IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO

ELIZABETH GOODWIN,
Plaintiff,
v. **Case No. 1:15-cv-27**

CITY OF CLEVELAND, et al.,
Defendants.

______________________________________/

PRELIMINARY EXPERT REPORT OF LOU REITER

1. My name is Lou Reiter. I have been actively involved in police practices and law enforcement since 1961. I was an active police officer for 20 years. Since my retirement in 1981 as an active police officer, I have been involved in police and law enforcement practices as a private police consultant.

2. Since 1983 I have been providing law enforcement consultation in police training and management. I provide law enforcement training in the following areas:

   - Investigation of critical incidents - officer involved shootings, use of force, and pursuits.
   - Managing the Internal Affairs function.
   - Police discipline.
   - Use of force and deadly force issues.
   - Police pursuit issues.
   - Investigative procedures and supervision.
   - Jail intake procedures.
   - Personnel practices.
   - Supervisory techniques
   - Crowd control procedures.
   - Liability management.
   - Policy and procedure development.
   - Management effectiveness.

I consult with police departments of 3 to 39,000 employees, performing internal audits for the police organization. Six of those have been as a consultant to the Special Litigation Section, Civil Rights Division, of the U.S. Department of Justice. My primary areas of focus during these audits are:

- Citizen complaint procedures.
- Discipline, internal affairs and early warning systems.
- Personnel practices including selection, hiring, EEOC/AA, promotion, assignment and retention.
- Specialized operations including traffic, investigations, narcotics, vice, intelligence, emergency response teams and unusual occurrence units.
- Organizational structure and command responsibilities.
- Police department governance.
- Policy and procedures development.
- Use of force policy and procedures.
- Investigation of critical incidents.

3. Since 1983, I have been retained in over 1100 police related cases. This involvement has been on a mix of approximately 2/3 plaintiff and 1/3 defense. Assistance provided includes case analysis and development and expert witness testimony. I have been qualified in state and Federal courts, including the District of Columbia and Puerto Rico, to provide trial testimony in many areas including:

- Field procedures including tactics, arrest techniques and pursuits.
- Standards of police misconduct investigations.
- Use of force and deadly force.
- Supervision.
- Investigative procedures.
- Jail intake procedures
  Police interaction with mentally ill subjects
- Police management and personnel practices.
- Investigation of citizen complaints and discipline.
- Police policy and procedures development.
- Police training.

4. I am a former Deputy Chief of Police of the Los Angeles Police Department. I served as a police officer in the Los Angeles Police Department for over twenty years until I retired in 1981. During that period of time I served as a patrol and traffic officer, supervisor, manager, command officer and executive staff officer. I was involved in police training, investigating allegations of police misconduct, Chairman of the Use of Force Review Board, member of the Unusual Occurrence Command Post Cadre, and researcher and author of the chapters on internal discipline, training and management/employee relations for the Police Task Force Report of the National Advisory Commission on Criminal Justice Standards and Goals. In 1993 I published the manual/guide Law Enforcement Administrative Investigations; the Second Edition in 1998, and the current Third Edition in 2006.

5. My experience, training and background is more fully described in the attached resume. A complete list of my testimony during the past four (4) years is attached.

6. I have reviewed the following materials to date regarding this case:

- Complaint and pleadings
- Other court documents
- Personnel file records of involved officers
- Officer Aldridge disciplinary documentation
- 142 reports of use of force involving persons with mental health issues
- Autopsy of Ms. Anderson
- UDFIT 14-18 Anderson investigation with all attachments
- Transcribed *Garrity* statements of Officers Aldridge and Myers
- Internal Affairs reports regarding the Anderson fatality
- U.S. D.O.J. agreements 2002 and 2014

- Various training records and portions of lesson plans on subject control, mental health, first aid and CIT
- CDP General Policy Orders concerning use of force, mental health encounters, Taser use
- Witness interviews Andrew Conard, Cassandra Jordan, Joelle Anderson and Theresa Overton
- Depositions
  - David Borden
  - James Chura
  - Melissa Dawson
  - Rhonda Gray
  - Brian Hefferman
  - Deirdre Jones
  - Jennifer Kemer
  - Brandon Kutz
  - Stephen McGrath
  - David Medina
  - Leroy Morrow
  - Anthony Muniz
  - Mellisa Patton
  - Robert Tucker
  - Sgt. Rochelle Bottone

7. These opinions are based upon the totality of my specialized knowledge in the field of police practices. This experience is derived from my personal police experience, research, knowledge and training. This expertise has been developed during my 55 years involvement in law enforcement at all various capacities as a practitioner and my continued experience as a trainer, auditor and litigation consultant. This experience has provided me with extensive personal and specialized training, experience and knowledge of police operations and generally accepted police practices. The body of knowledge that I have reviewed over the years coupled with my personal and professional experiences, my continued auditing of police agencies, my constant training of police supervisors, managers and executives, my continuous interaction with other police professionals,

organizations and training personnel, all form the foundation for the opinions I am rendering in this matter.

