

**OFFICE OF INSPECTOR GENERAL
CITY OF ALBUQUERQUE**



**INVESTIGATIVE REPORT
CASE # 12-201**



OFFICE OF INSPECTOR GENERAL
CITY OF ALBUQUERQUE

September 28, 2011

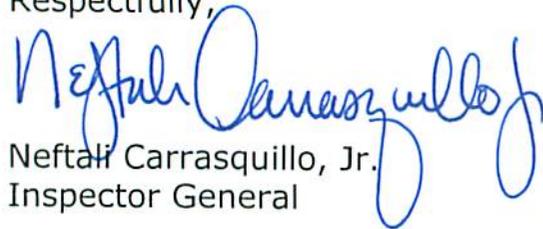
Don Harris, City Council President
City of Albuquerque
One Civic Plaza NW
Albuquerque, NM 87102

**Re: OC-11-27, Request for Inspector General Investigation into the
accident of July 6, 2011 involving Kathleen White**

On August 1, 2011, the City Council for the City of Albuquerque unanimously voted on OC-11-27 to formally request an impartial and thorough investigation into the events related to the single car accident of July 6, 2011 involving Kathleen White. The City Council also requested an examination of the actions of all current and former employees of the City of Albuquerque involved in this matter, to include employees of the Albuquerque Police Department (APD), Albuquerque Fire Department (AFD) and any other City department.

Pursuant to this request, enclosed please find a copy of the Office of Inspector General's report related to this matter. A copy of this report will be delivered to the Mayor's Office and to the Chief of Police and Fire Chief for the City of Albuquerque.

Respectfully,



Neftali Carrasquillo, Jr.
Inspector General

cc: Richard J. Berry, Mayor
Raymond D. Schultz, Chief of Police
James Breen, Fire Chief

EXECUTIVE SUMMARY

On August 1, 2011, the City Council for the City of Albuquerque unanimously voted on OC-11-27 to formally request an impartial and thorough investigation into the events related to the single car accident of July 6, 2011 involving Kathleen White, wife of former Director of Public Safety DPS.

On August 3, 2011, the OIG provided a written response advising the City Council that, in anticipation of receiving a formal request, the Inspector General met with the Accountability in Government Oversight Committee (AGOC). The OIG determined it could and should conduct this investigation and advised the City Council it would use all means and resources available to investigate and report the facts surrounding this incident.

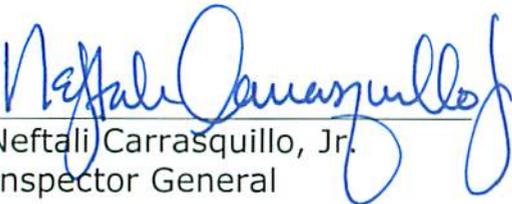
The OIG investigation into this matter commenced with sending an official request for information, documents, reports and list of interviews required to the Chiefs of Police and Fire on August 9, 2011. A total of 45 individuals were interviewed, a significant number of documents and information was reviewed and one subpoena issued.

The following are the conclusions made based on the interviews conducted, documents reviewed and evidence gathered:

- 1. The OIG concludes that the DPS was an intimidating presence on scene because of his position as the Director of Public Safety.**
- 2. The OIG concludes that the DPS did not interfere in any way with the on-scene personnel's performance of their duties.**
- 3. The OIG concludes that the DPS did not "whisk" his wife away but rather took his wife to the hospital after the AFD rescue/paramedic treatment was completed. The DPS was allowed to do so by the primary APD officer on the scene.**
- 4. The OIG concludes that there was enough information to conduct a DWI investigation.**
- 5. The OIG concludes that there is no basis for the allegation that there was a deal made or collusion between the DPS and the Primary APD Officer.**

6. **The OIG concludes that although the Primary APD Officer was asked to make minor administrative changes to his report, he was not ordered to redact/remove the prescription drug reference by the Deputy Chief or anyone else.**
7. **The OIG has concluded that a report containing the medical information of Kathleen White was improperly released, but cannot make a positive determination that it came from the Albuquerque Fire Department.**

Details of the investigation, as well as, recommendations made by the OIG are contained within in the investigative report and are attached to this executive summary.



