December 20, 2021

INDEPENDENT MONITORING TEAM'S REVIEW OF INVESTIGATIONS AND ADJUDICATION OF FATAL PURSUIT RESULTING IN THE DEATH OF TAMIA CHAPPMAN

I. Introduction.

This review evaluates the processes used by the City of Cleveland agencies responsible for conducting administrative investigations of a police pursuit that took place on December 20, 2019 and tragically resulted in the death of 13-year-old Tamia Chappman and the injury of her 11-year-old companion. Chappman and her companion were struck by a vehicle being driven by an armed carjacking suspect who was being chased by CDP officers at the time of the collision.

Officers are given a qualified exemption under state law from observing certain traffic laws while engaged in a lawful pursuit of a vehicle. They are not, however, relieved of the responsibility of driving with due regard for the safety of all people who could be impacted by this most dangerous of all police actions. Officers must consider the initiation of a police pursuit in the same light as a potential use of deadly force. As such, when the death of an innocent human being occurs as a result of a police pursuit, even when the criminal being pursued directly causes that death, a comprehensive investigation must follow that is of the highest caliber, and it must leverage every resource available to the police agency. The investigation must focus on the crime that was committed that resulted in the pursuit, as well as an administrative investigation in order to determine whether all applicable policies were followed, and whether new policies need to be implemented. The tragic events of December 20, 2019, that resulted in the death of Tamia Chappman deserved such an investigation.

This review does not evaluate the reasonableness of the disciplinary decisions made by the Cleveland Department of Public Safety in this case. The Monitoring Team has previously completed assessments regarding the reasonableness of disciplinary decisions and our obligations under the Consent Decree may require that we do so in the future. Instead, this review evaluates the processes used by the Cleveland Division of Police (CDP), the Office of Professional Standards (OPS) and the Department of Public Safety. We considered the extent to which the processes followed supported reasonable decision-making on the part of the Chief of Police and the Director of Public Safety when considering the conduct of involved CDP personnel. In virtually all respects, we find that the processes used by the Cleveland Division of Police were deficient, non-compliant with the Consent Decree, and insufficient to support reasonable and rational decision-making on the part of Department of Public Safety leadership.

Perhaps worst of all, these deficiencies should have been apparent to all levels of CDP leadership, including the Director of Public Safety, the Chief of Police, the Deputy Chief (Executive Officer) and the Internal Affairs Superintendent at the time of the investigation and adjudication of this case. The Department of Public Safety and CDP leadership failed to deploy adequate and available resources to ensure public faith in the outcome of the investigation. This was despite the significance of the incident and undoubtedly being aware that the Monitoring Team and the Department of Justice would carefully evaluate the investigation and adjudication processes. As such, the City squandered an opportunity to assure the Monitoring Team, the Department of Justice, the U.S. District Court and the public that police accountability has been successfully integrated into CDP practices.

This review also looked at the overall performance of the OPS, which conducted its own independent investigation into the incident. Although the OPS investigation of the incident was – in virtually all respects – superior to the investigation conducted by the CDP, it was not conducted in a timely manner. The untimely OPS investigation created an opportunity for the CDP to

ultimately disregard OPS' investigation and review process. In addition, the Monitoring Team is greatly concerned with decisions made by the Cleveland Police Review Board (CPRB) regarding its classification of violations sustained against some CDP members. These decisions by the CPRB did not appear to be in accord with the CDP's disciplinary matrix and no attempt was made by the CPRB to explain why it departed from the presumptive matrix classification. This issue remained unaddressed by all individuals responsible for the review process, with the exception of the OPS Administrator.

II. Findings.

The Monitoring Team has reviewed: 1) the reports and findings produced and relied upon by the CDP, the OPS and the CPRB; 2) video of the relevant CPRB hearings; and, 3) transcripts of pre-disciplinary and appeal hearings conducted by the CDP and the Director of Public Safety. Based on our review of those materials we have found that there was an overall systemic failure in the handling of the case investigations. Specifically, we find that:

1. CDP conducted its investigation in a manner where the result was a foregone conclusion. The Deputy Chief (Executive Officer) and the Chief of Police failed to ensure accountability by structuring the investigation in such a way that a truly objective evaluation of officer and supervisor conduct was impossible.