There is a large body of knowledge and literature about the practices and standards that modern, reasonably managed and administered police agencies across the U.S. should follow and apply to its operations. These generally accepted practices have developed over time to encourage and assist police agencies to deliver police services to communities serviced which are professional, reasonable, effective and legal. Many of these generally accepted practices have been developed from law enforcement critical analysis of field incidents and examinations of incidents reported to cause police liability, deficiencies and employee misconduct. These generally accepted practices have been a response to reported cases of police misconduct and liability and a desire by law enforcement to create a system to ensure that police conduct remains within acceptable legal and constitutional bounds. I am familiar with this body of knowledge and through my continuous training and audits assist law enforcement with this requirement for reasonable and legal police response to field incidents and for constant improvement.

My examination of the factors involved in this police practices incident embodies the basic fundamentals which I employ in my professional examination of police agencies during my audits and when working as a consultant with the U.S. Department of Justice. My opinions

are provided with a reasonable degree of certainty within the fields of law enforcement, police activity and police administration and supervision.

The terminology I use in my Expert Report is not meant to invade the purview of the court or the final jury determination. I use these terms in my training of police supervisors, managers and command officers when instructing on administrative investigations and civil liability. These are products of my continuous review of case law that should guide a reasonable police agency in supervising its employees. These terms have become common terms within law enforcement supervision, management and risk management; just as the terms of probable cause, reasonable suspicion and the prima facie elements of crimes have become common terminology for police field personnel and detectives.

8. I have been involved as a police practices expert in several cases involving the Cleveland Police Department dating back into the early 1990s. One of the first, coincidentally, involved a case of sudden death of a person arrested by CPD officers and who was discovered dead upon arrival in the sally port of the police facility. Nearly all of these cases also involved my review of the operations of the UDFIT investigation, use of force reports and administrative processes.

9. It is my understanding from my review of the extensive documents concerning the police incident resulting in the death of Tanisha Anderson that the following events occurred. On November 12, 2014, officers of the CDP were called to the home where Ms. Anderson resided

with her extended family. She had a history of mental illness, had been committed for evaluation and treatment recently, and was on an assortment of prescribed medication. Ms. Anderson was obese as she was 5'6" and weighed 251 pounds. See Report of Autopsy, Ex 4. The CDP officers who responded to the initial call from the family found that Ms. Anderson was not exhibiting signs and symptoms that would make her appropriate for an involuntary psychiatric evaluation. Subsequent to that, Officers Aldridge and Myers were dispatched to the residence after another call from the family. During the encounter with these officers, Ms. Anderson was forcibly detained, handcuffed, held down and restrained with a knee to her back while on the ground on her stomach, and left in that prone position for at least 14 minutes before any call for medical assistance was initiated. A supervisor, Rochelle Bottone, was called at 11:20:01 p.m. and she arrived at 11:34:14 p.m. (Bottone, Ex 44, Event Chronology). Tanisha was not rolled off her stomach until the supervisor arrived. EMS was not called until the supervisor arrived. Her autopsy determined that her death was a "Homicide" and the cause of death was listed in part as "sudden death associated with physical restraint in a prone position." Ex. 4.

10. This expert report will address four (4) areas of police practices: (1) Sudden death, specifically positional asphyxiation, (2) arrest and use of force issues, (3) providing medical care to subjects in custody, and (4) administrative investigations of critical incidents.

Issues of law enforcement sudden in-custody death, specifically positional asphyxiation

11. **The City of Cleveland, Cleveland Division of Police, in my opinion based upon my specialized knowledge, skills and training and my review of the documentation in this litigation, exhibited deliberate indifference in its training, supervision and policy development by not addressing the known, common field risks of positional asphyxiation. Officers Aldridge and Myers failed to follow basic precautions when restraining Tanisha Anderson in the prone position and caused her injuries due to positional asphyxia. Their actions were consistent with the City's critical lack of policy, training and supervision regarding the dangers of positional asphyxiation**.

