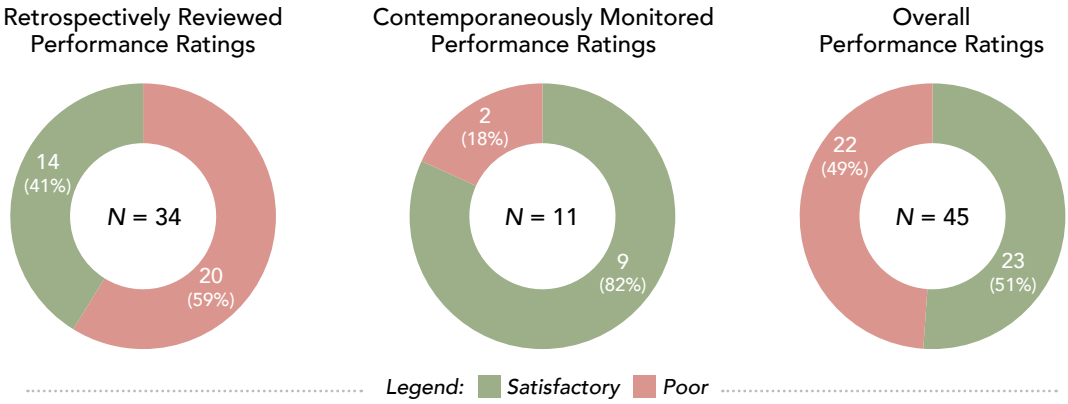
During July 2024, the OIG's Local Inquiry Team closed 45 monitored inquiries. Of those 45 inquiries, the OIG monitored 11 inquiries contemporaneously and monitored 34 inquiries retrospectively. The OIG rated the department's overall performance *poor* in 22 inquiries, or 49 percent. The OIG rated the department's overall performance *satisfactory* in 23 inquiries, or 51 percent.

45 Monitored Inquiries Closed by the Office of the Inspector General During July 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 45 monitored cases, or 51 percent.
- The Office of Internal Affairs adequately reviewed the draft inquiry report and appropriately determined whether the report was sufficient, complete, and unbiased in 21 of the 45 monitored cases, or 47 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 24 of the 45 monitored cases, or 53 percent.
- Aside from exceeding statutory, regulatory, or policy time lines, the department unreasonably delayed completing the inquiry in 13 of the 45 monitored cases, or 29 percent.
- Of the 34 inquiries the OIG monitored retrospectively, the OIG rated the department's performance *poor* in 20 inquiries, or 59 percent.

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

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OIG Case Number
24-0085241-INQ

Rating Assessment
Poor

Case Summary

On October 11, 2023, a canteen supervisor allegedly acted disrespectfully and unprofessionally towards an incarcerated person when he slammed the canteen distribution window in the incarcerated person's face and yelled, "Get away from my window! You are not shopping today!"

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 hiring authority assigned the first investigator to the inquiry on November 2, 2023, but the investigator failed to initiate any work on the inquiry. The department delayed until February 7, 2024, to assign a second investigator to the inquiry, 97 days after assigning the first investigator. The second investigator also failed to initiate any work on the inquiry before the department assigned a third investigator to the inquiry 40 days later. The third investigator then delayed 37 days to complete the first interview on April 24, 2024. Overall, the department completed the first interview 183 days after the Centralized Screening Team received the complaint. Due to the unreasonable delays, the department deleted the video-recorded evidence pursuant to its 90-day video retention policy before the hiring authority assigned the second and third investigators. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to employee professional conduct. The Office of Internal Affairs manager and the hiring authority failed to identify the investigator's omissions and approved the report as adequate. The Centralized Screening Team received the complaint on October 24, 2023; however, the hiring authority determined a finding for the allegation on May 19, 2024, 208 days thereafter and 118 days beyond the department's goal.

OIG Case Number
24-0085240-INQ

Rating Assessment
Poor

Case Summary

On February 13, 2024, a sergeant allegedly laughed at an incarcerated person when the incarcerated person experienced a medical emergency consisting of chest pains and shortness of breath.

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Case Disposition

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

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator interviewed the sergeant who was the subject of the inquiry but failed to document whether she provided a confidentiality admonishment to the sergeant during the interview. During a review of video recordings, the investigator discovered evidence that the sergeant left his department issued body-worn camera unattended on a desk for approximately 45 minutes. However, the investigator failed to identify the evidence as staff misconduct listed in the Allegation Decision Index and refer the case to the Office of Internal Affairs' Allegation Investigation Unit for investigation. The Office of Internal Affairs manager reviewed the inquiry and failed to refer the case for investigation based on evidence the sergeant failed to properly wear his department issued body-worn camera, which is staff misconduct listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. The hiring authority reviewed the inquiry report and discovered the evidence of the sergeant's failure to wear the camera and handled the potential misconduct separately from this case by opening an investigation. The Centralized Screening Team received the complaint on February 14, 2024, but the hiring authority did not determine a finding for the allegation until May 17, 2024, 93 days thereafter and three days beyond the department's goal.

