



Amarik K. Singh, Inspector General

Neil Robertson, Chief Deputy Inspector General

OIG | OFFICE of the INSPECTOR GENERAL

Independent Prison Oversight

May 2023

Monitoring the Staff Misconduct Review Process of the California Department of Corrections and Rehabilitation

2022 Annual Report



Despite a Revised Regulatory Framework for Processing Its Staff Misconduct Cases, the California Department of Corrections and Rehabilitation Continues to Earn Poor Ratings; Flawed Practices by Departmental Staff Into Staff Misconduct Allegations Cause Inquiries and Investigations to Be Deficient

Electronic copies of reports published by the Office of the Inspector General are available free in portable document format (PDF) on our website.

We also offer an online subscription service.

For information on how to subscribe, visit www.oig.ca.gov.

For questions concerning the contents of this report, please contact Shaun Spillane, Public Information Officer, at 916-288-4233.

Connect with us on social media



Regional OfficesSacramento
Bakersfield
Rancho Cucamonga

May 24, 2023

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol Sacramento, California

Dear Governor and Legislative Leaders:

Enclosed is the Office of the Inspector General's report titled *Despite Its Revised Regulatory Framework for Processing its Staff Misconduct Cases, the California Department of Corrections and Rehabilitation Continues to Earn Poor Ratings; Flawed Practices by Departmental Staff into Staff Misconduct Allegations Cause Inquiries and Investigations to Be Deficient*.

In January 2022, the California Department of Corrections and Rehabilitation (the department) implemented emergency regulations revising its statewide process for processing staff misconduct complaints. The revised regulatory framework became permanent on October 20, 2022. Effective May 31, 2022, our office began monitoring the department's implementation of this new process. From May 31, 2022, through December 31, 2022, we monitored staff misconduct complaint screening decisions made by the department's Centralized Screening Team, local inquiry cases completed by prison investigators, and investigations conducted by the Office of Internal Affairs' Allegation Investigation Unit. This report includes a summary of the screening decisions, inquiry cases, and investigations we monitored and closed from May 31, 2022, through December 31, 2022.

In addition to the above, in this report, we also discuss our monitoring of inquiry cases completed by the Office of Internal Affairs' Allegation Inquiry Management Section pursuant to the department's prior regulatory framework. From January 1, 2022, through October 26, 2022, the OIG monitored and closed a select number of these inquiry cases before transitioning to exclusively monitoring staff misconduct cases only, pursuant to the new regulatory framework.

In this report, we also include information regarding the department's retention period for body-worn cameras and surveillance video recordings; concerns we have regarding the department's limited retention period; and a recommendation to expand this period so as to improve the department's local inquiry cases and investigations into staff misconduct allegations.

From January 1, 2022, through December 31, 2022, the department's Centralized Screening Team received and screened a total of 138,037 grievances and identified 164,042 complaints. Beginning July 1, 2022, through December 31, 2022, we monitored and closed 1,067 grievances which included 1,682 complaints that the Centralized Screening Team received. We found that the department's Centralized Screening Team conducted *satisfactory* screening decisions in 1,008 of the 1,067 grievances, or 94 percent, of the decisions we monitored. In 58 complaints, or five percent, the Centralized Screening Team's performance was *poor*. In one case, we issued the department a *superior* rating.



The department's Allegation Inquiry Management Section received a total of 8,754 inquiries from January 1, 2022, through December 31, 2022. Of these, the OIG monitored 19 inquiry cases that the Allegation Inquiry Management Section received, opened, and completed. The OIG stopped monitoring any new Allegation Inquiry Management Section cases received on or after June 1, 2022. In addition, the department's Centralized Screening Team routed 9,122 allegations of staff misconduct to prisons for local inquiry. Of these, the OIG monitored 22 local inquiry cases.

In total, the OIG monitored and closed 41 staff misconduct inquiry cases: 19 staff misconduct inquiry cases completed by Office of Internal Affairs' Allegation Inquiry Management Section investigators and 22 staff misconduct cases completed by prison investigators. In these cases, we assessed the work of investigators and that of the wardens who made decisions regarding the inquiry cases. The OIG assessed the department's overall performance as *poor* in nine of the 19 cases, or 47 percent, and *satisfactory* in 10 cases, or 53 percent. Of the 22 local inquiry cases we monitored and closed, the OIG rated the work of departmental staff as *poor* in 13 cases, or 59 percent, and as *satisfactory* in nine cases, or 41 percent. We did not assign any inquiry cases a *superior* rating.

The department reported to the OIG that the Centralized Screening Team identified and routed a total of 10,589 allegations of staff misconduct to the Office of Internal Affairs for inquiry or investigation from January 1, 2022, through December 31, 2022. On May 31, 2022, the department's Office of Internal Affairs' Allegation Investigation Unit began investigating allegations of staff misconduct involving incarcerated people and parolees. From May 31, 2022, through December 31, 2022, the Office of Internal Affairs' Allegation Investigation Unit received a total of 1,835 allegations and completed a total of 742 investigations (with a total of 1,118 claims). There were 10,589 allegations, but only 1,835 cases because the Office of Internal Affairs' Allegation Investigation Unit combined related allegations into single cases for the 1,835 cases it opened. The OIG monitored and closed 10 of the total investigation cases that the department completed.

In these cases, we also assessed the work of the wardens who made findings and decisions regarding the investigation cases and the performance of department attorneys assigned to the cases. We found the performance of departmental staff *poor* in seven of 10 of the investigation cases the OIG monitored and *satisfactory* in three of the cases. Also, we determined the performance of department attorneys in these cases was *poor* in six of 10 cases and *satisfactory* in four of the cases; and the wardens' performance was *poor* in five of 10 cases and *satisfactory* in five of the cases. We did not assign any cases a *superior* rating.

Despite the department's restructuring of the staff misconduct complaint process, in an attempt to increase its independence and fairness in reviewing these complaints, the department is still fraught with confusion and inadequate inquiry and investigative techniques. We found that the department largely failed to implement a seamless inquiry process by not establishing clear policies and procedures, failed to retain video-recorded evidence, and inappropriately closed investigations without conducting thorough interviews and, sometimes, without conducting any interviews at all.

Sincerely,



Amarik K. Singh
Inspector General

Contents

Illustrations	v
Summary	1
Results in Brief	1
Introduction	5
Background	5
The Department’s Staff Misconduct Complaint Review Process	6
Oversight Areas Reported During the Period From January 1, 2022, Through December 31, 2022	8
Centralized Screening Team Monitoring Results	11
Overview of Centralized Screening Team Monitoring	11
Overall, the Centralized Screening Team’s Performance Was <i>Satisfactory</i> ; However, the OIG Identified Significant Inadequacies With Several Screening Decisions	12
The Department Failed to Adequately Train Screening Staff on How to Interview Incarcerated People	16
The Department Has Failed to Reclassify Allegations in Its Electronic Tracking System Despite Agreeing With the OIG’s Recommendations to Do So	18
Inquiry Cases Monitoring Results	21
Overview of Local Inquiry Case Monitoring	21
Overall, the Department’s Performance in Conducting Local Inquiries Was <i>Poor</i> ; the OIG Identified Significant Deficiencies in How Locally Designated Investigators Conducted Inquiries and How the Department Processed Inquiry Reports	21
Investigators Failed to Use Effective Interviewing Techniques When Conducting Interviews Because They Did Not Audio Record Each Interview	21
Investigators’ Inadequate Planning Resulted in Their Failure to Complete All Relevant Interviews, to Gather and Review All Relevant Documentary Evidence, and to Prepare Complete Inquiry Reports	23
The Office of Internal Affairs’ Allegation Investigation Unit Manager Did Not Adequately Review Draft Inquiry Reports	26
Overview of Monitoring of Office of Internal Affairs’ Allegation Inquiry Management Section Inquiry Cases	28

Investigation Cases Monitoring Results	33
Overview of Investigation Case Monitoring	33
Overall, the Department's Performance Was Poor in Its Investigations and Processing of Staff Misconduct Allegations	33
Our Review of the Department's Use and Retention of Body-Worn Cameras and Video Recordings	45
Departmental Policy Is Inadequate Regarding the Preservation of Body-Worn Camera Recordings, Which Leads to Video Evidence Being Prematurely Destroyed, Thus Making It Unavailable for Review During Inquiries and Investigations	45
Departmental Policy Requiring a 90-Day Retention Period for Video-Recording Preservation May Not Be Allowing Sufficient Time for Investigators to Request, Review, and Appropriately Preserve All Relevant Video Evidence Related to Staff Complaint Inquiries and Investigations	47
Findings and Recommendations	53
Appendices	55
Scope and Methodology	56
Case Summaries	58
Response to the OIG's Report	131

Illustrations

Figures

1. An Overview of the Department's Staff Misconduct Review Process	7
2. The Department's Actions on Complaints Submitted by Incarcerated People and Parolees	9

Tables

Terms Used in This Report	viii
1. Ratings of the Centralized Screen Team (CST) Referrals	3
2. The OIG's Ratings of Inquiries Conducted by the Department	4
3. The OIG's Ratings of Investigations Conducted by the Department's Office of Internal Affairs' Allegation Investigation Unit	4
4. The OIG's Ratings of the Centralized Screening Team's Screening Decisions	11
5. Seven Complaints the Department Agreed to Reclassify	19
6. The 10 Cases the Department Monitored From May 31, 2022, Through December 31, 2022	33
7. Time Period to Complete Staff Misconduct Investigations	51
8. State Corrections Agencies Minimum Retention Periods for Body-Worn Camera Recordings	52
9. The OIG's Findings and Recommendations	53

Exhibits

1. Excerpt From an Incarcerated Person's Complaint	13
2. Excerpt From the Office of Grievance's Response to an Incarcerated Person's Complaint	14
3. Excerpt From an Incarcerated Person's Complaint	14
4. Complaint Record From the Department's Electronic Tracking System	17
5. Excerpt From an Incarcerated Person's Complaint	31
6. Excerpt From an Incarcerated Person's Medical Report	31
7. Excerpt From Email Correspondence Between the OIG and the Department	42
8. Allegation Investigation Unit Closure Letter	43

Photographs

1. A Sergeant's Body-Worn Camera Still Photo Image	39
2. A Sergeant's Body-Worn Camera Still Photo Image	39

Graphics

The OIG's Mandate	vii
-------------------	-----

(This page left blank for reproduction purposes.)



LADY JUSTICE

The **Inspector General** shall provide contemporaneous oversight of grievances that fall within the department's process for reviewing and investigating inmate allegations of staff misconduct and other specialty grievances, examining compliance with regulations, department policy, and best practices. . . . **The Inspector General** shall issue reports annually, beginning in 2021.

– *State of California
California Penal Code
section 6126 (i)*

Terms Used in This Report	
Allegation Investigation Unit	The unit within the Office of Internal Affairs that conducts investigations into complaints alleging misconduct toward inmates and parolees as set forth in CCR, Title 15, section 3486.2, and reviews Allegation Inquiry Reports completed by Locally Designated Investigators.
Audio-Video Surveillance System (AVSS)	Audio-Video Surveillance System (AVSS) consists of fixed cameras mounted in various locations within the prison that may use audio, video, or both forms of recording technology. Used to enhance public safety and facility security by providing the ability for real-time monitoring and recording in order to conduct investigations and after-the-fact reviews by utilizing audio and video-recording technology.
Body-Worn Camera (BWC)	A video camera worn on clothing and used to record activity in front of the wearer.
Complaint	Any documentation or verbal statement received by the department, from any source, that contains a routine issue or alleges staff misconduct.
Corrective Action	A documented action, which is not adverse or disciplinary in nature, a hiring authority undertakes to assist an employee in improving work performance, behavior, or conduct. Examples are verbal counseling, training, written counseling, or a letter of instruction. Corrective action cannot be appealed to the State Personnel Board.
Disciplinary Action	A documented action, punitive in nature and intended to correct misconduct or poor performance or terminate employment and may be appealed to the State Personnel Board. It is the charging document served on an employee who is being disciplined, advising the employee of the causes for discipline and the penalty to be imposed. Examples of these actions include a letter of reprimand, pay reduction, suspension without pay, or termination. Also referred to as an adverse action or a notice of adverse action.
Employment Advocacy and Prosecution Team (EAPT)	The entity in the Office of Legal Affairs responsible for providing legal counsel and representation to the department during the employee investigation, discipline, and appeal processes.
Hiring Authority	An executive, such as a warden, superintendent, or regional parole administrator, authorized by the Secretary of the California Department of Corrections and Rehabilitation to hire, discipline, and dismiss staff members under his or her authority.

Continued on next page.

Terms Used in This Report (Continued)	
Inquiry	The gathering of relevant facts and evidence by a Locally Designated Investigator (LDI) for a complaint that contains an allegation of staff misconduct.
Investigation	The collection of evidence that supports or refutes an allegation of misconduct, including criminal investigations, administrative investigations, retaliation investigations, or allegation inquiries. The department conducts either criminal investigations, which concern the investigation of a potential crime or crimes, or administrative investigations, which concern the investigation of an alleged violation of a policy, procedure, or other administrative rule.
Investigation Assignment Index	The index used by an Office of Internal Affairs' Allegation Investigation Unit manager to make a decision regarding the level of Allegation Investigation Unit investigator to be assigned to conduct an investigation.
Office of Grievances	The entity within the department with the authority to log and track grievances filed by an incarcerated person or parolee. The Office of Grievances shall ensure that all routine claims returned from the Centralized Screening Team to the Office of Grievances are reviewed and answered.
Office of Internal Affairs	The Office of Internal Affairs (OIA) is the departmental entity with authority to investigate allegations of employee misconduct when appropriate.

Terminology in this table is compiled from *The California Code of Regulations* and the department's operations manual.

(This page left blank for reproduction purposes.)

Summary

Results in Brief

California Penal Code section 6126 (i) requires the Office of the Inspector General (the OIG) to provide contemporaneous oversight of grievances¹ that fall within the California Department of Corrections and Rehabilitation's (the department) process for reviewing and investigating incarcerated people's allegations of staff misconduct. This oversight includes our examination of compliance with regulations, departmental policy, and best practices. In January 2022, the department implemented emergency regulations revising its statewide process for reviewing incarcerated people's allegations of staff misconduct.

On January 1, 2022, the department's Centralized Screening Team began screening complaints submitted by incarcerated people and parolees. The Centralized Screening Team could assign complaints into one of three categories: 1) routine issue; 2) local inquiry; or 3) the Office of Internal Affairs for inquiry or investigation.² Beginning May 31, 2022, the Centralized Screening Team began assigning staff misconduct allegations into one of three categories: 1) routine issue; 2) local inquiry; or 3) investigation.³ Beginning May 31, 2022, this new process applied to six prisons: California Institution for Women (CIW); California State Prison, Corcoran (COR); California State Prison, Los Angeles County (LAC); Kern Valley State Prison (KVSP); Richard J. Donovan Correctional Facility (RJD); and Substance Abuse Treatment Facility and State Prison, Corcoran (SATF).

The Centralized Screening team uses the *Allegation Decision Index* to determine which allegations of staff misconduct should be routed to the Office of Internal Affairs and which allegations of staff misconduct should be returned to the hiring authority for local inquiry. If the allegation of staff misconduct is listed on the Allegation Decision Index, the allegation is routed to the Office of Internal Affairs and if the allegation of staff misconduct is not listed on the Allegation Decision Index, the allegation is routed to the hiring authority for a local inquiry.

1. An incarcerated person must file a grievance on a "CDCR Form 602-1" with the institutional or regional Office of Grievances for review of one or more claims or allegations to challenge any policy, decision, condition, or omission by the department that has a material adverse effect upon his or her health, safety, or welfare (*California Code of Regulations* (CCR), Title 15, sections 3480 (b) (10), 3481 (a), 3482 (c) (1), and 3486.1 (d)).

2. Beginning May 31, 2022, complaints from the California Institution for Women (CIW); California State Prison, Corcoran (COR); California State Prison, Los Angeles County (LAC); Kern Valley State Prison (KVSP); Richard J. Donovan Correctional Facility (RJD); and California Substance Abuse Treatment Facility and State Prison, Corcoran (SATF), routed to the Office of Internal Affairs by CST, received investigations by the Allegation Investigation Unit, while all other allegations of staff misconduct routed to the Office of Internal Affairs received allegation inquiries from the Allegation Inquiry Management Section.

3. The Centralized Screening Team is an entity within Office of Internal Affairs that reviews complaints to determine if the documentation contains a routine issue, alleges staff misconduct toward an inmate or parolee, or alleges staff misconduct not toward an inmate or parolee (DOM 33070.3 (j)).

On May 31, 2022, the OIG began to monitor select staff misconduct inquiries conducted by locally designated investigators⁴ at the prisons and began to monitor select staff misconduct investigations conducted by the Office of Internal Affairs' Allegation Investigation Unit.

From July 1, 2022, through December 31, 2022, the OIG began to monitor complaints filed by incarcerated people and parolees to determine whether the department's new Centralized Screening Team was routing complaints involving allegations of staff misconduct to the appropriate entity within the department.

From January 1, 2022, through December 31, 2022, the OIG monitored and closed:

- 1,067 grievances screened by the Centralized Screening Team
- 19 inquiry cases completed by the Office of Internal Affairs' Allegation Inquiry Management Section
- 22 inquiry cases completed by locally designated (prison) investigators
- 10 investigation cases conducted by the Office of Internal Affairs' Allegation Investigation Unit

For each of the cases we monitored, we assessed the performance of departmental staff and provided an overall rating. Our assessment methodology for the rating was based on the OIG's answers to each of the performance-related questions. We assessed the overall screening work of the Centralized Screening Team, the inquiry work of locally designated and Allegation Inquiry Management Section investigators, and the investigation work of the Office of Internal Affairs' Allegation Investigation Unit, department attorneys, and hiring authorities as *superior*, *satisfactory*, or *poor*. We used this rating system to evaluate and assess the department's overall performance in five main areas:

1. Whether the Centralized Screening Team appropriately screened and referred allegations of employee misconduct and other related complaints;
2. Whether the department appropriately conducted inquiries into allegations of employee misconduct;
3. Whether the Office of Internal Affairs' Allegation Investigation Unit appropriately conducted investigations;
4. Whether the department attorney or employee relations officer properly performed during the investigation, the disciplinary process, and the litigation process;

4. A *locally designated investigator* refers to departmental staff trained by the Office of Internal Affairs to collect evidence and conduct allegation inquiries.

5. And whether the hiring authority properly determined findings concerning alleged employee misconduct, and properly processed the employee disciplinary case.

In this report we also reviewed the department's retention period for body-worn camera and video recordings, and compared the retention period with those of other state correctional facilities.

From January 1, 2022, through December 31, 2022, the Centralized Screening Team received and screened a total of 164,042 complaints. Beginning July 1, 2022, through December 31, 2022, the OIG monitored 1,067 grievances which included 1,682 complaints that the Centralized Screening Team received. We found that the department's Centralized Screening Team conducted *satisfactory* screening decisions in 1,008 of the 1,067 grievances, or 94 percent, we monitored. In 58 complaints, or five percent, the Centralized Screening Team's performance was *poor*. In one case, we issued the department a *superior* rating.

The department's Centralized Screening Team routed 8,754 inquiry cases to the Allegation Inquiry Management Section from January 1, 2022, through December 31, 2022. The OIG monitored 19 inquiry cases for which the Allegation Inquiry Management Section had received inquiries, and had opened and completed cases during the period from January 1, 2022, through October 26, 2022; however, the OIG stopped its monitoring for any new inquiry cases that the Allegation Inquiry Management Section received on or after June 1, 2022.

The department's Centralized Screening Team also routed a total of 9,122 allegations of staff misconduct to prisons for local inquiries. The OIG monitored 22 inquiry cases for which the prisons had received inquiries, and had opened and completed cases during the period from May 31, 2022, through December 31, 2022.

In total, the OIG monitored 41 staff misconduct inquiry cases: 19 staff misconduct inquiry cases that were opened and completed by Office of Internal Affairs' Allegation Inquiry Management Section investigators; and 22 staff misconduct inquiry cases that were opened and completed by locally designated investigators. The OIG assessed the department's overall performance of Allegation Inquiry Management Section investigators as well as the decisions made by hiring authorities as *poor* in nine of the 19 cases, or 47 percent, and *satisfactory* in 10 cases, or 53 percent. Of the 22 local inquiries, the OIG rated the overall performance of locally designated investigators as *poor* in 13 cases, or 59 percent, and as *satisfactory* in nine cases, or 41 percent. We did not assign any cases a *superior* rating.

Table 1. Ratings of the Centralized Screen Team (CST) Referrals

Ratings	Number of CST Decisions
<i>Superior</i>	1
<i>Satisfactory</i>	1,008
<i>Poor</i>	58
Total	1,067

Note: In this reporting period, we monitored and rated 1,067 of the department's CST referrals.

Source: The Office of the Inspector General Tracking and Reporting System.

Table 2. The OIG's Ratings of Inquiries Conducted by the Department

Ratings	Number of Local Inquiries	Number of AIMS Inquiries
<i>Superior</i>	0	0
<i>Satisfactory</i>	9	10
<i>Poor</i>	13	9

Note: In this reporting period, we monitored and rated a total of 41 of the inquiries that the department conducted.

Source: The Office of the Inspector General Tracking and Reporting System.

From January 1, 2022, through December 31, 2022, the Centralized Screening Team identified and routed a total of 10,589⁵ allegations of staff misconduct to the Office of Internal Affairs for inquiry by the Allegation Inquiry Management Section or investigation by the Allegation Investigation Unit. On May 31, 2022, the department's Office of Internal Affairs' Allegation Investigation Unit began investigating allegations of staff misconduct involving incarcerated people and parolees.

From May 31, 2022, through December 31, 2022, the Office of Internal Affairs' Allegation Investigation Unit received a total of 1,835 cases.⁶ The OIG monitored and closed 10 of the total investigation cases that the department completed.

We assessed the work of the hiring authorities who made findings and decisions regarding the investigation cases, and the performance of department attorneys assigned to the cases. We found the performance of departmental staff *poor* in seven of 10 of the investigation cases the OIG monitored and *satisfactory* in three of the cases. In addition, we determined the performance of department attorneys in these cases *poor* in six of 10 cases and *satisfactory* in four of the cases; and the hiring authorities' performance was *poor* in five of 10 cases and *satisfactory* in five cases. We did not assign any cases a *superior* rating.

Table 3. The OIG's Ratings of Investigations Conducted by the Department's Office of Internal Affairs' Allegation Investigation Unit

Ratings	OIA-AIU Investigations	Department Attorneys	Hiring Authorities
<i>Superior</i>	0	0	0
<i>Satisfactory</i>	3	4	5
<i>Poor</i>	7	6	5

Note: In this reporting period, we monitored and rated 10 of the investigations that the department conducted.

Source: The Office of the Inspector General Tracking and Reporting System.

5. On March 22, 2023, the department reported to the OIG that its Centralized Screening Team received 10,589 allegations of staff misconduct from January 1, 2022, through December 31, 2022. The Office of Internal Affairs' Allegation Investigation Unit became operable beginning on May 31, 2022.

6. An Office of Internal Affairs' Allegation Investigation Unit investigation case may contain multiple allegations.

Introduction

Background

California Penal Code section 6126 (i) requires the Office of the Inspector General (the OIG) to provide contemporaneous oversight of grievances that fall within the department's process for reviewing and investigating incarcerated people's allegations of staff misconduct. This oversight includes our examination of compliance with regulations, departmental policy, and best practices. The law requires that we issue reports annually. This report covers the implementation of the department's new staff misconduct complaint process that went into effect on January 1, 2022.

Previously, the department referred allegations of staff misconduct to the Office of Internal Affairs' Allegation Inquiry Management Section for processing. In February 2021, the OIG issued its initial special review of the Allegation Inquiry Management Section process, in which the OIG recommended that the department require incarcerated people to submit staff misconduct complaints directly to the Allegation Inquiry Management Section. One of the problems we highlighted in the report was that wardens largely avoided sending misconduct complaints to the Office of Internal Affairs for inquiries, and the department had not increased its independence or fairness in the staff misconduct complaint process.

On January 1, 2022, the department implemented emergency regulations revising its statewide process for reviewing incarcerated people's allegations of staff misconduct. On October 20, 2022, the department permanently adopted these regulations. With the new staff misconduct complaint process, the wardens no longer refer complaints to the Office of Internal Affairs' Allegation Inquiry Management Section for inquiries. Instead, the prisons' grievance offices forward allegations of staff misconduct to a new unit, the Centralized Screening Team (CST), within the Office of Internal Affairs. The new process ensures that complaints are routed to the appropriate entity for review based on the substantive allegations contained in the complaint. The Centralized Screening Team reviews each complaint to determine whether it contains a routine issue, allegations of staff misconduct toward an incarcerated person or parolee, or allegations of staff misconduct not related to an incarcerated person or parolee.

The purpose of this new process is to increase the department's independence and fairness in reviewing these complaints. Allegations of staff misconduct are either formally investigated by the new Office of Internal Affairs' Allegation Investigation Unit (formerly known as the Allegation Inquiry Management Section) or returned to the prisons for locally designated investigators to conduct inquiries into the allegations. If the Centralized Screening Team determines that complaints do not constitute allegations of staff misconduct, the Centralized Screening

Team returns the complaints to the prisons or to a regional parole office to handle as routine complaints.

The Department's Staff Misconduct Complaint Review Process

The staff misconduct complaint process begins when an individual submits a grievance with the department alleging staff misconduct involving an incarcerated person or a parolee. These complaints are either collected daily from housing units or processed immediately following submission to a parole office, as depicted in Figure 1, page 3. All complaints are forwarded to the Office of Internal Affairs' Centralized Screening Team.

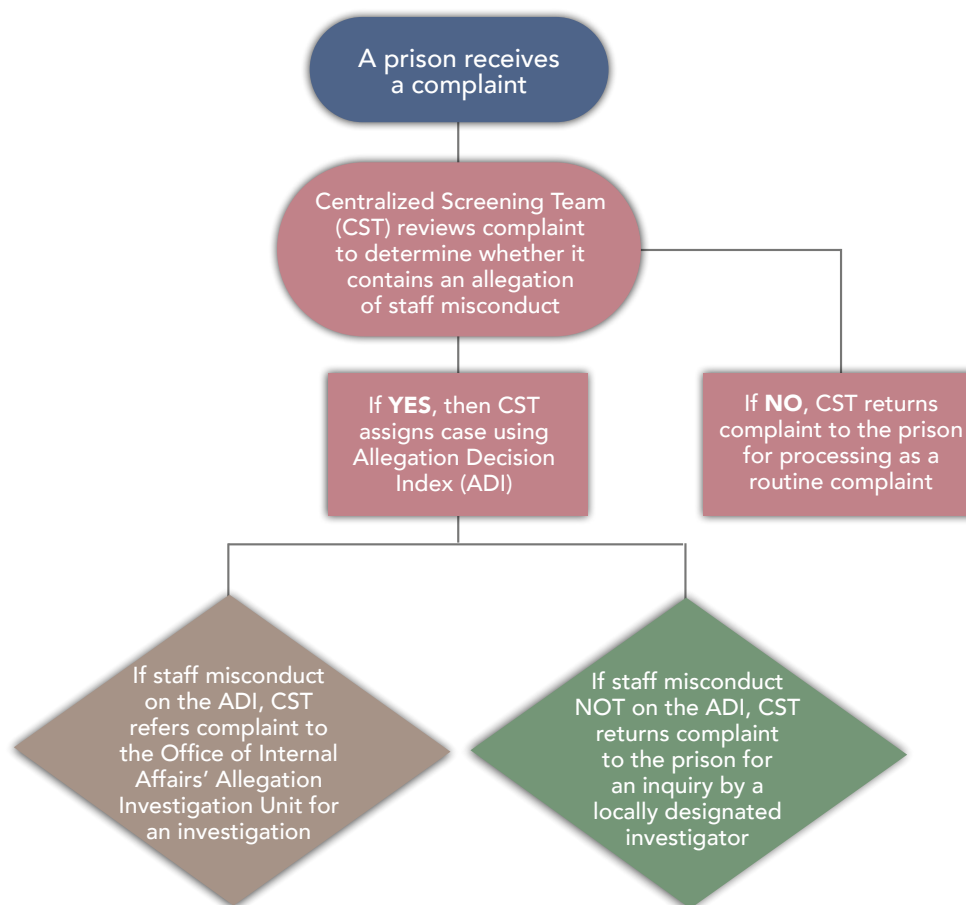
The department utilizes an index called the *Allegation Decision Index*, which identifies the criteria the Centralized Screening Team applies to determine where a complaint should be referred. The Allegation Decision Index is a list of the most serious allegations of misconduct toward incarcerated people or parolees. The Centralized Screening Team uses this list to determine whether an allegation of staff misconduct should be referred to the Office of Internal Affairs' Allegation Investigation Unit for investigation, or to the hiring authority for a local inquiry. If the complaint does not contain allegations within the Allegation Decision Index, the Centralized Screening Team refers the complaint to the appropriate prison to assign to a locally designated investigator for an inquiry.

The Centralized Screening Team reviews all complaints and makes the following screening decisions:

- Allegations identified as staff misconduct – the claim involves an allegation of staff misconduct toward an incarcerated person or parolee and shall be referred to the appropriate departmental authority to gather relevant facts.
- Allegations on the Allegation Decision Index are referred to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.
- Allegations not on the Allegation Decision Index are referred to the hiring authority for a locally designated investigator to conduct a local inquiry.
- Routine – only the Centralized Screening Team can perform the following tasks when a complaint includes an allegation of staff misconduct. However, when the complaint has been identified as a routine issue, a grievance office can take one of the following actions:
 - **Reassigned** to another authority (i.e., another prison where the allegation occurred)
 - **Redirected** or forwarded to an appropriate authority (i.e., health care concerns, a request for an interview, item, assistance, or service, etc.)

- **Rejected**, for example, the complainant did not submit the claim within the time constraints required, is substantially duplicative of a prior complaint, or is anticipatory in nature
- **No Jurisdiction** is outside of the department's jurisdiction⁷
- The following task is performed only by grievance offices:
 - **Disallowed** due to being contaminated with organic, toxic, or hazardous materials⁸

Figure 1. An Overview of the Department's Staff Misconduct Review Process



Source: The California Department of Corrections and Rehabilitation.

7. For *Reassigned*, *Redirected*, *Rejected*, or *No Jurisdiction* complaints, effective September 30, 2022, and the implementation of bifurcated screening, the Centralized Screening Team is responsible for processing claims of allegations of staff misconduct; however, for routine claims, the Centralized Screening Team is only responsible for identifying the claim and the local Office of Grievance is responsible for processing accordingly.