12. By 1994, the issues of "Sudden In-Custody Death Syndrome" were well published in the law enforcement community. This tragic problem is more common during control and restraint incidents by police when encountering subjects who are under the influence of narcotics, emotionally disturbed persons and persons of diminished capacity, such as Tanisha Anderson, and others.

13. Deaths such as these first came to the notice of law enforcement during the mid 1970's when the use of PCP produced subjects with unusual strength and tolerance to pain. The case of *Lyons v. City of Los Angeles* was the first and most noticeable such civil action. Many police agencies,

such as Kansas City, submitted amicus briefs when the case went to the U.S. Supreme Court in the early 1980's. During that same period, Dr. Kronblum of Los Angeles and Dr. Reay of Seattle began producing a series of articles on this police/subject cause of death.

14. San Diego City Police Department conducted two nationwide surveys regarding police experience with this problem and produced reports following each of these efforts. These were published in 1983 and 1992. During both of these studies, police agencies from throughout the country were contacted for information and supplied responses. These reports and the follow-up videotaped training programs have become a standard in the training of police officers regarding the issue of "Sudden In-Custody Death Syndrome." Examples of those police videotape training programs are the 1994 New York City Medical Examiner’s tape of the consequences of compression deaths during suspect handcuffing and control; the 1994 presentation by the Commissioner of the California Highway Patrol relying heavily on the San Diego Police information; and the police equipment firms of Monadnock and Ripp. In 1995 the U.S. Department of Justice, National Institute of Justice, National Law Enforcement Technology Center published the paper “Positional Asphyxia - Sudden Death.” (Ex. 41). That publication at page 2, lists obesity as a “predisposing factor to positional asphyxia.” The issue is also discussed in the widely accepted text from the 1992 publication of the Police Executive Research Forum <u>Deadly Force: What We Know</u> by Geller and Scott.

15. The danger of improper restraint techniques has been further described in longstanding references on the police handling of emotionally disturbed persons. Some of these are the Manual for the Police: How to Recognize and Handle Abnormal People by Matthews and Rowland. The original text was authored in 1954 and revised several times until the final in 1975. It is noted as a reference for the basic training curriculum on the subject by the Texas Commission on Law Enforcement Standards.

16. Similar references and direction are given on care in restraining and monitoring subjects believed to be emotionally disturbed in subsequent authoritative texts including both of those by Gerald Murphy, Special Care: Improving the Police Response to the Mentally Disabled in 1986 and Managing Persons with Mental Disabilities in 1989. Positional asphyxia is also addressed in the 1979 International Association of Chiefs of Police Training Key #274 Abnormal Behavior.

17. In 1996, and in the updated version in 2005, the International Association of Chiefs Police National Law Enforcement Policy Center reissued its paper and model policy on “Transportation of Prisoners.” In this paper, intended to instigate agency policy and training, it spends time discussing the lethal issue of positional asphyxia and prone positioning of subjects.

18. In my opinion based upon my continued education, research, training and specialized experience in generally accepted police practices, it was well established by 2014 that keeping a subject who was obese, had been involved in some physical altercation, handcuffed behind their back, and

left in a prone position would result in a definite increased risk of medical distress up to and including the potential for death.

19. The CDP has nothing in its written policies, procedures, directives or training materials that references in any manner the critical subject control issue of positional asphyxia. PA should be referenced but it is not referenced in any of the following general police orders:

- Ex. 8, GPO 3.2.06 (rev. 2011) "Handling the Mentally Ill."
- Ex 9, GPO 6.1.01 (2002) "Crisis Intervention Report."
- Ex. 10, GPO 3.2.17 (2004) "Crisis Intervention Officers."
- GPO 7.1.05 (2002) "Prisoner Supervision and Restraints" was one page without any reference to PA
- Ex. 35, CIT in-service 2008 involved observable symptoms and commitment procedures, but nothing re: PA
- Ex. 36, CIT in-service 2010 was a repeat of the above
- 2012 Basic Training "Subject Control Techniques (60 hours) has a section on 'prone cuffing principles,' but nothing re: PA or any concerns about leaving on stomach
- Subject Control Refresher Training (16 hours) curriculum for 2006, 2003 and 1999 had similar materials on 'prone cuffing principles' without reference to PA or concerns on allowing to stay on stomach.

