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OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

April 2024

The Office of the Inspector General Monitoring in 2023 of the California Department of Corrections and Rehabilitation's Staff Misconduct Complaint Screening, Inquiry, Investigation, and Employee Disciplinary Processes

2023 Annual Report

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Amarik K. Singh, Inspector General
Neil Robertson, Chief Deputy Inspector General

April 25, 2024

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

Dear Governor and Legislative Leaders:

The State of California has the second largest prison population in the United States, second only to Texas. The California Department of Corrections and Rehabilitation (the department) houses 93,623 incarcerated people and supervises 35,138 parolees. The department employs 57,176 employees, the most of any State of California department.

In 2023, the department received 183,051 complaints alleging that its employees engaged in misconduct against incarcerated people or parolees. The department maintains a process for reviewing and responding to staff misconduct complaints. Pursuant to Penal Code section 6126 (i), the OIG monitors this process. This report concerns the OIG's monitoring in 2023 of the department's staff misconduct complaint screening, inquiry, investigation and employee disciplinary process.

The department's Centralized Screening Team reviewed complaints received by the department and made screening decisions to determine the appropriate entity within the department to whom to refer the complaints. The Centralized Screening Team utilized a list called the Allegation Decision Index to determine whether the allegation the department received was an allegation of serious staff misconduct; if so, the Centralized Screening Team referred the complaint to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. If the allegation was a less serious allegation of staff misconduct, the Centralized Screening Team returned the complaint to the prison or parole office from which it came to conduct an allegation inquiry, not an investigation. If a complaint did not involve staff misconduct, the Centralized Screening Team returned the complaint to the prison or parole office to process as a routine matter.

From January 1, 2023, through December 31, 2023, we monitored the department's performance in conducting staff misconduct complaint screening decisions made by its Centralized Screening Team; allegation inquiry cases completed by prisons' local investigators; and investigations conducted by the Office of Internal Affairs' Allegation Investigation Unit and the employee disciplinary process for those cases. Overall, we determined the department performed satisfactorily when making screening decisions,

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poorly in completing inquiries, and poorly in conducting investigations and the employee disciplinary process.

We monitored 6,953 complaints for which the Centralized Screening Team made screening decisions. We found in 6,248, or 90 percent of complaints we monitored, the Centralized Screening Team performed satisfactorily. We monitored 113 inquiry cases completed by locally designated investigators and found the department performed poorly in 77 of the 113, or 68 percent, of the inquiry cases. Finally, we monitored 121 staff misconduct investigations and the employee disciplinary process for those cases. The department performed poorly in 77 of the 121, or 64 percent, of the investigations and the employee disciplinary process for those cases.

If you have any questions on this report, please contact our office at 916-288-4233.

Sincerely,

Amarik K. Singh
Inspector General

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Terms Used in This Report	
Complaint	Any documentation or verbal statement received by the department, from any source, that contains a routine issue or alleges staff misconduct.
Corrective Action	A documented action, which is not adverse or disciplinary in nature, that a hiring authority undertakes to assist an employee in improving work performance, behavior, or conduct. Examples are verbal counseling, training, written counseling, or a letter of instruction. Corrective action cannot be appealed to the State Personnel Board.
Disciplinary Action	A documented action, punitive in nature and intended to correct misconduct or poor performance or terminate employment and that may be appealed to the State Personnel Board. It is the charging document served on an employee who is being disciplined, advising the employee of the causes for discipline and the penalty to be imposed. Examples of these actions include a letter of reprimand, pay reduction, suspension without pay, or termination. Also referred to as an *adverse action* or a *notice of adverse action*.
Hiring Authority	An executive, such as a warden, a superintendent, or an assistant deputy director, authorized by the Secretary of the California Department of Corrections and Rehabilitation to hire, discipline, and dismiss staff members under his or her authority.
Inquiry	The gathering of relevant facts and evidence by a locally designated investigator (LDI) for a complaint that contains an allegation of staff misconduct.
Investigation	The collection of evidence that supports or refutes an allegation of misconduct, including criminal investigations, administrative investigations, retaliation investigations, or allegation inquiries. The department conducts either criminal investigations, which concern the investigation of a potential crime or crimes, or administrative investigations, which concern the investigation of an alleged violation of a policy, a procedure, or other administrative rule.
Office of Internal Affairs' Allegation Investigation Unit	The unit within the Office of Internal Affairs that conducts investigations into complaints alleging misconduct toward "inmates and parolees" as set forth in the *California Code of Regulations* (CCR), Title 15, section 3486.2, and that reviews allegation inquiry reports completed by locally designated investigators.

Terminology defined in this table is compiled from the *California Code of Regulations* and the department's operations manual.

Introduction

An allegation of staff misconduct is a complaint against any employee of the California Department of Corrections and Rehabilitation (the department) that alleges a violation of law, regulation, departmental policy, or an ethical or professional standard. Any individual, including incarcerated people, parolees, or any third-party individual or group can make an allegation of staff misconduct and submit a complaint to the department.

In 2022, the department restructured its staff misconduct review process by transferring the review of staff misconduct allegations involving an incarcerated person or parolee from the prisons or parole offices to a newly created Centralized Screening Team. The Centralized Screening Team is responsible to screen each complaint and determine if it contains an allegation of staff misconduct and forward that complaint to the appropriate departmental entity. If the complaint does not contain an allegation of staff misconduct, the Centralized Screening Team routes the complaint to the prison or parole office from where it originated to process as a routine matter. If the complaint contains an allegation of staff misconduct, the Centralized Screening Team will decide whether the allegation is a serious allegation of staff misconduct or a lesser allegation. A complaint may contain one or more allegations of staff misconduct.

The department maintains a list of the most serious allegations. This list is called the Allegation Decision Index. The Centralized Screening Team uses the Allegation Decision Index to determine whether to route a complaint to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

If the Centralized Screening Team determines an allegation is not on the Allegation Decision Index, the allegation is referred to the local prison or parole office for an inquiry. Inquiries are conducted by locally designated investigators, who are based in the prison or parole office where the complaint originated and who gather evidence and facts in the form of a confidential allegation inquiry report, which is not an investigation.

Per California Penal Code section 6126 (i), 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."[1] In

1. Any person can submit a complaint of staff misconduct when they believe departmental staff have engaged in behavior that resulted in a violation of law, policy, regulation, or procedure, or an ethical or professional standard. Incarcerated people and parolees can file a CDCR Form 602-1, a CDCR Form 602-HC, Health Care grievance, or a CDCR Form 1824, Reasonable Accommodation Request. Third parties can submit a Citizen's Complaint in writing. ***California Code of Regulations*** **(CCR), Title 15, sections 3486(a)(1), 3486(b)**, and **3417**.

this report, we use the terms *grievances* and *complaints* synonymously. The law requires that we issue reports annually. This report covers the Office of the Inspector General's (the OIG) monitoring and assessment of the department's handling of its staff misconduct complaint process from January 1, 2023, through December 31, 2023.

Oversight Areas Reported During the 2023 Reporting Period

From January 1, 2023, through December 31, 2023, the department reported receiving 183,051 complaints from incarcerated people, parolees, and third-party individuals or entities.[2] The department reported that it made the following screening decisions for the complaints it received in 2023:[3]

- 158,162 complaints routed and returned to prisons as routine issues
- 12,520 complaints routed to prisons for a local inquiry
- 11,149 complaints routed to the Office of Internal Affairs' Allegation Investigation Unit for an investigation

For each of the cases we monitored, we assessed the performance of departmental staff and provided an overall rating. We used an assessment tool that consisted of five overarching questions, each with a series of subquestions. We assessed the overall screening decisions of the Centralized Screening Team; the inquiry work of locally designated investigators; and the investigations conducted by the Office of Internal Affairs and the employee disciplinary process handled by hiring authorities and department attorneys as *superior*, *satisfactory*, or *poor*.

The Centralized Screening Team received and screened 176,814 complaints. Of those complaints, the OIG reviewed and monitored 6,953 complaints to determine whether the Centralized Screening Team routed allegations of staff misconduct to the appropriate entity within the department. Overall, the Centralized Screening Team performed in a *satisfactory* manner.

- The Centralized Screening Team conducted *satisfactory* screening decisions in 6,248 of the 6,953 complaints, or 90 percent.

2. Due to the department's phased roll out of the staff misconduct process, 6,237 complaints bypassed the Centralized Screening Team. Effective November 30, 2023, all staff misconduct complaints are routed through the Centralized Screening Team.

3. The Centralized Screening Team rerouted 1,220 complaints to the hiring authority because those complaints did not involve an incarcerated person or parolee. Per CCR, Title 15, section 3486.1 (b), "allegations of staff misconduct not involving an inmate or parolee" shall not be referred to the Centralized Screening Team. If a complaint is received by the Centralized Screening Team that does not contain allegations involving misconduct toward an inmate or parolee, the Centralized Screening Team shall refer the complaint to the hiring authority for disposition.

- The Centralized Screening Team made *poor* screening decisions in 701 of the 6,953 complaints, or 10 percent.
- The Centralized Screening Team performed in a *superior* manner when making screening decisions in four of the 6,953 complaints.

The department conducted 7,903 local inquiries. Of those local inquiries, the OIG monitored 113 inquiry cases to determine whether the performance of locally designated investigators who conducted the inquiries and the wardens who made decisions regarding the inquiry cases was sufficient, complete, and unbiased. Overall, the department performed poorly in conducting staff misconduct inquiry cases.

- The department performed poorly in 77 of the 113, or 68 percent, of the inquiry cases.
- The department performed satisfactorily in 36 of the 113, or 32 percent, of the inquiry cases.
- In no inquiry cases did the department perform in a *superior* manner when conducting inquiries.

The department completed 7,124 investigations. Of those investigations, the OIG monitored 121 staff misconduct investigations and the employee disciplinary process for those cases. The OIG evaluated the performance of Office of Internal Affairs investigators, department attorneys, and the wardens who made decisions regarding the investigation cases. Overall, the department performed poorly in conducting staff misconduct investigations and the disciplinary process.

- The department performed poorly in 77 of the 121, or 64 percent, of the investigation cases.
- The department performed satisfactorily in 44 of the 121, or 36 percent, of the investigation cases.
- The department did not perform in a *superior* manner in any investigation cases.

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The Centralized Screening Monitoring Team

In 2022, the department implemented the Centralized Screening Team to process allegations of staff misconduct toward incarcerated people or parolees. Prior to the implementation of the Centralized Screening Team, the individual prisons processed grievances alleging staff misconduct locally, and assigned them to a supervisor to conduct "staff misconduct inquiries" into the allegations. In 2018, our office conducted **a special review of the department's process for reviewing allegations of staff misconduct at Salinas Valley State Prison**. We reviewed 188 staff misconduct inquiries and made the following findings:

- There was at least one significant deficiency in 173, or 92 percent of the inquiries we reviewed.
- Of the 150 inquiries in which there was relevant evidence, the department failed to collect the relevant evidence in 90 cases, or 60 percent of inquiries we reviewed.
- Of the 61 reviewers who conducted inquiries, none of them received meaningful training in inquiry-related interview techniques, evidence collection, or report writing.

In 2022, the OIG published a special report of our findings concerning the department's processing of disabled incarcerated people's allegations of staff misconduct at R. J. Donovan Correctional Facility between August 2020 through July 2021. Of the 204 cases we monitored, we found the department's performance to be *poor* in 186, or 91 percent of those cases. We identified the following concerns:

- The department delayed in completing cases, sometimes not completing the cases before the deadline to take disciplinary action.
- Overall, the quality of the investigators' work was *poor*.
- Investigators compromised the confidentiality of several inquiry cases.
- The hiring authority made several inappropriate decisions, including decisions that were not supported by the evidence.

In 2022 and in response to litigation in federal court over the department's handling of complaints of staff misconduct toward incarcerated people, the department created the Centralized Screening Team and implemented regulations revising the process for reviewing and processing staff misconduct complaints. The Centralized Screening Team's function is to review and analyze allegations of staff misconduct

toward incarcerated people and determine how to appropriately route the allegation for investigation.

Under departmental policy, the Centralized Screening Team is required to route an allegation of staff misconduct toward an incarcerated person in one of three ways:

1. Allegations that are serious in nature and listed on the Allegation Decision Index, or any allegation of misconduct with complex issues, are routed to the Office of Internal Affairs' Allegation Investigations Unit for a full investigation.
2. Allegations of misconduct that are not listed on the Allegation Decision Index and are not complex are routed to the prison where the alleged misconduct occurred to be assigned to a locally designated investigator for a local inquiry.
3. Grievances that do not contain an allegation of misconduct are routed to the prison to be handled as routine matters.

When an allegation is unclear, the Centralized Screening Team may conduct a clarifying interview with the incarcerated person who filed the complaint if required to make the screening decision. The Centralized Screening Team is required to log the information obtained during the interview into a departmental database.

In 2023, the Centralized Screening Team received and screened a total of 176,814 complaints. In that same period, the OIG monitored 6,953 complaints and found that the department had performed poorly in 701 cases or 10 percent. Although we found that the department had processed a significant percentage of cases in a *satisfactory* manner, a shockingly large number of cases were handled poorly. We identified a 10 percent error rate in the complaints we monitored. If the department performed poorly at the same rate in all other cases we did not monitor, the Centralized Screening Team would have poorly processed approximately 17,681 complaints. Many issues caused the department to perform poorly in these cases; we will discuss four of those issues in this report.

Table 1. The OIG's Ratings of the Centralized Screening Team's Screening Decisions

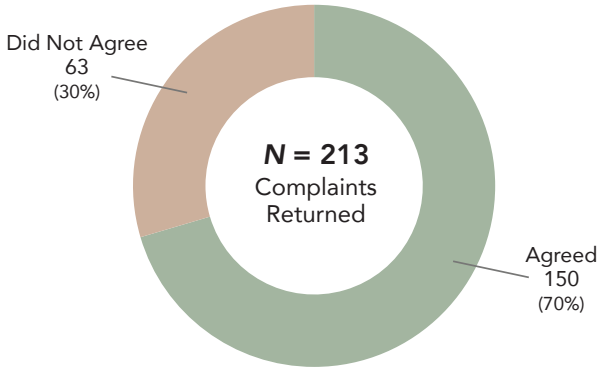
OIG Ratings	Number of Complaints
Superior	4
Satisfactory	6,248
Poor	701
Total	**6,953**

Source: The Office of the Inspector General.

While The Department Agreed With the OIG's Recommendations in a Majority of the Cases We Elevated to Supervisors or Management, We Also Found That the Department Made Significant Errors in Many Cases

Of the cases monitored by the OIG, we elevated 213 complaints and returned them to the Centralized Screening Team. Of the 213 complaints we elevated, the Centralized Screening Team agreed with the OIG's recommendations in 150 cases (70 percent).

Figure 1. Number and Percentage of Cases the OIG Elevated and Returned to the Department for Additional Review



Source: The Office of the Inspector General Tracking and Reporting System.

The OIG elevated complaints where we believed the Centralized Screening Team failed to identify an allegation of staff misconduct entirely, referred an allegation of staff misconduct on the Allegation Decision Index for a local inquiry rather than to the Office of Internal Affairs' Allegation Investigation Unit, failed to identify the need for a clarification interview prior to making a screening decision, failed to identify an imminent risk or make the required notifications, multiple-paged complaints appearing to contain several allegations of which the Centralized Screening Team only identified a single allegation, and so forth.

Of the 150 complaints in which the Centralized Screening Team agreed with the OIG's concerns, 77 resulted in new or amended screening decisions of staff misconduct:

- 50 complaints contained at least one allegation[4] the Centralized Screening Team referred to the Office of Internal Affairs' Allegation Investigation Unit, after originally considering the allegation to be routine or not identifying the allegation at all.
- 24 complaints contained at least one allegation the Centralized Screening Team referred to a locally designated investigator for a local inquiry, after originally considering the allegation to be routine or not identifying the allegation at all.
- Three complaints contained at least one allegation the Centralized Screening Team referred to the Office of Internal Affairs' Allegation Investigation Unit, after originally considering the allegation as lesser staff misconduct for a local inquiry.

In another 28 complaints, the Centralized Screening Team agreed a clarification interview was necessary before they could adequately determine staff misconduct, but the interview resulted in the allegation(s) being routine.

Of the 63 complaints where the Centralized Screening Team did not agree with the OIG, we believed 31 complaints contained at least one allegation the Centralized Screening Team should have referred to the Office of Internal Affairs' Allegation Investigation Unit, and seven complaints contained at least one allegation the Centralized Screening Team should have referred to a locally designated investigator for a local inquiry. The OIG believed the screening decision for another 10 complaints could not be adequately determined without a clarification interview, which the Centralized Screening Team did not conduct.

The remaining complaints contained other errors unrelated to the routing decision, including but not limited to, failing to identify an imminent risk, data entry, and documentation.

We also determined that the lack of consistent and documented training of screening staff likely contributed to a pattern of error. In 2023, like in 2022, the OIG requested copies of all Centralized Screening Team training materials and attended the Centralized Screening Team's training sessions. The Centralized Screening Team did not produce job aids or training materials for us until June 2023 when the department provided training materials about clarification interviews and health care grievances. In August 2023, the department shared additional training materials that it provided to screening staff.

4. Complaints may contain multiple allegations. In one of the 50 complaints, the Centralized Screening Team identified a single, routine allegation. Following the OIG's elevation, the Centralized Screening Team referred seven allegations to the Office of Internal Affairs' Allegation Investigation Unit.

The OIG then learned that until mid 2023, the department had relied primarily on oral training directives to screening staff. The department informed us that its high staff turnover rate caused much of the information shared through oral training to be lost. This information helps to explain the inconsistent and improper screening decisions that the OIG has observed.

On August 23, 2023, the OIG attended screening team training regarding the routing of grievances. At the training, a handout was provided to staff and the OIG. At the start of the training, instructors explained the objective of the training was to avoid inappropriate referrals to the Office of Internal Affairs' Allegation Investigation Unit. The training effectively discouraged the routing of grievances for investigations or inquiries and instead encouraged routing the grievances back to the prisons for a routine fact finding.