8. While routine, this type of complaint is not processed by the Centralized Screening Team, as it is disallowed by the local grievance office.

Upon receipt of an allegation from the Centralized Screening Team, Office of Internal Affairs' Allegation Investigation Unit investigators and locally designated investigators complete investigations and inquiries, respectively. Both types of investigators are required to analyze the complaint, thoroughly gather facts, gather and review all relevant evidence, conduct all necessary interviews, and prepare a confidential draft report that summarizes the facts and evidence gathered. The final reports and supporting exhibits are reviewed by an Office of Internal Affairs' Allegation Investigation Unit manager to determine whether the investigation or inquiry is sufficient, complete, and unbiased. Once approved, the reports are provided to the hiring authority. If the hiring authority finds the investigation or inquiry is sufficient, he or she shall determine a finding⁹ for each allegation.

Oversight Areas Reported During the Period From January 1, 2022, Through December 31, 2022

From January 1, 2022, through December 31, 2022, according to figures provided by the department, the Centralized Screening Team received a total of 164,042 complaints from incarcerated people or parolees.¹⁰ The Centralized Screening Team assigned all complaints into one of three categories: 1) routine issue; 2) local inquiry; or 3) the Office of Internal Affairs for investigation. In total, it routed 144,331, or 88.0 percent, of those allegations as routine issues, 9,122 allegations, or 5.6 percent, to prisons for a local inquiry, and 10,589, or 6.5 percent, to the Office of Internal Affairs for inquiry or investigation.

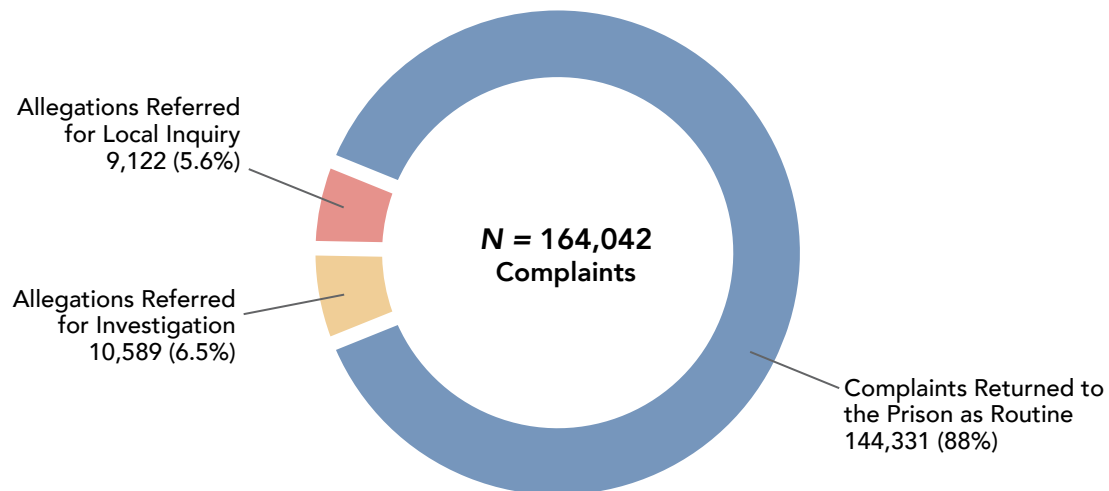
The Centralized Screening Team is generally required to screen and route all complaints within five business days. The department has 90 days to complete a local inquiry. If the subject of an internal investigation is a peace officer, the department generally has up to one year to complete an Office of Internal Affairs' Allegation Investigation Unit investigation and serve the subject of the investigation with a disciplinary action, if appropriate.

On May 31, 2022, the OIG began to monitor select staff misconduct inquiries conducted by locally designated investigators at the prison level and select staff misconduct investigations conducted by the Office of Internal Affairs' Allegation Investigation Unit. Effective July 1, 2022, the OIG began to monitor a portion of the complaints filed by incarcerated people to determine whether the department's new Centralized Screening Team had been routing complaints involving allegations of staff misconduct to the appropriate entity within the department.

9. CCR section 3486.3(a)(1): "The notification of the findings regarding the staff misconduct complaint shall be limited to whether the original complaint is sustained, not sustained, exonerated, unfounded, or no finding."

10. A complaint can contain multiple allegations that the Centralized Screening Team will review and route to different entities. For example, one complaint may contain three allegations in which Allegation № 1 is routed to a prison to handle as a routine issue, Allegation № 2 may be routed to a prison for a local inquiry, and Allegation № 3 may be routed to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.

Figure 2. The Department's Actions on Complaints Submitted by Incarcerated People and Parolees



Note: Numbers may not sum to 100 percent due to rounding.

Source: The California Department of Corrections and Rehabilitation's Offender Grievance Tracking System.

During the January 1, 2022, through December 31, 2022, reporting period, the OIG monitored 1,067 grievances routed to the Centralized Screening Team, 22 inquiries routed to prisons for a local inquiry, 10 investigations routed to the Office of Internal Affairs' Allegation Investigation Unit, and 19 Allegation Inquiry Management Section inquiries.



Centralized Screening Team Monitoring Results

Centralized Screening Team Monitoring Results

Overview of Centralized Screening Team Monitoring

On January 1, 2022, the Centralized Screening Team activated and began screening complaints submitted by the incarcerated population and parolees statewide to identify allegations of staff misconduct. The Centralized Screening Team began assigning complaints into one of three categories:

1. routine issue;
2. local inquiry; or
3. investigation.¹¹

From January 1, 2022, through December 31, 2022, the Centralized Screening Team received and screened a total of 164,042 complaints. Beginning July 1, 2022, through December 31, 2022, the OIG monitored 1,067 grievances, which included 1,682 complaints of the number of complaints that the Centralized Screening Team received. The OIG assessed how the Centralized Screening Team processed each grievance, rendering 1,067 ratings, rather than issuing a rating for each complaint. For example, the OIG monitored one grievance that contained 26 complaints. We reviewed each of the complaints for an appropriate screening decision, but rendered a single rating for the grievance, not for 26 individual ratings. Table 4 (right) depicts the overall ratings.

We found that the Centralized Screening Team's performance in conducting screening decisions was *satisfactory* in 1,008 cases, or 94 percent, of the grievances it screened and routed. Of those grievances, the OIG rated three grievances as *satisfactory* that were initially rated *poor*, but only after we elevated concerns to the Centralized Screening Team's administrators, and they made appropriate changes to their screening decision. In one case, we issued the department's Centralized Screening Team a *superior* rating.

Table 4. The OIG's Ratings of the Centralized Screening Team's Screening Decisions

OIG Ratings	Number of Grievances
<i>Superior</i>	1
<i>Satisfactory</i>	1,008
<i>Poor</i>	58
Total	1,067

Note: The 1,067 grievances that the OIG monitored and rated included 1,682 complaints.

Source: The Office of the Inspector General Tracking and Reporting System.

11. The Centralized Screening Team analyzes complaints and determines whether a complaint contains an allegation of staff misconduct or if it constitutes a complaint which is routine. If the Centralized Screening Team identifies an allegation of staff misconduct, it will then determine whether to route the allegation of staff misconduct to a locally designated investigator or to the Office of Internal Affairs' Allegation Investigation Unit.

The Centralized Screening Team's performance was *poor* in 58 cases, or five percent, of the grievances the department screened and routed, and that the OIG monitored in 2022. In eight cases, negative ratings stemmed from the Centralized Screening Team's failure to identify and make proper notifications to the hiring authority regarding allegations constituting an emergency.¹² When the department fails to identify an emergent allegation, both the incarcerated person and prison are at increased risk of serious harm.

In 59 cases, we determined that the Centralized Screening Team failed to identify every complaint within the grievance. However, if the unidentified or missed complaint had no effect on the grievance (i.e., if the Office of Grievances subsequently identified the complaint, screeners would have rejected the complaint due to time constraints, because the complaint would have been duplicative, or because the request had since been resolved), the OIG did not rate the routing decision *poor*.¹³

Overall, the Centralized Screening Team's Performance Was Satisfactory; However, the OIG Identified Significant Inadequacies With Several Screening Decisions

Overall, the Centralized Screening Team performance in processing complaints was *satisfactory*. Furthermore, the Centralized Screening Team has been receptive to the OIG's recommendations, has agreed with most of the concerns the OIG elevated, and has engaged in productive discussions with the OIG regarding process improvements. However, when the OIG identified Centralized Screening Team deficiencies, they were significant. In the 58 monitored complaints in which the OIG rated the screening decision *poor*, the deficiencies included, but were not limited to, failing to identify threats to personal safety, failing to identify every complaint within a grievance, misclassifying allegations of staff misconduct as routine, and reassigning complaints to an uninvolved prison. Below are examples of the Centralized Screening Team's failure to appropriately process and classify allegations.

On June 30, 2022, the Centralized Screening Team received the following complaint on the following page (see Exhibit 1, next page):

12. Initially, the Centralized Screening Team must identify whether complaints contain information constituting the following: 1) imminent risk to personal safety including possible loss of life or serious bodily injury, 2) sexual abuse or acts of sexual misconduct, 3) serious breach of the safety or security of a facility or program, 4) further aggravation of a potentially dangerous situation, 5) activities which would compromise or jeopardize an investigation, or 6) an illegal activity which may occur.

13. When assessing Centralized Screening Team decisions, the OIG took into consideration complaints not identified by the department. The unidentified complaints are not included in the total number of complaints processed by the department, or by the OIG, as reported on page 11 of this report.

Exhibit 1. Excerpt From an Incarcerated Person's Complaint

I went to committee on 5-29-22 acting warden
 put me up to a non medical facility, that
 does not accommodate little 2AD prisoners
 and took away my single cell status
 knowing I hear voices that tell me to
 kill my cellies.
 well documented and have done
 this was done as a retaliation, so my
 cellie can fuck me. I will have to kill
 my cellie. No to officer set me up to
 get raped.

Source: The California Department of Corrections and Rehabilitation.

On July 7, 2022, the Centralized Screening Team completed a review of the allegations and determined the complaint did not contain elements of an imminent risk. The OIG reviewed the same complaint on July 13, 2022. We identified that the incarcerated person was disputing the removal of his single-cell status and threatened to kill any cellmate housed with him. The OIG elevated this concern immediately, and the Centralized Screening Team agreed this was a safety concern and notified the hiring authority on the same day. Fortunately, the department had not housed the incarcerated person with a cellmate during the two intervening weeks; however, the repercussions of such actions could have resulted in imminent risk to the personal safety and security of incarcerated people.

In another example, on October 5, 2022, an incarcerated person submitted a complaint alleging he was not allowed to work or be paid based on his active job assignment. By the time the Office of Grievances reviewed the incarcerated person's complaint, he had been removed from his job assignment, effective October 10, 2022, for receiving a negative work performance evaluation covering the period from June 15, 2022, to September 6, 2022. The Office of Grievances denied the incarcerated person's complaint, finding no violation in policy. Based on the Office of Grievances' response (see Exhibit 2), it had failed to address the correct issue because the prison had accepted the complaint for review on October 6, 2022, four days prior to the incarcerated person's removal from his job assignment.

Exhibit 2. Excerpt From the Office of Grievance's Response to an Incarcerated Person's Complaint

A thorough review of the allegation presented has been conducted, and all submitted documents and supporting arguments have been considered and evaluated in accordance with CDCR departmental policies. It should be noted after reviewing the claimant's Inmate Assignment in Strategic Offender Management System (SOMS), the claimant was unassigned on 10/10/22 per the [redacted] and approved by Lieutenant [redacted]. Furthermore, the Job Performance evaluation date 6/15/22-09/06/22 stated, "multiple below average grades and unsatisfactory grades in the following categories? "Attitudes towards fellow inmates, Attitudes towards supervisors and staff, Interest in assigned work, Team work, Quality of work, and Quantity of work. The recommendation from the work supervisor [redacted] was to reassign the claimant. The OGG has found no violation in policy and in regards to the

Source: The California Department of Corrections and Rehabilitation.

On December 16, 2022, the incarcerated person resubmitted his complaint. This time, the incarcerated person alleged the work supervisor had altered a work performance report to have him removed from his job. The incarcerated person further claimed his removal was a result of retaliation for filing the initial complaint on October 5, 2022, against the work supervisor for not being allowed to work or be paid. The incarcerated person also attached the performance report he had received from the supervisor for the same period of June 15, 2022, through September 6, 2022. The incarcerated person claimed the performance report reflected only excellent grades and positive comments, and alleged the supervisor had altered the document after providing it to him (Exhibit 3).

Exhibit 3. Excerpt From an Incarcerated Person's Complaint

On Oct. 5, 2022, I submitted a grievance enumerating my not being allowed to work, or be paid, for my assigned job (see attached Exhibit A). That grievance, [redacted] was accepted for review on Oct. 6, 2022, as indicated on the top right corner of Exhibit A. Four days later, Oct. 10, 2022, I was unassigned from my job based solely upon the uncorroborated, and demonstrably **FALSE ACCUSATIONS** of acting laundry supervisor, [redacted] the subject of that grievance, i.e. Exhibit A. Evidence of [redacted] false accusations can be found within the highlighted portion of Exhibit B, i.e. Work Supervisor's Report for time period 6/15/22 - 9/6/22. Acting laundry supervisor, [redacted] made the following statement, verbatim, to describe my outstanding job performance:

"Mr. [redacted] has shown exceptional behavior as a lead Clothing room worker. He is prompt and shows up on time. Mr. [redacted] have been going over and beyond to achieve effectiveness for all the laundry needs during this hard time of COVID. He displays a very charismatic work ethic."

On Oct. 10, 2022, exactly four days after my grievance against [redacted] was filed, his story changed completely when he sought to have me removed from my paid job assignment by [redacted] making **FALSE ACCUSATIONS**, e.g. "Unsatisfactory Grades" on my Work Supervisor's Report during the same time

Source: The California Department of Corrections and Rehabilitation.

On December 19, 2022, a Centralized Screening Team staff member (screener) consulted with a subject matter expert based on the incarcerated person's use of "retaliation." However, the screener and the subject matter expert erroneously concluded that the incarcerated person had admitted to receiving a negative performance report, and therefore, the supervisor's actions were not retaliatory. During our monitoring of the Centralized Screening Team's decision regarding the incarcerated person's second complaint, we identified that he had made no such admission and that he had included his positive performance report as documentary evidence. The OIG elevated this issue to the Centralized Screening Team's administrators along with copies of the altered report covering the period of June 15, 2022, through September 6, 2022, which was authored by the same supervisor. The Centralized Screening Team's administrators agreed that the allegation was not a routine issue and rerouted the allegation to the Office of Internal Affairs' Allegation Investigation Unit for an investigation into alleged staff misconduct.

In another complaint, an incarcerated person alleged that staff at one prison threatened and assaulted him, and that he was in immediate danger from staff and other incarcerated people. The Centralized Screening Team rejected this complaint as a duplicate of a previously submitted complaint. The OIG reviewed the complaint and determined that although the allegations were similar, the two complaints named different staff at two different prisons. The Centralized Screening Team's decision was incorrect. After the OIG elevated the issue to the Centralized Screening Team's administrators, they agreed and processed the allegation accordingly.

Most egregiously, the OIG elevated two complaints to the Centralized Screening Team's administrators due to concerns of racial discrimination. Centralized Screening Team captains disagreed with our position, as detailed below:

An incarcerated person alleged that on October 11, 2022, an officer abused his power by issuing a rules violation report to the incarcerated person for not standing during the 4:00 p.m. count. The incarcerated person claimed to have been ready for the count at 4:00 p.m., but staff conducted it about 20 minutes late. The incarcerated person alleged that an officer oppressed black incarcerated people at the prison by issuing rules violation reports to only black and brown incarcerated people who did not stand for a count. The Centralized Screening Team considered this allegation to be about a rules violation report only and not a racial discrimination issue. They rejected the allegation as an anticipatory action because the hiring authority had not adjudicated the rules violation. The OIG questioned the decision because the allegation also described racial discrimination by an officer. The department provided, in part, the following response (Exhibit 4):

The inmate further states the Officer only writes up black and brown inmates for not standing for count. These are all things the inmate would be allowed to bring up during the hearing to plead their case. The grievance would need to be rejected as anticipatory and could be re-filed once the RVR [rules violation report] process had been completed.

The department failed to address the officer's alleged racial discrimination against the incarcerated person.

An incarcerated person alleged, on October 12, 2022, an officer “intentionally engaged in an act of invidious [sic] discrimination against [the incarcerated person] because of his race” and “released all other non Afrikan [sic] American prisoners in [the] building” scheduled for the communications class that day. The Centralized Screening Team identified the allegation as an education allegation about missing class. They referred the allegation to the prison for a routine fact finding. The OIG questioned the decision as the allegation also described racial discrimination by an officer against the incarcerated person. The department provided, in part, the following response:

Although [the incarcerated person] wrote that staff intentionally discriminated against the inmate based on their race, there could be a variety of issues such as active PSR's, temporary program disruptions, etc. that may very well be related to a group of inmates not being released. This group could be related to a particular race, a particular affiliation or other identifying attribute. We believe this complaint can be properly answered as a routine complaint but should during the fact-finding portion additional information come up this complaint can be suspended and elevated.

The Centralized Screening Team captain's response rationalized the officer's behavior without citing any corroborating evidence. The purpose of an investigation into staff misconduct is to determine whether such facts as described in the captain's response existed; it is not the Centralized Screening Team's responsibility to infer a reason the officer may have acted in the manner described in the allegation.

For both complaints, the OIG requested a final reconsideration to refer the allegations for investigation due to alleged staff misconduct (racial discrimination). The Centralized Screening Team's administrators provided no further response to either complaint, and they did not reclassify the allegations as staff misconduct.

The Department Failed to Adequately Train Screening Staff on How to Interview Incarcerated People

If a grievance submitted by an incarcerated person does not contain sufficient information to make a screening decision, the screener shall

conduct a clarifying interview of the incarcerated person. During a brief clarifying interview, the screener gathers additional information to make an appropriate decision about the alleged complaint.

Of the 1,067 grievances reviewed by the OIG, only 13 included a clarifying interview. The Centralized Screening Team conducted two of those 13 interviews only when the OIG recommended it. Moreover, the OIG identified another eight grievances that would have benefited from a clarifying interview.

Most notably, in one complaint, an incarcerated person alleged a counselor orchestrated an incident of “harassment, retaliation, and threats” perpetrated by an officer against the incarcerated person. The screener chose not to conduct a clarifying interview with the incarcerated person after documenting the following in the complaint record (see Exhibit 4):

Exhibit 4. Complaint Record From the Department’s Electronic Tracking System

<p>08/02/2022 09:02:10</p>	<p>Grievance Screening Completed</p>			<p>Claimant states that [REDACTED] orchestrated events perpetrated by [REDACTED]. Claimant gives broad statements and does not give details. Claimant has another grievance in which they are making allegations against [REDACTED]. Routine- Refer to OOG TimeStamp: 2 August 2022 09:01:49 --- User: [REDACTED]</p>
--	--------------------------------------	--	--	--

Source: The California Department of Corrections and Rehabilitation.

The use of the clarifying interview is infrequent, and staff have even chosen to not conduct a clarifying interview while documenting that the complaint did not contain sufficient information to make a decision. The OIG requested details from the Centralized Screening Team’s management about the training their analysts received, as well as copies of any work aides that are provided to help the analysts in the course of their duties. To date, the Centralized Screening Team has not provided any documentation. One manager reported they “had a conversation” with the analysts about explaining the purpose of the interview to the incarcerated person and keeping the interview to the scope of the allegation in question.

The Department Has Failed to Reclassify Allegations in Its Electronic Tracking System Despite Agreeing With the OIG's Recommendations to Do So

The OIG elevated 13 missed allegations of staff misconduct to the Centralized Screening Team's administrators. In seven instances, administrators agreed with our recommendations. The Centralized Screening Team reclassified six allegations as staff misconduct on the Allegation Decision Index and assigned them to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. The Centralized Screening Team reclassified one allegation that was not on the Allegation Decision Index as staff misconduct and assigned it to the hiring authority for a local inquiry.

Of the seven allegations the Centralized Screening Team agreed to reclassify, the OIG has been unable to confirm that the department processed two complaints. The OIG assigned each complaint a number from 1 to 7 as noted in Table 5 on the following page.








The OIG questioned the Centralized Screening Team about the reclassification of the two allegations. Administrators informed us concerning an issue with the direct entry¹⁴ function in the electronic tracking system. However, we determined that the direct entry feature worked with other cases. The OIG cannot ascertain what occurred with these two allegations, and whether the department processed them as allegations of staff misconduct (see Table 5, following page).

We outline below how the Centralized Screening Team administrators processed the six remaining missed allegations of staff misconduct that we elevated:

- In two instances, the Centralized Screening Team conducted clarifying interviews with incarcerated people and determined the allegations were not staff misconduct. The OIG concurred.
- In one instance, the Centralized Screening Team combined two allegations of staff misconduct and referred both allegations for an investigation. The OIG concurred.
- In one instance, the Centralized Screening Team never addressed the allegation.
- In the last two instances, administrators did not agree with the OIG's assessment that the allegations identified staff misconduct.

14. *Direct entry* means complaint details are manually entered directly into the department's Allegation Against Staff Tracking System rather than being pulled in from existing details in another database, usually the Strategic Offender Management System.

Table 5. Seven Complaints the Department Agreed to Reclassify

Case	Reassignment Details		Summary	Reassignment Confirmed
1	Decision SOMS* Update AASTS† Update Status‡	Investigation 7-22-22 7-23-22 "In Progress"	On July 22, 2022, the Centralized Screening Team notified the OIG of their agreement to reassign the complaint for an investigation. The investigator completed and returned the investigation to the hiring authority for disposition on October 6, 2022.	
2	Decision SOMS* Update AASTS† Update Status‡	Investigation None None Unknown	On August 11, 2022, the Centralized Screening Team notified the OIG that they agreed to reassign the complaint for an investigation. As of February 3, 2023, the OIG could not confirm the department reassigned the complaint.	
3	Decision SOMS* Update AASTS† Update Status‡	Investigation 9-28-22 9-28-22 "In Progress"	On September 26, 2022, the OIG elevated our concerns to Centralized Screening Team's administrators. On September 30, 2022, the Centralized Screening Team agreed to reassign the complaint for an investigation. The investigator completed and returned the investigation to the hiring authority for disposition on January 31, 2023.	
4	Decision SOMS* Update AASTS† Update Status‡	Investigation 12-29-22 12-29-22 "In Progress"	On December 13, 2022, the Centralized Screening Team agreed to reassign the complaint for an investigation. As of February 3, 2023, the investigation is on-going.	
5	Decision SOMS* Update AASTS† Update Status‡	Investigation None None Unknown	On December 13, 2022, the Centralized Screening Team agreed to reassign the complaint for an investigation. This complaint includes two distinct allegations of 1) use of force, and 2) retaliation. The OIG could not confirm if the investigator addressed the use-of-force allegation.	
6	Decision SOMS* Update AASTS† Update Status§	Local Inquiry 12-21-22 12-21-22 "Resolved"	On December 21, 2022, the Centralized Screening Team agreed to reassign the complaint for a local inquiry. The hiring authority signed off on the completed local inquiry on January 21, 2023.	
7	Decision SOMS* Update AASTS† Update Status‡	Investigation 12-30-22 12-30-22 "In Progress"	On December 30, 2022, the Centralized Screening Team agreed to reassign the complaint for an investigation. As of February 3, 2023, the investigation is on-going.	

* Strategic Offender Management System.

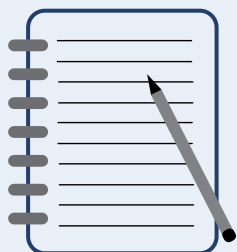
† Allegations Against Staff Tracking System.

‡ Status is reported as of February 3, 2023.

§ Status is reported as of May 22, 2023.

Note: In the column labeled *Reassignment Confirmed*, a green check mark means the OIG confirmed that the department routed the complaint and reassigned it; a red X means the OIG cannot confirm that the department processed the reassignment.

Source: The California Department of Corrections and Rehabilitation's electronic tracking systems.



Inquiry Cases Monitoring Results

Inquiry Cases Monitoring Results

The department's Centralized Screening Team routed 8,754 inquiry cases to the Allegation Inquiry Management Section from January 1, 2022, through December 31, 2022. The OIG monitored 19 inquiry cases for which the Allegation Inquiry Management Section had received inquiries, and had opened and completed cases during the period from January 1, 2022, through October 26, 2022; however, the OIG stopped its monitoring for any new inquiry cases that the Allegation Inquiry Management Section received on or after June 1, 2022.

The department's Centralized Screening Team also routed a total of 9,122 allegations of staff misconduct to prisons for local inquiries. The OIG monitored 22 inquiry cases for which the prisons had received inquiries, and had opened and completed cases during the period from May 31, 2022, through December 31, 2022.

In total, the OIG monitored 41 staff misconduct inquiry cases. The OIG initially monitored an additional seven staff misconduct local inquiry cases, but the department referred those cases to the Office of Internal Affairs' Allegation Investigation Unit for a formal investigation prior to completion of the inquiry.

Overview of Local Inquiry Case Monitoring

Overall, the Department's Performance in Conducting Local Inquiries Was *Poor*; the OIG Identified Significant Deficiencies in How Locally Designated Investigators Conducted Inquiries and How the Department Processed Inquiry Reports

We found that, overall, the department's performance was *poor*. Of the 22 local inquiry cases, the OIG rated the overall performance of the department *poor* in 13 cases, or 59 percent, and *satisfactory* in nine cases, or 41 percent. In no cases did the department receive a *superior* rating. Negative ratings stemmed from investigators' failure to use effective interview techniques when conducting interviews; failure to complete relevant interviews, failure to gather and review evidence, and prepare complete inquiry reports; and the Office of Internal Affairs' Allegation Investigation Unit managers' failure to adequately review draft inquiry reports.

Investigators Failed to Use Effective Interviewing Techniques When Conducting Interviews Because They Did Not Audio Record Each Interview

Through our monitoring, we determined that investigators' performance was *poor* in their use of effective interviewing techniques in seven inquiries of the 22 monitored local inquiries, or 32 percent. In the remaining 15 inquiries, or 68 percent, we rated the investigators' work *satisfactory*.

An investigator's use of effective interviewing techniques is vital to any inquiry. One effective technique is the use of audio-recording devices during interviews. A primary benefit of recording an interview is that it ensures a definitive record of what the investigator asked and the interviewee's response. It also allows the investigator to concentrate on the interview rather than note-taking, which can be a distraction to both the interviewee and the investigator. Besides providing an accurate record of the discussion during the interview, recorded interviews also allow the investigator and the interviewee to develop a rapport during the interview, which may lead the interviewee to disclose more detailed information. A recording allows the investigator an opportunity to review the interview and ensure that the draft inquiry report is fact-based, objective, accurate, and clear.

The department directs investigators who conduct local inquiries not to use audio-recording devices. On December 7, 2022, the department issued a memorandum to wardens, investigators, and the department's Office of Grievances that stated, in part, "Interviews will not be recorded by the LDI unless the employee (subject or witness) elects to record the interview."

Being constrained from recording interviews is a disadvantage to investigators when they prepare the inquiry report. It also is a disadvantage for the OIG if we are unable to be present during an interview. Without recorded interviews, the OIG's monitoring activities are limited to those interviews the OIG attends. If the investigator fails to notify our office of an interview, our ability to monitor that interview is lost, and we have no means of effectively monitoring all facets of an inquiry.

Contrary to departmental practices regarding audio-recording interviews, in a case involving allegations that an officer had disclosed an incarcerated person's sexual assault conviction information with staff, the investigator recorded the interviews. The investigator interviewed the incarcerated person on the first day of his assignment, prior to receiving the OIG's monitoring notification.¹⁵ The investigator's practice was to audio record interviews for local inquiries even though departmental policy did not require it. Because the investigator recorded the interview, he was able to provide the OIG with a copy of the audio recording. The investigator also audio recorded the subject interview and provided a copy of the recording to the OIG for review. The audio recordings allowed the OIG to effectively monitor the inquiry and assisted the investigator in recalling important facts while preparing an inquiry report.

15. The department's Centralized Screening Team (CST) referred this case for an inquiry by an investigator on May 31, 2022. The OIG is provided three business days to notify the Office of Grievances of cases to be monitored. The OIG notified departmental staff timely of our monitoring on June 2, 2022, two business days after the investigator's assignment.

In an example in which an officer allegedly failed to process and withheld an incarcerated person’s legal mail, the investigator did not audio record the interviews. During the inquiry, the investigator did not timely notify the OIG regarding three of four interviews he had conducted. The investigator’s lack of timely notification precluded the OIG from observing several interviews and providing real-time feedback. If the investigator had recorded the interviews, the recordings would have provided a transcript for the OIG and other reviewers, such as the Office of Internal Affairs’ Allegation Investigation Unit manager and the warden.

The investigator’s use of recording devices increases transparency in the inquiry process. The department’s directives to its locally designated investigators are contrary to the Office of Internal Affairs’ recommendation to its investigators to record interviews. The Office of Internal Affairs investigators’ January 2021 field guide states, in part:

When interviewing an employee concerning matters that could lead to an adverse personnel action, the complete interview shall be recorded, when reasonably possible. . . .

All witness recordings shall be retained with the original investigative/inquiry report. Recordings are part of the investigative/inquiry report. . . . Any recording of any interview shall be made openly with the full knowledge of the employee being interviewed, summarized as part of the final report, and retained for later transcription, if needed.¹⁶

As stated above, the department’s express purpose for recording interviews during investigations is to preserve statements made by an employee that could be used in any future potential “adverse personnel action.” The basis of an inquiry is to prove or disprove an allegation of departmental policy violations. If proven, the result may include an adverse personnel action against the subject of an inquiry. Thus, an investigator’s use of audio recordings allows for the preservation of witness and subject statements, and the recordings act as evidence to support the potential adverse action, if applicable.

Investigators’ Inadequate Planning Resulted in Their Failure to Complete All Relevant Interviews, to Gather and Review all Relevant Documentary Evidence, and to Prepare Complete Inquiry Reports

We found that investigators’ performance was *poor* when they did not

- complete all necessary and relevant interviews in 10 of the 22 monitored cases, or 45 percent;

16. The department’s Office of Internal Affairs, *Investigator’s Field Guide*, January 2021, p. 19, “Recording of Interviews.”

