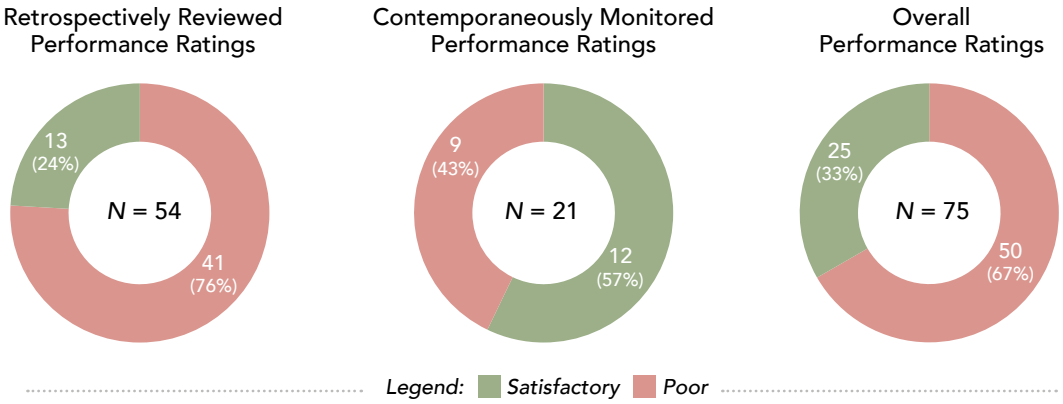
During October 2024, the OIG's Local Inquiry Team closed 75 monitored inquiries. Of those 75 inquiries, the OIG monitored 21 inquiries contemporaneously and monitored 54 inquiries retrospectively. The OIG rated the department's overall performance as poor in 50 inquiries, or 67 percent. The OIG rated the department's overall performance as satisfactory in 25 inquiries, or 33 percent.

75 Monitored Inquiries Closed by the Office of the Inspector General During October 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 26 of the 75 monitored cases, or 35 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in 31 of the 75 monitored cases, or 41 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 30 of the 75 monitored cases, or 40 percent.
- Aside from exceeding statutory, regulatory, or policy timelines, the department unreasonably delayed completing the inquiry in 34 of the 75 monitored cases, or 45 percent.
- Of the 54 inquiries the OIG monitored retrospectively, the OIG rated the department's performance as poor in 41 inquiries, or 76 percent.

The summaries that follow present 11 notable inquiries the OIG monitored and closed during October 2024.

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Retrospective Reviews

OIG Case Number
24-0092529-INQ

Rating Assessment
Poor

Case Summary

On an unidentified date, two officers allegedly conspired with the control tower officer to open an incarcerated person's cell so other incarcerated people could attack the incarcerated person. Additionally, the two officers allegedly conspired with incarcerated people to assault the incarcerated person.

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 Centralized Screening Team improperly routed this complaint for local inquiry even though the incarcerated person alleged that officers threatened to assault him, which is a type of allegation listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. The initial investigator also failed to identify that the complaint included an allegation of staff misconduct listed in the Allegation Decision Index and should have referred the complaint to the Centralized Screening Team for reassignment to the Office of Internal Affairs for investigation. Before the investigator initiated any interviews, the Office of Grievances reclassified the grievance, 270 days after receipt, as a routine issue for supervisory review even though the complaint included an allegation of staff misconduct toward an incarcerated person. The hiring authority reviewed the complaint for routine assignment but instead returned it with a request that the matter be reassigned for a local inquiry. The department then delayed assigning a second investigator to the inquiry, 279 days after the first investigator's assignment. The Office of Grievances failed to record in the department's staff misconduct complaint database the inquiry assignment date and name of the second investigator. Due to the unreasonable delays, the investigator failed to complete the first interview for 302 days after the Centralized Screening Team received the complaint. Additionally, the department deleted the video-recorded evidence pursuant to its 90-day video retention policy which concluded before the inquiry began. The investigator failed to have one officer who was a subject waive the 24-hour notice requirement in the written notice of interview. The investigator also failed to have an officer who was a witness, and a second officer who was a subject sign the acknowledgement in the written advisement of rights. The investigator failed to document in the inquiry report whether he provided a confidentiality admonishment during all interviews and a synopsis of the allegations during interviews with the incarcerated person who submitted the complaint, an incarcerated person and three officer who were witnesses, and two officers who were subjects. The investigator also failed to document whether

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Retrospective Reviews (continued)

he interviewed the incarcerated person who submitted the complaint and two incarcerated person who were witnesses in a location that afforded confidentiality of the discussions. The investigator failed to conduct thorough interviews to identify all potential witnesses and determine if the officers who were subjects had conspired to have the control officer open the incarcerated person's cell door. The investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing two officers who were subjects before interviewing three officers who were witnesses and did not provide justification in the inquiry report for this deviation. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations and an employee sign in sheet. The Office of Internal Affairs manager 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 315 days after the Centralized Screening Team received the complaint, and 225 days beyond the department's goal.

