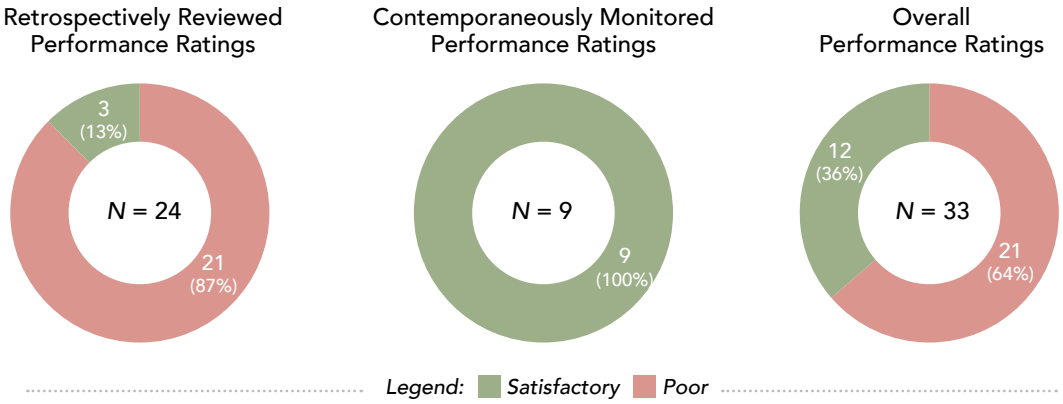
During November 2024, the OIG's Local Inquiry Team closed 33 monitored inquiries. Of those 33 inquiries, the OIG monitored nine inquiries contemporaneously and monitored 24 inquiries retrospectively. The OIG rated the department's overall performance as poor in 21 inquiries, or 64 percent. The OIG rated the department's overall performance as satisfactory in 12 inquiries, or 36 percent.

33 Monitored Inquiries Closed by the Office of the Inspector General During November 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 12 of the 33 monitored cases, or 36 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in 14 of the 33 monitored cases, or 42 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 13 of the 33 monitored cases, or 39 percent.
- Aside from exceeding statutory, regulatory, or policy timelines, the department unreasonably delayed completing the inquiry in 21 of the 33 monitored cases, or 64 percent.
- Of the 24 inquiries the OIG monitored retrospectively, the OIG rated the department's performance as poor in 21 inquiries, or 87 percent.

The summaries that follow present five notable inquiries the OIG monitored and closed during November 2024.

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Retrospective Reviews

OIG Case Number
24-0091186-INQ

Rating Assessment
Poor

Case Summary

On October 16, 2023, an officer allegedly falsely documented in a rules violation report that an incarcerated person was on his bunk when the officer conducted a search that resulted in the discovery of a mobile phone next to the bunk. The officer's false statements attributed possession of the mobile phone to the incarcerated person when he was not present at his bunk when the mobile phone was discovered.

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 Centralized Screening Team routed this complaint for local inquiry even though the incarcerated person who submitted the complaint alleged that an officer falsified an official record, which is an allegation listed in the department's Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. In addition, the investigator and the hiring authority failed to identify the allegation as staff misconduct listed in the Allegation Decision Index and failed to dispute the Centralized Screening Team's referral for proper assignment to the Office of Internal Affairs' Allegation Investigation Unit for investigation. The investigator failed to identify and obtain the records of departmental policy and procedure applicable to the officer's alleged misconduct. The investigator also failed to notify the officer in writing that she was the subject of the inquiry until 25 days after she was interviewed. Additionally, the investigator failed to provide an officer who was a witness the written notice of interview and advisement of rights during the interview and alternatively issued those important rights sometime after. The investigator also failed to document in the inquiry report whether he provided a confidentiality admonishment during any of the interviews he conducted. Furthermore, the investigator failed to ask an officer who was a pertinent witness questions to reconcile the inconsistent and potentially untruthful statements the witness made to the investigator with statements the witness previously made during a related administrative hearing. Specifically, the witness detailed her recollection of the dorm search to the investigator but stated she did not have any recollection about the details of the search during the administrative hearing. The investigator also interviewed the officer who was the subject and failed to ask any questions that challenged the officer's version of events from those of the incarcerated person who submitted the complaint and the incarcerated person and officer who were witnesses. Because the investigator's evidence resulted in inconsistent statements by a witness