Neftali Carrasquillo, Jr.
Inspector General

OIG INVESTIGATIVE REPORT: FINDINGS AND CONCLUSIONS OF THE OFFICE OF INSPECTOR GENERAL

On August 1, 2011, the City Council for the City of Albuquerque unanimously voted on OC-11-27 to formally request an impartial and thorough investigation into the events related to the single car accident of July 6, 2011 involving Kathleen White, wife of the former Director of Public Safety (DPS). The City Council also requested an examination of the actions of all current and former employees of the City of Albuquerque involved in this matter, to include employees of the Albuquerque Police Department (APD), Albuquerque Fire Department (AFD) and any other City department. This communication constituted a complaint by officials of the City, specifically, the City Council. The City Council understood the Office of Inspector General (OIG) to be independent of both the City Council and the Mayor, and therefore, upon review of this request the OIG would make a determination whether to accept this request and initiate an investigation.

On August 3, 2011, the OIG provided a written response advising the City Council that, in anticipation of receiving a formal request, the Inspector General met with the Accountability in Government Oversight Committee (AGOC), the Committee from which the OIG takes direction, to discuss the merits of conducting this investigation. As a result, the OIG determined it could and should conduct this investigation and advised the City Council it would use all means and resources available to investigate and report the facts surrounding this incident.

Independence is one of the most important elements of a strong performing OIG, helping to ensure that the OIGs' work is viewed as impartial by the City Council, the Mayor's Office and the employees and residents of the City of Albuquerque. In addition, the OIG must be independent in order to effectively carry out the charge to help prevent and detect fraud, waste, abuse, and mismanagement and promote economy, efficiency, and effectiveness. As such, the mission of the Office of Inspector General is:

***To promote a culture of integrity, accountability,
and transparency throughout the City of Albuquerque
in order to safeguard and preserve the public trust***

In accomplishing this mission, the OIG has four equally important goals:

1. Conduct investigations in an efficient, impartial, equitable and objective manner;

2. Prevent and detect fraud, waste and abuse in city activities including all city contracts and partnerships;
3. Deter criminal activity through independence in fact and appearance, investigation and interdiction; and,
4. Propose ways to increase the city's legal, fiscal, and ethical accountability to insure that the tax payers' dollars are spent in a manner consistent with the highest standards of local governments.

The OIG takes very seriously its responsibility to conduct investigations, as well as its equally important obligation to make recommendations to improve the efficiency in operations.

The OIG investigation into this matter commenced with sending an official request for information, documents, reports and list of interviews required to the Chiefs of Police and Fire on August 9, 2011. The OIG also made a commitment, due to the significant number of interviews anticipated, to work with APD and AFD points of contacts in scheduling these interviews so as to minimize the impact to their respective operations. The OIG met ahead of time with AFD and APD points of contacts and the respective Union representatives. These meetings, along with the questions asked, allowed the OIG to explain the investigative interview process and what the OIG expected. This meeting ultimately proved to be extremely beneficial as there were approximately 41 AFD/APD personnel that were eventually interviewed.

It should be noted that at some point during this investigation, the OIG was provided a copy of the full Independent Review Officer (IRO) Report which it did not review until all interviews were conducted and completed. The IG did read the IRO Executive Summary which was issued on July 29, 2011 but conducted its own independent review and investigation and did not rely on the content of the IRO report. The OIG independently explored some of the same issues, as well as looking at some that were not explored by the IRO.

A total of 45 individuals were interviewed, a significant number of documents and information was reviewed and one subpoena issued. All interviewees were administered an oath and advised of perjury implications. All requirements for union and/or counsel representation were respected as well as all other protections and rights provided to such employees.

The following were the issues the OIG investigated:

I. Did then Director of Public Safety (DPS) interfere, in any way, with the investigation of his wife as a result of her accident on July 6, 2011?