20. The consensus of the CDP personnel deposed in this litigation indicate that there was no specific training or direction by the CDP on positional asphyxia or the dangers of allowing a subject to remain prone after handcuffing.

- Detective Borden, Homicide Unit, stated that he never had any training on PA from the CDP (86).

- Lt. Tucker, Internal Affairs Unit, stated during his deposition in this matter that there was "no formal training or policy" in the CDP on the issue of positional asphyxiation (77).

- Detective Gray, Homicide Unit, also stated that she had never been trained in PA (65) and there were no warnings regarding PA in her in-service training (86). She suggested at page 69-70 that Cleveland officers were not adequately trained:

  Q. So in this instance when police officers are
  20 cuffing people who are prone of the ground, is it your
  21 view that -- at least is it your view that Cleveland
  22 police officers are adequately, or not, instructed of
  23 the dangers that getting prone on the ground could
  24 interfere with the breathing?

  2 A. I don't think they're adequately trained.

- Sgt. Jones, Homicide Unit, stated that she was unaware of any training in the CDP regarding PA (86).

- PO Muniz testified that he was not sure he had heard of PA (26) and had no recall of any training about precautions for obese subjects and leaving them on their stomach on the ground (27).

[2]

- Commander Brandon Kutz testified that he was a lieutenant over training for 3 ½ years and acknowledged that PA is not contained in any documentation for the FTO program (23), he believed that it was "touched" on in CIT and subject control training[3] to "get on side"

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[1]

A review of all of this training documentation failed to show that PA was addressed in these training programs.

(83), and he had no recall whether PA was included in the agency's in-service training (88).

- Police Officer David Medina, a CDP trainer, stated that he teaches PA (51), he believed it was included in the one-day doctors' training presented by the Cleveland Clinic (53), and he acknowledged that he gives no handouts to students that addresses PA (54).

- Captain James Chura testified that he is aware that you want subjects on their sides, if possible, (139), there should be something on PA in the academy training (143), and he had no recall if PA addressed in any general police orders (145).[4]

- Sgt. Melissa Dawson, OIC of the EAP unit and a training officer, stated that in CIT training it's taught to "encourage that they be sitting up," (66), there might be something regarding PA in the CIT handbook (70), she recalls one slide "get him back up quickly" (71), she had no recall of PA in in-service training (76), it was not in the 2010 in-service training (80), and there has been no discussion of PA since Ms. Anderson's death (96).

- Sgt. Bottone, the supervisor on the scene of the Anderson incident, testified in her deposition that she recalls some training in PA, but did not recall when. She had no recall of any training on this topic regarding the increased threat of putting any pressure on the subject's back. Just "make sure they're sitting up and not on their stomach." (74) "We have been trained to not leave them in the prone position for any extended amount of time in an area where they cannot breathe properly and have proper air circulation, ventilation. Nothing to do with them being – it's not just solely in that prone position. It's everything combined." (76) "And as long as you can – as long as you feel that they're still able to breathe, as long as they're – and be extended amount of time, I mean, you would never – I couldn't give you a number, but…probably be moved as soon as it's safe to move them…I can't give you a time." (77)

- Jennifer Kemer, former OIC of the officers teaching subject control at the Cleveland Police Academy, said that she thought that people were trained to roll people to their side, but there was no explanation as to why that was important. (21) She was not familiar with any time fame for within which a restrained subject should be rolled off the prone position (25), that there wasn't any time frame for doing it properly (and that there wasn't a time frame for how

[4] Again, there is no documentation in either of these source documents.

long to put pressure on someone's back, or when to call EMS).

Arrest and use of force issues

21. **The detention and use of force by Officers Aldridge and Myers, in my opinion, was contrary to generally accepted police practices, unreasonable and excessive for the circumstances these officers encountered with Ms. Anderson. These actions, in my opinion, were a consequence of the CDP's historical and continuous oversight failures and gross lack of supervisory control of use of force situations by CDP officers.**

22. The Safety Director, Chief of Police and Cleveland Department of Police were put on notice and agreed with the Technical Assistance Letter issued by the U.S. Department of Justice in 2002 regarding specific issues of deficiency in its handling, control and training regarding use of force and the investigation of non-deadly force incidents. In 2014 the U.S. D.O.J. entered into a Consent Decree with the CDP and the force issues involved in this agreement were "starkly similar to the findings in this (prior) letter." (DOJ Findings Letter, Ex 25, p. 2)

