Amarik K. Singh, *Inspector General*

Shaun Spillane, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

May 2025

The Office of the Inspector General's Monitoring in 2024 of the Local Inquiry Process of the Department of Corrections and Rehabilitation

2024 Annual Report

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Independent Prison Oversight

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Sacramento
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May 6, 2025

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

Dear Governor and Legislative Leaders:

Pursuant to California Penal Code section 6126(i), the Office of the Inspector General is responsible for the oversight of the staff misconduct local inquiry process of the California Department of Corrections and Rehabilitation (the department). This report describes the OIG's monitoring of the department's staff misconduct local inquiry process in 2024.

The OIG monitored the performance of the department's locally designated investigators in conducting inquiries and departmental staff involved in the process and provided an overall rating. For each of the local inquiry cases we monitored, we assessed the performance of departmental staff and provided an overall rating using an assessment tool that consisted of an overarching question with a series of subquestions. We assessed whether the department appropriately conducted inquiries into allegations of employee misconduct. We assessed the inquiry work of locally designated investigators as *superior*, *satisfactory*, or *poor*. We reviewed key criteria, including the department's regulations for addressing allegations of staff misconduct, as well as departmental directives regarding the inquiry process. We also participated in departmental training and reviewed the training materials used to instruct investigators who conduct inquiries at the prisons.

The OIG determined the department's performance was *poor* in conducting staff misconduct local inquiries. From January 1, 2024, through December 31, 2024, the OIG monitored and closed 415 local inquiries. The OIG assigned one of three overall ratings for each case: *superior*, *satisfactory*, or *poor*. The department's overall performance was *poor* in 270 of 415 cases, or 65 percent, and *satisfactory* in 145 cases, or 35 percent

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Sincerely,

Amarik K. Singh
Inspector General

Contents

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Introduction

The California Department of Corrections and Rehabilitation (the department) has a process in place in which an incarcerated person, a parolee, or any third-party individual or a group can make an allegation of staff misconduct and submit it to the department for further review and handling. An allegation of staff misconduct is a complaint in which an individual or group alleges that a departmental employee violated a law, a regulation, departmental policy, or an ethical or professional standard. A complaint may contain one or more allegations of staff misconduct. The Office of the Inspector General (the OIG) is statutorily required to "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, departmental policy, and best practices."[1]

The department maintains a list of the most serious allegations called the Allegation Decision Index. If the department receives an allegation that is less complex in nature and not listed in the Allegation Decision Index, the department refers the allegation to the proper hiring authority for a local inquiry. The hiring authority at the prison assigns a locally designated investigator, trained to conduct local inquiries, to the case. 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 report and supporting exhibits, along with any subsequent revisions to the report is reviewed by an Office of Internal Affairs manager to determine whether the inquiry is sufficient, complete, and unbiased. Once approved, the report is provided to the hiring authority. If the hiring authority finds the inquiry is sufficient, he or she will determine a finding for each allegation.

The OIG Staff Misconduct Monitoring Unit Local Inquiry Monitoring Team monitors cases involving less serious allegations against departmental staff that have been referred to a prison for a local inquiry. The Local Inquiry Monitoring Team, comprised of attorneys, monitors the department's local inquiries from the time the Centralized Screening Team sends an allegation to a hiring authority for assignment to a locally designated investigator until the hiring authority determines a finding regarding the allegation. In addition to contemporaneously monitoring local inquiries, the OIG also conducts retrospective case reviews. Through this process, the OIG reviews a selection of inquiry cases that the department completed and closed without contemporaneous monitoring or real-time feedback from the OIG to assess the department's performance in those cases.

1. California Penal Code section 6126 (i).

In all cases, retrospectively reviewed or contemporaneously monitored, OIG attorneys evaluated whether the department conducted thorough, unbiased, and timely local inquiries. Our assessment included whether investigators adequately collected and reviewed evidence and prepared timely inquiry reports. OIG attorneys also analyzed whether departmental managers properly reviewed inquiry reports to ensure reports were sufficient, complete, and unbiased. Moreover, OIG attorneys evaluated whether hiring authorities made reasonable decisions about the adequacy of completed inquiries, made appropriate findings for allegations, and imposed corrective action when warranted.

In 2024, the OIG produced and published select sets of monthly case blocks from the local inquiry cases we contemporaneously monitored and retrospectively reviewed each month. The case blocks consisted of a case summary, the department's disposition, and the OIG's overall assessment of each inquiry. The reports also included the overall ratings for all cases monitored that month. Case blocks can be found on the OIG's website.

In this report, the OIG uses the terms grievances and complaints synonymously. The law requires that we issue reports annually. This report covers the OIG's monitoring and assessment of the department's handling of its staff misconduct complaint local inquiries from January 1, 2024, through December 31, 2024.

On December 26, 2024, the department issued new regulations modifying its processes related to its review and handling of allegations of staff misconduct. As of January 1, 2025, the department processes allegations of staff misconduct as routine reviews if they are not listed in the department's Allegation Decision Index. Instead of locally designated investigators completing local inquiries into the allegations of staff misconduct not on the department's Allegation Decision Index, the allegations will be routed to a supervisor or manager at the prison for a routine review. The OIG will monitor the routine review process concerning allegations of staff misconduct that are not listed on the department's Allegation Decision Index.

Summary

In 2024, the OIG monitored and closed 415 staff misconduct local inquiry cases. Of the 415 inquiry cases, the OIG monitored 126 cases contemporaneously and 289 retrospectively. In all, some of the cases the OIG monitored and closed in 2024 were opened by the department in 2023 but not concluded until 2024. For each case, we assigned one of three overall ratings: *superior*, *satisfactory*, or *poor*. Overall, we determined the department's performance was *poor* in conducting local inquiries.

- The department's performance was poor in 270 of 415 inquiry cases, or 65 percent.
- The department's performance was satisfactory in 145 of 415 inquiry cases, or 35 percent.
- The department did not perform in a superior manner in any inquiry case.

Below, we provide specific information on our assessments of the department's performance in conducting local inquiries. In the concluding section of this report, we offer recommendations to the department for the improvement of its staff misconduct local inquiry processes.

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Monitoring Results

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

The department has a self-imposed goal to resolve local inquiries within 90 days of its Centralized Screening Team receiving a complaint alleging staff misconduct. During this reporting period we found the department did not meet the 90-day goal in 198 of the 415 local inquiries we monitored, or 48 percent. This was a decline in performance from the last reporting period when the department untimely completed 37 percent of the local inquiries we monitored. Several factors can lead to the untimely completion of local inquiries, but the primary cause is usually unreasonable and unnecessary delays by staff. We observed that departmental staff caused unreasonable and unnecessary delays throughout the inquiry process in 154 of 198 cases, or 78 percent[2].

