From February 1, 2024, through February 29, 2024, the OIG's Local Inquiry Team monitored and closed six cases. This document presents all monitored and closed cases during this period.

OIG Case Number
23-0058729-INQ

Rating Assessment
Poor

Case Summary

Between June 9, 2023, and June 13, 2023, a nurse allegedly violated professional standards by using inappropriate terminology when referring to an incarcerated person's body parts.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to provide the OIG with video-recorded evidence until after the inquiry was completed. The Office of Internal Affairs' Allegation Investigation Unit manager approved the inquiry report without first reviewing the video-recorded evidence and did not obtain and review the video-recorded evidence until the OIG inquired about it. In addition, the department unreasonably delayed the inquiry and ultimately failed to timely complete the inquiry. The investigator submitted the draft allegation inquiry report to the Office of Internal Affairs' Allegation Investigation Unit manager on August 22, 2023, but the manager did not return the inquiry report for revisions until October 2, 2023, 41 days thereafter. The investigator then submitted a revised inquiry report on October 2, 2023, but the California Correctional Health Care Services Staff Misconduct Team did not submit the inquiry report to the Office of Internal Affairs' Allegation Investigation Unit for review until October 26, 2023, 24 days thereafter. Finally, the California Correctional Health Care Services Staff Misconduct Team submitted the inquiry report to the hiring authority on November 9, 2023, but the hiring authority did not render a final decision on the allegation until February 14, 2024, 97 days thereafter. Altogether, 240 days elapsed from the date the Centralized Screening Team received the complaint on June 19, 2023, until the hiring authority rendered a final decision on February 14, 2024, 150 days beyond the department's goal.

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OIG Case Number
23-0063019-INQ

Rating Assessment
Poor

Case Summary

Prior to August 28, 2023, two officers allegedly confined an incarcerated person to his cell, improperly restricting his access to phone calls, legal resources, showers, group sessions, work assignments, and education programs.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator was not prepared to audio record an interview of an officer who elected to do so, resulting in the need to reschedule the interview. Subsequently, the department unreasonably delayed the inquiry and ultimately failed to timely complete the inquiry. Specifically, the investigator submitted the draft inquiry report to the Office of Internal Affairs' Allegation Investigation Unit manager on November 8, 2023, but the manager did not return the inquiry report to the investigator for revisions until December 19, 2023, 41 days thereafter. On December 19, 2024, the investigator received notice of the request for edits but further delayed the inquiry by failing to submit a revised draft inquiry report until February 6, 2024, 49 days thereafter. On February 26, 2024, the hiring authority rendered a final decision on the allegations, 181 days from the date the Centralized Screening Team received the complaint on August 29, 2023, and 91 days beyond the department's goal.

OIG Case Number
24-0073334-INQ

Rating Assessment
Poor

Case Summary

Prior to August 29, 2023, an officer allegedly refused to consider an incarcerated person's request for a bed move. A second officer allegedly agreed with the first officer's decision to deny the bed move because the second officer had previously issued a rules violation report to the incarcerated person.

Case Disposition

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

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Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to identify and include in the inquiry report the departmental policy and procedure standards related to the officer's alleged misconduct. The investigator also failed to document why a staff witness was interviewed during the inquiry. The Office of Internal Affairs' Allegation Investigation Unit manager inappropriately approved the inquiry report as adequate despite the investigator's omissions in the report. In addition, the department failed to timely complete the inquiry. Specifically, the Centralized Screening Team received the complaint on September 1, 2023, but the hiring authority did not make a final determination on the allegations until December 15, 2023, 105 days thereafter and 15 days beyond departmental goals. Finally, the department predated the closure memorandum response to the incarcerated person who submitted the complaint, giving the appearance that a determination was made before the hiring authority substantively reviewed the case.

OIG Case Number
24-0073851-INQ

Rating Assessment
Poor

Case Summary

Prior to November 2, 2023, a cook allegedly prepared food in unsanitary conditions, provided underportioned meals to incarcerated persons, made disrespectful comments to incarcerated persons, and bribed incarcerated persons with additional meals for positive endorsements on the food quality control sheet.