For example, Exhibit 1 below shows how the department trained screening staff to make the following screening decisions:

Exhibit 1. Excerpt From a Department's Training Handout

iii. For example, an allegation that "during an escort in restraints, it felt like staff pulled on me/my waist chains/handcuffs/etc. to go the other direction" would not be unnecessary UOF because staff are guiding the inmate without active resistance. These would be routed for grievance response after reviewing the totality of the Grievance Log.

Source: The California Department of Corrections and Rehabilitation.

The department's direction to staff is that this grievance should not be considered an allegation of unnecessary force "because staff are guiding the inmate without active resistance." This directive contradicts the mandate of the Centralized Screening Team. In the above example, the screening team should not assume facts about how the escort was completed. The facts surrounding the allegation should be discovered during an investigation, and not presumed before one is conducted. The screening team's job is clear; the screener should review the complaint and determine whether the complainant raised an allegation of misconduct. If the allegation is found on the Allegation Decision Index, the screener should route the allegation to the Office of Internal Affairs' Allegation Investigation Unit. Failure to route a use-of-force allegation based on conjecture is inconsistent with regulations and departmental policy. Therefore, the direction to the screening team that staff are to direct a case like this back to the prison as a routine matter is flawed and contradicts policy.

We found issues with another hypothetical situation in the training:

Exhibit 2. Excerpt From a Department's Training Handout

iii. For example, the allegation that "staff came up to me outside of the program office and we started arguing. The whole time he didn't have his BWC on" would not be referred for AIU as the staff member responded to a situation and lack of turning the BWC on does not show an intentional overt failure to comply, assuming no other misconduct was alleged. This would be identified for grievance response as there is no overt purposeful act to be dishonest.

Source: The California Department of Corrections and Rehabilitation.

The OIG would disagree with this decision because the example clearly states, "staff came up to me" and departmental directives state "with the exception of specific and identified circumstances, the [body-worn camera] shall remain on during the entire shift." Although the department has made exceptions for situations in which staff can deactivate their cameras, the directives require that staff "ensure the [body-worn camera] is reactivated immediately following." This example does not describe any of the identified exceptions, and staff's overt failure to activate their body-worn cameras prior to or while approaching the incarcerated person is a clear violation that should be identified as dishonesty on the Allegation Decision Index. The Centralized Screening Team should refer an allegation like this to the Office of Internal Affairs' Allegation Investigation Unit.

The OIG immediately raised concerns about the training to the Centralized Screening Team's management and departmental executives. To date, the department has neither retracted nor corrected its training. Consequently, the OIG has diminished confidence that screening staff understand how to properly apply the department's allegation decision index. In the OIG's opinion, this training represents a step backward in the department's implementation of its staff misconduct accountability process.

We monitored multiple cases in which the screener weighed evidence in making a screening decision, which is contrary to departmental policy. Below are some examples.

In one case, a lieutenant allegedly violated an incarcerated person's due process by refusing to postpone the incarcerated person's disciplinary hearing, denying his ability to call witnesses, and deciding whether the incarcerated person was guilty before the hearing. Specifically, when the incarcerated person tried to make a statement on his own behalf, the lieutenant allegedly stated, "I am not here for all that; I'm finding you guilty." The incarcerated person then requested that either the rules violation report be dismissed or that he be found not guilty. The

Centralized Screening Team routed one rules violation report dispute back to the prison as a routine issue rather than as an allegation of staff misconduct for deeming an incarcerated person guilty before the disciplinary hearing. After the OIG elevated the matter, the Centralized Screening Team conducted a fact-finding inquiry and determined the lieutenant's report of what had happened was more credible than the incarcerated person's account of what had happened. It affirmed its original screening decision noting that the hearing documents did not substantiate the incarcerated person's claim because the lieutenant did not document making the alleged statement.

In another case, an officer allegedly retaliated against an incarcerated person for filing lawsuits. On June 9, 2023, the officer allegedly stated he could "not stand" incarcerated people who file lawsuits and staff misconduct grievances or "blacks on [a certain] yard" because "they always complain." The officer allegedly eavesdropped on an incarcerated person's medical appointment and falsified a rules violation report against the incarcerated person based on the confidential discussion. The incarcerated person alleged he did not receive a copy of the rules violation report until July 28, 2023, and requested that it be removed from his file. The Centralized Screening Team determined the allegation to be a routine dispute about a rules violation report rather than an allegation of retaliation for filing staff misconduct grievances. Following an elevation by the OIG, the Centralized Screening Team responded that

> [a]lthough claimant is alleging this is falsified and retaliatory based on litigation/lawsuits, they don't provide the nexus that this is retaliation. Claimant does state the officer said they don't like inmates that file lawsuits like claimant, but this does not automatically mean the chrono is unwarranted and solely for retaliation. T**he Counseling Chrono is clearly articulated of what the Officer witnessed/heard**.... [emphasis added]

The Centralized Screening Team reviewed the documentation submitted by the officer and determined the officer's account of what had occurred was more credible than the account provided by the incarcerated person, and therefore, the allegation of retaliation for filing staff misconduct grievances did not warrant a referral to the Office of Internal Affairs' Allegation Investigation Unit.

In a third case, in retaliation against an incarcerated person for filing a staff misconduct grievance, a certified nursing assistant allegedly deliberately pulled an incarcerated person's shower chair out from under him, causing him to fall and sustain an injury. Subsequently, the certified nursing assistant allegedly refused orders to shower the incarcerated person. The Centralized Screening Team referred the allegations that the certified nursing assistant had pulled the shower chair out from under the incarcerated person to the Office of Internal Affairs' Allegation

Investigation Unit. The Centralized Screening Team acknowledged but failed to include the allegation of retaliation for filing a prior grievance, citing that there was no connection, despite the department's interview of the certified nursing assistant just weeks prior concerning a staff misconduct grievance submitted by the incarcerated person. After we elevated the matter, the Centralized Screening Team told us that the prior grievance was minor and would not lead to retaliation. The OIG disagreed and advised the department that the allegation of retaliation for filing staff misconduct grievances alone warranted a referral to the Office of Internal Affairs' Allegation Investigation Unit, and the allegation was directly related in time and scope to the allegation that the certified nursing assistant had pulled the shower chair out from under the incarcerated person, which also warranted inclusion in the referral of the allegations against the certified nursing assistant. The Centralized Screening Team eventually agreed to refer the allegation of retaliation to the Office of Internal Affairs' Allegation Investigation Unit. However, its initial decision to base the screening on whether it believed someone would retaliate over the prior complaint, caused a significant delay—40 business days—from the time it received the allegation until it referred the allegation for investigation. Furthermore, without intervention from the OIG, this allegation would have been inappropriately routed.

We also found that the department inappropriately routed claims as routine when it believed the grievance claim was either "impossible" or "implausible." We discuss a couple of examples below.

An incarcerated person alleged that a nurse and two officers allegedly tried to kill him with expired and poisoned beverages. A custody subject matter expert on the Centralized Screening Team referred the allegations against the officers to the Office of Internal Affairs' Allegation Investigation Unit for investigation, while the health care subject matter expert determined that because the incarcerated person had a documented history of delusions, there was no staff misconduct by the nurse. The OIG elevated the case because the department based its decision on the incarcerated person's history of delusions. Our concern was that the Centralized Screening Team would discount every allegation of staff misconduct the incarcerated person subsequently made for that same reason. If the department always presumes that allegations from an incarcerated person are implausible because of mental health issues, then those members of the incarcerated population become a target for harassment and other types of misconduct because their allegations would be dismissed from the outset. The Centralized Screening Team responded that the incarcerated person's allegation that staff were trying to kill him was merely "conjecture" because he did not witness officers or a nurse poisoning his beverages. The Centralized Screening Team reclassified the entire complaint as a routine complaint.

An incarcerated person alleged that three officers allegedly poisoned the incarcerated person's meal tray. The Centralized Screening Team referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit for an investigation, but later issued an amended decision letter stating it had incorrectly identified the allegation as staff misconduct and ordered a new grievance log to address the allegation as a factually implausible, routine issue. The OIG disagreed with the department's position that allegations of staff poisoning or tampering with an incarcerated person's food are implausible, and elevated the amended decision. However, the Centralized Screening Team elected to uphold its amended decision.

The OIG categorically rejects the department's analysis of these cases because it improperly prejudges the outcomes. Although it might make sense to route truly impossible claims back to the prison without an investigation, the routing of allegations that a screener arbitrarily deems to be implausible[5] is inappropriate. Making a determination that an allegation is implausible inherently calls for a weighing of evidence; it is wholly inappropriate for a screener on the Centralized Screening Team to assume this responsibility.

5. **Merriam-Webster's Unabridged Dictionary, Online**, s.v. "implausible": *adj*: not plausible; provoking disbelief.

The Department Failed to Properly Utilize the Clarification Interview Process in Several Cases

Departmental policy states in part:

> CST shall conduct a clarification interview if required to make a screening decision. The clarification interview shall be conducted in a manner that provides as much privacy for the claimant as operationally feasible.

The clarification interview is an important function of the screening process, which can provide more specific details to the screening team and result in more appropriate routing decisions. In our 2022 Staff Misconduct Review Process Monitoring Report, published in May 2023, we noted the infrequent use of clarification interviews. In June 2023, the OIG began monitoring clarification interviews for grievances monitored by our office. While monitoring these interviews we found significant deficiencies in the process.

The Centralized Screening Team's best practices document states that, "A [clarification interview] is to make a screening decision **not to gather facts and circumstances** (emphasis added)." This directive is confusing in that it tells the screener not to gather facts but to only ask questions to obtain enough information to make an appropriate screening decision. Although the screening team is directed not to gather facts and circumstances, allegations are often routed as routine after citing the incarcerated person failed to provide sufficient information to support an allegation of staff misconduct. We found that of the 225 clarification interviews we monitored, the screening team failed to conduct a thorough interview and obtain necessary information for a screening decision in 32 cases, or 14 percent. Below are some examples in which the screening team failed to ask necessary questions during a clarification interview.

In one case, an incarcerated person alleged that a sergeant and an officer punished him as retaliation. The screening team conducted a clarification interview, in which the incarcerated person stated the sergeant and officer issued him rules violation reports and denied him canteen access and programming based on his disability. After the clarification interview, the screening team routed the claim back to the prison as a routine issue. The screening team analyst who conducted the clarification interview failed to ask thorough questions about the incarcerated person's allegations of retaliation. Specifically, the analyst failed to ask when the events occurred and how they related to the incarcerated person's disability. The screening team then cited in its decision to route the matter as routine because the incarcerated person "did not provide sufficient detail to support the connection between the [staff] behavior and retaliation against [the Americans with Disabilities Act]."

In another case, officers allegedly used force on an incarcerated person, thereby causing mental and physical damage to the incarcerated person. The screening team conducted a clarification interview in which the incarcerated person stated that staff dropped him when they attempted to place him on a gurney, and he landed on his arm. The incarcerated person clarified that staff did not drop him on purpose; however, staff allegedly failed to provide him with medical attention after the incident. The screener who conducted the clarification interview failed to ask for the date of the incident and where it occurred. The screener also failed to ask how the use of force caused mental damage to the incarcerated person. The incarcerated person required the presence of a translator for the clarification interview, and the screener failed to document the translator's name and title. The Centralized Screening Team eventually referred the allegation that the incarcerated person did not receive medical attention after being dropped to the prison for a local inquiry. The other claims were routed as routine.

On October 18, 2023, we requested the opportunity to review the Centralized Screening Team's planned interview questions before monitoring any clarification interview to provide feedback and recommendations and, if necessary, to add value to the interview process. Weighing in on the interview questions would bring our monitoring efforts more in line with established practices our local inquiry and investigation monitoring teams are familiar with. Both of these monitoring teams conduct a short, private meeting to provide the department investigator with any suggestions or recommendations before wrapping up each interview. We acknowledged the abbreviated clarification interview did not lend itself to the pause-and-confer process established for investigative interviews but felt that providing feedback on the preplanned questions could achieve a similar result.

On November 2, 2023, managers from the Centralized Screening Team informed us that they had decided not to provide us with the questions in advance, due to time constraints. However, the interviewer and the interviewer's supervisors had already shared the questions via email with one another, and including the OIG on the email would not have taken any extra time.

We also found that the Centralized Screening Team failed to conduct interviews for certain types of allegations of staff misconduct and inappropriately routed the cases back to the prison as routine matters. Of the 348 cases we monitored where the complaint did not include sufficient information to make a screening decision, the screening team did not conduct a clarification interview in 145 cases, or 42 percent. Below are some examples.

In one case, an incarcerated person alleged that staff retaliated against him for filing a prior grievance by turning off his tablet signal for two weeks and failing to provide him with his mail. After reviewing the

grievance, the Centralized Screening Team inappropriately determined that the incarcerated person did not provide sufficient detail to support the allegation of retaliation. The OIG recommended the Centralized Screening Team conduct a clarification interview to obtain additional information about the alleged retaliation. Nevertheless, administrators chose not to conduct a clarification interview and instead routed the alleged retaliation as a routine issue about mail and a State-issued tablet. If the Centralized Screening Team had conducted the clarification interview, it would have gathered the details needed to make an informed screening decision.

In a second case, an incarcerated person alleged officers planted knives and weapon stock in his cell but did not identify the officers who allegedly committed the misconduct. The screening team failed to identify the claim that officers had planted knives in the incarcerated person's cell, documented the claim as a rules violation report dispute, and routed the claim back to the prison as a routine issue. The OIG recommended that the screening team conduct a clarification interview to address the allegation of planting evidence. However, the screening team managers determined that a clarification interview was unnecessary because the incarcerated person did not describe any behavior warranting an allegation of staff misconduct, and "solely" provided "conjecture that weapons were planted."

In a third case, an incarcerated person alleged that, by denying her access to the canteen, staff discriminated against her for being transgender. The incarcerated person also alleged that she did not have hygiene items or food even though she was diabetic and needed sugar. The screening team routed the claim that the incarcerated person had no hygiene items and was diabetic and in need of sugar back to the prison as a routine issue but failed to conduct a clarification interview for the claim of gender discrimination.

Recommendation

The department should clarify departmental policy in writing to require screeners to ask the complainant questions during a clarification interview to obtain sufficient information to ultimately make an informed screening decision about the allegation.

The Department Has Frequently Failed to Accurately Summarize Claims Resulting in Improper Routing Decisions and Inquiries and Investigations That Are Incorrectly Scoped

Since the OIG began this process, we have questioned the Centralized Screening Team's summarization of various claims made by the incarcerated population. Screening team analysts are required to review each grievance, identify every allegation, and summarize the grievance details. The OIG often finds that screening staff fail to document sufficient details or accurate information from the grievance. When this occurs there may be a trickle-down effect that leads to poorly conducted inquiries, investigations, or fact findings. Investigators are trained to focus only on the claims that the Centralized Screening Team assigns to them. As a result, poorly summarized claims that fail to identify all the allegations made can result in poor or incomplete inquiries or investigations and inappropriate responses to complainants. Table 2 presents the actual claims made by incarcerated people followed by the Centralized Screening Team's summary of the claims.

Table 2. Actual CDCR Form 602 Allegations Versus the Centralized Screening Team's Allegation Summaries

Case Number	Details
23-0058660-CSMT	*Actual 602:* . . . the sergeant's decision to hold my 602 grievance interview right in front of the program office was a very unprofessional choice . . . it was out in the open in front of other inmates, as well as, the officer whom I made mention in that 602 . . . I then expressed to the sergeant that I did not feel comfortable having this interview here . . . I assertively also made it clear to the sergeant that my "due process rights" to confidentiality upon request during a 602 interview was being violated . . . he became frustrated and defensive towards me stating, "I'm not doing things on your time," and "if you don't want to do this interview right now, then I will mark you down as a refusal." I then clearly told him that I was not refusing . . . this action by this sergeant is clearly a form of reprisal…
	Screening Team Determination: The screening team determined the complaint contained no allegations of staff misconduct, and the incarcerated person was dissatisfied with the interview process.
	The OIG's Concerns/Results: The screening team failed to identify the sergeant's alleged violation of the incarcerated person's right to a confidential interview, discourteous comments, erroneous assertion that the incarcerated person's request for a confidential setting constituted a refusal by the incarcerated person, and failed to consider the allegation of reprisal for filing a grievance.

Continued on next page.

Table 2. Actual CDCR Form 602 Allegations Versus the Centralized Screening Team's Allegation Summaries (continued)

Case Number	Details
23-0059051-CSMT	*Actual 602:* Sexual harassment, intimidation, transphobia, transgender discrimination… Building [redacted] . . . was being searched on 6-20-2023. C/O [redacted 1] told me to strip out. I showed him my Transgender Access card with female search preference and I requested a female C/O . . . A C/O [redacted 2] showed up to say they were Non-Binary. I still requested a female officer. C/O [redacted 2] said Non-Binary is OK. I said it's not ok and Non-Binary is not female . . . A voice out of site asked if I was refusing . . . I said I am not refusing and stripped out against my will and under duress . . . Furthermore, Sgt. [redacted] searched my cell and trashed it in a very disrespectful manner, as retaliation and this is a hate crime.
	Screening Team Determination: The screening team acknowledged the strip search, transgender concerns, stolen property, and a cell left in disarray. The screening team determined the complaint contained no allegations of staff misconduct, noting the incarcerated person used "buzz words," but failed to describe inappropriate behavior.
	The OIG's Concerns/Results: The screening team inappropriately combined allegations of a transgender search violation and a cell search with destruction of property. The screening team failed to identify the transgender search allegation as staff misconduct and missed an opportunity to conduct a clarification interview as to how staff left the incarcerated person's cell in disarray and stole the incarcerated person's property, after officers refused to honor the incarcerated person's documented search preference. The screening team incorrectly routed the entire claim as a routine issue, considering the allegation to be officers confiscating property during a cell search.
23-0059015-CSMT	*Actual 602:* My due process was violated . . . Lieutenant [redacted] refused me my right to postpone my hearing and couldn't ask for witnesses to gather information, so that I could properly defend myself. When I began to inform Lt. [redacted] about my side of the defense, she said, and I quote "I am not here for all that, I'm finding you guilty." . . . Lt. [redacted] shows by hear actions, that she had already in her mind found me guilty before my hearing had ever started. This is a prime example of bias…
	Screening Team Determination: The screening team summarized a routine, rules violation report dispute.
	The OIG Concerns/Results: The screening team failed to identify an allegation of staff misconduct by a lieutenant making an inappropriate and prejudicial comment and predetermining an incarcerated person's guilt prior to a disciplinary hearing and inappropriately routed the allegation as a routine issue.