OIG Case Number
24-0091808-INQ

Rating Assessment
Poor

Case Summary

On January 16, 2024, an officer allegedly searched an incarcerated person's cell and destroyed the incarcerated person's personal property, left the incarcerated person's legal paperwork in disarray, poured water onto the incarcerated person's clothing and mattress, and damaged the incarcerated person's television by squeezing it.

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 interviewed the incarcerated person who submitted the complaint and failed to document in the inquiry report if the investigator provided a confidentiality admonishment during the interview. The investigator failed to include in the inquiry report the complete records of departmental policy and procedure applicable to cell searches by excluding the final subsection requiring that departmental staff issue a written notice for any contraband seized and indicate the disposition of that property. The investigator also failed to include as a supporting exhibit to the inquiry report the written notice of staff complaint served on the officer who was the subject. Additionally, the investigator failed to interview officer who was a subject based on a reliance on video-recorded evidence. The investigator should have interviewed the officer about his knowledge

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of the policies and procedures related to cell searches, how he searched the cell, the specific items confiscated or damaged, and to give his account of the incident. The investigator also should have inspected the incarcerated person's television for damage and if it properly functioned because this evidence could not be determined from video-recordings. The investigator also failed to identify and interview any witnesses such as the staff member who was present during the cell search and seen on video-recordings. Additionally, the investigator made improper conclusions about whether the officer damaged any property and purposefully left the cell in disarray, 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 instead approved the report as adequate. The hiring authority did not determine a finding for each allegation 97 days after the Centralized Screening Team received the complaint, and seven days beyond the department's goal.

OIG Case Number
24-0091799-INQ

Rating Assessment
Poor

Case Summary

On an unknown date in August 2023, an unidentified staff person allegedly lost an incarcerated person's eyeglasses and orthopedic shoes during the incarcerated person's emergency transport to a hospital.

Case Disposition

The hiring authority determined the inquiry conclusively proved the misconduct did not occur. The OIG did not concur with the hiring authority's finding of unfounded regarding the allegations.

Overall Inquiry Assessment

Overall, the department performed poorly. The hiring authority unreasonably delayed 70 days to assign an investigator to complete the inquiry. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedures applicable to the allegation. The investigator interviewed the incarcerated person who submitted the complaint and failed to document whether the investigator provided a confidentiality admonishment during the interview. The investigator also failed to document in the inquiry report the investigative steps he took to determine how the incarcerated person's property was lost after the incarcerated person who submitted the complaint admitted during his interview that he had come back into possession of his glasses and shoes sometime after his hospitalization. When the investigator discovered that the incarcerated person had submitted a new complaint related to the status of his property following his recent transfer from one prison to another, the investigator focused his investigation on the

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Retrospective Reviews (continued)

incarcerated person's more recent complaint. Thus, the investigator failed to take the appropriate investigative steps to complete a fact-finding regarding whether the incarcerated person's original complaint about his lost glasses and orthopedic shoes resulted from staff misconduct. 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 reviewed the inquiry report and 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 allegation. Overall, the department untimely completed the inquiry 104 days after the Centralized Screening Team received the complaint, and 14 days beyond the department's goal.

OIG Case Number
24-0086260-INQ

Rating Assessment
Poor

Case Summary

Between January 8, 2024, and January 12, 2024, an officer allegedly told other officers to deny access to toilet paper, linens, and medical showers to an incontinent incarcerated person. The officer also allegedly refused to provide the incarcerated person with extra toilet paper and suggested that the incarcerated person transfer prisons because of his medical condition.

