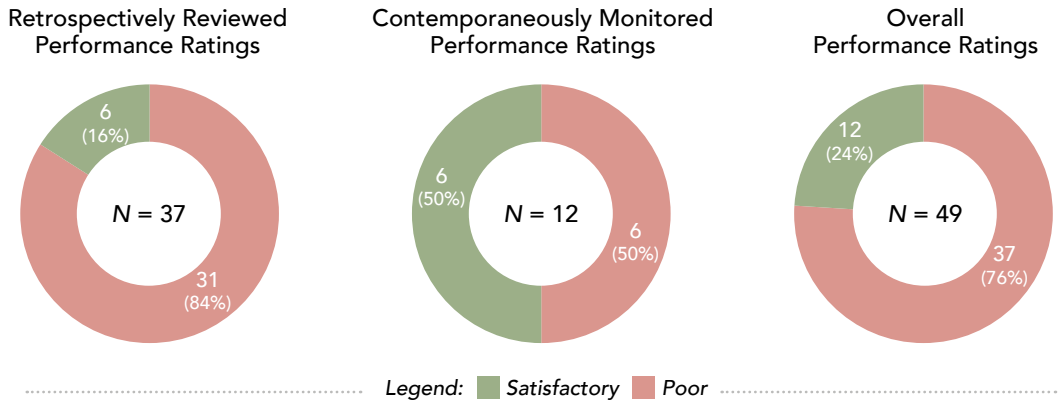
During June 2024, the OIG's Local Inquiry Team closed 49 monitored inquiries. Of those 49 inquiries, the OIG monitored 12 inquiries contemporaneously and monitored 37 inquiries retrospectively. The OIG rated the department's overall performance as *poor* in 37 inquiries, or 76 percent. The OIG rated the department's overall performance as *satisfactory* in 12 inquiries, or 24 percent.

49 Monitored Inquiries Closed by the Office of the Inspector General During June 2024



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

The OIG made the following noteworthy observations:

- The locally designated investigator thoroughly and appropriately conducted the inquiry in 11 of the 49 monitored cases, or 22 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in 12 of the 49 monitored cases, or 24 percent.
- The hiring authority made a timely determination on the allegations, within 90 days of the complaint being received by the Centralized Screening Team, in 15 of the 49 monitored cases, or 31 percent.
- Aside from exceeding statutory, regulatory, or policy timelines, the department unreasonably delayed completing the inquiry in 28 of the 49 monitored cases, or 57 percent.
- Of the 37 inquiries the OIG monitored retrospectively, the OIG rated the department's performance as poor in 31 inquiries, or 84 percent.

The summaries that follow present 10 notable inquiries the OIG monitored and closed during June 2024.

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OIG Case Number
24-0081097-INQ

Rating Assessment
Poor

OIA Case Number
20037181

Case Summary

Between January 1, 2023, and March 3, 2023, a licensed vocational nurse allegedly berated an incarcerated person, denied the incarcerated person access to his physician, and failed to assist the incarcerated person with his elevated blood sugar levels, which caused the incarcerated person to experience neuropathic pain in his hands and feet.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to ask the nurse questions pertaining to the allegations that she berated the incarcerated person and denied him access to his doctor. Instead, the investigator focused the interview questions on the nurse's job duties. The investigator also interviewed the incarcerated person who submitted the complaint at a table on the yard which did not afford confidentiality. In addition, the investigator made no attempt to determine the dates on which the alleged misconduct occurred. The investigator failed to document whether she provided an advisement of rights and confidentiality admonishment during an interview with the nurse who was the subject of the inquiry and failed to document whether she provided confidentiality admonishment during an interview with the incarcerated person who submitted the complaint. The Office of Internal Affairs manager who reviewed the draft inquiry report failed to identify the investigator's omissions and approved the report as adequate. The hiring authority then delayed 196 days from receipt of the inquiry report to determine a finding for the allegations and complete the inquiry. Overall, the department untimely completed the inquiry on February 27, 2024, 343 days after the Centralized Screening Team received the complaint on March 21, 2023, and 253 days beyond the department's goal.