Of all the cases the OIG monitored, we observed that cases involving California Correctional Health Care Services were the most problematic, with unreasonable and unnecessary delays resulting in untimely processing of local inquiries in 50 of 56 health care cases, or 89 percent. We attributed most of the unreasonable delays to the California Correctional Health Care Services Staff Misconduct Team[3], or to hiring authorities who caused significant delays in processing and reviewing inquiry reports and determining findings on allegations against health care staff. Of the cases we monitored that were not related to health care, we observed that the Division of Adult Institutions investigators commonly caused significant and unreasonable delays by failing to timely complete required inquiry work, including conducting interviews and writing inquiry reports.

This reporting period, the OIG only criticized the department for failing to meet its goal if it failed to complete inquiries well beyond its 90-day goal, or if the delays were beyond the department's 90-day goal and we also found multiple deficiencies in the case. Below are examples of inquiries in which the department significantly delayed.

- An incarcerated person alleged that an officer prematurely disconnected the incarcerated person's telephone call and then laughed at him. The hiring authority assigned an investigator to

2. There were 44 cases that were untimely, but those cases only experienced short delays, and did not include unreasonable delays at one or more steps in the process.

3. The California Correctional Health Care Services Staff Misconduct Team provides administrative oversight for inquiries involving allegation of staff misconduct against health care staff.

conduct the local inquiry on January 24, 2023, but the investigator did not conduct any interviews. A second investigator was assigned nearly one year later, and did not conduct his first interview until January 17, 2024, 358 days thereafter, and one day before the statutory deadline to take disciplinary action against the officer. Overall, 404 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority determined a finding on the allegations. Due to the delay in completing the inquiry, the department was statutorily time-barred from taking disciplinary action against the officer, had it been warranted.

- An incarcerated person alleged that a sergeant instructed two officers to transport the incarcerated person to a second prison without inventorying his property. Without the proper inventory records, the second prison refused to accept the incarcerated person's property, and his hearing aids were lost. The hiring authority assigned an investigator to conduct the inquiry on January 25, 2023, but the investigator failed to initiate any work on the inquiry. The hiring authority then unreasonably delayed 478 days before assigning a second investigator on May 17, 2024. As a result of the delay, the investigator failed to retrieve relevant video-recorded evidence before it was overwritten and purged pursuant to the department's 90-day video retention policy. Overall, 511 days elapsed between the day the Centralized Screening Team received the allegations and the day the hiring authority determined a finding on the allegations. Due to untimely completing the inquiry, the department was statutorily time-barred from taking disciplinary action against the sergeant and two officers, had it been warranted.

- An incarcerated person alleged that a nurse yelled at him and broke his television when the nurse pulled the power cord excessively hard. The Centralized Screening Team routed the complaint for a local inquiry on July 26, 2023, but the California Correctional Health Care Services Staff Misconduct Team failed to send the complaint to the hiring authority to assign an investigator until September 14, 2023, 50 days thereafter. The hiring authority then delayed an additional 32 days before assigning an investigator on October 16, 2023. The hiring authority assigned a second investigator on December 7, 2023, but the second investigator did not conduct his first interview until 67 days after he was assigned. The second investigator subsequently submitted his inquiry report to the Office of Internal Affairs for approval without including the report's exhibits, which caused an additional delay of 24 days. The Office of Internal Affairs approved the inquiry report on April 2, 2024, but the hiring authority unreasonably delayed until September 27, 2024, to determine a finding, 178 days thereafter. Overall, 434 days elapsed

between the day the Centralized Screening Team received the allegations and the day the hiring authority determined a finding on the allegations.

- An incarcerated person alleged that a nurse violated professional standards by using inappropriate language to refer to the incarcerated person's body parts, including the incarcerated person's genitals. The investigator submitted the inquiry report to the Office of Internal Affairs for approval on August 22, 2023, but the manager delayed 41 days reviewing the report before returning it to the investigator for additional inquiry work. The investigator submitted a revised inquiry report on October 2, 2023, but the California Correctional Health Care Services Staff Misconduct Team delayed 24 days before forwarding the report to the Office of Internal Affairs for approval. After the Office of Internal Affairs approved the report, it sent the report to the hiring authority on November 9, 2023, but the hiring authority delayed an additional 97 days before determining a finding on February 14, 2024. Overall, 240 days elapsed between the day the Centralized Screening Team received the complaint and the day the hiring authority determined a finding on the allegations.

The examples above demonstrate that local inquiries can become delayed at every point in the process. Sometimes multiple delays at different points in the process contribute to the untimely closure of a local inquiry. Delays can also cause significant problems in cases, such as lost evidence, impaired recollection by witnesses and subjects, delayed corrective action, and most significantly, the inability to take disciplinary action when significant misconduct is uncovered because the statute of limitations has expired.

The Department's Local Inquiries Were Compromised Because Investigators, Office of Internal Affairs Managers, and Hiring Authorities Failed to Identify the Departmental Policy, Procedures, and Standards Applicable to Alleged Staff Misconduct Before Making Determinations About Whether Staff Misconduct Occurred

The department has an obligation to investigate allegations of staff misconduct directed toward incarcerated people or supervised people and hold staff accountable when sufficient evidence is established to sustain allegations. Staff misconduct is behavior that results in a violation of law, regulation, policy or procedure, or actions contrary to an ethical or professional standard. To hold staff accountable, there must be a rule in place at the time of the incident governing the behavior alleged to be staff misconduct. Early identification of the rule, or rules, applicable to the alleged misconduct is an important investigative step locally designated investigators must take to determine the scope of an inquiry, identify pertinent witnesses, formulate relevant interview questions, and collect relevant evidence. The department encourages and directs investigators to obtain and review relevant rules related to allegations of staff misconduct when preparing to conduct interviews. Investigators should ask staff accused of misconduct about their knowledge and application of the governing rules as they apply to the circumstances of each allegation of misconduct and then identify and collect the appropriate evidence. The hiring authority must also have knowledge of the rules applicable to the alleged misconduct and apply those rules to the evidence collected during an inquiry to determine whether an allegation of misconduct should be sustained. Without proper identification of the rules applicable to the alleged misconduct, the investigator is left to execute an inquiry that lacks a proper foundation. Moreover, the hiring authority and subsequent reviewers are left without any framework upon which to assess the evidence, determine findings for allegations, or understand and evaluate the hiring authority's findings on allegations.

