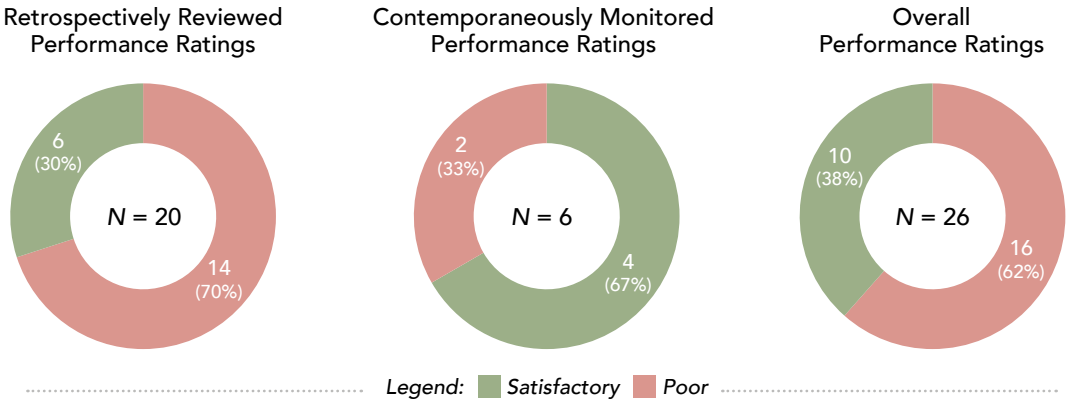
During August 2024, the OIG's Local Inquiry Team closed 26 monitored inquiries. Of those 26 inquiries, the OIG monitored six inquiries contemporaneously and monitored 20 inquiries retrospectively. The OIG rated the department's overall performance as poor in 16 inquiries, or 62 percent. The OIG rated the department's overall performance as satisfactory in 10 inquiries, or 38 percent.

26 Monitored Inquiries Closed by the Office of the Inspector General During August 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 26 monitored cases, or 42 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in 13 of the 26 monitored cases, or 50 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 26 monitored cases, or 58 percent.
- Aside from exceeding statutory, regulatory, or policy timelines, the department unreasonably delayed completing the inquiry in seven of the 26 monitored cases, or 27 percent.
- Of the 20 inquiries the OIG monitored retrospectively, the OIG rated the department's performance as poor in 14 inquiries, or 70 percent.

The summaries that follow present seven notable inquiries the OIG monitored and closed during August 2024.

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Retrospective Reviews

OIG Case Number
24-0086743-INQ

Rating Assessment
Poor

Case Summary

On December 23, 2022, a sergeant allegedly instructed two officers to transport an incarcerated person and his property to a second prison without inventorying the property until they arrived at the second prison. When the second prison refused to accept the property without a property inventory record from the first prison, the transportation officers allegedly failed to return the incarcerated person's property in full to the first prison before prison staff inventoried and stored the property pending the incarcerated person's return.

Case Disposition

The hiring authority conducted an inquiry and sustained the allegation against the sergeant. The hiring authority determined that corrective action was appropriate and issued training to the sergeant. The OIG concurred.

Overall Inquiry Assessment

Overall, the department performed poorly. The hiring authority assigned the first investigator to the inquiry on January 25, 2023, but the investigator failed to initiate any work on the inquiry. The department delayed until May 17, 2024, to assign a second investigator to the inquiry, 478 days after assigning the first investigator. The investigator completed the first interview on May 23, 2024, 491 days after the department received the complaint on January 18, 2023. Due to the unreasonable delays, the department deleted the video-recorded evidence pursuant to its 90-day video-retention policy before the inquiry began.

The investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing the sergeant who was the subject of the inquiry before interviewing the incarcerated person who submitted the complaint and did not provide justification in the inquiry report for this deviation. The investigator failed to ask the incarcerated person all relevant questions during the interview to discern what other personal property went missing during his transport. The hiring authority reviewed the inquiry report and sustained the allegation against the sergeant but initially did not impose a penalty. The hiring authority incorrectly opined that he could not impose a penalty without identifying the officers at the second prison who refused to accept the incarcerated person's noninventoried property. After the OIG inquired to the department regarding the hiring authority's rationale against issuing corrective action for a sustained allegation, the hiring authority reassessed his decision. The hiring authority determined the officers' identity was irrelevant given that the sending prison never inventoried the property, and the hiring authority identified the matter as a training issue. Overall, the department untimely completed the inquiry on June 12, 2024, 511 days after the Centralized

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Retrospective Reviews (continued)

Screening Team received the complaint on January 18, 2023, 421 days beyond the department's goal, and 146 days beyond the deadline to impose disciplinary action if warranted.

OIG Case Number
24-0085115-INQ

Rating Assessment
Poor

Case Summary

On January 7, 2024, an officer allegedly refused to alert medical staff that an incarcerated person's bandage was leaking discharge, refused to provide the incarcerated person with her name and badge number, and refused to activate her body-worn camera all out of discrimination based on the incarcerated person's transgender status.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to address and investigate the allegations that the officer who was the subject of the inquiry refused to provide her name and badge number to the incarcerated person and discriminated against the incarcerated person based on the incarcerated person's transgender identity. The investigator also failed to interview medical staff who were potential witnesses to the incident and failed to obtain medical documentation related to the incarcerated person's wound care to support or refute whether the officer notified medical staff about the leaking bandage.

In addition, the investigator failed to provide a detailed summary in the inquiry report of the video-recorded evidence, such as the relevant time stamps or the verbal exchange between the incarcerated person and the officer. Instead, the investigator improperly documented conclusions that the incarcerated person was not receptive and behaved rudely, which is a determination for the hiring authority to make. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations. Finally, the investigator unreasonably delayed the inquiry 71 days because the investigator submitted a draft inquiry report to the Office of Internal Affairs manager three times for review before the manager deemed the report adequate. The Office of Internal Affairs manager and the hiring authority ultimately failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate.

Retrospective Reviews (continued)

Overall, the department untimely completed the inquiry on June 17, 2024, 159 days after the Centralized Screening Team received the complaint on January 10, 2024, and 69 days beyond the department's goal.

OIG Case Number
24-0088720-INQ

Rating Assessment
Poor

Case Summary

On March 7, 2024, an officer allegedly referred to a male incarcerated person as the spouse of a second male incarcerated person. The officer also allegedly asked to view the first incarcerated person's tattoo in front of other incarcerated people and officers which caused the incarcerated person to feel uncomfortable. The second male incarcerated person also made a similar allegation about the officer referring to the first incarcerated person as a spouse in a separate complaint.

Case Disposition

The hiring authority conducted an inquiry into the first grievance and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's finding that there was insufficient evidence to sustain the allegation that the officer referred to the first incarcerated person as the spouse of the second incarcerated person. Contrary to the hiring authority's findings after the first inquiry, the hiring authority sustained the allegation against the officer after the inquiry into the second incarcerated person's complaint and provided the officer training.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team received separate written complaints from two incarcerated people who alleged an officer acted discourteously when she referred to one incarcerated person as the spouse of the other. Despite the identical allegation against the same officer, the department wasted resources by opening two separate inquiries and assigning each inquiry to two separate investigators. Consequently, the investigators interviewed the same individuals during each inquiry and collected conflicting evidence. The investigator assigned to the first inquiry failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegation. The investigator also failed to request or obtain any potentially relevant video-recorded evidence for lack of a specific time frame for the incident even though the incarcerated person who submitted the complaint provided the date and reasonable time frame for the misconduct. Due to the investigator's decision to not request video-recorded evidence, the department deleted the recordings pursuant to its 90-day video-retention policy. The investigator also made a self-contradictory statement in the inquiry report that video recordings did not show the alleged incident despite the investigator's failure to obtain the video footage. The investigator interviewed the