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OIG Case Number
24-0081093-INQ

Rating Assessment
Poor

OIA Case Number
20030734

Case Summary

On November 9, 2022, a psychologist allegedly engaged in misconduct by disclosing personal information about herself to an incarcerated person.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the psychologist's alleged misconduct. The investigator also failed to ask the psychologist questions to clarify how the incarcerated person knew or could have obtained personal information about her. Specifically, a lieutenant who was a witness reported to the psychologist that the incarcerated person who submitted the complaint had relayed the details of the psychologist's personal information, but the investigator did not take any steps to determine how the incarcerated person came into possession of those details. Instead, the investigator relied upon an implausible timeline in which the incarcerated person learned of the personal details from listening to the conversation between the psychologist and lieutenant, which occurred after the incarcerated person had already reported those personal details to the lieutenant. The investigator further failed to document whether he provided a confidentiality admonishment during each interview conducted. The investigator also failed to include the written complaint submitted by the incarcerated person, the written notice of interview provided to the witness lieutenant, and the advisement of rights provided to the witness lieutenant as supporting exhibits to the inquiry report. In addition, the investigator included a supporting exhibit but failed to list it in the inquiry report. The Office of Internal Affairs manager failed to identify the investigator's omissions and return the inquiry to the investigator for correction, and inappropriately approved the inquiry report as adequate. The hiring authority then delayed 318 days from receipt of the inquiry report to determine a finding for the allegation and complete the inquiry. Overall, the department untimely completed the inquiry on December 7, 2023, 337 days after the Centralized Screening Team received the complaint on January 4, 2023, and 247 days beyond the department's goal.

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OIG Case Number
24-0080473-INQ

Rating Assessment
Poor

OIA Case Number
20042885

Case Summary

On or about June 1, 2023, and June 2, 2023, unidentified health care staff allegedly forced an incarcerated person to submit to three tests for the COVID-19 virus which caused the incarcerated person to become infected with COVID-19. On unknown dates prior to June 4, 2023, unidentified medical staff allegedly instructed the incarcerated person to stop submitting requests for medical care related to COVID-19, and an unknown medical staff member allegedly asked the incarcerated person if he was pregnant.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to identify and obtain the records of departmental policy and procedures applicable to the allegations. The investigator failed to make any reasonable efforts to identify the dates the alleged misconduct occurred or the health care staff members who allegedly engaged in the misconduct. Instead, the investigator relied upon the incarcerated person's inexact recollection about the dates the misconduct may have occurred and determined there was no evidence of misconduct because the dates the incarcerated person documented in his complaint did not correspond to any dates on which he had medical appointments. The investigator did not attempt to independently identify and interview any subjects or witnesses. The investigator also failed to conduct any inquiry into the allegations that medical staff told the incarcerated person to stop submitting requests for medical services or that a medical staff person asked the incarcerated person if he was pregnant. The investigator failed to document in the inquiry report whether he provided a confidentiality admonishment during an interview with the incarcerated person who submitted the complaint. In addition, the investigator failed to include any supporting documentation with the inquiry report, such as the incarcerated person's written complaint, relevant medical encounter records, or COVID-19 testing and results information. The Office of Internal Affairs manager and the hiring authority inappropriately approved the report as adequate despite the significant deficiencies noted above. The department also unreasonably delayed the inquiry at multiple stages of the process. The Office of Internal Affairs manager delayed 45 days to complete his review of the inquiry report. The California Correctional Health Care Services' Staff Misconduct Team then delayed 29 days to send the report to the hiring authority. The department then delayed an additional

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105 days to administratively close the inquiry after the hiring authority reviewed the report and documented his findings.

Overall, the Centralized Screening Team received the complaint on June 6, 2023, but the department failed to complete the inquiry until February 22, 2024, 261 days thereafter and 171 days beyond the department's goal.

OIG Case Number
24-0080112-INQ

Rating Assessment
Poor

OIA Case Number
20032054

Case Summary

On January 16, 2023, an officer allegedly laughed at an incarcerated person after he prematurely disconnected the incarcerated person's telephone call.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to submit a timely request for all video recordings relevant to the inquiry. The investigator made the request for video-recorded evidence approximately one year after being assigned to conduct the inquiry which was more than nine months after the department deleted the video-recorded evidence pursuant to its 90-day video-retention policy. Further compounding the delay, the investigator requested video recordings from January 14, 2023, even though the misconduct allegedly occurred on January 16, 2023, thus rendering any received video recordings of no evidentiary value. The investigator failed to identify and confirm the actual date of the alleged misconduct which led to unnecessary confusion throughout the inquiry. For instance, the investigator documented January 14, 2023, as the incident date on the face page of the inquiry report but included as an exhibit to the inquiry report a staff sign-in sheet for January 16, 2023, which was used to identify other officers as potential witnesses. The investigator also unnecessarily delayed 358 days before conducting the first interview and prolonged over one year to conduct four interviews which included the interviews of the incarcerated person who submitted the complaint and the officer who was the subject of the inquiry.