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Retrospective Reviews (continued)

and the officer who was the subject, the investigator should have documented the inconsistent statements as additional potential misconduct in a report and referred the allegation to the Office of Internal Affairs for an investigation with notification to the hiring authority. The Office of Internal Affairs manager and the hiring authority failed to identify the issues above and instead approved the inquiry report as adequate.

OIG Case Number
24-0092556-INQ

Rating Assessment
Poor

Case Summary

On April 9, 2023, an officer allegedly retaliated against an incarcerated person by denying him a scheduled visit with his spouse because the incarcerated person submitted a complaint against the officer.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator interviewed an officer who was a witness over the telephone rather than in-person and failed to provide the rationale for that decision in the inquiry report. The investigator also interviewed the incarcerated person who submitted the complaint and failed to summarize that discussion in the inquiry report; the investigator documented only that the incarcerated person made the same allegations submitted in his grievance. The investigator also failed to document whether effective communication was achieved in the interview with the incarcerated person who submitted the complaint. The investigator failed to verify whether the incarcerated person previously submitted a staff complaint against the officer who was the subject of the inquiry which could have corroborated the incarcerated person's allegation that the officer retaliated against him. The investigator failed to attach as supporting exhibits to the inquiry report the written notice of staff complaint served on the officer who was the subject and the advance written notice of interview and advisement of rights addressed to an officer who was a witness to confirm that all procedural requirements were met prior to the interview. The investigator also failed to document whether she provided a confidentiality admonishment during all interviews. The investigator also failed to document whether each interview was done in a confidential setting. This is particularly concerning regarding the incarcerated person's interview as the inquiry reported indicated that his interview was conducted "cell front." The investigator failed to submit a 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 identify, reference, and include in the inquiry report the records of departmental

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policy and procedure applicable to family visits. The investigator completed the final interview on May 8, 2023, but unreasonably delayed 249 days to submit the draft inquiry report to Office of Internal Affairs manager. Overall, the department untimely completed the inquiry 282 days after the Centralized Screening Team received the complaint and 192 beyond the department's goal.

OIG Case Number
24-0092550-INQ

Rating Assessment
Poor

Case Summary

Between March 10, 2023, and March 11, 2023, a lieutenant, a sergeant, and four officers allegedly failed to properly inventory an incarcerated person's property during his transport to an outside hospital, deprived the incarcerated person of his medications, and unnecessarily withheld his durable medical equipment.

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.

Overall Inquiry Assessment

Overall, the department performed poorly. The hiring authority assigned an investigator that was not at least one rank higher than the highest-ranking subject who was a lieutenant. The investigator failed to serve on the lieutenant, sergeant, and four officers an advanced written notice of staff complaint and failed to initiate any work on the inquiry. The hiring authority then unreasonably delayed 273 days after assigning the first investigator to reassign the inquiry to a second investigator. The second investigator also failed to initiate any work on the inquiry, and again the hiring authority delayed 121 days before reassigning the inquiry to a third investigator. The first investigator failed to submit requests for video-recorded evidence relevant to the inquiry, thus the department deleted the recordings pursuant to its 90-day video retention policy which lapsed before the hiring authority assigned the second and third investigators. The third investigator who completed the inquiry failed to interview the incarcerated person who submitted the complaint. The investigator should have interviewed the incarcerated person to confirm the allegation details since departmental records did not show that officers transported the incarcerated person to an outside hospital on the dates documented in his complaint. With accurate information, the investigator could have requested date specific staff sign-sheets and incarcerated person housing records to identify potential subjects and witnesses, and to explore additional leads. The investigator also failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to inventorying personal property and providing access to both

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medications and durable medical equipment during medical transports. The Office of Internal Affairs and the hiring authority failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. Overall, the department untimely completed the inquiry 463 days after the Centralized Screening Team received the complaint, 373 days beyond the department's goal, and 98 days beyond the deadline to impose disciplinary action if warranted.