Many benefits are associated with identifying and applying the rules governing staff behavior in the context of inquiries into allegations of misconduct. Yet the department refuses to require its locally designated investigators to identify, reference, or include in inquiry reports the rules governing each allegation of staff misconduct. Instead, the department has taken the position that such collection and analysis is optional. To the contrary, for the reasons stated above, identifying the rules applicable to each allegation of staff misconduct, along with their consistent application, is always important, is a fundamental component to conducting a thorough inquiry, and is a critical component in making an appropriate determination about whether staff engaged in misconduct.

During this reporting period, the OIG found that investigators failed to obtain the records of departmental rules or standards applicable to the allegations of staff misconduct in 235 of the 415 local inquiries we monitored, or 57 percent[4]. The Office of Internal Affairs managers and hiring authorities approved these inquiry reports as adequate despite investigators' critical omissions. More troubling, hiring authorities made determinations about whether staff committed misconduct in these cases without any record of identifying the rules governing expected or required behavior of the accused staff. Below are some examples illustrating how pertinent evidence is overlooked or missed entirely, and how decisions by the hiring authority are ambiguous when the department fails to identify the rules governing staff behavior associated with allegations of staff misconduct.

- A wheelchair-bound incarcerated person alleged that an officer failed to properly secure his wheelchair in a transportation cart. The officer then drove the cart recklessly around a corner causing the incarcerated person and his wheelchair to fall out of the cart, injuring the incarcerated person. The investigator failed to obtain departmental policy and procedures applicable to the allegations, such as policy related to the transport of incarcerated people in wheelchairs, safety requirements or safety checks related to transports, and speed limits associated with wheelchair transports. Because the investigator failed to obtain this important foundational information, the investigator did not ask the officer any questions about his knowledge of transportation security measures or requirements, or how the officer applied his knowledge to the transport of the incarcerated person in this case. The Office of Internal Affairs and the hiring authority approved the inquiry report despite the investigator's omission. Although the hiring authority sustained the allegation against the officer, the OIG reviewed this case retrospectively and was unable to properly assess the hiring authority's decision because the case file was devoid of any rules or standards the hiring authority used to determine a finding.
- An incarcerated person alleged that a cook allowed kitchen workers to prepare food on kitchen surfaces covered with rodent feces. The cook also allegedly instructed kitchen workers to provide under portioned servings of food to incarcerated people using a four-ounce measurement instead of the required eight-ounce measurement. The investigator failed to obtain any departmental rules or standards related to sanitary food preparation, culinary contamination protocols, or meal portion sizes. Consequently, the investigator failed to elicit obtainable evidence related to these topics during the inquiry interviews. For example, if the investigator had obtained the serving size

4. "Records of departmental rules or standards" refers to any laws, regulations, policy and procedure, operating procedures, or directives.

measurement standards, she could have asked the cook or kitchen workers questions to determine what measurements were used to serve food at the time of the incident, which would have provided useful information to the hiring authority when determining whether incarcerated people were being served smaller than required portions. The Office of Internal Affairs and the hiring authority approved the inquiry report despite the investigator's omission and the hiring authority determined the allegations were unfounded.

Recommendation

The department is now processing allegations of staff misconduct as routine reviews if they are not listed in the department's Allegation Decision Index. The OIG recommends that the department develop and implement a policy requiring supervisors who conduct fact-finding during routine reviews to obtain and attach the laws, regulations, policy, procedure, or standards applicable to each allegation of staff misconduct to the record of every routine review.

Hiring Authorities Approved Inquiry Reports That Lacked Thorough Investigation and Were Missing Relevant Evidence

Hiring authorities are required to review each inquiry report and decide if the report is adequate to determine a finding for each allegation of staff misconduct. If the inquiry is insufficient, the hiring authority must request additional fact gathering[5]. Without a comprehensive inquiry, supported by all obtainable relevant evidence, the hiring authority cannot make a fully informed decision about allegations. During this reporting period, the OIG found that hiring authorities returned local inquiries for additional fact gathering in only eight of the 415 cases we monitored, or 2 percent. In May 2024, the OIG began assessing whether the hiring authorities appropriately determined the adequacy of the inquiry before determining a finding on the allegations. From May 1, 2024, through December 31, 2024, the OIG disagreed with the hiring authority's decision that an inquiry was adequate to determine a finding in 113 of 293 cases in which we assessed this requirement, or 39 percent. We disagreed with the hiring authority's assessments regarding the adequacy of the inquiries when investigators did not gather all substantive evidence, did not obtain relevant departmental records, did not interview pertinent witnesses, or failed to ask all relevant questions during interviews. The following cases highlight the hiring authorities' inappropriate approval of inquiries that were incomplete and did not include adequate evidence to enable them to make meaningful and informed findings for the allegations.

- An incarcerated person alleged that unidentified medical staff tried to poison the incarcerated person by administering medications that were not prescribed, forcing him to consume medication off the floor, and allowing officers to touch his medications. The investigator failed to conduct any inquiry work after the incarcerated person declined to participate in an interview. Instead, the investigator documented the incarcerated person's refusal in the inquiry report and failed to conduct further inquiry work such as reviewing medication administration records, medical records, staff sign-in sheets, video recordings, witnesses, other evidence, or any other information that could have led to the identity of the accused staff. The hiring authority inexplicably approved the inquiry report as adequate and found insufficient evidence to sustain the allegations even though the investigator failed to conduct any investigative work.
- A wheelchair-bound incarcerated person alleged that five officers refused to rise from their chairs to operate the elevator the incarcerated person needed to use to attend his class. The investigator failed to identify and interview any of the five officers

5. Title 15, section 3486.2(c)(4)(C)

even after obtaining evidence of exactly when the incident occurred, which officers were working at the time, and video-recorded evidence of an officer interacting with the incarcerated person at the time of the alleged incident. The hiring authority inappropriately approved the inquiry report as adequate and did not sustain the allegations even though the investigator failed to collect all relevant and easily obtainable evidence.

- An incarcerated person alleged that a nurse refused to examine the incarcerated person's nose after he reported to the medical clinic with blood and puss actively discharging from his nose. Instead, the nurse stated he did not care about the incarcerated person's health, offered the incarcerated person Tylenol, and ordered the incarcerated person to return to his housing unit. During his interview, the incarcerated person reported there were two officers present throughout his encounter with the nurse. The investigator interviewed one of the officers, who also recalled a second officer was present, but could not recall the identity of the second officer. The investigator knew the date, time, and location of the encounter between the incarcerated person and nurse yet failed to take any steps to identify and interview the second officer, such as obtaining a work assignment roster and eliciting a physical description of the second officer from the incarcerated person and the first officer during their interviews. The investigator also failed to identify and interview other medical staff who assisted with the incarcerated person's medical care. This would have been helpful because the nurse, who was the subject of the inquiry, stated during his interview that he did not have any interaction with the incarcerated person on the date of the incident, which indicated that nurse might not have been the appropriate subject of the inquiry. The hiring authority inappropriately approved the inquiry as adequate and did not sustain the allegations despite these evidentiary gaps.

