During December 2023, the OIG's Centralized Screening Monitoring Team randomly selected 556 grievances for monitoring. This document presents 12 notable cases monitored and closed by the OIG during December 2023.

OIG Case Number
23-0066393-CSMT

Rating Assessment
Poor

Incident Summary

On October 16, 2023, a nursing assistant allegedly pulled an incarcerated person's shower chair out from under him causing him to fall and injure himself, in retaliation for the incarcerated person's previous complaint against the nursing assistant. The nursing assistant then refused orders to shower the incarcerated person.

Disposition

The department's Centralized Screening Team referred the allegation that the nursing assistant pulled the shower chair out from under the incarcerated person to the Office of Internal Affairs' Allegation Investigation Unit and routed a medical equipment concern back to the institution as a routine issue. The OIG concurred with the Centralized Screening Team's decisions. However, the Centralized Screening Team failed to include the allegation of staff misconduct that the nursing assistant retaliated against the incarcerated person, citing there was no correlation. After the OIG elevated the complaint, the Centralized Screening Team agreed to refer the alleged retaliation to the Office of Internal Affairs' Allegation Investigation Unit.

Case Rating

Overall, the department performed poorly. The Centralized Screening Team failed to include an allegation of staff misconduct that a nursing assistant retaliated against an incarcerated person because the incarcerated person filed a prior complaint against the nursing assistant. The Centralized Screening Team interviewed the nursing assistant weeks prior related to the previous staff misconduct complaint the incarcerated person submitted. The OIG elevated the screening decision on November 1, 2023, and November 13, 2023. On November 20, 2023, the Centralized Screening Team informed the OIG that the prior complaint was minor, and they did not feel staff would retaliate over it. The OIG voiced concerns that the allegation of retaliation for filing staff misconduct complaints alone warranted a referral to the Office of Internal Affairs' Allegation Investigation Unit, and the retaliation allegation was directly related in time and scope to the allegation the nursing assistant pulled the shower chair out from under the incarcerated person. Thus, the retaliation allegation also warranted inclusion in the referral of the allegations against the nursing assistant. On December 22, 2023, the Centralized Screening Team referred the allegation to the

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Office of Internal Affairs' Allegation Investigation Unit's open investigation into the nursing assistant's alleged actions. Following the OIG's initial elevation on November 2, 2023, the Centralized Screening Team unreasonably delayed their decision and referral until December 22, 2023, 33 business days thereafter.

OIG Case Number
23-0067033-CSMT / 23-0068054-CSMT

Rating Assessment
Poor

Incident Summary

On October 31, 2023, an officer allegedly issued a rules violation report to an incarcerated person for possessing a deadly weapon after he took the weapon in self-defense from one of five incarcerated persons who attacked him. The incarcerated person alleged the same group of incarcerated persons attacked him a few weeks prior. However, when the incarcerated person reported the first attack to a second officer, the second officer allegedly stated he did not believe the incarcerated person and the incarcerated person was "too late." The second officer allegedly disregarded the incarcerated person's safety concerns about the first attack which resulted in the second attack.

Disposition

The department's Centralized Screening Team routed the rules violation report dispute and allegations against the five incarcerated persons back to the prison as routine issues. The OIG concurred with the Centralized Screening Team's decisions. However, the Centralized Screening Team failed to identify the allegation that a second officer disregarded the incarcerated person who reported an attack and safety concerns which resulted with the incarcerated person being attacked by the same group of incarcerated persons a second time. Following the OIG's elevation, the Centralized Screening Team opened a new grievance log to address the allegations against the second officer. The Centralized Screening Team initially routed the new grievance, that alleged the officer endangered the incarcerated person's life by disregarding the first attack and safety concerns, back to the prison as a routine issue. After the OIG's second elevation, the Centralized Screening Team referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit.

Case Rating

Overall, the department performed poorly. The Centralized Screening Team failed to identify the allegation that an officer disregarded an incarcerated person's report of an attack and related safety concerns which resulted in the same group of incarcerated persons organizing a second assault on the incarcerated person. Following the OIG's elevation, the Centralized Screening Team opened a new grievance log to address the allegations against the officer. However, when the Centralized Screening Team opened the new grievance to properly address the missed allegation, they routed the

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allegation against the officer back to the prison as a routine issue. Following the OIG's second elevation, the Centralized Screening Team referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.

OIG Case Number
23-0067573-CSMT

Rating Assessment
Poor

Incident Summary

On October 27, 2023, a nurse allegedly falsified medical records by documenting that an incarcerated person declined an X-ray after he sustained injuries to his eye. The incarcerated person requested copies of the falsified medical records and eyeglasses for his blurred vision.