Continued on next page.

Table 2. Actual CDCR Form 602 Allegations Versus the Centralized Screening Team's Allegation Summaries (continued)

Case Number	Details
23-0055451-CSMT	*Actual 602:* It's HOT! Please turn on the A.C. (or whatever is on the roof) on so the vents will blow cold air. It's very HOT in the cells.
	Screening Team Determination: The screening team summarized a routine concern about a state-issued tablet.
	The OIG's Concerns/Results: Institution staff mistakenly scanned two grievances from two different incarcerated people into the grievance log record. The screening team failed to verify the name, CDCR number, and grievance log number on the first page of the grievance and incorrectly summarized a grievance belonging to another incarcerated person. The correct grievance was located on the second page, made no mention of a tablet, and did not appear to be reviewed.
23-0064531-CSMT	*Actual 602:* . . . I did not receive the findings of my RVR until after 30 days of time . . . When I talked to Hearing Official [redacted] he said that my charge for 3011 Misuse of State Property was found guilty . . . I believe that after 30 days that I should lose nothing and the write for RVR . . . should be dropped.
	Screening Team Determination: The screening team summarized a routine, rules violation report dispute.
	The OIG's Concerns/Results: The screening team incorrectly identified and linked the wrong rules violation report (for refusal to work) in the grievance record when the incarcerated person clearly identified a rules violation report for misuse of state property. This resulted in the department responding to the wrong allegation entirely.

Note: The actual 602 language is reported exactly as written by the incarcerated person. The OIG did not edit or correct any spelling or grammar. The OIG only made edits to redact names or other identifying details.

Sources: The California Department of Corrections and Rehabilitation's electronic tracking systems and the Office of the Inspector General.

Departmental Medical Subject Matter Experts Frequently Conducted a Fact-Finding Analysis That Contradicted Policy

On May 31, 2023, the Centralized Screening Team began reviewing grievances that relate to health care. To ensure proper screening decisions for allegations related to medical care, the screening team designated nursing consultants as subject matter experts. The nurse consultants' duties included providing program consultation regarding nursing practices, procedures, and standards in their specified region. Although it is clear a nurse consultant should consult about nursing practices, procedures, and standards, the OIG determined that the nurse consultants had been conducting complete reviews, making findings of fact about incarcerated people's medical records, and concluding that claims did not constitute allegations of misconduct, but merely disagreements in treatment plans. As a result, many claims were inappropriately routed back to the prisons' health care grievance office as routine. Below are some examples.

In one case, a nurse allegedly abused an incarcerated person, using force to inject medications into his buttocks. Staff allegedly pulled down the incarcerated person's pants causing bruises to his body. The screening team determined the claim met criteria on the Allegation Decision Index for use of force but sent the grievance to the nurse consultant for review. The nurse consultant reviewed medical records and determined that staff had utilized a controlled use of force because the incarcerated person refused mental health medication, and a nurse administered medication as ordered. The nurse consultant believed that the most appropriate area to administer the medication is the buttocks, which can cause bruising or agitation. The nurse consultant perceived the incarcerated person's claims as a disagreement about treatment and recommended routing the matter as a routine issue. The nurse consultant undermined the mission of the division by fact-finding and, as a result, the department failed to appropriately refer an allegation of inappropriate use of force for investigation.

In another case, health care staff allegedly improperly housed an incarcerated person in a single cell after release from the hospital for the removal of a brain tumor. The incarcerated person indicated he fell on his face due to dizziness from chemotherapy and was found eight hours after his fall. The screening team recommended referring the claim to the hiring authority for a local inquiry. However, the nurse consultant determined an assessment by health care staff found the incarcerated person met the criteria for single-cell placement. The nurse consultant perceived the incarcerated person's claims as a disagreement about treatment and recommended routing the claim as a routine issue. We disagreed with the decision of the screening team and nurse consultant. Careless and improper care that leads to unintentional harm, and failure to meet standards of reasonably competent health care is negligence.

Furthermore, the claim met the requirements for referral to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.

The OIG discovered the nurse consultants' practice of fact-finding when reviewing medical records often reduced the alleged misconduct to conjecture or a disagreement about treatment. Moreover, nurse consultants often inappropriately disagreed with the screening team's identification of an allegation of staff misconduct on the Allegation Decision Index, and instead recommended referral to the hiring authority for a local inquiry. The nurse consultants made these recommendations with the understanding that the local investigator could suspend their review and elevate the allegation to the Office of Internal Affairs' Allegation Investigation Unit if the local investigator determined the misconduct had occurred. Below are some examples.

In one case, a nurse allegedly stole medication and refused to provide medications to incarcerated people in the mental health crisis bed. The incarcerated person who had submitted the grievance provided an officer's name as a witness to the alleged staff misconduct. Despite the allegation meeting criteria on the Allegation Decision Index of an allegation of staff misconduct, the nurse consultant recommended referral to the hiring authority for a local inquiry with considerations to suspend and elevate the matter if necessary.

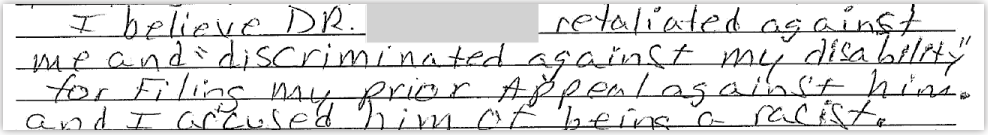
In a second case, an incarcerated person alleged he experienced knee pain for four years but did not receive medical attention. The nurse consultant reviewed the patient's medical records and noted, "Patient care seems to be adequate," determined the allegation to be a perceived disagreement about treatment, and recommended routing the claim as a routine issue. The nurse consultant's fact-finding included only an assumption that treatment appeared to be adequate. The nurse consultant should have identified the claim as a deviation from the standard of care because the patient did not receive proper care in a reasonable amount of time.

In a third case, an incarcerated person alleged that a physician falsified a medical record that he had refused a urine test. The grievance indicated a nurse had informed him of the falsified records and identified two other nurses as witnesses. The incarcerated person alleged the physician had falsified the record out of malice to cover up her inactions in providing his medical treatment. The screening team identified an allegation of staff misconduct on the Allegation Decision Index for dishonesty. Nevertheless, the nurse consultant reviewed the incarcerated person's medical records and determined that the physician had canceled the urine test for no specific reason. Even though a nurse told the incarcerated person that the physician had falsified the records and even though two witnesses were identified, the nurse consultant determined the claim to be a routine issue and cited the incarcerated person's allegations as conjecture.

The OIG also identified inconsistencies between nurse consultant reviews and custody subject matter expert reviews. Custody subject matter experts tended to agree with the screening team's identification of alleged staff misconduct, whereas nurse consultants tended to discount or negate allegations as routine. The OIG found the screening team requested nurse consultant reviews when identifying alleged medical staff misconduct on the allegation decision index. However, in such cases, a review by a custody subject matter expert would be more appropriate because the screening team managers informed us that nurse consultants should only review "medically related issues." The managers explained that a nurse consultant should review allegations that health care staff inappropriately administered an IV, whereas a custody subject matter expert should review use-of-force allegations against a health care provider. Here are some case examples that illustrate the issue.

In one case, a physician allegedly ignored an incarcerated person's reported blackouts, dementia, and lack of oxygen in his blood. The incarcerated person alleged the physician failed to conduct a medical evaluation but falsely entered evaluation notes into the incarcerated person's medical records in retaliation for the incarcerated person filing a staff misconduct grievance against the physician for being racist. The screening team identified the claim, shown in part below, as a routine issue. The nursing consultant reviewed the incarcerated person's health care record and agreed with the decision to route the matter as routine.

Exhibit 3. Excerpt From an Incarcerated Person's Complaint


I believe DR. [redacted] retaliated against me and discriminated against my disability" for filing my prior Appeal against him. and I accused him of being a racist.

Source: The California Department of Corrections and Rehabilitation.

The OIG disputed the screening decision and identified the allegation of retaliation by the physician. The screening team responded that the incarcerated person's allegation of racism appeared to be "conjecture" or use of a "buzz word," which the screening team perceived to be disagreement with treatment. The response went on to say the screening team staff are trained to interpret allegations stating, "I believe," "I think," or "I feel," to be conjecture, and therefore, routine rather than staff misconduct. The screening team also reported their own belief that if they referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit, the California Correctional Health Care Services' Staff Misconduct Team would have disputed the referral, so they chose not to refer it.

Using this logic, if the incarcerated person had written, "Dr. [last name] retaliated against me and 'discriminated against my disability' for filing my prior appeal against him. and I accused him of being a racist," the screening team would have treated the allegation as a statement of fact and as an allegation of staff misconduct. However, the incarcerated person's inclusion of "I believe . . ." led the screening team to treat the allegations of retaliation for filing staff complaints and racial discrimination as conjecture.

The OIG confirmed that the incarcerated person had previously filed a grievance against the physician. The physician's conduct met the criteria for retaliation because of the incarcerated person's previous grievance alleging staff misconduct or due to the use of the grievance process, a type of staff misconduct found on the Allegation Decision Index. The screening team should have referred the claim to Office of Internal Affairs' Allegation Investigation Unit for an investigation.

Unbeknown to the OIG, the screening team eventually amended its decision and opened a new grievance to address the deficiency. Through random sampling, the OIG discovered the new grievance. Review of the original grievance by a custody subject matter could have saved the department valuable time and resources.

As previously stated, the OIG has observed the nurse consultants discount or negate allegations originally considered staff misconduct to be routine by relying on medical documentation and fact-finding practices. Table 3 on the following page displays more examples.

Table 3. Health Care Subject-Matter Expert (SME) Referral Reviews

No.	Screening Team Staff Review (summarized)	SME Review Comments (summarized)
1	Claimant alleged on August 20, 2023, that a nurse told the claimant to take their "black ass" back to their cell and told the claimant he is a "bitch." The claimant also alleged they heard the nurse talking to other inmates about race issues and a second nurse, and the second nurse told the first nurse to calm down and she shouldn't be talking like that. The claimant alleged the first nurse called the second nurse a "bitch" and said that "all blacks deserve to be in prison." Claimant alleged on August 21, 2023, that the first nurse continued to harass the claimant by telling them that "snitches get stitches." The analyst recommended the allegation be referred as Discrimination, an allegation of staff misconduct on the Allegation Decision Index.	An NCPR conducted a review of the claimant's "relevant" medical files and noted the claimant was admitted to the mental health crisis bed during the August 20, 2023, incident and the claimant was diagnosed with schizophrenia. The NCPR noted the complaint was lengthy and primarily about disliking the first nurse, noting the claimant appeared to be fixated with her being racist, disrespectful, harassing them, etc. The NCPR went on to say it was not clear if the claimant's beliefs were part of their delusion or about an actual person. The NCPR directed the analyst not to refer the allegation to the Office of Internal Affairs' Allegation Investigation Unit but to a locally designated investigator for further inquiry instead.
2	The claimant alleged they heard a nurse say he is a pedophile, and the nurse said, "this 602 won't do shit, no one is going to believe you." The analyst recommended the allegations be referred to the Office of Internal Affairs' Allegation Investigation Unit as staff misconduct.	An NCPR conducted a review of claimant's "relevant" medical files, and noted the claimant was receiving a high level of mental health care and a medication nurse documented the claimant had been caught diverting their medications. While the nurse tried to counsel the claimant, he became argumentative and then accused the nurse and an officer of calling the claimant a child molester. The NCPR determined there was no allegation of staff misconduct and recommended a routine routing.
3	The claimant alleged a registered nurse tried to force feed him a pill and medical staff purposely shot air into the claimant's G-tube or provide the claimant with spoiled bolus feedings. The analyst recommended the allegations be referred as staff misconduct pursuant to the Allegation Decision Index: Use of Force (2); Other Misconduct (2).	An NCPR conducted a review of claimant's "relevant" medical files and noted the claimant made allegations against health care staff at one prison, surrounding his gastrostomy tube feeding and his wish to be transferred to a second prison. The NCPR noted the claimant refused care on and off but that a physician saw him recently on August 23, 2023, and documented a special device to assist claimant with self feeding via his G-tube had been ordered so he can feed himself and be discharged from the treatment center. The NCPR determined the allegations to be conjecture, not staff misconduct, and recommended routine routing.
4	The claimant alleged in August 2023, he was pressured by an unnamed male dentist during appointments not to go through with a surgery and was threatened that both the dentist and transportation staff would issue him a rules violation report if he requested to have the surgery, forcing the claimant to sign a refusal out of fear. The analyst suggested the allegations as staff misconduct on the Allegation Decision Index: Discrimination (3), Other Misconduct (4).	The NCPR determined the dentist "advised" rather than "threatened" the claimant of policy to issue rules violation reports for not showing up at a priority appointment and refusing to show up to sign a refusal form. The NCPR determined that even though the claimant alleged he did not have a follow-up appointment, the allegation would best be handled as routine, with considerations to suspend and elevate.
5	The claimant said he was placed in a holding cell waiting placement in the mental health crisis bed. The claimant alleged he made a noose to kill himself and the nurse observed him, watched him try to hang himself twice, and told him that she was there for the money and could care less if the claimant died or lived. After the claimant was moved to a cell, the same nurse was assigned to observe him. The analyst recommended the allegation be referred as staff misconduct. Integrity (1).	The NCPR conducted a review of the claimant's "relevant" medical files, noting the claimant was admitted to a mental health crisis bed due to suicidal ideation and two hanging attempts. The NCPR determined "there was no indication the allegations were true" based on the mental health documentation while the claimant was in the crisis bed, and recommended routine routing.
6	The claimant alleged that a clinician -- made sexual gestures to him and was "rubbing on himself, looking at me, on his private area making sexual gestures." The analyst recommended referring the allegation as staff misconduct on the Allegation Decision Index: Staff Sexual Misconduct (3).	An NCPR conducted a review of the claimant's "relevant" medical files and noted he had recently been discharged from the mental health crisis bed after more than a month where he presented with erratic behavior and delusional belief. The NCPR noted the claimant was on forced mental health medication injections and made similar allegations against another clinician Based on the claimant's mental health issues, the NCPR determined the allegation was conjecture and ordered a routine routing.

Source: The California Department of Corrections and Rehabilitation's Centralized Screening Team.

During our monitoring, we found that the screening team's subject matter experts review every claim that screeners determined to include an allegation of staff misconduct, but not all the allegations that screeners determined to be routine. The OIG's review of health care subject matter expert logs created by the screening team showed only intermittent reviews of grievances that were determined to be routine matters. Because of this, it appears the department focused its quality control tools on reviewing the initial decisions to approve investigations, but gave less attention to cases the screening team decided to route back to the prisons without an investigation or inquiry.

The department has informed us that they are revising their practice for subject matter expert reviews. The new practice will not require review of every claim referred for investigation, but the experts will be available to assist screeners in the decision-making process when needed.

The OIG applauds the department's recognition that there is no need at this point for subject matter experts to review every claim referred for investigation. It is our recommendation that the department redirect these resources toward quality control of claims that are routed routine.

Based on our review of cases that have been routed as routine in 2023, we believe that if the department required more random reviews of routine grievances, the Centralized Screening Team would identify more claims warranting investigation. Even a one percent error rate in the department's decision-making process is high given the volume of grievances received. By focusing their quality control efforts on cases that are initially routed as routine, the department will likely identify a large number of allegations of staff misconduct that otherwise would not have been investigated.

Recommendation

The OIG recommends the department focus more quality-control attention on claims initially identified as routine matters. We also recommend the department establish clear policy requiring medical subject matter experts review only claims related to medical treatment, and custody subject matter experts review claims related to custody and correctional issues, such as use of force, even when the person alleged to have committed misconduct is a medical employee.

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The Local Inquiry Monitoring Team

The Department's Local Inquiry Process

On October 20, 2022, the department permanently adopted regulations governing its statewide process for reviewing incarcerated people's allegations of staff misconduct. Pursuant to the regulations, a prison's grievance office forwards allegations of staff misconduct to the Centralized Screening Team within the Office of Internal Affairs, which then screens and routes complaints to the appropriate entity for review based on the substantive allegations contained in the complaint. The Centralized Screening Team reviews each allegation to route the complaint appropriately. Allegations of staff misconduct are either investigated by the Office of Internal Affairs' Allegation Investigation Unit or returned to the prison for a local inquiry. If the Centralized Screening Team determines that a complaint does not contain an allegation of staff misconduct, the Centralized Screening Team returns the complaint to the prison or to a regional parole office for processing.

The department uses an *Allegation Decision Index* to determine where a complaint should be referred. If the complaint contains allegations of staff misconduct that are not identified within the Allegation Decision Index, the Centralized Screening Team refers the complaint to the appropriate prison, and the hiring authority assigns a locally designated investigator at the prison to complete an inquiry. The locally designated investigator is responsible for analyzing the complaint, thoroughly gathering facts, gathering and reviewing all relevant evidence, conducting all necessary interviews, and preparing a confidential draft report that summarizes the facts and evidence. The preliminary reports and supporting exhibits, along with any subsequent revisions to the reports, are reviewed by an Office of Internal Affairs' Allegation Investigation Unit manager to determine whether the investigation or inquiry is sufficient, complete, and unbiased. Once approved, the reports are provided to the hiring authority. If the hiring authority finds the investigation or inquiry is sufficient, he or she shall determine a finding[6] for each allegation.

6. CCR section 3486.3 (a) (1): "The notification of the findings regarding the staff misconduct complaint shall be limited to whether the original complaint is sustained, not sustained, exonerated, unfounded, or no finding."