The best practice is to interview witnesses as close in time to the incident as possible since memories fade and the ability to recollect facts is significantly diminished over

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time. In addition, the investigator failed to use effective interviewing techniques and did not conduct thorough interviews. For example, given the significant amount of time that elapsed between the alleged incident and the interviews, the investigator failed to refresh the recollection of the incarcerated person and other witnesses and failed to confirm the date of the misconduct. By not clarifying the incident date with each witness, the investigator unfairly prejudiced the witnesses to speculate about the actual date of the alleged misconduct being investigated. The investigator further failed to specify the date of the alleged misconduct when questioning the subject officer about his interactions with the incarcerated person who submitted the complaint. What is more, the investigator failed to ask the officer whether he improperly disconnected the incarcerated person's phone call on January 16, 2023. In lieu of conducting a complete and thorough interview of the subject officer, the investigator improperly relied on hearsay evidence documented in a prior related Office of Appeals investigation as substantive proof to disprove the allegations in this case, which is a determination reserved solely for the hiring authority. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions and approved the investigator's inquiry report as adequate. Overall, the department untimely completed the inquiry on February 26, 2024, 404 days after the Centralized Screening Team received the complaint on January 18, 2023, and 314 days beyond the department's goal.

OIG Case Number
24-0080795-INQ

Rating Assessment
Poor

OIA Case Number
20043949

Case Summary

On June 9, 2023, a nurse allegedly refused to provide medicated shampoo to an incarcerated person and responded unprofessionally after the incarcerated person told the nurse he would submit a complaint.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The hiring authority unreasonably delayed the inquiry 76 days before assigning an investigator on August 31, 2023. In addition, the investigator did not conduct the first interview until February 7, 2024, 160 days thereafter. Due to departmental delays, the investigator did not interview the incarcerated person who submitted the complaint because the incarcerated person paroled from prison on July 15, 2023, 29 days after the Centralized Screening Team

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received the complaint and 47 days after the hiring authority assigned the inquiry to the investigator. The investigator continued the inquiry but made no attempt to contact the incarcerated person who submitted the complaint to conduct an interview. The investigator interviewed the nurse who was the subject of the inquiry and failed to document whether he provided a confidentiality admonishment during the interview. Further, the investigator failed to identify the records of departmental policy and procedure applicable to the allegation and include those records as supporting exhibits to the inquiry report. Lastly, the investigator improperly made conclusions regarding the evidence collected during the inquiry, which is a responsibility reserved for the hiring authority. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and approved the report as adequate. The hiring authority received the inquiry report on March 21, 2024, but delayed 35 days before determining a finding for the allegations. Overall, the department untimely completed the inquiry 314 days after the Centralized Screening Team received the complaint on June 16, 2023, and 224 days beyond the department's goal.

OIG Case Number
24-0080736-INQ

Rating Assessment
Poor

OIA Case Number
20037971

Case Summary

On March 23, 2023, a psychologist allegedly audio-recorded confidential communications with an incarcerated person during a one-on-one clinical session. Additionally, on the same day, the psychologist and a second psychologist allegedly twice laughed from a conference room when the incarcerated person walked past.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to document in the inquiry report if he achieved effective communication during the interview of the incarcerated person who submitted the complaint. The investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing two psychologists who were subjects of the inquiry before interviewing the incarcerated person who submitted the complaint and did not provide justification in the inquiry report for this deviation. In addition, the investigator interviewed the psychologists and the incarcerated person and failed to

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document whether he provided a confidentiality admonishment during each interview. The investigator also failed to provide the required advisement of rights during the interview with each psychologist and failed to include the signed advisements as exhibits to the report. Further, the investigator failed to identify, reference, and include in the inquiry report the source of the incarcerated person's complaint and the records of departmental policy and procedure applicable to the allegations such as the guidelines for recording confidential communications during one-on-one clinical sessions. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and approved the report as adequate. The California Correctional Health Care Services' Staff Misconduct Team unreasonably delayed the inquiry 139 days before submitting the inquiry report to the hiring authority for review. In addition, the department lost track of the inquiry after the hiring authority determined a finding for each allegation which led to the hiring authority's delay to complete the inquiry and failure to provide the incarcerated person with a case closure notification. Only after the OIG inquired to the California Correctional Health Care Services' Staff Misconduct Team about the inquiry's status did the department become aware of the oversight. Overall, the Centralized Screening Team received the complaint on March 29, 2023, but the hiring authority did not determine a finding for each allegation until November 6, 2023, 222 days thereafter and 132 days beyond the department's goal.