The OIG interviewed all AFD and APD personnel who were involved with the response and reporting of this accident involving Kathleen White, including the DPS. **Based on the interviews conducted, the OIG concludes that the DPS was an intimidating presence on scene because of his position as the Director of Public Safety.** The OIG does not question his legitimate presence on scene as a concerned husband, as this was to be expected. However, 3 of the 4 on-scene personnel stated that his presence was in fact intimidating as he was the "boss." During the interview of the DPS, he stated he understood how they could have felt that way. For the record, the on scene personnel referred to includes the two fire paramedics and the two police officers.

II. The question now becomes, "Did that intimidating presence cause the on-scene personnel to change their normal behaviors or prevent them from doing their jobs?"

Notwithstanding the intimidating presence of the DPS, none of the on-scene personnel stated that the DPS's presence prevented them from performing or completing their duties. One of the paramedics felt very intimidated by the DPS's presence and did not appreciate the DPS coming on scene and telling him he was going to take his wife to the hospital. However, when asked, this paramedic stated that he was never interfered with or prevented from doing his job. The evidence shows the paramedics responded and were able to perform their patient care duties to the best of their abilities and without interference from the DPS. **Based on the interviews conducted and evidence gathered, the OIG concludes that the DPS did not interfere in any way with the on-scene personnel's performance of their duties.** The aspect of whether or not, the DPS interfered or prevented a DWI investigation from being conducted by APD will be addressed later in this report

The previous point is important because of the allegation that the DPS "whisked" his wife away from the scene. The lead paramedic on scene stated that when the DPS arrived, the paramedic had completed his patient care and was in the process of completing an AFD Emergency (EMS) Liability Release form which is commonly referred to as a patient refusal form. This form is completed by AFD personnel, on scene, and then the patient

completes and signs an acceptance of responsibility and release of EMS. This acceptance signifies that the patient understands that EMS personnel have made a good faith determination and assessment that the patient is alert, oriented and understood the treatment options presented by the EMS and voluntarily releases EMS from any liability for any claims arising from the patient's decision to refuse further treatment and transport.

According to the AFD Rescue personnel, there was a private ambulance on scene that was on stand-by and ready to transport if necessary. It is also important to note that AFD paramedics are equipped and capable of transporting patients, if it was necessary or an emergency. Kathleen White was asked if she wanted to be transported by either the AFD Paramedics or private ambulance and she stated that her husband would be taking her to the hospital and signed the Liability Release form which acknowledged this fact. **Based on the evidence gathered and interviews conducted, the OIG concludes that the DPS did not "whisk" his wife away but rather took his wife to the hospital after the AFD rescue/paramedic treatment was completed. The DPS was allowed to do so, as well, by the primary APD officer on the scene.**

III. If there was enough information to conduct a DWI investigation, why was one not conducted?

This issue was extensively explored by the OIG via interviews and review of APD policies, procedures and practices. Upon arriving on-scene, AFD paramedics observed, concluded and ultimately reported that they suspected that Kathleen White was impaired and that she may possibly have been under the influence of an opiate and/or prescription drugs. Both paramedics stated that this information was shared with APD personnel on-scene. During the interview of the Primary APD Officer, he admitted making observations of Kathleen White that, based on his 38 years of experience and having conducted numerous DWI investigations in his career, would cause him to suspect she might have been impaired. The Primary APD Officer also stated that one of the paramedics had told him that she might have been under the influence of prescription drugs. The Primary APD Officer admitted that, based on his experience, what he was told and what he observed, he had enough information to conduct a DWI investigation. However, he further stated he was more concerned with whether Kathleen White was behaving in the manner she was as a result of a head injury. He also stated that when the DPS pulled up the first thing out of his mouth was that he was taking his wife to the hospital. The Primary APD Officer recognized that the DPS was the Director of Public Safety or "supreme commander" in his words, and that he (DPS) was going to do what he was going to do. In this situation, because of his (the Primary APD Officer) concern for her health condition, he

felt it was more important to let the DPS take Kathleen White to the hospital because he could always issue a summons and had six months to do so. The Primary APD Officer felt that he had enough evidence to pursue a future DWI investigation such as the statements made by Kathleen White and the testimony of the paramedics and other witnesses. The Primary APD Officer also stated that he had had situations in the past where he had issued summons in similar circumstances.

