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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2025

The Office of the Inspector General's Monitoring in 2024 of the Staff Misconduct Complaint Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation

2024 Annual Report

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Amarik K. Singh, Inspector General
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Regional Offices

Sacramento
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March 10, 2025

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California

Dear Governor and Legislative Leaders:

Pursuant to California Penal Code section 6126(i), the Office of the Inspector General is responsible for the oversight of the staff misconduct investigations and the employee disciplinary processes of the California Department of Corrections and Rehabilitation (the department). This report concerns the OIG's monitoring of the department's staff misconduct investigations and the employee disciplinary processes in 2024.

The OIG monitored the performance of the department's Office of Internal Affairs investigators in conducting investigations; the performance of hiring authorities, including wardens, in handling the employee discipline process for those cases; and the performance of department attorneys who provided legal advice to the investigators and hiring authorities and represented the department in legal proceedings, if any, regarding these cases. The OIG determined the department's performance was *poor* both in conducting staff misconduct investigations and in handling the employee disciplinary process. From January 1, 2024, through December 31, 2024, the OIG monitored and closed 162 staff misconduct investigations and the employee disciplinary process, if any, for those cases. The OIG assigned one of three overall ratings for each case: *superior*, *satisfactory*, or *poor*. The department's overall performance was *poor* in 119 of 162 cases, or 73 percent, and *satisfactory* in 43 cases, or 27 percent.

Three principal departmental entities were involved in cases the OIG monitored: investigators from the Office of Internal Affairs, department attorneys, and hiring authorities, such as wardens. In addition to providing an overall rating for each case, the OIG evaluated the performances of the investigators, department attorneys, and hiring authorities separately, and issued one of three ratings—*superior*, *satisfactory*, or *poor*—to each of the entities for each case. The OIG found the performance of investigators *poor* in 99 of 162 cases, or 61 percent, of investigations the OIG monitored and closed, and *satisfactory* in 63 cases, or 39 percent. Of the 162 cases the OIG monitored and closed in 2024, the department assigned an attorney in 83 cases. Of those 83 cases, the OIG found department attorneys performed poorly in 59 cases, or 71 percent, and satisfactorily in

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25 cases, or 30 percent. Regarding wardens and other hiring authorities, the OIG found their performance to be *poor* in 103 of 162 cases, or 64 percent, and *satisfactory* in 59 cases, or 36 percent.

Should you have any questions regarding this report, please contact the OIG at 916-288-4233.

Sincerely,

Amarik K. Singh
Inspector General

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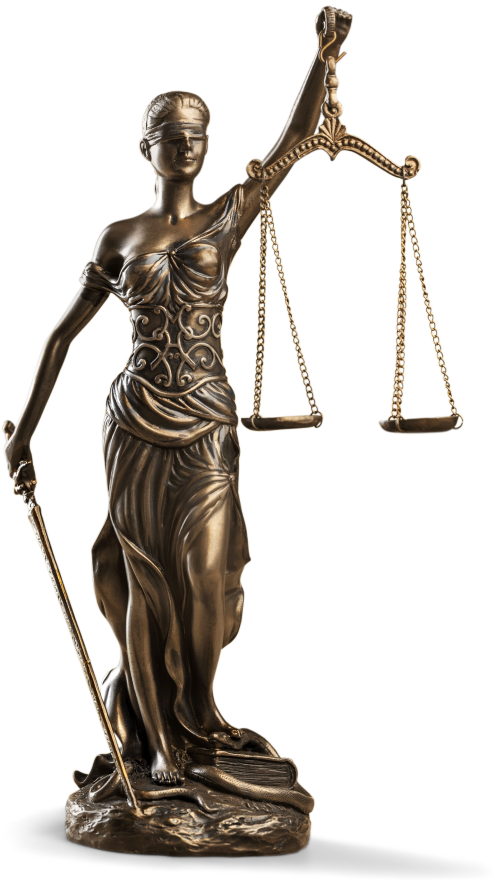

Lady Justice

The Inspector General shall be responsible for contemporaneous oversight of internal affairs investigations and the disciplinary process of the Department of Corrections and Rehabilitation, pursuant to Section 6133 under policies to be developed by the Inspector General.

—*State of California*
California Penal Code section 6126 (a)

The Inspector General shall provide contemporaneous oversight of grievances that fall within the department's process for reviewing and investigating inmate allegations of staff misconduct and other specialty grievances, examining compliance with regulations, department policy, and best practices. . . . **The Inspector General** shall issue reports annually, beginning in 2021.

—*State of California*
California Penal Code section 6126 (i)

The Office of the Inspector General shall be responsible for contemporaneous public oversight of the Department of Corrections and Rehabilitation investigations and staff grievance inquiries conducted by the Department of Corrections and Rehabilitation's Office of Internal Affairs.

—*State of California*
California Penal Code section 6133 (a) (1)

The Office of the Inspector General shall be responsible for advising the public regarding the adequacy of each investigation and whether discipline of the subject of the investigation is warranted.

—*State of California*
California Penal Code section 6133 (a) (3)

Introduction

The California Department of Corrections and Rehabilitation (the department) has a process by which an incarcerated person, a parolee, or any third-party individual or group can submit an allegation of staff misconduct to the department for further review and handling. An allegation of staff misconduct is one in which an individual or group alleges that a departmental employee violated a law, a regulation, departmental policy, or an ethical or a professional standard. The California Penal Code directs that the Office of the Inspector General (the OIG) "shall provide contemporaneous oversight of grievances that fall within the department's process for reviewing and investigating inmate allegations of staff misconduct and other specialty grievances, examining compliance with regulations, department policy, and best practices."[1]

The department maintains a list of the most serious allegations called the Allegation Decision Index. The department's Office of Internal Affairs investigates the department's most serious staff misconduct allegations as noted in an Allegation Decision Index. In turn, the OIG Staff Misconduct Monitoring Unit Investigations Monitoring Team monitor the most serious cases involving allegations against staff for misconduct. These cases often involve allegations of dishonesty, unreasonable force, retaliation, and sexual misconduct.

The OIG's Staff Misconduct Monitoring Unit Investigations Monitoring Team consists of a group of seasoned attorneys with a broad range of experience in various legal disciplines, including criminal prosecution, employment law, administrative law, and civil litigation. These OIG attorneys monitored the performances of departmental staff members who conducted investigations into staff misconduct allegations and who handled the employee discipline process. OIG attorneys monitored cases from the start of investigations until the conclusion of the cases, and in doing so, evaluated the performances of investigators, department attorneys, and hiring authorities, such as wardens. If an investigation led to discipline of an employee, the OIG attorneys continued to monitor the case until its conclusion.