OIG Case Number
24-0079815-INQ

Rating Assessment
Poor

OIA Case Number
20055894

Case Summary

Between October 22, 2023, and December 15, 2023, two officers allegedly offered incarcerated persons additional meals as reparation for not providing them privileges such as showering, yard time, and phone access so that the officers could use their time to play cards during their shift. The officers also allegedly caused the incarcerated persons' written complaints to go missing.

Case Disposition

The hiring authority conducted an inquiry and determined the inquiry conclusively proved the misconduct did not occur. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding or that the evidence conclusively proved the misconduct did not occur.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to identify, reference, or include in the inquiry report the records of departmental policy and

procedure applicable to the officers' alleged misconduct. The investigator also failed to submit a timely request for all video-recorded evidence relevant to the inquiry, thus the department deleted the recordings pursuant to its 90-day video retention policy. The investigator failed to address any of the allegations when interviewing the first officer who was a subject of the complaint and addressed only one allegation when interviewing the second officer who was also a subject. The investigator alternatively concentrated on matters that were not the focus of the inquiry. In addition, the investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing the two incarcerated person witnesses after interviewing the subject officers and did not provide justification in the inquiry report for this deviation. The investigator conducted six interviews and failed to document whether he provided a confidentiality admonishment during each interview. Moreover, the investigator failed to document whether he established effective communication during each interview with incarcerated persons. The investigator made failed attempts to acquire the segregation record, which records when an incarcerated person receives showers, meals, and yard privileges, for the time frame of the alleged misconduct but neglected to explain in the inquiry report the basis for its unavailability. The investigator also attached a supporting exhibit to the inquiry report but failed to list the exhibit in the report. In addition, the investigator failed to summarize or cross reference in the report narrative the phone log documentation included as a supporting exhibit to the inquiry report. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. The hiring authority issued a finding for one allegation but failed to address the allegation that the officers caused incarcerated persons' complaints to disappear.

Finally, the hiring authority inappropriately determined the inquiry conclusively proved the misconduct did not occur when according to the department's operations manual, the evidentiary threshold was not met in this case. The hiring authority should have determined there was insufficient evidence to sustain the allegations.

OIG Case Number
24-0082082-INQ

Rating Assessment
Poor

OIA Case Number
20043848

Case Summary

On unspecified dates prior to June 10, 2023, a nurse allegedly twice administered the incorrect medication to an incarcerated person. The nurse also allegedly acted unprofessionally toward the incarcerated person and concealed her name tag from the incarcerated person's sight.

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Case Disposition

The hiring authority determined that the inquiry conclusively proved the misconduct did not occur. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding or that the inquiry conclusively proved that the misconduct did not occur.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to achieve effective communication prior to interviewing the incarcerated person who submitted the complaint. The investigator conducted interviews of an officer and a nurse who were witnesses but did not explain how he identified the witnesses or their relevance to the inquiry. The investigator conducted four interviews and failed to document in the inquiry report whether each interview occurred in a confidential setting. The investigator also failed to document whether he provided a confidentiality admonishment during each interview and failed to document an advisement of rights during interviews of staff witnesses and the nurse who was the subject of the inquiry. The investigator conducted all interviews over the telephone instead of in-person and did not provide an explanation in the inquiry report addressing why he did not conduct in-person interviews. The investigator failed to ask staff witnesses relevant questions such as whether the nurse administered incorrect medication to the incarcerated person and failed to ask the nurse if she had ever acted unprofessionally toward the incarcerated person. The investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing the subject nurse before conducting witness interviews and did not provide justification in the inquiry report for this deviation. The investigator failed to identify, reference, and include as supporting exhibits to the inquiry report the records of departmental policy and procedure applicable to the allegations. The investigator also did not include as supporting exhibits to the inquiry report a notice of staff complaint and an advisement of rights issued to the nurse and failed to include a notice of interview and an advisement of rights to each staff witness. The investigator failed to request video-recorded evidence and did not provide an explanation in the inquiry report.