OIG Case Number 24-0084648-INQ

Rating Assessment
Poor

Case Summary

On January 22, 2024, an officer allegedly conducted a retaliatory cell search when an incarcerated person refused to move to another cell. The officer also allegedly told the incarcerated person to kill himself later that day.

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 the records of departmental policy and procedure applicable to the allegations and

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include those records as supporting exhibits to the inquiry report. The investigator obtained incomplete video-recorded evidence as the body-worn camera footage from the officer who was the subject of the inquiry contained a four-minute gap in which the officer's actions were not accounted for. The investigator failed to obtain the missing footage or articulate in the inquiry report the reason for the missing body-worn camera footage. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate. In addition, the hiring authority inaccurately found the inquiry report sufficient and determined a finding for the allegations.

Overall, the department delayed completing the inquiry until May 22, 2024, 99 days after the Centralized Screening Team received the complaint on February 13, 2024, and nine days beyond the department's goal.

OIG Case Number 24-0084638-INQ

Rating Assessment
Poor

Case Summary

On January 23, 2024, unidentified officers allegedly failed to allow an incarcerated person to participate in his video court appearance.

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 determination that the inquiry was adequate to make a finding.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator failed to document in the inquiry report any attempts made to identify a reasonable time frame within which the incarcerated person allegedly and repeatedly requested to be taken to his court hearing. Absent a specific time frame for the alleged misconduct, the investigator did not request video-recorded evidence. Further, the investigator failed to ask the incarcerated person who submitted the complaint questions which may have revealed the identity of the officers who prevented him from attending his court hearing. The investigator also failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure related to the alleged misconduct, such as the guidelines for administering and coordinating an incarcerated person's attendance at court hearings to expose the identity of potential subjects and witnesses. Moreover, the investigator discovered that the incarcerated person indeed had a scheduled court appearance on January 23, 2024, the date of the alleged misconduct, but the investigator failed to conduct additional inquiry work to determine the cause of the procedural failure and which staff if any, were responsible.

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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. After receiving the inquiry report on March 27, 2024, the hiring authority unreasonably delayed 36 days before determining a finding for the allegation. Overall, the department untimely completed the inquiry on May 2, 2024, 99 days after the Centralized Screening Team received the complaint on January 24, 2024, and nine days beyond the department's goal.

OIG Case Number
24-0084097-INQ

Rating Assessment
Poor

Case Summary

On an unknown date prior to January 11, 2024, a sergeant and an unidentified officer allegedly verbally ridiculed an incarcerated person while he received medical treatment.

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 take steps to identify the date of the alleged misconduct after the incarcerated person who submitted the complaint could not recall the date. For example, the investigator could have identified the incarcerated person's records of medical transports and encounters that occurred within a reasonable time frame of the date the incarcerated person submitted the complaint. Absent the alleged misconduct date, the investigator failed to request, obtain, or review any video-recorded evidence, and failed to identify and interview the officer who allegedly ridiculed the incarcerated person. The investigator also failed to include as an exhibit to the inquiry report a list of the incarcerated person's outside hospital transfers, which the investigator referenced in the inquiry report. The Office of Internal Affairs manager failed to identify the investigator's omissions in the inquiry report and instead approved the report as adequate.

Similarly, the hiring authority reviewed the inquiry report and inaccurately found the inquiry sufficient to determine a finding for the allegation. The Centralized Screening Team received the complaint on January 16, 2024; however, the hiring authority determined a finding for the allegation on May 2, 2024, 107 days thereafter and 17 days beyond the department's goal.

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OIG Case Number
24-0083816-INQ

Rating Assessment
Poor

Case Summary

On January 2, 2024, an officer allegedly acted aggressively as he approached an incarcerated person, called the incarcerated person a derogatory name, and laughed as he drove off in a golf cart.

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 investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the officer's alleged misconduct and failed to include in the inquiry report the written notice identifying the officer as the subject of the inquiry. The investigator also failed to attach the supporting exhibits in the same order as they were listed in the inquiry report. In addition, the investigator reinterviewed a sergeant who was a witness because the investigator failed to provide the sergeant with the required written notice of interview and the advisement of rights during the first interview. Furthermore, the investigator failed to follow departmental training and best practices regarding the order for completing interviews by interviewing the sergeant after the officer who was the subject of the inquiry and did not provide justification in the inquiry report for this deviation. After the hiring authority assigned the investigator to conduct the inquiry, the investigator unreasonably delayed 83 days to submit the first draft inquiry report to the Office of Internal Affairs manager. The investigator caused further delays after an Office of Internal Affairs manager deemed the investigator's draft inquiry report inadequate and directed the investigator to complete additional inquiry work on three separate occasions. The manager who reviewed the fourth draft report approved the report as adequate despite the investigator's failure to correct each deficiency the manager identified in the third draft report. The Office of Internal Affairs manager did not determine the report adequate and submit it to the hiring authority until May 30, 2024, 57 days after the investigator submitted the first draft inquiry report on April 3, 2024. Overall, the department untimely completed the inquiry on May 31, 2024, 144 days after the Centralized Screening Team received the complaint on January 8, 2024, and 54 days beyond the department's goal.

