December 2024 Local Inquiry Team Case Blocks

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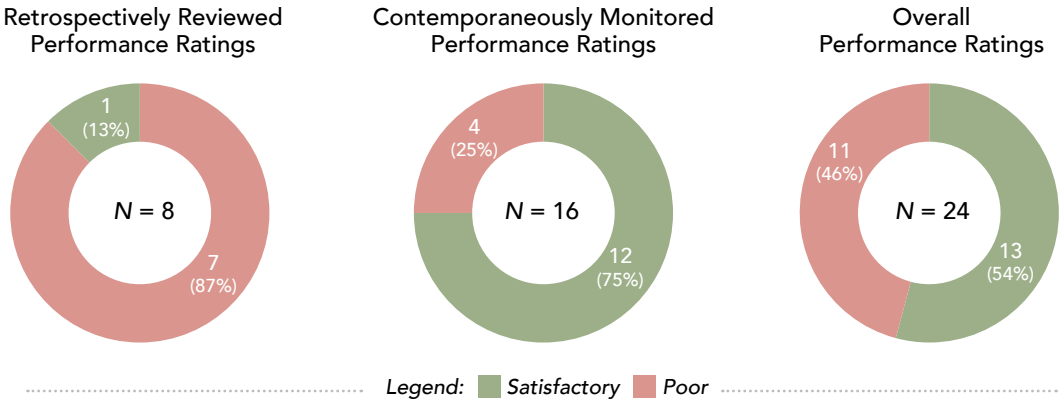
During December 2024, the OIG's Local Inquiry Team closed 24 monitored inquiries. Of those 24 inquiries, the OIG monitored 16 inquiries contemporaneously and monitored eight inquiries retrospectively. The OIG rated the department's overall performance as poor in 11 inquiries, or 46 percent. The OIG rated the department's overall performance as satisfactory in 13 inquiries, or 54 percent.

24 Monitored Inquiries Closed by the Office of the Inspector General During December 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 13 of the 24 monitored cases, or 54 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in 15 of the 24 monitored cases, or 63 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 24 monitored cases, or 63 percent.
- Aside from exceeding statutory, regulatory, or policy timelines, the department unreasonably delayed completing the inquiry in 10 of the 24 monitored cases, or 42 percent.
- Of the eight inquiries the OIG monitored retrospectively, the OIG rated the department's performance as poor in seven inquiries, or 87 percent.

The summaries that follow present three notable inquiries the OIG monitored and closed during December 2024.

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Retrospective Reviews

OIG Case Number
24-0086261-INQ

Rating Assessment
Poor

Case Summary

On August 11, 2023, an officer allegedly failed to call for help when an incarcerated person experienced chest pains. The officer also allegedly failed to bring the incarcerated person indoors after a sergeant directed her to do so.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team routed this complaint for a local inquiry even though the incarcerated person who submitted the complaint alleged an officer failed to call for help after he reported a possible medical emergency. This type of allegation is staff misconduct listed in the department's Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. The investigator, the Office of Internal Affairs manager, and the hiring authority also failed to identify the allegation as staff misconduct listed in the Allegation Decision Index and dispute the referral. During the inquiry, the investigator discovered evidence that the officer who was the subject failed to comply with the department's body-worn camera activation policy when she improperly deactivated her body- worn camera five times while supervising incarcerated people on the yard and inappropriately cited a lack of contact with incarcerated people as her justification. Furthermore, the officer deactivated her camera twice more without providing an audible explanation. However, the investigator failed to identify that this evidence supported an additional allegation of staff misconduct listed in the Allegation Decision Index and refer the allegation to the Office of Internal Affairs' Allegation Investigation Unit for investigation or the hiring authority. Additionally, the investigator failed to serve on the officer who was the subject written notice that she was the subject of the inquiry. The investigator then interviewed the officer who was the subject, and a nurse and a sergeant who were witnesses, and failed to document in the inquiry report whether he provided the required advisement of rights during the interviews and whether he provided the officer and nurse with a written notice of interview. The investigator also failed to document in the inquiry report whether he provided a confidentiality admonishment during any of the interviews he conducted. The investigator also failed to follow departmental training and best practices by failing to document the time and location of each interview. Notwithstanding the incarcerated person who submitted the complaint and his cellmate, the investigator also failed to independently identify and interview any of the incarcerated people who were visible on the video recordings who

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Retrospective Reviews (continued)

could have provided potential evidence relevant to the inquiry. The Office of Internal Affairs manager and the hiring authority failed to identify the report's deficiencies and instead approved the report as adequate. The department delayed 236 days after the hiring authority determined a finding for the allegations to administratively update and close the inquiry in its staff misconduct complaint database. The hiring authority also delayed 371 days to provide the officer who was the subject with training as corrective action and did so only after the OIG requested the training records.