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 interviewed the incarcerated person who submitted the complaint, five officers who were witnesses, and the officer who was the subject and failed to document in the inquiry report if the investigator provided a confidentiality admonishment during each interview. The investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing an officer who was a witness after interviewing the officer who was the subject and did not provide justification in the inquiry report for this deviation. The investigator failed to obtain the housing unit's work schedule to identify potential and relevant witnesses to the alleged misconduct and alternatively interviewed two officers as witnesses because the officers frequently worked the shift associated with the time of the alleged misconduct. Further, the investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations. The investigator also failed to attach to the inquiry report the written notice of staff complaint served on the

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Retrospective Reviews (continued)

officer who was the subject. Additionally, the investigator failed to draft each advance written notice of interview and written advisement of rights prior to interviewing five officers who were witnesses. Instead, the investigator completed the documents nearly two months after he interviewed the officers and only after the Office of Internal Affairs manager directed the investigator to include the documents with the inquiry report. Due to the delay to draft these documents, the OIG could not verify if the investigator properly served each officer with sufficient notice of their scheduled interview and proper advisement of their rights before conducting interviews. The investigator unreasonably delayed the inquiry after having to submit the draft inquiry report to the Office of Internal Affairs manager three times before the manager deemed the report adequate. Despite this, the Office of Internal Affairs manager and the hiring authority failed to identify the investigators omissions in the inquiry report and instead approved the report as adequate. Overall, the department untimely completed the inquiry 148 days after the Centralized Screening Team received the complaint, and 58 days beyond the department's goal.

OIG Case Number
24-0085988-INQ

Rating Assessment
Poor

Case Summary

On March 29, 2024, after an officer allegedly made false statements about the results of a canine search, prison staff placed an incarcerated person on contraband surveillance watch. Unknown officers then allegedly failed to timely remove the incarcerated person's restraints when he needed to use the restroom, causing him to urinate and defecate on himself. Finally, a second officer allegedly denied the incarcerated person a copy of the department's regulations.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation that an officer made false statements about the results of a canine search; the OIG did not concur that the inquiry was adequate to make this finding. The hiring authority found insufficient evidence to sustain the allegation that a second officer denied the incarcerated person a copy of the department's regulations; the OIG concurred. The hiring authority did not determine a finding regarding the allegation that unknown officers failed to timely assist the incarcerated person during contraband surveillance watch.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team routed the complaint for a local inquiry even though the incarcerated person who submitted the complaint alleged that an officer made false statements about the results of a canine search. This type of allegation is staff misconduct listed in the department's Allegation

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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 all failed to independently identify that the complaint included an allegation of staff misconduct listed in the Allegation Decision Index and should have referred the complaint to the Centralized Screening Team for reassignment to the Office of Internal Affairs for investigation. Additionally, the department misidentified an officer as the subject when the officer was a witness to the alleged misconduct. As a result, the investigator erroneously treated the witness officer as the subject and the canine officer who allegedly made false statements as a witness. During the investigator's interview of the canine officer, the officer provided an account of the search he conducted; however, the investigator failed to identify this officer as the appropriate subject. The investigator should have stopped the interview, re-noticed the officer as a subject, afforded the officer all the rights provided to a subject, and then resumed with a subject interview of the officer. The investigator also failed to conduct the interview of the incarcerated person who submitted the complaint in a confidential location and instead conducted the interview on the tier of the housing unit. Additionally, the investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing an officer who was a witness after one of the officers who was a subject and did not provide justification in the inquiry report for this deviation.

Although the investigator submitted a timely request for video-recorded evidence, the investigator failed to obtain any meaningful explanation about why the investigative services unit denied the request and the footage was unavailable. The investigator failed to include as exhibits to the inquiry report the written notices of staff complaint served on the officers who were subjects and the contraband surveillance log which the investigator referenced in the inquiry report. Additionally, the investigator failed to include the signature page of the advisement of rights served on one officer who was a subject, rendering it unclear whether that officer understood or acknowledged the advisement. The investigator also failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to contraband surveillance watch, canine searches, or incarcerated people's access to the department's regulations. Thereafter, investigator improperly made conclusions in the inquiry report about whether the officers appropriately followed departmental policy and procedure during the incarcerated person's time on contraband surveillance watch, which is a responsibility reserved for the hiring authority. The investigator also failed to conduct any investigative work into the allegation that unknown officers failed to timely allow the incarcerated person to use the bathroom during contraband surveillance watch which caused the incarcerated person to urinate and defecate on himself. Thus, the hiring authority failed to determine a finding for that allegation and instead should have sent the inquiry back to the investigator to conduct additional inquiry work. The Office of Internal Affairs manager and the hiring authority failed to identify the inquiry's inadequacies and instead approved the inquiry report as adequate.

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Retrospective Reviews (continued)

OIG Case Number
24-0085262-INQ

Rating Assessment
Poor

Case Summary

On March 13, 2024, an officer allegedly ignored an incarcerated person's medical emergency announcement after the incarcerated person cut his wrist and began to bleed.