Recommendation

The department is now processing allegations of staff misconduct as routine reviews if they are not listed on the department's Allegation Decision Index. The OIG recommends that the department implement standards and training for hiring authorities and designated decision-makers to improve their ability to appropriately assess routine reviews for all relevant evidence before determining findings on allegations of staff misconduct.

The Department Performed Worse in Conducting Thorough, Complete, and Unbiased Inquiries When Not Monitored by the OIG

The OIG completed retrospective reviews of a selection of local inquiry cases the department completed and closed in 2024. We found the department performed significantly worse in these cases when compared to cases the OIG contemporaneously monitored. The OIG reviewed and closed 289 retrospective local inquiry cases during 2024. Of those cases, the OIG rated the overall performance of the department as *poor* in 222 cases, or 77 percent, and *satisfactory* in 67 cases, or 23 percent. Conversely, out of the 126 local inquiry cases the OIG contemporaneously monitored during 2024, the OIG rated the overall performance of the department *poor* in 48 cases, or 38 percent, and *satisfactory* in 78 cases, or 62 percent. When the OIG did not contemporaneously monitor the department, we found that the department performed worse in most aspects of the local inquiries, including the most critical components of the process.

The OIG's retrospective reviews revealed that locally designated investigators failed to complete thorough inquiries and allegation inquiry reports at significantly higher rates when the OIG did not contemporaneously monitor the inquiries. Locally designated investigators who completed inadequate inquiries provided incomplete information and evidence to hiring authorities. These deficiencies can result in the hiring authority's failure to appropriately hold staff accountable for misconduct. Below are the OIG's most significant findings.

- Locally designated investigators properly gathered and reviewed all relevant evidence in only 57 of 289 retrospectively reviewed cases, or 20 percent. When contemporaneously monitored by the OIG, the locally designated investigators gathered all relevant evidence in 99 of 126 cases, or 79 percent. In most cases in which the OIG negatively assessed this issue, the locally designated investigator failed to identify or attach the relevant regulation, policy, or procedure that departmental staff allegedly violated.
- Locally designated investigators completed all relevant interviews in only 206 of 289 retrospective cases, or 71 percent. When contemporaneously monitored by the OIG, the locally designated investigators completed all relevant interviews in 105 of 126 cases, or 83 percent. When investigators failed to identify and interview all relevant witnesses, the hiring authority did not have a complete set of facts and evidence on which to base its findings.
- Locally designated investigators completed thorough allegation inquiry reports that included all relevant facts, evidence, and supporting exhibits in only 48 of 289 retrospective cases, or

17 percent. When contemporaneously monitored by the OIG, the locally designated investigators completed thorough allegation inquiry reports in 81 of 126 cases, or 64 percent.

Because locally designated investigators conducted poor and incomplete inquiries when not contemporaneously monitored by the OIG, the resulting allegation inquiry reports were also lacking information, which could have affected the hiring authority's ability to make informed determinations about allegations of staff misconduct.

The OIG Made a Significant Impact on the Quality of Local Inquiries When Contemporaneously Monitoring the Department

We found that the department performed significantly better in most aspects of local inquiries when contemporaneously monitored by the OIG. Specifically, locally designated investigators performed significantly better in identifying all witnesses and completing all relevant interviews, gathering and reviewing all relevant evidence, and completing thorough allegation inquiry reports that included all relevant facts, evidence, and supporting exhibits.

Of the 126 local inquiry cases the OIG contemporaneously monitored in 2024, the OIG had a significant impact on how the department conducted the inquiry in 68 cases, or 54 percent. Below are examples of cases in which the OIG had a significant impact on how the department conducted the inquiry.

- In one case, the OIG recommended the investigator provide a written notice of interview and advisement of rights to a subject of the inquiry after the investigator failed to do so. The investigator adopted the recommendation. Furthermore, the OIG identified evidence of additional potential staff misconduct not directed toward an incarcerated person and recommended that the locally designated investigator refer the evidence to the hiring authority. As a result, the hiring authority referred the evidence of additional misconduct to the Office of Internal Affairs for consideration of an investigation.
- In another case, the department assigned an investigator who was the subject's supervisor to conduct the inquiry. The department reassigned the inquiry to another investigator after the OIG provided the recommendation to the hiring authority.
- In another case, an incarcerated person alleged that two officers were engaged in a romantic relationship and allegedly kissed in an office. The OIG recommended that the hiring authority challenge the screening decision since the allegations of misconduct were not directed toward an incarcerated person and therefore should have been screened as a routine issue. The department agreed.

Correctional Heath Care Services Locally Designated Investigators Performed Poorly in Completing Thorough, Complete, and Timely Inquiries

The OIG conducted a special retrospective review of 40 local inquiries completed by the California Correctional Health Care Services (CCHCS) from May 2023 through May 2024, to assess the performance of CCHCS in conducting inquiries into allegations of misconduct against health care staff. We assessed CCHCS' overall performance to be *poor* in all 40 cases.

We determined that inquiries into allegations of staff misconduct against health care staff were inadequate at almost every stage of the process, including investigators' preparation for inquiries and overall investigative work, which resulted in insufficient and incomplete allegation inquiry reports. CCHCS also unreasonably delayed processing inquiries, which led to untimely completion of inquiries in all 38 cases in which the hiring authority determined a finding[6]. Our review demonstrated that health care investigators lack the fundamental investigative training, knowledge, and skills necessary to perform adequate inquiries. The following are the OIG's most significant findings.

CCHCS Locally Designated Investigators Performed Poorly in Completing Thorough and Complete Inquiries

To complete a thorough inquiry, an investigator should obtain facts and evidence that enable a hiring authority to make an appropriate decision regarding allegations included in a staff misconduct complaint. The OIG found that investigators did not consistently conduct thorough inquiries, which resulted in nearly all monitored inquiries being deficient. Of the 40 local inquiries the OIG retrospectively reviewed, the locally designated investigator failed to thoroughly and appropriately conduct the inquiry in 38 cases, or 95 percent. An investigator's thoroughness in completing an inquiry is necessary for a hiring authority to conduct a fair review of an allegation of staff misconduct, and to hold staff accountable when necessary. Without a comprehensive inquiry supported by all available and relevant evidence, the hiring authority cannot make a fully informed decision about the allegations.

