Safety issued a disciplinary decision instead of the Chief.

of Public Safety. In the first case, it took 165 days for the Director to resolve the case (taking 101 days for a hearing to be scheduled and an additional 64 days for the Director to make a disciplinary decision). In subsequent cases, the Director laudably put into place a process where hearings could be conducted within three days of a CPRB decision to appeal.

Even so, in the next two cases decided by the Director, it took him 76 and 97 days to make his decision. And while there was a significant improvement in the amount of time the Director took to make his decision in the final case we reviewed (35 days), improvements in the amount of time it takes to issue these decisions would positively impact on the overall timeline for complaint adjudication.