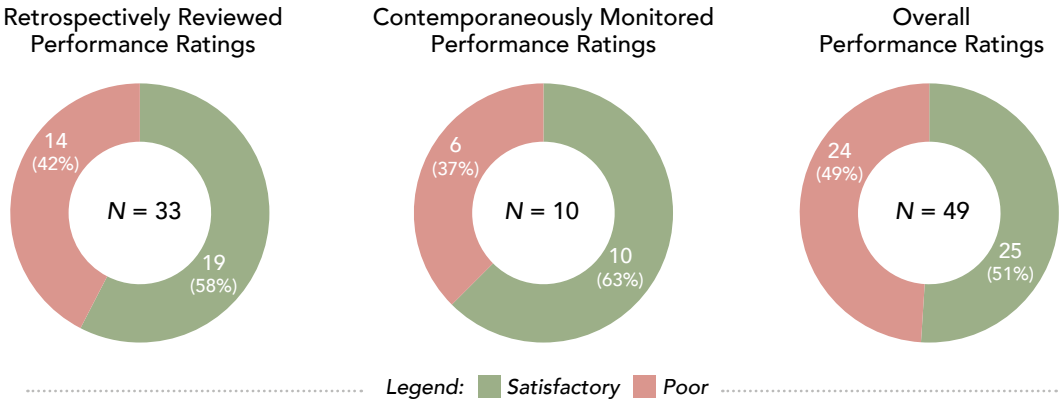
During September 2024, the OIG's Local Inquiry Team closed 49 monitored inquiries. Of those 49 inquiries, the OIG monitored 16 inquiries contemporaneously and monitored 33 inquiries retrospectively. The OIG rated the department's overall performance as *poor* in 25 inquiries, or 51 percent. The OIG rated the department's overall performance as *satisfactory* in 24 inquiries, or 49 percent.

49 Monitored Inquiries Closed by the Office of the Inspector General During September 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 23 of the 49 monitored cases, or 47 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in 22 of the 49 monitored cases, or 45 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 30 of the 49 monitored cases, or 61 percent.
- Aside from exceeding statutory, regulatory, or policy timelines, the department unreasonably delayed completing the inquiry in 13 of the 49 monitored cases, or 27 percent.
- Of the 33 inquiries the OIG monitored retrospectively, the OIG rated the department's performance as poor in 19 inquiries, or 58 percent.

The summaries that follow present 12 notable inquiries the OIG monitored and closed during September 2024.

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Retrospective Reviews

OIG Case Number
24-0086648-INQ

Rating Assessment
Poor

Case Summary

On May 5, 2023, a dental hygienist allegedly ignored an incarcerated person's reports of pain during a dental exam, improperly denied the incarcerated person topical medication to manage the pain, and then inappropriately stopped the exam because she did not like the incarcerated person's complaints.

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. The hiring authority unreasonably delayed 92 days to assign an investigator to conduct the inquiry. Due to the delay to assign an investigator, the department deleted the video-recorded evidence pursuant to its 90-day video-retention policy which lapsed before the investigator began the inquiry. 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 document in the inquiry report whether she provided a confidentiality admonishment during each interview conducted. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. The hiring authority delayed 214 days after receiving the inquiry report before making findings for the allegations. Overall, the department untimely completed the inquiry 382 days after the Centralized Screening Team received the complaint and 292 days beyond the department's goal.

OIG Case Number
24-0085723-INQ

Rating Assessment
Poor

Case Summary

On March 15, 2024, an officer allegedly failed to respond to an incarcerated person's multiple reports of a medical emergency.

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.

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Retrospective Reviews (continued)

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team improperly routed this complaint for local inquiry even though the incarcerated person alleged that an officer repeatedly failed to respond to his medical emergency. This type of allegation is staff misconduct listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. In addition, the investigator failed to identify the allegation as staff misconduct listed in the Allegation Decision Index and should have disputed the referral for proper assignment to the Office of Internal Affairs' Allegation Investigation Unit for investigation. In addition, the investigator failed to use effective interviewing techniques, failed to conduct thorough interviews, and failed to conduct a thorough inquiry. For example, the investigator conducted interviews and failed to document in the inquiry report if she provided a confidentiality admonishment during each interview. The investigator also interviewed two officers who were witnesses but failed to explain how she identified one officer's relevance to the inquiry. The investigator limited her questioning, asking both officer witnesses only if they were familiar with the incarcerated person who submitted the complaint and whether they could recall any time when the subject officer ignored the incarcerated person's medical issues. The investigator failed to ask both officer witnesses specific questions regarding the alleged misconduct and the possible presence of additional staff or incarcerated persons as witnesses.