In 30 percent of cases the OIG monitored, the investigator failed to independently complete all necessary and relevant interviews. When investigators fail to identify and interview all relevant witnesses, the hiring authority does not have a complete set of facts and evidence on

6. Two of the inquiries retrospectively reviewed by the OIG were elevated to the Office of Internal Affairs' Allegation Investigation Unit for investigation and therefore did not result in a decision by the hiring authority.

which to base its findings. Moreover, when hiring authorities must request further interviews of obvious witnesses, delays in the inquiry process ensue. Investigators should identify all pertinent witnesses and interview them in a timely manner. Below are examples of cases in which a CCHCS locally designated investigator failed to complete all necessary and relevant interviews.

- In one case, an incarcerated person alleged that a social worker made false statements regarding the incarcerated person's mental health. In addition, a psychiatric technician and an unknown medical staff member allegedly revealed to other incarcerated people that the incarcerated person had previously filed a complaint against medical staff. The hiring authority bifurcated the inquiry and divided the two allegations between two investigators. One of the investigators failed to interview the incarcerated person who submitted the complaint and relied solely on the other investigator's interview with that incarcerated person even though that interview related to different allegations.
- In another case, an incarcerated person alleged that a recreational therapist showed movies to incarcerated people during group therapy sessions that depicted nudity, sex, and glorified violence. The investigator failed to obtain a group therapy roster to identify and interview incarcerated people who were witnesses and could have provided pertinent testimony regarding the types of movies shown during the group therapy sessions.

In 43 percent of cases the OIG monitored, the investigator failed to ask all relevant questions during interviews. When investigators fail to ask all relevant questions during interviews, the hiring authority does not have all the relevant facts and evidence on which to base its findings. Moreover, when hiring authorities must request a claimant, witness, or subject be reinterviewed, an inquiry can become unreasonably delayed. Below is a case where the investigator failed to ask all relevant questions during an interview.

- In one case, an incarcerated person alleged that a nurse was unhelpful and spoke unprofessionally to the incarcerated person when the incarcerated person requested a liquid nutritional supplement. The nurse allegedly did not believe the incarcerated person needed the supplement and raised his voice and repeatedly yelled at the incarcerated person stating that he was obese and needed to lose weight. The investigator interviewed the incarcerated person who submitted the complaint but failed to ask any questions regarding the allegations made against the nurse. Instead, the investigator simply documented that the incarcerated person did not provide any incarcerated person witnesses or staff witnesses and referenced lab tests conducted three months after the alleged incident to show evidence that the incarcerated person did not require a nutritional supplement.

In 85 percent of cases the OIG monitored, the investigator failed to properly gather and review all relevant documentary, video, and other evidence. Failures associated with these basic investigative requirements demonstrate the inability of CCHCS locally designated investigators to identify, gather, and report on all available and relevant evidence in an inquiry, and result in incomplete allegation inquiry reports. Below are examples of cases in which the investigator failed to properly gather video and photographic evidence.

- In one case, an incarcerated person underwent a medical examination by a nurse who documented the incarcerated person's injuries. The incarcerated person alleged that the nurse later falsified documentation during a second examination, pursuant to directions from an officer, and allegedly removed injuries that were listed in the prior documentation. The investigator failed to submit a timely request for all video-recorded evidence relevant to the inquiry without explanation and despite the nurse specifically referencing video footage in her interview. Consequently, the investigator was not able to retrieve relevant video-recorded evidence before it was overwritten and purged pursuant to the department's 90-day video retention policy. Furthermore, the investigator failed to review all available evidence, including photographic documentation of the incarcerated person's alleged injuries.
- In another case, a nurse allegedly provided an incarcerated person with an insulin syringe absent 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. The investigator failed to include any items as supporting exhibits to the inquiry report, including the source of the incarcerated person's complaint, video-recorded evidence, the advisement of rights provided to the first nurse, and the records of departmental policy and procedure applicable to the allegations.

CCHCS Locally Designated Investigators Performed Poorly in Completing Thorough and Complete Allegation Inquiry Reports

Because CCHCS locally designated investigators conducted inadequate inquiries, as discussed above, the resulting allegation inquiry reports were also lacking information sufficient to enable the hiring authority to make informed determinations about allegations of staff misconduct. The OIG determined that 36 of 40 allegation inquiry reports we reviewed were inadequate, or 90 percent. Conversely, the locally designated investigator prepared a draft inquiry report that included all relevant facts, evidence, and supporting exhibits in only four out of the 40 cases the OIG reviewed, or 10 percent. Failures associated with these basic investigative requirements demonstrated health care staff's inability

to fulfill the investigator's role to efficiently and accurately report the facts and evidence gathered during an inquiry. As a result, investigators submitted inadequate final inquiry reports to hiring authorities that did not include all relevant facts, evidence, or supporting exhibits. The inadequate inquiry reports hindered the hiring authority's ability to make fully informed and appropriate decisions regarding allegations of staff misconduct. Below are two examples:

- In one case, the documents the investigator listed as exhibits in the allegation inquiry report did not match the actual exhibits attached to the report. In addition, the investigator failed to identify, reference, or attach the records of departmental policy and procedure applicable to the allegations.
- In another case previously mentioned, the investigator's first draft inquiry report was deemed inadequate by the Office of Internal Affairs and returned with instructions to complete additional inquiry work, including the completion of additional interviews and a written description of why video-recorded evidence was not requested. The investigator resubmitted a second draft report without following the Office of Internal Affairs' instructions whatsoever.

CCHCS Performed Poorly in Meeting the Department's Own 90-Day Goal to Resolve Staff Misconduct Local Inquiries

Our review demonstrated that CCHCS performed poorly in meeting the department's own goal of completing local inquiries within 90 days. Of the 40 CCHCS local inquiries the OIG retrospectively reviewed, the hiring authority failed to timely complete the inquiry in all 38 cases in which the hiring authority rendered a decision. These delays caused the most significant problems in cases in which the inquiry had to be elevated for investigation to the Office of Internal Affairs' Allegation Investigation Unit. In these circumstances, delays potentially hindered the department from completing the investigation before the statutory deadline to take disciplinary action. In addition, delays created significant deficiencies and resulted in inadequate investigations, especially when witnesses were not timely interviewed, or evidence was lost. The ability to recollect facts and memories was impaired with the passage of time. Investigators should conduct interviews as close in time to the incident as possible to ensure the integrity of an investigation. Below are examples of cases in which the department failed to timely complete an inquiry within its 90-day goal.

- In one case, the hiring authority approved the inquiry report and rendered a decision for the allegations, but did not return its findings to the California Correctional Health Care Services Staff Misconduct Team until 134 days thereafter. Furthermore, the hiring authority failed to complete the inquiry and provide an inquiry response to the incarcerated person until 342 days

after the hiring authority made its initial findings. Ultimately, the department untimely completed the inquiry 404 days after the Centralized Screening Team received the complaint, and 314 days beyond the department's goal.

