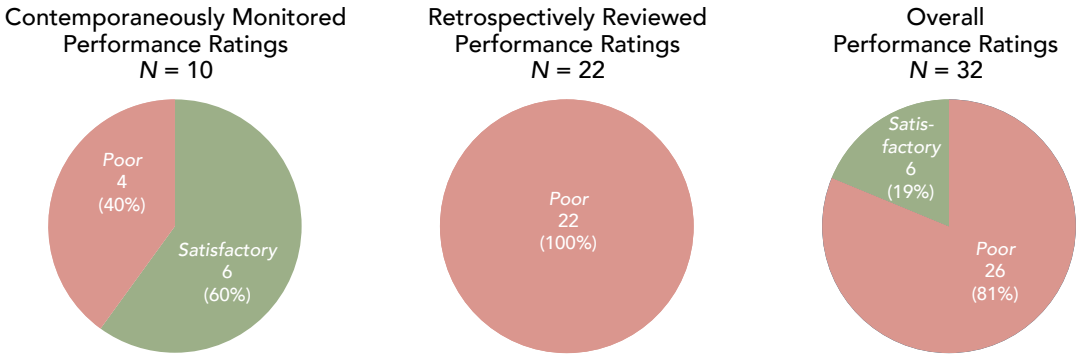
During May 2024, the OIG's Staff Misconduct Monitoring Unit's Local Inquiry Team closed 32 monitored inquiries. Of those 32 inquiries, the OIG monitored 10 inquiries contemporaneously and monitored 22 inquiries retrospectively. The OIG rated the department's overall performance as poor in 26 inquiries, or 81 percent. The OIG rated the department's overall performance as satisfactory in six inquiries, or 19 percent.

32 Monitored Inquiries Closed by the Office of the Inspector General During May 2024



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

The OIG made the following noteworthy observations:

- The locally designated investigator thoroughly and appropriately conducted the inquiry in seven of the 32 monitored cases, or 22 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in eight of the 32 monitored cases, or 25 percent.
- The hiring authority made a timely determination on the allegations, within 90 days of the complaint being received by the Centralized Screening Team, in seven of the 32 monitored cases, or 22 percent.
- Aside from exceeding statutory, regulatory, or policy timelines, the department unreasonably delayed completing the inquiry in 19 of the 32 monitored cases, or 59 percent.
- Of the 22 inquiries the OIG monitored retrospectively, the OIG rated the department's performance as poor in all inquiries, or 100 percent.

The summaries that follow present 10 notable inquiries the OIG monitored and closed during May 2024.

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OIG Case Number
24-0078331-INQ

Rating Assessment
Poor

Case Summary

On April 8, 2023, an officer allegedly waited 10 minutes to respond to an incarcerated person's medical emergency after other incarcerated persons notified the officer many times. The officer also allegedly used derogatory and profane language toward the incarcerated person who suffered the medical emergency and other incarcerated persons who called for medical assistance.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's finding that there was insufficient evidence to sustain the allegations.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team improperly routed one of the allegations for a local inquiry even though the incarcerated person alleged that an officer delayed in responding to a medical emergency, thereby endangering 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. In addition, the OIG discovered that another incarcerated person submitted a separate complaint regarding the same incident and alleged misconduct against the same officer, but the Centralized Screening Team routed that complaint to the Office of Internal Affairs, therefore resulting in duplicative work by the Office of Internal Affairs and the locally designated investigator. The Centralized Screening Team's conflicting screening decisions also demonstrated the lack of consistency in the department's screening and routing of allegations related to staff misconduct. Subsequently, the investigator submitted a timely request for video-recorded evidence and received a response from the investigative services unit which stated video recordings were unavailable for the incident, but failed to provide an explanation why video-recorded evidence was unavailable.

Pursuant to departmental policy, the investigative services unit made the unilateral determination that there was no video-recorded evidence, therefore impeding the investigator's autonomy to determine whether any video-recorded evidence existed or its relevance to the inquiry. The investigator then failed to identify, reference, or include in the inquiry report the departmental policy and procedure standards related to the officer's alleged misconduct. The investigator also mischaracterized in the inquiry report that the sergeant who was a witness was present when the alleged misconduct occurred although the evidence demonstrated that the sergeant arrived only after the medical alarm was called and was therefore not present during the time the alleged misconduct occurred.