23. The DOJ found that the CPD engaged in "Excessive force against persons who are mentally ill or in crisis, including in cases where the officers were called exclusively for a welfare check…" (Ex 25, p. 3). On page 31 of the findings letter the DOJ states, "Supervisory investigations of force are

inadequate." "CDP's internal review mechanisms are inadequate," pg. 33 "CDP's crisis intervention policies and practices are underdeveloped, and CDP has not yet fully integrated these practices into its response to individuals in crisis, resulting in the use of unreasonable force against these individuals," pg. 52 "We saw no evidence that CDP's staffing plan or car plan attempts to ensure that there is adequate CIT coverage or CIT officers assigned to shifts with a greater need for their skills," pg. 53. "Currently, CDP recruits are not receiving sufficient basic mental health training, and it does not appear that CDP has offered any in-service mental health training since at least 2010," Ex 25, pg. 54.

24. These principles are eerily similar to my conclusions in several past cases involving force litigation issues with the CDP in the late 1990s and 2004.

25. In this case I supervised the development of a matrix designed to determine CDP officers' use of force when interacting with persons with mental health issues. The incidents spanned from January 2009 to December 2014. These produced documents covered 142 encounters. I made several observations from this review, however, in this report I will address three (3) specific conclusions. There were only 34 reports that indicated that a CIT report was filled out. This represented 24 percent and the vast majority of these CIT reports were filed since June 2012. The lack of reference to reports completed regarding the incidents indicate that these investigations themselves are incomplete. The second observation was that in 8 percent of the incidents there was not sufficient reporting of

the necessary basis to use force which would be warranted if the subject presented a danger to themselves or others. The last noteworthy observation was that not one of the initial investigators of the use of force found that the force used violated the CDP policy. A handful did identify ancillary procedural issues like reporting errors.

26. This is most significant for the following reason. The field supervisor who either appears on the scene or is contacted immediately following the incident commonly does the initial investigation. These supervisors are the most influential with the field officers. They are in a position of have first hand knowledge of the officer's actions and the specific uses of force. These field supervisors establish what is commonly known in law enforcement practices as the 'operational policy' that might be significantly different than the 'official policy and training' of the agency. It is problematic when no supervisor in these 142 encounters found that the use of force by his/her officer was out of policy.

27. One of the common and reoccurring issues with the CDP is the lack of supervisory oversight on use of force issues. This has been noted in both of the agreements with the U.S. D.O.J. In this litigation, Deputy Chief Leroy Morrow was deposed and he acknowledged that until 2015 he had not reviewed CIT reports (63).

██ On the day of Ms. Anderson's death, the CDP received two calls regarding a mental female. The first unit, Officers Muniz and McGarth, cleared as "temporarily settled for the evening." A little over two hours later, Officers

Aldridge and Myers received a call regarding a "non-violent family trouble."

29. This incident was typical of those common police encounters involving persons in mental crisis. The role of the police in these types of incidents is to assist the family and the person in crisis for the voluntary commitment for a mental health evaluation. The CDP written policies on handling mentally ill persons[6] is very specific to the differences between this type of police encounter that involves no criminal behavior and other encounters that do involve criminal behavior. These GPOs are similar in many respects to the model policies of the IACP and PERF.

31. It is also significant that Ms. Anderson was obese weighing 251 pounds and was 5'6" tall. Ex 4, Autopsy report. Normal field police cars with prisoner cages are uncomfortable for anyone who is not rather small and very uncomfortable for someone the size of Ms. Anderson.

[5]

[6] GPO 3.2.06 (2011) and GPO 6.1.01 (2002)

32. From my review of the produced use of force reports, it appears that the CDP regularly has used EMS to transport mental health persons from the scene of the police call.

35. Officer Aldridge and Myers arrived on the scene at 2251 hours. Their initial call for a supervisor was at 2321 and the second request "here right now" was at 2322. The supervisor arrived 11 minutes later at 2333 hours. The request from the supervisor for EMS occurred one minute later and arrived at 2341 hours.

36. Sgt. Bottone stated in her deposition that Officer Aldridge told her he did draw his Taser, but didn't use it. "He thought maybe it would intimidate her," but put it away at the request of Anderson's brother (51-52).