- In another case, the investigator did not conduct the first interview until 62 days after being assigned to conduct the inquiry. The investigator completed the inquiry report 51 days after conducting the final interview. 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 inquiry 262 days after the Centralized Screening Team received the complaint and 172 days beyond the department's goal.

A Departmental Strike Team Conducted Inadequate Local Inquiries at Two Prisons

In 2024, two prisons had a backlog of open local inquiries. In response, the department established a strike team comprised of several investigators gathered from various other prisons to help with the backlog. The strike team investigated 99 inquiries from the two prisons and the OIG retroactively reviewed 52 of those completed inquiries. Due to the backlog, the strike team cases went mostly untouched until reassigned to strike team investigators which impacted the timeliness and overall integrity of these inquiries. The delays led to the department's failure to meet their self-imposed 90-day deadline goal in 46 cases, or 88 percent of the strike team cases we reviewed. In 16 of those cases, or 35 percent, the delays were so significant that even if the allegations involved potentially serious misconduct the deadline to impose disciplinary action would have expired. The delays also caused the loss of video-recorded evidence, and in many cases, the department had already overwritten and purged the most relevant video footage due to its 90-day video retention policy. The delays also caused memory issues for witnesses and subjects who were unable to recall the specifics of an incident. Significant passage of time led some incarcerated people to refuse to cooperate due to their apathy and distrust of the complaint system, which was originally designed to uncover staff misconduct committed against the incarcerated population. We also identified cases where the Centralized Screening Team missed allegations listed in the Allegation Decision Index. In most of these cases the statute of limitations would have expired before the case was rerouted to the Office of Internal Affairs' Allegation Investigation Unit for investigation. Below are some examples of cases negatively impacted by significant delays.

- In one case, a disabled incarcerated person alleged that an officer harassed him and denied his requests to report early to his shift in the dining hall in retaliation for submitting a complaint against the officer one week earlier. The hiring authority assigned the first investigator to conduct the inquiry, but the investigator failed to initiate any work or make any requests for video-recorded evidence, despite being assigned to the inquiry for 449 days. As a result, by the time a second investigator was assigned, the department had overwritten and purged the video footage pursuant to its 90-day video retention policy. Due to the unnecessary delays, the incarcerated person, who was interviewed 498 days after the Centralized Screening Team received the complaint, could not adequately recall the details surrounding his complaint.
- In a second case, an incarcerated person alleged that a captain and two sergeants denied the incarcerated person and other incarcerated people access to necessary medications. In this case, the investigator conducted his first interview 410 days

after the Centralized Screening Team received the complaint. Due to the significant delays, the captain and both sergeants could not adequately recall the details of the incident during their interviews.

- In a third case, an incarcerated person alleged that a lieutenant, a sergeant, and four officers failed to properly inventory his property, deprived him his right to carry his medications and unnecessarily withheld his medical durable equipment during his transport to an outside hospital. In this case, the hiring authority delayed 394 days to assign and reassign three separate investigators. After the passage of 435 days, the third investigator finally completed the draft inquiry report. Due to the investigators' delays, no video-recorded evidence was ever requested or obtained, and the department overwrote and purged all available video-recorded evidence pursuant to its 90-day video retention policy. Overall, the department delayed 463 days before completing the inquiry and 98 days beyond the deadline to impose disciplinary action had it been warranted.
- In a fourth case, an incarcerated person alleged that an officer racially discriminated against him when she failed to timely provide him with a medically necessary shower, causing the incarcerated person to catch a cold. The incarcerated person further alleged that the officer favored incarcerated people of a specific race who engage in same sex relationships. After the hiring authority assigned three separate investigators who failed to initiate any work on the inquiry, the hiring authority assigned a fourth investigator who finally interviewed the incarcerated person who submitted the complaint, 441 days after the Centralized Screening Team received the compliant. The incarcerated person informed the investigator that he had moved on; therefore, he elected not to cooperate with the inquiry.
- In a fifth case, an officer allegedly failed to meet with an incarcerated person prior to his rules violation report hearing and failed to assist the incarcerated person in his defense. The incarcerated person further alleged that a second officer failed to consider the incarcerated person's hearing impairment and need for adaptive services when making the appropriate disciplinary finding. In this case, the hiring authority assigned and reassigned three separate investigators, the last of whom the hiring authority assigned 417 days after the Centralized Screening Team received the complaint. The first investigator, however, failed to submit a timely request for relevant video footage and the department overwrote and purged all video-recorded evidence pursuant to its 90-day video retention policy before the second and third investigators were assigned to the inquiry. Overall, the department delayed 438 days before completing the inquiry and 73 days beyond the deadline to impose disciplinary action had it been warranted.

The OIG found that the department's Centralized Screening Team incorrectly routed serious allegations of staff misconduct for a local inquiry even though those allegations were listed in the department's Allegation Decision Index and should have been designated for investigation by the Office of Internal Affairs. Moreover, in some instances, the cases that alleged serious misconduct that the department had incorrectly routed for a local inquiry, were then reassessed by the department and incorrectly routed for a routine review. When routing errors occurred, the delays in the identification and the rerouting of cases were sometimes so significant that the deadline to impose disciplinary action, had it been warranted, had expired. Investigators who were assigned to inquiries but who conducted little or no inquiry work compounded these routing error delays. Below are some examples of these types of delays.

- In one case, an incarcerated person alleged that an unidentified officer from the prison's investigative services unit issued the incarcerated person a false rules violation report for possessing illegal drugs. The incarcerated person alleged he had a prior arrangement with the investigative services unit to work in an official capacity as a confidential informant and therefore was in lawful possession of the drugs. The incarcerated person was found guilty in a subsequent hearing despite his claim that the investigative services unit lawfully provided the incarcerated person with the drugs. In this case, the Centralized Screening Team failed to identify the allegation of dishonesty against an officer for issuing a false rules violation report against the incarcerated person. Instead of referring the matter to the Office of Internal Affairs' Allegation Investigation Unit for investigation, the Centralized Screening Team referred the allegations to the prison for a local inquiry. After a lengthy delay, the second assigned investigator recognized the error and properly elevated the matter. However, the first investigator had been assigned to the case for 370 days and failed to conduct any inquiry work or identify the routing error. As a result, by the time the second investigator was assigned to the inquiry, the department overwrote and purged the video-recorded evidence pursuant to its 90-day video retention policy, which had lapsed even before the case was rerouted to the Office of Internal Affairs' Allegation Investigation Unit. Compounding the issues, even if the hiring authority had sustained the allegation of serious misconduct, the one-year statute of limitations would have expired before the department could have taken adverse action against the officer, had it been warranted.
- In a second case, an incarcerated person alleged that a captain and two sergeants denied the incarcerated person and other incarcerated people access to necessary medications. Again, the Centralized Screening Team failed to identify the allegation of endangering the health of incarcerated people by failing

to provide access to necessary medications, which is staff misconduct listed in the Allegation Decision Index. In addition to the routing error, the investigator failed to conduct his first interview for 410 days after the date the Centralized Screening Team received the complaint. The investigator also failed to request all relevant video footage prior to the department overwriting and purging the evidence pursuant to its 90-day video retention policy. Furthermore, due to the delays, even if the hiring authority had sustained the allegations against the captain and both sergeants, the deadline to impose disciplinary action would have lapsed.