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The investigator, the Office of Internal Affairs manager, and the hiring authority failed to identify evidence of staff misconduct related to the officer's failure to respond to a possible medical emergency, which is staff misconduct listed on the Allegation Decision Index and should have been referred to the Office of Internal Affairs for investigation. The Office of Internal Affairs manager returned the inquiry report to the investigator for additional inquiry work, but the investigator unreasonably delayed the inquiry by failing to submit a revised draft inquiry until 135 days later. Ultimately, the department exceeded 90 days to complete the inquiry, concluding the inquiry 229 days after the Centralized Screening Team received the complaint and 139 days beyond the department's goal. Finally, the OIG did not concur with the hiring authority's determination that there was insufficient evidence to sustain the allegation. Four incarcerated people who were witnesses, who were all located at different prisons at the time the investigator interviewed them, gave consistent and corroborating statements related to the officer's alleged misconduct, but the hiring authority believed the officer's statement over the incarcerated people's consistent accounts.

OIG Case Number 24-0081084-INQ

Rating Assessment
Poor

Case Summary

On March 1, 2023, a nurse allegedly provided an incarcerated person an insulin syringe without its protective cap and with the needle pointed at the incarcerated person, thereby putting the incarcerated person at risk of injury. A second nurse allegedly failed to change her gloves between interactions with different patients.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The incarcerated person who submitted the complaint made two allegations of staff misconduct. However, the Centralized Screening Team improperly conducted fact-finding and determined the allegation that the second nurse failed to change gloves between patients was not an allegation of staff misconduct; therefore, that allegation was not investigated. The first nurse stated during her interview that she always handed the incarcerated person the insulin syringe with the point directed toward either side and in the presence of officers. However, the investigator failed to ask the nurse any questions that would help to identify the officers present on the date of the incident so the investigator could interview them as witnesses.

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Moreover, the investigator's first draft of the inquiry report included a summary of video-recorded evidence the investigator reviewed, which depicted two officers and another incarcerated person who were present during the incident, but the investigator did not identify and interview those witnesses. In addition, the investigator's review of the video- recorded evidence, as documented in the draft inquiry report, identified a third nurse as the person who actually handed the syringe of insulin to the incarcerated person who submitted the complaint, but the investigator failed to pursue the evidence to identify the correct subject and failed to reference this evidence in the final inquiry report. This evidentiary problem is compounded by the fact that the first nurse stated during her interview that she did not have any interactions on the date of the incident with the incarcerated person who submitted the complaint, indicating the investigator needed to conduct additional inquiry to verify the identity of the nurse who allegedly engaged in the misconduct. The investigator failed to document whether she provided an advisement of rights and confidentiality admonishment to the nurse during her interview. The investigator also interviewed the incarcerated person who submitted the complaint and failed to document whether she provided a confidentiality admonishment during the interview. The investigator failed to include any items as supporting exhibits to the inquiry report, including the source of the incarcerated person's complaint, the video-recorded evidence, the advisement of rights provided to the first nurse, and documentation that the first nurse was the appropriately identified subject of the inquiry. The investigator also failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations. In addition, the investigator made an improper conclusory statement that the incarcerated person's complaint had no basis, which is a factual determination reserved for the hiring authority. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report, failed to require the investigator to pursue and produce the video-recorded evidence, and instead inappropriately approved the report as adequate.

The manager also unreasonably delayed the inquiry by allowing 67 days to elapse before completing a review of the inquiry report. According to the department's database, the manager returned the draft inquiry report to the investigator for additional work, but the inquiry itself was not returned to the investigator until 34 days thereafter. The Centralized Screening Team received the complaint on March 10, 2023, but the hiring authority did not make a finding until November 1, 2023, 236 days thereafter and 146 days beyond the department's goals.

OIG Case Number
24-0080713-INQ

Rating Assessment
Poor

Case Summary

On November 23, 2023, a nurse allegedly acted unprofessionally toward an incarcerated person during medication distribution when the nurse yelled at, turned her back on, and refused to give her name to the incarcerated person.

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Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to submit a request for video-recorded evidence that may have captured the incident and failed to document in the inquiry report the reason why the investigator did not request it. The investigator also failed to identify and interview a pertinent staff witness, even though the incarcerated person who submitted the complaint named an officer as a witness, without including the reasoning behind that decision in the inquiry report.