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 interview the officer who was the subject and three officers who were witnesses based on a reliance on video-recorded evidence. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations, such as policies related to medical emergency response. The investigator also failed to investigate and include in the inquiry report all relevant evidence such as the work schedule and medical records documenting the injury to the incarcerated person's wrist and the timeframe for the injury. Doing so could have identified potential subjects and witnesses and a more specific incident timeframe and provided proof to corroborate the incarcerated person's injuries or lack thereof. 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.

OIG Case Number
24-0083913-INQ

Rating Assessment
Poor

Case Summary

On February 15, 2024, 10 officers within a specialty treatment clinic allegedly socialized rather than perform their work duties. Additionally, an eleventh officer allegedly slept while on duty.

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.

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Retrospective Reviews (continued)

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to issue 10 officers who were subjects a written notice of staff complaint prior to their interviews and issued one subject officer a written notice of staff complaint on the day of the interview. The investigator failed to provide a sufficient summary of the allegations to one officer in the notice of interview and to three officers in the advisement of rights. Additionally, the investigator provided a notice of interview to seven officers that contained the incorrect interview date. The investigator rescheduled two interviews with officers and failed to provide the officers with a new notice of interview. The investigator interviewed the incarcerated person who submitted the complaint and failed to document in the inquiry report if the investigator conducted the interview in a confidential setting. The investigator also failed to document if he provided a confidentiality admonishment during interviews with all eleven officers and a sergeant. The investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing the officers who were subjects before interviewing the sergeant who was a witness and did not provide justification in the inquiry report for this deviation. The investigator failed to document in the inquiry report whether he asked relevant questions in all interviews to inquire if officers had excessively socialized while performing their work duties. Rather, in each interview, the investigator asked the same questions and failed to ask follow-up questions. The investigator failed to identify and interview potential witnesses from the scheduled appointment sheet and failed to explain the reasoning behind that decision in the inquiry report. The investigator failed to identify the records of departmental policy and procedure applicable to the allegations and include those records as supporting exhibits to the inquiry report. The Office of Internal Affairs manager initially determined the draft inquiry report insufficient and returned it to the investigator with directives to interview three officers as subjects whom the investigator originally interviewed as witnesses and to remove one officer as a subject.

The investigator failed to follow the manager's direction and did not reinterview the three officers as subjects nor remove the one officer as a subject. Although the investigator provided the three officers with a revised subject notice of staff complaint, the investigator failed to provide the officers with an adjusted subject's advisement of rights. The investigator also improperly modified the inquiry report to reflect that he interviewed two of the three officers as subjects. The Office of Internal Affairs manager and the hiring authority approved the investigator's inquiry report as adequate despite the investigator's oversights and refusal to follow the manager's direction.

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Retrospective Reviews (continued)

OIG Case Number
24-0083564-INQ

Rating Assessment
Poor

Case Summary

On February 19, 2024, a supervising cook allegedly harassed and intimidated an incarcerated person when the supervising cook improperly directed an officer to search the incarcerated person. Additionally, the supervising cook allegedly constantly followed, yelled, and cursed at the incarcerated person.

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 documented in the inquiry report that he did not provide a written notice of interview to an officer and a supervising cook who were both witnesses and then failed to document if they gave verbal waivers in interviews. The investigator failed to follow departmental training and best practices regarding the order for completing interviews by to interviewing the supervising cook who was a subject prior to interviewing two incarcerated persons and a supervising cook who were witnesses and did not provide justification in the report for this deviation. The investigator interviewed an incarcerated person who allegedly observed the supervising cook scream and curse at other incarcerated people under his supervision on several occasions and failed to document in the inquiry report whether he asked the incarcerated person to disclose the identity of those incarcerated people. Further, the investigator interviewed a second supervising cook as a witness to the incident and failed to document in the inquiry report whether he inquired if the second supervising cook observed the first supervising cook yell and curse at the incarcerated person on the date of the alleged incident. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations and a staff sign-in sheet for the date of the incident which could have identified other pertinent witnesses. 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
24-0086319-INQ

Rating Assessment
Poor

Case Summary

On July 6, 2024, an officer allegedly used inflammatory and inciteful language used by street gangs when speaking to an incarcerated person. Later that day, the officer allegedly returned with a second officer and asked the incarcerated person and his cellmate if they wanted to fight the first officer. The first officer then kicked and banged on the cell door and yelled out for the cell door to be opened. The second officer failed to do anything to stop the first officer's unprofessional behavior.