The OIG Is Responsible for Monitoring Local Inquiries

California Penal Code section 6126 (i) requires the OIG to provide contemporaneous oversight of grievances[7] that fall within the department's process for reviewing and investigating incarcerated people's allegations of staff misconduct. This oversight includes our examination of compliance with regulations, departmental policy, and best practices. The OIG's Local Inquiry Team is responsible for monitoring grievances alleging staff misconduct that are referred to the prisons for a local inquiry. The Local Inquiry Team monitors the department's local inquiries from the time the Centralized Screening Team sends an allegation to the hiring authority for assignment to a locally designated investigator until the hiring authority makes a determination regarding the allegation.

From January 1, 2023, through June 30, 2023, the OIG's Deputy Inspectors General, who are not attorneys, conducted the OIG's monitoring of local inquiries. Beginning on July 1, 2023, the OIG shifted the duties of monitoring local inquiries to attorneys.

During the second half of 2023, the OIG's Local Inquiry Team also implemented a process to complete retrospective case reviews. Through this process, the team reviewed randomly chosen inquiry cases that the department had completed and closed to assess the department's performance when the OIG had not provided contemporaneous monitoring or real-time feedback on the inquiry cases.

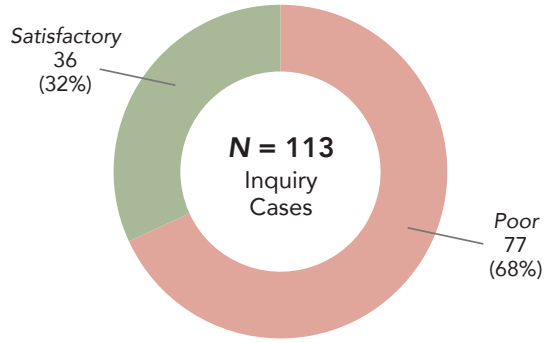
From January 1, 2023, through December 31, 2023, the OIG's Local Inquiry Team monitored and closed a total of 113 inquiry cases completed by locally designated investigators. The Local Inquiry Team monitored and closed 89 cases that were monitored contemporaneously. Twenty-four cases were reviewed retrospectively.

7. An incarcerated person must file a grievance on a "CDCR Form 602–1" with the institutional or regional Office of Grievances for review of one or more claims or allegations to challenge any policy, decision, condition, or omission by the department that has a material adverse effect upon his or her health, safety, or welfare (CCR, Title 15, sections 3480 (b) (10), 3481 (a), 3482 (c) (1), and 3486.1 (d)).

The OIG Found That the Department Performed Poorly in Conducting Local Inquiries

From January 1, 2023, through December 31, 2023, the department's Centralized Screening Team routed a total of 12,520 allegations of staff misconduct to prisons for local inquiries. The OIG monitored and closed 113 inquiry cases during that same period. Of the 113 inquiry cases, the OIG monitored 89 cases contemporaneously and 24 retrospectively. We found that, overall, the department's performance was poor. After monitoring the 113 inquiry cases, the OIG rated the department's overall performance as poor in 77 cases, or 68 percent, and satisfactory in 36 cases, or 32 percent. The department did not receive a *superior* rating in any of the inquiry cases we monitored.

Figure 2. The Department's Overall Performance Ratings for 113 Inquiry Cases Monitored During the 2023 Reporting Period



Source: The Office of the Inspector General Tracking and Reporting System.

As discussed below, during our reporting period the department failed to implement a cohesive and sustainable local inquiry process, which resulted in systemwide failures, confusion, and frustration among departmental staff. The OIG identified significant deficiencies and gaps in policy, which led to insufficient and incomplete inquiries, decisions about alleged misconduct that were inconsistent with the evidence, untimely case processing, and failure by the department to communicate with our office, thereby denying the OIG the ability to effectively conduct its statutorily required monitoring.

Locally Designated Investigators

Locally designated investigators are individuals within the department who are responsible for conducting thorough allegation inquiries, and ensuring that all relevant evidence is gathered and reviewed, and all necessary interviews are conducted. Upon completion of an allegation inquiry, locally designated investigators are responsible for drafting a confidential allegation inquiry report with all applicable supporting exhibits and submitting the draft report to the Office of Internal Affairs' Allegation Investigation Unit manager for review and approval. The OIG evaluates the performance of locally designated investigators throughout this fact-gathering and reporting processes.

Locally Designated Investigators Performed Poorly in Conducting Unbiased Inquiries

The Department's Local Inquiries Are Compromised Because Hiring Authorities Do Not Consistently Assign Appropriately Ranked Investigators or Properly Evaluate Investigators for Potential Conflicts of Interest, Which Results in Bias

The department has an obligation to ensure its inquiry reports are unbiased.[8] In the OIG's January 2019 report on the department's processing of staff misconduct allegations at Salinas Valley State Prison, the OIG identified bias as an area of concern. Our review highlighted a problem with nonindependent staff who favored fellow staff and, at times, ignored the testimony of incarcerated people entirely. Although the department has attempted to implement safeguards to prevent bias, including requiring the assigned investigator to be at least one rank higher than the highest-ranking subject in the inquiry, we observed multiple instances where the department failed to abide by its own policy.

- In one case, two officers and a sergeant allegedly denied a shower to an intersex incarcerated person based on race, and because the incarcerated person requested to wear sweatpants during the escort to the shower. An officer also allegedly referred to the incarcerated person using an inappropriate term. The department assigned a sergeant to conduct the inquiry, a person with the same rank as one of the subjects of the inquiry.
- In another case, a lieutenant allegedly acted in a disrespectful and argumentative way toward an incarcerated person during a rules violation hearing. The assigned investigator was a lieutenant, which was the same rank as the subject of the inquiry.
- In a third case, a captain allegedly improperly allowed an incarcerated person to possess an electronic tablet while in a cell. When a second incarcerated person informed a sergeant about the situation, the sergeant said that he could not take any action because the captain had allowed it. The department assigned a lieutenant as the investigator; this investigator was one rank lower than one of the subjects of the investigation—the captain.
- In a fourth case, a lieutenant advised the OIG that he had been assigned to a temporary out-of-class position as a captain for the purpose of completing local inquiries

8. An AIU manager shall review the draft Allegation Inquiry Report, and supporting exhibits, to determine whether the Allegation Inquiry is sufficient, complete, and unbiased. CCR, Title 15, section 3486.2(c)(4)(A).

because no captains in the prison volunteered to complete local inquiry work.

The department has promulgated a conflict-of-interest review and acknowledgment for its Office of Internal Affairs' investigators, but it does not require the same review and acknowledgment for investigators conducting local inquiries. The department's Office of Internal Affairs has a conflict-of-interest review process that requires its investigators to consider whether there might be an actual or potential conflict of interest and requires investigators to be recused from conducting the investigation if a conflict exists. The review process requires investigators to consider personal or professional relationships that would preclude their involvement in the investigation.[9]

A conflict-of-interest review and acknowledgment serves to prevent actual bias or the appearance of bias resulting from a personal or professional relationship between the investigator and a subject, witness, or complainant of the investigation. Despite the clear benefits of a conflict-of-interest review, the department does not require it for its local inquiries. During this review period, our office identified several cases in which a conflict of interest existed that could influence or appear to influence the investigator's judgment, and would warrant reassignment of the case to a different investigator. In some cases, the department agreed to assign a new investigator, but in others it declined.

- In one case, a lieutenant allegedly threatened to find an incarcerated person guilty at his forthcoming disciplinary hearing and then acted with prejudice by finding the incarcerated person guilty at the hearing. The hiring authority assigned an investigator who supervised the lieutenant and who classified the incarcerated person's rules violation report. The hiring authority did not assign a new investigator until the OIG identified the conflict and recommended that a new investigator without a conflict of interest be assigned to complete the inquiry.
- In a second case, a sergeant allegedly refused to address an incarcerated person's concerns about access to departmental services and activities and told staff she did not care about the needs of incarcerated people. The department reassigned inquiry responsibilities for this case twice because the first two investigators were current and former supervisors of the sergeant. The two initial

9. Possible sources of conflict of interest include: marital or family relationship with subject/victim/complainant; close personal relationship (past or present) with subject/victim/complainant; business relationship (past or present) with subject/victim/complainant; current supervisory or subordinate relationship with subject/victim/complainant; any other prior relationship which involved circumstances which might be agreed to have clouded judgment in this case (i.e., prior discipline, poor evaluations, complaints filed by or against the subject/victim/complainant.

investigators did not recognize the conflict of interest until the issue was raised by the OIG.

- In a third case, an officer allegedly acted discourteously toward an incarcerated person and refused to provide the incarcerated person with canteen issue. During an initial consultation with the OIG, and in reference to the officer, the investigator made the statement, "I know these guys," which seemed to suggest that the investigator did not believe the officer had committed misconduct based on bias toward the officer.

In the examples above, the department could have independently identified and addressed the conflicts had the investigator been required to conduct a conflict-of-interest review. Despite the OIG's recommendation that the department's locally designated investigators adopt the Office of Internal Affairs' conflict-of-interest review procedures and acknowledgment form already in use as a no-cost solution, the department refused to implement the safeguard and refused to provide an acceptable reason.

Recommendation

The OIG recommends the department require locally designated investigators to complete a conflict-of-interest review and acknowledge that they do not have an actual or potential conflict of interest before an inquiry begins. The OIG recommends the department adopt its already-existing conflict-of-interest form, used by the Office of Internal Affairs.

The Department Refuses to Audio-Record Interviews, Which Results in the Loss of Evidence Vital to the Investigators, the Office of Internal Affairs' Allegation Investigation Unit, and the Hiring Authority

The department directs locally designated investigators not to audio-record interviews. On December 7, 2022, the department issued a memorandum to wardens, investigators, and the department's Office of Grievances that stated, in part, "[i]nterviews will not be recorded by the LDI unless the employee (subject or witness) elects to record the interview."

Our 2022 annual report described several of the many benefits that result from recording interviews. Recording allows the investigator to focus on the interview, the interviewee's responses, and formulating supplemental or clarifying questions. Recordings also provide a valuable tool to assist investigators when they prepare their draft inquiry report, which may not be written until weeks or months after the interview occurred. Recordings also provide the hiring authority with an important source of evidence to consult when making its determination and finding for each allegation of staff misconduct. Similarly, if a local inquiry is transferred to the Office of Internal Affairs' Allegation Investigation Unit for an investigation, the investigator who inherits the case can review previously recorded interviews to obtain an understanding of the evidence collected through interviews and develop an appropriate plan to complete the investigation.

Our report also recommended that locally designated investigators audio-record all interviews. However, the department rejected our recommendation and responded, in part:

> Audio-recording interviews is an investigative technique utilized by [The Office of Internal Affairs] during the formal investigative process. The [locally designated investigation] process is to complete an inquiry into all the facts behind an allegation and forward the facts on an inquiry report to the Hiring Authority (HA) for a determination.

The department's position is misplaced, fails to acknowledge the importance of its local inquiries, and creates an illusory distinction between local inquiries and "formal" investigations by the Office of Internal Affairs' Allegation Investigation Unit. Although the department may use the term "inquiry" to identify allegations of staff misconduct investigated by locally designated investigators, those investigators are nonetheless responsible for the collection of evidence and facts in a manner that enables the hiring authority to make an informed

decision about whether staff misconduct occurred. Both inquiries and investigations are equally tasked with the following:

> To ensure that allegations of staff misconduct toward an inmate or parolee are addressed and that allegation inquiries and investigations are sufficient, thorough, complete, and unbiased so a Hiring Authority can determine a finding for each allegation.

Accordingly, the purpose of formal investigations and inquiries is the same, and labeling them differently is based on a distinction without a difference. Allegations of less serious staff misconduct are still allegations of staff misconduct, and the department should not hinder its responsibility to fully investigate and preserve all relevant evidence related to such allegations. Moreover, preserving evidence by using audio-recordings fosters trust and accountability that investigators are accurately documenting the statements of witnesses and staff accused of misconduct. Finally, the department's statement that the local inquiry process is simply to "forward the facts on an inquiry report" is inconsistent with the process in place. Investigators already attach documentary and video evidence as exhibits to their inquiry reports. The department has not provided a valid reason for not audio-recording interviews and attaching the recordings as exhibits.

During this reporting period we continued to observe problems that resulted from the department's ongoing refusal to equip locally designated investigators with audio-recording devices and require investigators to record interviews conducted in local inquiries. Below is an example:

- Three officers allegedly searched the cell of an incarcerated person and threw the incarcerated person's property around the cell, ripped the incarcerated person's bedsheets and clothing, and improperly confiscated the incarcerated person's medical equipment. The officers' actions were allegedly motivated by their frustration with the incarcerated person for being on a hunger strike. The investigator conducted three interviews, including interviews of the incarcerated person who submitted the complaint, a witness, and an officer who was the subject of the complaint, without recording them and without notification or coordination with the OIG. As a result, the OIG could not monitor the three interviews and, therefore, could not provide substantive feedback about the interviews. Failure to record the interviews also prevented the Office of Internal Affairs' Allegation Investigation Unit manager and the hiring authority from confirming whether the investigator's written summary accurately reflected the information elicited during the interviews.

The department remains steadfast in its position not to audio-record its interviews unless the witness first opts to audio-record the interview. The department has not provided and refuses to provide the OIG with a substantive reason why it refuses to audio record its interviews, an essential investigative resource that the department's own investigators in its Office of Internal Affairs utilize. The failure to audio-record interviews hinders the ability of the department's local investigators to accurately and completely document interviews with the specificity necessary for a hiring authority to have the confidence that all evidence has been presented to make final decisions on staff misconduct. The benefit of being able to rely on recorded interviews while preparing investigative reports is self-evident. Without recorded interviews, details, tone, and intonation are lost. Furthermore, at the time of the interview, investigators are understandably focused on writing down responses to interview questions rather than developing a natural flow to their questioning. This can lead to the failure to ask follow-up questions, which is fundamental to a thorough investigation.

Recommendation

The OIG renews the recommendation made in our 2022 annual report that locally designated investigators audio-record all interviews.[10]

10. ***Monitoring the Staff Misconduct Investigation and Review Process of the California Department of Corrections and Rehabilitation: 2022 Annual Report.***

The Department's Policy Regarding Video Retrieval Inappropriately Limits Investigators' Ability to Obtain Potentially Relevant Video-Recorded Evidence

Departmental investigators use video recordings as evidence in its local inquiries and attach them to their inquiry reports. However, the department has limited investigators' autonomy to identify relevant evidence by inappropriately allowing each prison's investigative services unit to dictate what it believes to be relevant footage, regardless of what the investigator requested.

The investigative services unit within each prison extracts and preserves all body-worn-camera and video-surveillance recordings requested by locally designated investigators and Office of Internal Affairs' investigators. However, departmental policy gives the investigative services unit the following authority:

> An LDI or OIA investigator requests two hours of AVSS [audio-video surveillance system] footage based on the written allegation they are investigating. During the review of the AVSS footage, ISU [the investigative services unit] identifies that the entirety of the incident occurs in a 15-minute period of the two hours requested.
>
> ISU will provide the 15 minutes of AVSS footage from the fixed cameras capturing the described event, BWC [body-worn-camera] footage from staff identified as subject(s) and witness(s), and any other AVSS footage that provides additional value or perspective to the described event. . . .

The department's decision to authorize investigative services units to determine what evidence is relevant to an incident inappropriately places the investigative services unit into the role of the investigator. The circumstances leading up to and following an incident often provide evidence and context relevant to an inquiry and can help the investigator formulate and execute an appropriate investigative plan. The department's policy diminishes the investigators' autonomy to complete these important tasks and unnecessarily impedes the investigators from completing a thorough inquiry and report. Below is an example demonstrating how the policy almost caused the destruction of evidence of misconduct.

- An officer allegedly refused to provide an incarcerated person with a new pair of sweatpants, which the incarcerated person had ordered to replace a previously stolen pair, and was unprofessional while speaking to the incarcerated person. The prison's investigative services unit

refused to provide the investigator with a comprehensive copy of the video evidence requested, and when the investigator followed up on the request, the investigative services unit informed the investigator that any video outside what had already been provided was irrelevant to the investigation. The investigative services unit also refused to produce a written denial of the investigator's request. Lastly, the investigative services unit disregarded the OIG's recommendation to produce the entirety of the video-recorded evidence to the investigator and instead informed the investigator that the OIG could submit a separate request for the video-recorded evidence. Ultimately, after the investigative services unit received additional training on the issue, the investigator received the video evidence originally requested. The additional video evidence resulted in the discovery of a policy violation by a second officer, which the hiring authority addressed through the issuance of corrective action in the form of an employee counseling record.

Recommendation

The OIG recommends that the department amend its policy to permit investigators the independence and authority to identify, obtain, and review all video-recorded evidence that they have determined to be potentially relevant to their inquiry.

Investigators Failed to Interview All Pertinent Witnesses and Identify Relevant Evidentiary Documents

An investigator's thoroughness in completing an inquiry is necessary in order for a hiring authority to conduct a fair review of an allegation of staff misconduct. Without a comprehensive inquiry, supported by all relevant evidence, the hiring authority cannot make a fully informed decision about the allegations. In more than one-third of the cases monitored by the OIG, we determined that investigators did not thoroughly and appropriately conduct the inquiry. This set of cases included those in which the investigator failed to complete all necessary and relevant witness interviews and failed to gather all relevant documentary or other evidence, among other considerations the OIG assessed.

In 19 percent of cases we monitored, the investigator either failed to independently identify or complete all necessary and relevant witness interviews. Below are some examples of cases in which the investigator failed to identify a key witness.