OIG attorneys evaluated whether investigators conducted thorough and timely investigations. They assessed whether department attorneys provided appropriate and timely advice to investigators and hiring authorities. OIG attorneys also analyzed whether department attorneys properly handled employee disciplinary cases, including any litigation stemming from employee disciplinary actions. Moreover, OIG attorneys evaluated whether hiring authorities made reasonable decisions about whether staff misconduct occurred, selected the appropriate penalty, timely served the disciplinary action paperwork, and, if there was a settlement, appropriately settled the case.

1. California Penal Code, section 6126 (i).

The law requires that we issue reports annually. This report covers the OIG's monitoring and assessment of the department's handling of its staff misconduct complaint investigations and employee disciplinary processes from January 1, 2024, through December 31, 2024.

Summary

In 2024, the OIG monitored and closed 162 staff misconduct investigations and the employee disciplinary process for those cases. Some of the cases the OIG monitored and closed in 2024 were opened by the Office of Internal Affairs in 2023, but did not conclude until 2024. For each case, we assigned one of three overall ratings: *superior*, *satisfactory*, or *poor*. Overall, the department's performance was *poor* in conducting staff misconduct investigations and the disciplinary process.

- The department's performance was *poor* in 119 of the 162 cases, or 73 percent.
- The department's performance was *satisfactory* in 43 of the 162 cases, or 27 percent.
- The department did not perform in a *superior* manner in any cases pertaining to staff misconduct investigations and the employee disciplinary process.

Below, we provide specific information on our assessments of the performances of the three main entities—investigators, department attorneys, and hiring authorities, such as wardens—responsible for the department's internal staff misconduct investigations and employee disciplinary processes. As a whole, these performances led to the overall *poor* rating we assigned to the department. In the concluding section of this report, as well as in the individual sections below, we also offer recommendations to the department for the improvement of its internal investigative and employee disciplinary processes.

The Office of Internal Affairs Conducted Mostly *Poor* Staff Misconduct Investigations

The OIG monitored Office of Internal Affairs' staff misconduct investigations from the time the Office of Internal Affairs received a staff misconduct allegation for investigation until the Office of Internal Affairs closed its investigation and sent a final investigative report to a hiring authority for review.

In 2024, the OIG monitored and closed 162 staff misconduct investigative cases. Of these, the OIG found Office of Internal Affairs investigators poorly conducted 99 investigations, or 61 percent. The OIG found Office of Internal Affairs investigators satisfactorily conducted 63 investigations, or 39 percent. In no cases did an Office of Internal Affairs investigator perform in a *superior* manner. The Office of Internal Affairs received *poor* ratings due to excessive delays in conducting investigations, a lack of preparedness, ineffective questioning during interviews, failure to collect relevant evidence, and unnecessary duplication of investigative work.

Office of Internal Affairs Investigators Delayed Completing More Than Half the Investigations Monitored by the OIG

The OIG found the Office of Internal Affairs delayed completing investigations in 100 of the 162 cases the OIG monitored and closed in 2024, or 62 percent. Investigators delayed performing the following investigative activities: conducting an initial case conference, obtaining video recordings, conducting the initial interview in an investigation, and conducting the final interview in an investigation. In addition, investigators allowed significant delays to occur between interviews; delayed completing investigative reports; and failed to thoroughly conduct investigations, which resulted in the hiring authority returning cases to Office of Internal Affairs investigators for further investigation. Moreover, the Office of Internal Affairs caused delays when it reassigned cases to different investigators.

Time is of the essence during investigations. Delays can lead to a loss of critical evidence due to unavailable witnesses, faded memories, or the destruction of video recordings. In addition, delayed investigations cause both the complaining parties and the subjects of investigations undue stress and loss of morale as they await resolution. Incarcerated people may lose faith in the complaint reporting process if they are made to wait from several months to a year for closure. The department has a one-year statutory deadline in which it can issue disciplinary penalties against officers. Delayed investigations impact the department's ability to issue and sustain disciplinary penalties against officers, which may further undermine the trust of incarcerated people and that of the public in the department's commitment to holding officers accountable for misconduct they carry out against incarcerated people and parolees.

The department is aware that investigations must be completed in a timely manner. As part of a court-ordered remedial plan,[2] investigations involving complaints by disabled incarcerated people at six prisons must be completed within either four or six months.[3] The department has informally adopted the same time frames for prisons not bound by the remedial order. Yet despite its stated commitment to completing investigations promptly, the department continues to inefficiently complete investigations.

The OIG found investigators delayed investigations at the outset by not conducting timely initial case conferences in 23 of the 162 monitored cases, or 14 percent of the investigations. The department's operations manual requires investigators to hold an initial case conference within 10 business days of case assignment.[4] In one case, the investigator did not conduct an initial case conference until 54 an initial days after the Office of Internal Affairs assigned the case to an investigator. The initial case conference is an important meeting during which the investigator, the OIG, and the department attorney, if one is assigned, meet to discuss the investigative plan and strategies, determine the order of witnesses to interview, and schedule a tentative first interview date. Because the initial case conference typically precedes the first interview, delaying the initial case conference may lead to a delayed first interview, which then threatens to delay the entire investigation.

The OIG found investigators delayed conducting interviews in 100 of the 162 cases we monitored, or 62 percent. In general, the first person an investigator interviews is the person who filed the complaint so that the investigator can clarify the complaint and establish all important dates. This first interview is vital because the investigator must ensure that video recordings for all relevant dates are requested and obtained, and witnesses and subjects identified. In 100 cases, investigators delayed conducting the first interview by more than one month. In one case, the investigator did not conduct the first interview until six months after having been assigned the case. The OIG also found instances in which the investigator had months' long gaps between interviews. In another case, the investigator's delay in preparing to interview two percipient staff witnesses in a use-of-force case prevented the investigator from interviewing them at all. Although the Office of Internal Affairs assigned an investigator to the case on October 5, 2023, the investigator did not attempt to send a notice of interview to an officer witness until February 29, 2024, and learned only on March 4, 2024, that the officer's last day with the department was March 7, 2024. On April 30, 2024, the investigator attempted to interview a nurse but learned

2. The court implemented the *Armstrong Remedial Plan* at the following prisons: California Institution for Women (CIW); California State Prison, Corcoran (COR); Kern Valley State Prison (KVSP); California State Prison, Los Angeles County (LAC); and Substance Abuse Treatment Facility and State Prison, Corcoran (SATF). Richard J. Donovan Correctional Facility (RJD) is also under a remedial plan with substantially similar remedial measures (*Armstrong et al.* v. *Newsom et al.*, No. 94-cv-02307-CW, U.S. District Court for the Northern District of California).

3. Per the *Armstrong Remedial Plan*, the department must complete investigations within 120 days (when assigned to a sergeant or a lieutenant) or 180 days (when assigned to a special agent). The time frames may be extended for extenuating circumstances (*Armstrong et al.* v. *Newsom et al.*, No. 94-cv-02307-CW).