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incarcerated person who submitted the complaint, two incarcerated person witnesses, an officer witness, and the officer who was the subject of the inquiry but failed to document if he provided a confidentiality admonishment during the interviews. The Office of Internal Affairs manager initially found the investigator's draft inquiry report insufficient and directed the investigator to obtain the video-recorded evidence. However, the manager unreasonably delayed 20 days to review the inquiry report resulting in the department's deletion of the video footage pursuant to its 90-day video-retention policy prior to returning the report to the investigator. The hiring authority reviewed both inquiries and sustained the allegation against the officer in one inquiry but did not sustain the allegation in the corresponding inquiry.

The hiring authority failed to identify the duplicate inquiries and the varying evidence each inquiry unveiled, such as the officer's conflicting statements to investigators. Overall, the department untimely completed the inquiry on July 1, 2024, 112 days after the Centralized Screening Team received the complaint on March 11, 2024, and 22 days beyond the department's goal.

OIG Case Number
24-0087899-INQ

Rating Assessment
Poor

Case Summary

On April 7, 2024, an officer allegedly yelled expletives toward incarcerated people while holding a less-lethal weapon. Also, the officer and two additional unknown officers allegedly yelled with regularity at incarcerated people in the housing unit and created a hostile environment which could be harmful to incarcerated persons with mental health issues.

Case Disposition

The hiring authority conducted an inquiry and sustained the allegation against the officer. The hiring authority determined that corrective action was appropriate and issued training to the officer. The OIG concurred.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to investigate the allegation that two additional officers constantly yelled at incarcerated people and created a hostile environment in a housing unit. Thus, the investigator made no attempts to identify and interview the two officers as subjects of the inquiry. The investigator also failed to ask all relevant questions during the interviews such as to ask witnesses if they could identify the two officers who yelled with regularity in the housing unit and if those officers' actions created a hostile environment for the incarcerated population. The investigator also failed to identify, reference, and

Retrospective Reviews (continued)

include in the inquiry report the records of departmental policy and procedure applicable to the allegations. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate.

OIG Case Number
24-0086273-INQ

Rating Assessment
Poor

Case Summary

On May 12, 2024, an officer allegedly failed to reclaim handcuffs from an incarcerated person after the incarcerated person refused to return the handcuffs and instead left the incarcerated person unsupervised in his cell for up to two hours while the incarcerated person remained in possession of the handcuffs.

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 officer who was the subject of the inquiry questions about what specific actions he took to retrieve the handcuffs from the incarcerated person who submitted the complaint. The investigator failed to ask the sergeant who was a witness questions to explore the incarcerated person's reported habit of taking handcuffs from officers and what steps supervisors and officers took to prevent the incarcerated person's behavior from continuing. The investigator should have obtained a statement of this nature to provide the hiring authority more evidence about the officer's actions, reasoning, and compliance with departmental policies and procedures. During the inquiry, the investigator obtained information related to the allegation that the incarcerated person remained unsupervised while in possession of handcuffs which implicated the sergeant as a subject of the inquiry; however, the investigator failed to properly identify and treat the sergeant as a subject. As a result, the investigator failed to investigate any potential misconduct attributable to the sergeant. The investigator also failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the officer's alleged misconduct. 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.

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Contemporaneously Monitored

OIG Case Number
24-0080094-INQ

Rating Assessment
Poor

Case Summary

On April 4, 2024, a nurse and a psychiatric technician allegedly refused to provide an incarcerated person with his court-ordered medication or mandatory backup medication. The nurse also allegedly failed to contact the prescribing clinician to determine if the medicine should be forcefully administered. When the incarcerated person engaged in self-harm that triggered an alarm, a second nurse allegedly refused the incarcerated person's request for court-ordered medication and informed him that he was not on a court order for medication. In addition, a third nurse allegedly denied the incarcerated person's request for court-ordered medication over the prison intercom.