The investigator also failed to examine how the offender appointment list indicated the incarcerated person who submitted the complaint was in a medical appointment at the time of alleged misconduct. In addition, the investigator did not interview the officer who was the subject of the inquiry and failed to explain the rationale behind that decision. The investigator failed to obtain and review a sufficient duration of video-recorded evidence relative to the alleged incident time frames. For example, the investigator relied only on 14 seconds of footage captured from the subject officer's body-worn camera and 10 minutes of security video which did not reveal the entirety of the encounter between the officer and the incarcerated person. The investigator reviewed and summarized additional video recordings but failed to include the video recordings as supporting exhibits to the inquiry report. The investigator also did not attach the request for video-recorded evidence as an exhibit to the inquiry report. Conversely, the investigator attached the witness officer's notice of interview and advisement of rights to the inquiry report but failed to list the documents as supporting exhibits. The investigator also improperly identified in the inquiry report the incarcerated person who submitted the complaint as an incarcerated person witness. Finally, 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 instead approved the report as adequate.

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Retrospective Reviews (continued)

OIG Case Number
24-0087460-INQ

Rating Assessment
Poor

Case Summary

On June 24, 2024, a supervising librarian allegedly refused to make photocopies of legal paperwork for an incarcerated person after inappropriately determining the material was offensive. When the incarcerated person informed the supervising librarian that he would submit a complaint concerning her refusal to make him photocopies, the supervising librarian allegedly called the incarcerated person a snitch in front of other incarcerated people.

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 identify, reference, and include in the inquiry report the records of departmental policy and procedure which outline the standards for "offensive" materials and the reproduction of documents for court filings. Thus, the investigator failed to provide the criteria necessary to assess if the supervising librarian violated departmental policy given her admission that she refused to photocopy legal paperwork which she deemed offensive. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. The OIG could not assess the appropriateness of the hiring authority's finding related to the supervising librarian's refusal to photocopy documents since the investigator failed to provide for the hiring authority the applicable policy and procedure as a basis to make a finding.

OIG Case Number
24-0073179-INQ

Rating Assessment
Poor

Case Summary

Between July 30, 2023, and October 16, 2023, three officers allegedly harassed an incarcerated person when they tampered with the incarcerated person's mail and forced him to live in a cell for over one month without a working light which caused him to fall and injure himself. The three officers also allegedly conducted excessive and retaliatory searches of the incarcerated person's cell because he previously submitted written complaints about the officers. In addition, the first officer allegedly used profanity toward the incarcerated person, and the first and second

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Retrospective Reviews (continued)

officers allegedly issued false rules violation reports stating the incarcerated person possessed alcohol. Unknown officers allegedly also inappropriately denied the incarcerated person's request for a different housing assignment.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations that the three officers acted discourteously towards the incarcerated person and targeted his cell for excessive searches. The hiring authority also found insufficient evidence to sustain the allegation that unknown officers inappropriately denied the incarcerated person's request for a housing unit move. In addition, the hiring authority properly determined that the first and second officers issued rules violation reports to the incarcerated person for possession of alcohol that were justified, lawful, and proper. The hiring authority failed to determine a finding on the allegations that the three officers allegedly tampered with the incarcerated person's mail, forced him to live in a cell for over one month without a working light causing him injury, and that the first officer allegedly used profanity toward the incarcerated person. The OIG did not concur that the inquiry was adequate to make findings on the allegations.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team screened the grievance and identified only vague allegations that three officers acted discourteously toward the incarcerated person. The Centralized Screening Team failed to identify allegations that officers forced the incarcerated person to live in a cell for over one month without a working light, officers tampered with the incarcerated person's mail, and that one officer used profanity toward the incarcerated person.