The Primary APD Officer stated he was intimidated because of the power the DPS had and was fearful of retaliation. The Primary APD Officer went on to explain a situation regarding a complaint filed against him by a citizen because of how the Primary APD Officer was parked at a gas station where he was allegedly blocking the entrance. The Primary APD Officer stated he was called in and told not to go to that station again and later found out that the citizen making that complaint was the DPS. The DPS confirmed that he in fact had complained about this situation. The Primary APD Officer stated that he had this knowledge, of who had made the complaint, prior to the accident on July 6, 2011. He further stated that if he had it in for the DPS, he could have had a field day. The Primary APD Officer said he chose instead to act professionally because otherwise this could have been a prime opportunity to get back at him. The Primary APD Officer stated he stayed impartial and his concern for Kathleen White's health outweighed his notion to conduct a DWI investigation. The Primary APD Officer stated he did not do any special favors for the DPS and that he handled himself appropriately in this situation.

This last point is important because of the allegation that the DPS used his position to try and cover up the circumstances surrounding this accident investigation. The DPS was asked if he understood that his wife could have been arrested or been the subject of a DWI investigation. The DPS responded by stating that he had done DWI investigations in the past and that it was clear to him that a DWI investigation could have been conducted. He further stated it was his belief that the Primary APD Officer had conducted a DWI investigation already. The DPS admitted that based on his experience and what he observed of his wife, he would have been concerned that she was under some kind of impairment and he would not have questioned anyone, especially the Primary APD Officer, if he had conducted a DWI investigation. Because of his relationship with the Primary APD Officer, the DPS stated he was very careful not to offer any suggestions or direction because that would have opened the door for interfering allegations. The DPS also stated that he believed that the Primary APD Officer was recording the incident. For the record, the OIG is unaware of any official recordings made which are related to the on-scene activities of this accident.

During the interview of the DPS, he was very specific in stating that the Primary APD Officer and he had some history. Because he knew, or at least suspected, that the Primary APD Officer was recording their conversation, he was very careful not to interfere with the Primary APD Officer. This is evidenced by the comments made by the DPS, which the Primary APD Officer confirms, where the DPS says, "You do what you have to do." The DPS did admit that he believed there was enough evidence to conduct a DWI investigation, if he was the officer on-scene, and would not have questioned if one had been conducted. The Primary APD Officer, when asked whether or not the DPS ever ordered or gave him an instruction to do or not do something, stated "no" and that the DPS told him to do what he had to do and that he repeated that he was taking his wife to the hospital. Based on the evidence gathered and interviews conducted, the OIG has concluded that the DPS did not interfere with this investigation but it is clear that his presence on scene was very intimidating. It is also clear that the primary officer on scene understood that there was enough information to conduct a DWI investigation but chose not to do one because of his stated concern for Kathleen White's well-being and his belief in his ability and past practice to issue a summons. **Based on the interviews conducted and the evidence gathered, the OIG concludes that there was enough information to conduct a DWI investigation.**

IV. There was also information regarding an alleged tape of a "secret" meeting with the Primary APD Officer and the DPS. This was being used as proof of some kind of deal or collusion for a cover-up of this incident. The OIG investigated this issue and, based on interviews conducted and evidence gathered, knows that this meeting or rather encounter, did occur and was not secret. The OIG understands that a tape of this encounter does exist and that this encounter occurred at a Valero Station which both the Primary APD Officer and the DPS frequent. The OIG did not review this tape but understands that the tape does not contain audio, only visual. The Primary APD Officer, a second Police Officer and the DPS were interviewed regarding this encounter and all three stated that they did talk, that it was cordial, and what was discussed was the DPS telling them that he was on his way to the hospital, that his wife had been admitted and that his wife had suffered some memory loss. **Based on this information, the OIG concludes that there is no basis for the allegation that there was a deal made or collusion between the DPS and the Primary APD Officer.**