Case Disposition

The investigator suspended the inquiry and referred it to the Office of Internal Affairs' Allegation Investigation Unit for investigation after the investigator discovered evidence of staff misconduct listed in the Allegation Decision Index. The OIG did not monitor the investigation following the referral.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team improperly routed the complaint for local inquiry because the incarcerated person alleged that medical staff failed to provide him court-ordered medication. This type of allegation is staff misconduct listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. The hiring authority unreasonably delayed 48 days to assign an investigator to the inquiry. The investigator failed to document in the inquiry report whether she conducted interviews in a confidential setting and whether she established effective communication with the incarcerated person who submitted the complaint prior to conducting his interview. The investigator failed to have a copy of the complaint for reference during the incarcerated person's interview and required use of the OIG's copy to provide a synopsis of the allegations. The investigator asked compound and inappropriate leading questions during the interview with the incarcerated person. The investigator asked questions out of chronological order which confused the incarcerated person and herself. In addition, the investigator interviewed the incarcerated person and failed to provide a confidentiality admonishment during the interview. The investigator failed to properly summarize in the inquiry report her interview with the incarcerated person and failed to document her source of information such as whether she gained the information from her interview with the incarcerated person or from a review of medical records. The investigator failed to investigate all allegations such as the allegation that a nurse denied the incarcerated person's request for court-ordered medication over the prison intercom.

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Contemporaneously Monitored (continued)

The investigator unreasonably delayed 38 days to submit the draft inquiry report to the Office of Internal Affairs manager. Overall, the investigator was not adequately trained in the general processes and procedures for conducting a local inquiry and the required elements of an inquiry report. Throughout the inquiry, the OIG made several recommendations which the investigator adopted, such as drawing the investigator's awareness to the Allegation Decision Index and the process to elevate this complaint to the Office of Internal Affairs' Allegation Investigation Unit for investigation after the investigator discovered evidence of staff misconduct listed in the Allegation Decision Index.

OIG Case Number
24-0088378-INQ

Rating Assessment
Poor

Case Summary

On March 2, 2024, two officers allegedly rehoused an incarcerated person in a general population housing unit even though the incarcerated person wore a white jumpsuit typically designated for incarcerated persons housed in restricted housing units. A third officer allegedly opened the general population housing unit's day room door and cell door for the first incarcerated person wearing the white jump suit which triggered a second incarcerated person to assault the first incarcerated person. The third officer also allegedly failed to properly holster his lethal firearm and failed to carry a radio on his person when responding to the second incarcerated person's assault of the first incarcerated person.

Case Disposition

The hiring authority suspended the inquiry and referred it to the Office of Internal Affairs' Investigation Unit for investigation after discovering evidence of staff misconduct that could result in disciplinary action. The OIG did not monitor the investigation following the referral.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to ask all relevant questions during interviews. For example, the investigator failed to ask the lieutenant who was a witness if the escort officers should have transported the incarcerated person to a restricted housing unit for safety concerns instead of a general population housing unit. The investigator also did not ask the lieutenant to explain the significance of an incarcerated person donning a white jumpsuit. In addition, the investigator failed to interview the control booth officer who was a subject of the inquiry based on a reliance of video-recorded evidence. Thus, the investigator missed an opportunity to ask the control booth officer if he observed the incarcerated person dressed in a white jumpsuit, about the meaning of wearing a white jumpsuit, and if he correctly opened the day room door and the cell door giving the incarcerated

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Contemporaneously Monitored (continued)

person whose safety was at risk access to the general population housing unit. Similarly, the investigator failed to inquire why the control booth officer disengaged his body-worn camera while interacting with the incarcerated person after opening the dayroom door and the cell door that led to the incarcerated person's assault. 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 OIG recommended the hiring authority suspend the inquiry and refer it to the Office of Internal Affairs' Allegation Investigation Unit for investigation after discovering evidence of staff misconduct that could result in disciplinary action. The hiring authority agreed with the OIG's recommendation.

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