- In one case, an incarcerated person alleged that a correctional counselor told him that his housing assignment would not change, but then reassigned him to general population where the incarcerated person allegedly told four officers that he had safety concerns before he was assaulted by three other incarcerated people. After reviewing body-worn-camera evidence and noting conversation heard in the background, the OIG monitor recommended that the investigator interview an additional witness who was subsequently added as an additional subject to the inquiry.
- In a second case, an incarcerated person alleged that a lieutenant and two sergeants ordered multiple incarcerated people to undergo unclothed body searches in the presence and view of multiple other incarcerated people. The investigator did not interview the sergeant who gave the order for the unclothed body search until the hiring authority returned the investigation to the investigator with an instruction to complete the interview, based on the OIG's recommendation.
- In a third case, an incarcerated person alleged that an officer refused to allow him to shower after experiencing incontinence, and when the incarcerated person entered an alternate shower instead, the officer shut off the water. Despite an instruction by the Office of Internal Affairs' Allegation Investigation Unit manager to interview staff

and incarcerated person witnesses heard on the video evidence, the investigator did not do so and twice submitted an inadequate draft report to the Office of Internal Affairs' Allegation Investigation Unit manager for approval. The local inquiry was ultimately suspended and elevated to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

When investigators fail to interview all relevant witnesses, the hiring authority does not have a complete set of facts on which to base disciplinary decisions. When hiring authorities must request further interviews of obvious witnesses, delays in the disciplinary process ensue. Investigators should identify all pertinent witnesses and interview them in a timely manner.

In 35 percent of cases, investigators did not properly gather all relevant evidence. Some examples are found below.

- In one case, an incarcerated person alleged that two counselors failed to approve him for transfer to another prison and improperly denied him access to his mental health clinician during a classification committee hearing. The investigator failed to identify and include as exhibits, the departmental policies and procedures relating to incarcerated-person transfer due to mental health status.
- In a second case, an incarcerated person who identified as nonbinary and transgender alleged that after mistakenly agreeing to be housed with a second incarcerated person, the incarcerated person attempted to tell a sergeant that it was a mistake and requested to be housed with a different incarcerated person, to which the sergeant allegedly laughed and made unprofessional remarks. The investigator refused to obtain additional video evidence despite the OIG's suggestion that the body-worn-camera footage collected was incomplete, that it included only one of two relevant days, that it was cut off in mid-conversation between the incarcerated person and the sergeant, and that additional footage was available from the body-worn camera of another officer who was a witness and was present at the time of the incident. After reviewing the investigator's draft inquiry report by the Office of Internal Affairs' Allegation Investigation Unit manager, the manager instructed the investigator to obtain additional video evidence, but by that time the video evidence was no longer available due to the department's 90-day video retention policy.
- In a third case, an incarcerated person alleged that a supervising cook was observed resting his arm and shoes

on morning meal trays to be served to incarcerated people, and that the supervising cook had engaged in similar conduct previously. The investigator initially only requested 20 seconds of video evidence. When the OIG monitor recommended obtaining additional video evidence, the investigator declined and indicated there was no other relevant footage available, even though there was no record of the investigator having requested, obtained, or reviewed any additional video evidence. Ultimately, further video evidence was obtained. Moreover, the investigator's report failed to identify any applicable policies and procedures including those relating to proper food handling.

With the department's implementation of audio-video surveillance systems and body-worn cameras, video evidence is of paramount importance to any inquiry. In its monitoring, the OIG observed investigators failing to request video evidence in a timely manner even though video evidence is lost after 90 days under the department's video-retention policy. The OIG also observed investigators only reviewing narrow windows of video evidence, which precluded them from fully understanding the circumstances of the incident, and investigators failing to observe enough video evidence before concluding that an alleged event simply did not occur.

The Hiring Authority

Hiring Authorities Made Final Decisions That Were Inconsistent With Evidence

The hiring authority is responsible to review the allegation inquiry report, along with the evidence collected during the inquiry, and determine whether staff misconduct warranting corrective action occurred. Hiring authorities must make specific and accurate findings for each allegation of staff misconduct and implement corrective action when warranted. We found that hiring authorities made decisions that were inconsistent with the evidence in 20 percent of the cases we monitored. Some examples are found below.

- In one case, a control booth officer allegedly failed to secure an incarcerated person's cell door, which resulted in the theft of the incarcerated person's food items. Video evidence obtained during the investigation revealed that the control booth officer violated policy by opening and closing a cell door without the presence of a floor officer or supervisor. Video evidence also demonstrated that the control booth officer improperly opened a second cell door at the request of an incarcerated person who did not live in the cell. The control booth officer's actions potentially caused significant risk to the prison's safety and security and, therefore, should have been referred to the Office of Internal Affairs' Allegation Investigation Unit for investigation; however, the hiring authority refused to refer the potential misconduct. The hiring authority then improperly determined the investigation was sufficient and did not sustain the allegation even though the investigator had failed to ask the control booth officer questions about the officer's understanding of the policy governing the opening and closing of cell doors.
- In a second case mentioned earlier in this report, a supervising cook allegedly rested his arm and shoe on the morning meal trays used to serve food to incarcerated people, and on three prior occasions mishandled food trays in a similar manner. In this case, the investigator did not interview the supervising cook, and only reviewed two 20-second video recordings. The hiring authority failed to recognize that the inquiry report lacked relevant evidence and failed to return the report to the investigator with a request for additional relevant evidence. Instead, the hiring authority improperly deemed the inquiry adequate and found insufficient evidence to sustain the allegations.
- In a third case, an officer allegedly refused to follow local policy to double-lock an incarcerated person's handcuffs

during a cell search, and kept the incarcerated person handcuffed for more than two hours, thereby causing the incarcerated person's wrists to become red, swollen, painful, and numb for two days. The investigator documented in the inquiry report that the officer had admitted in the interview that he did not double-lock the handcuffs. The inquiry report also confirmed the officer's failure to double lock the handcuffs via video evidence. Despite two independent sources of evidence confirming the allegation, including the officer's own admission during an interview, the hiring authority improperly found insufficient evidence to sustain the allegation.

Recommendation

Hiring authorities should receive training on how to conduct thorough reviews of allegation inquiry reports and on departmental policy to ensure that they make proper staff misconduct determinations.

The Department Consistently Failed to Meet Its Own 90-Day Goal to Resolve Staff Misconduct Local Inquiries

On July 28, 2022, the department advised the OIG of its goal to have departmental staff resolve local inquiries within 90 days. Notably, although the department's Division of Adult Institutions and California Correctional Health Care Services operate with a shared goal of completing local inquiries within 90 days, the department's failure to provide clear policy direction regarding when the 90-day time frame begins has resulted in the Division of Adult Institutions and California Correctional Health Care Services using different start dates. The Division of Adult Institutions uses the date that the Centralized Screening Team receives a grievance, and the California Correctional Health Care Services calculates the start of its local inquiry process from the date the locally designated investigator is assigned to the case.

The OIG found that the department delayed completing inquiries in 42 of the 113 local inquiries we monitored, or 37 percent of the time. Delays were not necessarily limited to any particular point in the inquiry process. We observed delays by investigators, prison Office of Grievances, the Office of Internal Affairs' Allegation Investigation Unit, and the hiring authorities themselves. Although any one delay may not appear significant, multiple delays in the inquiry process can result in failure to meet the 90-day goal. This reporting period, the OIG only criticized the department for failing to meet its goal if the delays were well beyond the 90-day goal, and noted the department's failure to meet the goal if we found multiple deficiencies in the case. Below are examples of delays by investigators.

- An incarcerated person alleged that during an escort, officers failed to adhere to a special handcuffing provision that required the officers to use waist restraints rather than handcuffing the incarcerated person behind the back because handcuffing caused pain. The incarcerated person also alleged that the officers denied his request for medical aid. The investigator was assigned to conduct the local inquiry on June 22, 2022, but did not complete the first interview until September 16, 2022, 86 days later. Overall, 213 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority made a decision on the allegations.
- In another case, an incarcerated person alleged that a sergeant intimidated him during an administrative hearing by standing over him and kicking a wall. The investigator was assigned to conduct the local inquiry on March 24, 2023, but did not complete the first interview until May 18, 2023, 55 days thereafter. Overall, 123 days

elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority made a decision on the allegations.

- In a third case, an incarcerated person alleged that a sergeant hit a table and yelled at him during an interview after the incarcerated person had asked for an attorney, and that a lieutenant who was present did not report the sergeant's behavior. The investigator was assigned to conduct the local inquiry on November 2, 2022, but did not complete the first interview until January 22, 2023, 81 days thereafter. Overall, 226 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority made a decision on the allegations.
- In a fourth case mentioned earlier in this report, an incarcerated person alleged that an officer was verbally unprofessional and refused to allow the incarcerated person to replace a stolen pair of sweatpants with a new pair. The investigator completed the final interview on April 24, 2023, but did not submit the draft inquiry report to the Office of Internal Affairs' Allegation Investigation Unit for review until August 25, 2023, 123 days thereafter. Overall, 166 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority made a decision on the allegations.

The OIG also observed significant delays by other stakeholders. Below are some examples.

- In one case, an incarcerated person alleged that an officer failed to stop a second incarcerated person from taunting and insulting him, and the officer and a second officer verbally harassed the first incarcerated person and refused to rehouse him to a different housing unit. Although the investigator completed the inquiry report on August 29, 2023, the Office of Grievances did not forward the report to the Office of Internal Affairs' Allegation Investigation Unit for review until September 28, 2023, 30 days later. Overall, 142 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority made a decision on the allegations.
- In another case, an incarcerated person alleged that an officer violated policy by failing to double-lock the incarcerated person's handcuffs during a cell search, which resulted in an injury. The investigator submitted a revised draft inquiry report to the Office of Internal Affairs' Allegation Investigation Unit on December 12, 2022, but

the Office of Internal Affairs' Allegation Investigation Unit manager did not review and approve the report until March 1, 2023, 79 days later. Overall, 183 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority made a decision on the allegations.

- In another case mentioned earlier in this report, an incarcerated person alleged that an officer harassed and intimidated him by repeatedly walking past his cell, questioning him, making faces at him, and attempting to house a second incarcerated person with him despite his mental health condition. The hiring authority received the inquiry report on April 11, 2023, but did not make a decision until May 22, 2023, 41 days later. Overall, 144 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority made a decision on the allegations.

The OIG also observed delays that resulted from the need for multiple revisions to investigator inquiry reports. Below are some examples:

- In a case mentioned earlier in this report, an incarcerated person alleged that a correctional counselor had told him that his housing assignment would not change, but then reassigned him to general population, where the incarcerated person allegedly told four officers that he had safety concerns before three incarcerated people assaulted him. The investigator submitted the draft inquiry report to the Office of Internal Affairs' Allegation Investigation Unit for review on January 5, 2023, but the report was returned to the investigator five times for additional work. As a result, the hiring authority did not receive the final inquiry report until June 4, 2023, 150 days after the first draft of the report was submitted to the Office of Internal Affairs' Allegation Investigation Unit for review.
- An incarcerated person alleged that two officers opened his cell door while he was away, which resulted in his personal property being stolen. The incarcerated person also alleged that the officers failed to properly observe movement in the housing unit because they had been improperly browsing the internet and using their personal mobile phones. The first draft of the inquiry report was submitted to the Office of Internal Affairs' Allegation Investigation Unit for review on March 23, 2023. After being returned for further revisions three times, the hiring authority did not receive the final inquiry report until May 9, 2023, 47 days later.

The examples above illustrate the many points at which a local inquiry can become delayed, which precludes the timely processing of the

inquiry. These delays cause the most significant problems in cases in which the inquiry must be elevated for investigation to the Office of Internal Affairs' Allegation Investigation Unit. In these circumstances, delays could hinder the department from completing the investigation before the statutory deadline to take disciplinary action. Significant delays can also result in rushed investigations and witnesses' memories fading. Below is an example of a case involving a significant delay before the matter was elevated to the Office of Internal Affairs' Allegation Investigation Unit.

- An incarcerated person alleged that an officer used profanity toward him and placed him in a holding cell for 90 minutes without water or a restroom break. During the inquiry, the investigator discovered evidence of potential staff misconduct that could result in adverse disciplinary action. This discovery required immediate suspension of the local inquiry and elevation of the case to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. The investigator, however, did not submit the inquiry report to the Office of Internal Affairs' Allegation Investigation Unit, and identify the need to elevate the case until April 20, 2023, 71 days after the investigator learned of the need to do so.

Recommendation

The OIG recommends the department implement a policy requiring locally designated investigators and hiring authorities to complete the local inquiry process within 90 days of the date the Centralized Screening Team receives an allegation.

The Department Failed to Adequately Communicate With the OIG, Thereby Preventing the OIG From Performing Its Statutorily Required Monitoring Functions

In 41 of the 89 contemporaneously monitored local inquiries, or 46 percent of the time, the department failed to share information with the OIG that was necessary to complete monitoring activities related to the review and approval of inquiry reports, and the hiring authority's decision-making process. California law requires that the OIG provide contemporaneous oversight of the department's process for reviewing and investigating allegations of staff misconduct, including examining the department's compliance with regulations, departmental policy, and best practices. The department is obligated to share case information and documents, and keep the OIG apprised on the status of local inquiries so that the OIG could fulfill its statutory mandate.

The OIG has requested, and the department has verbally agreed, that each prison's local Office of Grievances would inform the OIG when a draft local inquiry report was completed and ready for review by an Office of Internal Affairs' Allegation Investigation Unit manager, and when the hiring authority made a final decision about the allegations. To ensure that the local Office of Grievances is aware when the OIG is monitoring a case, the OIG monitor sends a direct notification to the local Office of Grievances.

Unfortunately, in 2023, the department failed to adhere to its agreement and instead consistently prevented our office from performing critical monitoring activities. In one case, an incarcerated person alleged that two officers contaminated his food and drink when they searched both without wearing gloves, and that a sergeant improperly canceled the incarcerated person's family visit. After the investigator completed the draft inquiry report, the Office of Grievances failed to notify the OIG monitor that the draft report had been completed and forwarded to the Office of Internal Affairs' Allegation Investigation Unit for review, and then failed to notify the OIG monitor that the report had been sent to the hiring authority for a final decision. After not receiving any status updates for a period of time, the OIG monitor independently searched for the case status and learned that the hiring authority had already rendered a decision and that the case had been closed. The OIG had been denied the opportunity to review the draft inquiry report, in any form, and to provide feedback to the department. The OIG was further prevented from communicating with the hiring authority to provide recommendations about the sufficiency of the inquiry, the adequacy of the evidence obtained, and the hiring authority's decision. When the OIG asked why it was not provided with proper notice, the local associate warden advised that there was no requirement to do so, but advised that

"as a courtesy" we could request the status of the individual cases we are monitoring.

Because of the above interaction and the department's ongoing failures to notify the OIG of the progress of inquiry reports, the OIG has requested that the department memorialize in writing its prior verbal agreement of cooperation; nevertheless, the department has refused. Because departmental staff have not been directed in writing to communicate with the OIG as a policy requirement, some staff believe their communication with our office is merely a courtesy. This is incorrect. The department is required to share information necessary for compliance with legislative mandates before the information becomes stale. Unfortunately, the example above is not unique; the department's failures to communicate about inquiry reports and hiring authorities' determinations are pervasive.

Throughout this review period our office consistently reported to departmental executives during monthly meetings about the department's failure to communicate with us. We also provided the department with copies of our assessment of every local inquiry we monitored and closed during each month in the review period, which provided specific details about the department's failure to permit the OIG to perform its monitoring functions. In addition, our office activated an electronic mailbox that the department could use as a single source to share information related to monitored inquiries. The department proposed some possible solutions to the issue discussed above but declined to implement an interim procedure to address the issue until a permanent solution is developed. On November 15, 2023, the department notified us that they will use the OIG's electronic mailbox to update us on critical junctures in the inquiry process starting January 15, 2024. We are hopeful that the solution will resolve this long-standing impediment.

In contrast, California Correctional Health Care Services established a process to update the OIG at critical junctures, which has enabled us to effectively complete contemporaneous monitoring of inquiry reports and hiring-authority determinations. The California Correctional Health Care Services' Staff Misconduct Team notifies the OIG monitor via email when a draft inquiry report has been reviewed by the Office of Internal Affairs' Allegation Investigation Unit manager, thereby triggering the OIG's review of the draft report to provide both the investigator and manager with feedback and recommendations. The California Correctional Health Care Services' Staff Misconduct Team also recently agreed to inform the OIG monitor via email when the hiring authority has made its determination, but before the inquiry is closed, thereby alerting the OIG monitor to communicate with the hiring authority about the inquiry, if necessary. Although the OIG monitored only a small number of local inquiries related to allegations of staff misconduct by health care staff during this review period, the processes

that the California Correctional Health Care Services' Staff Misconduct Team implemented have proven useful thus far. The OIG has had the opportunity to timely review the inquiry reports and hiring-authority decisions related to complaints against health care staff. Therefore, it is clear that effective communication channels can be developed and administered to eliminate the significant failures in communication that we have observed during this review period.

Recommendation

The OIG recommends that the department develop, implement, and maintain a policy and process to require meaningful communication with the OIG during the course of each local inquiry to enable the OIG to perform its statutorily required monitoring activities. The OIG also recommends that the department hold employees accountable for failing to communicate with the OIG.

The Department Performed Worse in Cases We Did Not Contemporaneously Monitor

During this reporting period, the OIG implemented a new component to its monitoring by completing retrospective reviews of randomly selected local inquiry cases that had been completed and closed within the past year. The purpose of this new monitoring component is to assess the department's performance when the OIG had not provided contemporaneous monitoring. We found that the department performed poorly in these cases. The OIG reviewed and closed 24 retrospective local inquiry cases. Of those cases, the OIG rated the overall performance of the department as poor in 21 cases, or 88 percent, and satisfactory in three cases, or 12 percent. Our office found that the department performed significantly worse in most aspects of the local inquiries, including the most critical components of the process, when they were not being monitored by the OIG.