V. The Primary APD Officer was asked why a supervisor was not called. The Primary APD Officer stated that he and the secondary APD Officer on scene discussed the possibility but he felt confident in his ability to handle this situation. When interviewing the supervisor responsible for the two police officers, the Sergeant actually stated that he would have wanted to receive a

call, because of who was involved, and would have personally responded. It should be noted that when this point was discussed with the DPS, he also agreed that in hindsight there was merit in having a supervisor on scene. The Primary APD Officer also admitted that it might have been a good idea to call a supervisor because of the presence of someone in a position like the DPS on-scene. **In the review and investigation of this particular aspect of this incident, the OIG has concluded that having called an on-duty supervisor, who could have responded to the scene, would have possibly prevented some of the allegations that eventually surfaced.** The OIG understands that there currently exist APD procedures which address notification of significant events, however, the OIG recommends that both APD and AFD review their respective policies and consider adding the requirement of a supervisor actually responding, regardless of how minor the event is initially perceived, when someone of note i.e. a city official, a person in the chain of command, etc., is involved. The OIG strongly believes that having a supervisor on scene that could have dealt with the DPS, on the side and away from on-scene activities, would have been the better way to handle a situation like this and would have prevented allegations of intimidation and interference.

VI. The OIG interviewed an APD Lt. who currently works Special Investigations in the Career Criminal Section. Prior to this current assignment, the APD Lt. was over the DWI Section and was in charge of the Drug Recognition Expert (DRE) Program and wrote many of the DRE Program Standard Operating Procedures (SOPs). The APD Lt. was asked what training is required to conduct a DWI investigation and to also explain how a DWI investigation is conducted; what criteria, observations and facts are needed to initiate a DWI investigation; and, what options are available to officers. The APD Lt. stated that the DWI procedures have changed over the years and as such, since 2004 the State has mandated updated DWI training every two years for all officers.

The APD Lt. was provided with the on-scene facts based on the OIG's review of the reports and interviews conducted. Based on these facts, the APD Lt. stated that, absent any indication of head injuries, an attempt should have been made to have Kathleen White perform a Field Sobriety Test (FST) to identify impairment for alcohol or drugs. If she had refused, that would have been enough probable cause to make an arrest. If the officer had health concerns or felt the person may hurt themselves conducting the FST, alternative tests could have been conducted such as a sitting HGN, finger count, finger-to-nose, alphabet or countdown. These alternative tests could have been performed in a seated or lying down position if necessary. Other options available could have also included placing her in custody, if she needed to go to the hospital, and then at the

hospital reading her implied consent and then having a blood draw conducted. The officer could have also placed her in custody, taken her to a sub-station and then called a DRE who would have conducted their investigation, which could have included a breath test and/or blood draw. Once a DRE is called the investigation is then turned over to them.

The APD Lt. was very clear that allowing Kathleen White to be transported to the hospital, by her husband, should not have occurred if there was any intention of either conducting or following up with a DWI investigation. The APD Lt. stated that this action would result in having no way to prove that any impairment observed on-scene, or that any medication she admitted taking, was in fact the cause of that impairment because it was not tested for via an official investigative process. In addition, issuing a summons also has the same effect because you would have lost the ability to test for the cause of the impairment.

VII. During the investigation of this particular aspect, some of the interviewees raised the issue of a comment attributed to the Police Chief which was in conflict with one of the conclusions and findings of the Independent Review Officer. In the July 12, 2011 *Albuquerque Journal*, an article entitled, "Safety Chief Welcomes Probe of Wife's Accident", states the following: "Shultz said no DWI investigation was conducted because it appears there wouldn't have been probable cause to do so". The OIG interviewed the Police Chief regarding this particular issue, as well as, his knowledge of the events and department policies.

The Police Chief was asked if he had made this comment and if so, on what information was he relying when he made this comment. The Police Chief stated that the day before, July 11, 2011, a media availability session was held and not a press conference. The purpose for the media availability session was for the APD to release a copy of the original police report submitted by the Primary APD Officer, as well as, a copy of the corrected version which would have included the changes made which will be explained later on in this report. The Police Chief stated that releasing both reports was important in this situation because he wanted to avoid questions and/or allegations that something was changed that changed the accuracy of the report.