- gather and review all relevant documentary evidence in 11 of the 22 monitored cases, or 50 percent; and
- prepare complete inquiry reports in 10 of the 22 monitored cases, or 45 percent.

To complete a thorough inquiry, an investigator should obtain facts and evidence that enable a hiring authority to make an appropriate decision regarding allegations included in a staff misconduct complaint. Essential steps an investigator should perform during an inquiry include the following:

- develop an inquiry plan that includes an initial inquiry strategy to define what needs to be done, by whom, and how;
- list each allegation and the appropriate departmental policy and procedure, if applicable;
- identify and document evidence and information that require collection, such as documents and video evidence;
- create an initial interview list of witnesses and subjects to obtain information to support or refute the allegation; and
- draft an inquiry report for the hiring authority that provides sufficient, relevant, and unbiased information.

Departmental policy outlines the expectation that investigators conduct a thorough inquiry and that the inquiry undergo a management review. Title 15 of the *California Code of Regulations*, section 3486.2 (c) (3), states:

- (A) “LDIs [locally designated investigators] shall conduct thorough allegation inquiries, and ensure all relevant evidence is gathered and reviewed, and necessary interviews are conducted. . . .”
- (B) “Upon completion of the Allegation Inquiry, the LDI shall author a confidential draft Allegation Inquiry Report with all applicable supporting exhibits, and provide the draft report to the [Allegation Investigation Unit] manager for review and approval.”

The OIG found that investigators did not consistently perform all essential steps, which resulted in nearly half the monitored cases being deficient. Investigators did not collect or include all documentary evidence as exhibits in an inquiry report to adequately support or refute an allegation of staff misconduct.

Investigators also failed to identify and interview relevant witnesses, and elected not to interview witnesses or subjects based on body-worn or fixed-camera video recordings. Furthermore, investigators did

not identify or include all relevant facts and evidence, which would have allowed wardens to make appropriate decisions concerning staff misconduct allegations.

An example of an investigator who did not collect all evidence involved a case in which an officer allegedly rushed up to a wheelchair-bound incarcerated person and yelled, “Get-get-get!” The officer then stood over the incarcerated person in a threatening manner, stating, “I’m not asking you; I’m telling you.” The incarcerated person identified the officer and a witness (a counselor) as subjects in a prior complaint that the incarcerated person had filed. Even though the incarcerated person provided the complaint number, the investigator failed to obtain a copy of the past complaint or consider its relevance to the current inquiry. The investigator should have obtained a copy of the incarcerated person’s past complaint and questioned both the counselor and the officer about the complaint. The investigator’s review of the past complaint and further questioning of the counselor and officer may have provided additional information to determine whether the officer’s actions were retaliatory. The OIG subsequently confirmed that the incarcerated person had filed a staff misconduct complaint against the officer and counselor only 18 days prior to this incident.

An example of an investigator not completing any witness or subject interviews, involved a departmental employee who allegedly did not respond to an incarcerated person’s complaint of electrical and plumbing issues in his cell and in numerous adjacent cells. The employee allegedly denied the incarcerated person’s request to move to another cell and instead gave him gloves and a bag to use to transfer feces from a nonfunctioning toilet to a working toilet outside his cell. During the inquiry, the investigator discovered that several other incarcerated people in nearby cells had similar electrical and plumbing issues.

The investigator attempted to interview one incarcerated person, who declined to be interviewed. The investigator did not interview other incarcerated people in nearby cells. As a result, the investigator failed to conduct a thorough inquiry that could have assisted the investigator in proving or disproving the incarcerated person’s allegations.

In another example, an officer allegedly failed to notify medical staff when an incarcerated person expressed suicidal thoughts. During the inquiry, the investigator identified, but did not interview several witnesses, including a sergeant, another officer, and medical staff. The OIG recommended that the investigator interview the witnesses; however, the investigator declined. The warden concluded that the first officer had failed to assist the incarcerated person after the incarcerated person had informed the officer that he had suicidal thoughts. Although the department issued a letter of instruction to the officer, the OIG disagreed with the imposition of corrective action. In our opinion, the warden should have referred the matter to the Office of Internal Affairs’ Allegation Investigation Unit for investigation.

The Office of Internal Affairs' Allegation Investigation Unit Manager Did Not Adequately Review Draft Inquiry Reports

After an investigator prepares a draft inquiry report, the Office of Grievances submits it to the Office of Internal Affairs' Allegation Investigation Unit manager via the department's Microsoft SharePoint site. The Office of Internal Affairs' Allegation Investigation Unit manager reviews the draft inquiry report and determines whether the inquiry is sufficient, complete, and unbiased. The OIG found that the Office of Internal Affairs' Allegation Investigation Unit manager inappropriately determined that the investigator's draft inquiry report was sufficient, complete, and unbiased in 10 of the 22 monitored cases, or 45 percent.

The quality of an Office of Internal Affairs' Allegation Investigation Unit manager's review of the investigator's work is a critical step because the warden makes a final decision concerning the allegations of staff misconduct after the Office of Internal Affairs' Allegation Investigation Unit manager determines a report is adequate (i.e., "complete and unbiased"). One example in which we assessed the Office of Internal Affairs' Allegation Investigation Unit manager's review as deficient, involved an officer who allegedly disregarded a transgender incarcerated person's request for a female officer to search the incarcerated person. The investigator shared his completed draft inquiry report with the OIG. We identified several discrepancies in the report, including the following:

- The subject officer disclosed that he had "called his supervisor who was identified as Sergeant [redacted]" after this incident. Although this sergeant was identified in the draft inquiry report as being the only witness for this inquiry, the investigator did not interview the sergeant. The OIG recommended that the investigator interview the sergeant as a witness.
- The subject officer stated that following the incident, the incarcerated person claimed to have suicidal thoughts; therefore, the officer started a holding-cell log and notified mental health staff. The OIG recommended that the investigator obtain a copy of the holding-cell log and mental health notification to confirm the officer's statements and include these documents as exhibits in the inquiry report.
- Throughout the report, the investigator cited that departmental staff had conducted a "clothed" body search of the incarcerated person, except for two references to staff conducting an "unclothed" body search. The OIG recommended that the investigator clarify or correct the type of search departmental staff had conducted.

The OIG provided the recommendations to the investigator on November 15, 2022, one business day after the investigator completed the draft inquiry report. However, the investigator waited 11 business days to respond to the OIG, stating, “I submitted the complaint [draft inquiry report] to [the] Office of Internal Affairs’ Allegation Investigation Unit [manager] without your recommendations and it was approved.”

The OIG’s review of the department’s tracking system¹⁷ confirmed that the investigator had submitted the draft inquiry report to the Office of Internal Affairs’ Allegation Investigation Unit manager on November 15, 2022, and the Office of Internal Affairs’ Allegation Investigation Unit manager had approved the report and deemed the inquiry adequate on the same date. The Office of Internal Affairs’ Allegation Investigation Unit manager failed to independently identify the deficiencies the OIG found.

17. The department’s Allegation Against Staff Tracking System (AASTS) includes a change log display that documents each processing step, such as the date of assignment to an investigator, date the draft report is submitted to the Allegation Investigation Unit manager, and date the final report is submitted to the warden.

Overview of Monitoring of Office of Internal Affairs' Allegation Inquiry Management Section Inquiry Cases

The department activated the Allegation Inquiry Management Section in 2020. It established this section to conduct inquiries into staff misconduct allegations which hiring authorities had determined that, if true, were likely to result in adverse disciplinary action, but for which reasonable belief did not exist. However, even with the establishment of this new section, most allegations of staff misconduct were still reviewed by locally designated investigators under the previously existing process.

Effective March 1, 2023, the department no longer routes staff misconduct complaints to the Allegation Inquiry Management Section. However, the OIG monitored 19 Allegation Inquiry Management Section cases that were assigned prior to the May 31, 2022, start date of the present local inquiry process. Those cases included steps similar to the prevailing local inquiry process, and our findings parallel those identified for local inquiries. Therefore, while we make no recommendations regarding the prior Allegation Inquiry Management Section process, to highlight the similarity of findings, certain cases and issues merit mention, as identified below.

For each of the Office of Internal Affairs' Allegation Inquiry Management Section cases we monitored, we assessed the performance of departmental staff and provided an overall rating. The OIG assessed the department's overall performance as *poor* in nine of the 19 cases, or 47 percent, and *satisfactory* in 10 cases, or 53 percent. We did not assign any cases a *superior* rating. The ratings were based primarily on whether the Allegation Inquiry Management Section investigator appropriately conducted an inquiry of the allegations of staff misconduct. The OIG reviewed documentary evidence, photographs, audio and video recordings, body-worn camera recordings, and final inquiry reports in connection with these monitored cases.

During this review, the OIG observed investigators who did not conduct all relevant interviews and used improper interview techniques. Investigators also failed to obtain available evidence, resulting in deficient inquiries. This led to investigators submitting inadequate final inquiry reports to wardens for final determinations that did not include all relevant facts, evidence, or supporting exhibits.

In one example, two officers allegedly did not provide an incarcerated person with his prescribed medication and meals. One of the officers allegedly said, "Your [sic] on a diet now." Later, the first two officers along with additional officers and sergeants allegedly rushed into the incarcerated person's cell for an emergency cell entry. One of the sergeants allegedly deployed pepper spray, and one of the additional

officers allegedly slammed the incarcerated person into the back of the cell. Two additional officers escorted the incarcerated person to the shower, and they allegedly slammed the incarcerated person's head into a wall.

One of the two additional officers allegedly turned on hot water to decontaminate the incarcerated person from the pepper spray. A few hours later, other officers allegedly called the incarcerated person a derogatory name and handled him roughly while he was being treated by medical personnel for a seizure. The investigator identified multiple allegations as well as multiple subjects. However, the investigator only conducted one subject interview.

The subject failed to identify and address all the allegations included in the staff misconduct complaint during the inquiry. The investigator failed to follow departmental policies and procedures regarding the controlled use of force and pepper-spray decontamination. The investigator did not interview the other seven subject officers and sergeants involved in the incident. Finally, the investigator omitted from the inquiry report the subject's acknowledgment for one of the allegations, when the subject stated, "I probably shouldn't have said it, but I told him you're on a diet today, you can eat again tomorrow if you follow procedure." Furthermore, the investigator did not obtain evidence to support or refute each allegation. Thus, the hiring authority did not have all available facts to make an appropriate determination regarding each allegation. Despite the deficiencies in the inquiry, the hiring authority determined that the inquiry proved the alleged misconduct had not occurred.

In another inquiry, an officer allegedly grabbed an incarcerated person's neck and strangled him until he almost lost consciousness. The investigator did not begin interviews until four months and one day had passed from the initial assignment by the Centralized Screening Team. The investigator failed to identify a subject regarding this allegation based on evidence collected during the inquiry.

Furthermore, the investigator did not identify the department's policy regarding an officer's use of a physical restraint that prevents a person from swallowing or breathing.¹⁸

18. DOM Section 51020.5, Use of Force Options states, in part, that a choke hold or any other physical restraint which prevents the person from swallowing or breathing shall not be used unless the use of deadly force will be authorized.

The incarcerated person’s complaint form stated that while in the “[medical] treatment room,” an unnamed officer grabbed the incarcerated person’s neck “until I [incarcerated person] almost passed out” (see Exhibit 5, following page). The investigator interviewed the medical staff member who stated she did not witness the incarcerated person being strangled. The investigator provided a collection of photographs to the medical staff member who authored the medical report. The photographs included custody staff assigned to the treatment room during the date and time of the alleged incident. However, the medical staff member stated she could not remember who the officer was even though an officer’s name was included in the medical report she had authored (and the same officer’s photo was included on the photograph sheet). The investigator included an unredacted medical report as an exhibit in the final inquiry report the investigator submitted to the warden (see Exhibit 6, following page). Because the investigator failed to identify a subject for this inquiry and did not interview the officer identified in the medical report, the inquiry was incomplete. Yet the warden inappropriately determined the inquiry was sufficient. The warden should have returned the inquiry to the investigator to recommend he interview the officer cited in the medical report.

Exhibit 5. Excerpt From an Incarcerated Person's Complaint

A. Continuation of CDCR 602, Section A only (Explain your issue) WHAT THEY WOULD LIKE
AND AM ABLE TO IDENTIFY THEM IF I SEE THEM
AGAIN- WHILE IN THE TREATMENT ROOM BEING TALKED
TO BY MEDICAL- ONE OF THE UNNAMED CORR.
OFFICERS GRABBED ME BY THE THROAT AND BEGAN
TO CHOKER ME, I BEGAN TO STRUGGLE, BECAUSE
THE C/O HAD BOTH HANDS AROUND MY NECK AND I
COULDN'T BREATHE. THE UNNAMED C/O CHOKED ME
UNTIL I ALMOST PASSED OUT
THIS WAS AN UNPROVOKED ATTACK AGAINST ME
I HAD COMMITTED NO MISCONDUCT, NO ATTEMPTS TO
ASSAULT ANYONE.
END OF STATEMENT

Source: The California Department of Corrections and Rehabilitation.

Exhibit 6. Excerpt From an Incarcerated Person's Medical Report

Immediately upon entering the exam room, patient became belligerent and confrontational, arguing and threatening staff. RN [REDACTED] was present during the entire encounter, as well as Custody Officer [REDACTED].

Patient reportedly broke a window with his cane and was fighting with officers. As such, his cane was discontinued. Patient was aggressively demanding his cane reordered. Patient also demanded his orthotic shoes were reordered. When asked why he needed these shoes, patient could not provide a specific medical reason.

Nothing could be found in the chart. Patient was yelling and swearing and became increasingly loud and threatening to myself and others. **As result, for staff safety, the appointment was discontinued.** [REDACTED]

Source: The California Department of Corrections and Rehabilitation.



Investigation Cases Monitoring Results

Investigation Case Monitoring Results

Overview of Investigation Case Monitoring

Overall, the Department's Performance Was *Poor* in Its Investigations and Processing of Staff Misconduct Allegations

From January 1, 2022, through December 31, 2022, the Centralized Screening Team identified and routed a total of 10,589 allegations of staff misconduct to the Office of Internal Affairs for inquiry or investigation. On May 31, 2022, the department's Office of Internal Affairs' Allegation Investigation Unit began investigating allegations of staff misconduct involving incarcerated people and parolees.

From May 31, 2022, through December 31, 2022, the Office of Internal Affairs' Allegation Investigation Unit received and investigated a total of 1,835 complaints. The OIG monitored and closed 10 of the total investigation cases that the department completed. The types of allegations included excessive use of force, dishonesty, retaliation, neglect of duty, and discrimination. Table 6 (below, right) shows the distribution of the allegation type for these 10 cases. Overall, the department's performance was *poor* in its investigation and processing of these allegations. The OIG rated the department's overall performance *poor* in seven cases and *satisfactory* in three cases. In no cases did the department receive a *superior* rating.

Of the 10 cases the OIG monitored and closed in 2022, the overall performance of investigators was *poor* in seven cases and *satisfactory* in three cases. In no cases did investigators receive a *superior* rating. Negative ratings stemmed from investigators' failure to thoroughly investigate, failure to adequately communicate with stakeholders, failure to ensure confidentiality during remote interviews, and in one case, a failure to preserve video evidence.

Of the 10 cases the OIG monitored and closed in 2022, the department attorneys' performance was *poor* in six cases and *satisfactory* in four cases. In no case did a department attorney receive a *superior* rating. Negative ratings stemmed from a failure to make proper recommendations to the assigned investigator and hiring authority regarding a sufficient investigation, timely preservation of evidence, and providing notice to officers.

Of the 10 cases the OIG monitored and closed in 2022, the performance of hiring authorities was *poor* in five cases and *satisfactory* in the remaining five cases. In no case did a hiring authority receive a *superior* rating. Negative ratings stemmed from hiring authorities' findings that no staff misconduct had occurred when investigators conducted insufficient investigations or when hiring authorities delayed in providing proper notice to staff accused of misconduct at the close of investigations.

Table 6. The 10 Cases the Department Monitored From May 31, 2022, Through December 31, 2022

Allegation Type	Number of Cases
Excessive Use of Force	4
Dishonesty	2
Retaliation	2
Neglect of Duty	1
Discrimination	1
Total	10

Source: The Office of the Inspector General Tracking and Reporting System.

The Office of Internal Affairs' Allegation Investigation Unit Failed to Conduct Necessary Interviews, Resulting in Insufficient Investigations; This Failure Led to Department Attorneys Making Improper Recommendations and Hiring Authorities Making Inappropriate Disciplinary Findings

Our monitoring revealed that the quality of the Office of Internal Affairs' Allegation Investigation Unit investigators' work in conducting investigations was *poor* in three of the 10 monitored cases because investigators failed to conduct any interviews of 1) the incarcerated person who had submitted the staff misconduct complaint, 2) any involved staff, and 3) any witnesses. This wholesale lack of interviews resulted in incomplete investigations.

In two of the three cases, department attorneys inappropriately recommended to both the Office of Internal Affairs' Allegation Investigation Unit and hiring authorities that the investigations were sufficient, despite investigators' failure to conduct any interviews whatsoever.

The hiring authority is responsible for reviewing investigation reports and associated evidence, and determining the following:

- whether the investigation is sufficient,
- whether the allegations of staff misconduct are founded, and
- the appropriate discipline for any allegation of staff misconduct that is sustained.

In all three cases in which the investigator did not conduct any interviews, the hiring authority nonetheless determined the investigations were sufficient and then made a finding of insufficient evidence to sustain any of the allegations of staff misconduct.

The importance of conducting interviews goes beyond obtaining details regarding the alleged claim of staff misconduct. Witness testimony can assist in proving or disproving facts, providing unknown details regarding an allegation, or revealing additional allegations that had heretofore been unknown. An investigator who fails to conduct all appropriate interviews reduces the amount of pertinent information the investigation could include, thereby rendering the investigation incomplete.

In its April 8, 2022, written notice proposing the adoption of regulations governing allegations of staff misconduct against an incarcerated person or parolee, the department committed that its staff misconduct regulations would establish the Office of Internal Affairs' Allegation Investigation Unit to conduct investigations into allegations of staff misconduct referred by the department's Office of Internal Affairs' Centralized Screening Team. The department further committed to conduct full investigations into staff misconduct that had been directed toward incarcerated people and parolees as set forth in the Allegation

Decision Index. The department's regulations require that investigators conduct thorough investigations and ensure that all relevant evidence is gathered and reviewed, and necessary interviews are conducted.¹⁹

Despite the department's regulations requiring full and thorough investigations, the Office of Internal Affairs' Allegation Investigation Unit takes the position that investigators are not required to conduct interviews as a necessary investigative step in every case. On August 3, 2022, the department's Office of Internal Affairs' Allegation Investigation Unit issued a memorandum with an accompanying report template called the "Investigative Report With No Evidence of Misconduct," also referred to as a *video quick-close report*. Investigators can use this template when evidence exists that clearly refutes the allegations of staff misconduct and justifies terminating any further investigative efforts.²⁰ The Office of Internal Affairs' Allegation Investigation Unit has used this memorandum and report template to justify some of its decisions not to conduct any investigative interviews when its review and assessment of other evidence—particularly video evidence—leads it to conclude that the allegations have been refuted.

The department's position that investigations can be closed and deemed sufficient without its staff conducting a single interview to collect evidence is flawed for several reasons. First, although video evidence is a useful source of evidence, its existence does not render interviews unnecessary. Video evidence submitted to the department's Office of Internal Affairs' Allegation Investigation Unit does not always provide a complete account of what happened during an incident of alleged staff misconduct. Interviews are critical to provide context and detail that cannot be ascertained from a review of video evidence alone.

Second, the department has provided conflicting information to its investigators regarding the use of the video quick-close report template. On October 6, 2022, the department's Division of Adult Institutions deputy director provided direction that locally designated investigators are not permitted to complete inquiries without conducting interviews:

Local [sic] Designated Investigators (LDIs) are not authorized to complete inquiry with the same methodology used by [the Allegation Investigation Unit] for the quick closure reports. LDIs are expected to complete thorough, unbiased and complete inquiries.²¹

The Office of Internal Affairs' Allegation Investigation Unit is tasked with investigating the most serious allegations of staff misconduct

19. Title 15, CCR section 3486.2 (b) (3) (A) states, in part: "(b) AIU Staff Misconduct Investigations. . . . (3) Completion of Investigations. (A) AIU investigators shall conduct thorough investigations, and ensure all relevant evidence is gathered and reviewed, and necessary interviews are conducted."

20. Memorandum by the Office of Internal Affairs' Allegation Investigation Unit Chief, dated August 3, 2022.

21. Email from a deputy director to all hiring authorities dated October 6, 2022.

directed toward incarcerated people and parolees, as described in the Allegation Decision Index,²² while staff misconduct allegations not on the Allegation Decision Index are assigned to locally designated investigators. Despite the mission of the Office of Internal Affairs' Allegation Investigation Unit to investigate the most serious allegations of staff misconduct directed toward incarcerated people and parolees, it appears the unit's staff have set an investigative standard lower than that used by locally designated investigators.

Third, an investigation that relies solely on video evidence is arguably not an investigation at all. The hiring authority is tasked with independently reviewing video evidence, documents, interview recordings, and any other evidence collected during the investigation when preparing for the findings and penalty conference. When the department's Office of Internal Affairs' Allegation Investigation Unit submits investigation reports that include only a review of video evidence—which the hiring authority is also obligated to independently review—the Office of Internal Affairs' Allegation Investigation Unit does not provide the hiring authority with any substantive investigatory information and fails to fulfill the important objective of providing thorough and complete investigative reports to the hiring authority.

Fourth, additional systemwide factors support the belief that an investigation which does not include any interviews is not a sufficient investigation. Incarcerated people should be provided with the opportunity to be heard about their complaint and to provide additional details that may not be communicated well through the medium of a written staff misconduct complaint. Many incarcerated people cannot adequately describe their issues on a written complaint form due to educational level, disability, or a lack of proficiency in communicating their staff misconduct complaint via the written word.

Incarcerated people and others who submit staff misconduct complaints should, therefore, be afforded the opportunity to be heard, which also can include providing the following:

- additional details gathered or recalled after the staff misconduct complaint is initially submitted,
- clarification about the staff misconduct complaint, or additional witnesses who may have information relevant to the investigation.

In addition, details about an allegation of staff misconduct may not have been captured clearly on video recordings—if at all. The incarcerated person should be afforded the opportunity to explain this supporting information. The overarching importance of providing due process and fulfilling the department's commitment to conducting full investigations

22. The department's Allegation Decision Index includes serious allegations of misconduct including, but not limited to, use of force, staff sexual misconduct, dishonesty, discrimination or harassment, retaliation, code of silence, and integrity.

supports the OIG's position that interviews are a necessary component to a sufficient investigation.

Fifth, is the Office of Internal Affairs a higher authority than the hiring authority? The use of a video quick-close report by an investigator usurps the role of the hiring authority to determine whether staff misconduct occurred. This type of abbreviated report provides a conclusion that no staff misconduct occurred; however, only a hiring authority can reach such a conclusion.

In all three cases in which no interviews were conducted, the hiring authority inappropriately determined the investigations were sufficient and then made findings to not sustain any of the allegations based on the insufficient investigations.

One case in which we rated the hiring authority's decision *poor* involved two officers who allegedly entered a holding cell prior to an unclothed body search of an incarcerated person and punched the naked incarcerated person. The Office of Internal Affairs' Allegation Investigation Unit concluded its investigation by relying on the video evidence and written reports, without having conducted any interviews. The video evidence did not show every possible view of the entire incident; therefore, it is possible that an officer struck the incarcerated person. We know this because one of the involved officers documented in his written report that the other involved officer whom the incarcerated person punched during the incident stated that a punch had taken place, even though the video did not capture it. The hiring authority accepted the assertion that the officer did not commit misconduct because the video did not show that the officer punched the incarcerated person. At the same time, the hiring authority relied on the officer's statement that the incarcerated person had punched him—despite having no video evidence showing it. The investigator left these evidentiary issues unresolved by failing to conduct any interviews. Even though the investigation was incomplete, the hiring authority determined it was sufficient and found insufficient evidence to sustain the allegations.

It is unclear how widespread the Office of Internal Affairs' use of the video quick-close report process was in 2022. Our staff observed its use in three of 10 closed investigations, and we also asked the Office of Internal Affairs Allegation Investigation Unit's executive leadership how many video quick-close reports were completed in 2022, especially for use-of-force allegations. The response from the department was that such information is not tracked and, thus, is unknown.

Department Attorneys Inappropriately Advised Hiring Authorities That Investigations Were Sufficient for Cases in Which No Interviews Were Conducted

Department attorneys are tasked with providing legal consultation to the assigned investigator and to the hiring authority for all designated cases, including consultation about whether an investigation is sufficient.

However, in the three cases we reviewed in which no interviews were conducted, the department attorney provided inappropriate legal advice to the hiring authority and recommended that the hiring authority find the investigations sufficient and that the allegations of staff misconduct not be sustained, even though the investigator had not interviewed any witnesses. The OIG deems this legal advice to be *poor*.

In one case we monitored, a sergeant allegedly ordered four officers to attack an incarcerated person after the incarcerated person had refused to be handcuffed and escorted to a cell. The sergeant and four officers allegedly slammed the incarcerated person to the ground, causing him to suffer a chipped tooth, abrasions, and contusions. One of the officers allegedly attempted to strangle the incarcerated person while he was on the ground, thereby causing him to suffer a seizure. To close the investigation, the Office of Internal Affairs' Allegation Investigation Unit investigator and manager both relied on written reports authored by the involved staff along with video evidence that did not provide a complete view of the entire incident. Moreover, the investigator did not conduct any interviews of the incarcerated person, the officers, or the sergeant.

The investigator's failure to conduct interviews resulted in an incomplete investigation because the Office of Internal Affairs' Allegation Investigation Unit failed to obtain relevant evidence regarding injuries sustained by the incarcerated person and the officers, failed to address a possible inconsistent statement made by one of the officers, and failed to identify and address in the investigative report that one of the officer's body-worn cameras was missing three minutes of recording, which included the alleged strangling. In addition, much of the video evidence was visually blacked out and did not clearly show the amount of force used. The video evidence thus left questions unanswered and evidentiary issues unresolved. To close these evidentiary gaps and complete a thorough investigation, the Office of Internal Affairs' Allegation Investigation Unit should have conducted interviews of the incarcerated person who had submitted the staff misconduct complaint, along with interviews of the sergeant and the officers who allegedly had used excessive force. However, the Office of Internal Affairs' Allegation Investigation Unit incorrectly determined the video evidence provided sufficient evidence that the allegations made by the incarcerated person did not happen and also, that the investigation was sufficient without a single interview having been conducted.

Photo 1 on the following page is an image taken from the sergeant's body-worn camera during much of the use-of-force incident. It is similar to scenes that the other officers' video recordings depict during the actual use of force. Despite the lack of any discernible detail or activity seen in it, the investigator asked no questions of any witnesses and instead relied on only this record of video recordings to determine that no misconduct occurred. The department attorney not only agreed with the investigator's assessment, but also recommended that the hiring authority find the investigation sufficient.

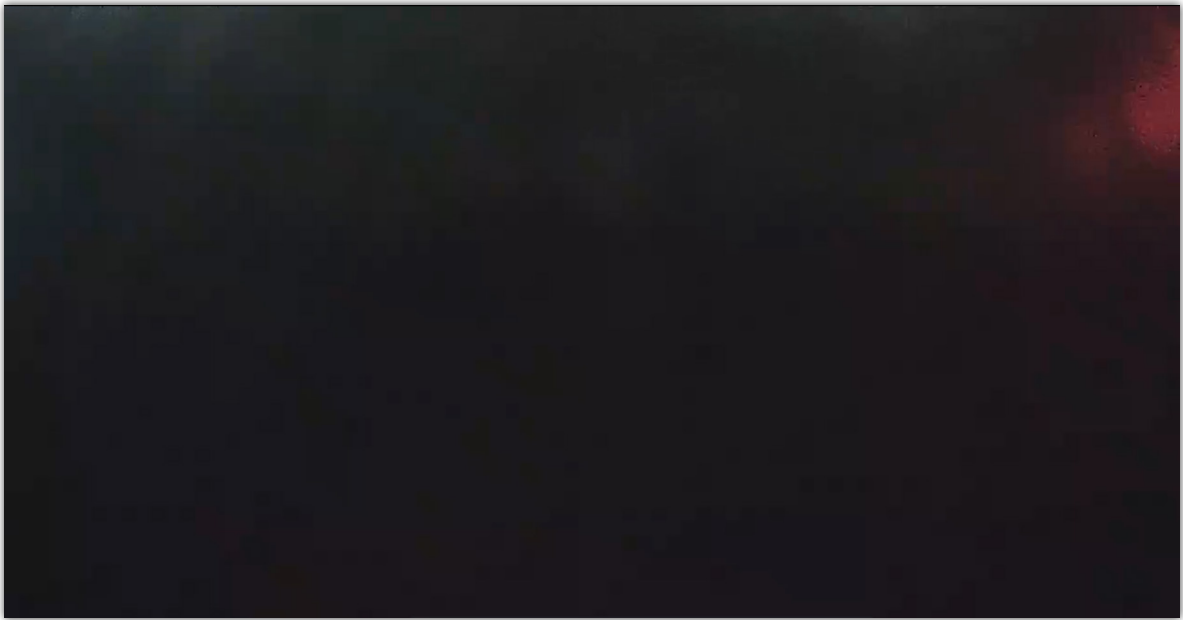


Photo 1. A sergeant's body-worn camera still photo image.

Source: The California Department of Corrections and Rehabilitation.

For the same scene, another officer's body-worn camera video captured the scene depicted in Photo 2 below, in which another officer had his arm on top of the incarcerated person's neck. The incarcerated person complained that he could not breathe during the incident.

The camera of the officer who had his arm on the incarcerated person's neck had no video recordings of this moment, above; his body-worn camera recording was missing three minutes of activity that occurred during the incident. Nevertheless, the investigator did not interview the officer who had put his arm on the incarcerated person's neck and concluded there was no evidence of staff misconduct. The department



Photo 2. A sergeant's body-worn camera still photo image.

Source: The California Department of Corrections and Rehabilitation.

attorney not only agreed with the investigator's assessment, but recommended that the hiring authority find no staff misconduct had occurred.