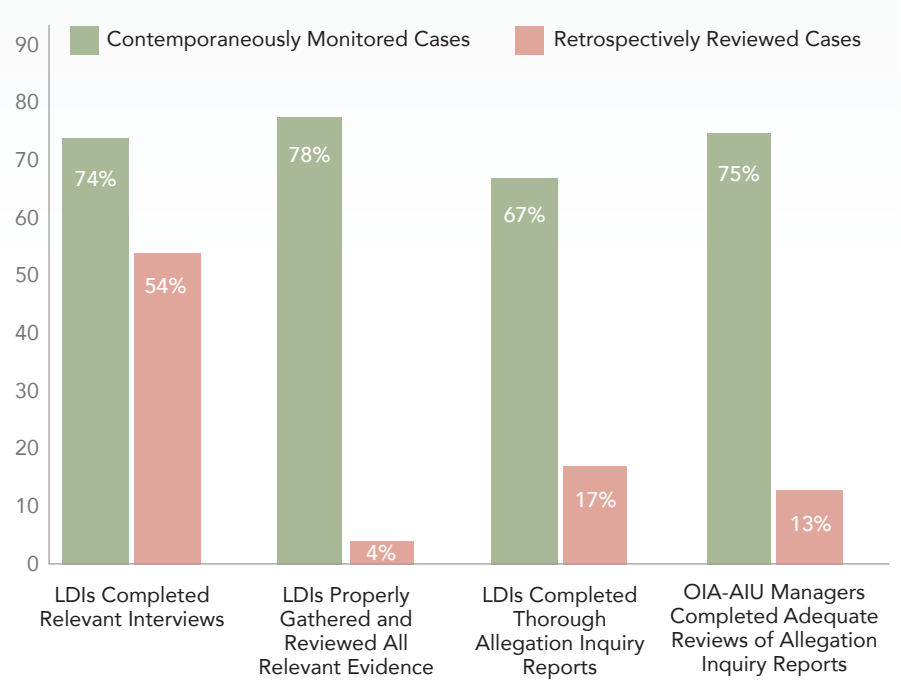
The OIG's retrospective reviews revealed that locally designated investigators failed to complete thorough inquiries and allegation inquiry reports at significantly higher rates when they were not being monitored by the OIG:

- Locally designated investigators completed all relevant interviews in 13 of 24 retrospective cases, or 54 percent. When monitored by the OIG, the locally designated investigators completed all relevant interviews in 66 of 89 cases, or 74 percent of the time.
- Locally designated investigators properly gathered and reviewed all relevant evidence in only one of 24 retrospective cases, or 4 percent. When monitored by the OIG, the locally designated investigators gathered relevant evidence in 69 of 89 cases, or 78 percent of the time. In almost every case in which the OIG negatively assessed this indicator, the locally designated investigator failed to identify or attach the relevant regulation, policy, or procedure that allegedly had been violated. In order to sustain a finding of misconduct, there must be a valid regulation, policy, or procedure in effect at the time and of which the staff was or should have been aware. In addition, an intentional violation of a known regulation, policy, or procedure may lead to adverse disciplinary action. Therefore, it is imperative that the investigator identify the regulation, policy, or procedure applicable to the allegation of misconduct.
- Locally designated investigators completed thorough allegation inquiry reports that included all relevant facts, evidence, and supporting exhibits in only four of 24 retrospective cases, or 17 percent. When monitored by

the OIG, the locally designated investigators completed thorough allegation inquiry reports in 60 of 89 cases, or 67 percent of the time.

Before allegation inquiry reports are sent to the hiring authority, the Office of Internal Affairs' Allegation Investigation Unit's managers are responsible to review all draft allegation inquiry reports to determine whether the allegation inquiry is sufficient, complete, and unbiased. The Office of Internal Affairs' Allegation Investigation Unit managers performed significantly worse in completing reviews of the allegation inquiry reports when the OIG did not monitor the inquiry. The Office of Internal Affairs' Allegation Investigation Unit managers completed an adequate review to determine whether the allegation inquiry report was sufficient, complete, and unbiased in only three of the 24 retrospective cases, or 13 percent. When monitored by the OIG, the Office of Internal Affairs' Allegation Investigation Unit managers performed satisfactorily in 67 out of 89 cases, or 75 percent of the time. The Office of Internal Affairs' Allegation Investigation Unit managers performance was most often determined to be poor because the manager who reviewed the allegation inquiry report approved the report despite the investigator's failure to identify the relevant regulation, policy, or procedure that allegedly had been violated.

Figure 3. The Department Performed Better in Cases That the OIG Contemporaneously Monitored



Source: The Office of the Inspector General Tracking and Reporting System.

Poor-quality local inquiries coupled with poor-quality manager reviews by the Office of Internal Affairs' Allegation Investigation Unit resulted in incomplete information being presented to the hiring authority. These deficiencies can result in the failure to appropriately hold staff accountable for misconduct. Our findings made through retrospective reviews underscore the department's inability to appropriately and thoroughly investigate allegations of staff misconduct in the local inquiry process when the OIG does not provide contemporaneous oversight.

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Overall, the Department Poorly Conducted Staff Misconduct Complaint Investigations and the Employee Disciplinary Process

In 2023, the OIG monitored and closed 121 staff misconduct investigations and the employee disciplinary process for those cases. The department completed 7,124 investigations in 2023. We assessed the overall performance of the departmental staff members responsible for the investigations and employee disciplinary process. For each case, we assigned one of three overall ratings: *superior*, *satisfactory*, or *poor*. The OIG found that of the 121 cases monitored and closed in 2023, the department performed poorly in 77, or 64 percent. The department performed satisfactorily in 44, or 36 percent, of the cases. The department did not perform in a *superior* manner in any cases.

The OIG's Staff Misconduct Monitoring Unit Investigations Monitoring Team consists of a group of seasoned attorneys with a broad range of experience in criminal prosecution, employment law, civil law, and other legal disciplines. Pursuant to Penal Code section 6126 (i), these OIG attorneys monitor the performance of departmental staff members who conduct investigations into staff misconduct allegations and handle the employee discipline process. These departmental staff members include investigators, department attorneys, and wardens.

The department maintains a list of the most serious staff misconduct allegations. This list is called the Allegation Decision Index. The Office of Internal Affairs' Allegation Investigation Unit investigates the department's most serious staff misconduct allegations as noted in the Allegation Decision Index. In turn, OIG attorneys monitor the most significant cases involving these allegations, including cases involving allegations that staff members were dishonest, used excessive force, retaliated against others, or engaged in sexual misconduct.

OIG attorneys monitored the performance of investigators, department attorneys, and wardens. We monitored cases from the start of investigations until the conclusion of the cases. If an investigation led to discipline of an employee, then our attorneys continued to monitor the employee discipline process until its conclusion.

We evaluated whether investigators conducted thorough and timely investigations. We assessed whether department attorneys provided appropriate and timely advice to investigators and wardens. We also analyzed whether department attorneys properly handled employee disciplinary cases, including any litigation stemming from employee disciplinary actions.

Moreover, OIG attorneys evaluated whether wardens 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.

The Office of Internal Affairs Conducted Mostly Poor Staff Misconduct Investigations

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

In 2023, the OIG monitored and closed 121 investigation cases. We found that Office of Internal Affairs' Allegation Investigation Unit investigators poorly conducted 71 investigations, or 59 percent of monitored investigations. We found that the Office of Internal Affairs' Allegation Investigation Unit investigators satisfactorily conducted 50 investigations, or 41 percent of monitored investigations. In no cases did an Office of Internal Affairs' Allegation Investigation Unit investigator perform in a *superior* manner. The Office of Internal Affairs' Allegation Investigation Unit received poor ratings primarily because its investigators conducted biased investigations, conducted incomplete investigations, used poor investigative techniques, and failed to ensure the confidentiality of investigations.

Some Office of Internal Affairs Investigators Conducted Biased Investigations

The OIG found that investigators displayed bias in 11 of the 121 cases it monitored and closed in 2023, or nine percent of investigations. The Office of Internal Affairs' Allegation Investigation Unit investigators displayed bias in many ways, but primarily by appearing to favor officers who were subjects of the investigations and by not conducting thorough investigations into misconduct allegations against fellow officers.[11]

One example in which investigators displayed bias was a case involving allegations that multiple staff members at a prison neglected their duty to keep incarcerated people safe. In that case, on November 30, 2022, a warden, a chief deputy warden, an associate warden, a captain, a sergeant, and four officers allegedly allowed 29 incarcerated people—who were armed with at least 15 weapons and a wooden cane—to stab, cut, and strike 12 unarmed incarcerated people who were members of a rival gang as they arrived at the prison for the first time. The unarmed incarcerated people sustained numerous stab wounds and broken bones. After the attack, departmental staff transported four of the newly arrived incarcerated persons to an outside hospital for medical treatment. An

11. In this context, the term *officers* means sworn peace officers. The investigators are sworn peace officers, just as some personnel working in the prisons, such as officers and sergeants, are sworn peace officers.

incarcerated person remained on life support for two weeks after the incident.

Before the 12 incarcerated people arrived at the prison, the warden had issued a written order that staff were to escort the newly arrived incarcerated people onto an exercise yard at the prison. An associate warden and a captain allegedly violated the warden's directive by ordering officers not to escort the newly arrived incarcerated people onto the yard.

On the day in question, officers "staged" themselves across the exercise yard, far from where the newly arrived incarcerated people would enter the yard. The officers stood up before the exercise yard gate opened, but they did not leave this location until it was too late to stop the 29 incarcerated people from quickly surrounding the 12 incarcerated people from a rival gang and attacking them.

The OIG first noticed bias or the appearance of bias in this case in the actions of the Office of Internal Affairs' Allegation Investigation Unit manager who oversaw the investigation. On March 23, 2023, investigators interviewed the captain who allegedly ordered officers not to escort the newly incarcerated people onto the exercise yard. The Office of Internal Affairs manager was present for the interview. At the conclusion of the interview, the captain who was a subject of the investigation attempted to shake hands with the Office of Internal Affairs manager, but the Office of Internal Affairs manager declined and insisted on hugging the captain instead. This took place in the room in which the interview occurred and in the presence of investigators and an OIG attorney.

Moreover, although the investigators conducted 40 interviews on 14 different days over the course of the investigation, the Office of Internal Affairs manager attended in-person interviews only on the day investigators interviewed the captain who was the subject of the investigation and whom she hugged after the interview. Despite the apparent overfamiliarity and conflict of interest, the Office of Internal Affairs manager did not remove herself from the investigation.

Secondly, the OIG detected bias during this investigation when an investigator asked multiple witnesses and subjects of the investigation whether the alleged misconduct even mattered. Specifically, an investigator asked both witnesses and subjects of the investigation to speculate about whether an escort by officers of the newly arrived incarcerated people would have made any difference in the outcome of the incident.

In a third example of bias in this case, the Office of Internal Affairs' Allegation Investigation Unit investigative team—two investigators, a manager, an associate warden, and a chief—all refused to add an officer and a sergeant as subjects of the investigation even though the evidence

reflected that both had committed misconduct. The OIG raised this issue with the Office of Internal Affairs deputy director. The deputy director agreed that the investigators should interview the officer and the sergeant as subjects, and also conduct additional relevant witness interviews. The investigators conducted the additional interviews. Following the investigation, the warden ultimately found that the officer had, in fact, engaged in misconduct and imposed discipline on the officer. This occurred despite the resistance of the investigative team to add the officer as a subject of the investigation.

The OIG found that investigators in other cases also displayed bias in favor of officers who were subjects of staff misconduct investigations. Here are additional examples:

- An officer allegedly slammed an incarcerated person to the ground and threatened to kill him. During an interview, the investigator told the officer that the investigator did not believe the officer's use of force was unreasonable.
- An officer allegedly punched an incarcerated person and pressed an elbow to the incarcerated person's throat. A second officer allegedly fractured one of the incarcerated person's ankles. The investigator stated to the OIG attorney he did not want to put the second officer through the "stress of being a subject of an investigation." The OIG attorney recommended that the investigator interview the second officer as a subject of the investigation. After the OIG's recommendation, the investigator conducted the interview.
- During an investigation into an allegation that an officer allegedly slammed an incarcerated person to a floor, the investigator did not want to conduct an interview of the officer who was the subject of the investigation about the officer's use of force because the investigator believed an interview would get the officer into more trouble than he was already in.
- An officer allegedly failed to follow procedures to decontaminate an incarcerated person who had been exposed to pepper spray. The investigator told the incarcerated person during an interview that the investigator did not believe the officer had violated policy.

Recommendation

The OIG recommends that the department require all members of an Office of Internal Affairs investigation team, including managers, to complete conflict-of-interest forms and recuse themselves from working on investigations in which they have a conflict of interest with—or bias for or against—any of the subjects or witnesses of an investigation.

Some Office of Internal Affairs Investigators Conducted Incomplete Staff Misconduct Investigations

During 2023, the OIG also observed that some investigators did not conduct thorough investigations. This failure took various forms, such as investigators deciding not to investigate certain aspects of allegations to investigators not conducting relevant interviews for investigations.

The department's operations manual tasks its investigators with writing sufficient, thorough, complete, and unbiased investigation reports.[12] Also, Penal Code section 6065(c) sets forth that "investigators shall conduct investigations and inquiries in a manner that provides a complete and thorough presentation of the facts regarding the allegation or complaint. All extenuating and mitigating facts shall be explored and reported. The role of the investigator is that of a fact finder. All reports prepared by an investigator shall provide the appointing authority with a complete recitation of the facts and shall refrain from conjecture or opinion."[13]

However, the investigators did not always perform investigations consistent with these requirements. For example, investigators told OIG attorneys that injuries were not relevant in use-of-force investigations. One of those cases in which investigators opined that injuries were not relevant involved allegations that two officers threw an incarcerated person to the ground and beat the incarcerated person with batons, causing the incarcerated person to suffer a laceration to the head and a collapsed lung. In a second case in which an investigator opined that injuries were not relevant, an officer allegedly fractured one of the ankles of an incarcerated person.

The investigators were incorrect in stating that injuries were irrelevant to these cases. Regulations require a warden to review the extent of an incarcerated person's injuries as part of a use-of-force evaluation.[14] Also, the department has guidelines for the imposition of employee discipline penalties. The guidelines reflect that injuries suffered by an incarcerated person in a use-of-force case are a factor for a warden to consider when deciding the level of penalty to impose on an employee; if the use of force was likely to cause serious injury, a higher level of penalty would be imposed.[15]

In addition to investigators not exploring important aspects of allegations, the investigators sometimes did not conduct relevant interviews. In 32 of the 121 investigations monitored by the OIG, investigators did not conduct relevant interviews; only did so after the

12. Department Operations Manual, Section Chapter 3, 31140.40, et seq.
13. For purposes of this report, an *appointing authority* is a warden.
14. CCR, Title 15, section 3268, et seq.
15. Department Operations Manual, Chapter 3, Sections 33030.17 to 33030.19.

OIG recommended the interviews; or completed an investigation without conducting any interviews at all.

In our report titled ***Monitoring the Staff Misconduct Investigation and Review Process of the California Department of Corrections and Rehabilitation***, published on May 24, 2023, we discussed that investigators failed to perform necessary interviews in 30 percent of the investigations we monitored in 2022. Despite our published findings, we observed a similar trend in staff misconduct investigations in 2023. In 26 percent of monitored investigations, investigators failed to perform necessary interviews or would not have done so without OIG recommendation. Furthermore, in six investigations we monitored and closed in 2023, the investigator attempted to close an investigation without interviewing anyone at all.

In one case, an investigator and his supervisor told the OIG attorney and the department attorney that the only reason the Office of Internal Affairs conducted any interviews during an investigation was to appease the OIG and the department attorney. The supervisor stated that the Office of Internal Affairs' Allegation Investigation Unit closes most of its investigations that include video footage without conducting any interviews.

The OIG followed up on this statement to determine how often the Office of Internal Affairs' Allegation Investigation Unit closed its investigations without conducting any interviews whatsoever. On January 4, 2024, the Office of Internal Affairs' Allegation Investigation Unit associate wardens, who are the program managers, advised the OIG that, of the 7,124 investigations completed by the Office of Internal Affairs' Allegation Investigation Unit in 2023, the Office of Internal Affairs' Allegation Investigation Unit closed 1,390 investigations, or 20 percent, without investigators conducting any interviews.

The Office of Internal Affairs' Allegation Investigation Unit allows its investigators to use a truncated version of its investigation report template to close investigations without conducting any interviews when an investigator summarily concludes video footage is dispositive of a staff misconduct allegation. The department has applied various names to these abbreviated reports. The department previously called this type of report a "video quick-close report." In our report published on May 24, 2023, we discussed at length the various reasons why the department should eliminate the use of video quick-close reports. The department did not eliminate them. Instead, in 2023, the department introduced a new name for this type of report: a "summarized investigation report."

The use of a summarized investigation report allows investigators to, in essence, assume the role of a warden and make conclusions as to the alleged staff misconduct. This is because the process allows for an

investigator to conclude that there is no staff misconduct and close a case without conducting any interviews whatsoever.

In these summarized investigation reports, the investigator simply summarizes his or her review of the video footage. However, a warden is tasked with independently reviewing all evidence that investigators collect during an investigation, including any video footage. When an investigator submits an investigation report to a warden that only includes a statement regarding an investigator's review of video evidence—evidence which a warden is also obligated to independently review—the investigator does not provide the warden with any substantive investigatory information and fails to fulfill the important objective of providing a thorough and complete investigation report to a warden.

Recommendation

The OIG recommends that the department eliminate the use of summarized investigation reports which allow investigators to close staff misconduct investigations without conducting any interviews.

Office of Internal Affairs Investigators Failed to Secure Video Evidence in Some Investigations

As we reported in our 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 implemented the use of body-worn cameras and audio-video surveillance systems at some prisons. In 2023, the department expanded its use of video recording devices, thereby creating video-recorded evidence for use in an increasing number of staff misconduct investigations.

Departmental policy requires that video recordings be retained for a period of 90 days. The department destroys video recordings after 90 days unless a *triggering event* exists which requires the recording to be retained for a longer period. Some 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.

However, even with a policy requiring video recordings to be held for longer than 90 days in certain cases, the department's policy for the retention of video recordings proved to be inadequate to guarantee the availability of video-recorded evidence for all staff misconduct investigations. In 2023, the OIG monitored eight staff misconduct cases in which the department destroyed recordings after the minimum retention period of 90 days.

Factors that contributed to the investigators' failure to obtain video recordings as evidence for investigations included delays by the Office of Internal Affairs in the assignment or reassignment of investigators, delays by investigators in conducting interviews, and the decisions of individual investigators to affirmatively not collect video recordings as evidence.