4. Department Operations Manual, Section 33070.10.6. This manual is also referred to as the DOM.

that she had left the department's employment on February 4, 2024. Although the investigator continued to attempt to schedule interviews with these witnesses, once the employees had left the department, the investigator was unable to reach them to secure their cooperation, preventing the hiring authority from having the benefit of their eyewitness accounts.

The OIG also observed delays in the investigative process that resulted in a failure to obtain video recordings before their destruction. As we reported in the OIG publication titled Monitoring the Staff Misconduct Investigation and Review Process of the California Department of Corrections and Rehabilitation, published on May 24, 2023, the department adopted a retention policy that requires retaining video recordings for only a 90-day period, unless a triggering event requires the recording to be retained for a longer period.[5] As noted in that publication, delayed interviews and reassignment of investigators contributed to investigators' failure to obtain video recordings. The OIG observed this concern continued to be a problem in 2024. For instance, in one case, an officer acted dishonestly when he added false information to a departmental form, which caused an incarcerated person to lose his prison job assignment. The department assigned an investigator on March 13, 2023. The department reassigned the case to another investigator on May 3, 2023. Both investigators delayed reviewing the available video evidence. By the time the second investigator reviewed the video recordings and realized the investigator needed additional earlier video footage, the department had already purged the earlier video recording.

In another case, the Office of Internal Affairs assigned an investigator who conducted no interviews and then reassigned the case to a second investigator who delayed the investigation by prolonging the time needed to conduct nine interviews. The investigator needed seven days to complete the nine interviews, yet the investigator spread out the interviews over the three months and 18 days. The Office of Internal Affairs subsequently reassigned the case to yet another investigator who took two months and 26 days to provide the investigative report to the hiring authority, one month before the deadline to take disciplinary action was set to expire. In this example, the Office of Internal Affairs took nine months and 13 days to provide its investigative report to the hiring authority from the date the Office of Internal Affairs first assigned an investigator to the case.

The OIG also found investigators delayed conducting final interviews and completing investigative reports. Of the 162 cases the OIG monitored, in 60 cases, the investigator delayed completing the final interview,[6] which is often the last investigatory task before the investigator prepares the final investigative report for the hiring authority's review. In one example, the investigator did not complete the final interview until 333 days had elapsed, nearly a year, from when the Office of Internal Affairs assigned the case to an investigator. The OIG found in 84 of 162 cases it monitored, the investigator delayed in completing

5. Examples of triggering events are use-of-force incidents; incidents resulting in serious bodily injury, great bodily injury, or death; sexual assault allegations; and allegations of staff misconduct.

6. In these 60 cases, the investigator conducted final interviews beyond the investigation completion deadlines.

the final investigative report for the hiring authority.[7] In one instance, the investigator completed the last interview on September 27, 2023, but did not complete the final investigative report until February 16, 2024, four months and 20 days thereafter.

Untimely investigations not only impacted an investigator's ability to secure evidence, but also directly impacted the hiring authority's ability to impose disciplinary action when appropriate. The department must complete an investigation and impose disciplinary actions within one year of the department's discovery of any alleged act of misconduct by an officer.[8] The longer an investigator takes to complete the investigation, the less time the hiring authority has to review the investigative report, the supporting documentation, the video evidence, and the audio recordings; to make findings; to determine penalties, if any; and to ensure the preparation and service of disciplinary actions. In one case, the investigator did not provide the hiring authority with the final investigative report until 22 days before the deadline to take disciplinary action was set to expire.

At times, investigators' attempts to quickly close cases resulted in insufficient investigations. Of the 162 cases the OIG monitored, the hiring authority had to return seven cases to Office of Internal Affairs investigators for further investigation. When a hiring authority returns a case to the Office of Internal Affairs, the investigator must conduct more interviews and prepare a new investigative report, which requires the hiring authority to undergo the disciplinary process anew. In one case, the investigator's failure to conduct a thorough investigation required the hiring authority to return the case to the investigator for further investigation, causing a delay of three months and 15 days before the hiring authority could reconvene the investigative and disciplinary findings conference. To alleviate these concerns, the OIG recommends that investigators conduct the initial interview in staff misconduct investigations and request all video recordings within one month of case assignment.

The Office of Internal Affairs Created Duplicative and Superfluous Investigations, Resulting in an Inflated Investigation Count and Inefficient Use of Resources

The Office of Internal Affairs reported completing 7,990 staff misconduct investigations in 2024.[9] While there was a substantial number of staff misconduct investigations in 2024, the Office of Internal Affairs compounded the problem by opening new investigative cases relating to alleged staff misconduct that the Office of Internal Affairs had already investigated or was currently

7. In these 84 cases, the investigator completed the final investigative report beyond the investigation completion deadlines.

8. Government Code section 3304(d) provides that the department cannot impose disciplinary action against a peace officer for any act of misconduct if the investigation of the allegation is not completed within one year of the department's discovery by a person authorized to initiate an investigation of the allegation.

9. Based on data provided by the California Department of Corrections and Rehabilitation, Office of Research.

investigating. The Office of Internal Affairs opened a new investigative case when an incarcerated person or parolee filed a complaint, when a third-party filed a complaint, when departmental staff initiated a complaint, and when the hiring authority, such as a warden, initiated an investigation into the same allegation. Instead of ensuring that they were not creating more than one case for the same allegations, the Office of Internal Affairs knowingly created separate cases when a complainant made both a verbal and written complaint about the same incident, when one incarcerated person filed multiple complaints about the same incident, and when multiple people filed complaints about the same incident. The creation of duplicative cases and the failure to combine allegations related in time and scope into one investigation inflated the actual number of staff misconduct investigations the Office of Internal Affairs handled in 2024 and caused investigators to use resources inefficiently.

The Office of Internal Affairs routinely created new cases when there were already existing investigative cases that addressed the same or related allegations. The Office of Internal Affairs identified some of these cases as "duplicate" cases and some as "subsequent source" cases, meaning the complaint related, at least in part, to a previous complaint for which the Office of Internal Affairs had already assigned an investigation. However, the Office of Internal Affairs failed to identify many of the duplicative and subsequent source cases as such and failed to uniformly document the duplicative nature of investigations that the Office of Internal Affairs identified in the staff misconduct database. Due to the existence of unidentified duplicative investigations, it is difficult to measure the actual number of staff misconduct investigations the Office of Internal Affairs completed in 2024. The Office of Internal Affairs uncovered some previously unidentified duplicative investigative cases during the investigative stage when subjects stated they had already been interviewed for the same allegations. In other situations, hiring authorities discovered the duplicative nature of investigations when holding or preparing for the investigative and disciplinary findings conference. Of the 162 cases the OIG monitored and closed in 2024, at least 19 of the cases were duplicative and had some relation to another pending or closed investigation. For these 19 cases the OIG monitored, the Office of Internal Affairs opened and counted approximately 40 staff misconduct investigations. Some of the duplicative investigations the OIG monitored related to other investigations the Office of Internal Affairs handled; however, many of the duplicative investigations the OIG monitored were related to more than one additional staff misconduct investigation.