During the session, the Police Chief stated that the DPS decided he wanted to talk to the media and at some point the Police Chief stated he was asked a question, by the media, as to why there had been no blood or breath test conducted. The Police Chief explained that the reason none of these tests were conducted was that probable cause had not yet been established that allows an officer to get to that level. The Police Chief went

on to explain, to the OIG, that it was he who brought the DRE Program to State of New Mexico when he was a DWI Sergeant back in 1990/1991. As such, he knew an officer needed to establish probable cause before the officer could conduct a blood or breath test. The Police Chief stated that based on the police report and the information he had at the time, the Primary APD Officer never got to the point to develop probable cause. For the record, the OIG is not aware of any criminal DWI investigation that was or is being currently conducted regarding this accident involving Kathleen White on July 6, 2011.

The OIG also discussed, with the Police Chief, the issue of medical information that is contained in police reports and subsequently made public. The OIG agrees that when medical information is germane to an investigation and formulates the basis of criminal charges, then release of that information is appropriate. In this situation, when there is no criminal investigation conducted, notwithstanding whether or not you believe one should have been done, consideration should be given to redaction of that information before it is released. The OIG understands that this has not been the practice, in the past, and merely wants to point this situation out for possible review and reconsideration.

VIII. Did the APD Deputy Chief order the Primary APD Officer to remove drug references from the official report he submitted regarding this accident investigation?

The accident occurred on July 6, 2011, and by APD Department policy, the report should have been submitted by the end of shift/day. According to the Primary APD Officer, the report was actually submitted, Saturday evening (July 9, 2011), three days after it was required. The Primary APD Officer admitted knowing the policy requirements but stated that he did not submit the report due to his laptop being down. The Primary APD Officer also admitted receiving a call from his supervisor on that Saturday looking for the report and then being requested to have the report be completed and submitted. The Primary APD Officer did not inform his supervisor or request an extension for submitting his report late as is required. The Primary APD Officer had options to complete his report, such as using other computers at the sub-station, but did not avail himself of this. He also could have submitted his report, on time, utilizing a written format which is what he ultimately did.

Based on interviews conducted and review of the evidence and documents gathered, the OIG is only aware of two police reports related to this accident investigation that have been filed. There exists the Primary APD Officer's original report which was submitted the evening of July 9, 2011 and

an amended report which includes some corrections/additions which were requested of the Primary APD Officer. The corrections/additions requested were as follows: (a) a grammatical correction in the narrative to reflect a change of "he" to "her", which the Primary APD Officer stated he had no problem making this change; (b) the addition of towing company information which was left blank and the Primary APD Officer added, and had no problem doing that, but stated the information was contained on an attached sheet which has been his practice to do it this way; and, (c) crossing out or placing an "X" in the section describing a second vehicle to reflect there was no second vehicle involved in the accident and the Primary APD Officer stated he had no problem doing that. What was actually done was that an "N/A" was written in that section to reflect there was no second vehicle involved. The Primary APD Officer was asked if any of these changes, that he was asked to make, materially changed the report to make it inaccurate and he said "no".

The Primary APD Officer stated he was asked to change a box reflecting injury to non-injury but he refused because he stated he was dispatched to an accident with injuries and he did not know whether she had suffered injuries or not. The Primary APD Officer stated he was also asked to add 2 lines to his narrative explaining that there were no injuries to Kathleen White. The Primary APD Officer's Sergeant confirmed that he was the one that asked the Primary APD Officer to make this addition but stated that the Primary APD Officer refused to make that change unless given an order to do so. The Sergeant stated he did not give PO AW that order. The Primary APD Officer was asked if someone forced him to change his report and he responded "no". The Primary APD Officer stated that they (Deputy Chief) had sent 2 Public Service Aides (PSA) and his Sergeant to the courthouse where he was with a report that had yellow stickies with arrows in order to have these changes made. **The fact is that the Primary APD Officer did change his report to reflect the changes previously described and the Primary APD Officer admits he made these changes because they were needed and he had no problem making them.**