OIG Case Number
24-0079201-INQ

Rating Assessment
Poor

Case Summary

On March 20, 2024, an officer allegedly left an incarcerated person naked for 30 minutes in a holding cell after performing an unclothed body search. A female sergeant allegedly walked into the area while the naked incarcerated person occupied the holding cell.

Case Disposition

The hiring authority determined that the inquiry conclusively proved the misconduct did not occur. The OIG concurred.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team unreasonably delayed 23 days to make a screening decision after receiving the complaint. The Office of Grievances failed to update the department's staff misconduct complaint database with the identity of the locally designated investigator assigned to the inquiry. Unaware that the hiring authority had assigned an investigator who commenced the inquiry, the OIG initially selected the inquiry for contemporaneous monitoring rather than for retrospective review. Additionally, the grievance coordinator failed to respond to the OIG for 38 days after the OIG initially emailed the Office of Grievances, and subsequently twice more, with notification that the OIG had selected the inquiry for monitoring. The department's lack of adequate communication prevented the OIG from conducting contemporaneous monitoring and providing feedback. Additionally, the Office of Grievances incorrectly documented that the inquiry was resolved with a finding of unfounded 38 days before the grievance coordinator sent the inquiry report to the hiring authority for a determination. The grievance coordinator made the premature entry that the hiring authority resolved the inquiry when the investigator had submitted the inquiry report to the Office of Internal Affairs manager for review. The grievance coordinator also failed to timely upload the inquiry report casefiles for the Office of Internal Affairs manager's review. The Office of Grievances also failed to document in the staff misconduct complaint database when the grievance coordinator submitted the inquiry report to the Office of Internal Affairs

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Retrospective Reviews (continued)

manager, when the Office of Internal Affairs manager returned the inquiry report to the investigator for further inquiry, when the Office of Internal Affairs manager approved the revised inquiry report, and when the grievance coordinator submitted the inquiry report to the hiring authority for review. Overall, the department's lack of adequate record keeping within its staff misconduct complaint database prevented the OIG from determining the dates of critical inquiry junctures. Further, the investigator failed to document in the inquiry report if she conducted interviews in a confidential setting. The investigator also interviewed an officer and a sergeant who were subjects and failed to document in the inquiry report whether she provided an advisement of rights during the interviews. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to unclothed body searches and staff sign-in sheets. After the investigator submitted a revised inquiry report to the Office of Internal Affairs manager, the manager delayed 59 days to approve the report. 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 hiring authority indicated in the inquiry report that he approved the report as adequate based on his subsequent review; however, he never returned the report to the investigator for additional inquiry work. Overall, the department untimely completed the inquiry 105 days after the Centralized Screening Team received the complaint and 15 days beyond the department's goal.

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Contemporaneously Monitored

OIG Case Number
24-0085961-INQ

Rating Assessment
Poor

Case Summary

On unknown dates prior to July 4, 2024, an officer allegedly harassed an incarcerated person about wearing shower shoes to and from the shower. Then on July 4, 2024, the officer allegedly refused to allow the incarcerated person to perform her work duties because of her ethnicity.

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. During the inquiry, the investigator decided to suspend the inquiry and refer the allegations to the Office of Internal Affairs' Allegation Investigation Unit for investigation based on evidence that the officer exhibited racial discrimination toward the incarcerated person who submitted the complaint. However, the investigator unreasonably delayed 34 days to submit her draft inquiry report to the Office of Internal Affairs manager with the recommendation to elevate the inquiry for investigation. The Office of Internal Affairs manager reviewed the inquiry report, disagreed with the investigator's recommendation to elevate the inquiry for investigation, and returned the report to the investigator with directives to collect additional evidence. The investigator then delayed 31 days to conduct additional interviews. Additionally, the investigator failed to provide the OIG with sufficient advanced notice of one additional interview with an officer who was a witness and thus conducted the interview without the OIG present to provide contemporaneous monitoring and feedback. Due to the investigator's delays to complete the draft inquiry report, the Office of Internal Affairs manager eventually deemed the report adequate 57 days after the investigator submitted the first draft. Overall, the department untimely completed the inquiry 135 days after the Centralized Screening Team received the complaint and 45 days beyond the department's goal.

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