Of the 7,990 staff misconduct investigative cases completed in 2024, the Office of Internal Affairs reported 103 as "duplicate" cases. In addition, the Office of Internal Affairs also identified 48 cases as a "subsequent source." However, even when it identified a case as a "duplicate" or "subsequent source," the Office of Internal Affairs created a new case number for subsequent complaints, which caused the Office of Internal Affairs to open superfluous cases. Sometimes, the Office of Internal Affairs seemed unaware that complaints were duplicative and assigned multiple investigators to conduct identical investigations. Other times, the Office of Internal Affairs assigned duplicative cases to the same investigator. Even when the Office of Internal Affairs assigned cases to the

same investigator, investigators repeated the same investigative tasks, which wasted resources.

The OIG monitored several cases in which the Office of Internal Affairs intentionally assigned duplicative investigations to the same investigator, who then prepared and submitted separate investigative reports to the hiring authority. For example, after one incarcerated person made both a verbal and a written complaint that an officer used unreasonable force by firing a less-lethal round that hit him in the head, the Office of Internal Affairs created two cases, assigned both cases to the same investigator, and the investigator submitted two separate investigative reports to the warden. In another instance, the Office of Internal Affairs created one case after an incarcerated person filed a complaint that alleged officers used unreasonable force against another incarcerated person after he witnessed an incident and then created a second case after the incarcerated person involved in the incident subsequently filed a complaint alleging that the officers used unreasonable force against him. Again, the Office of Internal Affairs assigned both cases to one investigator who prepared and submitted two separate investigative reports to the warden. In another example, the Office of Internal Affairs created two cases after two incarcerated people filed separate complaints alleging officers used unreasonable force against them even though they had complied with officers' orders to stop fighting. The Office of Internal Affairs assigned both cases to the same investigator who prepared and submitted two separate investigative reports to the warden.

The OIG also monitored two sets of cases in which different investigators simultaneously investigated identical allegations in separate cases. In the first set of cases, during an investigative and disciplinary findings conference, the hiring authority recognized he had already made findings on two identical allegations under a different case number. This occurred because the Office of Internal Affairs assigned an investigator to one investigation on July 6, 2023, and then assigned a different investigator to the duplicative investigation two weeks later, on July 17, 2023. Both investigators completed their separate investigations of the same allegations. The first investigator submitted a report to the hiring authority on August 18, 2024, and the second investigator submitted a report to the hiring authority on December 5, 2023.

In the second set of cases, an incarcerated person filed a complaint on May 1, 2023, alleging that officers endangered him and created an environment that caused other incarcerated people to injure him, and the Office of Internal Affairs assigned an investigator to investigate the allegations on May 8, 2023. On June 12, 2023, another incarcerated person filed a complaint alleging he witnessed the same misconduct as referenced by the initial complainant, and the Office of Internal Affairs assigned a different investigator to investigate the allegations on June 28, 2023. In the initial investigation, the investigator conducted 11 interviews and submitted an investigative report to the hiring authority on November 16, 2023. In the subsequent investigation, the investigator interviewed four witnesses, including two that were interviewed for the previous case, and submitted an investigative report to the hiring authority on November 2, 2023. The Office of Legal Affairs discovered the duplicative case

after the OIG sought a higher level of review of the hiring authority's findings at the investigative and disciplinary findings conference in the initial case.

In addition to investigating identical and related allegations in multiple cases, the Office of Internal Affairs also divided single complaints into multiple cases, which further unnecessarily duplicated investigatory work. In contrast to the low numbers of cases identified as a duplicate of a subsequent source, the Office of Internal Affairs reported 950 of the investigations it completed in 2024 were related to its process of splitting cases.

The Office of Internal Affairs divided single complaints into multiple cases when complainants alleged misconduct that occurred at different prisons and at different times even where the allegations of staff misconduct were within the same scope and involved a continuous course of conduct. The Office of Internal Affairs further divided complaints when they included allegations that the department deemed less serious, and when the department determined that a complaint included allegations that were not related. In addition, the Office of Internal Affairs routinely created separate cases involving both health care staff and custody staff. In one example, an incarcerated person submitted a single complaint alleging a sergeant had directed a nurse to falsify a medical evaluation of the complainant after having used unreasonable force against him. The Office of Internal Affairs not only created a case for the allegation involving the sergeant but also created a separate case for the allegation against the nurse. All the information obtained during the investigation involving the nurse was relevant to the investigation involving the sergeant. Because the allegations were directly related, the Office of Internal Affairs should not have divided them into two separate cases.

To address these concerns, the OIG recommends that the department develop and implement a process to identify allegations that have already been investigated, are currently being investigated, or are related to an open investigation, and then combine all related allegations into a single investigation. Because all duplicative allegations may not always be identified during the screening process, the OIG also recommends that the department develop and implement a policy to combine related investigations and close out superfluous case numbers once the department identifies them. The OIG further recommends that only one investigator investigate all related allegations in one investigation and that the department discontinue the practice of dividing complaints. Doing so would ensure consistency in investigations, ensure that investigators are familiar with all relevant evidence, and ensure the department uses resources efficiently.

Department Attorneys Performed Poorly in Most Staff Misconduct Cases Monitored by the OIG

During the 2024 reporting period, the OIG monitored and closed 162 staff misconduct investigative cases and the employee disciplinary process for those cases. Of the 162 OIG-monitored staff misconduct cases, the department assigned an attorney to 83 of them, which included one case where the department assigned an attorney solely to consult with an employee relations officer who drafted the disciplinary action and represented the department during disciplinary proceedings. The OIG assessed how well department attorneys provided legal advice to investigators and to wardens. The OIG also evaluated the performance of the department attorney in litigating employee disciplinary actions. The OIG found department attorneys performed poorly in 59 of the 83 cases, or 71 percent of investigations in which the department assigned an attorney to the case. The OIG found in 24 or 83 of the cases, or 29 percent, department attorneys performed satisfactorily. Department attorneys did not perform in a *superior* manner in any cases.

Department Attorneys Drafted Few Disciplinary Actions and Did Not Litigate Any Evidentiary Hearings Before the State Personnel Board in 2024 on OIG-Monitored Cases

In 2024, the OIG monitored and closed 162 staff misconduct cases. The department assigned an attorney to 83 of the 162 cases. Of these 83 cases, hiring authorities sustained an allegation of misconduct in only 22 of the cases, or 27 percent. In one case, a lieutenant retired before the department could serve him with disciplinary action. In another case, the department assigned an attorney to consult with the employee relations officer who represented the department during the disciplinary proceedings. In five of the remaining 20 cases, the hiring authority sustained an allegation, but issued only corrective action, and did not impose disciplinary action. Of the 15 cases in which the department attorney drafted a disciplinary action, officers filed an appeal in seven of the cases, including one case in which an officer withdrew his appeal. Department attorneys advised the hiring authority to settle the remaining six cases for a lesser penalty. In one case, the hiring authority reduced the penalty from disciplinary action to corrective action. In two cases, the hiring authority reduced a previously imposed salary reduction and agreed to the early removal of the disciplinary action from the officer's personnel file. In three other cases in which employees filed appeals, hiring authorities withdrew previously imposed penalties of dismissal, including in one case in which the hiring authority withdrew disciplinary actions against three officers in their entirety. Because the department entered settlements on all the appeals, department attorneys did not present an evidentiary hearing before the State Personnel Board on OIG-monitored cases. In contrast, the OIG monitored one case in which an employee relations officer litigated an evidentiary hearing before the State Personnel Board in 2024.