2. Both the CDP and OPS failed to communicate with one another and failed to collaborate as required by the OPS and IA Manuals.

3. The OPS investigation was untimely, particularly given the significance of the case.

4. The Internal Affairs Superintendent, the Deputy Chief (Executive Officer) and the Chief of Police approved an incomplete investigation.

5. The CPRB failed to provide any rationale for departing from the CDP's Discipline Matrix; the Chief and Director appeared to take full advantage of the CPRB unexplained departure and engaged in a less-than-thoughtful process by simply accepting the CPRB decision, even after the OPS Administrator repeatedly raised the issue during the pre-disciplinary hearing process.

6. The Chief of Police and Director of Public Safety made statements to the media that the investigation into the incident was thorough and complete. Our review identified significant deficiencies that would indicate otherwise.

7. The Director of Public Safety attempted to place blame for systemic failures solely on the OPS, when, in fact, the CDP was the primary stakeholder at fault.

III. Explanation for Findings:

There was an overall systems failure in the handling of the CDP and OPS case investigations with multiple participants contributing in significant ways to the overall failures. The Monitoring Team identified mistakes made by virtually everyone involved in the investigation and review process, to include:

1. *CDP conducted its investigation in a manner where the result was a foregone conclusion. The Deputy Chief (Executive Officer) and the Chief of Police failed to ensure accountability by structuring the investigation in such a way that a truly objective evaluation of officer and supervisor conduct was impossible.*

   Documentation and statements by involved officers in the file indicate that a Lieutenant who assisted the pursuit supervisor during the pursuit was ordered by Deputy Chief Joellen O'Neill to complete the administrative investigation. That lieutenant was also ordered to conduct the initial administrative evaluation of the incident. By assigning the administrative investigation of the case to a supervisor who was personally involved in the underlying incident, Deputy Chief O'Neill and Chief Calvin Williams virtually ensured an investigation which would be defensive in nature.[1]

   The result of the pursuit, the death of an innocent child, would clearly weigh heavily on any and all of the involved officers. It is illogical to expect a police supervisor, personally involved in a fatal pursuit, to conduct an objective investigation and assessment of the incident. The assignment of this case was not aligned with the requirements of the Consent Decree which requires that police-involved critical incident investigations be conducted by staff who were not personally involved in a critical incident.[2] The Division has provided no rational explanation for why the Division's Force Investigation Team (FIT) was not called out in this case to coordinate the investigation in conjunction with the Accident Investigations Unit.

2. *Both the CDP and OPS failed to communicate with one another and failed to collaborate as required by the OPS and IA Manuals. The CDP proceeded with the imposition of discipline even though the OPS investigation was pending; potentially making any findings made by the CPRB irrelevant to the case. Adding to the problematic nature of it all was*

[1] The idea that a supervisor should not investigate incidents in which they were involved is written into CDP policy. See UOF Supervisory Review and Investigations GPO. While this incident was not a use of force, the problems inherent in an involved supervisor conducting an investigation are so obvious, it should not require an express prohibition.

[2] For example, the Consent Decree required that the CDP create a "Force Investigation Team," … "comprised of personnel who have specialized training and expertise" to conduct administrative investigations of "Level 3 uses of force" (which includes police "uses of force resulting in death or serious physical injury.") (See, Consent Decree paragraph 87(c) and Section E.3 (paragraphs 110-123).

the failure of OPS to ensure it had access to all CDP documents relating to its administrative review of the incident.

The OPS Manual, revised as a condition of Consent Decree paragraph 200, contains provisions which require IA and OPS to communicate and collaborate when cases are being concurrently handled by the two agencies.[3] Specifically, in a case where the CDP has already initiated an investigation into an incident, as in this case, OPS is required to defer its investigation until the completion of the CDP investigation. Upon completion of the CDP investigation, OPS Manual Section 305 anticipates that the CDP will provide its investigation to the OPS for their review and to conduct any additional investigation as required. The completed OPS investigation is expected to be submitted to the CPRB for adjudication—only then is discipline to be imposed by the Chief and/or the Director.[4]

After an unexplained five-month delay,[5] on November 19, 2020, Chief Williams instructed his Case Preparation Unit to proceed with the issuance of charge letters to three involved officers. This was done even though the OPS still was actively investigating the incident, including interviewing involved officers, since July 16, 2020. In fact, the OPS interviewed twelve different officers between July 16 and November 19, 2020. In addition, "IA Pro"[6] logs show that officers assigned to the Case Preparation Unit, a Unit that works closely with the Chief's Office, attempted to access the OPS case in IA Pro on July 10, 2020, September 16, 2020, September 18, 2020, September 24, 2020, and September 25, 2020. These access attempts indicate that the Division was, in fact, aware of the existence of the OPS case investigation and sought to obtain information about its status.