Disposition

The department's Centralized Screening Team returned the incarcerated person's request for eyeglasses back to the prison as a routine claim. The OIG concurred. However, the Centralized Screening Team failed to identify the allegation that the nurse falsified the incarcerated person's medical records. Following the OIG's elevation, the Centralized Screening Team amended their decision and opened a new grievance to include the allegation, which they referred to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.

Case Rating

Overall, the department performed poorly. The Centralized Screening Team initially failed to identify an allegation of staff misconduct that a nurse falsified an incarcerated person's medical records. Following the OIG's elevation, the Centralized Screening Team amended their decision and referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit. However, the Centralized Screening Team's initial decision on the incarcerated person's request for eyeglasses was incomplete and inappropriate because the Centralized Screening Team did not address the falsified medical records allegation.

OIG Case Number
23-0067838-CSMT

Rating Assessment
Poor

Incident Summary

On May 31, 2023, staff members on the Institutional Classification Committee allegedly punished an incarcerated person for a six- year-old rules violation report. During the committee hearing, a counselor allegedly made threatening comments to the incarcerated person. The counselor allegedly retaliated against the incarcerated

person and coerced the incarcerated person to sign documents he did not understand. A captain, the first counselor, and a second counselor allegedly failed to respond to the incarcerated person's requests for copies of the committee actions. Medical staff allegedly refused to assess the incarcerated person's mental health and physical injuries the first counselor inflicted. On November 1, 2023, staff allegedly lost, tampered with, and gave the incarcerated person's mail to other incarcerated persons.

Disposition

The department's Centralized Screening Team returned the dispute that a particular counselor reviewed the incarcerated person's records, rules violation reports, and complaints back to the prison as a routine issue. The OIG concurred. However, the Centralized Screening Team failed to identify the allegation of a counselor's threatening and retaliatory behavior, or allegations against committee staff, medical staff, and other staff who allegedly mishandled the incarcerated person's mail. Following the OIG's elevation, the Centralized Screening Team opened a new grievance and referred the counselor's threatening and retaliatory behavior to the Office of Internal Affairs' Allegation Investigation Unit, referred the mail allegations to the hiring authority for a local inquiry, and routed the remaining allegations back to the prison as routine issues.

Overall, the department performed poorly. The department's Centralized Screening Team failed to identify an allegation of staff misconduct that a counselor threatened and retaliated against the incarcerated person. Additionally, the Centralized Screening Team failed to determine the complaint contained allegations that staff lost, tampered with, and gave the incarcerated person's mail to other incarcerated people; committee staff punished an incarcerated person for a six-year-old incident; and medical staff failed to assess an incarcerated person's mental and physical health. Following the OIG's elevation, the Centralized Screening Team amended their decision and opened a new grievance to address the previous unidentified allegations. However, the Centralized Screening Team initially failed to identify two allegations of staff misconduct and multiple routine claims.

OIG Case Number
23-0067935-CSMT

Rating Assessment
Poor

Incident Summary

On November 6, 2023, an officer allegedly failed to promptly respond to an incarcerated person's call for medical assistance. On November 10, 2023, officers allegedly failed to respond to the incarcerated person's call again for medical assistance for 15 minutes. When a lieutenant ordered officers to do a welfare check on the incarcerated person, officers allegedly directed another incarcerated person to check on him. A nurse initially ignored the incarcerated person and eventually had him taken to medical at which time a second officer allegedly threatened to strap the

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incarcerated person's mouth with a gurney strap. Officers allegedly laughed and made sarcastic comments each time the incarcerated person had a medical emergency.

Disposition

The department's Centralized Screening Team routed the claim about the officer's comment to strap the incarcerated person's mouth with a gurney strap to the hiring authority for a local inquiry and redirected the claim against the nurse to health care. The OIG concurred. However, the Centralized Screening Team missed allegations that officers twice failed to timely respond to the incarcerated person's medical emergency, officers had an incarcerated person conduct a welfare check, and officers laughed at and mocked the incarcerated person's medical emergencies. Following the OIG's elevation, the Centralized Screening Team agreed to route the claim related to the welfare check and that officers mocked medical emergencies to the hiring authority for a local inquiry and routed the alleged delayed responses to the incarcerated person's call for medical assistance back to the prison as routine issues.

Case Rating

Overall, the department performed poorly. The Centralized Screening Team failed to identify allegations that officers twice failed to timely respond to an incarcerated person's call for medical assistance, officers had an incarcerated person conduct a welfare check, and officers mocked an incarcerated person's medical emergencies. Following the OIG's elevation, the Centralized Screening Team amended their decision and opened a new grievance to address the unidentified allegations. However, the Centralized Screening Team initially failed to identify two allegations of staff misconduct and a routine claim.

OIG Case Number 23-0068103-CSMT

Rating Assessment
Poor

Incident Summary

On September 21, 2023, a sergeant and officers allegedly joked with other incarcerated people about an incarcerated person's commitment crimes causing him to feel suicidal. On September 22, 2023, two medical staff allegedly disregarded the incarcerated person's reported suicidal and homicidal ideations and denied his request for placement in a crisis bed which resulted in the incarcerated person attempting suicide by cutting his wrist and forearm with a razor blade.