Department Attorneys Provided Incorrect or Poor Advice to Either the Investigator or the Hiring Authority in Almost Two-Thirds of All OIG-Monitored Cases

Department attorneys are assigned to provide legal consultation to investigators and to hiring authorities, including wardens. The OIG found department attorneys provided poor advice to investigators about investigations in 41 of 83 cases, or 49 percent. The OIG found department attorneys gave poor advice to hiring authorities regarding investigations or disciplinary findings in 39 of 83 cases, or 47 percent, or to both investigators and hiring authorities, in 27 of 83 cases, or 33 percent. In 53 cases, or 64 percent, department attorneys provided poor advice to either the investigator or the hiring authority.

In 41 of 83 monitored cases, department attorneys failed to provide appropriate advice to an investigator concerning an investigation. Department attorneys failed to advise investigators to include all relevant allegations, interview percipient witnesses, and collect necessary evidence such as medical records for investigations.

For example, in one case, a sergeant allegedly slammed an incarcerated person's face onto a concrete floor, causing the incarcerated person to suffer a fractured eye socket and spinal injuries. The department attorney failed to advise the investigator to interview the incarcerated person who filed the complaint and failed to advise the investigator to obtain medical records to evaluate the injuries the incarcerated person may or may not have received due to the incident. The department attorney failed to advise the investigator to include information about the extent of the injuries in the investigative report. The department attorney later inappropriately advised the hiring authority—a warden—to find the investigation to be sufficient even though the Office of Internal Affairs investigator failed to interview the incarcerated person who filed the complaint and did not include important information about the extent of the incarcerated person's injuries in the investigative report. The department attorney further advised the warden to find that the sergeant's use of force was justified, lawful, and proper, even though the Office of Internal Affairs had not thoroughly investigated the allegation.

In 39 of 83 monitored cases, the department attorney advised hiring authorities, including wardens, to make incorrect investigation and disciplinary findings. Incorrect investigation and disciplinary findings included finding an investigation to be sufficient when incomplete; selecting an inappropriate finding for an allegation of sustained, not sustained, unfounded, exonerated, or no finding; and selecting an insufficient penalty.

In one case, one officer allegedly disclosed an incarcerated person's confidential records to a second incarcerated person, causing another incarcerated person to assault the first incarcerated person, and then lied during her Office of Internal Affairs' interview. A second officer allegedly filed a false report that the incarcerated person instigated a fight with a third incarcerated person. The hiring authority found insufficient evidence to sustain the allegations, but

after the OIG sought a higher level of review, the hiring authority's supervisor sustained allegations that the first officer disclosed confidential records and lied during her Office of Internal Affairs' interview and dismissed the first officer. The department did not assign an attorney until the case went through the higher level of review. The department attorney advised the hiring authority to withdraw the allegation that the officer disclosed the incarcerated person's confidential records, which was the conduct that provided the motivation for the officer to lie during her interview. The department attorney then advised the hiring authority to settle the case with the officer, a process that reinstated her to the position of officer and amended the disciplinary action to remove the dishonesty allegation and which, instead, would reflect the allegation of unauthorized access to confidential information. The department attorney advised the hiring authority to agree to modify the officer's penalty from a dismissal to a waiver of six months and one day of back pay because there was insufficient evidence to prove the officer's motive to lie even though there was evidence to support the allegations and the penalty.

Employee Relations Officers Often Performed Poorly While Representing the Department in Employee Disciplinary Cases

An employee relations officer is a department employee responsible for coordinating the administrative process for employee discipline cases. Employee relations officers also represent the department during the employee disciplinary process and at any administrative hearings in cases without an assigned department attorney. These are called nondesignated cases. The department's operations manual provides a similar definition and notes that the employee relations officer is an employee designated by a hiring authority to coordinate disciplinary actions. The employee relations officer has many duties, but some of the most significant duties are drafting disciplinary actions and representing the department in all nondesignated cases before the State Personnel Board. A nondesignated case is one in which the department has not assigned a department attorney to represent the department.

Of the cases monitored by the OIG in 2024, there were 10 instances in which the employee relations officer drafted the disciplinary action, represented the department in settlement discussions, represented the department in State Personnel Board proceedings, or a combination of the above. It is noteworthy that of the cases monitored by the OIG in 2024, department attorneys represented the department in the roles noted above on 15 occasions. Thus, in the 25 cases monitored by OIG requiring an individual to represent the department in the disciplinary process, an employee relations officer—not an attorney—represented the department in 40 percent of the cases.

In more than half of monitored cases for which an employee relations officer represented the department during the disciplinary process, the OIG negatively assessed the employee relations officer's performance. In many of these instances, the performance of the employee relations officer led to poor outcomes for the department, or could have, if not for OIG recommendations. Specifically, the department settled cases in which it otherwise should not have but for the

performance of the employee relations officer. In other cases, if not for OIG monitoring, substantial errors would likely have been made by the employee relations officer.

The first noteworthy example encompasses two separate cases monitored by the OIG. In both cases, a hiring authority sustained allegations of misconduct against a sergeant. However, despite originating from the same prison, each case had a different employee relations officer from different prisons representing the department. Moreover, there were two additional cases with sustained allegations against the sergeant that the OIG did not monitor with still two other employee relations officers involved in the cases. These four cases gave rise to four separate disciplinary actions, including one in which a hiring authority dismissed the sergeant, which was one of the cases monitored by the OIG. Despite all four disciplinary actions concerning the same sergeant, the four employee relations officers did not coordinate among themselves to draft the disciplinary actions or to represent the department until right before entering into a global settlement agreement. This lack of coordination led to many errors, the first of which was that the department served two of the disciplinary actions on the sergeant after the department had already dismissed him from employment, negating their use in supporting the sergeant's dismissal. Had there been proper coordination among the employee relations officers, or a single employee relations officer handling all matters related to the sergeant, the department could have drafted a single disciplinary action, which would have provided substantial support to the department's decision to dismiss the sergeant.