In addition, the Centralized Screening Team improperly routed the complaint for a local inquiry even though the incarcerated person alleged that the three officers targeted his cell for searches because he had submitted a prior complaint and that two of the officers authored falsified rules violation reports against him. These types of allegations are staff misconduct listed in the department's Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. The investigator, the Office of Internal Affairs manager, and the hiring authority also failed to identify the complaint contained allegations of staff misconduct listed in the Allegation Decision Index and should have disputed the referral for proper assignment to the Office of Internal Affairs for investigation. The investigator failed to identify and investigate the allegations that the first officer used profanity toward the incarcerated person and that officers tampered with the incarcerated person's mail. The investigator identified but failed to meaningfully investigate the allegations that the incarcerated person fell and injured himself because officers failed to respond appropriately to his nonfunctioning light and that officers inappropriately denied his request to change his bed assignment. The investigator failed to obtain video-recorded evidence for the inquiry because

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Retrospective Reviews (continued)

the investigator submitted an overly broad request for video recordings to the investigative services unit and failed to include the relevant rules violation report log numbers as a reference to identify the dates and times of potentially relevant footage. The investigator interviewed the incarcerated person who submitted the complaint, two incarcerated people who were witnesses, three staff witnesses, and the three officers who were the subjects of the inquiry and failed document in the inquiry report if he provided a confidentiality admonishment during the interviews. The investigator failed to ask the officers who were the subjects of the inquiry questions about cell search policies and procedures or why the incarcerated person's cell was searched during the relevant time frames, which could have yielded useful insight into the officers' decisions to search the incarcerated person's cell. The investigator also failed to follow departmental training and best practices regarding the order for completing interviews by interviewing two staff witnesses after two officers who were subjects of the inquiry and did not provide justification in the inquiry report for this deviation. In addition, the investigator failed to interview witnesses who were identified during the inquiry, such as the cellmate of the incarcerated person who submitted the complaint and a staff witness who was present when officers discovered alcohol in the incarcerated person's cell. The investigator failed to identify, reference, and include the records of departmental policy and procedure applicable to the officers' alleged misconduct, such as policies and procedures related to cell searches and contraband. The investigator also failed to attach documents referenced as exhibits to the inquiry report such as the departmental records related to the incarcerated person's cell searches and alcohol-related rules violation reports. The Office of Internal Affairs manager and the hiring authority failed to identify the oversights in the inquiry report and instead approved the report as adequate. The Centralized Screening Team received the complaint on October 16, 2023, but the hiring authority did not determine a finding for each allegation until January 22, 2024, 98 days thereafter and eight days beyond the department's goal.

OIG Case Number
24-0087464-INQ

Rating Assessment
Poor

Case Summary

On April 1, 2024, two officers allegedly made a comment in a housing unit that an incarcerated person raped a little girl and used disrespectful nicknames to refer to the incarcerated person.

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Retrospective Reviews (continued)

Case Disposition

The hiring authority determined that the inquiry conclusively proved the misconduct did not occur. The OIG did not concur with the hiring authority's findings regarding the allegations nor 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 incarcerated person who submitted the complaint, but the investigator failed to collect any new information and documented in the inquiry report only that the incarcerated person reiterated the allegations in his complaint. The investigator should have elicited additional information or details related to the allegations. The investigator then failed to interview the two officers who were subjects of the inquiry and instead relied solely upon the video-recorded evidence he obtained to determine that interviews of the officers were unnecessary. The investigator's decision was inappropriate because the investigator obtained incomplete video-recorded evidence which did not provide evidence sufficient to justify the decision to not interview the officers. Specifically, the incarcerated person identified in his written complaint a 20-minute period during which the alleged misconduct occurred, but the investigator only obtained approximately 12 minutes of body-worn-camera footage for each officer. The investigator failed to explain in the inquiry report why the video recordings he obtained did not include the entire period the incarcerated person reported. The investigator also failed to conduct any follow-up investigation to substantiate the date and time of the incident after the video-recordings did not reveal any interactions between the incarcerated person and the officers. 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 instead approved the report as adequate.

OIG Case Number
24-0086257-INQ

Rating Assessment
Poor

Case Summary

On unknown dates on or prior to March 24, 2024, unidentified officers allegedly broadcast vulgar and disturbing video recordings inside a housing unit which encouraged violence and caused an incarcerated person to experience mental instability.

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Retrospective Reviews (continued)

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 identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the officers' alleged misconduct. The investigator failed to request and obtain video-recorded evidence relevant to the inquiry. The investigator inaccurately documented in the inquiry report that the prison's body-worn or video-recording cameras were inoperative and that the alleged misconduct was restricted to the inside of the cell of the incarcerated person who submitted the complaint. Since the investigator failed to request video- recorded evidence, the department deleted the recordings pursuant to its 90-day video retention policy before the department finalized the inquiry. The investigator interviewed nine people who were witnesses and asked eight of them only one question. For example, the investigator asked an incarcerated person who was a witness only if he heard or saw anything unusual on or about the date of the incident. The investigator also failed to provide the witness any details about the alleged incident to refresh his recollection to potentially gather relevant evidence.