Disposition

The department's Centralized Screening Team failed to identify the allegation that a sergeant and officers discussed an incarcerated person's commitment crimes with other incarcerated people and failed to recognize the allegation that medical staff

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ignored the incarcerated person's suicidal ideation as staff misconduct. Following the OIG's elevation, the Centralized Screening Team partially amended their decision and referred the allegation against the sergeant and officers to the Office of Internal Affairs' Allegation Investigation Unit as staff misconduct. However, the Centralized Screening Team failed to refer the allegation against medical staff as staff misconduct.

Overall, the department performed poorly. The Centralized Screening Team initially failed to identify one allegation of staff misconduct entirely and failed to recognize a second allegation as staff misconduct. Following an elevation by the OIG, the Centralized Screening Team partially amended their decision and referred the allegation that a sergeant and officers joked about an incarcerated person's commitment crimes with other incarcerated people to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. The Centralized Screening Team refused to refer the allegation that medical staff disregarded the incarcerated person's reported suicidal and homicidal ideations, after which the incarcerated person allegedly cut his wrist and forearm, as staff misconduct, claiming the allegation to be a routine disagreement over placement in the crisis bed.

OIG Case Number
23-0068455-CSMT

Rating Assessment
Poor

Incident Summary

On November 15, 2023, an officer allegedly announced over the loudspeaker a housing unit section would not get dayroom and pointed to an incarcerated person's cell when asked why not. The officer allegedly announced the only way to get programming back would be to "take off on that cell," which placed the incarcerated person's safety in jeopardy. The incarcerated person also requested a radio, a transfer, and new headphones from medical in his complaint.

Disposition

The department's Centralized Screening Team routed the allegation that the incarcerated person did not get dayroom and requests for a radio and transfer back to the prison as routine issues. While the OIG concurred with the radio and transfer allegations, the Centralized Screening Team failed to identify the officer's alleged misconduct surrounding the dayroom allegation, or the incarcerated person's safety concern resulting from the officer's alleged behavior. The Centralized Screening Team also failed to identify the request for headphones. Following the OIG's elevation, the Centralized Screening Team referred the allegations against the officer to the Office of Internal Affairs' Allegation Investigation Unit and routed the incarcerated person's request for headphones back to the prison as a routine issue.

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Case Rating

Overall, the department performed poorly. The Centralized Screening Team failed to identify allegations that an officer placed an incarcerated person's safety in jeopardy by encouraging other incarcerated people to "take off on" him if they wanted their dayroom privileges back and failed to identify a routine request for headphones. Following the OIG's elevation, the Centralized Screening Team appropriately amended their decision and referred the allegation against the officer to the Office of Internal Affairs' Allegation Investigation Unit and the request for headphones back to the prison as a routine issue. However, the Centralized Screening Team initially failed to identify an allegation of staff misconduct and a serious safety concern, as well as a routine request.

OIG Case Number 23-0068885-CSMT

Rating Assessment
Poor

Incident Summary

On November 16, 2023, two physicians and a social worker allegedly failed to treat or place an incarcerated person, who reported a plan to commit suicide, under observation and returned the incarcerated person back to his cell. The two physicians and social worker allegedly minimized the incarcerated person's prior attempts to commit suicide. On November 26, 2023, the incarcerated person allegedly cut himself with, and then swallowed, a razor blade.

Disposition

The department's Centralized Screening Team referred a routine disagreement with treatment back to health care as a routine issue because a subject matter expert opined that the incarcerated person was angling for a higher level of mental health care. The OIG did not concur. Following the OIG's elevation, the Centralized Screening Team upheld their initial decision.

Case Rating

Overall, the department performed poorly. The Centralized Screening Team identified the allegation that two physicians and a social worker minimized an incarcerated person's plan to commit suicide, which the incarcerated person allegedly attempted to carry out the following day as a routine issue. The OIG elevated its concerns that the allegation met the criteria on the Allegation Decision Index of creating an opportunity for an incarcerated person to harm themself and possibly misconduct resulting in significant injury of an incarcerated person. During a joint meeting on December 8, 2023, the Centralized Screening Team management acknowledged that at face value the grievance met the criteria for the Allegation Decision Index. However, rather than referring the grievance to the Office of Internal Affairs' Allegation

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Investigation Unit, the Centralized Screening Team conducted their own fact finding into the incarcerated person's medical record, determined the allegation to be a disagreement with treatment, and routed it as a routine issue.