Moreover, during a settlement conference before the State Personnel Board, the employee relations officer representing the department for the dismissal action entered into a global settlement agreement for all four disciplinary actions related to the sergeant, reducing the dismissal to a demotion, and withdrawing the other three disciplinary actions outright. While the three other employee relations officers were brought into the settlement conference, it was clear that they were not fully informed of the details of the settlement. In the other associated case monitored by the OIG, communication with the employee relations officer revealed she was not even fully aware that the terms of the global settlement withdrew the disciplinary action in her case. In addition, the hiring authority for the same disciplinary action failed to even respond to an inquiry from the OIG questioning whether he had provided settlement authority. Finally, it should also be noted that the final settlement report drafted by the department reflected that four separate hiring authorities were consulted during the settlement discussions. However, one of those listed hiring authorities did not even work for the department at the time of the settlement discussion, which draws into question who the employee relations officer consulted before the single employee relations officer attempted to settle four cases at once.

In another example of *poor* performance by a departmental employee relations officer, an employee relations officer failed to consult with departmental staff prior to listing the staff member as an expert witness in a prehearing witness list filed with the State Personnel Board. The employee relations officer was not aware of the content of the expected testimony of those witnesses during a State

Personal Board hearing and only consulted with the individuals after submitting the witness list to the State Personnel Board. After consulting with the witnesses, the employee relations officer realized that the witnesses would not support the department's position regarding the staff misconduct the department alleged in the disciplinary action. This failure to properly identify supporting expert witnesses and consult with witnesses before listing them in support of the disciplinary action led to the department settling the case for a lesser penalty than was warranted for the misconduct.

In still additional cases, the OIG attorney made recommendations to an employee relations officer concerning significant flaws in disciplinary documents. On one occasion, an employee relations officer drafted a disciplinary action that contained an incorrect penalty, an incorrect incident date, an inaccurate description of who authored the investigative report, and failed to include multiple exhibits from the investigative report. Even after the OIG attorney recommended that the employee relations officer correct the inaccuracies, the employee relations officer failed to include relevant prior discipline in the disciplinary action, requiring an amended disciplinary action. The employee relations officer then needed to draft a second amended disciplinary action based on OIG recommendations after the OIG attorney pointed out that the employee relations officer had not corrected the incident date in the disciplinary action. In another case, the OIG attorney made substantial recommendations to an employee relations officer concerning a disciplinary action.

Given the identified deficiencies in the performance of employee relations officers in representing the department in the employee discipline process, the OIG recommends that the department provide more robust training to employee relations officers concerning the employee disciplinary process and how to represent the department during that process. In addition, the OIG recommends that the department, at a minimum, assign an attorney to represent the department in any employee discipline that has the potential to result in an evidentiary hearing before the State Personnel Board.

In Most OIG-Monitored Cases Involving Alleged Staff Misconduct, Hiring Authorities Performed Poorly in Making Decisions and Processing Cases

The OIG monitored the performance of hiring authorities from the time a hiring authority, such as a warden, received a completed investigation from the Office of Internal Affairs through the cessation of any employee discipline-related proceedings. In a majority of cases monitored by the OIG, the sole hiring authority was a warden. However, a health care executive served as a hiring authority in a few OIG-monitored employee discipline case. In 2024, the OIG monitored 162 staff misconduct cases. The OIG found the hiring authority performed poorly in 103 of those cases and satisfactorily in 59 of the cases. The OIG did not rate any hiring authority's performance as *superior* in 2024. Therefore, hiring authorities performed poorly in 64 percent of cases monitored by the OIG. This is a marked increase in *poor* performance from last year, in which we found hiring authorities performed poorly in 50 percent of the cases we monitored.

Similar to the OIG's findings for the 2023 reporting period, a great deal of *poor* ratings during the 2024 reporting period resulted from hiring authority delays in conducting the investigative and disciplinary findings conferences. In 81 of 162 cases the OIG monitored, or 50 percent, the hiring authority failed to timely conduct the investigative and disciplinary findings conference. This reflects a lack of notable improvement from our report last year, in which we documented similar delays in 52 percent of cases monitored by our staff. In fact, in 2024, the average time from when a hiring authority received a report to the date a hiring authority held an investigative and disciplinary findings conference was 52 days. Moreover, in 21 instances, it took 100 days or more for the hiring authority to hold the conference.

Hiring authorities also made *poor* findings. For cases the OIG monitored and closed in 2023, hiring authorities made *poor* findings in 19 percent. In 2024, the OIG found hiring authorities made *poor* findings in 39 of 162 cases, or 24 percent, which reflects hiring authorities were making inappropriate findings in a substantial number of cases and did so at a rate even greater than that found during the prior year. *Poor* findings include making an inappropriate determination concerning the sufficiency of an investigation as well as failing to appropriately determine the findings for each allegation. On eight occasions in 2024, the hiring authority's findings were so egregious the OIG sought a higher level of review by the hiring authority's supervisor.

Finally, the hiring authority settled cases or modified the penalty in 20 cases monitored by the OIG. In 17 of those cases, or 85 percent, the OIG found the settlement or modification failed to comply with policy. Inappropriately settling cases or modifying penalties at such a high rate is suggestive of a concerning trend. The department has clear policy that a hiring authority must follow when determining whether settlement or modification is appropriate. Despite repeated OIG recommendations to adhere to the policy, hiring authorities frequently defied the policy.

The Department Did Not Have a Current Policy Regarding Officers' Use of Physical Holds

In recent years, law enforcement agencies have shown a heightened awareness regarding officers' use of neck restraints. On May 25, 2020, four Minneapolis Police Department officers detained a man named George Floyd. One of the officers, Derek Chauvin, applied one of his knees to the side of Floyd's neck for an extended period, which resulted in the death of Floyd. Authorities arrested and charged the four officers for their involvement in Floyd's death, after which they were convicted and sentenced to prison. At the time of the incident, the Minneapolis Police Department allowed officers to use neck restraints. Prior to the incident, only two states, Tennessee and Illinois, had enacted bans on physical holds that restricted either air or blood flow. In the year following Floyd's death, 24 states, including California, enacted bans, or restrictions on officers' use of neck restraints.

On September 20, 2020, less than four months after the incident involving Floyd, California Governor Gavin Newsom signed Government Code section 7286.5 into law, which became effective January 1, 2021. The law banned officers in law enforcement agencies throughout California from using "chokeholds" and carotid restraints. However, under Government Code section 7286(a)(5), the definition of a "law enforcement agency" did not include the California Department of Corrections and Rehabilitation even though it employs more than 20,000 officers.

In contrast to the governor's prompt response, the department delayed updating its use-of-force regulation of its officers' physical holds on the neck until November 16, 2022, nearly two and a half years after Floyd's death. The department not only delayed instituting this important regulatory change, but even now, more than four years after Floyd's death, the department still has not updated its policy manual (the Department Operations Manual, also known as the DOM), specifically Section 51020.5, to match the regulatory change.