[3] OPS Manual Section 305 reads as follows: "COMPLAINTS OTHERWISE INVESTIGATED BY CDP. If, upon receipt of a complaint, OPS determines that CDP has already initiated an investigation into the incident, OPS will defer its investigation until the completion of the CDP investigation. OPS will retain jurisdiction even if CDP has already opened an investigation into the incident, unless disciplinary proceedings have been initiated by CDP. In the event it appears that CDP will not complete its investigation according to the timelines set forth in the IAU Manual, OPS will confer with IAU to determine appropriate next steps. Additionally, any information obtained by OPS from the complainant, including information provided by a citizen during any OPS interview, will be provided to CDP for inclusion in its investigation as provided in the IAU Manual. Upon receipt of a completed CDP investigation that was initiated before a complaint was made to OPS or as the result of an OPS referral to CDP, the investigation must be reviewed by OPS to determine if any additional investigation is required prior to submission of the investigation to the PRB for appropriate findings. OPS has the authority to conduct additional investigation of any incident falling within its jurisdiction, whether or not CDP has or has not previously investigated the underlying incident, circumstances, or nucleus of underlying facts. In addition, in any case where a CDP criminal or critical incident investigation did not cover all possible policy, practice or training issues, additional administrative investigation may be necessary.

[4] The City and the CDP are fully aware of the content of the OPS Manual which has been reviewed and approved by the Federal Court as part of the Consent Decree process.

[5] According to entries made in the IA Pro database, Chief Williams received the case for review on June 29, 2020, but did not forward the case to the Case Preparation Unit to prepare "charge letters" until November 19, 2020. On December 8, 2021, the Monitoring Team sent an email to Chief Williams and the Law Department, requesting any potential explanation for this delay. As of the writing of this report, the Monitoring Team has not received a response.

[6] "IA Pro" is the information management system used by the CDP and the OPS to manage their cases.

The Monitoring Team discovered that the discipline the Chief ultimately imposed was entered into IA Pro only hours after the OPS provided its investigatory report to the CPRB and the Law Department.[7] By making disciplinary decisions prior to the CPRB hearings, the Division constructively precluded the CPRB from having jurisdiction over any related allegation. By all appearances, the Division seems to have acted intentionally and deliberately to make the OPS investigation meaningless and deny the CPRB any real opportunity to participate in the decision-making process. We base this conclusion on the City's previous statements that it is obligated to provide its employees with a single adjudication of all related incidents.

The OPS, however, also shares some responsibility for the lack of communication between its office and CDP. There is no documentation in the OPS file to even indicate any attempt to verify the status of the internal CDP investigation into the incident. And, the OPS investigation was completed without the Division sharing all of its reports and findings with OPS.[8] As such, when the CPRB considered the case, they were not made aware that the Division had already rendered disciplinary decisions regarding three of the involved officers.[9]

3. *Unjustifiable delays in the OPS investigation significantly hampered that investigation. The untimely nature of the civilian complaint process is of great concern in all cases but especially so in critical incidents of compelling public interest.*

OPS received the initial complaint requesting an investigation into this incident on February 11, 2020, approximately six weeks after the incident. It was not until July 16, 2020 – more than five months later – that the investigator conducted the first interview with an involved officer. It subsequently took the OPS another six months to complete its interviews with Division personnel and another two months before the investigative report was completed (See Appendix 1, Timeline of Events).