Compromised Confidentiality Continued to Be a Problem for Department Investigators: In Three Investigations, Investigators Did Not Take Adequate Measures to Ensure Confidentiality

The OIG has previously reported on the issue of departmental staff keeping internal affairs' inquiries and investigations of allegations of staff misconduct confidential. Compromised confidentiality can lead to retaliation directed toward the complaining incarcerated person by staff or other incarcerated people. Our recently published reports discuss this situation: the first was published in 2019, and is titled *Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct*;²³ the second, in 2021, is our *Special Report: The California Department of Corrections and Rehabilitation's Processing of Disabled Incarcerated Persons' Staff Misconduct Allegations at the Richard J. Donovan Correctional Facility*.²⁴

All internal investigations into alleged staff misconduct are confidential. Investigators are trained to keep the interviews confidential. Investigators advise witnesses they must keep information disclosed during interviews confidential. It is a misdemeanor²⁵ for an investigator to improperly disclose confidential information related to an internal investigation. However, in three of the 10 OIG- monitored cases, investigators did not take adequate measures to ensure confidentiality.

In one case, during an interview on August 12, 2022, of a counselor accused of falsifying a record, the OIG appeared in person while the Office of Internal Affairs investigator and department attorney both appeared remotely from home offices via Microsoft Teams. When the interview of the counselor began, the investigator and the department attorney were unaware that an office technician had not closed the interview room door, having been ordered by a lieutenant at the prison to keep the door open during the interview while the office technician remained outside the interview room and could hear everything being said. The counselor appeared without a representative and had never been the subject of an administrative investigation before, and therefore did not know this activity could be a problem. The OIG advised the investigator of the issue. The investigator then spoke to the office technician who still would not close the door because he had

23. See page 61, titled, "Staff Frequently Compromised the Confidentiality of the Staff Complaint Inquiry Process." The OIG published the report on January 6, 2019.

24. See page 22, titled, "The Investigators Compromised the Confidentiality of Some Cases." The OIG published this report on March 1, 2022.

25. California Penal Code, section 11142, states: "Any person authorized by law to receive a record or information obtained from a record who knowingly furnishes the record or information to a person who is not authorized by law to receive the record or information is guilty of a misdemeanor."

been ordered by a lieutenant to keep it open. The investigator phoned a different lieutenant at the prison, and an officer from the prison's Investigative Services Unit then came to the interview room and closed the door. The office technician was not authorized to be privy to the confidential interview of the counselor conducted by the Office of Internal Affairs. If the OIG had not been present, the investigator (and the department attorney) may not have discovered that the setting for this interview initially lacked confidentiality.

In a second case, during an interview with the incarcerated person on July 26, 2022, the investigator did not provide an admonishment regarding confidentiality to the incarcerated person prior to a break in the interview. The incarcerated person then spoke about the content of his interview with an officer outside the interview room during the break. That officer was a potential witness to the underlying allegation of staff misconduct. The incarcerated person alleged retaliation by a sergeant, and the officer who was a potential witness also worked for the sergeant. The investigator was not present, appearing on screen remotely via Microsoft Teams while the OIG appeared in person at the prison.

In a third case, officers allegedly denied an incarcerated person access to mental health assistance when the incarcerated person began to have suicidal thoughts. During the only interview conducted by the Office of Internal Affairs' Allegation Investigation Unit on July 25, 2022, the investigator did not seem to have adequate control of the interview setting to ensure that the interview room would remain confidential and free of distractions. The investigator and the department attorney were not present, appearing on screen remotely from home offices via Microsoft Teams while the incarcerated person appeared on screen from a program office at the prison. The investigator allowed the interview room door to remain ajar, and officers could be heard talking and laughing outside the interview room. In addition, the investigator conducted the interview while a copy machine located inside the interview room noisily operated, printing output on four separate occasions. The incarcerated person's statements could presumably be heard by the officers outside the door to the interview room, thereby compromising the interview's confidentiality. The OIG did not appear in person for this case but made the noted observations via Microsoft Teams.

In Two Cases, the Hiring Authority Delayed Providing Notice to Two Officers and a Sergeant That the Office of Internal Affairs Had Conducted an Investigation Concerning Them and Informing Them of the Findings the Hiring Authority Had Made

Once an internal affairs investigation is complete, the department is required to notify staff of both the investigation and the hiring authority's decision based on the investigation. Department Operations Manual, Section 33030.13.2, states the following:

Upon conclusion of each internal affairs investigation, the ERO/Disciplinary Officer shall transmit an “Internal Affairs Investigation Closure” memorandum to each subject of an investigation. The closure memorandum shall be signed by the Hiring Authority, shall outline the findings for each specific allegation. . . . The ERO/Disciplinary Officer shall forward the original closure memorandum to the subject of the investigation. . . .

In one case we monitored involving allegations of staff misconduct against two officers, the hiring authority initially refused to provide the officers notice per the above policy once the investigation closed.

On September 26, 2022, at the conclusion of the investigative and disciplinary findings conference, the hiring authority refused to provide notice to two officers regarding the internal affairs investigation of allegations of staff misconduct against them, and inform them of the hiring authority’s decisions concerning those allegations. Although we recommended that the hiring authority provide both officers with notice, the department attorney offered no recommendation concerning this issue for the hiring authority at the conference. On September 29, 2022, we sought a higher review from the hiring authority’s supervisor, and the supervisor agreed with our assessment. The department attorney also agreed once we had sought a higher review. On October 14, 2022, 18 days after the investigative and disciplinary findings conference—but only after we had elevated the matter to the hiring authority’s supervisor—the hiring authority provided notice to the officers (see Exhibit 7).

Exhibit 7. Excerpt from Email Correspondence Between the OIG and the Department

Subject: RE: [REDACTED]

Date: Thursday, September 29, 2022 at 8:36:18 AM Pacific Daylight Time

From: [REDACTED]@CDCR

To: [REDACTED]

CC: [REDACTED]@CDCR, [REDACTED]

Attachments: image002.gif

CAUTION: This email originated from outside of the OIG. Do not click any links or open any attachments unless you recognize the sender and know the content is safe.

Good Morning [REDACTED]

I did confer with [REDACTED] on this matter. Our position is that if the subject(s) are not interviewed or even notified at any point that they are under investigation, we will treat the case as we do a direct adverse action. Subjects do not receive a closure memo for direct adverse action cases.

We will note OIG’s position. Thank you.

Source: The California Department of Corrections and Rehabilitation.

In another case involving an allegation of retaliation by a sergeant, the investigation concluded during an investigative and disciplinary findings conference on September 27, 2022. The OIG requested, per departmental policy, that the hiring authority provide a closure memorandum to the sergeant, which would apprise the sergeant that an internal affairs investigation had been conducted naming the sergeant as the subject of a complaint of staff misconduct and that the sergeant would receive notice of the final determination by the hiring authority concerning the allegation. Initially, the employee relations officer stated that the closure letter would be filed by the department, but not provided to the sergeant. At our recommendation, and that of the department attorney, the employee relations officer agreed to provide notice to the sergeant. The employee relations officer provided a copy of the closure letter to the OIG on December 2, 2022, but did not include proof of service to the sergeant. We requested proof of service from the employee relations officer on December 5, 2022, and the department then served the sergeant with a copy of the closure letter the same day, 69 days after the initial investigative and disciplinary findings conference (see Exhibit 8).

Exhibit 8. Allegation Investigation Unit Closure Letter

State of California	Department of Corrections and Rehabilitation
Memorandum	
Date:	September 29, 2022
To:	[REDACTED]
Subject:	ALLEGATION INVESTIGATION UNIT CLOSURE ([REDACTED])
<p>I have reviewed the Allegation Investigation Unit report for [REDACTED], wherein allegations of misconduct were reviewed. Based on this review of the allegations, my findings are as follows:</p>	
<u>Allegation 1:</u>	It is alleged that on or about May 1, 2022, you retaliated against inmate [REDACTED], for filing a 602 in February 2022, by threatening to effectively take away his phone privileges.
Finding:	Not Sustained
<p>This investigation is closed. If you have any questions please contact [REDACTED] Disciplinary Officer, at [REDACTED].</p> <p>[REDACTED]</p>	
cc:	ERO [REDACTED]

Source: The California Department of Corrections and Rehabilitation.



Body-Worn Cameras & Video Recordings

Our Review of the Department's Use and Retention of Body-Worn Camera and Video Recordings

Departmental Policy Is Inadequate Regarding the Preservation of Body-Worn Camera Recordings, Which Leads to Video Evidence Being Prematurely Destroyed, Thus Making It Unavailable for Review During Inquiries and Investigations

The department's implementation of body-worn cameras (BWC) and audio-video surveillance systems (AVSS) is critical in providing video evidence to substantiate or refute allegations of staff misconduct. Specifically, on March 11, 2021, a United States District Court ordered the department to implement remedial measures to achieve compliance with the *Armstrong* Remedial Plan and the Americans with Disabilities Act (ADA) at five California State prisons.²⁶ To assist with complying with the *Armstrong* Remedial Plan, the court ordered the implementation of video surveillance cameras and body-worn cameras at all five prisons. As part of the court order, the remedial plan mandated that the department draft policies and procedures regarding camera use and the retention period for video recordings secured through cameras. Previously, on September 8, 2020, a United States District Court ordered substantially similar remedial measures at the Richard J. Donovan Correctional Facility (RJD).

Our monitoring at these six prisons disclosed that investigators failed to collect recordings from body-worn cameras and video recordings during several local inquiries and investigations. Given the court's order, such failure is problematic not only for the adequacy and integrity of inquiries and investigations, but also for the department's compliance with the court's order.

In reviewing inquiries and investigations for which investigators did not obtain body-worn camera images and video recordings because they had already been purged, it became apparent that departmental policies contributed to the issue. Allegations of staff misconduct made by an incarcerated person are included as one of 10 "triggering events"²⁷ that require video evidence be retained beyond 90 days. But departmental

26. The five prisons' remedial plan was initiated at the following prisons: California Institution for Women (CIW); California State Prison, Corcoran (COR); Kern Valley State Prison (KVSP); California State Prison, Los Angeles County (LAC); and Substance Abuse Treatment Facility and State Prison, Corcoran (SATF).

27. The department classifies a "triggering event" to include, in part, any use-of-force incident; any incidents resulting in serious bodily injury, great bodily injury, and all deaths; all Prison Rape Elimination Act (PREA); and allegations of staff misconduct by an incarcerated person, employee, visitor, or other person (DOM, Section 47040.8, AVSS Retention Triggers).

staff were not always able to “preserve the recorded data as potential evidence in an inquiry, investigation, and/or an administrative, civil, or criminal proceeding”²⁸ for cases we monitored. Currently, video and audio evidence are downloaded and retained for 90 days. The 90-day retention period has not been sufficient to allow investigators to obtain all relevant video evidence for an inquiry and investigation.

28. All camera and audio recordings that may become evidence in an administrative, civil or criminal proceeding shall be stored indefinitely, unless other direction is provided (DOM, section 47040.9(c), Preserving Recorded Data).

Departmental Policy Requiring a 90-Day Retention Period for Video-Recording Preservation May Not Be Allowing Sufficient Time for Investigators to Request, Review, and Appropriately Preserve All Relevant Video Evidence Related to Staff Complaint Inquiries and Investigations

The Office of Internal Affairs' Centralized Screening Team (CST) reviews all complaints incarcerated people and parolees submit to the department and determines whether a complaint includes one or more allegations of staff misconduct. If the Centralized Screening Team determines an allegation is included on the Allegation Decision Index (ADI), the Centralized Screening Team refers the allegation to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. If an allegation is not on the ADI, the Centralized Screening Team refers the allegation to the hiring authority for a locally designated investigator to conduct a local inquiry. Every Centralized Screening Team referral for an investigation or local inquiry at one of the six prisons with an *Armstrong* remedial plan requires the following:

Body-worn camera footage will be downloaded and retained in an appropriate data server at the conclusion of every shift. All footage shall be retained for a minimum of 90 days. All camera and audio footage of . . . triggering events . . . shall be retained for five years.

As a result, unless an investigator submits a specific request for video recordings within the 90-day retention period, including triggering events, the department automatically deletes video evidence after 90 days.

In its monitored cases, the OIG identified delays in the department assigning and starting inquiries and investigations, and in requesting pertinent video recordings and in processing video requests by Investigation Services Unit staff. In other instances, the alleged incident took place months before the complaint was filed, and the retention period had lapsed. All these issues are contributing factors to the department's deleting video evidence. However, given that delays like these inevitably occur, the 90-day retention period unnecessarily results in the destruction of critical video- and audio-recorded evidence, incomplete inquiries and investigations, and potentially erroneous hiring-authority decisions regarding staff misconduct.

For example, in one monitored investigation, an incarcerated person alleged that on July 14, 2022, a sergeant provoked the incarcerated person to hurt himself after he had filed a grievance on the previous day. The incarcerated person alleged the sergeant said, "Don't hurt yourself," as

he walked by, and an officer laughed at the statement. The incarcerated person claimed a second officer talked about funerals, visiting the incarcerated person's nephew in spirit, and the incarcerated person's children being taken away. The incarcerated person also alleged that a third officer retaliated against the incarcerated person for filing a complaint the previous day, and the third officer took the incarcerated person's coffee cup out of his hand and threw the coffee.

The incident occurred on July 14, 2022, and in this case, the departmental policy is to retain video evidence for 90 days, or until October 12, 2022. On August 4, 2022, the Office of Internal Affairs' Allegation Investigation Unit manager assigned the first investigator to investigate the incident, only 21 days after the incident. However, the first investigator did not request that the prison preserve the video evidence. On September 21, 2022, an Office of Internal Affairs' Allegation Investigation Unit manager reassigned a second investigator 69 days after the incident. Although 21 days had elapsed before the video was set to expire, the second investigator also did not request that the prison preserve the video. On November 17, 2022, the Office of Internal Affairs' Allegation Investigation Unit then reassigned the investigation to a third investigator, 126 days after the incident and 36 days after the 90-day expiration date, on October 12, 2022.

Even though the 90-day expiration date had already elapsed, on December 2, 2022, the third investigator attempted to obtain the video recording from the prison. An officer at the prison denied the request because the investigator asked for more than one hour of video recording. On December 12, 2022, the hiring authority directed the investigator to interview the incarcerated person to narrow the time frame for the amount of video recording requested. On December 15, 2022, the investigator interviewed the incarcerated person and then submitted a renewed request for the video recording, this time with a shorter time frame. On December 16, 2022, an officer denied the third investigator's second request for the video because the request arrived more than 90 days after the incident.

In another case, on April 8, 2022, an officer allegedly reported that an incarcerated person refused to sign a compatibility agreement form. However, the incarcerated person stated that he was unable to sign the form because he could not see due to having been pepper sprayed on his face. The incarcerated person stated the officer's body-worn camera video would confirm that the incarcerated person had not refused to sign the compatibility agreement form. The departmental policy of keeping video recordings for 90 days allowed for an investigator to request that the recording be preserved until July 7, 2022.

On June 13, 2022, the Office of Internal Affairs' Centralized Screening Team assigned the staff misconduct complaint to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. On June 17, 2022, the Office of Internal Affairs' Allegation Investigation Unit assigned an investigator to the case. On June 20, 2022, the OIG contacted

the investigator to request case materials and to schedule an initial case conference. The investigator did not respond to the OIG, and 15 days later, on July 5, 2022, the OIG again contacted the investigator. On July 5, 2022, the investigator responded to the OIG. He stated he would review the case the next day and provide an update, but he did not. The investigator did not respond to the OIG until after the 90-day video retention period had ended, and the relevant video evidence was lost. Moreover, although the Office of Internal Affairs' Centralized Screening Team assigned the investigation on June 13, 2022, the department did not assign a department attorney until July 1, 2022, 15 days after policy requires. The department attorney did not provide a recommendation for the investigation until July 12, 2022, five days after the video recording had expired.

In a third case, a sergeant allegedly ignored an incarcerated person's request to move to another cell after the incarcerated person had mistakenly signed an acknowledgment to share a cell with another incarcerated person on the previous day. When the incarcerated person said they were housed with an incompatible cellmate, the sergeant allegedly laughed at the incarcerated person and told the incarcerated person, who identified as nonbinary and transgender, to "Man up."

The case was assigned to an investigator on September 9, 2022, 45 days after the alleged incident. On October 13, 2022, 34 days after the case assignment, the OIG received and reviewed a copy of the body-worn camera recordings, and video recordings and audio recordings that the investigator had secured. On October 14, 2022, one day later, the OIG advised the investigator to obtain additional body-worn camera recordings of the sergeant and an officer, and audio recordings of the interaction between the sergeant and the incarcerated person. On October 16, 2022, two days after the OIG provided a recommendation, the investigator responded to the OIG, "I feel the footage reviewed coupled with all exhibits and interview that I conducted was sufficient enough to complete this inquiry." On October 20, 2022, four days after the investigator's response, the OIG again recommended that the investigator obtain additional recordings after reviewing the investigator's inquiry report. The investigator again failed to accept the OIG's recommendations. On November 4, 2022, 56 days after the case assignment, the Office of Internal Affairs' Allegation Investigation Unit manager recommended that the investigator obtain additional body-worn camera recordings, video recordings, and audio recordings. On January 10, 2023, 123 days after the case assignment, the investigator notified the OIG that the video evidence had been deleted as more than 90 days had elapsed since the date of the incident. The investigator's failure to accept the OIG's recommendation to timely secure the evidence, along with the department's inability to preserve relevant video evidence for a triggering event (allegation of staff misconduct by an incarcerated person), prevented all available evidence to be reviewed by the OIG, the Office of Internal Affairs' Allegation Investigation Unit manager, and the hiring authority.

The current 90-day retention period is a significant factor in investigators not obtaining and reviewing video evidence, and in the department improperly purging this type of evidence. Factors such as when an incarcerated person or parolee submits a complaint following an alleged incident, how long the complaint screening takes, the availability of investigators, the workload of the Investigative Services Unit, and the availability of witnesses all affect the timing of an investigation or inquiry. Although an investigator may submit a video request within the minimum retention period, given the workload challenges that many Investigative Services Units face, the 90-day period means that if investigators submit requests for video near the end of the retention period, the Investigative Services Unit may not complete such requests before the department purges the recording. Therefore, because video evidence is critical for a thorough and unbiased investigation or inquiry, the current 90-day minimum retention period is too short to ensure that such evidence is consistently available. Accordingly, the department should extend its minimum retention period.

Furthermore, the 90-day minimum retention period may hamper the department's ability to obtain and review all relevant video evidence prior to completing an investigation and imposing disciplinary action. For instance, the OIG monitored 10 investigations, and each took more than 90 days, with an average of 146 days, to be reviewed and approved by a hiring authority (see Table 7, next page). Because the hiring authority reviews supporting documentation, video evidence, and the investigative report, any reviews occurring after the 90-day minimum retention period increase the possibility of the department purging the video. Thus, if the department is unable to ensure, in its current process, that all relevant video evidence is secured within the current 90-day period for every "triggering event," the department should extend the requirement to ensure that sufficient time and resources will be made available to retain necessary evidence. To the extent that the department must complete an investigation and impose disciplinary action within one year of the department's discovery of any alleged act of misconduct by a peace officer,²⁹ it would be reasonable and appropriate that it establish a video-retention policy that parallels the one-year period within which a hiring authority must take disciplinary action.

To provide perspective on what might be an appropriate minimum video-retention period, we contacted correctional managers in other states, whose prison staff also use body-worn cameras. Table 8 on page 54 provides minimum-retention periods used to retain body-worn camera recordings in other correctional settings. Notably, the department's minimum retention period was shorter than the minimum retention periods of other states' correctional agencies.

29. Government Code section 3304 (d) (1) provides that the department cannot impose disciplinary action against a peace officer for any act of misconduct if the investigation of the allegation is not completed within one year of the department's discovery by a person authorized to initiate an investigation of the allegation.

Table 7. Time Period to Complete Staff Misconduct Investigations

OIG Case Number	Incident Date Through Hiring Authority Decision Date (in days)
22-0043603-INV	274
22-0043448-INV	195
22-0043892-INV	152
22-0043450-INV	146
22-0043449-INV	137
22-0043789-INV	128
22-0043889-INV	110
22-0043509-INV	109
22-0043767-INV	105
22-0044120-INV	100
Average Time Period	146

Source: The OIG's tracking and reporting system of monitored investigations.

According to a manager at the Virginia Department of Corrections, the minimum retention period for nonevidentiary video recordings (i.e., recordings not used for investigative purposes) is five years, and the recordings are stored on a cloud database. According to the manager, the Virginia Department of Corrections' body-worn camera policy defines when correctional officers, and other staff must activate their cameras and includes exceptions when officers are prohibited from recording. For instance, activations must occur, in part, when making rounds in housing units, interacting with or managing a disruptive incarcerated person, responding to an incident, and during prison lockdowns or searches. This differs from departmental staff at the six California prisons with *Armstrong* remedial plans, whose body-worn cameras must remain turned on throughout an entire shift. However, the department added body-worn camera requirements in 2023 at four new prisons in which procedures allow for deactivation of body-worn cameras when no incarcerated people are present or when there is no interaction with incarcerated people, such as the following:

- When staff are in the program office, and no incarcerated people are present;
- While in a control booth, and no incarcerated people are present to monitor in the dayroom;

- When staff are walking from the program office to their work site, and no incarcerated people are present; and
- When staff are in their housing unit office, and no incarcerated people are present.

Table 8. State Corrections Agencies Minimum Retention Periods for Body-Worn Camera Recordings

State Corrections Agencies	Minimum Retention Periods
Virginia Department of Corrections	5 years
Georgia Department of Corrections	3 years
New York Department of Corrections and Community Supervision	6 months
Ohio Department of Rehabilitation and Corrections	120 days
California Department of Corrections and Rehabilitation	90 days

Note: The above retention periods are in order of longest to shortest, thereby highlighting the California department's inadequate retention period.

Source: OIG interviews with State Corrections managers in March 2023, and review of body-worn camera operating policies and procedures.

Findings and Recommendations

For each section of the department's staff misconduct review process that we monitored in 2022, we narrowed our findings and submit our recommendations, a portion of which are outlined in Table 9 below.

Table 9. The OIG's Findings and Recommendations

Findings	Recommendations
<i>Centralized Screening Team Decisions</i>	
The department suffers from deficiencies with its electronic tracking system and has failed to reclassify allegations based on its agreement to the OIG's recommendations.	The OIG recommends that the department resolve issues preventing a direct entry into the electronic tracking system and ensure that allegations it agrees to are reclassified.
The department failed to adequately train screening staff on how to interview incarcerated people.	The OIG recommends that the department provide meaningful training to the Centralized Screening Team analysts in how to conduct clarifying interviews.
<i>Local Inquiry Cases</i>	
Investigators failed to use effective interviewing techniques when conducting interviews by not audio recording each interview.	The OIG recommends that locally designated investigators audio record all interviews.
Inadequate planning resulted in investigators' failure to complete all relevant interviews, to gather and review all relevant documentary evidence, and to prepare complete inquiry reports.	The OIG recommends that locally designated investigators submit an inquiry case plan to an Office of Internal Affairs' Allegation Investigation Unit manager or the investigator's manager, prior to conducting interviews, to encourage thoroughly completed inquiries.
<i>Investigation Cases</i>	
In some cases, hiring authorities inappropriately determined investigations were sufficient and made disciplinary findings in cases where no interviews were conducted at all.	The OIG recommends that the department eliminate video quick-close reports as an option in staff misconduct investigations as they are contrary to regulations which require thorough investigations, are inconsistent with how local prison investigators conduct inquiries into staff misconduct, provide a conclusion regarding the staff misconduct allegation that usurps or undermines the hiring authority's role as the one to determine if there is or is not staff misconduct, and have led to poor recommendations by department attorneys, and poor decisions by hiring authorities.
<i>Body-Worn Camera and Video Surveillance Recordings</i>	
Departmental policy requiring a 90-day retention period for preservation of video may not be long enough to allow investigators to request, review, and preserve all relevant video evidence for staff complaint inquiries and investigations.	The OIG recommends that the department revise its policy to prevent the deletion of video evidence after 90 days for inquiries and investigations. One key change is to increase the minimum video retention and storage policy to one year for all allegations of staff misconduct the Centralized Screening Team refers for an inquiry and investigation.

Source: The Office of the Inspector General.

(This page left blank for reproduction purposes.)

Appendices

Scope and Methodology

The OIG monitored the department's Centralized Screening Team's decisions regarding 1,067 grievances, which included 1,682 complaints, received from July 1, 2022, and closed by December 31, 2022. The OIG also monitored 19 staff misconduct inquiry cases that were opened from February 9, 2021, and completed by Office of Internal Affairs' Allegation Inquiry Management Section investigators through October 26, 2022, 22 staff misconduct inquiry cases that were opened and completed by locally designated investigators, and 10 staff misconduct investigation cases completed by the Office of Internal Affairs' Allegation Investigation Unit that were opened beginning on May 31, 2022, and completed through December 31, 2022.

We reviewed several key criteria, including the department's proposed emergency regulations for addressing allegations of staff misconduct implemented on January 1, 2022, final adopted regulations effective October 20, 2022, as well as departmental directives regarding the screening, inquiry, and investigation processes. We also participated in departmental training and reviewed the training materials used to instruct screeners, investigators who conduct inquiries and investigations, and staff who are engaged in the process at the prisons.

We monitored the Centralized Screening Team's screening decisions by randomly selecting complaints to monitor. After we selected the complaints, we conducted research of records, documents, and departmental databases, such as the offender grievance tracking system and the Allegations Against Staff Tracking System (AASTS).³⁰ We analyzed each screening decision to assess how the Centralized Screening Team processed each allegation included in a complaint. The OIG assigned a rating of *superior*, *satisfactory*, or *poor* to each complaint monitored rather than each allegation we reviewed. If we encountered discrepancies during the screening process, we contacted the department and elevated our concerns.

To assess the thoroughness of the department's inquiries and investigations, we conducted field work at prisons throughout the State and analyzed the investigators' resulting inquiry and investigation reports and corresponding exhibits. For each local inquiry or investigation, an investigator submitted a draft report to an Office of Internal Affairs' Allegation Investigation Unit manager and subsequently to the hiring authority for a final decision. Our monitoring activities included real-time observations of interviews and reviews of video recordings, as well as review of other documentary evidence, such as post orders, cell search logs, and analysis of data pertaining to the cases from several of the department's electronic systems, including the offender grievance tracking system, the allegation against staff tracking

30. The Allegations Against Staff Tracking System (AASTS) is an electronic data system used to log and track allegations of staff misconduct involving department staff (DOM Section 33070.3(a)).

system, and its Microsoft SharePoint site. We also received and reviewed memoranda from wardens concerning their review and resolution of the cases.

To properly assess the monitored inquiry and investigation cases, we analyzed the relevant dates for each, including, but not limited to, the date assigned to the investigators, the date of the final interview, the date completed, the deadlines to take disciplinary action, and the date of the warden's decision. We also analyzed the number of days that transpired between certain events, such as the number of days between the start of each inquiry or investigation and when the investigator completed and submitted the final report. We also performed a qualitative analysis of the inquiry or investigative work conducted by the assigned investigators—including their interviews, evidence collection, and report preparation—for all monitored cases.

For the 10 monitored Office of Internal Affairs' Allegation Investigation Unit investigations, we also assessed the performance of department attorneys who provided legal advice to the Office of Internal Affairs and to hiring authorities, and who litigated any resulting employee disciplinary cases. Further, we assessed the performance of the hiring authorities, who made findings concerning the investigations and any resulting disciplinary actions.

For the screening decisions, local inquiries, and investigations we monitored, we assessed the performance of departmental staff and provided an overall rating.

Our assessment methodology for the ratings were based on the OIG's response to performance-related questions. We assessed the overall work in each case *superior*, *satisfactory*, or *poor*. We used this rating system to evaluate and assess the department's overall performance in the Centralized Screening Team's screening decisions, and in completing local inquiry and investigation cases. We used an Assessment Tool that consisted of five overarching questions, each with a series of subquestions.

Case Summaries

2022 Local Inquiry Case Summaries

Inquiry Case Summaries

Overall Rating

Poor

OIG Case Number

22-0043609-INQ

Case Summary

On February 4, 2022, custody staff allegedly did not provide an incarcerated person with a medical evaluation and compatible housing assessment following an altercation with another incarcerated person. On February 25, 2022, a lieutenant, serving as a senior hearing officer, allegedly denied any witnesses during a rules violation report hearing for the incarcerated person involved in the altercation. The lieutenant allegedly yelled at the incarcerated person during the hearing and dismissed the incarcerated person from the lieutenant's office.

Case Disposition

The hiring authority conducted an inquiry and determined that the conduct did occur but the actions were justified, lawful, and proper.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator failed to adequately conduct a fact-finding into whether the lieutenant yelled at the incarcerated person and kicked him out of the lieutenant's office. The investigator failed to collect additional information related to missing body-worn camera footage related to the incident. Further, the investigator failed to ask relevant questions during witness interviews and did not conduct other relevant witness interviews.

Questions

Did the hiring authority assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject allegedly involved in the misconduct?

The investigator held the same rank as the subject who was a lieutenant.

Did the investigator ask all relevant questions during interviews?

The investigator did not ask all relevant questions during a witness interview. During an interview with a witness, the investigator failed to ask relevant questions relating to an officer's missing body-worn camera footage related to the incident.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator did not use effective interviewing techniques when conducting interviews. At the start of the staff witness and subject interview, the investigator played all of the available body-worn camera evidence. Thus, it allowed the witnesses to presume that the investigator did not have video evidence of the alleged incident during the rules violation report hearing. The investigator's questions only related to the video evidence. Instead, the investigator should have first asked the witnesses their recollection of the alleged incident during the hearing to provide an independent account of what they observed or actions they took.

Did the investigator complete all necessary and relevant interviews?

The investigator failed to conduct interviews of relevant witnesses related to unaccounted body-worn camera footage of the lieutenant. The investigator did not interview an officer who requested the body-worn camera footage as evidence. Also, the investigator did not interview another witness, who was depicted in a video of the incident. Both witnesses may have provided additional information regarding the incarcerated person's allegations.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather and review all relevant video evidence. The investigator failed to secure all body-worn camera footage related to the allegation where the lieutenant yelled at the incarcerated person. If the investigator had secured all video recordings, he would have been able to review the officer's body-worn camera video who was in the hearing room to identify and interview all potential witnesses.

Did the investigator thoroughly and appropriately conduct the inquiry?