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OIG Case Number
24-0083495-INQ

Rating Assessment
Poor

Case Summary

On unknown dates prior to December 3, 2023, unidentified medical staff allegedly allowed unidentified officers to touch an incarcerated person's medication and forced the incarcerated person to consume medication that had fallen on the ground. The medical staff also allegedly tried to poison the incarcerated person by administering him unprescribed medication.

Case Disposition

The hiring authority conducted an inquiry and found insufficient evidence to sustain the allegations that medical staff allowed officers to touch the incarcerated person's medication and administered medication to the incarcerated person that had fallen on the ground. The hiring authority did not make any determination regarding the allegation that medical staff attempted to poison the incarcerated person by administering unprescribed medication. 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 Centralized Screening Team routed the complaint for a local inquiry even though the incarcerated person who submitted the complaint alleged that medical staff attempted to poison him by administering unprescribed medications, which is an allegation of staff misconduct listed in the department's Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. Instead, the Centralized Screening Team documented in the department's staff misconduct database that the allegation was conjecture and dismissed the allegation from investigation. The investigator, the Office of Internal Affairs manager, and the hiring authority failed to independently identify that the complaint included an allegation of staff misconduct listed in the Allegation Decision Index and refer it to the Office of Internal Affairs. The investigator further 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 make any attempts to determine the dates of or the staff responsible for the alleged misconduct after the incarcerated person declined to participate in an interview. Instead, the investigator documented in the inquiry report the incarcerated person's refusal and failed to conduct further inquiry work such as reviewing medication administration records, medical records, staff sign-in sheets, video recordings, or any other information that could have led to the identity of the accused staff, witnesses, or other evidence. The investigator also improperly concluded that no evidence existed to support the allegations, which is a responsibility reserved for the hiring authority. The Office of Internal Affairs manager and the hiring authority failed to identify the inquiry's inadequacies and instead approved the inquiry report as adequate. Finally, the department unreasonable delayed the inquiry at several

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steps in the process. The Centralized Screening Team received the complaint on December 6, 2023, but the hiring authority did not assign an investigator until January 29, 2024, 54 days thereafter. After attempting to interview the incarcerated person on February 5, 2024, the investigator delayed 63 days to submit the draft inquiry report to the Office of Internal Affairs manager. Overall, the department untimely completed the inquiry on May 22, 2024, 168 days after the Centralized Screening Team received the complaint on December 6, 2023, and 78 days beyond the department's goal.

OIG Case Number
24-0082814-INQ

Rating Assessment
Poor

Case Summary

On March 15, 2024, an officer allegedly failed to properly secure a wheelchair bound incarcerated person into a transportation cart and then drove the cart too fast, injuring the incarcerated person who fell out of the cart.

Case Disposition

The hiring authority conducted an inquiry and sustained the allegation. The hiring authority provided training to the officer. The OIG did not concur with the hiring authority's finding. The hiring authority failed to refer the case to the Office of Internal Affairs' Allegation Investigation Unit for an investigation based on evidence found during the inquiry that the officer made false statements to his supervisor, which is misconduct listed in the Allegation Decision Index.

Overall Inquiry Assessment

Overall, the department performed poorly. The Centralized Screening Team initially routed the complaint to the Office of Internal Affairs' Allegation Investigation Unit for an investigation, but the Office of Internal Affairs disputed the screening decision. As a result, the Centralized Screening Team rerouted the complaint for a local inquiry even though the incarcerated person who submitted the complaint alleged that the officer injured him when he fell out of a transport cart. The officer allegedly failed to lock the incarcerated person's wheelchair and the cart's gate, and then drove too fast, which is an allegation of staff misconduct listed in the Allegation Decision Index and designated for investigation by the Office of Internal Affairs' Allegation Investigation Unit. The OIG disagreed with the department's decision to reroute the complaint for a local inquiry. The investigator assigned to the inquiry failed to identify, reference, or include the records of departmental policy and procedure applicable to the allegations, such as the department's policy related to the transport of disabled incarcerated people or safety checks related to transports. The investigator also failed to take steps to identify and interview the incarcerated person that helped load the wheelchair into the transportation cart. The investigator conducted interviews