Because only the incarcerated person and the nurse who was the subject of the complaint were interviewed, and each had differing recollections of the interaction, additional witnesses could have yielded useful evidence. The investigator interviewed the nurse who was the subject of the inquiry and failed to document whether the investigator provided the required advisement during the interview and failed to include the nurse's personnel number in the inquiry report. The investigator interviewed the incarcerated person and the nurse but failed to document whether the investigator provided a confidentiality admonishment during each interview. The investigator documented in the inquiry report that the nurse stated she treated incarcerated people the same way when she observed them taking their medication incorrectly, but the investigator failed to ask follow-up questions to ascertain exactly how the nurse treats them. This information is important because it relates to the allegation that the nurse acted in an unprofessional manner by yelling at the incarcerated person for not taking his medication correctly. The investigator also failed to identify, reference, or include in the inquiry report the records of departmental policy and procedure applicable to the allegations. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and approved the report as adequate. The Centralized Screening Team received the complaint on November 29, 2023, but the hiring authority did not determine a finding for each allegation until April 25, 2024, 148 days thereafter and 58 days beyond the department's goal.

OIG Case Number
24-0072911-INQ

Rating Assessment
Poor

Case Summary

On January 18, 2024, after an officer already had control of an incarcerated person's right arm for an escort, a second officer allegedly tried to take hold of the incarcerated person by his left arm. The second officer then continued to closely follow the escort and attempted to take hold of the incarcerated person's arm even though the

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incarcerated person requested that the officer not touch him. On January 22, 2024, the first officer allegedly harassed the incarcerated person when he told the second officer to escort the incarcerated person who had a negative history with the second officer and was fearful of him.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. Initially, the Centralized Screening Team appropriately screened the allegations and routed them for a local inquiry. The hiring authority disputed the screening decision and the Centralized Screening Team inappropriately rerouted the allegations back to the prison as routine issues. The OIG disputed the Centralized Screening Team's revised screening decision and, as a result, the Centralized Screening Team again routed the allegations for a local inquiry. A total of 59 days elapsed from the time the Centralized Screening Team received the complaint to the time the routing dispute was resolved. During the inquiry, the investigator's supervisor inappropriately determined that video-recorded evidence alone was sufficient to enable the hiring authority to make a determination regarding the allegation against the first officer. As a result, the investigator's supervisor instructed the investigator to interview the first officer only as a witness to the second officer's alleged misconduct and to not question the first officer about his alleged misconduct. Finally, the Centralized Screening Team received the complaint on January 24, 2024, but the hiring authority did not render a determination on the allegations until May 16, 2024, 113 days thereafter and 23 days beyond the department's goal.

OIG Case Number 24-0081056-INQ

Rating Assessment
Poor

Case Summary

On October 2, 2023, a nurse allegedly acted unprofessionally toward an incarcerated person when she yelled at the incarcerated person and called him a "weirdo."

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegation. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to ask all relevant questions during the interviews. The investigator interviewed three incarcerated

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persons who were witnesses of the inquiry but failed to ask each of them if they were familiar with the incarcerated person who submitted the complaint and if they observed the nurse who was the subject of the inquiry act unprofessionally toward the incarcerated person. Additionally, the investigator failed to ask the incarcerated persons who were witnesses of the inquiry if they observed the nurse yell at the incarcerated person who submitted the complaint and if they heard the nurse call him a "weirdo." Instead, the investigator limited her questioning to only one vague and overly broad question; whether the incarcerated persons who were witnesses of the inquiry noted anything that stood out to them on the date in question. Further, the investigator interviewed the incarcerated person who submitted the complaint, three incarcerated persons, an officer, and a nurse who were witnesses of the inquiry, and a nurse who was the subject of the inquiry and failed to provide a confidentiality admonishment during each interview. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations. The investigator also failed to include the advance written notice of interview provided to the officer and nurses and the advisement of rights provided to the nurse who was the subject of the inquiry as supporting exhibits to the inquiry report. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and approved the report as adequate. The Centralized Screening Team received the complaint on October 20, 2023, but the hiring authority did not determine a finding for the allegation until February 23, 2024, 126 days thereafter and 36 days beyond the department's goal.

OIG Case Number 24-0080793-INQ

Rating Assessment
Poor

Case Summary

On February 27, 2023, a psychologist allegedly acted unprofessionally toward an incarcerated person when she falsely accused the incarcerated person of lying about his mental health condition during a mental health clinical evaluation.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator interviewed a psychologist who was the subject of the complaint and failed to document whether the investigator provided the required advisement of rights admonishment during the interview. The investigator interviewed the incarcerated person who submitted the complaint and the psychologist and failed to document whether the investigator provided a confidentiality admonishment during each interview. The investigator

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also failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the alleged misconduct. Additionally, the investigator failed to include the written notice of staff complaint, the advance written notice of interview, and the advisement of rights provided to the psychologist as supporting exhibits to the inquiry report. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and approved the report as adequate. Overall, the department untimely completed the inquiry on April 29, 2024, 405 days after the Centralized Screening Team received the complaint on March 21, 2023, and 315 days beyond the department's goal.