During the interview with the incarcerated person, the investigator discovered that a full and complete body-worn camera recording of the lieutenant's actions during the hearing was missing. The incarcerated person alleged that the missing video recording contained images of possible misconduct by the lieutenant. The OIG raised this concern to the investigator, but the investigator failed to follow up on this issue to ascertain the details or cause of the missing body-worn camera evidence.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included all relevant facts, evidence and supporting exhibits. The investigator did not include in the report the steps taken to address the missing body-worn camera recording of the lieutenant's actions and the impact on the inquiry.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager did not identify that the investigator did not include all missing body-worn camera evidence and all relevant witness interviews.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

OIG Case Number

22-0043453-INQ

Case Summary

On May 3, 2022, an officer transporting an incarcerated person in a van allegedly accelerated the van, causing the incarcerated person to hit his head on the back of the van.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The hiring authority did not complete the inquiry within 90 days as required by departmental directive. The investigator did not use effective interview techniques and did not provide evidence to the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. In addition, the grievance coordinator did not notify the OIG that the grievance coordinator submitted the inquiry report to the hiring authority. As a result, the OIG was unable to provide feedback or positively impact the inquiry or the hiring authority's final decision.

Questions**Did the investigator adequately prepare for all aspects of the inquiry?**

The investigator did not adequately prepare for all aspects of the inquiry. On May 31, 2022, the department assigned an investigator to conduct the inquiry. On June 14, 2022, the investigator asked the OIG, "Hi! I honestly have no idea what is this about. Am I part of this investigation and in what is it about?" The investigator did not conduct timely and appropriate research to determine the location of the incarcerated person who submitted the complaint. After the investigator determined the incarcerated person had transferred to another prison, the investigator did not conduct research into the process to interview the incarcerated person at the other prison and instead asked the OIG how to effectuate that interview.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator did not use effective interviewing techniques. The investigator did not ask foundational questions or follow-up questions to obtain all relevant information. In addition, the investigator did not ensure confidentiality while conducting an interview with the incarcerated person who submitted the complaint. The investigator conducted a video conference interview of the incarcerated person and allowed an uninvolved third party to be present on the call for approximately five minutes while the third party had an unrelated conversation with a co-worker. The investigator failed to pause the interview and address the intrusion, and instead the investigator continued the interview with the incarcerated person while speaking over the third party's conversation with a co-worker.

Did the investigator properly gather and review all relevant documentary and other evidence?

On May 31, 2022, the department assigned the investigator to conduct the inquiry. The investigator did not timely gather and review evidence. On June 20, 2022, the investigator conducted interviews of the incarcerated person who submitted the complaint without having gathered and reviewed the video recordings. On July 14, 2022, the investigator conducted an interview of one of the officers who was one of the subjects of this inquiry without having gathered and reviewed the video recordings. On August 1, 2022, the investigator received the video recordings after having conducted two interviews.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator failed to conduct an inquiry into the allegation that officers failed to respond to the incarcerated person's request for a medical evaluation, and failed to include facts in the inquiry report concerning this allegation.

Did the investigator complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team?

The investigator failed to complete the inquiry within 90 calendar days. The Centralized Screening Team received the incarcerated person's complaint on May 4, 2022, and the hiring authority did not approve and close the inquiry until November 15, 2022, 6 months and 11 days thereafter.

Did the department handle and process the inquiry with due diligence?

The department did not process and handle the inquiry with due diligence. The department did not complete the inquiry and render a decision within 90 days as required by departmental policy. The investigator did not conduct an inquiry into the allegation that officers failed to respond to the incarcerated person's request for a medical evaluation, and failed to include facts in the inquiry report concerning this allegation. In addition, the investigator did not use effective interview techniques by failing to ask foundational questions and did not clarify questions and answers provided during the interviews. Further, the investigator failed to coordinate interviews with and provide evidence to the OIG. On June 3, 2022, the OIG first requested video recordings and body-worn camera evidence from the investigator. The OIG made at least three subsequent requests, but the investigator did not provide the recordings until September 28, 2022, 3 months and 25 days thereafter.

Did the investigator adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

OIG Case Number

22-0043443-INQ

Case Summary

Between February 23, 2022, and May 15, 2022, an officer allegedly disregarded a transgender incarcerated person's request to be searched by a female officer. During that same time period, the officer allegedly refused to allow the incarcerated person to go to the exercise yard because the incarcerated person would not submit to a clothed body search.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

The department poorly handled the inquiry. The department did not complete the inquiry within 90 days. The investigator did not interview a pertinent witness, and did not request relevant body-worn camera footage within 90-days of the incident, which resulted in the video being deleted by the department before it could be reviewed. In addition, the investigator did not collect and review pertinent documentary evidence.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not adequately prepare for all aspects of the inquiry. The investigator failed to request the relevant body-worn camera footage within 90 days of the incident. As a result, the department deleted the video footage before the investigator could review it.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During an interview on October 20, 2022, the investigator did not provide a confidentiality admonishment to the subject.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. The investigator failed to interview a sergeant identified by the subject as having knowledge of the incident.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather and review all relevant documentary and other evidence for the inquiry. For example, the investigator did not obtain relevant evidence, such as medical records and cell logs, that could have established what occurred and whether the subject statement was accurate. The investigator did not request body-worn camera video footage within 90 days of the incident. As a result, the department deleted the video footage before the investigator could review it. On May 31, 2022, the department assigned the inquiry to the investigator. The investigator did not interview the incarcerated person who submitted the complaint and the subject until 91 days and 142 days, respectively, after the department assigned the inquiry.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator's delay in conducting the inquiry resulted in relevant video recording evidence not being available. The delay also compromised the recollection of the incarcerated person who submitted the complaint and the subject. Further, the investigator did not obtain relevant evidence, such as medical records and cell logs, that could have established what occurred and whether the subject's statement was accurate.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator failed to obtain a video recording, medical records, cell logs, and interview a pertinent witness.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager determined that the inquiry was sufficient, complete, and unbiased although it did not include a relevant video recording, documentary evidence, and a pertinent witness interview.

Did the investigator complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team?

The investigator did not complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team. The Centralized Screening Team received the complaint on May 17, 2022; however, the investigator did not complete the inquiry until November 14, 2022, 181 days thereafter.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority did not make the appropriate finding for each allegation. The hiring authority found the inquiry sufficient to find that the allegation was not sustained. However, the inquiry did not include a pertinent witness interview, a video recording, and documentary evidence. The inquiry was not sufficient and should have been sent back to the investigator to obtain the necessary additional evidence.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence. The inquiry was not completed within 90 days of the complaint being submitted to the Centralized Screening Team. The investigator did not conduct a pertinent witness interview and did not review or include documentary and video recording evidence in the draft inquiry report.

Did the investigator adequately consult with the OIG?

The investigator did not adequately consult with the OIG. The investigator did not promptly respond to requests from the OIG for information on scheduling interviews or to obtain information the investigator gathered during the inquiry. Throughout the inquiry process, the investigator failed to respond to the OIG's ongoing requests for information.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the allegation inquiry report.

Overall Rating

Satisfactory

OIG Case Number

22-0043573-INQ

Case Summary

On May 16, 2022, an officer allegedly yelled at an incarcerated person and called him a derogatory name.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During an interview on August 12, 2022, the investigator did not provide a confidentiality admonishment to a witness.

Did the investigator complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team?

The investigator failed to complete the inquiry within 90 calendar days. The Centralized Screening Team received the complaint on June 17, 2022, and the hiring authority issued a decision on October 19, 2022, 124 days thereafter.

Did the investigator adequately consult with the OIG?

The investigator did not adequately consult with the OIG. The investigator did not notify the OIG of two witness interviews which prevented the OIG from monitoring those interviews.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Did the OIG have an impact on how the department conducted the inquiry?

During interviews with an incarcerated person, a witness, and the subject, the investigator accepted the OIG's recommendation to ask additional follow-up questions. The investigator cited the responses in the final inquiry report.

Overall Rating

Poor

OIG Case Number

22-0043434-INQ

Case Summary

Between January 1, 2022, and May 17, 2022, an officer allegedly shared an incarcerated person's sexual assault conviction information multiple times with medical and custody staff in an attempt to cause the incarcerated person to be targeted for assault by other incarcerated persons.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator did not ask all relevant questions during the interviews, did not identify additional potential witnesses, and did not timely notify the OIG the inquiry report was completed. In addition, the grievance coordinator did not notify the OIG that the grievance coordinator submitted the inquiry report to the hiring authority. As a result, the OIG was unable to provide feedback or positively impact the inquiry or the hiring authority's final decision.

Questions**Did the investigator ask all relevant questions during interviews?**

The investigator did not ask relevant questions during the interview with the incarcerated person who submitted the complaint. For example, the investigator failed to ask if the incarcerated person could identify any additional female officers the incarcerated person stated were present during the incidents. The investigator failed to ask if there were any additional witnesses during the incidents.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator did not use effective interviewing techniques when conducting interviews. The investigator did not ask appropriate follow-up questions during the interview of the incarcerated person who submitted the complaint. The investigator also failed to ask relevant questions during the interview. For example, the investigator failed to ask if the incarcerated person could identify any additional female officers the incarcerated person stated were present during the incidents. The investigator failed to ask if there were any additional witnesses during the incidents.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator did not ask all relevant questions during the interview of the incarcerated person who submitted the complaint as he made no attempt to identify other relevant witnesses.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The inquiry report did not include an attempt by the investigator to identify and interview additional relevant witnesses.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager did not identify that the investigator did not attempt to identify other relevant witnesses.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence because interviews did not include all relevant questions, the investigator did not identify additional potential witnesses, the grievance coordinator did not notify the OIG when they submitted the report to the Office of Internal Affairs' Allegation Investigation Unit, and the grievance coordinator did not notify the OIG when they submitted the report to the hiring authority.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the allegation inquiry report.

Overall Rating

Satisfactory

OIG Case Number

22-0043476-INQ

Case Summary

On May 19, 2022, four officers allegedly failed to provide an incarcerated person his meals for the day, despite repeated requests by the incarcerated person.

Case Disposition

The hiring authority conducted an inquiry and sustained the allegation that officers failed to provide meals to the incarcerated person. The hiring authority required the officers to receive training regarding meal procedures. The officers received training on August 4, 2022.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During interviews on June 23, 2022, the investigator did not provide admonishments to the subjects.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included a supporting exhibit. The inquiry report included a reference to the controlling departmental policy that the officers violated; however, the investigator did not incorporate the departmental policy as an exhibit in the report.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager did not identify that the investigator failed to incorporate the departmental policy as an exhibit in the report.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

OIG Case Number

22-0043513-INQ

Case Summary

Between May 19, 2022, and May 26, 2022, an unknown departmental employee allegedly did not respond to an incarcerated person's complaints that there were electrical and plumbing issues within his assigned cell. The employee allegedly denied the incarcerated person's request to be moved to another cell, but instead gave him gloves and a bag to transfer feces from a non-working toilet to a working toilet outside of his cell. In addition, the employee allegedly taunted the incarcerated person via a "frequency (wi-fi)" causing him psychological, emotional, and physical injury.

Case Disposition

The hiring authority conducted an inquiry and determined that the inquiry conclusively proved the misconduct did not occur.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator did not conduct all relevant interviews and did not include video recording evidence. Further, the investigator did not coordinate with the OIG to facilitate monitoring of the inquiry as required by departmental policy. Specifically, the investigator excluded the OIG from interviews, did not share documentation and other evidence, and did not address the OIG's recommendations.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not adequately prepare for all aspects of the inquiry. The investigator did not obtain and review relevant evidence, such as staff sign-in sheets from May 19, 2022, through May 26, 2022, bed assignment rosters, video recordings, or body-worn camera footage.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. The investigator discovered that several other inmates in surrounding cells did have work orders on file identifying similar electrical and plumbing issues. The investigator attempted to interview only one of these incarcerated persons, who declined to be interviewed. However, there were other potential witnesses to the plumbing and electrical issue who the investigator did not attempt to interview.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather and review all relevant documentary and other evidence. The investigator failed to obtain copies of video recordings within the housing unit where the alleged incidents occurred. The investigator also failed to obtain the body-worn camera footage of two witnesses who were present during the incidents.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator did not interview all potential witnesses and did not obtain all relevant evidence including video recording and body-worn camera footage. Further, the investigator did not inform the OIG of interviews and did not share documents and evidence which prevented the OIG from performing its monitoring function.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not include in the draft inquiry report why body-worn camera footage was unavailable and why he did not request video recording evidence. The investigator also failed to include in the inquiry report all relevant staff sign-in sheets of officers on duty at the time of the alleged incidents.

Did the investigator complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team?

The investigator failed to complete the inquiry within 90 calendar days. The Centralized Screening Team received the incarcerated person's complaint on May 24, 2022, and the hiring authority approved the inquiry on October 3, 2022, 132 days thereafter and 42 days after policy required.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence. The department did not complete the inquiry within 90 days of the complaint being submitted to the Centralized Screening Team. The investigator did not conduct all relevant interviews and did not include video recording evidence in the draft inquiry report. Further, the investigator did not coordinate with the OIG to facilitate monitoring of the inquiry as required by departmental policy. Specifically, the investigator excluded the OIG from all interviews conducted, did not share documentation and other evidence, and did not address the OIG's recommendations.

Did the investigator adequately consult with the OIG?

The investigator did not adequately consult with the OIG. The investigator failed to notify or include the OIG in the interview process. These actions prevented the OIG from determining the adequacy of the interviews. The investigator completed his inquiry activities and composed a draft report without consulting with the OIG.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report. The investigator did not provide inquiry related information to the OIG, frequently citing that the prison management instructed him not to provide any information to the OIG.

Overall Rating

Poor

OIG Case Number

22-0043512-INQ

Case Summary

Between May 23, 2022, and June 1, 2022, a sergeant allegedly denied a visually impaired incarcerated person an audio Bible which had been provided to him as an accommodation. The sergeant allegedly did not ensure the audio Bible was delivered to the incarcerated person and did not ensure the incarcerated person was aware of ordering requirements. The officer allegedly retaliated against the incarcerated person by refusing to deliver the audio Bible.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator did not verbally admonish six witnesses and the subject, did not complete all necessary and relevant interviews, failed to show the subject a photograph of the incarcerated person, and failed to notify the OIG of the completion and submission of the allegation inquiry report to the Allegation Investigation Unit manager or the hiring authority.

Questions**Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?**

During interviews on June 28, 2022, the investigator did not provide a confidentiality admonishment to five witnesses. During two interviews on July 13, 2022, the investigator did not provide a confidentiality admonishment to a witness and subject.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator failed to use effective interviewing techniques when conducting interviews. The investigator did not ask the incarcerated person a follow-up question after the incarcerated person stated his friend ordered the personal property appliance on his behalf. Thus, it was unknown whether the friend was another incarcerated person or someone who is not incarcerated. The investigator also failed to show the subject a photograph of the incarcerated person after the subject stated they did not know the incarcerated person.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all relevant interviews. The investigator did not interview a sergeant identified by the incarcerated person as a witness. Instead, the investigator reviewed the sergeant's body-worn camera footage and determined the sergeant did not interact with the incarcerated person on May 23, 2022, or May 26, 2022. It is unknown if the sergeant ever communicated with the incarcerated person regarding the allegation outside of these two dates. The investigator missed an opportunity to interview a witness who may have offered information relevant to the allegation.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator did not adequately question the incarcerated person when he indicated his friend ordered the personal property, did not interview a sergeant identified as a witness by the incarcerated person, and did not show the subject a photograph of the incarcerated person when the subject indicated they did not know the incarcerated person. The investigator did not provide a confidentiality admonishment to witnesses and a subject.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant supporting exhibits. The investigator listed a document as an exhibit in the inquiry report but did not include it as an exhibit. Also, the investigator included five documents in the inquiry report, but they were not identified as exhibits.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager concluded the inquiry was sufficient despite a relevant witness not being interviewed.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was sent to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was sent to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Did the OIG have an impact on how the department conducted the inquiry?

During an interview on June 28, 2022, the investigator accepted the OIG's recommendation to interview additional witnesses and to obtain the relevant policy or procedure when ordering items to be given to incarcerated persons as accommodations.

Overall Rating

Poor

OIG Case Number

22-0043461-INQ

Case Summary

On May 26, 2022, a supervising correctional cook allegedly rested his arm and shoe on the morning meal food trays being served to incarcerated persons. Further, on three other occasions in May 2022, the supervising correctional cook allegedly mishandled the incarcerated person's food in a similar manner.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator failed to obtain relevant evidence. The OIG was not advised when the inquiry was initially closed by the hiring authority. The hiring authority did not advise the OIG when the inquiry was reopened for additional inquiry work. Further, the hiring authority failed to provide the OIG with an additional relevant recording. The hiring authority did not make the appropriate finding for the allegation. The hiring authority determined their finding based on insufficient evidence.

Questions

Did the investigator appropriately provide an advisement at the beginning of each interview and an admonishment at end of each interview?

During the interview on June 23, 2022, the investigator did not provide a confidentiality admonishment to the incarcerated person who submitted the complaint.

Did the investigator ask all relevant questions during interviews?

On June 23, 2022, during the investigator's interview with the incarcerated person who submitted the complaint, the investigator failed to ask questions to clarify the timeline of events to ensure the correct video evidence was obtained. The investigator failed to ask the incarcerated person for any other incarcerated person witnesses that would have been present during the alleged incident.

Did the investigator use effective interviewing techniques when conducting interviews?

During an interview with an incarcerated person on June 23, 2022, the investigator failed to clarify the other alleged dates of occurrence, as written in the complaint. The investigator failed to use a visual recording that he obtained as evidence to clarify with the incarcerated person his location during the alleged incident.

Did the investigator complete all necessary and relevant interviews?

The investigator failed to conduct an interview with the supervising correctional cook.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not gather all relevant evidence. The investigator failed to obtain and review all relevant visual recordings related to the allegation. The investigator failed to obtain departmental policy regarding food safety.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator failed to conduct effective interviews to obtain sufficient information regarding the incarcerated person's allegation. The investigator failed to obtain sufficient visual recordings related to the alleged incident and failed to obtain departmental policy regarding food safety. The department failed to properly communicate with the OIG after the hiring authority reopened the inquiry on two separate occasions, based on the OIG's recommendations. As a result, the investigator notified the OIG of only one of three interviews conducted, which prevented the OIG from monitoring two of the three interviews.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to document that the OIG was present for the interview on June 23, 2022, with the incarcerated person. The investigator failed to obtain relevant evidence related to the alleged incident. The investigator failed to obtain departmental policy regarding the alleged incident. The investigator failed to document the visual recordings as exhibits in the inquiry report.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager failed to identify that the investigator conducted a deficient interview with the incarcerated person who submitted the complaint. During an interview with the incarcerated person on June 23, 2022, the investigator failed to clarify the other alleged dates of occurrence, as written in the complaint. The investigator also failed to use a visual recording that he obtained as evidence to clarify with the incarcerated person his location during the alleged incident.

Did the hiring authority's decision, based on the completed inquiry, occur within 90 days of the complaint being received by the Centralized Screening Team?

The investigator failed to complete the inquiry within 90 calendar days. The Centralized Screening Team received the complaint on June 3, 2022, and the hiring authority made a decision on October 19, 2022, 138 days thereafter.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority did not make the appropriate finding for the allegation. The hiring authority determined their finding based on incomplete evidence. Specifically, the investigator only obtained two 20-second visual recordings that did not pertain to the alleged incident. The investigator should have obtained the full visual recordings for the time the incarcerated person

identified. The hiring authority failed to identify that the investigator did not obtain all relevant evidence, conducted a deficient interview with the incarcerated person, and did not interview all relevant witnesses and the supervising correctional cook.

Did the investigator adequately confer with the OIG?

The investigator failed to notify the OIG of two witness interviews the investigator conducted. The investigator's lack of communication prohibited the OIG from providing real-time feedback.

Did the hiring authority adequately confer with the OIG?

The department did not adequately confer with the OIG. The hiring authority failed to properly communicate with the OIG after the inquiry was reopened on two occasions. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Did the OIG have an impact on how the department conducted the inquiry?

The OIG made recommendations to the hiring authority on two separate occasions, and as a result, the hiring authority reopened the inquiry and the investigator conducted additional inquiry work.

Overall Rating

Satisfactory

OIG Case Number

22-0043465-INQ

Case Summary

On May 28, 2022, a sergeant and an officer allegedly questioned an incarcerated person about what the incarcerated person had placed inside a locker located on Native American spiritual grounds. The officer allegedly made an unauthorized entry onto the Native American spiritual grounds and touched the spiritual medicine. The incarcerated person further alleged that everything on spiritual grounds can only be touched by those approved by the warden.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

The investigator failed to provide confidentiality admonishments at the end of all witness and subject interviews.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Satisfactory

OIG Case Number

22-0043749-INQ

Case Summary

Between June 1, 2022, and July 19, 2022, an officer and a psychiatric technician allegedly made jokes about a previous incident in which the incarcerated person grabbed the officer's genitalia.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

OIG Case Number

22-0043618-INQ

Case Summary

On June 3, 2022, an officer allegedly failed to process an incarcerated person's legal mail. Further, the officer allegedly opened, resealed, and withheld mail, thereby delaying the processing of the incarcerated person's legal mail.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations but determined the officer needed training regarding the processing of outgoing confidential mail. Therefore, the hiring authority caused training to be provided to the officer.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator failed to provide any documents to the OIG for review until the inquiry was completed and notified the OIG of only one of four interviews conducted. Thus, the OIG was unable to provide real-time feedback during the inquiry or the department's review of the inquiry report.

Questions

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

The investigator failed to provide a confidentiality admonishment during the officer's interview.

Did the investigator complete all necessary and relevant interviews?

The investigator notified the OIG of only one of four interviews conducted, thereby preventing the OIG from providing real-time feedback during three interviews and determining whether additional interviews were warranted.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. On July 7, 2022, during an initial case conference between the OIG and the investigator, the OIG outlined expectations to be notified of all interviews before they occurred, to be provided all evidence as it was collected, and to be provided with a copy of the draft inquiry report when it was submitted to the Office of Internal Affairs' Allegation Investigation Unit. On July 8, 2022, the investigator interviewed the incarcerated person who submitted the complaint and did not notify the OIG of the interview. In addition, the investigator failed to inform the OIG of additional witness interviews he conducted until the OIG discovered the interviews occurred upon receipt of the final inquiry report.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was sent to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was sent to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Did the OIG have an impact on how the department conducted the inquiry?

During an interview conducted on July 20, 2022, the investigator accepted the OIG's recommendation to ask the officer additional follow-up questions. The investigator also accepted the OIG's recommendation to determine who collected and processed the mail following the incident date, resulting in an additional witness interview. The investigator did not inform the OIG of the witness interview, thereby preventing the OIG from providing real-time feedback.

Overall Rating

Satisfactory

OIG Case Number

22-0043473-INQ

Case Summary

On June 5, 2022, two officers allegedly scattered an incarcerated person's food and hygiene products during a cell search, which resulted in the majority of the food products being inedible. The same two officers allegedly overturned the incarcerated person's books, spreading pages all over the cell. The officers allegedly opened the incarcerated person's sauces and condiments and spread them across the bed, floor, and on the incarcerated person's personal items.

Case Disposition

The hiring authority conducted an inquiry and determined that the inquiry conclusively proved the misconduct did not occur.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. One of the subject officers was unavailable due to being on extended military leave and the investigator elected to not interview the other subject officer.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator failed to interview the available subject officer.

Did the investigator complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team?

The investigator failed to complete the inquiry within 90 calendar days. The Centralized Screening Team received the complaint on June 6, 2022, and the hiring authority made a decision on November 4, 2022, 151 days thereafter.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Satisfactory

OIG Case Number

22-0043474-INQ

Case Summary

On June 5, 2022, two officers allegedly destroyed an incarcerated persons property, confiscated his television during a cell search and denied the incarcerated person's request to speak to a sergeant.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations but determined the officers needed training for proper wearing of facial coverings and searching for dangerous contraband. Therefore, the hiring authority caused training to be provided to one officer. The second officer was on leave and could not complete the training.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team?

The investigator failed to complete the inquiry within 90 calendar days. The Centralized Screening Team received the complaint on June 6, 2022, and the hiring authority made a decision on December 6, 2022, 183 days thereafter.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the allegation inquiry report.

Did the OIG have an impact on how the department conducted the inquiry?

During a subject interview on July 8, 2022, the investigator accepted the OIG's recommendation to ask questions related to the subject's understanding of the cell search policy, if he searched the cell according to policy, and about an allegation that he falsified a cell search receipt.

Overall Rating

Satisfactory

OIG Case Number

22-0043623-INQ

Case Summary

On June 11, 2022, a lieutenant, a sergeant, and two officers allegedly failed to move an incarcerated person after the incarcerated person stated he had safety concerns about being assaulted by other incarcerated persons.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the hiring authority assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject allegedly involved in the misconduct?

The investigator held the same rank as the sergeant she was assigned to investigate, and a lesser rank than the lieutenant she was assigned to investigate which violates departmental policy.

Did the investigator complete the inquiry within 90 calendar days of the complaint being submitted to the Centralized Screening Team?

The investigator failed to complete the inquiry within 90 calendar days. The Centralized Screening Team received the complaint on June 22, 2022, and the hiring authority made a decision on November 17, 2022, 148 days thereafter.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Did the OIG have an impact on how the department conducted the inquiry?

During a subject interview on August 10, 2022, the investigator accepted the OIG's recommendation to ask if the incarcerated person's safety concerns were addressed. The response was cited in the final inquiry report. During a subject interview on September 15, 2022, the investigator accepted the OIG's recommendation to ask additional follow-up questions which prompted the investigator to conduct an additional witness interview.

Overall Rating

Satisfactory

OIG Case Number

22-0043610-INQ

Case Summary

From May 31, 2022, to June 21, 2022, prison officials allegedly improperly classified an incarcerated person which resulted in him not receiving his mail, packages, and property while housed in the administrative segregation unit. A sergeant allegedly instructed officers to inappropriately return the incarcerated person's mail and packages to the mailroom and instructed mailroom staff to delay or tamper with incoming mail. In addition, mailroom staff were allegedly forging the incarcerated person's signature to have his mail returned to the sender. Further, on June 16, 2022, the sergeant allegedly stole a different incarcerated person's package.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations but determined the sergeant needed training for not wearing body-worn camera and proper wearing of facial coverings. Therefore, the hiring authority caused training to be provided to the sergeant for both deficiencies.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions**Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?**

The investigator did not appropriately provide an admonishment and advisement at the beginning and end of each witness interview.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not share or provide any documents or exhibits during the course of the inquiry. This prevented the OIG from assessing evidence and providing real-time feedback during the inquiry process. The grievance coordinator and investigator both informed the OIG that the hiring authority had instructed them not to provide any documentation to the OIG until the investigator completed the inquiry report.

Did the investigator adequately consult with the OIG?

The investigator did not adequately consult with the OIG. The investigator failed to notify the OIG of his interview with the incarcerated person. This prevented the OIG from monitoring the interview or providing recommendations.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

IG Case Number

22-0043744-INQ

Case Summary

On June 28, 2022, two officers allegedly threw an incarcerated person's property on the floor, destroyed food items, walked on clothing and bedding, and illegally confiscated personal property during a cell search.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator did not prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. Further, the investigator did not provide the OIG with relevant recordings before the investigator conducted the interviews.

Questions

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not provide the OIG with visual recording and body-worn camera footage before the investigator conducted the interviews. This, prevented the OIG from providing real-time feedback during the inquiry process.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not include in the draft inquiry report details related to the incarcerated person's property that was destroyed or confiscated and did not include key dates for related incidents and interviews.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager determined that the inquiry was sufficient, complete, and unbiased although it did not include details related to the incarcerated person's property that was destroyed or confiscated and did not include key dates for related incidents and interviews.

Did the investigator adequately consult with the OIG?

The department did not adequately consult with the OIG. Based on instructions from the hiring authority, the investigator did not provide documents, exhibits, and evidence to the OIG until the inquiry report was completed. This prevented the OIG from monitoring the inquiry in real-time.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

IG Case Number

22-0044085-INQ

Case Summary

On June 30, 2022, an officer allegedly rushed up towards a wheelchair-bound incarcerated person outside the facility library and yelled, "Get-get-get!" The officer then allegedly stood over the incarcerated person in a threatening manner stating, "I'm not asking you, I'm telling you."

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator did not identify a secondary allegation that the officer and a counselor were included as subjects in a recent complaint filed by the incarcerated person. The investigator never asked the officer and the counselor about the prior staff complaint filed by the incarcerated person. The investigator did not interview a relevant witness who was present during the incident.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not adequately prepare for the inquiry. The investigator did not obtain or review a past complaint cited by the incarcerated person prior to conducting interviews. The incarcerated person alleged that he filed a previous complaint, including the log number, which involved the officer and the counselor.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

On September 16, 2022, and September 19, 2022, the investigator did not appropriately provide an admonishment and advisement at the beginning and the end of interviews with the officer and a witness.

Did the investigator use effective interviewing techniques when conducting interviews?

On September 16, 2022, during a witness interview the investigator described what she observed in the video evidence instead of letting the witness first describe the events that occurred.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. The investigator did not interview an incarcerated person who was present during the incident.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather and review all relevant evidence. The investigator did not consider the allegation of a past complaint filed by the incarcerated person against the officer and the counselor. Since the investigator never reviewed the prior complaint identified by the incarcerated person, the investigator never determined its relevance and whether this incident may have been retaliatory. The counselor stated during the interview that he knew who the incarcerated person was since the incarcerated person had "filed a grievance alleging staff misconduct against him a couple of months ago." The investigator did not ask the counselor follow-up questions regarding the prior complaint.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. On September 9, 2022, the investigator advised the OIG that she would not conduct additional interviews, including a staff witness and the officer. The OIG recommended that both interviews be conducted to ensure the inquiry was thorough and complete. The investigator agreed to complete both interviews. However, the investigator did not interview an incarcerated person who was present during the incident, despite knowing the incarcerated person's first name and cell number.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to identify the prior complaint noted by the incarcerated person in the complaint he submitted. The investigator never determined its relevance and whether this incident may have been retaliatory. The counselor stated the incarcerated person had "filed a grievance alleging staff misconduct against him a couple of months ago." Yet the investigator never asked any follow-up questions regarding the prior complaint.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager did not identify that the investigator did not conduct all relevant interviews and that the investigator did not follow-up on a prior complaint the incarcerated person filed against the officer and the counselor.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Did the OIG have an impact on how the department conducted the inquiry?

The OIG recommended that the investigator conduct interviews with the officer, counselor, and a witness. The investigator conducted an interview with the officer and the counselor.