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and failed to document in the inquiry report whether he provided a confidentiality admonishment during each interview and whether he and by what means he achieved effective communication during his interview with the incarcerated person who submitted the complaint. Finally, the inquiry generated evidence that the officer who was the subject of the inquiry potentially made false or misleading statements to a supervisor, which is staff misconduct listed in the Allegation Decision Index warranting referral to the Office of Internal Affairs for investigation. Specifically, the officer authored and signed a memorandum stating that he instructed the incarcerated person to lock his wheelchair, and then he secured the cart's ramp gate and visually checked the gate on the other side of the cart. A sergeant who was a witness provided conflicting information to the investigator that the officer reported having locked the breaks on the wheelchair. In addition, the investigator documented in the inquiry report that video recordings showed the officer did not check the other side of the cart's gate before driving off. Considering these inconsistencies, the investigator should have ceased further inquiry, documented the evidence in a report, referred the case to the Office of Internal Affairs for an investigation, and notified the hiring authority.

OIG Case Number
24-0082771-INQ

Rating Assessment
Poor

Case Summary

On July 19, 2022, an officer allegedly made a whistling sound to gain the attention of an incarcerated person. The officer allegedly responded with discourteous language toward the incarcerated person after the incarcerated person told the officer whistling was inappropriate.

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 department received the complaint on July 29, 2022, but the department's Office of Appeals did not provide the Centralized Screening Team with the complaint until August 29, 2023, 396 days thereafter. The Centralized Screening Team then delayed 19 days after receiving the complaint before it made a screening decision. The hiring authority assigned the investigator to the inquiry on September 20, 2023, but the investigator delayed 212 days before conducting the first interview. Due to the department's unreasonable delays, the investigator failed to interview the officer who was the subject of the inquiry because the officer separated from state service on May 29, 2023. In addition, the department

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deleted the video-recorded evidence before the inquiry began pursuant to its 90-day video-retention policy. The investigator interviewed the incarcerated person who submitted the complaint but failed to document in the inquiry report whether she achieved effective communication, provided a synopsis of the allegations, and provided a confidentiality admonishment during the interview. The investigator failed to identify, reference, and include in the inquiry report the records of departmental policy and procedure applicable to the allegations. Because the investigator also failed to locate employee sign in sheets, she did not identify and interview a possible additional officer who may have witnessed the alleged misconduct. The Office of Internal Affairs manager initially determined the draft inquiry report was inadequate and returned it to the investigator with directives to review employee sign in sheets and interview additional officer witnesses. The investigator failed to follow the manager's direction and resubmitted a deficient draft inquiry report without obtaining the additional documentation or conducting additional interviews. The Office of Internal Affairs manager and the hiring authority approved the investigator's inquiry report despite the investigator's oversights. The department untimely completed the inquiry on April 30, 2024, 245 days after the Centralized Screening Team received the complaint on August 29, 2023, 155 days beyond department's goal, and 641 days after the Office of Appeals originally received the complaint on July 29, 2022.

OIG Case Number
24-0076199-INQ

Rating Assessment
Poor

Case Summary

On November 29, 2023, an officer allegedly allowed an incarcerated person to move the personal property of a second incarcerated person to a different housing unit without an escort, resulting in the loss of the second incarcerated person's personal property.

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 finding that the allegation was unfounded.

Overall Inquiry Assessment

Overall, the department performed poorly. The investigator interviewed the incarcerated person who submitted the complaint and failed to document in the inquiry report whether he achieved effective communication with the incarcerated person and failed to document whether he provided a confidentiality admonishment to the incarcerated person during the interview. In addition, the investigator interviewed an officer who was a witness and failed to document whether he provided the required advisement of rights and confidentiality admonishment during the interview. The investigator also failed to ask relevant questions to identify additional staff or

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incarcerated people who were witnesses at the time of the alleged misconduct. The investigator interviewed and identified a witness officer as the subject of the inquiry but failed to properly classify the officer as the subject in the inquiry report. The investigator failed to make any efforts to request video-recordings or ensure if any were available. The investigator failed to identify, reference, and include in the inquiry report relevant staff sign-in sheets and the records of departmental policy and procedure applicable to the allegation. In addition, the investigator failed to include the incarcerated person's submitted grievance, property receipt, and housing records, and failed to include the witness officer's written notice of interview and advisement of rights as supporting exhibits to the inquiry report. 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 failed to document a decision regarding the adequacy of the inquiry report before making a finding for the allegation. The hiring authority incorrectly determined the inquiry conclusively proved the misconduct did not occur when according to the department's operations manual, the evidentiary threshold was not met in this case. The hiring authority should have determined there was insufficient evidence to sustain the allegation. The department incorrectly remitted a case closure memorandum response dated December 21, 2023, to the incarcerated person who submitted the complaint which predated the hiring authority's review of the inquiry report on January 12, 2024.

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