For example, in one case, on August 4, 2022, the Office of Internal Affairs' Allegation Investigation Unit assigned an investigator to investigate a staff misconduct allegation received on July 15, 2022, regarding alleged misconduct that occurred on July 14, 2022.[16] The investigator failed to submit a timely request for video-recorded evidence within the 90-day retention period. On November 17, 2022, the Office of Internal Affairs' Allegation Investigation Unit reassigned the case to a second investigator. When the second investigator submitted a request for video recorded evidence, a warden denied the investigator's request for the footage due to the amount of video footage the investigator requested and directed the investigator to conduct an interview of the incarcerated person who submitted the complaint to narrow down the request for video footage. The second investigator interviewed the incarcerated person on December 15, 2022, but by the time the investigator narrowed the scope of his request, the department had already destroyed the video recordings.

In another case, on May 19, 2023, the department received an allegation that an officer entered an incarcerated person's cell and touched the incarcerated person's genitals every two days between April 7, 2023, and May 19, 2023. On June 5, 2023, the Office of Internal Affairs' Allegation Investigation Unit assigned an investigator to the case and, on July 3, 2023, reassigned the case to a different investigator. The second investigator did not conduct the first interview for the investigation until August 7, 2023, more than 90 days after the majority of the alleged incident had occurred. Despite repeated recommendations from the OIG to timely obtain relevant video-recorded evidence, the investigator failed to obtain any video-recorded evidence before the department destroyed the recordings.

The OIG also found that even when investigators had the opportunity to request the video recordings within 90 days of an incident, they did not always do so. For example, in one case, an investigator failed to obtain video recordings before the end of the retention period even though the investigator received the case assignment on May 13, 2023, and the 90-day retention period did not end until August 2, 2023. In this case, an incarcerated person alleged that two officers spread confidential information about him to others. The incarcerated person stated that the incident occurred on May 4, 2023, and another incarcerated person specified a 45-minute time frame and date on which he allegedly heard

16. Some of the cases the OIG monitored and closed in 2023 were opened by the Office of Internal Affairs in 2022, but not concluded until 2023.

an officer sharing confidential information about the incarcerated person. Despite the opportunity and information to secure video footage as evidence, the investigator failed to do so.

Recommendation

The OIG recommends that the department expand its video-recording retention policy by increasing the minimum retention time for all recordings to one year to ensure that relevant video-recorded evidence is available for staff misconduct investigations.

Office of Internal Affairs Investigators Used Poor Investigative Techniques When Using Video Evidence in Investigations

As noted above, the OIG monitored some staff misconduct investigations in which an investigator had video evidence available for the investigation. However, investigators at times conducted interviews of officers—as subjects or witnesses—in which the investigator failed to establish the officer's independent recollection of an incident before showing the officer the video recording. This is a poor practice.

First, showing a video to an officer before independently questioning the officer about an incident does not allow an investigator to accurately determine the information the officer independently remembers about the incident. Second, doing so can create a new perception of an incident that the officer did not have before viewing the video. For example, when viewing the video, an officer may observe the incident from a different angle which contradicts what the officer experienced or saw during the incident. Third, review of video evidence before questioning gives a dishonest officer an advantage because the officer can tailor answers to questions to align with the video evidence.

In 2023, the department agreed with the California Correctional Peace Officers Association to allow officers who are subjects of an investigation to review their body-worn-camera footage with their representative present before any interview occurs. As such, investigators now allow officers who are subjects to view their video recordings before requiring officers to answer any questions related to allegations of staff misconduct. This agreement precludes an investigator from accurately determining a subject officer's independent recollection of an incident.

In a separate but related issue, the OIG found that investigators did not properly identify which video recordings, and which portion of those recordings, investigators presented to subjects or witnesses during interviews. In four cases monitored by the OIG, investigators failed to document which portion of a video file an investigator shared with a witness during the interview. This is problematic. First, a warden who reviews the audio recording of the interview has no record of which portion of the video the witness referred to when answering questions.

Second, when an officer makes an important statement about video evidence during an interview, but there is no record of which portion of the video the officer is referencing, the officer's statements cannot be used to impeach the officer should the case result in litigation. For example, during an audio-recorded interview in an OIG-monitored investigation, the investigator not only failed to note which video file the investigator presented to the witness, but also failed to note which portion of the video recording the investigator presented to the witness.

Recommendations

The OIG recommends that investigators determine the independent recollection of a witness before presenting him or her with video evidence.

The OIG recommends that, during recorded interviews, Office of Internal Affairs investigators properly document which video file and which portion of the video file—including a time stamp—the investigator presents to the subject or witness during an interview.

Office of Internal Affairs Investigators Failed to Ensure the Confidentiality of Investigations

The OIG found investigators failed to maintain confidentiality in 22 of the 121 investigations, or 18 percent, that the OIG monitored and closed in 2023. In prior reports,[17] the OIG reported on the issue of investigators compromising the confidentiality of investigations pertaining to staff misconduct allegations.

When an investigator compromises an investigation's confidentiality, this impairs the integrity of the overall investigation and potentially jeopardizes the safety of the incarcerated person who filed the complaint. Compromised confidentiality of investigations can also lead to the following outcomes:

- Staff or incarcerated persons may retaliate against the complaining incarcerated person,
- Witnesses may be perceived as not credible, or
- Complainants may ultimately lose confidence in the investigation.

17. See the following OIG reports: ***Special Review of Salinas Valley Prison's Processing of Inmate Allegations of Staff Misconduct***, published January 6, 2019; ***The California Department of Corrections and Rehabilitation's Processing of Disabled Incarcerated Persons' Allegations of Staff Misconduct at the Richard J. Donovan Correctional Facility***, published March 1, 2022; and ***Monitoring the Staff Misconduct Investigation and Review Process of the California Department of Corrections and Rehabilitation***, published May 24, 2023.

In nine of the 22 investigations in which investigators did not take adequate measures to ensure the confidentiality of the investigations, investigators failed to ensure that they conducted interviews in a confidential setting. For example, in one case, an investigator conducted a virtual interview of a witness. A child of the witness interrupted the interview. Furthermore, in six cases, investigators failed to maintain confidentiality of the interview room by allowing either prison staff or incarcerated people to enter the interview room and interrupt the interview.

Aside from investigators not conducting interviews in confidential settings, investigators compromised the confidentiality of investigations in different manners. For example, while conducting during a virtual conference with a department attorney and an OIG attorney about a staff misconduct investigation, an investigator discussed the pending confidential investigation even though one of the investigator's family members was present in the background. The department attorney advised the investigator to require that the family member leave and to only discuss the investigation in a confidential setting.

In a related issue, the OIG found that, in 16 cases, investigators failed to inform witnesses of the need to maintain the confidentiality of the investigations. For example, in one case, an investigator took a break during an interview of an incarcerated person, but failed to direct the incarcerated person, who was a witness in the investigation, to not discuss the case and to maintain the confidentiality of the investigation. During the break, prison staff seated the incarcerated person, who was a witness in the investigation, next to the incarcerated person who had filed the staff misconduct complaint. The two incarcerated people then proceeded to discuss the investigation.

In another case, an investigator attempted to conduct a virtual interview of an incarcerated person who had filed a staff misconduct complaint. The investigator refused to conduct the incarcerated person's interview in person. Instead of traveling to the prison for an in-person interview, the investigator asked prison staff to coordinate a virtual interview.

The incarcerated person who filed the complaint was in a holding cell. There were other incarcerated people in nearby holding cells. In the presence of the other incarcerated people, a sergeant announced to the incarcerated person that it was time for his interview with the Office of Internal Affairs regarding his complaint against prison staff. The incarcerated person declined to participate in the interview. Even though incarcerated people who file complaints or submit to interviews with law enforcement are viewed negatively by other incarcerated people and are subject to being attacked, the sergeant made the announcement in the presence of other incarcerated people, thus potentially placing the incarcerated person at risk and dissuading the incarcerated person from participating in the interview. The department captured the sergeant's

announcement on video and the investigator subsequently reviewed the video. Nevertheless, the investigator refused to attempt to interview the incarcerated person in a safe and confidential setting. Instead, the investigator closed the investigation without interviewing the incarcerated person.

Recommendation

The OIG recommends that the Office of Internal Affairs conduct interviews in confidential settings. The OIG recommends that the Office of Internal Affairs investigators order subjects and witnesses to maintain the confidentiality of investigations while investigations are pending.

Department Attorneys Performed Poorly in Nearly 50 Percent of Staff Misconduct Cases Monitored by the OIG

During the 2023 reporting period, the OIG monitored 121 staff misconduct investigation cases and the employee disciplinary process. Of the 121 OIG-monitored staff misconduct cases, the department assigned an attorney to 68 of the cases.[18] The department attorneys were responsible for handling a case from an investigation to the conclusion of any resulting employee disciplinary process. We assessed how well department attorneys provided legal advice to investigators and to wardens. We also evaluated the performance of the department attorney in litigating employee disciplinary actions.

We found that department attorneys performed poorly in 32 cases, or 47 percent of investigations in which the department assigned an attorney to the case. We found that in 36 cases, or 53 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 2023

In 2023, the OIG monitored 121 staff misconduct cases. The department assigned an attorney to 68 of the 121 cases. Of these 68 cases, wardens imposed discipline in only eight of the cases, or 12 percent. Of the eight cases, department attorneys drafted a disciplinary action in seven cases. In an eighth case, the hiring authority sustained an allegation, but imposed only corrective action, not disciplinary action. Of the seven cases in which the department attorney drafted a disciplinary action, six officers filed appeals to the State Personnel Board. The department attorneys settled all six cases for either a lesser penalty, early removal of the disciplinary action from a subject's official personnel file, or both. Because the department entered settlements on all the appeals, they did not present an evidentiary hearing before the State Personnel Board.

Between January 1, 2023, and December 31, 2023, the department assigned its attorneys to 735 staff misconduct complaint cases. Of the 735 cases, a warden imposed discipline on an employee in only 69, or 9 percent, of the cases. Of the 69 cases in which a warden imposed disciplinary action, 32 of the disciplined employees filed an appeal with the State Personnel Board. The department settled 23 cases, or 72 percent, of those 32 appeals. In 2023, department attorneys conduct no

18. In the remaining 53 monitored cases, the department did not assign an attorney to the case. During the investigation of these cases, the investigator did not have an attorney assigned to provide advice regarding investigatory issues or regarding the investigation report. In addition, a nonattorney, known as an employee relations officer, litigated any resulting employee disciplinary action.

evidentiary hearings regarding staff misconduct complaint cases before the State Personnel Board.[19]

Department Attorneys Provided Incorrect or Poor Advice in Almost One-Third of All Monitored Cases

The OIG monitored and closed 121 staff misconduct cases in 2023. The department assigned an attorney in 68 of the 121 cases. Department attorneys are assigned to provide legal consultation to investigators and to wardens. The OIG found that department attorneys provided poor advice to investigators about investigations and to wardens regarding investigations or disciplinary findings, or both, in 22 of the 68 cases, or 32 percent. Four cases involved poor advice on both investigation issues and incorrect advice on investigation and disciplinary findings.

In 12 of the 68 monitored cases, department attorneys failed to provide appropriate advice to an investigator concerning an investigation. Department attorneys failed to advise investigators to collect relevant evidence, such as medical documents and video recordings, or to interview key persons with knowledge of an allegation.

For example, in one case, an officer allegedly utilized a leg flip to throw an incarcerated person to the ground, causing the incarcerated person to lose consciousness after his head hit a wall. While the incarcerated person was on the ground, a second officer allegedly applied pressure to the incarcerated person's right elbow, causing a laceration requiring sutures. The department attorney failed to advise the investigator to interview several staff witnesses who were present during the alleged incident. The department attorney failed to advise the investigator to obtain additional medical documentation about the extent of the injuries the incarcerated person suffered during the incident. The department attorney failed to advise the investigator to include information about the extent of the injuries in the investigation report. The department attorney later inappropriately advised the warden to find the investigation to be sufficient even though the Office of Internal Affairs investigator failed to interview relevant witnesses and did not include important information about the extent of the incarcerated person's injuries in the investigation report.

In 14 of the 68 monitored cases, the department attorney advised a warden to make incorrect investigation and disciplinary findings. A warden must decide which one of five findings is appropriate for each staff misconduct allegation. In 14 of the 168 monitored cases, the department advised a warden to make incorrect investigation and disciplinary findings. A warden must decide which one of five findings is appropriate for each staff misconduct allegation: no finding, not sustained, unfounded, exonerated, or sustained.

19. As of the publication of this report in 2024, the remaining nine cases are pending.

In one case, an officer allegedly retaliated against an incarcerated person by confronting him about his submission of a declaration on behalf of another incarcerated person's sexual assault complaint. The officer allegedly conspired with a second officer and a sergeant to prohibit the incarcerated person from reporting the misconduct. The investigation revealed that the officer confronted the incarcerated person about submitting a declaration, but there was not enough evidence to prove the officer's intent. The department attorney advised the warden to find the officer's alleged act of retaliation to be justified, lawful, and proper. The department attorney's advice was incorrect because retaliation is never justified, lawful, or proper. There was insufficient evidence for the warden to make that finding.

In the same case, the department attorney also incorrectly advised the warden to find that the remaining allegations conclusively did not occur. The department attorney's advice was incorrect because there was some evidence to support the incarcerated person's claims. When there is some evidence, but not enough to prove or disprove an allegation, the appropriate determination is a finding of not sustained. Therefore, the department attorney should have advised the warden to find that there was not enough evidence to prove the allegations.

In another case, four officers allegedly kicked an incarcerated person and broke three of his ribs. The four officers allegedly allowed other incarcerated people to assault the incarcerated person. The incarcerated person suffered a concussion and lacerations to his head. The Office of Internal Affairs assigned an investigator to investigate the allegations. However, the investigator failed to conduct any interviews, failed to identify the officers involved, and failed to indicate whether there were medical records that corroborated the incarcerated person's injuries. The department attorney advised the warden to find that the investigation conclusively proved that the misconduct did not occur. The department attorney's legal advice was poor because the investigator conducted an incomplete investigation, and therefore, a finding that the investigation conclusively proved that the misconduct did not occur was an inappropriate finding.

Prison Wardens Performed Poorly in Half the Staff Misconduct Cases Monitored by the OIG

The OIG monitored the performance of wardens from the time a warden received an investigation report from the Office of Internal Affairs until the conclusion of the employee disciplinary process. In 2023, the OIG monitored 121 staff misconduct cases. We found that wardens performed poorly in 61 of the 121, or 50 percent, of the cases. We found that in 60 of the 121 cases, or 50 percent, wardens performed satisfactorily. Wardens did not perform in a *superior* manner in any cases. Wardens received poor ratings primarily because they made poor findings on the staff misconduct cases, delayed in making findings, or engaged in poor record-keeping in the department's staff misconduct database.

Wardens Made Poor Findings in Many Staff Misconduct Cases

After a warden received an investigation report from the Office of Internal Affairs, the warden reviewed the report and made findings on the staff misconduct allegations. The OIG found that wardens made poor findings in 23 of 121 cases, or 19 percent, that the OIG monitored. Wardens made poor findings concerning whether the Office of Internal Affairs conducted sufficient investigations and whether to sustain staff misconduct allegations.

For example, in one case, an officer allegedly struck an incarcerated person multiple times with a baton in the back of the head and on his back near the spine. The incident occurred while the officer responded to a fight between two incarcerated people. The officer acknowledged that he used a Monadnock[20] baton to strike one of the incarcerated people.

The officer described holding the baton with both hands and using a downward motion to strike the incarcerated person's back twice. The baton hit the lower scapula shoulder area toward the right side of the incarcerated person's back. The officer reported that he was confident the incarcerated person did not move as the officer prepared to deploy the baton strike to the incarcerated person's back. Another officer photographed the incarcerated person's back shortly after the incident on the same day. The photograph showed red bruising on the incarcerated person's back where the officer struck him with the baton.

The top portion of the red bruising is located on the spine, and the remaining portion of the red bruising is slightly to the right of the spinal area. The shape of the bruising is consistent with a baton strike.

20. This is a type of expandable baton. Correctional peace officers carry expandable batons while on duty and are authorized to use them with reasonable force to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.

Departmental policy and training pertinent to using a baton prohibits strikes on the head, neck, and spine, which are deemed "red zones." Departmental policy considers strikes to those areas as deadly force.

Because sufficient evidence substantiated that the officer struck the incarcerated person with a baton in the spinal area, which could have resulted in serious bodily injury, the warden should have imposed disciplinary action on the officer for his unreasonable use of force. However, the warden did not sustain the allegation against the officer.

The warden's finding was so unreasonable that the OIG requested that the warden's manager review the warden's finding. The warden's manager also determined that there was insufficient evidence to sustain the allegation against the officer. The OIG disagreed with both the warden and his manager's decisions not to sustain the allegation because the investigation revealed sufficient evidence to prove that the officer used unreasonable force when he struck the incarcerated person with a baton.

In another example of a warden making inappropriate findings, two officers allegedly slammed an incarcerated person against a wall and to the floor, causing a laceration to the incarcerated person's left eyebrow. One of the officers allegedly held the incarcerated person down with his right knee on the incarcerated person's neck and struck the incarcerated person with a baton on the head.

The investigation revealed that officers used force to bring the incarcerated person to the ground to restrain him after he resisted and refused to submit to handcuffs. The incarcerated person landed on his back, and the officers attempted to roll him onto his stomach. During the officers' attempts to place the incarcerated person in handcuffs, and while the incarcerated person was lying on his left side, an officer placed his right knee on the incarcerated person's neck to push him to roll onto his stomach. Once the incarcerated person was on his stomach, the officer continued to push his right knee on the incarcerated person's neck even though other officers were holding the incarcerated person down with their collective body weight.

The officer then moved over to the incarcerated person's right side, pulled out his baton, and struck the incarcerated person on the head with the baton. A body-worn-camera recording showed one of the other officers telling the officer to put away the baton. There was no need to use the baton because enough officers were present and near the incarcerated person to restrain him.