Overall Rating

Satisfactory

OIG Case Number

22-0044167-INQ

Case Summary

On June 16, 2022, an officer authored a rules violation report indicating discovery of contraband during an incarcerated person's cell search, which allegedly contradicted body-worn camera footage. The officer allegedly failed to provide the incarcerated person with a cell search receipt reflecting the discovery and removal of the contraband, causing the incarcerated person to allege the rules violation report should be dismissed. A counselor also allegedly failed to document the items that were confiscated from the incarcerated person on the cell search receipt.

Case Disposition

The hiring authority conducted an inquiry and determined that the inquiry conclusively proved the misconduct did not occur. However, the hiring authority imposed training on the officer for failing to complete and provide a required cell search receipt to the incarcerated person. The hiring authority did not take any action against the counselor.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator did not provide a confidentiality admonishment to the incarcerated person who submitted the complaint, one witness, and two subjects. The investigator failed to establish applicable departmental policy and procedures and failed to obtain the witness' and subjects' understanding of policy. The hiring authority made an inappropriate finding regarding the allegation against the officer; however, the hiring authority did impose the appropriate training to the officer.

Questions**Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?**

The investigator did not provide a confidentiality admonishment to the incarcerated person who submitted the complaint, one witness, and two subjects.

Did the investigator ask all relevant questions during interviews?

The investigator failed to establish applicable departmental policy and procedures and failed to obtain the witness' and subjects' understanding of policy.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator failed to follow proper interview techniques when the investigator interviewed a subject before the witness of the inquiry and did not document why he interviewed the subject first.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator failed to properly gather and review all relevant documentary evidence. The investigator failed to obtain departmental policy pertaining to cell search procedures. The investigator also failed to provide information related to the subjects' and witness' knowledge of cell search procedures in the final inquiry report.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator failed to obtain departmental policy pertaining to cell search procedures. The investigator also failed to provide information related to the subjects' and witness' knowledge of cell search procedures and include the procedures as an exhibit in the report.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator failed to obtain departmental policy pertaining to cell search procedures. The investigator also failed to provide information related to the subjects' and witness' knowledge of cell search procedures and include the procedures as an exhibit in the report.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report to determine whether the inquiry was sufficient and complete. The Office of Internal Affairs' Allegation Investigation Unit manager did not identify that the investigator failed to obtain departmental policy pertaining to cell search procedures and include the policy as an exhibit in the report.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority did not make an appropriate finding regarding the allegations. The hiring authority determined that the inquiry conclusively proved the misconduct did not occur as to the officer. The hiring authority should have made a finding of sustained as to the officer based on her failure to complete a cell search receipt regarding the contraband that she discovered during the cell search.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

OIG Case Number

22-0044205-INQ

Case Summary

On August 3, 2022, during a cell move, three officers allegedly left an incarcerated person's cell door open and his personal property unattended on a dayroom table which resulted in his property being stolen. The officers allegedly had been careless with the incarcerated person's property before and were targeting him by placing him with an incompatible cellmate.

Case Disposition

The hiring authority conducted an inquiry and determined that the conduct did not occur. However, the inquiry revealed the actions were justified, lawful, and proper.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator did not adequately communicate with the OIG which precluded the OIG from monitoring the interview with the incarcerated person. In addition, the investigator did not perform the investigation with due diligence as the investigator failed to interview all relevant witnesses and subjects.

Questions

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

The investigator did not provide all appropriate admonishments. During an interview on August 24, 2022, the investigator did not provide a confidentiality admonishment to the incarcerated person who submitted the complaint.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all relevant interviews as he failed to conduct interviews with relevant witnesses and three subject officers.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not conduct a thorough investigation as he failed to conduct interviews with all relevant witnesses and the three subject officers.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority did not make an appropriate finding regarding the allegation. The hiring authority determined that the conduct did occur, but the officers' actions were justified, lawful, and proper. The hiring authority should have made a finding of not sustained based on body-worn camera footage the investigator reviewed and documented in the inquiry report. Further, the investigator explained in the inquiry report that the incarcerated person's property was not stolen during the incident.

Did the department handle and process the inquiry with due diligence?

The department did not handle the inquiry with due diligence. The investigator failed to conduct interviews with the three subjects or witnesses, bypassing the critical steps necessary to conduct an independent fact-finding inquiry.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit manager. The grievance coordinator also failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

OIG Case Number

22-0044567-INQ

Case Summary

On September 13, 2022, an officer allegedly directed an incarcerated person to distribute mail to other incarcerated persons in the housing unit.

Case Disposition

The hiring authority conducted an inquiry and sustained the allegation based on the hiring authority's determination that there is an established departmental expectation that only staff will deliver mail to incarcerated persons. The officer received on-the-job training regarding this expectation.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator did not note in the report that there were no policies or procedures prohibiting incarcerated persons from delivering mail to other incarcerated persons. The investigator did not interview the subject or any witnesses to determine if this alleged misconduct was a one-time occurrence.

Questions**Did the investigator adequately prepare for all aspects of the inquiry?**

The investigator did not adequately prepare for all aspects of the inquiry. Although the investigator gathered various departmental policies, the investigator did not exhibit a proper understanding that there was no policy which the officer violated.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During an interview on October 12, 2022, the investigator did not provide a confidentiality admonishment to the incarcerated person who submitted the complaint.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. Although the investigator stopped the inquiry when he observed alleged misconduct on the body-worn camera footage on the alleged date of the incident, the investigator did not interview the subject or witnesses who may have provided additional relevant information. For instance, the investigator should have asked other witnesses if the incarcerated person distributed confidential and non-confidential mail and whether the subject officer had other incarcerated persons distribute mail on other days.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator did not note in the report that there were no policies or procedures prohibiting incarcerated persons from delivering mail to other incarcerated persons. The investigator did not interview the subject or any witnesses to determine if this alleged misconduct was a one-time occurrence. However, without subject and witness interviews, the investigator was limited to body-worn camera evidence for the date in question.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not provide a specific departmental policy that the officer violated. Instead, the investigator highlighted the officer took full accountability of this error as the officer apologized to the incarcerated persons who received their mail from another incarcerated person. Further, the officer explained from body-worn camera evidence that she "wanted to knock out (have the mail issued) before she left and her relief (officer) arrived."

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report. The Office of Internal Affairs' Allegation Investigation Unit manager did not identify that the investigator did not note in the report that there were no policies or procedures prohibiting incarcerated persons from delivering mail to other incarcerated persons. In addition, the Office of Internal Affairs' Allegation Investigation Unit manager failed to recommend the investigator conduct subject and witness interviews.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the draft inquiry report was sent to the Office of Internal Affairs' Allegation Investigation Unit manager. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

Overall Rating

Poor

OIG Case Number

22-0044661-INQ

Case Summary

On September 20, 2022, a sergeant allegedly failed to deliver a package to an incarcerated person. Later in the day an officer failed to notify medical staff when the incarcerated person expressed suicidal thoughts.

Case Disposition

The hiring authority conducted an inquiry regarding the allegations. The hiring authority found insufficient evidence to sustain the allegation regarding the delivery of the incarcerated person's package. However, the hiring authority sustained the allegation that the officer failed to respond when the incarcerated person expressed suicidal thoughts. The hiring authority issued a letter of instruction to the officer for failing to give the incarcerated person assistance after he informed the officer that the incarcerated person had suicidal thoughts. The OIG did not agree with the letter of instruction issued to the officer. The hiring authority should have referred the matter to the Office of Internal Affairs for further investigation.

Overall Inquiry Assessment

The department poorly handled the inquiry. The investigator failed to review all relevant evidence including medical records, daily logs, and body-worn camera footage. Further, the investigator did not interview all relevant witnesses and did not notify the OIG of a follow-up interview with a subject. In addition, the letter of instruction the hiring authority issued to the officer was

not appropriate given the nature of the misconduct. The hiring authority should have referred the inquiry to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not adequately prepare for all aspects of the inquiry. The investigator did not obtain and review all relevant evidence including daily logs, medical records, and body-worn camera footage, prior to conducting interviews. The investigator failed to identify a sergeant as a subject and instead interviewed this sergeant as a witness.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

The investigator did not appropriately provide admonishments to the incarcerated person, witnesses, or the subject.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. The investigator did not interview the officer's supervisors, other officers, medical staff, and mental health staff that could have provided information about the timeline of events and whether the incarcerated person was under direct observation by officers until medical staff arrived. The investigator also failed to identify a sergeant as a subject and instead interviewed this sergeant as a witness.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather and review all relevant evidence for the inquiry. The investigator did not gather and review applicable medical records, daily logs, and body-worn camera footage.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator failed to review all relevant evidence including medical records, daily logs, and body-worn camera footage. Further, the investigator did not interview all relevant witnesses and did not notify the OIG of a follow-up interview with the subject. The investigator also failed to identify a sergeant as a subject and instead interviewed this sergeant as a witness. In addition, the letter of instruction the hiring authority issued to the officer was not appropriate given the nature of the misconduct. The hiring authority should have referred the inquiry to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator did not prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The inquiry report did not include all relevant interviews of the officer's supervisors, medical staff, and mental health staff. In addition, the inquiry report did not include relevant evidence including daily logs and body-worn camera footage.

Did the Office of Internal Affairs' Allegation Investigation Unit manager adequately review the draft inquiry report and appropriately determine whether the inquiry was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager did not adequately review the draft inquiry report appropriately to determine whether the inquiry was sufficient, complete, and unbiased. The Office of Internal Affairs' Allegation Investigation Unit manager failed to request the investigator conduct all relevant interviews of the officer's supervisors, medical staff, and mental health staff. In addition, the Office of Internal Affairs' Allegation Investigation Unit manager did not request the investigator gather daily logs and body-worn camera footage.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence despite evidence of misconduct listed on the Allegation Decision Index, and the inquiry was not sent to the Office of Internal Affairs' Allegation Investigation Unit for investigation. In addition, the investigator failed to review all relevant evidence, did not interview all relevant witnesses, did not notify the OIG of a follow-up interview with the subject, and the letter of instruction issued to the officer was not appropriate given the nature of the misconduct.

Did the investigator adequately consult with the OIG?

The investigator did not adequately consult with the OIG. The investigator did not inform the OIG of a follow-up interview with the subject, did not provide all evidence timely, and did follow the OIG's recommendation to obtain and review relevant evidence such as daily logs and medical records.

Did the hiring authority adequately consult with the OIG?

The department did not adequately confer with the OIG. The grievance coordinator failed to notify the OIG when the final inquiry report was submitted to the hiring authority. Thus, the OIG was unable to provide real-time feedback during the department's review of the inquiry report.

2022 AIMS Inquiry Case Summaries

Overall Rating

Satisfactory

OIG Case Number

21-0041325-SC

Case Summary

On July 20, 2021, an officer issued a rules violation report to an incarcerated person for allegedly being overly familiar with a psychologist. From August 11, 2021, through August 17, 2021, the psychologist allegedly coordinated with officers to prevent the incarcerated person from attending mental health appointments. On August 19, 2021, one of those officers allegedly did not release the incarcerated person from his cell to attend scheduled mental health treatment sessions, causing the incarcerated person to feel suicidal. The same officer allegedly falsified a memorandum indicating the incarcerated person refused to attend his mental health treatment sessions.

Case Disposition

The hiring authority sent a letter to the incarcerated person with the following statement: "All information pertaining to the allegation has been reviewed and all issues were adequately addressed." The hiring authority sent to the OIG proof that the prison provided training to custody staff regarding documenting refusals by incarcerated persons of medical treatment and proper wearing of facial coverings.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator ask all relevant questions during interviews?

The investigator did not ask the subject officer questions related to the documentation process for incarcerated persons' participation in more than one mental health appointment on the same day. The investigator also failed to ask the subject officer clarifying questions about his actions shown in body-worn camera footage while canvassing for incarcerated persons to attend mental health appointments.

Did the investigator complete all necessary and relevant interviews?

The investigator did not interview a psychologist who went to the incarcerated person's cell front on August 19, 2021, and allegedly did not approve the incarcerated person to exit his cell to attend a therapy session.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not obtain the relevant departmental policy for daily procedures for mental health appointments.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant evidence related to departmental policy for daily procedures for mental health appointments.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority failed to identify its findings regarding each staff misconduct allegation. The hiring authority concluded that, "All information pertaining to the allegation has been reviewed and all issues were adequately addressed."

Did the investigator adequately consult with the OIG?

The investigator did not adequately consult with the OIG. The investigator did not give the OIG advance notice prior to a staff witness interview and conducted the interview without the OIG's presence. The investigator subsequently provided the OIG with an audio recording of the interview.

Overall Rating

Poor

OIG Case Number

22-0042685-SC

Case Summary

On February 11, 2022, two officers allegedly failed to provide an incarcerated person his prescribed medication, breakfast, and lunch. One of the officers allegedly said, "Your (sic) on a diet now." Later, the first two officers, two additional officers, and two sergeants allegedly rushed into the incarcerated person's cell. One of the sergeants allegedly deployed pepper spray and one of the additional officers allegedly slammed the incarcerated person into the back of the cell. A fifth and a sixth officer escorted the incarcerated person to the shower and they allegedly slammed the incarcerated person's head into a wall. The fifth officer allegedly turned on boiling hot water in the shower to decontaminate the incarcerated person from the pepper spray. A few hours later, unknown officers allegedly called the incarcerated person a derogatory name and roughly handled him while he was being treated by medical personnel for a seizure.

Case Disposition

The hiring authority conducted an inquiry and determined that the inquiry conclusively proved the misconduct did not occur. The department failed to identify the allegations that the incarcerated person submitted in the staff misconduct grievance.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The department failed to identify all claims in the complaint. Specifically, the department did not address allegations that officers allegedly slammed an incarcerated person's head on the wall multiple times during an escort and allegedly turned on boiling hot water in the shower to decontaminate the incarcerated person from pepper spray. The department failed to address a pertinent subject admission to one of the allegations identified in the complaint.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not adequately prepare for the inquiry. The investigator's inquiry plan did not include all of the allegations in the incarcerated person's complaint. The investigator did not identify allegations that officers repeatedly slammed the incarcerated person's head on the wall while being escorted to the shower and that an officer allegedly turned on boiling hot water to decontaminate the incarcerated person from pepper spray.

Did the investigator ask all relevant questions during interviews?

The investigator failed to ask all relevant questions during the interviews. The investigator did not ask witnesses and subjects questions regarding their knowledge of departmental policies and procedures related to the controlled use of force, pepper spray decontamination, and distribution of incarcerated persons' medications and meals.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all relevant interviews. The investigator failed to interview additional subjects because the investigator did not address all the allegations the incarcerated person submitted in his complaint.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator failed to properly gather and review relevant evidence. The investigator did not obtain

departmental policies regarding the controlled use of force and pepper spray decontamination. In addition, the investigator did not review departmental policies on denying an incarcerated person his medication and meals

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator failed to address all the claims indicated in the complaint and did not include departmental policies and procedures regarding controlled use of force, pepper spray decontamination, and distribution of incarcerated persons' medications and meals.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to include a subject officer's complete statement when he stated, "I probably shouldn't have said it, but I told him you're on a diet today you can eat again tomorrow if you follow procedure."

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority failed to identify that the investigator did not address the allegations that officers allegedly slammed an incarcerated person's head on the wall repeatedly during an escort. Officers allegedly turned on boiling hot water for the incarcerated person to decontaminate from pepper spray. The hiring authority should have returned the inquiry to the investigator to address all the allegations.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence. The investigator failed to address all allegations in the complaint. The investigator did not address the allegation that officers slammed an incarcerated person's head on the wall repeatedly and an officer allegedly turned on boiling hot water to decontaminate the incarcerated person from pepper spray. The investigator also failed to include a subject officer's complete statement, "I probably shouldn't have said it, but I told him you're on a diet today you can eat again tomorrow if you follow procedure." The hiring authority should have returned the inquiry to the investigator for further fact-finding.

Overall Rating

Poor

OIG Case Number

22-0041986-SC

Case Summary

On July 13, 2021, a sergeant allegedly slammed an incarcerated person to the ground when the incarcerated person would not enter his new cell. Two officers then allegedly dragged, kicked, and struck the incarcerated person with their knees, while the sergeant allegedly stomped on the incarcerated person's head. The incarcerated person sustained a scraped knee, black eye, and swollen wrist.

Case Disposition

The hiring authority did not identify staff misconduct. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator failed to obtain relevant evidence and incorporate it into the inquiry report. The investigator also failed to accurately report a witness statement in the final inquiry report and to provide the confidentiality admonition at the conclusion of five witness interviews.

Questions

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

The investigator failed to provide a confidentiality admonition at the conclusion of each interview. The investigator did not provide confidentiality admonitions to the incarcerated person who submitted the complaint and incarcerated person witnesses.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather and review all relevant evidence for the inquiry. During the incarcerated person's interview on February 1, 2022, the incarcerated person stated he sent an email to a relative from a department-issued device after the alleged unreasonable force incident. The investigator did not confirm during subsequent interviews if the incarcerated person sent an email from a department-issued device.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly conduct the inquiry. The investigator did not identify the interview location during witness interviews. Further, the investigator selected an interview location that was not in a confidential setting, free of distractions and outside noise. The investigator did not pause an interview and failed to identify the source of humming and whistling sounds during the interview.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts. The investigator did not accurately document statements from a staff witness in the inquiry report. The report indicates the incarcerated person went inside their newly assigned cell without incident. However, a staff witness stated that one of the three subjects grabbed the incarcerated person's right arm to assist the incarcerated person into his cell. It was during that action, the incarcerated person allegedly pulled away from the officer, which resulted in another subject officer being called to provide assistance.

Did the hiring authority adequately consult with the OIG?

The hiring authority did not adequately consult with the OIG. The hiring authority failed to timely provide the final disposition to the OIG. The hiring authority provided the final disposition to the OIG 43 days after the OIG's request for the information.

Overall Rating

Poor

OIG Case Number

22-0042718-SC

Case Summary

On September 28, 2021, an officer allegedly pulled the arm of an incarcerated person through the food port of a cell door and swung the incarcerated person's arm back and forth, causing the incarcerated person's arm to strike the sides of the food port. The officer allegedly failed to activate his personal alarm after the incident and threw the incarcerated person's lunch through the food port on to the floor. A lieutenant allegedly falsified an administrative segregation placement notice.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not obtain relevant departmental policy for use-of-force incidents, activation of personal alarm devices, and serving kosher meals.

Questions

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator failed to use effective interviewing techniques when conducting interviews. The investigator did not ask open-ended questions, prompting those being interviewed to provide short and vague responses.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not obtain relevant departmental policy for use-of-force incidents, activation of personal alarm devices, and serving kosher meals.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not obtain relevant departmental policy for use-of-force incidents, activation of personal alarm devices, and serving kosher meals.

Overall Rating

Poor

OIG Case Number

22-0042721-SC

Case Summary

On February 21, 2022, an officer allegedly pushed an incarcerated person into a wall multiple times. The officer allegedly threw the incarcerated person's food onto the ground.

Case Disposition

The hiring authority conducted an inquiry and determined that the inquiry conclusively proved the misconduct did not occur. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

The department poorly handled the inquiry. Due to poor planning, the investigator did not interview the incarcerated person who filed the complaint. The investigator did not interview an additional witness he identified in his inquiry plan. Moreover, the investigator did not include information concerning a site visit in the inquiry report.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

On March 25, 2022, the department assigned the investigator to conduct the inquiry; however, the investigator did not learn the status of the incarcerated person until April 18, 2022, at which time the investigator learned that the department had already released the incarcerated person on parole on April 7, 2022.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. The investigator did not interview the incarcerated person who submitted the complaint. The department assigned the investigator to conduct the inquiry on March 25, 2022. The department released the incarcerated person on parole on April 7, 2022, 13 days thereafter. The investigator later contacted the incarcerated person's spouse to schedule an interview with the incarcerated person but he refused to participate. In addition, the investigator identified another witness in his inquiry plan but never conducted an interview of the other witness.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator prepared a draft inquiry report that did not include the investigator's May 2, 2022, site visit to the location where the alleged incident occurred.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence. The investigator did not interview the incarcerated person who submitted the complaint. The department assigned the investigator to conduct the inquiry on March 25, 2022. The department released the incarcerated person on parole on April 7, 2022, 13 days thereafter. The investigator later contacted the incarcerated person's spouse to schedule an interview with the incarcerated person but he refused to participate. In addition, the investigator identified another witness in his inquiry plan but never conducted an interview of the other witness.

Overall Rating

Poor

OIG Case Number

22-0042684-SC

Case Summary

On October 27, 2021, an officer allegedly placed both of his arms between an incarcerated person's left shoulder and right neck area. The officer then allegedly punched the incarcerated person in the mouth and forced him to the ground. The officer also allegedly directed profanity towards the incarcerated person and falsified a report regarding the incident. In addition, a sergeant allegedly also submitted a false report.

Case Disposition

The hiring authority did not identify staff misconduct as to the officer. The documentation received from the hiring authority only reflected a finding as to the officer, not as to the sergeant. Later, the hiring authority sent an email to the OIG reflecting that the hiring authority had not sustained allegations as to either subject. The OIG agreed with the hiring authority's decision as to the officer and the sergeant.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not include in the inquiry report departmental policies and procedures, such as use-of-force and body search policies.

Questions

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not obtain relevant departmental policies for use-of-force incidents and body searches.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not include in the inquiry report departmental policies and procedures, such as use-of-force and body search policies.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not include in the inquiry report departmental policies and procedures, such as use-of-force and body search policies.

Did the hiring authority determine the inquiry was sufficient to determine a finding for each allegation?

The hiring authority failed to identify an allegation that a sergeant allegedly falsified his report. As a result, the hiring authority did not make an appropriate finding for each allegation.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority failed to identify an allegation that a sergeant allegedly falsified his report. As a result, the hiring authority did not make an appropriate finding for each allegation.

Overall Rating

Poor

OIG Case Number

22-0042659-SC

Case Summary

On October 18, 2021, officers allegedly did not secure medical treatment for an incarcerated person when he reported that he swallowed a razor blade. A captain, two sergeants, and two officers allegedly threatened the incarcerated person when the incarcerated person refused to exit the cell. The two officers allegedly attacked the incarcerated person with a shield, causing him to fall out of his wheelchair and suffer injuries to his head.

Case Disposition

The hiring authority did not identify staff misconduct. Due to the poor quality of the inquiry work, the OIG did not reach a conclusion regarding whether there was a reasonable belief of staff misconduct.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. Aside from the medical evaluation form, the investigator failed to obtain medical records regarding whether the incarcerated person had swallowed a razor blade and also concerning the medical treatment of the incarcerated person after the incident. Additionally, the investigator did not interview a psychologist who met with the incarcerated person after the alleged incident. The investigator used poor interviewing techniques during an interview of the incarcerated person who submitted the complaint. The investigator did not interview a relevant witness. The hiring authority did not assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject, a captain, and the investigator held the same rank as one of the subjects who was a lieutenant.

Questions

Did the hiring authority assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject allegedly involved in the misconduct?

The hiring authority did not assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject, a captain, allegedly involved in using excessive force against an incarcerated person. In addition, the investigator held the same rank as one of the subjects who was a lieutenant.

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not gather all applicable documents. The investigator did not gather documents related to the incarcerated person's visit to see a physician for x-rays, his medical clearance from the psychologist, or his transfer paperwork.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

The investigator failed to provide confidentiality admonishments at the end of witness and subject interviews.

Did the investigator ask all relevant questions during interviews?

The investigator did not ask all relevant questions during interviews. The investigator did not ask the subjects what the department's use-of-force policy states to confirm and establish the subjects' knowledge of the policy. The investigator failed to ask one subject foundational questions relating to his work experience and time with the department.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator failed to use effective interviewing techniques when conducting an interview. During an interview with the incarcerated person who submitted the complaint, the investigator incorrectly summarized the incarcerated person's statement, prompting the incarcerated person to correct the investigator. The investigator stated, "So the R&R sergeant told unknown COs to go in there and beat you up?" The incarcerated person corrected the investigator and said, "He did not say beat me up...he said, "Go in there and get him."

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews. The investigator did not interview a lieutenant who was mentioned by two officers and one sergeant as being present during the removal of the incarcerated person from a cell and had knowledge of the incarcerated person telling the officers he swallowed a razor.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not gather all applicable documents that could corroborate statements the incarcerated person or subjects made during their interviews. For example, the investigator did not obtain any medical records pertaining to the incarcerated person's medical treatment. The investigator did not obtain any medical documentation relating to the incarcerated person being cleared for transportation to another facility. The documentation could have confirmed the subjects' claim that the incarcerated person was cleared to be transported to another facility after the incarcerated person alleged he swallowed a razor blade.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator failed to interview a lieutenant who was mentioned by two officers and one sergeant as being present during the cell extraction and had knowledge of the incarcerated person telling the officers he swallowed a razor. The investigator also failed to gather and review the incarcerated person's medical clearance from the psychologist, or the incarcerated person's transfer paperwork, that could have confirmed the subjects' claim that the incarcerated person was cleared to be transported to another facility after allegedly swallowing a razor.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The investigator failed to interview a lieutenant who was identified by others as present during the incarcerated person's cell extraction. The hiring authority failed to identify that the investigator did not interview a relevant witness and therefore did not make an appropriate finding concerning the inquiry.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence because they failed to return the inquiry to the investigator to conduct an interview with the lieutenant who was allegedly present during the incarcerated person's cell extraction. The additional interview could have corroborated or refuted statements provided by the subjects.

Overall Rating

Poor

OIG Case Number

22-0042663-SC

Case Summary

On August 12, 2021, five officers allegedly punched, kicked, and struck with their knees an incarcerated person in the head and neck area. One of the officers allegedly deployed pepper spray on the incarcerated person. The incarcerated person subsequently lost consciousness, suffered an asthma attack, and sustained a broken nasal cavity. Further, the officers allegedly used racially discriminatory and derogatory language toward the incarcerated person during the incident.

Case Disposition

The hiring authority did not identify staff misconduct. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator failed to appropriately admonish the incarcerated person who submitted the complaint, witnesses, and subjects concerning the confidentiality of the interviews. The investigator did not maintain confidentiality by disclosing security threat group information to incarcerated person witnesses. By not maintaining confidentiality, the investigator placed the incarcerated person at risk. Further, the final inquiry report did not include that the investigator disclosed to witnesses that the incarcerated person was a member of a security threat group.

Questions

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During interviews on March 28, 2022, through May 23, 2022, the investigator did not provide the confidentiality admonishment to the incarcerated person that submitted the complaint, witnesses, and subjects.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator did not use effective interviewing techniques when conducting interviews. The investigator disclosed confidential security threat group information to witnesses. By not maintaining confidentiality, the investigator placed the incarcerated person that submitted the complaint at risk.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts. The inquiry report did not include that the investigator disclosed to an incarcerated person witness that the incarcerated person who filed the complaint was a member of a security threat group.

Overall Rating

Poor

OIG Case Number

21-0038405-SC

Case Summary

On February 2, 2021, a chief deputy warden, two captains, a lieutenant, and a sergeant allegedly rehoused an incarcerated person from his mental health housing to a management cell in retaliation for previous lawsuits he filed and withdrew.

Case Disposition

The hiring authority did not identify staff misconduct. Due to the poor quality of the inquiry work, the OIG did not reach a conclusion regarding whether there was a reasonable belief of staff misconduct.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator asked questions that did not pertain to the allegation that the incarcerated person was rehoused from his mental health housing to a management cell. The investigator failed to complete a thorough inquiry and did not conduct interviews with the subjects to document their statements regarding their alleged role in rehousing the incarcerated person from his mental health housing to a management cell. Lastly, while the department determined staff did not violate policy, the department failed to render the decision before the deadline to take disciplinary action.

Questions

Did the hiring authority assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject allegedly involved in the misconduct?

The hiring authority did not assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject allegedly involved in the staff misconduct. The investigator was a captain, whereas one of the subjects was a chief deputy warden.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During interviews on August 10, 2021, through November 29, 2021, the investigator did not provide a confidentiality admonishment to the incarcerated person who submitted the complaint, a subject, and witnesses.

Did the investigator ask all relevant questions during interviews?

The investigator failed to ask all relevant questions during the interviews. The investigator did not ask the subjects questions regarding departmental policies related to rehousing incarcerated people from mental health housing.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator did not use effective interviewing techniques when she conducted interviews. The investigator failed to prepare and document the interview questions that resulted in an unorganized interview. The investigator asked questions that did not pertain to the incarcerated person's allegation that prison staff rehoused the incarcerated person from his mental health housing to what he referred to as a "torture" cell.

Did the investigator complete all necessary and relevant interviews?

The investigator failed to complete five subject interviews.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather departmental policies and procedures regarding incarcerated persons' cell assignments when an incarcerated person is perceived as a threat.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly and appropriately conduct the inquiry. The investigator did not conduct interviews with five subjects. Additionally, the investigator did not properly gather departmental policies and procedures regarding incarcerated persons' cell assignments when an incarcerated person is perceived as a threat.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare an inquiry report that included all relevant facts. Specifically, the investigator did not interview five subjects. Additionally, the investigator did not properly gather departmental policies and procedures regarding incarcerated persons' cell assignments when an incarcerated person is perceived as a threat.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence. The department did not render a final determination of alleged staff misconduct until one year, nine months, and six days after the department received the complaint. The deadline to take disciplinary action had expired by the time the department rendered its decision.

Overall Rating

Poor

OIG Case Number

22-0042682-SC

Case Summary

On January 3, 2022, an officer allegedly refused an incarcerated person's request to be handcuffed in front due to a medical condition and placed him in a wheelchair covered in animal feces and dirt. A second officer allegedly handcuffed the incarcerated person's hands in back and pulled hard, causing pain to the incarcerated person's shoulder. A third officer allegedly forced the incarcerated person, who had a hernia, to walk a long distance from the treatment triage area to the administrative segregation unit. Further, an unknown classification committee member allegedly told the incarcerated person that custody staff could not issue special handcuffing memorandums. Unknown medical staff allegedly told the incarcerated person they did not want to accommodate his medical requests because prison staff would be mad.

Case Disposition

The hiring authority did not identify staff misconduct as to the officers, but determined that a lieutenant and a counselor needed training regarding requests from incarcerated persons for reasonable accommodations. Therefore, the hiring authority caused training to be provided to the lieutenant and counselor. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator did not complete all necessary and relevant interviews, did not obtain all relevant records, and failed to prepare an inquiry report that included all relevant facts and allegations.