37. The use of force and delays by Officers Aldridge and Myers were unreasonable and appeared to be conscious choices both officers made. They were dealing with a mental health subject for a voluntary evaluation by medical personnel. There was no crime committed. Ms. Anderson was not under arrest. There was no police necessity to use any degree of force under these circumstances and their use of force, in my opinion, was contrary to generally accepted police practices.

Delay in providing medical care

38. **Officer Aldridge and Myers failed to use reasonable and generally accepted police practices in failing to provide medical care for Ms. Anderson. Their actions, in my opinion, displayed their deliberate indifference to her obvious medical needs.**

39. There is no ambiguity in generally accepted police practices that police officers are responsible to provide necessary and reasonable medical care for persons they restrain or who are in some form of custody. The IACP model policy regarding the care and transportation of persons is explicit in this requirement.[7] See also, Ex 14, GPO 2.1.01 p 4 – "ensure that medical care is provided as needed."

[7] In the first instance, transporting officers should be aware of physical reactions by keeping close watch over prisoners following arrest and during transportation. Any obvious physical injuries should be treated as soon as possible rather than waiting for such a determination to be made at booking. All

41. Sgt. Bottone stated in her deposition that when she got to the scene the officers were standing by Anderson who was "unconscious." (89)

42. In this case there was absolutely no excuse to not place Ms. Anderson in a position of less restraint, remove her handcuffs or begin any form of immediate first aid. It was only when the sergeant arrived that EMS was called and even then the handcuffs were not removed. Ms. Anderson's brother, Joell, has recounted that the officers told him they could not touch his sister since she was a female and they would have to wait the arrival of their supervisor.[8]

Administrative investigations

prisoner complaints of serious injury or physical problems should be taken seriously, and medical aid summoned immediately."

IACP National Law Enforcement Policy Center, "Transportation of Prisoners," Revised October, 1996

[8] This is a ridiculous position, if true. There is no rational reason for an officer to believe this would be true and is a reflection of an absence of reasonable training in providing medical care to subjects in custody of the officers.

44. Law enforcement administrative investigations are a principal and essential element to ensure that a police agency and individual employees operate in a manner to guarantee that professional, legal and Constitutional policing are maintained. Police officers operate in the field essentially autonomously. Their daily performance is monitored and controlled by training, policies and procedures and supervisory techniques and systems, including administrative investigations. These three (3) elements establish the parameters within which field police officers perform. These systems and practices inform officers what they should or should not do particularly when dealing with citizens during enforcement encounters. The supervisory practices, techniques, systems and administrative investigations are the most critical aspect of controlling, monitoring and guiding field officer performance.

45. Administrative investigations, commonly referred to as Internal Affairs or Professional Standards, are vital to maintaining reasonable parameters of field performance by officers. These investigations can originate from a myriad of sources. A common police practice is to investigate allegations of police misconduct which come to the attention of the police agency from any source if the allegation, if later proven true, would amount to

misconduct. This type of system protects the concerns and rights of the four (4) essential elements to such a system - the aggrieved person, the accused officer, the involved police agency, and the community served by the police agency. These systems of administrative investigations establish the environment within the involved agency for field officers to know that they will be held accountable for their actions in the field.

46. These practices are not new in the police field. They have been delineated in frequent national studies on police practices including the 1931 Wickershim Commission, 1967 President Johnson's Commission, 1968 Kerner Commission Report, 1974 Police Task Force Report of the National Advisory Commission on Criminal Standards and Goals, and other similar studies since that time. These practices are embodied in model policies of nationally recognized police professional groups such as the International Association of Chiefs of Police and the Police Executive Research Forum. They have been continuously referenced in authoritative texts such as the O.W. Wilson Police Administration, a former Chicago Police Superintendent, and its many successors and the International City Management Association's texts on municipal police practices. It is extensively covered in specific training for administrative investigations by national training entities including the Institute for Police Technology and Management (FL), International Association of Chiefs of Police (VA), Americans for Effective Law Enforcement (IL), Northwestern University Police Traffic Institute (IL), Southern Police Institute (KY), and

Public Agency Training Council (IN).

47. I regularly train on this subject to police practitioners and use my publication, Law Enforcement Administrative Investigations, as a training tool. I frequently conduct internal audits of police agencies in the practice of administrative investigations. I have personally been an investigator of police misconduct allegations and have adjudicated other cases of police misconduct for 11 years as a police command officer. I am familiar with the effect these practices have within police agencies.