The department's omission in its policy manual is significant. Former Officer Chauvin applied pressure to the side of Floyd's neck, cutting off blood flow to the brain. The department now prohibits this type of neck restraint under the *California Code of Regulations* (CCR), section 3268(c)(2), which bans any neck restraint that restricts blood flow to the brain. However, the current 2024 DOM, specifically section 51020.5, continues to only ban neck restraints which restrict air flow alone and makes no mention of neck restraints that restrict blood flow to the brain. The department amended CCR section 3268(c)(2) on November 16, 2022, and the department updated its DOM in 2023 and again in 2024. However, the department still has not updated DOM Section 51020.5 to match the amended regulation during either of these annual revisions. The department's delay to amend its regulation on neck restraints and its subsequent continued failure to update its policy manual on improper neck restraints shows a lack of urgency by the department that is inconsistent with the urgent responses by the State of California, and the nation, following the public outcry over officers using physical restraints on an individual's neck.

To remedy this problem, the OIG recommends that the department delay no longer and immediately update DOM Section 51020.5 to prohibit officers from using any neck restraints limiting blood flow to the brain.

In Multiple Cases, Hiring Authorities Failed to Enforce the Department's Use-of-Force Regulation Related to Improper Physical Holds

The OIG found a lack of consistency between the department regulation and departmental policy regarding neck restraints. The OIG also noticed a lack of enforcement of the department's use-of-force regulation related to physical holds on the neck, even in the face of video evidence.

Case Example 1

In one case, an officer allegedly grabbed an incarcerated person by the throat and threw him to the ground in the presence of three other officers while the incarcerated person was handcuffed with his hands behind his back. The hiring authority originally found the officer used an improper neck restraint and imposed a salary reduction. However, the hiring authority later changed his mind and determined the officer's use of force was not a "chokehold" and chose to withdraw the disciplinary action. To justify his position, the hiring authority stated the officer's hold around the incarcerated person's neck was only for three seconds, and the officer did not appear to be squeezing very hard. The OIG did not agree with the hiring authority's assessment and asked the hiring authority if he would at least train the officer to not use this type of hold in the future. The hiring authority said he would not train the officer, nor any other officers, unless his supervisor specifically told him the hold was improper. The OIG elevated the matter to the hiring authority's supervisor, and the hiring authority's supervisor acknowledged the officer violated the department's use-of-force policy and imposed the original salary reduction. However, the hiring authority's supervisor entered into a settlement agreement with the officer whereby he reduced the length of time for the salary reduction by half and agreed to remove the disciplinary action from the officer's personnel file after only one year instead of the standard three years required by policy. The OIG did not concur with the settlement.

Case Example 2

In another case, a hiring authority found insufficient evidence to sustain an allegation that an officer used an improper physical hold on an incarcerated person's neck. The hiring authority and the department attorney argued they could not see from the body-worn-camera video evidence whether the officer's arm was placed over the incarcerated person's neck or on his upper back. However, the video footage was clear, certainly enough to establish by a preponderance of the evidence, that the officer's arm was on top of the incarcerated person's neck. Furthermore, the incarcerated person described the incident as a "normal takedown including forearms to the neck." The incarcerated person did not file a complaint, but a member of the hiring

authority's executive staff saw the video, was concerned it showed the officer's arm on the incarcerated person's neck and recommended an investigation take place. Despite all the above, the hiring authority and department attorney insisted they could not see the officer's arm on the incarcerated person's neck.

Case Example 3

The OIG has observed an additional example of departmental stakeholders who did not accept video evidence as sufficient proof of an officer using an improper neck restraint despite it being depicted on a video recording. In this instance, the officer used a headlock to take control of the incarcerated person and ultimately took the incarcerated person to the ground while still holding him around the neck. Despite what can be seen in the surveillance video, the department attorney, and the hiring authority, refused to accept that the video recording showed beyond a preponderance of the evidence that the officer had used an improper physical hold on the incarcerated person's neck, even when the incarcerated person told an investigator he could not breathe during the incident. The OIG elevated the matter to the hiring authority's supervisor who also did not find the video evidence compelling enough to establish proof by a preponderance of the evidence that the officer used an improper restraint of the incarcerated person's neck.

Case Example 4

In yet another case, a hiring authority initially found an officer did not commit misconduct when he used a neck restraint on an incarcerated person. However, the OIG attorney recommended that the hiring authority find the officer had used improper force. The hiring authority agreed and found the officer violated the regulation on neck restraints and imposed a salary reduction on the officer. The officer appealed to the State Personnel Board, and the hiring authority entered into a settlement agreement with the officer, inappropriately reducing the length of time for the salary reduction when there was no change in circumstances. The OIG did not concur with the settlement.

To alleviate these concerns, the OIG recommends that in-depth training pertaining to officers using physical holds on the neck be provided to all departmental officers, staff who review uses of force, and staff who represent the department in use-of-force cases, and that the department consistently enforce its regulation banning any neck restraint that restricts air or blood flow.

Hiring Authorities, Including Wardens, Did Not Make Consistent Notifications to Complainants After the Conclusion of Staff Misconduct Investigations

After the department completed an investigation, the hiring authority, most often a warden, was required to provide written notice about the outcome of the complaint to the person who initiated the complaint, which may have been an incarcerated person, a citizen, or a departmental employee.

Even though the notification requirement is stated in the department's operations manual (DOM) and is also codified in CCR, the language of these requirements is vague regarding the specific information that must be included in the written notices to the complainants.[10] As such, the OIG observed a lack of consistency on the part of hiring authorities in providing written complainant notifications. The department's practice for notifying complainants appeared to vary—not only among prisons, but also within prisons. The OIG reviewed complainant notifications from various hiring authorities at different prisons and observed the following varying levels of specificity:

- Some prisons listed each allegation and included the category of the allegation, the names of departmental staff members who were subjects of the investigation, and brief facts about the allegations.
- Some prisons listed the allegations and included the category and the name of the staff member who was a subject of the investigation, but no facts about the allegation itself.
- Some prisons listed the allegation and included brief facts but did not provide the category of the allegation.

In another other example, we noted the hiring authority at one prison provided inconsistent information to be included in the complainant notification. In some instances, the hiring authority provided allegations with some facts, but did not provide the category of the allegation. In another instance, the hiring authority included the category of the allegation, but did not provide any facts about the allegation itself or provide the name of the staff member who was a subject of the investigation.

In one example of our monitoring activity, our office learned that on June 19, 2024, the department's Division of Adult Institutions office emailed the employee relations officers at each of the institutions instructing the institutions to provide written notice to the complainant only for the allegations spelled out in the original complaint. In that email, the department noted that some institutions sent response letters to complainants that included more information than the findings on the initial allegations submitted by complainants. The email provided examples illustrating that any allegations not included in the initial allegations submitted by the complainant should be excluded from the written notifications. The email also noted that when allegations were added by the hiring authority, the employee relations officers should note in the department's staff misconduct database that the hiring authority was the complainant for those additional allegations. While the email provided some guidance to the institutions on what information should be included in the complainant notifications, it failed to address situations whereby the complainant added allegations after having submitted a grievance or clarified details that subsequently were formed into additional allegations after the initial complaint or grievance was submitted. The email also failed to address situations in which the hiring authority initiated an investigation after review of an incident.