Questions

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary and relevant interviews regarding an additional allegation that a counselor allegedly ignored the incarcerated person's verbal and written requests during classification committee meetings.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not obtain relevant records of departmental policy regarding special handcuffing requests.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly conduct the inquiry. The investigator did not identify or address all of the allegations within an incarcerated person's complaint. The hiring authority returned the inquiry to the investigator for clarifying information on an additional allegation that while being handcuffed the incarcerated person collapsed, resulting in a popping noise and pain in his shoulder. An unknown medical staff member allegedly did not want to accommodate the incarcerated person's requests because it would make correctional staff mad. The investigator was asked by the hiring authority to obtain additional evidence and conduct additional interviews to address the missed allegations. The investigator also addressed allegations that the incarcerated person's constitutional rights had been violated, that an unknown classification committee member told the incarcerated person custody staff could not assist or issue a special handcuffing memorandum, and that requests for a special handcuffing memorandum had gone unheard.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence and supporting exhibits. The investigator did not identify all the allegations in the inquiry report. Further, the investigator failed to include relevant records of departmental policy for special handcuffing requests and failed to note the reason why a subject was not interviewed.

Did the hiring authority determine the inquiry was sufficient to determine a finding for each allegation?

The hiring authority did not find the inquiry sufficient to determine a finding for each allegation. The hiring authority returned the inquiry to the investigator to obtain additional information for an allegation that while being handcuffed, the incarcerated person collapsed, resulting in a popping noise and pain in his shoulder. An unknown medical staff member allegedly did not want to accommodate the incarcerated person's medical requests because it would make correctional staff mad.

Overall Rating

Poor

OIG Case Number

21-0041331-SC

Case Summary

Between May 19, 2021, and September 15, 2021, four officers allegedly conducted racially-motivated searches and issued racially-targeted rules violation reports. On September 2, 2021, one of those officers allegedly planted a substance containing marijuana in an incarcerated person's bunk area.

Case Disposition

The hiring authority did not identify staff misconduct. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator failed to identify and interview three officers as subjects, instead the investigator interviewed the officers as witnesses. The hiring authority should have returned the inquiry to the investigator for further clarification regarding the identity of the subjects. In addition, the investigator obtained incarcerated persons rules violation reports from June 2021 through September 2021 to determine the race of incarcerated persons who received the violations. The investigator provided the reports to the OIG; however, the investigator did not explain if he reviewed reports or concluded findings, and did not include the reports as exhibits in the final inquiry report.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not adequately prepare for the inquiry. The investigator failed to identify three of the four subject officers who allegedly conducted searches based on incarcerated persons' race. Instead, the investigator interviewed three witnesses and asked them subject-related questions.

Did the investigator ask all relevant questions during interviews?

The investigator did not ask the subject questions regarding a confidentiality violation after the incarcerated person informed the investigator the subject officer approached the incarcerated person about the allegations in the complaint.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not properly gather and review all relevant evidence for the inquiry. The investigator did not gather and review cell search logs to identify three officers who allegedly conducted racially motivated searches.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator did not thoroughly conduct the inquiry. The investigator interviewed three officers as witnesses when he should have interviewed the officers as subjects.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not include in the inquiry report rules violation reports from June 2021 through

September 2021 to address the allegation of racially motivated searches, nor did the investigator incorporate the documents as exhibits in the final inquiry report.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence. The investigator failed to identify three of the four officers as subjects. The department should have returned the inquiry to the investigator for further fact-gathering to interview three subject officers. Instead, the investigator interviewed the three officers as witnesses and asked them subject-related questions.

Overall Rating

Satisfactory

OIG Case Number

22-0042365-SC

Case Summary

On April 11, 2021, a sergeant and an officer allegedly retaliated against an incarcerated person by falsifying a visitor application to reflect that the incarcerated person's wife had criminal convictions when that was not the case. The sergeant's and officer's actions allegedly caused the incarcerated person's wife's visiting privileges to be suspended. The incarcerated person's wife allegedly had previously filed a complaint against the sergeant.

Case Disposition

The hiring authority did not identify staff misconduct, and the OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator did not gather documentary evidence related to departmental policies and procedures regarding processing visitor applications.

Did the investigator adequately consult with the OIG?

The investigator failed to adequately consult with the OIG. The investigator did not provide the OIG with documentary evidence within 24-hours of receipt during the inquiry. Further, the investigator failed to notify the OIG the inquiry report was sent to the hiring authority for a determination.

Overall Rating


 Poor

OIG Case Number

22-0041881-SC

Case Summary

On July 23, 2021, an officer allegedly grabbed an incarcerated person's neck and strangled him until he lost consciousness.

Case Disposition

The hiring authority did not identify staff misconduct. Due to the poor quality of the inquiry work, the OIG did not reach a conclusion regarding whether there was a reasonable belief of staff misconduct.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The department waited four months and one day to conduct interviews. The investigator failed to identify and interview a subject who was listed on a medical report, did not confirm the witnesses' knowledge of the department's use-of-force policy, and did not confirm specific details with staff present during the subject's alleged unreasonable force against the incarcerated person.

Questions

Did the investigator adequately prepare for all aspects of the inquiry?

The investigator did not adequately prepare for the inquiry. The investigator failed to identify an officer who was listed as present during the incarcerated person's medical appointment, where another officer allegedly strangled the incarcerated person. The investigator failed to identify and interview a witness officer who completed a log for July 23, 2021, that noted a medical incident occurred involving force.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During interviews on January 21, 2022, the investigator did not provide a confidentiality admonishment to five witnesses. During an interview on February 1, 2022, the investigator did not provide a confidentiality admonishment to a witness.

Did the investigator ask all relevant questions during interviews?

The investigator did not ask all relevant questions during interviews. The investigator did not ask the witnesses what the department's use-of-force policy stated to establish their knowledge of the policy. The investigator failed to ask a witness present during the alleged incident to confirm the date and time of the incident. The investigator did not ask the witness if she had been named in a complaint the incarcerated person previously filed.

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator failed to use effective interviewing techniques when conducting interviews. The investigator did not ask the witnesses questions to establish their knowledge of the department's use of force policy. The investigator also failed to ask the witness a follow up question to establish a timeline of events for the subject's alleged unreasonable force against the incarcerated person.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all relevant interviews. The investigator failed to identify and interview an officer

who was present during the subject's alleged unreasonable force against an incarcerated person.

Did the investigator properly gather and review all relevant documentary and other evidence?

The investigator failed to properly gather and review relevant evidence. The investigator failed to thoroughly review a medical report that listed the name of an officer who was present during the alleged unreasonable force incident. The investigator failed to gather and review an additional daily log of incidents which may have included relevant information to the inquiry.

Did the investigator thoroughly and appropriately conduct the inquiry?

The investigator failed to thoroughly review evidence that listed the name of an officer who was present during the subject's alleged unreasonable force against an incarcerated person, and did not interview the witness.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits. The investigator did not include in the inquiry report a copy of the department's use-of-force policy. The investigator also inaccurately summarized the incarcerated person's statements from the complaint in the inquiry report.

If the hiring authority found the inquiry sufficient to determine a finding for each allegation, did the hiring authority make the appropriate finding or findings for each allegation?

The hiring authority failed to identify an officer who was present during a subject's alleged unreasonable force against an incarcerated person. The hiring authority should have returned the inquiry to the investigator to interview the officer.

Did the department handle and process the inquiry with due diligence?

The department did not handle and process the inquiry with due diligence because the investigator failed to thoroughly review a medical report. The report summarized the medical appointment with the incarcerated person when he alleged an officer grabbed him by the neck and strangled him until he lost consciousness. On September 20, 2021, the department assigned the inquiry to the investigator. On January 21, 2022, the investigator conducted his first interview, four months and one day after being assigned the inquiry.

Overall Rating

Satisfactory

OIG Case Number

22-0042724-SC

Case Summary

On December 29, 2021, an officer allegedly denied an incarcerated person access to a scheduled telephone call because of his race and in retaliation for filing past complaints. Instead, the officer allowed another incarcerated person to use the phone during the incarcerated person's scheduled time.

Case Disposition

The hiring authority did not identify staff misconduct. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all relevant interviews. The investigator did not interview an incarcerated person witness who alleged to have an encounter with the subject officer regarding telephone privileges. The investigator did not disclose in the inquiry report why he did not interview the additional witness.

Overall Rating

Poor

OIG Case Number

22-0042854-SC

Case Summary

Between March 28, 2022, and March 29, 2022, an officer allegedly forced an incarcerated person to send alleged excess property to her residence in retaliation for previously being housed in the security housing unit. Additionally, the officer allegedly exhibited inappropriate sexual behaviors with incarcerated persons.

Case Disposition

The hiring authority did not identify staff misconduct. Due to the poor quality of the inquiry work, the OIG did not reach a conclusion regarding whether there was a reasonable belief of staff misconduct.

Overall Inquiry Assessment

Overall, the department poorly conducted the inquiry. The investigator failed to conduct a thorough investigation by not interviewing the subject officer despite the investigator identifying an additional allegation against the officer during the interview with the incarcerated person. The investigator also conducted an interview of a witness in a setting that was not confidential. Further, the investigator inaccurately depicted an incarcerated person's declination to be interviewed in the final inquiry report.

Questions

Did the investigator use effective interviewing techniques when conducting interviews?

The investigator did not use effective interviewing techniques when conducting interviews. The investigator conducted an interview of an incarcerated person in a setting that was not confidential. The interview room was at an officer's station with large, uncovered windows, and numerous incarcerated persons walked by and looked into the room during the interview.

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete all necessary interviews. The investigator did not interview the subject officer to address either the original allegation in the incarcerated person's complaint or the additional allegation the incarcerated person made during her interview.

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts. The investigator prepared a report that stated an incarcerated person witness declined to be interviewed by the investigator; however, the investigator failed to indicate in the report the witness had agreed to go on record to document her refusal and provide additional details related to the incident.

Overall Rating

Poor

OIG Case Number

21-0041769-SC

Case Summary

On September 16, 2021, in retaliation for an incarcerated person filing a complaint against an officer, the officer allegedly denied an incarcerated person access to a housing unit in which the incarcerated person was scheduled to work. The officer's action allegedly interfered with the incarcerated person performing his job duties.

Case Disposition

The hiring authority did not identify staff misconduct. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department poorly handled the inquiry. The investigator did not complete a necessary and relevant interview.

Questions

Did the investigator complete all necessary and relevant interviews?

The investigator did not complete a necessary and relevant interview. On November 1, 2021, the department assigned the investigator to conduct the inquiry, but he did not schedule an interview of the incarcerated person who submitted the complaint until December 22, 2021, 51 days thereafter. The investigator scheduled the interview for December 27, 2021; however, the department released the incarcerated person on parole on December 27, 2021, before the interview took place. The investigator never interviewed the incarcerated person.

Overall Rating

Satisfactory

OIG Case Number

21-0041529-SC

Case Summary

On May 7, 2021, the officer allegedly authored a false rules violation report in retaliation for the incarcerated person filing prior complaints against the officer.

Case Disposition

The hiring authority did not identify staff misconduct. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department conducted the inquiry in a satisfactory manner.

Questions

Did the investigator prepare a draft inquiry report that included all relevant facts, evidence, and supporting exhibits?

The investigator failed to prepare a draft inquiry report that included all relevant facts. The investigator did not include in the inquiry report that the subject officer escorted an incarcerated person witness to a room for an interview. Based on the subject officer's inappropriate actions, the investigator rescheduled the interview.

Did the hiring authority adequately consult with the OIG?

The hiring authority did not adequately consult with the OIG and did not timely provide the final disposition. On August 5, 2022, and September 7, 2022, the OIG requested the final disposition from the hiring authority. The hiring authority provided the OIG with the final disposition on September 7, 2022, 33 days after the OIG's initial request for the information.

Overall Rating

Satisfactory

OIG Case Number

22-0042406-SC

Case Summary

On October 13, 2021, a sergeant allegedly authored a false rules violation report against an incarcerated person for possession of a wireless device. On November 19, 2021, a lieutenant allegedly denied the incarcerated person his right to a staff assistant during the disciplinary hearing for the rules violation. On December 5, 2021, the associate warden approved the alleged false rules violation report.

Case Disposition

The hiring authority did not identify staff misconduct. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

Questions

Did the hiring authority assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject allegedly involved in the misconduct?

The hiring authority did not assign an investigator to conduct the inquiry who was at least one rank higher than the highest-ranking subject allegedly involved in the misconduct. The investigator held the same rank as one of the subjects, a lieutenant, he was assigned to investigate, which violates departmental policy.

Did the investigator ask all relevant questions during interviews?

The investigator failed to ask all relevant questions during the interviews. The investigator did not ask the lieutenant why he did not allow the incarcerated person to provide evidence of support during his disciplinary hearing. In addition, the investigator did not ask the lieutenant if the incarcerated person should have been assigned a staff assistant during the disciplinary hearing.

Overall Rating

Satisfactory

OIG Case Number

21-0041390-SC

Case Summary

On September 10, 2021, a library assistant allegedly used a racial epithet when addressing an incarcerated person. Additionally, the library assistant allegedly documented that the incarcerated person was argumentative, due to a complaint the incarcerated person filed against the library assistant.

Case Disposition

The hiring authority did not identify staff misconduct and did not refer the matter to the Office of Internal Affairs. The OIG agreed with the hiring authority's decision.

Overall Inquiry Assessment

Overall, the department handled the inquiry in a satisfactory manner.

2022 Investigation Case Summaries

Investigation Case Summaries

Incident Date

February 3, 2022

OIG Case Number

22-0043603-INV

Case Summary

On February 3, 2022, and May 30, 2022, an officer allegedly called a transgender incarcerated person improper pronouns.

Assessment Ratings

Satisfactory



Case Disposition

The hiring authority found insufficient evidence to sustain the allegations. The OIG concurred.

Overall Assessment

The department's performance was satisfactory.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The OIG found no major deficiencies, resulting in a satisfactory assessment.

Did the department handle the investigation and its processing with due diligence?

The Office of Internal Affairs' Allegation Investigation Unit manager approved the report on September 30, 2022. However, the Office of Internal Affairs' Allegation Investigation Unit did not provide the report to the hiring authority until October 17, 2022, 17 days later.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The OIG found no major deficiencies, resulting in a satisfactory assessment.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult with the Office of Internal Affairs concerning the assignment of the investigator.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The OIG found no major deficiencies, resulting in a satisfactory assessment.

Incident Date

April 8, 2022

OIG Case Number

22-0043448-INV

Case Summary

On April 8, 2022, an officer allegedly filed a false rules violation report reflecting that an incarcerated person refused to sign a compatibility agreement form, when, in fact, the incarcerated person wanted to sign the form, but could not sign because another officer had recently deployed pepper spray on the incarcerated person's eyes.

Assessment Ratings



Case Disposition

The hiring authority sustained the neglect of duty allegation, but did not sustain the dishonesty allegation, and imposed a letter of instruction. The OIG concurred.

Overall Assessment

The department's performance was poor because the investigator failed to preserve body-worn camera video evidence, failed to prepare adequately for interviews, and the Office of Internal Affairs' Allegation Investigation Unit delayed delivery of its report to the hiring authority. Also, the department attorney did not provide timely advice to the investigator about preserving the video-recorded evidence.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The investigator's performance was poor because the investigator did not preserve the body-worn camera video recordings, and did not adequately prepare for remote interviews.

Did the investigator adequately prepare for all aspects of the investigation?

During attempted interviews on July 21, 2022, July 22, 2022, and July 28, 2022, the investigator failed to adequately prepare for remote interviews of three incarcerated witnesses and none of the interviews occurred. On August 9, 2022, the investigator conducted in-person interviews with each of the three incarcerated persons, however did not have a video camera to provide video of the interviews for the department attorney. Also, the investigator failed to preserve the video recordings from the officer's body-worn camera before the recordings expired.

Did the investigator properly gather and review all documentary and other evidence?

The investigator failed to preserve relevant video-recorded evidence before the recordings expired.

Did the investigator thoroughly and appropriately conduct the investigation?

The investigator failed to preserve relevant video-recorded evidence before the recordings expired.

Did the department handle the investigation and its processing with due diligence?

The investigator failed to preserve relevant video-recorded evidence before the recordings expired. Also, the investigator conducted the final interview on August 19, 2022. However, the Office of Internal Affairs' Allegation Investigation Unit did not provide its report and exhibits to the hiring authority until October 4, 2022, 46 days thereafter.

Did the OIG have an impact on the Office of Internal Affairs' handling of the investigation?

The OIG provided a recommendation to correct the draft report which contained a reference to an incorrect grievance number. The investigator corrected the error.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The department attorney's performance was poor because the advice was untimely and did not allow for video evidence to be preserved.

Did the department attorney provide timely and appropriate advice and recommendations to the investigator during the investigation?

The department attorney did not timely advise the investigator to preserve the video recordings.

Did the department attorney or employee relations officer handle the case with due diligence?

The Office of Internal Affairs' Centralized Screening Team determined an investigation should be conducted on June 13, 2022. However, the department did not assign an attorney to the case until July 1, 2022, 18 days thereafter, and 15 days after policy requires.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The hiring authority's performance was satisfactory.

Incident Date

May 15, 2022

OIG Case Number

22-0043449-INV

Case Summary

On May 15, 2022, an officer allegedly struck an incarcerated person with a shield, and one of a group of six officers and a sergeant allegedly made sexually derogatory statements to the incarcerated person.

Assessment

Ratings

Satisfactory



Case Disposition

The hiring authority found insufficient evidence to sustain the allegations against the sergeant and six officers. The OIG concurred.

Overall Assessment

The department's performance was satisfactory.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The investigator's performance was satisfactory.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The department attorney's performance was satisfactory.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult with the Office of Internal Affairs concerning the assignment of the investigator.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The hiring authority's performance was satisfactory.

Incident Date

May 17, 2022

OIG Case Number

22-0043450-INV

Case Summary

On May 17, 2022, a counselor allegedly falsified a document by recording that an incarcerated person attended a committee meeting when the incarcerated person did not attend the meeting.

Case Disposition

The hiring authority found insufficient evidence to sustain the allegation. The OIG concurred with the hiring authority's determination.

Overall Assessment



The department's handling of the case was poor because the investigator did not prepare adequately for the interview environment during two interviews to ensure adequate communications and confidentiality. Also, the Office of Internal Affairs' Allegation Investigation Unit unduly delayed providing the final report to the hiring authority.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The Office of Internal Affairs' Allegation Investigation Unit's performance in investigating allegations of employee misconduct was poor because the investigator did not adequately prepare for interviews conducted both remotely and in person. Also, the Allegation Investigation Unit did not exercise due diligence when it delayed completion and delivery of the report and exhibits to the hiring authority.

Did the investigator adequately prepare for all aspects of the investigation?

During an interview of an incarcerated person on July 18, 2022, the investigator needed to borrow the OIG's mobile phone in order to allow for the department attorney to hear the interview remotely. During an interview of the counselor on August 12, 2022, the investigator failed to make arrangements ahead of time to ensure the interview could be conducted with the officer in a confidential setting while the investigator and department attorney appeared remotely.

Did the department handle the investigation and its processing with due diligence?

The investigator completed the final interview on August 12, 2022. However, the Office of Internal Affairs' Allegation Investigation Unit did not provide its final report and exhibits to the hiring authority until September 28, 2022, 47 days thereafter.

Did the OIG have an impact on the Office of Internal Affairs' handling of the investigation?

During an interview of the incarcerated person on July 18, 2022, the investigator requested and utilized the OIG's mobile phone in order to allow for the department attorney to hear the interview because the investigator did not prepare other means for the department attorney to participate remotely. Also, during an interview of the counselor on August 12, 2022, the OIG appeared in person while the investigator and department attorney both appeared remotely. When the interview of the counselor began, the investigator and the department attorney did not know an office technician had not closed the door of the interview room and had been ordered by a lieutenant at the prison to keep the door open during the interview while the office technician remained outside the interview room and could hear everything being said. The investigator addressed the issue only after the OIG brought the matter to the investigator's attention.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The OIG found no major deficiencies, resulting in a satisfactory assessment.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult with the Office of Internal Affairs' Allegation Investigation Unit manager regarding the assignment of the investigation. The manager correctly assigned a lieutenant to conduct the investigation.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The OIG found no major deficiencies, resulting in a satisfactory assessment of the hiring authority's performance.

Incident Date

May 17, 2022

OIG Case Number

22-0043509-INV

Case Summary

On May 17, 2022, a sergeant allegedly told an incarcerated person that his telephone privileges would continue to be taken away if the incarcerated person continued to file staff misconduct complaints.

Case Disposition

The hiring authority found insufficient evidence to sustain the allegation. The OIG concurred with the hiring authority's determination.

Assessment Ratings

Poor

**Overall Assessment**

The department's performance was poor because the Office of Internal Affairs' Allegation Investigation Unit sent its report to the wrong person at the prison, resulting in the hiring authority being unaware of the investigation's completion. While this breakdown in communication between the Office of Internal Affairs' Allegation Investigation Unit and the hiring authority occurred, the department attorney assigned to advise the investigator and the hiring authority did not communicate with the hiring authority that the investigation concluded until after the OIG requested it. Also, the investigator failed to advise a witness of the admonition concerning confidentiality, resulting in the witness discussing his interview with another witness during a break in the interview. Lastly, the department did not provide notice to the sergeant of the allegations and the hiring authority's decision until after the OIG twice requested it.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The Office of Internal Affairs' Allegation Investigation Unit's performance was poor because the investigator did not properly admonish a witness regarding the confidentiality of the interview process, which led to the compromise of confidentiality of that interview, and because the Office of Internal Affairs' Allegation Investigation Unit mailed its report and exhibits to the wrong person at the prison which led to a delay in the hiring authority obtaining and conducting the investigative and disciplinary findings conference.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During an interview with the incarcerated person on July 26, 2022, the investigator did not provide an admonishment regarding confidentiality to the incarcerated person prior to a break in the interview. The incarcerated person then spoke about the content of his interview with the officer outside the interview room during the break. The officer was a potential witness to the underlying allegation of staff misconduct.

Did the department handle the investigation and its processing with due diligence?

The Office of Internal Affairs did not send the final report and exhibits to the correct person at the prison, leaving the hiring authority unaware the investigation had concluded and was ready for an investigative and disciplinary findings conference, which led to a delay in the setting of the conference.

Did the OIG have an impact on the Office of Internal Affairs' handling of the investigation?

On September 6, 2022, the OIG made the employee relations officer aware the investigator completed the investigation, and the OIG provided the tracking number for the package containing the report and exhibits the Office of Internal Affairs' Allegation Investigation Unit mailed to the prison. The employee relations officer then learned the report and exhibits had been mailed to the prison and received on August 29, 2022. However, the Office of Internal Affairs' Allegation Investigation Unit addressed the package to the wrong person at the prison.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The department attorney's performance was poor because the department attorney did not advise the Office of Internal Affairs' Allegation Investigation Unit manager regarding the proper type of investigator to be assigned to the investigation, did not follow up with the employee relations officer to schedule a timely investigative and disciplinary findings conference once the investigation concluded, and did not follow up with the hiring authority to ensure the employee relations officer provided notice to the sergeant of the allegations and the hiring authority's determination at the conclusion of the investigation.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult the Office of Internal Affairs' Allegation Investigation Unit manager regarding the assignment of the investigation.

Did the OIG have an impact on the performance of the department attorney or employee relations officer?

The OIG invited the department attorney to reach out to the hiring authority to schedule an investigative and disciplinary findings conference. This initiative by the OIG is significant because department attorney planned to wait for the hiring authority to schedule the conference while the hiring authority did not know the investigation had concluded and therefore did not know a need for scheduling the conference existed.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The hiring authority's performance was poor because the hiring authority did not timely conduct the investigative and disciplinary findings conference, did not timely provide the OIG with a copy of the closure letter, and unnecessarily delayed notice to the sergeant of the investigation and its result until after the OIG twice requested it.

Did the hiring authority timely consult with the OIG and department attorney regarding the investigation, findings, and disciplinary determinations?

The hiring authority received the report and exhibits on August 29, 2022. However, due to an error by the Office of Internal Affairs' Allegation Investigation Unit, the hiring authority did not become aware the report and exhibits arrived at the prison until September 6, 2022, when the OIG advised the employee relations officer of the tracking number for the report and exhibits. Policy requires the hiring authority to conduct an investigative and disciplinary findings conference within 14 days after the final report and exhibits are received. However, the hiring authority did not conduct the conference until September 27, 2022, 29 days after the report was delivered, and 21 days after the OIG advised the hiring authority of the need to schedule the conference.

Did the hiring authority handle the case with due diligence?

The hiring authority did not conduct a timely investigative and disciplinary findings conference. Also, the OIG requested a copy of the closure letter to the sergeant from the hiring authority at the findings and penalty conference on September 27, 2022, in an email on October 11, 2022, another email on October 31, 2022, and during an unrelated conference on November 30, 2022. The employee relations officer provided a copy of the closure letter to the OIG on December 2, 2022, 66 days after the original request. Lastly, the closure letter provided on December 2, 2022, did not include proof of service to the sergeant, which is a key purpose of the letter. The OIG requested proof of service from the employee relations officer on December 5, 2022, and the department then served the sergeant with a copy of the closure letter the same day, 69 days after the initial investigative and disciplinary findings conference concluded.

Did the OIG have an impact on the hiring authority's handling of the case?

During the investigative and disciplinary findings conference on September 27, 2022, the OIG requested, per department policy, the hiring authority provide a closure letter to the sergeant so the sergeant would have notice of the allegation made against him and notice of the final determination by the hiring authority of that allegation. Initially, the employee relations officer stated the closure letter would be filed by the department but not provided to the sergeant. At the recommendation of the OIG, and the

department attorney, the employee relations officer agreed to do so. The employee relations officer provided a copy of the closure letter to the OIG on December 2, 2022, but no proof of service to the sergeant was included. The OIG requested proof of service from the employee relations officer on December 5, 2022, and the department then served the sergeant with a copy of the closure letter the same day, 69 days after the initial investigative and disciplinary findings conference.

Incident Date

June 28, 2022

OIG Case Number

22-0043767-INV

Case Summary

On June 28, 2022, a sergeant allegedly ordered four officers to attack an incarcerated person after the incarcerated person reported the ability to return to the incarcerated person's cell without an escort and refused to be handcuffed and escorted to the cell. The sergeant and four officers allegedly slammed the incarcerated person to the ground, causing the incarcerated person to suffer a chipped tooth, abrasions, and contusions. One of the officers allegedly attempted to strangle the incarcerated person while the incarcerated person was on the ground, causing the incarcerated person to suffer a seizure.

Case Disposition

The hiring authority found insufficient evidence to sustain the allegations. The OIG did not agree with the hiring authority's decision.

Assessment Ratings



Overall Assessment

The department's handling of the case was poor because the Office of Internal Affairs' Allegation Investigation Unit, department attorney, and hiring authority determined the investigation was sufficient although the Office of Internal Affairs' Allegation Investigation Unit did not interview the incarcerated person who submitted the complaint or the sergeant and officers who were the subjects of the investigation. The investigator failed to identify all of the officers who allegedly committed misconduct, failed to follow up on the incarcerated person and officers' injuries as evidence of whether the force used was excessive or not, failed to address a possible inconsistent statement by one of the officers, and failed to identify and address in the investigation report that one of the officer's body-worn camera was missing three minutes of footage. The hiring authority relied upon the insufficient investigation to determine the officers and sergeant did not commit the alleged misconduct.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The Office of Internal Affairs' Allegation Investigation Unit's performance was poor because the investigator and Office of Internal Affairs' Allegation Investigation Unit manager relied on video evidence, which did not provide a complete view of the entire incident, to close the investigation and did not conduct any interviews of the incarcerated person, the officers and sergeant who allegedly committed the misconduct. The Office of Internal Affairs' Allegations Investigation Unit investigator and manager also failed to identify and include two additional officers involved in the use of force to investigate their actions, failed to obtain relevant evidence regarding injuries sustained by the incarcerated person and officers, failed to address a possible inconsistent statement by one of the officers, and failed to identify and address in the investigative report that one of the officer's body-worn camera was missing three minutes of footage. The Office of Internal Affairs' Allegation Investigation Unit manager approved the investigator's report based on an insufficient investigation.

Did the investigator adequately prepare for all aspects of the investigation?

The investigator did not adequately prepare for the investigation. The investigator did not follow up on treatment of injuries (or the lack thereof) for the incarcerated person and two of the officers that received treatment for their alleged injuries after the incident. The investigator did not conduct an interview of an officer that put an arm on the neck of the incarcerated person during the incident, whom the incarcerated person accused of attempting to strangle him. The investigator failed to include in the investigation report

an assessment about why the same officer's body-worn camera video did not have three minutes of the incident recorded, which omission included when the officer put an arm on the incarcerated person's neck.

Did the investigator complete all necessary and relevant interviews?

The investigator closed the investigation without conducting any interviews at all and relied solely on video evidence and written reports. However, none of the body-worn camera video recordings show a clear view of the entire incident, and much of the video recordings have a black screen and play audio only. Furthermore, the most egregious allegation is that one officer attempted to strangle the incarcerated person. The investigator did not interview that officer, and that officer's body-worn camera video did not have any recording of the time when he put his arm on the incarcerated person's neck. Also, based upon the OIG's review of the video-recorded footage, one sergeant and four officers used force on the incarcerated person during the incident but the investigator only identified the sergeant and two officers as subjects of the investigation. Also, the investigator failed to follow up on medical treatment of injuries the incarcerated person and two officers allegedly received during the incident. All of the above issues could have been addressed by witness interviews, but the investigator did not conduct any.

Did the investigator properly gather and review all documentary and other evidence?

The investigator did not conduct any interviews.

Did the investigator thoroughly and appropriately conduct the investigation?

The investigator closed the investigation without conducting any interviews at all and relied solely on video evidence and written reports, and failed to identify issues that required additional investigation. The investigator failed to identify all of the officers involved in the use of force as possible subjects of the investigation, and failed to follow up on the incarcerated person and officers' injuries as evidence of whether the force used was excessive or not. The investigator should have conducted interviews of the incarcerated person, officers, and sergeant to ask questions regarding these unresolved issues as part of a sufficient and thorough investigation.