[7] According to the OPS, its investigatory report, recommending sustained charges against ten different officers, was sent to the CPRB members and the Law Department for their review on February 25, 2021 between 9:00 and 10:00 a.m. According to IA Pro User Logs, the Lieutenant of the Case Preparation Unit entered the Chief's disciplinary decisions as to the three officers who were sustained by the CDP chain-of-command on February 25, 2021, between 12:44 and 12:55 p.m. The Law Department has represented to the Monitoring Team that this timing was coincidental and that the Law Department did not provide any information regarding the OPS case to the CDP upon receipt of the OPS investigation report. The dismissal of charges against the supervising Sergeant was ultimately served on him on March 2, 2021. Written reprimands were formally served on the two involved officers on March 30, 2021.

[8] In fact, the first time the OPS was provided with the findings and conclusions made by IA Superintendent Ron Bakeman (dated June 23, 2020) was on June 21, 2021, when the Lieutenant who supervised and investigated the pursuit presented that document during his pre-disciplinary hearing with the Chief on the OPS case.

[9] This failure to collaborate between CDP and OPS lead to a disconcerting observation made by one of the involved officers in his OPS pre-disciplinary hearing: "So I mean, again, these are charges that I've already gone in front of a board for… So, I'm not understanding why I'm here." (Pre-disciplinary Hearing Transcript (June 21, 2021), p. 42).

Although we understand that this was just one of many cases under investigation by the OPS, and the OPS did document some challenges in obtaining some information from the CDP in a timely fashion, given the nature and significance of this case, the timeline appears, on its face, to have been unduly delayed.[10]

4. *The Internal Affairs Superintendent, the Deputy Chief (Executive Officer) and the Chief of Police approved an investigation that was incomplete.*

   As indicated above, the investigation was ultimately completed by the same Lieutenant who supervised the pursuit. Although the Lieutenant incorporated into his own investigation information obtained by the Accident Investigation Unit, we identified numerous deficiencies in the investigation, to include:

   - No interviews of involved police personnel were conducted as part of the administrative investigation; instead, officers were directed to prepare "Form 1" written statements, which were, in most cases, devoid of detail regarding the pursuit itself.[11]
   - There was no attempt to obtain or review a report prepared by the "EDGE Accident Investigation Unit (consisting of personnel from four different police departments) that was called into service by the East Cleveland Police Department (where the fatal collision occurred) and which conducted an independent "Fatal Crash Analysis."
   - There was no attempt to obtain or review a Traffic Crash Report (OH-1) prepared by the East Cleveland Police Department which would have been relevant to any evaluation of the pursuit and the conclusion of the pursuit.
   - It was not until February 6, 2020 that any CDP personnel conducted a canvas for third-party video along the pursuit route. As a result, potential video from three third-party locations were no longer available for review or analysis. (See AIU report, dated February 27, 2020, "External Cameras," p. 9).
   - The administrative investigation contained no specific information or analysis regarding AVL ("Automatic Vehicle Locator") data, which should have been able to be used to determine the actual speed of any of the police vehicles involved in the pursuit.[12]

[10] Although the OPS investigator documented challenges relating to obtaining a copy of the CDP's "Blue Team" report, reports prepared by the supervising Lieutenant and the Accident Investigation Team, and third-party video of the pursuit, there was no documentation of the dates the documents were actually received, nor any documented attempts to obtain cooperation at the Chief-level in a timely manner.

[11] Although involved personnel were interviewed by the Homicide Bureau in support of the criminal investigation against the suspect who was being pursued by the police, and whose vehicle struck the victims, the content of those interviews was not included or considered in the administrative review of the pursuit.

[12] Ultimately, although the CDP reported that one of the two pursuing vehicles was equipped with AVL capacity, no specific information regarding the speed of that vehicle was contained in any CDP report and the OPS report indicated that no such information was provided by the CDP during the course of its investigation.

In addition to failing to identify the above-noted deficiencies, although the case was submitted to the Internal Affairs (IA) Superintendent for review and comment, no additional investigation was conducted by Internal Affairs. Instead, the IA Superintendent reported the he personally "spoke" to one of the involved officers and a District Captain. In clear violation of best practices, these conversations were neither formal, witnessed, or video or audio recorded; nor were any contemporaneously prepared notes included in the file.

Deputy Chief O'Neill and Chief Williams were ultimately responsible for reviewing and approving the administrative investigation. The deficiencies in the investigation were so readily apparent that it should have been sent back for further investigation by Internal Affairs.