The officer used unreasonable force by placing one of his knees on the incarcerated person's neck and striking the incarcerated person with a baton while the incarcerated person was lying on his stomach. Three other officers were already using the collective weight of their

bodies to subdue the incarcerated person, who was lying face down, and proceeded to place him in handcuffs. There was no imminent threat to the officers' safety. Therefore, the warden should have found misconduct and sustained the allegation against the officer who had placed a knee on the incarcerated person's neck and struck the incarcerated person with a baton.

Instead, the warden improperly found that there was insufficient evidence to sustain the allegations against the officer and misapplied the department's use-of-force policy to allow an officer to use any type of force in any interaction with an incarcerated person. The warden improperly concluded that if the use of force was justified, an officer could not be judged for the tool used. The warden also improperly determined that there was insufficient basis to add an allegation against the officer for using his baton because the department's use-of-force policy does not specify a best-tool requirement when using force.

Wardens Delayed Investigative and Disciplinary Findings Conferences

The OIG found that wardens delayed in making findings and conclusions on staff misconduct cases. We observed that wardens delayed conducting an investigative and disciplinary findings conference in 63 of 121, or 52 percent, of staff misconduct cases the OIG monitored in 2023.

After a warden received an investigation report from the Office of Internal Affairs, the hiring authority was required to make findings on the investigation and the allegations in a timely manner. A warden meets with other personnel to discuss the case and makes findings on whether the investigation was sufficient, whether to sustain the staff misconduct allegations, and the appropriate disciplinary penalty. This is called an investigative and disciplinary findings conference (hereinafter "findings conference"). Department Operations Manual, Section 33030.13, states the following:

> As soon as operationally possible, but no more than fourteen (14) calendar days following receipt of the final investigative report, the Hiring Authority shall review the investigative report and supporting documentation. The Hiring Authority shall consult with the Vertical Advocate, for all designated cases, and the SAIG, for all cases monitored by the BIR when reviewing the investigation and making investigative findings.[21]

21. The "BIR" is the former Bureau of Independent Review. This was a unit of OIG attorneys who monitored Office of Internal Affairs investigations and the employee disciplinary process. OIG attorneys from the following teams are currently assigned to these responsibilities: the Staff Misconduct Monitoring Unit, Investigations Monitoring Team, and the Discipline Monitoring Unit. A "SAIG" is a Special Assistant Inspector General, an OIG attorney classification.

Some departmental personnel previously opined that the above policy only requires a hiring authority, such as a warden, to *review* the materials within 14 days but does not necessarily require the warden to *conduct* the findings conference within 14 days of receipt of the investigation report. The OIG disagrees with this interpretation. The OIG's position is that a warden is required to conduct the findings conference within 14 days of receipt of the investigation report.

Given the difference in interpretations, the OIG has recommended that the department clarify its policy to more clearly reflect when a warden must conduct a findings conference. The OIG has made this recommendation in previous multiple reports.[22]

On June 1, 2020, in response to the OIG's recommendation, the department responded that it would articulate a clear deadline for a hiring authority, such as a warden, to conduct the findings conference in the next revised version of the Department Operations Manual. However, the department did not do so. The department published its latest version of the Department Operations Manual, effective January 1, 2023, which includes the same section quoted above with no changes. The department did not clarify its position despite its stated intention to do so.

The OIG found that in 2023 wardens routinely delayed conducting findings conferences in staff misconduct cases. The OIG found that hiring authorities delayed holding findings conferences by the number of days or months noted below:

- Wardens delayed conducting findings conferences for more than 14 days in 111 of 121 investigations, or 92 percent of cases.
- Wardens delayed conducting findings conferences for more than 30 days in 63 of 121 investigations, or 52 percent of cases.
- Wardens delayed conducting findings conferences for more than three months in 13 of 121 investigations, or 11 percent of cases.

In one example, a warden did not make findings on an investigation until six months and 27 days after receipt of the investigation report from the Office of Internal Affairs. When the warden finally made findings, she

22. For example, see the OIG report titled ***Monitoring the Internal Investigations and Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, Semiannual Report January–June 2019)***, published November 25, 2019, pages 52–57, and page 77; the OIG report titled ***Monitoring Internal Investigations of the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, Semiannual Report July–December 2019***, published June 5, 2020, pages 39–41, and page 57; and the OIG report titled ***Monitoring Internal Investigations of the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, Semiannual Report July–December 2020***, published December 10, 2020, pages 40–42, and page 67.

stated that she did not believe the investigator conducted a sufficient investigation. However, there was not enough time left to conduct further investigation because the deadline for taking disciplinary action was in 28 days of the conference. As a result, the warden determined that no misconduct had occurred based on an insufficient investigation.

When a warden delays conducting findings conferences, it can put an unnecessary strain on subjects of investigations, incarcerated people, parolees, and witnesses. In cases in which staff misconduct complaints lack merit, there is no need for subjects of the investigations to endure the undue stress of an unresolved investigation for long periods of time.

Likewise, in cases in which staff misconduct complaints have merit, officers who committed misconduct against incarcerated people or parolees may continue to interact with those individuals, and with witnesses of the misconduct, for extensive periods of time. These circumstances may provide opportunities for retaliation against those who filed the complaint. Furthermore, delays in conducting the investigative and disciplinary findings conference often compound existing conflicts and allow further misconduct to be committed.

Recommendation

The OIG recommends that the department issue a specific policy concerning the time frame in which a hiring authority, such as warden, must conduct an investigative and disciplinary findings conference after receipt of an Office of Internal Affairs investigation report.

Departmental Staff Entered or Failed to Correct Inaccurate Information About Some of Its Staff Misconduct Cases in Its Database

The department maintains a computer database with information regarding its staff misconduct investigations and disciplinary cases. The OIG found that departmental staff did not consistently enter or maintain accurate information in the database. In 13 of the 121 staff misconduct cases the OIG monitored in 2023, or 11 percent, the Office of Internal Affairs' Allegation Investigation Unit, a department attorney, or a warden entered or failed to ensure the accuracy of information in the database. In some of the cases, departmental staff were unaware of the incorrect information in the database until the OIG informed them of the errors.

The inaccurate information included, but was not limited to, the following types of information:

- Allegations
- Number of subjects in a case
- Dates of alleged staff misconduct
- Penalties

In three of the 13 cases, a department attorney failed to advise an investigator to correct inaccurate information about allegations in the database. In one of these instances, the department attorney initially did not agree with the OIG's recommendation that the department should maintain an accurate record of the allegations in the staff misconduct database. However, the department attorney eventually agreed with the OIG's recommendation.

In another case, an associate governmental program analyst from a prison entered unauthorized information about a staff misconduct case into the database. The analyst improperly closed the staff misconduct investigation and entered unauthorized findings into the staff misconduct database even though a warden had not yet made findings regarding the case.

The warden was unaware of the improper case closure and only became aware of it after the OIG inquired as to why the staff misconduct database showed that the investigation had been closed and that the warden had completed the findings conference without notifying the OIG. The warden later learned that the analyst, who was assigned to the prison's Office of Grievances, had improperly closed the case without the warden's knowledge. The prison's Office of Grievances is under the direct management of the warden, and the analyst was not authorized to enter the information into the department's staff misconduct database.

The warden subsequently conducted a findings conference and updated the department's staff misconduct database with accurate information.

In another example, Office of Internal Affairs' Allegation Investigation Unit staff failed to accurately document in the database that the OIG was monitoring an investigation. This occurred even though the investigator and her manager met with an OIG attorney for an initial case conference regarding the investigation plan.

The Office of Internal Affairs' Allegation Investigation Unit later assigned a different investigator to the case. The second investigator relied on the incorrect information in the database, conducted all interviews without notifying the OIG, and closed the case, all without OIG monitoring.

The Office of Internal Affairs' Allegation Investigation Unit submitted its investigation report to the warden without notifying the OIG, which resulted in the warden not consulting with the OIG about the investigative and disciplinary findings. We subsequently learned about the warden's findings after the warden closed the matter without sustaining any allegations.

We subsequently reviewed the investigation materials, including all recorded interviews, and determined that the investigation was insufficient. The investigator failed to ask the incarcerated person who filed the complaint about his allegation that the officers falsified their reports. The investigator also failed to interview an officer who was a subject of the investigation. The investigator failed to obtain medical records, which could have provided information about the incarcerated person's injury, for the investigation.

We notified the Office of Internal Affairs' Allegation Investigation Unit that its staff had failed to communicate with us about the investigation and failed to accurately maintain its database to reflect that the OIG was monitoring the case. Although the Office of Internal Affairs' Allegation Investigation Unit acknowledged the error, it failed to correct the information in its database.

In yet another case, a warden inaccurately recorded the settlement terms of a case in its staff misconduct database. The warden reduced an officer's penalty from a 10 percent salary reduction for seven months to a 10 percent salary reduction for five months. In the staff misconduct database, the employee relations officer entered the penalty as a five percent salary reduction for 10 months. The OIG recommended that the employee relations officer correct the error and verify that the department had imposed the correct penalty. The employee relations officer confirmed that the department imposed the correct penalty and acknowledged the inaccurate information reflected in the database. The employee relations officer informed the OIG that, because the

departmental database lacked a function to allow staff to select the modified penalty, the employee relations officer had "manipulated" the system to capture the equivalent of the actual modified penalty.

Recommendation

The OIG recommends that the department require its investigators, department attorneys, and wardens, or staff designated by a warden, to enter and maintain accurate information in its staff misconduct database. Moreover, the OIG recommends that the department establish a clear policy as to which departmental personnel are responsible for updating and maintaining specific information in the database to ensure that the records are timely and accurate.

Appendices

Scope and Methodology

The OIG monitored the department's Centralized Screening Team's decisions made regarding 6,953 complaints between January 1, 2023, and December 31, 2023. The OIG also monitored 113 staff misconduct inquiry cases, including retrospective reviews, completed by locally designated investigators. The OIG added a new component to its local inquiry monitoring by completing retrospective reviews of randomly selected local inquiry cases that had been completed and closed within the past year. The purpose of this new monitoring component was to assess the department's performance when the OIG had not provided contemporaneous monitoring. Additionally, we monitored 121 staff misconduct investigation cases completed by the Office of Internal Affairs' Allegation Investigation Unit and the employee disciplinary process for those cases.

We reviewed key criteria, including the department's regulations for addressing allegations of staff misconduct, as well as departmental directives regarding the screening, inquiry, and investigation processes. We also participated in departmental training and reviewed the training materials used to instruct screeners, investigators who conduct inquiries and investigations, and staff who are engaged in the process at the prisons.

We monitored the Centralized Screening Team's screening decisions by randomly selecting complaints to monitor. After we selected the complaints, we conducted research of records, documents, and departmental databases, such as the offender grievance tracking system and the Allegations Against Staff Tracking System (AASTS).[23] We analyzed each screening decision to assess how the Centralized Screening Team processed each allegation included in a complaint. The OIG assigned a rating of *superior*, *satisfactory*, or *poor* to each complaint monitored. If we encountered discrepancies during the screening process, we contacted the department and elevated our concerns.

To assess the thoroughness of the department's inquiries, we conducted field work at prisons throughout the State and analyzed the investigators' resulting inquiry reports and corresponding exhibits. For each local inquiry, an investigator submitted a draft report to an Office of Internal Affairs' Allegation Investigation Unit manager and subsequently to the hiring authority for a final decision. Notwithstanding retrospective reviews, our monitoring activities included real-time observations of interviews and reviews of video recordings, as well as review of other

23. The Allegations Against Staff Tracking System (AASTS) is an electronic data system used to log and track allegations of staff misconduct involving departmental staff (DOM, Section 33070.3 (a)).

documentary evidence, such as post orders, cell search logs, and analysis of data pertaining to the cases from several of the department's electronic systems, including the offender grievance tracking system, the allegation against staff tracking system, and its Microsoft SharePoint site. We also received and reviewed memoranda from wardens concerning their review and resolution of the cases.

The OIG contemporaneously monitored Office of Internal Affairs investigations and the employee disciplinary process for those cases. We monitored these cases by assessing the performance of Office of Internal Affairs investigators. We did this by monitoring initial case conferences conducted by investigators, by contemporaneously monitoring interviews, by reviewing the collection of evidence, and monitoring the production of investigation reports. We provided real-time feedback and recommendations to investigators and the department attorneys during the investigations.

We also monitored the employee disciplinary process for those cases, including monitoring conferences at which the hiring authority made findings regarding the investigations and the disciplinary cases. We also monitored the performance of the department attorneys who provided legal advice to hiring authorities regarding investigations and the disciplinary cases. We also monitored the performance of department attorneys and other departmental staff as they prepared disciplinary actions and litigated any resulting disciplinary actions before the State Personnel Board.

For the screening decisions, local inquiries, and investigations we monitored, we assessed the performance of departmental staff and provided an overall rating.

Our assessment methodology for the ratings was based on the OIG's response to performance-related questions. We assessed the overall work in each case *superior*, *satisfactory,* or *poor.* We used an assessment tool that consisted of five overarching questions, each with a series of subquestions to assess the department's overall performance in five main areas:

1. Whether the Centralized Screening Team appropriately screened and referred allegations of employee misconduct and other related complaints;
2. Whether the department appropriately conducted inquiries into allegations of employee misconduct;
3. Whether the Office of Internal Affairs' Allegation Investigation Unit appropriately conducted investigations;

4. Whether the department attorney or employee relations officer properly performed during the investigation, the disciplinary process, and the litigation process; and

5. Whether the hiring authority properly determined findings concerning alleged employee misconduct, and properly processed the employee disciplinary case.

In 2023, of the Centralized Screening Team's screening decisions the OIG monitored, we produced and published a select number of case blocks monthly. The case blocks included a summary of the incident, the department's screening decision, and the OIG's assessment of that screening decision. The case blocks can be found on **the OIG's website**.

The OIG also produced and published case blocks for the 113 local inquiry cases we monitored and retrospectively reviewed. The case blocks consisted of the case summary, the department's disposition, and the OIG's overall inquiry assessment. The case blocks can also be found on **the OIG's website**.

Lastly, the OIG produced and published case summaries for the 122 Office of Internal Affairs' Allegation Investigation Unit investigations and the disciplinary process for those cases that we monitored. The case summaries consisted of the incident summary, the department's disposition, the OIG's case rating, and the OIG's assessment of the investigator, the department's attorney, and the hiring authority. The case summaries are also published on **the OIG's website**.

Recommendations

The OIG reiterates the following recommendations as presented in this report:

Centralized Screening Monitoring Team Decisions

- The department should clarify departmental policy in writing to require screeners to ask the complainant questions during a clarification interview to obtain sufficient information to ultimately make an informed screening decision about the allegation. (Page 16)
- The OIG recommends the department focus more quality-control attention on claims initially identified as routine matters. We also recommend the department establish clear policy requiring medical subject matter experts review only claims related to medical treatment, and custody subject matter experts review claims related to custody and correctional issues, such as use of force, even when the person alleged to have committed misconduct is a medical employee. (Page 25)
- The OIG recommends the department require locally designated investigators to complete a conflict-of-interest review and acknowledge that they do not have an actual or potential conflict of interest before an inquiry begins. The OIG recommends the department adopt its already-existing conflict-of-interest form, used by the Office of Internal Affairs. (Page 33)

Staff Misconduct Local Inquiry Cases

- The OIG renews the recommendation made in our 2022 annual report that locally designated investigators audio-record all interviews.[24] (Page 36)
- The OIG recommends that the department amend its policy to permit investigators the independence and authority to identify, obtain, and review all video-recorded evidence that they have determined to be potentially relevant to their inquiry. (Page 38)
- Hiring authorities should receive training on how to conduct thorough reviews of allegation inquiry reports and on departmental policy to ensure that they make proper staff misconduct determinations. (Page 43)

24. ***Monitoring the Staff Misconduct Investigation and Review Process of the California Department of Corrections and Rehabilitation: 2022 Annual Report.***

- The OIG recommends the department implement a policy requiring locally designated investigators and hiring authorities to complete the local inquiry process within 90 days of the date the Centralized Screening Team receives an allegation. (Page 47)
- The OIG recommends that the department develop, implement, and maintain a policy and process to require meaningful communication with the OIG during the course of each local inquiry to enable the OIG to perform its statutorily required monitoring activities. The OIG also recommends that the department hold employees accountable for failing to communicate with the OIG. (Page 50)

Staff Misconduct Investigation and Employee Disciplinary Cases

- The OIG recommends that the department require all members of an Office of Internal Affairs investigation team, including managers, to complete conflict-of-interest forms and recuse themselves from working on investigations in which they have a conflict of interest with—or bias for or against—any of the subjects or witnesses of an investigation. (Page 59)
- The OIG recommends that the department eliminate the use of summarized investigation reports which allow investigators to close staff misconduct investigations without conducting any interviews. (Page 62)
- The OIG recommends that the department expand its video-recording retention policy by increasing the minimum retention time for all recordings to one year to ensure that relevant video-recorded evidence is available for staff misconduct investigations. (Page 64)
- The OIG recommends that investigators determine the independent recollection of a witness before presenting him or her with video evidence. (Page 65)
- The OIG recommends that, during recorded interviews, Office of Internal Affairs investigators properly document which video file and which portion of the video file—including a time stamp—the investigator presents to the subject or witness during an interview. (Page 65)
- The OIG recommends that the Office of Internal Affairs conduct interviews in confidential settings. The OIG recommends that the Office of Internal Affairs investigators order subjects and witnesses to maintain the confidentiality of investigations while investigations are pending. (Page 67)

- The OIG recommends that the department issue a specific policy concerning the time frame in which a hiring authority, such as warden, must conduct an investigative and disciplinary findings conference after receipt of an Office of Internal Affairs investigation report. (Page 75)
- The OIG recommends that the department require its investigators, department attorneys, and wardens, or staff designated by a warden, to enter and maintain accurate information in its staff misconduct database. Moreover, the OIG recommends that the department establish a clear policy as to which departmental personnel are responsible for updating and maintaining specific information in the database to ensure that the records are timely and accurate. (Page 78)

The Office of the Inspector General Monitoring in 2023 of the California Department of Corrections and Rehabilitation's Staff Misconduct Complaint Screening, Inquiry, Investigation, and Employee Disciplinary Processes

2023 Annual Report

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STATE *of* CALIFORNIA
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OIG