The Primary APD Officer was next asked about the allegation that he was ordered to redact/remove the references of prescription drugs in his police report. The Primary APD Officer stated that PSA brought a report to him, while he was at Metro Court, which had yellow stickies with arrows on it which reflected where the changes needed to be made. The Primary APD Officer stated that the PSA asked him to redact/remove the references to the prescription drugs. I asked the Primary APD Officer if he ever received an order or was told directly by the Deputy Chief to redact/remove the prescription drug references in his report and his response was "no". The Primary APD Officer was advised that the OIG had interviewed the two PSA's

and his Sergeant and that all three stated that they never received an instruction to ask the Primary APD Officer to redact/remove the references of prescription drugs in his report nor did they tell the Primary APD Officer to do so. They are also clear, and their interviews and recollection of this event are the same, that the Primary APD Officer was only asked to make the changes previously delineated, as items (a-c), and the clarification to the narrative regarding injuries. **Based on the interviews conducted and evidence gathered the OIG concludes that though the Primary APD Officer was asked to make minor administrative changes to his report but, he was not ordered to redact/remove the prescription drug reference by the Deputy Chief or anyone else.**

IX. Was a report, containing the medical information of Kathleen White, inappropriately released from the Albuquerque Fire Department?

On or about July 11, 2011, a TV news segment was aired where it showed what looked to be parts of a report obtained from emergency responders first on scene, as stated by the reporter. The parts of the report shown provided information regarding prescription drugs and the physical condition of Kathleen White as a result of the accident she was involved in. The implication, based on what was described and shown, would have been that this document was either part of or was the actual AFD report of the accident that they had responded to on July 6, 2011 involving Kathleen White.

The Albuquerque Fire Department utilizes its Records Management System (RMS) to enter, among other things, information regarding their responses to calls to include information related to their response to this accident. The OIG extensively looked into this release of information to determine whether or not it came from the AFD RMS and, if so, was it done in violation of AFD policy.

The OIG, after obtaining a medical release from Kathleen White, obtained a copy of the official AFD incident report regarding this incident. The OIG then issued a subpoena to one of the media outlets in order to obtain a copy of what was aired. The OIG was very specific, in its subpoena, as far as articulating what was being requested as we understand and respect the media's interest in protecting its sources of information. The OIG only requested a copy of what was aired/shown and advised the media outlet that they could take whatever steps necessary to redact or remove any information that would in any way identify their source. Unfortunately, this particular media outlet objected to both our requests and was uncooperative with our investigative efforts. This refusal to cooperate and provide the copy

requested did not allow the OIG to compare what was shown with what could have been obtained from RMS and, as such, the OIG could not positively determine the origin of this report. **The OIG has concluded that a report containing the medical information of Kathleen White was improperly released but cannot make a positive determination that it came from the Albuquerque Fire Department.**

X. In conducting this aspect of the investigation, the OIG identified some opportunities for improvement related to RMS and procedures and, as a result, will make recommendations for consideration by the AFD. Based on numerous AFD interviews conducted and the information reviewed, the following are some of those opportunities:

- a) The RMS system, utilized by AFD, does not currently have audit capabilities. The significance of this is that there is no way to track who accesses RMS and more specifically, who may have accessed this particular report in question. Thus, if an AFD employee with access did in fact access this report, for whatever reason, RMS cannot identify that individual or individuals.
- b) During our investigation, the OIG was advised that approximately 30-40 AFD personnel, mostly supervisors and above, had an access level capable to recall reports and print them. This, as it was reported to us, should have been the only level of access sanctioned to print reports other than those who work in the RMS section and have administrative rights. Based on our sworn interviews of these personnel, no one admitted to accessing, printing and releasing this particular report outside of the Department. However, the OIG did identify two instances where this particular report was printed. The OIG is confident that the purposes were legitimate and that the reports were not released outside AFD in these two instances.
- c) The OIG was advised of a "back door" process where it is possible to view any report. Once a report was on screen, an individual could utilize cut and paste or print screen to get a printed version of the report. Utilization of this "back door" process was available to anyone who had access to AFD RMS and knew how the process worked. The OIG could not determine how many AFD personnel knew about this process but some of those interviewed did. It should also be noted that RMS, nor most systems we are aware of, could prevent an individual having the inclination to do so from utilizing a camera phone to take a

picture of what is displayed on screen which can then later be emailed, printed and/or shared.