The investigator failed to document in the inquiry report if she provided a psychologist who was a witness an advanced written notice of interview, advisement of rights, and if she provided the psychologist a confidentiality admonishment during the interview. In addition, the investigator failed to document if she provided the incarcerated person and seven officers who were witnesses with a confidentiality admonishment during their interviews. The Office of Internal Affairs manager and the hiring authority failed to identify the inquiry report's insufficiencies and instead approved the report as adequate. Overall, the department untimely completed the inquiry 94 days after the Centralized Screening Team received the complaint and four days beyond the department's goal.

OIG Case Number
24-0087467-INQ

Rating Assessment
Poor

Case Summary

Between March 27, 2024, and March 30, 2024, unknown officers allegedly forced an incarcerated person to sleep on a wet mattress and sheets after they failed to act in response to the incarcerated person's multiple reports that his cell was leaking water.

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Retrospective Reviews (continued)

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 obtain any video-recorded evidence after he submitted an overly broad request for video footage spanning a three-day period of the incarcerated person's cell. The investigative services unit denied the video request and provided vague reasoning that the video recordings were unavailable. The investigator inaccurately documented in the inquiry report that he could not locate any video recordings because the incarcerated person who submitted the complaint did not provide specific dates or times. To the contrary, the incarcerated person provided specific dates in his written complaint, and the investigator should have developed a reasonable time frame directed during the evening time to formulate a more specific request for video recordings based on the incarcerated person's claim that officers forced him to sleep on a wet mattress. The investigator interviewed the incarcerated person who submitted the complaint and failed to document in the inquiry report any details concerning the incarcerated person's complaint. In addition, the investigator failed to gather evidence such as the gender, physical descriptions, or any other information to identify the officers who allegedly failed to assist the incarcerated person after he reported having a wet mattress. 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 inaccurately numbered the exhibits which made it difficult to reference the exhibits in the inquiry report. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's oversights in the inquiry report and instead approved the report as adequate. The department also delayed the inquiry at several steps, which caused the inquiry to be completed untimely. First, the hiring authority delayed 24 days to assign an investigator after receiving the case from the Centralized Screening Team. The investigator then delayed 43 days after completing the final interview to submit the inquiry report to the Office of Internal Affairs manager for review. The Office of Internal Affairs manager then delayed 35 days to review and approve the inquiry report. Overall, the department untimely completed the inquiry 120 days after the Centralized Screening Team received the complaint, and 30 days beyond the department's goal.

OIG Case Number
24-0091194-INQ

Rating Assessment
Poor

Case Summary

On May 30, 2024, an officer allegedly opened an incarcerated person's legal mail outside the incarcerated person's presence and without his permission.

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Retrospective Reviews (continued)

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 failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations such as guidelines for handling and distributing legal mail for incarcerated people. The investigator requested video-recorded evidence but failed to document and include his request as an exhibit to the inquiry report. The investigator also failed to document whether he obtained and reviewed video-recorded evidence or why the video-recorded evidence was not available. In addition, the investigator failed to ask the officer who was the subject to clarify if the legal mail he delivered to the incarcerated person was previously opened and the department's policy regarding the processing and opening of mail, including legal mail, prior to delivering mail to incarcerated people.

OIG Case Number
24-0082958-INQ

Rating Assessment
Poor

Case Summary

On or prior to October 23, 2023, an officer allegedly confiscated sheet hangings from only incarcerated persons of a specific race during a security check. The officer also allegedly used vulgar language and created a hostile environment for incarcerated persons.

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 include a synopsis of the allegations in the notification of staff complaint served on the officer. The investigator also failed to complete all interviews until 109 days after the hiring authority assigned the inquiry to an investigator. The investigator interviewed failed to document in the inquiry report if he provided a confidentiality admonishment during the interviews he conducted. The investigator interviewed the incarcerated person who submitted the complaint and failed to ask questions beyond if the incarcerated person had anything to add to his written complaint. The investigator failed to submit

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Retrospective Reviews (continued)

a timely request for all video-recorded evidence relevant to the inquiry, thus the department deleted the recordings pursuant to its 90-day video retention policy. The investigator failed to identify, reference, and include in the inquiry report all records of departmental policy and procedure applicable to the allegations. The department incorrectly remitted a case closure memorandum response dated April 26, 2024, to the incarcerated person who submitted the complaint which predated the hiring authority's approval of the inquiry report on April 27, 2024. The hiring authority did not determine a finding for each allegation until 97 days beyond the department's goal.