- In a third case, an officer allegedly pushed an incarcerated person into a cell and assaulted him. A second officer allegedly unlawfully deployed pepper spray at a second incarcerated person. The department's Centralized Screening Team incorrectly routed the allegations for a local inquiry rather than to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. Over the following 14-month time frame, the department assigned three separate investigators who each failed to complete any work on the inquiry. The prison's strike team subsequently rereviewed the initial screening decision and improperly rerouted the allegations as a routine matter, 449 days after the department initially received the complaint and 84 days beyond the deadline to impose disciplinary action had it been warranted. Moreover, the prison's chief deputy warden reviewed the case and incorrectly confirmed the allegations as a routine issue not identified as staff misconduct.
- In a fourth case, an incarcerated person alleged that an unidentified officer attempted to persuade him to assault a second incarcerated person who was a sex offender. A second unknown officer allegedly told the incarcerated person to mind his own business after the incarcerated person reported that he observed other unknown officers use excessive force on another incarcerated person. The department's Centralized Screening Team incorrectly routed the allegations for a local inquiry despite the seriousness of the allegations, which were more appropriate for an Office of Internal Affairs investigation. The hiring authority assigned two separate investigators to complete the inquiry, but neither investigator completed any investigative work for 491 days. When the prison's strike team reviewed the allegations as part of its backlog of cases, the strike team improperly rerouted the allegations as a routine issue not identified as staff misconduct. The strike team rerouted the allegations as a routine matter 492 days after the department initially received the complaint and 127 days beyond the deadline to impose disciplinary action had it been warranted. Moreover, the prison's chief deputy warden reviewed the case and incorrectly confirmed the allegations as a routine issue.

- In a fifth case, two officers allegedly conspired with a control booth officer to open an incarcerated person's cell door so other incarcerated people could attack him. The Centralized Screening Team improperly routed the allegations for a local inquiry. The complaint should have been routed to the Office of Internal Affairs because it included an allegation of staff misconduct listed in the Allegation Decision Index. After 270 days elapsed from having received the complaint, and not a single interview completed, the prison's Office of Grievances reclassified the complaint as a routine issue for supervisory review. However, when the hiring authority reviewed the complaint for routine assignment, the hiring authority disputed the new referral and returned the case to be investigated as a local inquiry. Ultimately, the department assigned a second investigator to complete the inquiry 279 days after having assigned the first investigator. Due to the delays, the second investigator was unable to obtain video footage since it was overwritten and purged pursuant to the department's 90-day video retention policy.
- In a sixth case, an incarcerated person alleged that a counselor attempted to move him to another yard to be murdered. Despite the serious nature of the allegations, the department's Centralized Screening Team improperly routed the allegations for a local inquiry rather than to the Office of Internal Affairs for an investigation. The hiring authority subsequently assigned an investigator to conduct the inquiry 120 days later, which occurred after the department had overwritten and purged all relevant video-recorded evidence pursuant to its 90-day video retention policy.

Recommendation

The OIG recommends that the department properly route incarcerated people's complaints, and investigators collect and review all relevant evidence and timely complete inquiries or reviews of allegations to ensure complaints from incarcerated people are properly handled.

Investigators Consistently Failed To Make Requests for Video-Recorded Evidence

Investigators should always request and review all available video-recorded evidence, regardless of whether the complainant refuses to provide a statement to the investigator. There are several reasons why an incarcerated person may not want to participate in an investigation inside of a prison. The incarcerated person could fear retaliation when they cooperate with investigators and provide statements regarding an officers' alleged misconduct. An incarcerated person may also feel uncomfortable with having their credibility questioned, especially when it is their word against the word of an officer. Video-recorded evidence can be useful to investigators even when the complainant does not cooperate. First, video-recorded evidence can refresh a witness' recollection when needed because of the passage of time. Second, during an investigation, video-recorded evidence can assist an investigator with identifying potential witnesses who were not previously identified. Lastly, video-recorded evidence, which is objective and unbiased, can exonerate or exculpate the subject of the inquiry.

Investigators did not properly gather and review all relevant evidence, such as relevant video-recorded evidence, in 253 out of 415 or 61 percent of all retrospective and contemporaneous cases we monitored. Some examples are found below:

- In one case, an officer allegedly allowed an incarcerated person to move another incarcerated person's property to a different housing unit without an escort. The officer's action allegedly resulted in the loss of property belonging to the incarcerated person who submitted the complaint. In this case, the investigator failed to document whether he made requests for video-recorded evidence, therefore, the investigator failed to determine the video recording's usefulness, if available.
- In a second case, an incarcerated person alleged that an officer failed to provide the incarcerated person with his medical drink and called him a racial slur. The investigator incorrectly decided not to request video-recorded evidence because the incarcerated person refused to cooperate and participate in an interview. The video-recorded evidence could have potentially served as useful evidence to support or refute the allegations.
- In a third case, an incarcerated person alleged that officers and kitchen staff attempted to trick the incarcerated person into eating pork when they knew the incarcerated person did not eat pork due to religious reasons. Because the incarcerated person refused to be interviewed, the investigator failed to request relevant video-recorded evidence even though a review of video recordings could have identified potential witnesses or even been dispositive to the allegations.

- In a fourth case, an officer allegedly referred to a male incarcerated person as the spouse of a second male incarcerated person. Even though the incarcerated person who submitted the complaint provided the date and reasonable time frame for the misconduct, the investigator reasoned that for lack of a specific time frame he did not request video-recorded evidence. The investigator further confused matters, when he documented in the inquiry report that video recordings did not show the alleged incident despite his failure to obtain the recordings. The Office of Internal Affairs manager who reviewed the investigator's draft inquiry report initially found the report insufficient and directed the investigator to obtain the video-recorded evidence. However, the manager delayed 20 days reviewing the report during which time the department overwrote and purged the video recordings pursuant to its 90-day video-retention policy.