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 incarcerated person who submitted the complaint alleged the incident began when the first officer approached him and stated, "What's brackin' blood?" which is a phrase commonly used by security threat group members to challenge a rival security threat group member to a fight. The nature of the officer's alleged statement and subsequent actions warranted referral of the case to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. The investigator who completed the inquiry failed to identify the second officer as a subject of the inquiry even though the written complaint, the department's database, and the Centralized Screening Team's screening decision identified the first and second officers as subjects. The investigator who was initially assigned to complete the inquiry properly identified both officers as subjects, but the second investigator who ultimately completed the inquiry purposefully removed the second officer as a subject, which was contrary to the OIG's recommendation. Thus, the investigator improperly regarded the second officer as a witness of the inquiry and failed to meaningfully investigate the allegation that the officer failed to act after he witnessed the first officer's misconduct. Additionally, the investigator failed to list as exhibits in the inquiry report the written notice of interview and the advisement of rights for each staff witness, which the investigator attached as supporting exhibits to the inquiry. The Office of Internal Affairs manager failed to identify the inquiry's inadequacies and instead approved the report as adequate. The grievance coordinator failed to notify the OIG upon submitting the inquiry report to the hiring authority for review. The lack of adequate communication prevented the OIG from conducting contemporaneous monitoring and providing real-time feedback and recommendations. Despite the inquiry's deficiencies, the hiring authority found the inquiry report sufficient and then failed to determine a finding for the allegation that the second officer failed to act. The hiring authority also incorrectly remitted a case

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Contemporaneously Monitored (continued)

closure notification dated October 23, 2024, to the incarcerated person who submitted the complaint which pre-dated the hiring authority's approval of the inquiry report on October 24, 2024. Finally, the department untimely completed the inquiry 98 days after the Centralized Screening Team received the complaint and eight days beyond the department's goal.

OIG Case Number
24-0084932-INQ

Rating Assessment
Poor

Case Summary

On February 16, 2024, an officer allegedly disclosed to unidentified staff members and incarcerated people that an incarcerated person takes a prescribed opioid.

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 grievance coordinator failed to notify the OIG during all phases of the inquiry report review and approval process, including submission of the final inquiry report to the hiring authority for review. The lack of adequate communication prevented the OIG from conducting contemporaneous monitoring and providing real-time feedback and recommendations. The hiring authority did not assign an investigator to the inquiry until 120 days after the Centralized Screening Team received the complaint. Overall, the department untimely completed the inquiry 162 days after the Centralized Screening Team received the complaint and 72 days beyond the department's goal.

OIG Case Number
23-0063757-INQ

Rating Assessment
Poor

Case Summary

On May 18, 2023, a nurse allegedly broke an incarcerated person's television when she pulled the television's power cord excessively hard and then yelled at the incarcerated person.

Case Disposition

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

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Contemporaneously Monitored (continued)

Overall Inquiry Assessment

Overall, the department performed poorly. The California Correctional Health Care Services Staff Misconduct Team unreasonably delayed 55 days to forward the complaint to the hiring authority for assignment. The hiring authority then unreasonably delayed an additional 32 days to assign an investigator who later took a leave of absence before initiating any inquiry work. The hiring authority assigned a second investigator to complete the inquiry on December 7, 2023; however, the investigator then delayed 67 days to conduct his first interview. In total, 206 days elapsed between the date the California Correctional Health Care Services Staff Misconduct Team received the complaint and when the second investigator conducted his first interview. The investigator arranged interviews without the OIG present; thus, the investigator's lack of collaboration prevented the OIG from conducting contemporaneous monitoring and providing real-time feedback and recommendations.

The investigator also failed to include medical records as a supporting exhibit to the inquiry report after he indicated in the inquiry report that the records revealed a psychiatric technician assisted the incarcerated person on the day of the alleged misconduct. Additionally, the investigator failed to interview the psychiatric technician as a pertinent witness and failed to explain the rationale behind that decision in the inquiry report. When the investigator submitted the draft inquiry report to the Office of Internal Affairs manager, he failed to include the report's exhibits. To avoid further delays, the OIG forwarded the investigator's exhibits after the OIG learned the investigator took a leave of absence. The hiring authority then unreasonably delayed 147 days from receipt of the inquiry report to determine a finding for the allegations. Overall, the department untimely completed the inquiry 434 days after the Centralized Screening Team received the complaint, and 344 days beyond the department's goal.

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