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Contemporaneously Monitored

OIG Case Number
24-0084212-INQ

Rating Assessment
Satisfactory

Case Summary

On June 19, 2024, an officer allegedly harassed and verbally insulted an incarcerated person after the incarcerated person refused to move to a different table in the dining hall.

Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed satisfactorily. Initially, the investigator was not going to interview the officer who was a subject of the inquiry; however, after the OIG's recommendation the investigator interviewed the officer.

OIG Case Number
24-0072393-INQ

Rating Assessment
Poor

Case Summary

On December 9, 2023, a nurse allegedly accused an incarcerated person of fabricating his medical emergency. Upon arrival at the medical clinic, the nurse allegedly had staff place the incarcerated person in a holding cell where he remained for over two hours without receiving medical attention.

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. Prior to the initial case conference with the OIG, the investigator failed to collect any evidence and had not considered who to interview to complete a thorough inquiry which rendered her ill prepared to discuss her investigative plan with the OIG. The investigator conducted an interview of the incarcerated person who submitted the complaint and failed to provide the OIG with proper notice which prevented the OIG from monitoring and providing real-

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Contemporaneously Monitored (continued)

time feedback and recommendations. The investigator failed to provide a summary of the allegations to two witnesses and failed to use a work roster to refresh the recollections of two witnesses who were uncertain if they worked on the date of the alleged misconduct. During two interviews, the investigator repeated a question to the point of visibly frustrating an officer who was a witness and the representative of the nurse who was the subject. The investigator failed to interview a sergeant whom the subject nurse identified as a potential witness who responded to the code alarm and failed to explain in the inquiry report the rationale behind that decision. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. The investigator unreasonably delayed the inquiry by completing interviews 64 days after being assigned to complete the inquiry. The investigator further delayed an additional 31 days to submit the draft inquiry report to the Office of Internal Affairs manager. The hiring authority unreasonably delayed 72 days from receipt of the inquiry report to determine a finding for the allegations. Overall, the department untimely completed the inquiry 223 days after the Centralized Screening Team received the complaint, and 133 days beyond the department's goal. Finally, the hiring authority incorrectly found the inquiry conclusively proved the nurse did not accuse the incarcerated person of fabricating his illness but later changed the finding to not sustained based on the OIG's recommendation.

OIG Case Number 24-0077018-INQ

Rating Assessment
Poor

Case Summary

On February 18, 2024, two officers allegedly ordered an incarcerated person to place his hands behind his back and a sergeant allegedly ordered the second officer to handcuff the incarcerated person contrary to a medical order which required a special handcuffing accommodation.

Case Disposition

The hiring authority conducted an inquiry and determined that the conduct did occur, but the actions were justified, lawful, and proper. The OIG did not agree as the hiring authority should have sustained the allegations.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to include the written notice of staff complaint provided to the sergeant who was a subject of the inquiry as a supporting exhibit to the inquiry report. The investigator failed to ask the sergeant and both officers who were subjects of the inquiry the details of the preceding battery on staff incident, particularly those details which warranted the officers' emergency response and thereby a disregard for the incarcerated person's

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Contemporaneously Monitored (continued)

medical order for a special handcuffing accommodation. In addition, the investigator failed to ask the first officer who was the victim of the battery if he was injured, felt pain, or experienced discomfort when the incarcerated person, while seated, underhand tossed a T-shirt toward the officer's right hand. Or, if he did not suffer any injury, whether he believed the contact with the T-shirt to his right hand was offensive since a battery is defined as the application of force upon a person which either results in offensive contact or injury. The investigator also failed to interview the incarcerated person's cellmate who was a potential witness to the alleged battery on staff and who could have provided further evidence regarding the incarcerated person's behavior towards officers that warranted an emergency response. The grievance coordinator failed to notify the OIG during all phases of the inquiry report review and approval process, including submission of the final inquiry report to the hiring authority for review. The lack of adequate communication prevented the OIG from conducting contemporaneous monitoring and providing real-time feedback. The hiring authority incorrectly determined that the conduct did occur, but the actions were justified, lawful, and proper when according to the department's operations manual and the evidence collected, the evidentiary threshold was not met in this case. The hiring authority should have sustained the allegations. In addition, the hiring authority incorrectly remitted a case closure memorandum response dated June 28, 2024, to the incarcerated person who submitted the complaint which predated the approval of the inquiry report on July 10, 2024. Finally, the hiring authority did not determine a finding for each allegation until 24 days beyond the department's goal.

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