OIG Case Number
23-0069261-CSMT

Rating Assessment
Poor

Incident Summary

On October 24, 2023, two officers allegedly confiscated an incarcerated person's denture adhesive in retaliation for the incarcerated person previously filing a staff misconduct complaint against one of the officers. Additionally, one of the officers allegedly yelled at the incarcerated person. The incarcerated person requested to move to another building due to safety concerns with the officers.

Disposition

The department's Centralized Screening Team routed the denture adhesive and housing move claims back to the prison as routine issues. The OIG concurred with the decision regarding the housing move claims. However, the Centralized Screening Team failed to identify an allegation of staff misconduct that officers confiscated the denture adhesive in retaliation for filing staff misconduct complaints. Following the OIG's elevation, the Centralized Screening Team amended their decision and referred the retaliation allegation to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.

Case Rating

Overall, the department performed poorly. Initially, the Centralized Screening Team incorrectly identified the allegation that officers confiscated an incarcerated person's denture adhesive in retaliation for the incarcerated person previously filing a complaint against one of the officers as a routine issue. Following the OIG's elevation, the Centralized Screening Team appropriately amended their decision and referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. However, the Centralized Screening Team initially failed to identify an allegation of staff misconduct.

OIG Case Number
23-0069408-CSMT

Rating Assessment
Poor

Incident Summary

On November 22, 2023, an incarcerated person alleged a physician caused the incarcerated person pain and bleeding during a pelvic examination. Additionally, the physician allegedly put his finger in the incarcerated person's vaginal cavity on

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three separate occasions, while he badgered and acted aggressively toward the incarcerated person.

Disposition

Despite a recommendation by the Investigative Services Unit to refer the allegation to the Office of Internal Affairs' Allegation Investigation Unit, the department's Centralized Screening Team determined the complaint did not contain allegations of staff misconduct. The OIG disagreed as the incarcerated person clearly made an allegation of staff sexual misconduct by a physician. Following the OIG's elevation, the Centralized Screening Team referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit.

Case Rating

Overall, the department performed poorly. Initially, the Centralized Screening Team arbitrarily determined the incarcerated person felt uncomfortable during a pelvic examination due to being a female-to-male transgender person who still required routine gynecological care; therefore, the allegation against the physician was not staff sexual misconduct. Following the OIG's elevation, the Centralized Screening Team referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit.

OIG Case Number 23-0069467-CSMT

Rating Assessment
Poor

Incident Summary

On November 22, 2023, a nurse allegedly falsified records indicating she provided an incarcerated person with 15 pages of discharge instructions, when she allegedly removed several pages and only provided the incarcerated person 10 pages. The nurse allegedly acted rudely and failed to ensure the incarcerated person understood his discharge instructions due to her racial bias against incarcerated people of a certain race.

Disposition

The department's Centralized Screening Team summarized the allegation that a nurse falsified medical records and acted rudely toward the incarcerated person but referred the allegation to the hiring authority for a local inquiry rather than the Office of Internal Affairs' Allegation Investigation Unit. The OIG elevated the Centralized Screening Team's contradictory summary and screening decision, as well as their failure to identify the vague allegation of racial bias. The Centralized Screening Team attempted to conduct a clarification interview, but the incarcerated person refused to participate. Following a joint discussion, the Centralized Screening Team and the OIG agreed the complaint, in its entirety, should be referred to the hiring authority for a local inquiry. Subsequently, the Centralized Screening Team referred only the nurse's alleged rude behavior and failure to explain discharge instructions to the incarcerated

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person to the hiring authority and routed the allegations that the nurse failed to provide all pages of a medical report to an incarcerated person, while documenting that she had done so, and was racially biased back to the prison as routine issues.

Following a final disagreement by the OIG, the Centralized Screening Team cited a technical issue in their database, and reported all allegations would be referred for a local inquiry.

Case Rating

Overall, the department performed poorly. The Centralized Screening Team failed to identify the need to conduct a clarification interview with the incarcerated person about the racial bias, and only attempted a clarification interview following the OIG's elevation. The Centralized Screening Team also summarized an allegation that staff falsified medical records, but only referred the allegation to the hiring authority for a local inquiry rather than to the Office of Internal Affairs' Allegation Investigation Unit.

Following the OIG's elevation, the Centralized Screening Team attempted to conduct a clarification interview with the incarcerated person. After a joint discussion, the Centralized Screening Team agreed to amend their initial documentation, add details regarding the vague allegation of racial bias, and refer the grievance in its entirety to the hiring authority for a local inquiry. However, the Centralized Screening Team only referred the nurse's alleged rude behavior and failure to explain discharge instructions to the incarcerated person to the hiring authority. The Centralized Screening Team routed the nurse's alleged failure to provide all the pages of a medical report, while documenting she had provided the pages to the incarcerated person, and racial bias as routine.

Following a final disagreement by the OIG, the Centralized Screening Team cited a technical issue in their database, and reported all allegations would be referred for a local inquiry.

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