10. DOM, Section 31140.4.10, and the *California Code of Regulations*, Title 15, section 3486.3.

The OIG is concerned that such an instruction limiting the information provided in the complainant notification could be construed to limit the search for information and might discourage investigators from seeking out all possible allegations to add to the original complaint as the investigation progresses. Similarly, if a complainant makes additional allegations during the investigation, that person may be inclined to initiate a new complaint rather than amend a standing one, which could lead to a strain on resources. Ultimately, the current process presents a risk that a complainant would have no notice about critical findings or closure for allegations not clearly articulated in the initial staff misconduct complaint form.

Furthermore, an email providing guidance on what should be included in the written notification is not formal policy. As a result, hiring authorities are not bound to comply, and the type of information included in the complainant notifications will continue to be inconsistent.

Therefore, the OIG recommends that the department update its Department Operations Manual to clarify the specific information that hiring authorities need to include in the written complainant notification. The OIG recommends that the written notice to the complainant include all allegations the complainant made, including the allegations in the initial complaint form, any additional allegations the complainant made after submitting the initial staff misconduct complaint, and any allegations the hiring authority added regarding the same incident.

OIG Recommendations to the California Department of Corrections and Rehabilitation Regarding Its Staff Misconduct Complaint Investigation and Employee Disciplinary Process

1. The OIG recommends that Office of Internal Affairs investigators conduct the initial interview in staff misconduct investigations and request all video recordings within one month of case assignment.

2. The OIG recommends that the department implement a process to identify allegations that have already been investigated, are currently being investigated, or are related to an open investigation, and combine all related allegations into a single investigation. The OIG recommends that the department develop and implement a policy to combine related investigations and close out superfluous case numbers once the department identifies them. The OIG recommends that only one investigator investigate all related allegations in one investigation and that the department discontinue the practice of dividing complaints.

3. The OIG recommends that the department provide more robust training to employee relations officers concerning the employee disciplinary process and how to represent the department in that process. In addition, the OIG recommends that the department, at a minimum, assign an attorney to represent the department in any employee discipline that has the potential to result in an evidentiary hearing before the State Personnel Board.

4. The OIG recommends that the department update its Department Operations Manual, Section 51020.5, to prohibit officers from using any neck restraints limiting blood flow to the brain.

5. The OIG recommends that in-depth training pertaining to officers using physical holds on the neck be provided to all departmental officers, staff who review uses of force, and staff who represent the department in use-of-force cases, and that the department consistently enforce its regulation banning any neck restraint that restricts air or blood flow.

6. The OIG recommends that the department update its Department Operations Manual to clarify the specific information that hiring authorities need to include in the written complainant notification. The OIG recommends that the written notice to the complainant include all allegations the complainant made, including the allegations in the initial complaint form, any additional allegations the complainant made after submitting the initial staff misconduct complaint, and any allegation the hiring authority added regarding the same incident.

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The Department's Response to Our Staff Misconduct Monitoring Report

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STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

OFFICE OF THE SECRETARY
PO Box 942883
Sacramento, CA 94283-0001

February 20, 2025

Ms. Amarik Singh
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The California Department of Corrections and Rehabilitation (CDCR) has reviewed the draft report entitled *The Office of the Inspector General's Monitoring in 2024 of the Staff Misconduct Complaint Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation,* and acknowledges the concerns outlined regarding staff misconduct investigations and the employee disciplinary process. We recognize that many of the challenges highlighted stem from the overwhelming number of cases processed within our system. The volume of investigations continues to outpace the capacity of the Allegation Investigation Unit (AIU) to complete them within the desired timeframes. While delays have occurred, they are not due to a lack of commitment but rather the operational realities of managing an extraordinarily high caseload.

Over the past eight months, CDCR has been working diligently with external stakeholders, including the Office of the Inspector General (OIG), to identify and engage in meaningful steps to continue reforming its investigative and disciplinary processes. These efforts include, but are not limited to, filing an emergency Staff Misconduct regulations package with the Office of Administrative Law, simplifying the staff misconduct process by eliminating the Local Designated Inquiry Process, revising the Allegation Decision Index to provide greater clarity, consolidating Information Technology systems to improve case tracking and management, and developing Peace Officer Standards and Training certified training to enhance investigator preparedness. In addition, the department is currently seeking to hire an outside consultant to review and make meaningful recommendations on the Department's Use of Force regulations, policy and training. Lastly, the Department recently completed a series of trainings for staff hired into the newly established Centralized Allegation Resolution Unit, which will review, as part of a centralized and independent unit, completed investigations which involved or originated from incarcerated persons residing within six specific *Armstrong* designated institutions.

CDCR has implemented case prioritization strategies to focus on meeting statutory deadlines, addressing cases based on their age and complexity, and ensuring compliance with legal obligations. While we recognize that some cases have exceeded the prescribed timelines, AIU is continuously refining its processes to improve efficiency without compromising the integrity of investigations. To further address timeframe related challenges, CDCR is actively recruiting

all vacant investigator positions within AIU and has repositioned several internal vacancies to hire additional investigative staff. CDCR also continues to refine its intake process to better identify overlapping or duplicative complaints at the outset, reducing redundant investigative efforts while maintaining a complete review of all allegations. By streamlining the case review and assignment process CDCR has improved efficiency and made better use of investigative resources. CDCR is consistently improving its case management system used to manage investigations, to ensure effective tracking and streamlining of information related to casework for all stakeholders. Furthermore, CDCR is working toward additional improvements to its case management system that will enhance communication, efficiencies and ensure compliance with policies and regulations.

I am troubled by the robust discussion in the report of the May 2020 death of George Floyd and the force used by members of the Minneapolis Police Department, which appears to be an attempt to provoke readers into undeserved ill-will towards CDCR. To be clear, CDCR does not authorize chokeholds or any other physical restraints, which prevents the person from swallowing or breathing or restricts blood flow to the brain. CDCR provides regular and consistent annual training to staff related to the use of force, which includes discussion and training on chokeholds and positional asphyxia to ensure the safety awareness of the incarcerated population.

CDCR is dedicated to working with OIG and other stakeholders to ensure success across all mission areas. Through ongoing communication and collaboration, we strive to enhance accountability, improve operations and achieve our shared goals. If you have any questions, contact me at (916) 323-6001.

Sincerely,

Signed by:
Diana Toche for
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JEFF MACOMBER
Secretary

The Office of the Inspector General's Monitoring in 2024 of the Staff Misconduct Complaint Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation

2024 Annual Report

OFFICE *of the* INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
March 2025

OIG