OIG Case Number 24-0080797-INQ

Rating Assessment
Poor

Case Summary

On April 14, 2023, a physician assistant allegedly insulted and verbally and physically abused an incarcerated person while he improperly disapproved the incarcerated person's lower-level bunk accommodation in a housing unit.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to use effective interviewing techniques when he interviewed the physician assistant who was the subject of the inquiry. Specifically, the investigator did not ask the physician assistant any questions about his recollection of the incident. Instead, the investigator failed to follow departmental training and best practices when he directly copied the physician assistant's progress notes into the inquiry report instead of conducting a formal and thorough interview. The investigator also failed to provide a confidentiality admonishment to the physician assistant during the interview. Further, the investigator caused unreasonable delays by failing to timely conduct interviews. The investigator did not conduct the first interview until 62 days after the hiring authority assigned the inquiry to him. The investigator completed the inquiry report 51 days after he conducted the final interview. Additionally, the investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and approved the report as adequate. The California Correctional Health Care Services' Staff Misconduct Team submitted the inquiry report to the hiring authority to render findings for the allegations, but the hiring authority did not determine a finding for each allegation until 69 days later. Overall, the department untimely completed the

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inquiry on April 8, 2024, 262 days after the Centralized Screening Team received the complaint on July 21, 2023, and 172 days beyond the department's goal.

OIG Case Number
24-0081033-INQ

Rating Assessment
Poor

Case Summary

Between November 10, 2022, and November 21, 2022, a social worker allegedly made false statements regarding an incarcerated person's mental health and attempted to have the incarcerated person admitted as suicidal. Additionally, a psychiatric technician and an unknown medical staff member allegedly revealed to other incarcerated persons that the incarcerated person had filed a complaint against medical staff.

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 hiring authority improperly bifurcated the inquiry and divided the two allegations between two investigators under the same grievance log number. The hiring authority did not assign investigators to the inquiry until 42 days after the Centralized Screening Team received the complaint. The first investigator failed to provide a summary of the allegations to the psychiatric technician who was a subject of the inquiry in the written advisement of rights and the notice of interview. The investigator interviewed the psychiatric technician and failed to provide the required advisements during the interview. The investigator interviewed the incarcerated person who submitted the complaint and the psychiatric technician and failed to provide an accurate synopsis of the allegations and failed to provide a confidentiality admonishment during each interview. The investigator failed to document in the inquiry report whether effective communication was achieved prior to interviewing the incarcerated person. The investigator failed to ask relevant questions to determine additional staff or incarcerated persons who may have been witnesses. The investigator improperly provided a synopsis of the interview with the psychiatric technician in the inquiry report under a heading titled "Complainant interview." The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the alleged misconduct. The Office of Internal Affairs' manager directed the investigator to interview additional witnesses and to include an inquiry note explaining why video footage was not requested, however, the investigator failed to follow the manager's direction and resubmitted a draft inquiry report without conducting any additional interviews and without adding an inquiry note.

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The investigator's revised inquiry report indicated that a follow-up interview with the incarcerated person who submitted the complaint was unnecessary but failed to provide an explanation why it was unnecessary. The Office of Internal Affairs manager returned the inquiry report to the investigator three times for additional inquiry before the report was submitted to a second Office of Internal Affairs manager, who inappropriately deemed the report to be adequate despite the investigator's failure to properly address the first manager's requests for additional inquiry work. The California Correctional Health Care Services Staff Misconduct Team did not provide the final revised inquiry report to the Office of Internal Affairs manager until 206 days after the investigator submitted the revised report. The hiring authority did not render a decision until 67 days after the Office of Internal Affairs manager submitted the final draft report. The hiring authority failed to make a determination regarding the sufficiency of the first investigator's inquiry report.

The second investigator did not conduct the first interview until 93 days after being assigned the inquiry. The investigator failed to provide a summary of the allegations to the social worker who was the subject of the complaint in the written advisement of rights and the notice of interview. Additionally, the investigator interviewed the incarcerated person who submitted the complaint and the social worker but failed to provide a confidentiality admonishment during each interview. The investigator failed to document in the inquiry report whether the interview with the incarcerated person was conducted in a confidential setting and whether effective communication was achieved. The investigator also failed to ask relevant questions to identify additional staff or incarcerated person witnesses and did not complete all necessary and relevant interviews. The investigator failed to ask any relevant questions during the interview of the incarcerated person and the social worker. Instead, the investigator inserted into the inquiry report the verbatim entries of two medical documents the social worker had previously generated and also statements the incarcerated person made during his clarifying interview with the Centralized Screening Team. The inquiry report consisted entirely of a verbatim compilation of previous information in the record and did not contain any new information. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the alleged misconduct.