5. *The CPRB failed to provide any rationale for departing from the CDP's Discipline Matrix; the Chief and Director appeared to take full advantage of the CPRB unexplained departure from the matrix and engaged in a less-than-thoughtful process by simply accepting the CPRB decision, even after the OPS Administrator repeatedly raised the issue during the pre-disciplinary hearing process.*

After concluding that four different officers had committed violations of the Division's pursuit policy, the CPRB was required to recommend a discipline level (as defined by the Division's Discipline Matrix) for the Chief of Police to consider.

Given that it was alleged that the pursuit violations at hand actually resulted in the death of Tamia Chappman and serious injury to her 11-year-old companion, the violations fell squarely within the definition of a Group III offense.[13] And, in fact, the first motion at CPRB to make a disciplinary recommendation for a pursuit violation, was for the violation to be classified as a Group III offense. That motion, however, was defeated by a 6-2 vote, with no explanation being provided by the majority. The CPRB subsequently voted unanimously for Group I designations (which would carry a maximum penalty of five-days suspension) for the pursuit violations they sustained against all four involved officers.[14]

[13] A Group III offense is the most serious possible violation identified in the Discipline Matrix and is punishable by a range of 10 days suspension to demotion or termination. A Group III offense is defined in the Division's Discipline Matrix as: "[C]onduct that involves a serious abuse or misuse of authority, unethical behavior, or an act that results in an actual or serious and adverse impact on officer or public safety or to the professionalism of the Division. *Any violation of law, rule, policy or training which foreseeably results in death or serious physical harm to another person*; or constitutes a willful and wanton disregard of Division values; or involves any act which demonstrates a lack of the integrity, ethics or character related to an officer's fitness to hold the position of police officer; or involves egregious misconduct substantially contrary to the standards of conduct reasonably expected of one whose sworn duty is to uphold the law; or involves any conduct which constitutes the failure to adhere to any contractual condition of employment or requirement of certification mandated by law." (Emphasis added).

[14] See, April 13, 2021 CPRB Hearing, located at: April 13, 2021 | Cleveland CPRB Meeting - YouTube. Findings and voting by CPRB starts at 2 hour, 29-minute mark; ends at 3 hour, 31-minute mark. The CPRB also voted to exonerate

Although it was certainly permissible for the CPRB to consider mitigating factors in making their recommendations on discipline, the failure of the CPRB to even discuss their rationale for departing from the Discipline Matrix was contrary to best practices and not in compliance with the Consent Decree or the CPRB's own policy manual.[15]

Even though the OPS Administrator brought up this departure issue on multiple occasions to both the Chief and the Director during pre-disciplinary hearings on the OPS cases, neither the Chief nor the Director engaged in any discussion or findings about the basis or potential for departing from the PRB recommendations in this regard.

6. *The Chief of Police and Director of Public Safety made statements to the media that the investigation into the incident was thorough and complete. Our review identified significant deficiencies that would indicate otherwise.*

According to an article by *cleveland.com,* published on December 3, 2020, (as the one-year anniversary of the death of Tamia Chappman approached), Chief Williams and Director Karrie Howard discussed the investigation into the pursuit with the editorial board for *cleveland.com* and *The Plain Dealer.*[16]

Chief Williams was quoted by *cleveland.com* and *The Plain Dealer* as saying: "We made sure the investigation was going to be thorough and comprehensive, … We did our due diligence." Chief Williams was further quoted as saying "Everything from A to Z, if there's something we could look at we did that…" Williams reportedly advised the editorial board that "the review included use of videos from businesses and police body cameras, radio logs, interviews with officers and investigators actually driving the chase route to create a clear picture of the events."

Chief Williams' description of the investigation and review process was misleading. In fact, as discussed above, the Division conducted a limited and incomplete review of the incident and was acting to impose discipline even though an OPS investigation into the incident was still pending.

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one officer (who was the passenger in one of the pursuit vehicles) for a pursuit violation and to find allegations of "self-dispatch" against five additional officers to be "unfounded."

[15] Consent Decree paragraph 246 required that the CDP review its disciplinary matrix "to ensure consistency in the imposition of discipline." The CPRB Manual, reviewed and approved by the Federal Court pursuant to the Consent Decree Process, further requires the CPRB to make disciplinary recommendations that are consistent with the Disciplinary Matrix (See PPRB Manual Section I.3.a.iv & I.7.c.)