48. I have been a police practices expert in other litigation involving the CDP. In 2004 I authored an expert report in the case of *Moore v. City of Cleveland,* 1:03cv01258. Part of my analysis involved reviewing 45 UDFIT case files of incidents occurring between 1999-2002. The observations I made then are very much similar to the observations I've made in this current litigation,

49. The U.S. Department of Justice has found similar systemic deficiencies in its 2014 investigation of the CDP: "Another critical flaw we discovered is that many of the investigators in CDP's Internal Affairs Unit advised us that they will only find that an officer violated Division policy if the evidence against the officer proves, beyond a reasonable doubt, that an officer engaged in misconduct—an unreasonably high standard reserved for criminal prosecutions and inappropriate in this context. This standard apparently has been applied, formally or informally, for years to these

investigations and further supports the finding that the accountability systems regarding use of force at CDP are structurally flawed. In actuality, we found that during the time period we reviewed that officers were only suspended for any period of time on approximately six occasions for using improper force. Discipline is so rare that no more than 51 officers out of a sworn force of 1,500 were disciplined in any fashion in connection with a use of force incident over a three-and-a half-year period. However, when we examined CDP's discipline numbers further, it was apparent that in most of those 51 cases the actual discipline imposed was for procedural violations such as failing to file a report, charges were dismissed or deemed unfounded, or the disciplinary process was suspended due to pending civil claims. A finding of excessive force by CDP's internal disciplinary system is exceedingly rare. A member of the Office of Professional Standards (or "OPS"), which, among other duties, has been charged with investigating use of deadly force incidents, stated that the office has not reviewed a deadly force incident since 2012. CDP's systemic failures are such that the Division is not able to timely, properly, and effectively determine how much force its officers are using, and under what circumstances, whether the force was reasonable and if not, what discipline, change in policy or training or other action is appropriate. The current pattern or practice of constitutional violations is even more troubling because we identified many of these structural deficiencies more than ten years ago during our previous investigation of CDP's use of force.

In 2002, we provided initial observations regarding CDP's use of force and accountability systems and, in 2004, we recommended that the Division make changes to address some of the deficiencies we identified. CDP entered into an agreement with us, but that agreement was not enforced by a court and did not involve an independent monitor to assess its implementation. The agreement did require CDP to make a variety of changes, including revising its use of force policy and establishing new procedures for reviewing officer- involved shootings. In 2005, we found that Cleveland had abided by that agreement and it was terminated. It is clear, however, that despite these measures, many of the policy and practice reforms that were initiated in response to our 2004 memorandum agreement were either not fully implemented or, if implemented, were not maintained over time. It is critical that the City and the Division now take more rigorous measures to identify, address, and prevent excessive force to protect the public and to build the community's trust. We believe that a consent decree and an independent monitor are necessary to ensure that reforms are successfully implemented and sustainable. We are encouraged that the City also recognizes that these measures are essential to sustainable reform in the Joint Statement of Principles." DOJ Findings Letter, Ex 25, p 5 – 6.

[redacted] I have in the past written about the apparent lack of understanding by the CDP in the concept of compelled statements (*Garrity* statements) for involved officers in critical incident investigations. [redacted]

51. Sgt. Bottone stated that it is the custom and practice of the CDP to have a prosecutor present during any walk through process conducted by the UDFIT unit. She didn't recall seeing one at the walk through at the Anderson scene (69).[9]

[9] If Sgt. Bottone's statement is correct this would cloud and taint any attempt by the prosecutor's office to bring criminal charges against the involved officers. The involved officers' participation in this form of walk through would be a compelled action and could not be used or the fruits of it in any subsequent criminal prosecution of the officers.

55. It is my understanding that additional materials may be in process of being produced or may be requested later. I would request that this report be considered a preliminary report. Should any subsequent information be produced and materially affect or alter any of these opinions, I will either submit a supplemental response or be prepared to discuss them during any scheduled deposition.

56. At this point in the development of this case I do not know whether I will be using any demonstrative aids during my testimony. Should I decide to use any such tool, I will assure that they are made available for review, if requested, prior to their use.

57. My fees for this professional service is a flat Case Development Fee of $8500 and a fee of $2500 for a deposition in the Atlanta area or $2500 per day plus expenses for services away from the Atlanta area including depositions and trial appearances.

58. This report is signed under penalty of perjury on this 8th day of July 2016, in Jasper, GA.

Lou Reiter