Did the Office of Internal Affairs' Allegation Investigations Unit manager adequately review the investigation report and appropriately determine whether the investigation was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigation Unit manager inappropriately determined the case could be closed without conducting any interviews, including interviews of the incarcerated person who submitted the complaint and the sergeant and officers who allegedly committed misconduct. The Office of Internal Affairs' Allegation Investigation Unit manager failed to identify that the investigation report did not include the fact that an officer's body-worn camera video did not have three minutes of the incident recorded, which missing footage is from the body-worn camera of the officer that put an arm on the incarcerated person's neck during the use of force.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The department attorney's performance in providing legal advice to the Office of Internal Affairs' Allegation Investigation Unit and the hiring authority was poor because the department attorney assessed the investigation and investigation report as sufficient even though the Office of Internal Affairs' Allegation Investigation Unit conducted no interviews and because the department attorney failed to identify evidentiary issues that remained unresolved. The department attorney also inappropriately recommended the hiring authority make findings about the alleged misconduct based on an insufficient investigation.

Did the department attorney provide timely and appropriate advice and recommendations to the investigator during the investigation?

The department attorney failed to recommend the investigator conduct witness interviews and instead agreed with the investigator early on that the video evidence and written reports were sufficient to close the case. The department attorney also failed to identify issues that supported the need to conduct interviews as part of a sufficient investigation, including the failure to identify all appropriate officers that used force, the failure to follow up on the incarcerated person and officers' injuries as evidence of whether the force used was excessive or not, and the failure to identify and address that one of the officers that put an arm on the neck of the incarcerated person during the incident was missing that part of the incident on the officer's body-worn camera recording. The department attorney should have identified these deficiencies and recommended that the investigator conduct interviews of the incarcerated person and all officers and sergeant involved in the use of force to ask questions regarding these unresolved, relevant issues as part of a sufficient investigation.

Did the department attorney provide appropriate, thorough, and timely feedback and recommendations to the investigator regarding the investigation report?

Although the department attorney provided timely feedback, the department attorney should not have recommended the report was sufficient because the investigator closed the investigation without conducting any interviews at all and relied solely on video evidence and written reports, and the department attorney failed to identify issues that required additional investigative measures. The department attorney failed to identify all of the officers involved in the use of force as possible subjects of the investigation, failed to recommend follow up on the incarcerated person and officers' injuries as evidence of whether the force used was excessive or not, and failed to identify and make recommendations regarding an officer's body-worn camera evidence that was missing three minutes of footage. The department attorney should have concluded the investigation report was insufficient and further recommended the investigator conduct interviews of the incarcerated person, officers, and sergeant to ask questions regarding these unresolved issues.

Did the department attorney provide appropriate advice and recommendations to the hiring authority regarding the investigation, investigative findings, and disciplinary determinations?

The department attorney provided inappropriate advice to the hiring authority by recommending that the hiring authority find that the investigation was sufficient even though the Office of Internal Affairs' Allegation Investigation Unit conducted no interviews and because there were unresolved evidentiary issues that were not investigated. The department attorney also erred in recommending the hiring authority make a finding of insufficient evidence to support the allegations of misconduct because the investigation was insufficient and incomplete.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The hiring authority's performance was poor because the hiring authority determined the investigation to be sufficient even though the investigator conducted no interviews and did not completely follow up on injuries to the incarcerated person or two officers. The hiring authority then relied on the insufficient investigation and inappropriately determined the evidence did not support that any staff misconduct occurred.

Did the hiring authority adequately prepare for and consult with the OIG regarding the investigation, findings, and disciplinary determinations?

The hiring authority failed to identify issues in the investigation report and supporting evidence that required additional investigative measures before informed findings could be made. The hiring authority failed to identify all of the officers involved in the use of force as possible subjects of the investigation, failed to identify the need for follow up on the alleged injuries of the incarcerated person and two officers which are relevant to as a factor in consideration of whether force used was excessive or not, failed to identify a possible inconsistent statement by one of the officers, and failed to identify that an officer's body-worn camera evidence was missing three minutes of the incident including when the officer put an arm on the incarcerated person's neck.

Did the hiring authority properly deem the Office of Internal Affairs investigation sufficient or insufficient?

The hiring authority improperly deemed the Office of Internal Affairs' Allegation Investigation Unit investigation sufficient although the Office of Internal Affairs' Allegation Investigation Unit did not conduct any interviews and evidentiary issues remained unresolved.

Did the hiring authority appropriately determine the findings for each allegation?

The hiring authority made findings based on an insufficient investigation and investigation report. Because the investigation was insufficient, the hiring authority should not have made findings for each allegation and should have requested additional investigation to be conducted.

Incident Date

July 1, 2022

OIG Case Number

22-0043892-INV

Case Summary

On July 1, 2022, an officer allegedly approached an incarcerated person from behind, picked the incarcerated person off the ground and slammed him down face first, injuring the incarcerated person's mouth, eye, shoulder, and back. A second officer who had been speaking face-to-face with the incarcerated person allegedly stepped to the side just before the first officer battered the incarcerated person.

Assessment Ratings

Satisfactory



Case Disposition

The hiring authority found insufficient evidence to sustain the allegations. The OIG concurred.

Overall Assessment

The department's performance was satisfactory.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The OIG found no major deficiencies, resulting in a satisfactory assessment.

Did the investigator appropriately provide an admonishment and advisement at the beginning and end of each interview?

During an interview of the incarcerated person on September 14, 2022, the investigator did not admonish the incarcerated person of the need to be truthful, nor of the need to keep the investigation confidential while the investigation is pending.

Did the OIG have an impact on the Office of Internal Affairs' handling of the investigation?

The investigator wanted to close the case without conducting any interviews. However, the investigator conducted three interviews after the OIG recommended the interviews be conducted.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The OIG found no major deficiencies, resulting in a satisfactory assessment.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult with the Office of Internal Affairs concerning the assignment of the investigator.

Did the OIG have an impact on the performance of the department attorney or employee relations officer?

The department attorney initially recommended the investigator not conduct any interviews. However, after the OIG recommended interviews be conducted, the department attorney also recommended the investigator conduct interviews. Also, the department attorney advised the investigator the first draft report was sufficient. However, the OIG found two significant factual errors and recommended changes, which the investigator corrected.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The OIG found no major deficiencies, resulting in a satisfactory assessment.

Incident Date

July 20, 2022

OIG Case Number

22-0044120-INV

Case Summary

On July 20, 2022, two officers allegedly entered a holding cell prior to an unclothed body search of an incarcerated person and punched the naked incarcerated person.

Assessment Ratings

Poor



Case Disposition

The hiring authority found insufficient evidence to sustain the allegations against the officers. The OIG did not concur with the hiring authority's determination.

Overall Assessment

The department's performance was poor because the investigator, the department attorney, and the hiring authority failed to use the department's resources to conduct even a single witness interview when the video-recorded evidence did not provide a full view of the entire incident.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The Office of Internal Affairs' Allegation Investigation Unit's performance was poor because the investigator did not conduct any interviews.

Did the investigator adequately prepare for all aspects of the investigation?

The investigator did not prepare for or conduct any witness interviews.

Did the investigator complete all necessary and relevant interviews?

The investigator did not interview the incarcerated person who filed the complaint, nor the two officers who allegedly punched the incarcerated person, nor any of the percipient witnesses.

Did the investigator properly gather and review all documentary and other evidence?

The investigator did not interview any relevant witnesses to the alleged incident.

Did the investigator thoroughly and appropriately conduct the investigation?

The investigator should have conducted witness interviews in order to complete a full investigation, however, the investigator only observed the video recordings and summarized the recordings in a report to the hiring authority.

Did the Office of Internal Affairs' Allegation Investigations Unit manager adequately review the investigation report and appropriately determine whether the investigation was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigations Unit manager should have required the investigator to conduct witness interviews because the video recordings did not provide a complete view of the entire incident.

Did the department handle the investigation and its processing with due diligence?

The Office of Internal Affairs' Allegation Investigation Unit completed its report on October 13, 2022. However, the deadline for taking disciplinary action was not until July 28, 2023, nine months and fifteen days thereafter. Despite having the time, the Office of Internal Affairs' Allegation Investigation Unit did not conduct a single interview.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The department attorney's performance was poor because the department attorney failed to identify the video recordings did not provide sufficient evidence on whether the allegation occurred. The department attorney should have recommended to the investigator, and the hiring authority, that interviews should be conducted because the video recordings do not show the entire view of the incident.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult with the Office of Internal Affairs concerning the assignment of the investigator.

Did the department attorney provide thorough and appropriate advice and recommendations to the investigator during the initial case conference?

The department attorney should have advised the investigator to conduct an investigation that included at least one witness interview, but the department attorney advised the investigator not to conduct any interviews.

Did the department attorney provide timely and appropriate advice and recommendations to the investigator during the investigation?

The department attorney should have recommended the investigator conduct witness interviews because the video recordings do not provide a clear view of the entire incident.

Did the department attorney provide appropriate advice and recommendations to the hiring authority regarding the investigation, investigative findings, and disciplinary determinations?

The department attorney inappropriately recommended the hiring authority find the investigation sufficient and recommended the allegations of staff misconduct not be sustained when the investigator did not interview any witnesses and the video recordings do not show a clear view of the entire incident.

Did the department attorney or employee relations officer handle the case with due diligence?

The department attorney failed to identify the requirement for a full investigation to be conducted by the Office of Internal Affairs' Allegation Investigation Unit for an allegation of staff misconduct.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The hiring authority's performance was poor because although nine months remained before the deadline for taking disciplinary action expired the hiring authority still did not request the investigator conduct a single witness interview.

Did the hiring authority properly deem the Office of Internal Affairs investigation sufficient or insufficient?

The hiring authority should not have deemed the investigation sufficient because the Office of Internal Affairs' Allegation Investigation Unit did not conduct any witness interviews when the video-recorded evidence failed to show a clear view of the entire incident.

Did the hiring authority appropriately determine the findings for each allegation?

The hiring authority should not have determined findings based upon an insufficient investigation.

Did the hiring authority handle the case with due diligence?

On October 28, 2022, the hiring authority found insufficient evidence to sustain the allegations, however, the department had until July 28, 2023, before the deadline for taking disciplinary action expired, which gave the hiring authority nine months to have the Office of Internal Affairs' Allegation Unit investigator interview the incarcerated person, and the two officers that allegedly struck the incarcerated person. Instead, the hiring authority relied on video recordings that failed to show the entire incident and also failed to corroborate an important alleged fact in the first officer's report.

Incident Date

May 21, 2022

OIG Case Number

22-0043789-INV

Case Summary

On May 21, 2022, two officers allegedly refused an incarcerated person's request to see a mental health clinician after he stated he was experiencing suicidal thoughts.

Case Disposition

The hiring authority found insufficient evidence to sustain the allegations against the officers. The OIG concurred.

Assessment Ratings

Poor



Overall Assessment

The department's handling of the case was poor. The Office of Internal Affairs' Allegation Unit failed to adequately communicate with the hiring authority regarding delivery of the report and exhibits. The department attorney initially failed to provide adequate legal advice on providing notice to the officers at the conclusion of the investigative and disciplinary findings conference with the hiring authority. Until the OIG elevated the hiring authority's decision for higher review, the hiring authority refused to follow departmental policy and provide notice to the two officers that the Office of Internal Affairs' Allegation Investigation Unit investigated them for allegations of staff misconduct, and that the hiring authority made findings related to the misconduct allegations at the conclusion of the investigation.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The Office of Internal Affairs' Allegation Investigation Unit's handling of the case was poor. The investigator did not adequately ensure a confidential setting for the interview of an incarcerated person, nor did the investigator adequately prepare the necessary technology in order to remotely conduct the interview. Also, the Office of Internal Affairs' Allegation Investigation Unit delivered the report to the wrong person at the prison, which delayed the hiring authority's receipt of the report. Lastly, the Office of Internal Affairs' Allegation Investigation Unit manager delayed in responding to questions by the department attorney and the OIG, which compounded the delay caused by the Office of Internal Affairs' delivery of the report to the wrong person at the prison.

Did the investigator adequately prepare for all aspects of the investigation?

During the only interview conducted by the Office of Internal Affairs, the investigator did not prepare to have adequate control of the interview setting to ensure the interview room remained confidential and free of distractions. The investigator allowed the interview room door to remain cracked open and officers could be heard talking and laughing outside the room. Also, the investigator conducted the interview while a printer inside the interview room noisily printed on four separate occasions. Lastly, the investigator could not play the video recording smoothly over the software used to conduct the interview from a remote location.

Did the department handle the investigation and its processing with due diligence?

The Office of Internal Affairs' Allegation Investigation Unit completed its report on August 12, 2022. However, the Office of Internal Affairs' Allegation Investigation Unit did not deliver the report to the hiring authority until August 31, 2022. Also, the Office of Internal Affairs' Allegation Investigation Unit mailed the

report to the wrong person at the prison so the hiring authority did not know it had arrived. The Office of Internal Affairs' Allegation Investigation Unit manager delayed in responding to questions by the department attorney and the OIG regarding the status of delivery of the report. The department attorney learned from the Office of Internal Affairs' Allegation Investigation Unit manager on September 15, 2022, that the prison received the report on August 31, 2022. On September 15, 2022, the department attorney contacted the hiring authority and provided the tracking number used when the Office of Internal Affairs' Allegation Investigation Unit mailed the report to the prison. The hiring authority then located the final report at an incorrect location at the prison. The Office of Internal Affairs' Allegation Investigation Unit failed to mail the report to the correct person at the prison, failed to follow up with the prison to ensure the hiring authority received the report, and failed to timely notify other stakeholders that sought an update on the status of the report's delivery. The hiring authority is required to conduct a findings and penalty conference within 14 days from the date the report is received from the Office of Internal Affairs' Allegation Investigation Unit. The Office of Internal Affairs' Allegation Investigation Unit's failure to confirm the correct delivery location with the hiring authority, and the manager's delay in responding to inquiries from the department attorney and the OIG led to a delay in the investigative and disciplinary findings conference, which did not occur until September 26, 2022, 27 days after the report arrived at the prison.

If the case was designated, did the investigator adequately cooperate and consult with the department attorney?

The Office of Internal Affairs' Allegation Investigation Unit did not timely provide the department attorney with confirmation the Office of Internal Affairs' Allegation Investigation Unit mailed the report to the hiring authority until September 15, 2022, 16 days after the report arrived at the prison, albeit to the wrong person at the prison.

Did the investigator adequately consult with the OIG?

The OIG sent emails to Office of Internal Affairs' Allegation Investigation Unit manager on August 29, 2022, and September 9, 2022, to request confirmation regarding delivery of the report to the hiring authority. However, the Office of Internal Affairs' Allegation Investigation Unit manager did not respond to the OIG until September 13, 2022, two weeks after the original email. On September 13, 2022, the Office of Internal Affairs' Allegation Unit manager informed the OIG that the report was delivered to the prison on August 31, 2022, but unknown to the manager, the Office of Internal Affairs' Allegation Investigation Unit sent the report to the wrong person at the prison.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The department attorney's performance was poor because the department attorney did not initially advise the hiring authority to provide notice to the two officers of the allegations against them and the hiring authority's findings.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult with the Office of Internal Affairs' Allegation Investigation Unit manager regarding the investigator assignment.

Did the department attorney or employee relations officer handle the case with due diligence?

On August 17, 2022, the department attorney submitted a memorandum to the hiring authority summarizing the completed investigation conducted by the Office of Internal Affairs' Allegation Investigation Unit and included the department attorney's opinion of the sufficiency of the investigation, recommendations whether any discipline of staff was necessary, and requested an investigative and disciplinary findings conference. However, the employee relations officer emailed the department attorney on the same day, advising the department attorney the hiring authority had not received any notice of the investigation nor any report or exhibits related to it, and therefore refused to schedule the

investigative and disciplinary findings conference. Rather than help bridge the communication gap between the hiring authority and the Office of Internal Affairs' Allegation Investigation Unit, the department attorney waited for the two parties to communicate with each other to resolve the concern. The investigative and disciplinary findings conference was delayed until September 26, 2022, in part because the Office of Internal Affairs sent the report and exhibits to the wrong person at the prison, but also because the department attorney did not get involved sooner to assist both parties in resolving their concerns. The department's Employment Advocacy and Prosecution Team assigned the department attorney to work with both the Office of Internal Affairs' Allegation Investigation Unit and the hiring authority, therefore the department attorney should have taken a more active role communicating with the two parties when the miscommunication between the Office of Internal Affairs' Allegation Investigation Unit and the hiring authority became apparent.

Did the OIG have an impact on the performance of the department attorney or employee relations officer?

The department attorney did not initially recommend that the two officers be notified regarding the allegations against them, and the hiring authority's findings regarding those allegations. The OIG recommended the two officers be notified. The department attorney eventually advised the hiring authority to provide the officers with notice, but only after the OIG sought a higher review to the hiring authority's supervisor.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The hiring authority's performance was poor because the hiring authority refused to provide notice to the two officers who had been investigated by the Office of Internal Affairs' Allegation Investigation Unit for allegations of staff misconduct, and that the hiring authority found insufficient evidence to support the allegations. The OIG had to seek higher review to ensure the two officers received notice as required by departmental policy.

Did any party request executive review to raise an issue to a higher level of management for review?

The OIG requested a review by the hiring authority's supervisor after the hiring authority refused to provide notice to the two officers of staff misconduct allegations against them that the Office of Internal Affairs' Allegation Investigation Unit investigated and for which the hiring authority made findings.

Did the OIG need to invoke executive review?

The OIG requested a review by the hiring authority's supervisor after the hiring authority refused to provide notice to the two officers of staff misconduct allegations against them that the Office of Internal Affairs' Allegation Investigation Unit investigated and for which the hiring authority made findings.

Did the hiring authority handle the case with due diligence?

The hiring authority refused to provide notice to the two officers of allegations of staff misconduct against them, and the hiring authority's decisions on those allegations, even after the department attorney and the OIG advised the hiring authority to do so. On September 26, 2022, the hiring authority determined insufficient evidence of misconduct. On September 29, 2022, the OIG sought a higher review from the hiring authority's supervisor. On October 14, 2022, 17 days after the investigative and disciplinary findings conference with the hiring authority, and after the matter had been elevated by the OIG to the hiring authority's supervisor, the hiring authority provided notice to the officers.

Did the OIG have an impact on the hiring authority's handling of the case?

The OIG ensured the two officers received notice they had been investigated by the Office of Internal Affairs' Allegation Investigation Unit for allegations of staff misconduct, and also notice that the hiring authority found insufficient evidence to support the allegations.

Incident Date	OIG Case Number
July 8, 2022	22-0043889-INV

Case Summary

On July 8, 2022, two officers allegedly confiscated an incarcerated person's medical dietary beverages and the first officer allegedly spat and coughed on the incarcerated person's meal. The officers allegedly committed these acts to retaliate against the incarcerated person because he submitted a staff misconduct complaint the day prior and allegedly because of the incarcerated person's race. A sergeant allegedly failed to take any action when the incarcerated person complained of the alleged staff misconduct after the incident.

Case Disposition

The hiring authority found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination.

Assessment

Ratings

Poor



Overall Assessment

The department's handling of the case was poor because the investigator failed to conduct any interviews during the investigation and failed to provide the department attorney and the OIG a copy of the report for review and feedback before the investigator provided the report to the hiring authority. Also, the hiring authority failed to follow recommendations from both the department attorney and the OIG to return the case to the Office of Internal Affairs to conduct an interview before the hiring authority made a decision about the alleged staff misconduct.

OIA Investigator Assessment: How well did the Office of Internal Affairs conduct the investigation?

The investigator's performance in investigating allegations of employee misconduct was poor because the investigator relied solely on video-recorded evidence and did not conduct any interviews. Also, the investigator did not provide the department attorney or the OIG with a draft report for review and comment before the investigator submitted the report to the hiring authority.

Did the investigator adequately prepare for all aspects of the investigation?

Against the recommendations made by the OIG and the department attorney, the investigator completed the investigation without conducting any interviews whatsoever, and instead relied solely on the video footage evidence. An interview of the incarcerated person is a critical component of conducting a sufficient investigation because incarcerated people should be provided the opportunity to be heard about their complaint and provide additional details and evidence that may not be communicated well through a written complaint. Incarcerated people should also be afforded the opportunity to review the video relied upon by the investigator and explain or clarify the footage. There may be details about an allegation that are not captured clearly on the video footage, or at all, to which the incarcerated person should be afforded the opportunity to explain.

Did the investigator complete all necessary and relevant interviews?

The investigator did not conduct any interviews at all. An interview of the incarcerated person should have been conducted to fully understand the nature of the staff misconduct complaint, the timeline of alleged events, to allow the incarcerated person the opportunity to provide additional details, information, and clarification regarding the allegations, and to allow the investigator to show the incarcerated person the video evidence in order to challenge the allegations presented by the incarcerated person. Here, the investigator should have afforded the incarcerated person the opportunity to review the video evidence and clarify the date and time of the alleged staff misconduct and provide additional details regarding the allegations.

Did the investigator properly gather and review all documentary and other evidence?

The investigator failed to conduct any interviews as part of the investigation; therefore, relevant evidence may have been missed. Incarcerated people should be provided the opportunity to be heard about their complaint and provide additional details, witnesses, and evidence. Incarcerated people should also be

afforded the opportunity to review the video relied upon by the investigator and explain or clarify the footage. There may be details about an allegation that are not captured clearly on the video footage, or at all, to which the incarcerated person should be afforded the opportunity to explain.

Did the investigator thoroughly and appropriately conduct the investigation?

The investigator closed the investigation without conducting any interviews to gather evidence although both the department attorney and the OIG recommended that the incarcerated person be interviewed as part of the investigation. Instead, the investigator relied solely on the video evidence to complete the investigation. An interview of the incarcerated person is a critical component of conducting a sufficient investigation because incarcerated people should be provided the opportunity to be heard about their complaint and provide additional details and evidence that may not be communicated well through a written complaint. Incarcerated people should also be afforded the opportunity to review the video relied upon by the investigator and explain or clarify the footage. There may be details about an allegation that are not captured clearly on the video footage, or at all, to which the incarcerated person should be afforded the opportunity to explain.

Did the investigator prepare an investigation report that included all relevant facts and evidence?

The investigator prepared a written report that did not include all relevant facts and evidence necessary for a thorough and complete investigation.

Did the Office of Internal Affairs' Allegation Investigations Unit manager adequately review the investigation report and appropriately determine whether the investigation was sufficient, complete, and unbiased?

The Office of Internal Affairs' Allegation Investigations Unit manager inappropriately determined the investigation was sufficient and complete. The manager should have required the investigator to conduct interviews.

Did the Office of Internal Affairs' Allegation Investigation Unit provide the final investigation report to the hiring authority and to the department attorney?

The investigator did not allow the OIG or department attorney to review the final investigation report before it was submitted to the hiring authority, thereby denying the department attorney and the OIG from providing any recommendations or discussing any disagreements before the Office of Internal Affairs' Allegation Investigation Unit sent the report to the hiring authority.

Did the department handle the investigation and its processing with due diligence?

The investigator did not conduct a sufficient investigation because the investigator did not interview any witnesses, and did so against the advice of the department attorney and the recommendation of the OIG. The investigator did not provide the department attorney or the OIG with a draft report for review and comment before the Office of Internal Affairs' Allegation Investigation Unit provided the final report to the hiring authority.

If the case was designated, did the investigator adequately cooperate and consult with the department attorney?

The investigator did not follow the department attorney's advice that the incarcerated person be interviewed in order to complete a sufficient investigation. The investigator did not provide the department attorney with a copy of the draft report for review and comment before the Office of Internal Affairs' Allegation Investigation Unit provided the final report to the hiring authority.

Did the investigator adequately consult with the OIG?

The investigator did not follow the OIG's recommendations that the incarcerated person be interviewed in order to complete a sufficient investigation. The investigator did not provide the OIG with a copy of the investigation report for review and comment before submitting the final report to the hiring authority.

CDCR Attorney Assessment: How well did the department attorney or employee relations officer perform during the investigation, the disciplinary process, and the litigation process?

The department attorney's performance was poor because the department attorney initially advised the investigator to close the case without interviews, and did not make any attempts to verbally persuade the hiring authority to deem the investigation insufficient during the investigative and disciplinary findings conference.

During the consultation regarding the assignment of the investigation, did the department attorney provide appropriate advice and recommendations to the Office of Internal Affairs' Allegation Investigation Unit manager?

The department attorney did not consult with the Office of Internal Affairs' Allegation Investigation Unit manager regarding the type of investigator assigned to the case.

Did the department attorney provide appropriate, thorough, and timely feedback and recommendations to the investigator regarding the investigation report?

The department attorney did not provide any feedback on the investigation report because the investigator provided the investigation report to the hiring authority without ever providing the department attorney an opportunity to review the report and provide feedback and recommendations.

Did the department attorney or employee relations officer handle the case with due diligence?

While the department attorney provided appropriate recommendations to the hiring authority in written communications, the department attorney did not verbalize or otherwise try to persuade the hiring authority to follow the department attorney's recommendations during the investigative and disciplinary findings conference after the hiring authority disagreed with the department attorney's recommendation that the investigation was insufficient.

Did the OIG have an impact on the performance of the department attorney or employee relations officer?

The department attorney incorrectly calculated the deadline for taking disciplinary action. The OIG recommended the department attorney revise the deadline for taking disciplinary action, which the department attorney subsequently did. Also, the department attorney initially advised the investigator that the investigation could be closed based on a review of the video evidence and without conducting an interview of the incarcerated person. However, the OIG advised the department attorney the investigation was insufficient and the department attorney agreed and recommended the investigator conduct an interview of the incarcerated person.

Hiring Authority Assessment: How well did the hiring authority determine findings concerning alleged employee misconduct and process the employee disciplinary case?

The hiring authority's performance in determining its findings for alleged misconduct was poor because the hiring authority deemed the investigation sufficient to make findings for each allegation when the Office of Internal Affairs' Allegation Investigation Unit conducted no witness interviews and the department attorney and the OIG recommended both recommended at least one interview be conducted.

Did the hiring authority properly deem the Office of Internal Affairs investigation sufficient or insufficient?

The hiring authority should have determined the investigation to be insufficient because the incarcerated person was not interviewed as the department attorney and OIG both recommended.

Did the hiring authority appropriately determine the findings for each allegation?

The hiring authority should have found the investigation insufficient because the Office of Internal Affairs' Allegation Investigation Unit did not conduct any interviews. Therefore, there was not a sufficient investigation to support the hiring authority's determinations.

(This page left blank for reproduction purposes.)

Response to the OIG's Report

DocuSign Envelope ID: 777CE1E1-5ACD-4692-B494-FEA8C5F64E87

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION

GAVIN NEWSOM, GOVERNOR

OFFICE OF THE SECRETARY

P.O. Box 942883
Sacramento, CA 94283-0001



May 15, 2023

Ms. Amarik Singh
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The California Department of Corrections and Rehabilitation (CDCR) has reviewed the draft entitled *The Office of the Inspector General's Monitoring in 2022 of the California Department of Corrections and Rehabilitation's Staff Misconduct Review Process: Despite a Revised Regulatory Framework for Processing Its Staff Misconduct Cases, the California Department of Corrections and Rehabilitation Continues to Earn Poor Ratings; Flawed Practices by Departmental Staff Into Staff Misconduct Allegations Cause Inquiries and Investigations to Be Deficient*.

CDCR appreciates the work that went into this review and recognizes the report provides valuable feedback we will consider as we continue to improve how allegations against staff are addressed. As a Department, we take every allegation of misconduct by staff very seriously, and work hard to ensure there is accountability when allegations are sustained as negative staff behaviors do not reflect the great work of the vast majority of our staff. We remain committed to being proactive with staff misconduct identification, investigation, and the disciplinary process, and will continue to refine procedures to improve accountability, efficiency, and transparency throughout.

The report pointed out deficiencies we agree require immediate attention. We are committed to constantly improving through training and internal review to ensure compliance with established policies related to the staff misconduct process. We also appreciate the recommendations made for improving these processes as they relate to established policies and will take them into consideration as well.

2022 was a year of significant changes to the allegations of staff misconduct process. The first was implementing an independent centralized screening process for all inmate and parolee grievances. The Centralized Screening Team activated on schedule, January 1, 2022, and has continued to refine processes throughout the year so that by December 31, 2022, over 130,000 grievances with more than 160,000 individual claims had been screened by an independent unit and routed to the appropriate areas for response. We were pleased to see that in the OIG review of over 1,000 screened grievances, 94% of the screening decisions by the Centralized Screening Team were satisfactory. This is a testament to the demonstrated commitment of CDCR staff to standing up this important part of the process.

DocuSign Envelope ID: 777CE1E1-5ACD-4692-B494-FEA8C5F64E87

Amarik Singh, Office of the Inspector General
Page 2

The Department does not necessarily agree with all the conclusions noted in this report as some of the conclusions appear to be based on what the OIG believes the policies should be rather than whether CDCR staff followed the current policies established for this process. It's important to note that this report and its conclusions are based on the review of only 51 cases (41 inquiries and 10 investigations). This accounts for less than 1% of the 10,813 allegations of staff misconduct routed to OIA and does not fully or accurately represent the positive process improvements and great work completed by CDCR staff as we learn how to work in this new process.

Each allegation of staff misconduct and the resulting investigation or inquiry is unique, and as a result, the amount of work needed to complete an inquiry or investigation will vary. The Office of Internal Affairs (OIA) and locally designated investigators proceed with their investigations and inquiries in a thoughtful manner, collecting the evidence that is relevant, conducting necessary interviews, and drafting thorough and complete reports, so that hiring authorities can make appropriate determinations. As we evaluate the existing process to identify efficiencies, we are committed to ensuring the most serious allegations of staff misconduct are investigated by the OIA and will continue fine-tuning our processes to align with budget resources while focusing on investigating the most serious allegations of staff misconduct while maintaining transparency with outside stakeholders.

We thank you for the opportunity to review and comment on the draft report. CDCR wholly appreciates the importance of maintaining integrity and fairness when investigating allegations of staff misconduct and is committed to the continued monitoring of these reviews. CDCR is persistently working to improve and welcomes the observations of the OIG as they continue to monitor this process.

If you have further questions, please contact me at (916) 323-6001.

Sincerely,

DocuSigned by:
Jeffrey Macomber
5967F5D0C55F473
JEFF MACOMBER
Secretary

Monitoring the Staff Misconduct Review Process of the California Department of Corrections and Rehabilitation

*Despite a Revised Regulatory Framework for Processing
Its Staff Misconduct Cases, the California Department
of Corrections and Rehabilitation Continues
to Earn Poor Ratings; Flawed Practices
by Departmental Staff Into Staff Misconduct
Allegations Cause Inquiries and
Investigations to Be Deficient*

2022 Annual Report

OFFICE *of the* INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
May 2023

OIG