[16] See, Robert Higgs (December 3, 2020; Updated April 13, 2021), located at: Cleveland police review finds chase that led to 13-year-old's death was within department protocol - cleveland.com.

Director Howard was quoted in the above-noted article as reporting that "the review involved a series of questions," which were asked and answered as follows:

> "Were proper criteria met for the pursuit? Yes."
> "Were more than two vehicles involved in the pursuit? No. Only two cruisers."
> "Did any units self-deploy? Yes, one car joined before being authorized."
> "Was the pursuit properly supervised? Yes, radio logs show a commanding sergeant was regularly updated."
> "Were recording devices used? Yes, body cameras were active."
> "Was proper notification made? Yes. East Cleveland police were at the scene."

Director Howard's participation in a discussion with the media served to corroborate the Chief's representations that the incident had been timely and thoroughly investigated and that no serious policy violations had taken place. The Director's representations ended up being diametrically opposed to the ultimate and eventual findings of the OPS and the CPRB, which both found that the pursuing officers conducted an out-of-policy pursuit by driving at excessive speeds in an unfamiliar area.[17]

Unfortunately, the Director's answers to the aforementioned questions were based solely on the CDP's inadequate administrative investigation and were expressed while the OPS investigation was still pending. Even though the Director ultimately concluded that the findings later made by Chief Williams were reasonable, and declined to follow the recommendations of the CPRB, a reasonable observer would be led to question whether the Director's ultimate findings were based on an objective evaluation of the evidence or were made to justify his prior public statements.

Director Howard's participation in this discussion was particularly disconcerting given that, at the time, the OPS and CPRB reported to the Director of Public Safety. We would expect that, prior to speaking publicly about such a significant incident, the Director would have conferred with the OPS about the existence of an investigation and any issues that had been identified at that point in time.

7. *The Director of Public Safety attempted to place blame for systemic failures solely on the OPS, when, in fact, the CDP was the primary stakeholder at fault.*

At the conclusion of the adjudication of the case, Director Howard issued decisions dismissing the CPRB's appeals of decisions made by Chief Williams with respect to two involved officers and the Sergeant who supervised the pursuit. In his final decision, dated

[17] See, "Findings Letter" from Civilian Police Review Board to Chief Williams, dated May 7, 2021.

December 3, 2021, Director Howard included language in his decision quoting section 305 of the OPS Manual and concluding that "because of the procedures outlined in section 305 of the Office of Professional Standards manual were not followed, I have a problem with addressing the merits of the [OPS] complaint…"

Director Howard opined that: "OPS' investigation should not have gone forward because[,] at the time it initiated its investigation[,] IA was already investigating the matter."[18] In fact, OPS Manual Section 305 clearly supports a process by which the OPS can be expected to go forward with an administrative investigation upon the conclusion of an IA investigation.

Although Director Howard ultimately addressed the merits of the CRPB's appeal, the suggestion that the OPS investigation was unjustified was emblematic of a failure to hold the CDP accountable for its attempts to foreclose the jurisdiction of the civilian oversight of law enforcement structure, as embodied in the Cleveland City Charter.

IV. Conclusion:

The Monitoring Team's ultimate responsibility is to report to the Court on the City of Cleveland's compliance with the Settlement Agreement entered into by the City with the United States Department of Justice on June 12, 2015.

More than six years have passed since the City agreed to reform its Division of Police and ensure accountability for the actions of its officers. It is with great disappointment that the Monitoring Team is required to report that, in this case, the City failed to use the accountability structures devised by the Consent Decree in a manner that would have appropriately served the family of Tamia Chappman and the Cleveland community as a whole.

However, we do look forward to addressing our concerns with the new City leadership with the expectation that future police-involved critical incidents will be investigated and adjudicated in a responsible manner, with collaboration and cooperation between the CDP and the OPS. Further, the CDP will need to develop a policy addressing its administrative response to any police pursuit or police emergency driving that may, in the future, result in serious injury or death to any person. We look forward to assisting the City in that regard.

Ultimately, in order for the people of Cleveland to have trust in the CDP accountability structures, the new City leadership will need to ensure all the stakeholders engage in honest and open dialogue regarding roles, responsibilities and relationships.

[18] See footnote 3, *supra*.