Case Disposition

The hiring authority determined that the inquiry conclusively proved the misconduct did not occur.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team failed to route an allegation of bribery (use of position to solicit gratuities or favors form an incarcerated person), which is an allegation of staff misconduct listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. Neither the investigator, the Office of Internal Affairs' Allegation Investigation Unit manager, nor the hiring authority identified that there was an allegation of bribery (use of position to solicit gratuities or favors form an incarcerated person) that should have been elevated to the Office of Internal Affairs' Allegation Investigation Unit for an investigation because it is an allegation of staff misconduct contained on the department's Allegation Decision Index. The investigator also failed to reference and include in the inquiry report the departmental policy and procedure standards related to the alleged misconduct, such as those relating to sanitary work conditions, meal portion sizes, or unprofessional conduct. The investigator failed to include supporting documentation for the identification of

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witnesses, including documentation to identify incarcerated persons and correctional staff assigned to work in the kitchen at the time of the incident. The investigator failed to follow departmental training and best practices regarding the order for completing interviews and did not provide an explanatory statement about why there was a deviation from training and best practices. The Office of Internal Affairs' Allegation Investigation Unit manager inappropriately approved the inquiry report as adequate despite the investigator's omissions in the report. The department's December 1, 2023, closure memorandum response to the incarcerated person who submitted the complaint predates the hiring authority's December 12, 2023, approval of the inquiry report. Finally, the hiring authority incorrectly determined the inquiry conclusively proved the misconduct did not occur regarding one allegation in this case. According to the department's operations manual, the evidentiary threshold regarding the allegation that the cook bribed incarcerated persons to fill out the quality control sheet was not met in this case. Thus, the hiring authority should have separately determined there was insufficient evidence to sustain this allegation.

OIG Case Number 23-0063974-INQ

Rating Assessment
Satisfactory

Case Summary

On September 9, 2023, an officer allegedly failed to maintain constant visual supervision of an incarcerated person who was on suicide watch and improperly kept the incarcerated person in handcuffs for over four hours. On September 10, 2023, when the incarcerated person's cell became flooded by sewage water, a second officer placed the incarcerated person into a holding cell and allegedly did not offer water or bathroom breaks.

Case Disposition

The investigator suspended the inquiry and referred it to the Office of Internal Affairs' Allegation Investigation Unit for investigation after discovering evidence of staff misconduct that he believed could result in disciplinary action. The OIG did not monitor the investigation following the referral.

Overall Inquiry Assessment

Overall, the department performed satisfactorily.

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OIG Case Number
23-0068681-INQ

Rating Assessment
Poor

Case Summary

On November 25, 2023, a sergeant allegedly refused to address a water leak inside an incarcerated person's cell, resulting in the cell becoming flooded with water.

Case Disposition

The hiring authority determined that the inquiry conclusively proved the misconduct did not occur.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to identify and include in the inquiry report the departmental policy and procedure standards related to the officer's alleged misconduct. The Office of Internal Affairs' Allegation Investigation Unit manager improperly deemed the investigator's inquiry report as adequate despite the investigator's omission in the report. In additional, the grievance coordinator failed to notify the OIG when the Office of Internal Affairs' Allegation Investigation Unit manager returned the draft inquiry report to the investigator for further inquiry, when the investigator resubmitted the revised inquiry report for manager review, and when the manager approved the revised inquiry report. The grievance coordinator also failed to notify the OIG upon submitting the inquiry report to the hiring authority for review, and upon receipt of the hiring authority's findings on the allegation. The grievance coordinator's lack of adequate communication prevented the OIG from conducting contemporaneous monitoring and providing feedback of the case. Finally, the hiring authority improperly made a determination that the allegation was unfounded when in fact the inquiry proved the occurrence of a water leak that was reported to third watch staff, determined to be nonurgent, and addressed the next morning. The hiring authority determined staffs' actions were not in violation of policy and procedure; therefore, the proper finding for this inquiry should have been exonerated.

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