OIG Case Number
24-0092522-INQ

Rating Assessment
Poor

Case Summary

On September 27, 2022, an unidentified officer allegedly issued a rules violation report to an incarcerated person for possessing illegal drugs despite a prior arrangement wherein unidentified officers assigned to the prison's investigative services unit allegedly provided the incarcerated person with illegal drugs and used him as a confidential informant.

Case Disposition

The investigator suspended the inquiry and referred it to the Office of Internal Affairs' Allegation Investigation Unit for investigation after discovering 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 failed to properly review the complaint and identify an allegation of dishonesty against an officer for issuing a false rules violation report to an incarcerated person. This sort of allegation is staff misconduct listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. Similarly, the first investigator assigned to complete in inquiry failed to identify that the complaint included an allegation of staff misconduct listed in the Allegation Decision Index and failed to dispute the Centralized Screening Team's referral for proper assignment to the Office of Internal Affairs' Allegation Investigation Unit for investigation. After the hiring authority assigned the first investigator to the inquiry, the investigator failed to initiate any work on the inquiry. However, the hiring authority unreasonably delayed 370 days after assigning the first investigator to reassign the inquiry to a second investigator. Additionally, the first investigator 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 which lapsed before the second investigator began the inquiry. During the inquiry, the second investigator properly suspended the inquiry and referred the case to the Office

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of Internal Affairs for investigation after identifying evidence of staff misconduct listed in the Allegation Decision Index.

OIG Case Number
24-0092427-INQ

Rating Assessment
Poor

Case Summary

On November 14, 2022, an officer allegedly discriminated against an incarcerated person based on race by denying him a timely medically necessary shower which caused him to catch a cold. The officer also allegedly favored incarcerated people of another race who engaged in same sex relationships.

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 Centralized Screening Team failed to properly review the complaint and identify the allegations of discrimination based on race and sexual orientation. These sorts of allegations are staff misconduct listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit.

Additionally, all four investigators and the hiring authority failed to identify that the complaint included allegations of staff misconduct listed in the Allegation Decision Index and failed to dispute the Centralized Screening Team's referral for proper assignment to the Office of Internal Affairs' Allegation Investigation Unit for investigation. Initially, the hiring authority delayed 30 days to assign the first investigator, but the investigator failed to initiate any work on the inquiry. The hiring authority then unreasonably delayed 89 days after assigning the first investigator to reassign the inquiry to a second investigator, but the second investigator also failed to initiate any work on the inquiry. Compounding the delays, the hiring authority then delayed another 294 days after assigning the second investigator to reassign the inquiry to a third investigator who also failed to initiate any work on the inquiry. Finally, the hiring authority delayed another 22 days after assigning the third investigator to reassign the inquiry to a fourth investigator. Consequently, the fourth investigator did not complete the first interview until 441 days after the Centralized Screening Team received the complaint. As of result of the investigative delays, the incarcerated person who submitted the complaint was hesitant to cooperate during his interview and had since disregarded the incident. The fourth investigator then

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failed to document whether he provided the incarcerated person a confidentiality admonishment during the interview. The fourth investigator also failed to interview two officers and a sergeant whom the incarcerated person identified and the officer who was the subject of the inquiry and failed to explain the rationale behind each of those decisions in the inquiry report. All four investigators failed to submit timely requests for video-recorded evidence relevant to the inquiry, thus the department deleted the recordings pursuant to its 90-day video retention policy. Additionally, the fourth investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations. The Office of Internal Affairs manager and the hiring authority failed to identify the fourth investigator's omissions in the inquiry report and instead approved the report as adequate. Overall, the department untimely completed the inquiry 475 days after the Centralized Screening Team received the complaint, 385 days beyond the department's goal, and 110 days beyond the deadline to impose disciplinary action if warranted.

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