The California Correctional Health Care Services' Staff Misconduct Team did not provide the inquiry report to the Office of Internal Affairs manager until 199 days after the investigator submitted the inquiry report. The Office of Internal Affairs manager improperly indicated on the second investigator's approved inquiry report that the incarcerated person's interview would be used for the first investigator's approved inquiry report even though both reports related to different allegations. The Office of Internal Affairs' manager approved the investigator's inquiry report despite the investigator's oversights. The hiring authority did not render a decision until 67 days after the Office of Internal Affairs manager submitted the inquiry report. The hiring authority failed to make a determination regarding the sufficiency of the second investigator's inquiry report. Overall, the department untimely completed the inquiry on March 5, 2024, 406 days after the Centralized Screening Team received the complaint on January 24, 2023, and 316 days beyond the department's goal.

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OIG Case Number
24-008081-INQ

Rating Assessment
Poor

Case Summary

Between October 1, 2022, and October 31, 2022, a recreational therapist allegedly showed movies to incarcerated persons during group therapy sessions that depicted nudity, sex, and glorified violence.

Case Disposition

The hiring authority conducted an inquiry and sustained the allegations against the recreational therapist. The hiring authority determined that corrective action was appropriate and provided training to the recreational therapist. The OIG concurred.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator conducted two interviews with the recreational therapist who was a subject of the inquiry and failed to provide the required advisements during the second interview. Additionally, the investigator interviewed the incarcerated person who submitted the complaint and the recreational therapist and failed to provide a confidentiality admonishment during each interview. The investigator failed to document in the inquiry report whether he interviewed the incarcerated person in a confidential setting and whether he achieved effective communication. The investigator failed to obtain a group therapy roster to identify and interview additional incarcerated person witnesses to the alleged incidents. Additionally, the investigator failed to attach to the draft inquiry report the request for video-recorded evidence and the recreational therapist group assignment. The investigator made improper conclusions regarding the evidence collected during the inquiry and improperly determined that corrective action was appropriate, which is a responsibility reserved for the hiring authority. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and approved the report as adequate.

The hiring authority did not determine that the inquiry was insufficient until 68 days after the Office of Internal Affairs manager submitted the initial inquiry report. The investigator submitted a revised inquiry report; however, the hiring authority signed the initial draft inquiry report as adequate. It is unclear whether the hiring authority reviewed the revised inquiry report when making a final determination. The hiring authority did not determine a finding for the allegation until 387 days after the Office of Internal Affairs manager resubmitted the inquiry report. Overall, the department untimely completed the inquiry on March 27, 2024, 495 days after the Centralized Screening Team received the complaint on November 18, 2022, and 405 days beyond the department's goal. Due to the department's insufficient record keeping, the OIG found it difficult to determine the dates of critical inquiry activities. The hiring authority failed to issue an allegation investigation response to the incarcerated person who submitted the complaint until 65 days after making a final determination, and only issued one after the OIG notified him about the issue.

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OIG Case Number
24-0081635-INQ

Rating Assessment
Poor

Case Summary

On unspecified dates prior to December 1, 2022, a psychiatric technician allegedly acted rudely towards an incarcerated person and denied the incarcerated person medical services that were provided to other incarcerated people. The psychiatric technician's unprofessional attitude was allegedly in retaliation against the incarcerated person for filing previous complaints.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations. The OIG did not concur with the hiring authority's determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator interviewed the psychiatric technician who was a subject of the inquiry and a second psychiatric technician who was a witness of the inquiry and failed to provide the required advisements for each interview. The investigator interviewed the incarcerated person who submitted the complaint and the two psychiatric technicians and failed to provide a confidentiality admonishment during each interview and also failed to document whether each interview was conducted in a confidential setting. The investigator failed to document whether the investigator achieved effective communication before interviewing the incarcerated person. The investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing the psychiatric technician who was a subject of the inquiry before interviewing the psychiatric technician who was a witness and did not provide justification in the inquiry report for this deviation. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations and include those records as supporting exhibits to the inquiry report. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and approved the report as adequate. The hiring authority did not determine a finding for each allegation until 371 days after the California Correctional Health Care Services' Staff Misconduct Team submitted the inquiry report. Overall, the department untimely completed the inquiry on January 3, 2024, 426 days after the Centralized Screening Team received the complaint on November 3, 2023, and 336 days beyond the department's goal.

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