According to departmental policy and training, the investigator must prioritize obtaining video-recorded footage as soon as receiving his or her assignment since video recordings are typically only preserved for 90 days. Investigators are further encouraged to obtain all available video angles. During the training and certification process for locally designated investigators, the investigators are highly encouraged to request and review video-recorded evidence. Video recordings provide an impartial view of the alleged incident and can limit the need for extensive interviews. However, we found that investigators frequently did not request video recordings prior to the 90-day retention period ending. Below are some examples:

- In one case, an incarcerated person alleged that an officer used profanity toward the incarcerated person when the incarcerated person used an incorrect pronoun to address the officer. The investigator was timely assigned to conduct the inquiry just 13 days after the incident occurred; however, the investigator delayed 85 days before completing his first interview and failed to make a timely request for video-recorded evidence. Consequently, the department overwrote and purged the video footage pursuant to its 90-day retention policy. The investigator opined that he was unable to locate any potential witnesses due to the obscure location of the incident in a clinic hallway which underscored the need to obtain all relevant evidence because the video footage could have assisted with identifying other potential witnesses.
- In a second case, officers allegedly watched television for four days straight while on duty. In this case, an initial investigator was timely assigned just 15 days after the incident occurred but conducted no inquiry work for 153 days and failed to request or obtain any video-recorded footage. Subsequently, the hiring authority assigned a second investigator to conduct the inquiry, but by that time the department overwrote and purged the video-recordings pursuant to its 90-day video retention policy.

- In a third case, an incarcerated person alleged that two officers failed to properly inventory his personal property during his transport to a second prison which resulted in the incarcerated person's loss of property. The hiring authority timely assigned the first investigator to conduct the inquiry just seven days after the department received notice of the complaint, but the first investigator failed to initiate any inquiry work and failed to request or obtain any relevant video footage for 478 days. As a result, by the time the hiring authority assigned a second investigator, and initiated any inquiry work, the department overwrote and purged all available video-recordings pursuant to its 90-day retention policy.

The Department Continues to Inappropriately Limit an Investigator's Ability to Obtain Potentially Relevant Video-Recorded Evidence.

Despite the OIG's recommendations in our 2022 report that the department provide investigators with the independence to identify, obtain, and review all video-recorded evidence, the department continues to allow each prison's investigative services unit to determine what video footage is relevant to the investigator's inquiry. The current departmental policy not only impedes the investigator's independence but also undermines the investigator's credibility and authority to complete a competent inquiry. Below are some examples where the departmental policy hindered the integrity of a local inquiry.

- In one case, on separate dates, unidentified officers allegedly forced an incarcerated person to sleep on a wet mattress and sheets after the officers failed to respond to the incarcerated person's multiple reports of a water leak in his cell. In this case, the investigator submitted an overly broad request for video footage of the incarcerated person's cell spanning a three-day period. The investigative services unit denied the investigator's video request and provided a vague response that the video recordings were unavailable. If the investigator had the independence to identify and obtain the video-recorded evidence he could have retrieved it himself to complete his inquiry.
- In a second case, an officer allegedly delayed ten minutes in responding to an incarcerated person who required emergency medical care. The officer also allegedly used derogatory and profane language toward the incarcerated person who had the emergency medical need and other incarcerated people who called for medical assistance. In this case, the investigator made a timely request for video-recorded evidence; however, the investigative services unit denied the request and responded that the video footage was unavailable without providing an explanation.

In the two above-mentioned cases, and pursuant to the department's process for extracting and including video-recorded evidence of allegations against staff in inquiries, the investigative services unit made unilateral determinations that video-recorded evidence was not available. Therefore, the investigative services unit impeded the investigator's independence to determine if video-recorded evidence existed or its relevancy to each inquiry.

Recommendation

The OIG continues to recommend 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 Typically Placed an Over-Reliance on Video-Recorded Evidence in Lieu of Conducting an Interview of the Incarcerated Person Who Submitted a Complaint, and the Subjects and Witnesses of an Inquiry.

Video-recorded evidence is a valuable investigative tool for investigators. As an objectively reliable tool, video-recorded evidence is often uncontradicted and provides an unbiased viewing angle of an incident. However, video-recorded evidence should not always take the place of an in-person interview with a witness. For example, while video-recorded evidence may show that an officer cursed at an incarcerated person, in most cases, video footage cannot explain the officer's intent. It is important to interview all witnesses for mitigation and any plausible explanation that could give the hiring authority the officer's unique perspective regarding his or her behavior. A personal interview could uncover the reason behind the officer's actions, but a video recording alone cannot. The following are two examples:

- In one case, two officers allegedly made inappropriate comments in a housing unit that an incarcerated person raped a child and referred to the incarcerated person with disrespectful nicknames. In this case the investigator failed to interview both officers and instead relied solely on video-recorded evidence to determine that the officers' interviews were unnecessary. However, this decision was inappropriate since the investigator obtained incomplete video footage which did not provide evidence sufficient to justify the decision to not interview the officers. Specifically, the incarcerated person identified a 20-minute incident period in his complaint during which the misconduct occurred. The investigator only obtained approximately 12 minutes of body-worn camera footage for each officer. The investigator further failed to conduct any follow-up investigation to substantiate the date and time of the incident after the incomplete video recordings did not reveal any interactions between the incarcerated person and the officers.
- In a second case, an incarcerated person alleged that an officer ignored his request for medical assistance while he experienced chest pains. In this case, the investigator relied solely on video-recordings as determinative evidence and failed to interview the officer. The investigator's failure to interview the officer was inexplicable, especially after the investigator discovered that the officer had improperly deactivated his body-worn camera at various times throughout the day of the alleged incident.

Investigators should always interview subjects of an inquiry, even if video-recorded evidence exists, so that the subject may challenge the veracity of any relied-upon video-recorded evidence, articulate their own recollection of the event in question, and be provided an opportunity to deny, explain, or mitigate their behavior.

Recommendations

1. The department is now processing allegations of staff misconduct as routine reviews if they are not listed in the department's Allegation Decision Index. The OIG recommends that the department develop and implement a policy requiring supervisors who conduct fact-finding during routine reviews to obtain and attach the laws, regulations, policy, procedure, or standards applicable to each allegation of staff misconduct to the record of every routine review.

2. The department is now processing allegations of staff misconduct as routine reviews if they are not listed on the department's Allegation Decision Index. The OIG recommends that the department implement standards and training for hiring authorities and designated decision-makers to improve their ability to appropriately assess routine reviews for all relevant evidence before determining findings on allegations of staff misconduct.

3. The OIG recommends that the department properly route incarcerated people's complaints, and investigators collect and review all relevant evidence and timely complete inquiries or reviews of allegations, to ensure complaints from incarcerated people are properly handled.

4. The OIG continues to recommend 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.

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The Office of the Inspector General's Monitoring in 2024 of the Local Inquiry Process of the Department of Corrections and Rehabilitation

2024 Annual Report

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OIG