Finally, the investigator improperly made conclusions regarding the evidence collected during the inquiry, which is a responsibility reserved for the hiring authority. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. The California Correctional Health Care Services' Staff Misconduct Team submitted the inquiry report to the hiring authority for review on October 30, 2023, but the hiring authority delayed 87 days to determine a finding for each allegation and failed to affirm the report's sufficiency upon which to base the findings. The hiring authority also made an incomplete finding which failed to include a decision regarding the second allegation. Moreover, the hiring authority incorrectly determined the inquiry conclusively proved the misconduct did not occur when according to the department's operations manual, the evidentiary threshold was not met in this case. The hiring authority should have determined there was insufficient evidence to sustain the allegations. Overall, the department untimely completed the inquiry on January 25, 2024, 224 days after the Centralized

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Screening Team received the complaint on June 15, 2023, and 134 days beyond department's goal.

OIG Case Number
24-0082060-INQ

Rating Assessment
Poor

OIA Case Number
20043855

Case Summary

On February 10, 2023, and February 23, 2023, a dentist allegedly provided an incarcerated person with inadequate dental care that resulted in broken teeth and severe pain for the incarcerated person. On March 9, 2023, when the incarcerated person advised the dentist about his discomfort, the dentist allegedly acted unprofessionally and disregarded the incarcerated person's concerns.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation. The OIG did not concur with the hiring authority's finding that there was insufficient evidence to sustain the allegations.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to document whether he achieved effective communication with the incarcerated person who submitted the complaint during the interview. The investigator conducted four interviews and failed to document in the inquiry report whether each interview occurred in a confidential setting. The investigator also failed to document whether he provided a confidentiality admonishment during each interview and failed to provide an advisement of rights during interviews of staff witnesses. In addition, the investigator failed to contact and interview the dentist who was the subject of the complaint. The investigator failed to identify, reference, and include as supporting exhibits to the inquiry report the records of departmental policy and procedure applicable to the allegations. Furthermore, the incarcerated person who submitted the complaint claimed that dental X-rays substantiated the allegation that the dentist damaged the incarcerated person's teeth, but the investigator failed to review those X-rays and include a summary of that review in the inquiry report. The investigator also made improper conclusions regarding the evidence collected during the inquiry, which is a responsibility reserved for the hiring authority. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. The California Correctional Health Care Services' Staff Misconduct Team submitted the inquiry report to the hiring authority for review on October 3, 2023, but the hiring authority delayed 141 days to determine a finding despite first failing to affirm the report's sufficiency to base a finding. Overall, the

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department untimely completed the inquiry on February 21, 2024, 250 days after the Centralized Screening Team received the complaint on June 16, 2023, and 160 days beyond the department's goal.

OIG Case Number
24-0082047-INQ

Rating Assessment
Poor

OIA Case Number
20038513

Case Summary

On March 14, 2023, a registered nurse allegedly refused to document an incarcerated person's self-inflicted cuts after the incarcerated person asked for the cuts to be documented during a suicide assessment.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation. The OIG did not concur with the hiring authority's finding that there was insufficient evidence to sustain the allegation.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator did not conduct the first interview until 39 days after the hiring authority assigned the investigator to complete the inquiry. The investigator failed to include a summary of the allegations in both the advisement of rights and notice of interview issued to the nurse who was the subject of the inquiry. The investigator also failed to provide the nurse with a subject notice of staff complaint. In addition, the investigator failed to document whether she provided a confidentiality admonishment during interviews with the nurse and the incarcerated person who submitted the complaint. The investigator failed to identify, reference, and include as supporting exhibits to the inquiry report the records of departmental policy and procedure applicable to the allegations. Furthermore, the investigator failed to sign and date the inquiry report. The investigator unreasonably delayed the inquiry by failing to submit a revised inquiry report 65 days after the Office of Internal Affairs manager returned the draft inquiry report to the investigator for revisions. The Office of Internal Affairs manager approved the investigator's inquiry report as adequate despite the investigator's failure to correct all deficiencies the manager identified. The California Correctional Health Care Services' Staff Misconduct Team submitted the inquiry report to the hiring authority for review on August 18, 2023, but the hiring authority delayed 186 days to determine a finding and failed to affirm the report's sufficiency upon which to base the finding. Overall, the department untimely completed the inquiry on February 20, 2024, 319 days after the Centralized Screening Team received the complaint on April 7, 2023, and 229 days beyond department's goal.

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