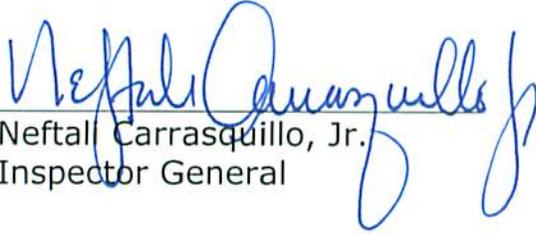
- d) There are occasions, for any number of very legitimate reasons, where a firefighter needs to have a report “unlocked” so that a modification can be made. The process entails contacting his/her supervisor and requesting that the report be “unlocked”. The supervisor then logs into RMS and unlocks that particular report and then the firefighter can access that report and make the modification. This unlocking process, and subsequent modification, does not currently have a review or monitoring process required of supervisors. As a result, there is no assurance that the modifications made, to the original report, were in fact the only modifications made. The OIG does not have any indication that any wrongdoing has occurred but merely wishes to point out a potential liability issue.
- e) In the interviews conducted with AFD personnel, it was unclear whether or not AFD had a policy or provided training regarding the safeguarding and release of personal medical information. Some stated they have never had any training while others remembered taking training at some point in their career.

The OIG recognizes that AFD management has acknowledged that RMS is flawed and needs to be replaced. It is our current understanding that they are working with some vendors to see what software/systems are available. The OIG does not know whether or not AFD has the funding to accomplish this but would strongly support and recommend that the City provide a funding source to make this change possible, as necessary. AFD should consider a system which has audit and tracking capabilities and provides the security and functionality features needed such as: monitoring, and allowing for changes to reports to be made without deleting the original report. Absent this type of system/software functionality, AFD should consider a policy or prescribed procedure for supervisory monitoring and review of amended reporting. AFD should also consider reducing the number of personnel having write access and “unlocking” capabilities. We are not suggesting the elimination of these essential functions just the reduction of the number of personnel who have that ability. AFD should review its policies and procedures regarding proper release of medical information and ensure all personnel are aware the need to safeguard this information. AFD can ensure that their personnel understand this critical issue by providing and documenting annual training.

XI. The OIG, as a result of the Director of Public Safety position being eliminated, peripherally pursued the issue of whether or not the DPS utilized his lights and siren to respond to the accident scene involving his wife on July 6, 2011. As such, the OIG requested an official job description of the Director of Public Safety position from the Director of Human Resources Department. We were advised that they did not have an official job description but were provided with a document that was drafted in May 2011 but never finalized. Though this was not an official job description, it was expressed to us, that this document appeared to reasonably characterize the duties and responsibilities of the Director of Public Safety position.

In reviewing this job description, essential function # 10 stated the following: "*Respond to and may command police and/or fire emergencies or community disasters.*" Accordingly, the OIG does not question the right of the Director of Public Safety, having oversight for Police, Fire, and emergencies, to respond utilizing an official vehicle assigned to him by the City. **The question is whether or not he had the authority to use emergency equipment, i.e. lights and siren, when responding.** It is unclear whether or not the DPS had permission to operate an official vehicle equipped with lights and siren, as per section 8-6-20 Emergency Equipment of the City Ordinance. The DPS, in his position as Director of Public Safety was not a current sworn officer or first responder. Thus, if the DPS had permission to operate his official vehicle which had emergency equipment and could use that emergency equipment, who gave it to him? In addition, where is the documentation contained that reflects this authorization? When interviewing the DPS, he stated he was not aware of the existence of any policy that covered his authority to use emergency equipment in an official vehicle.

XII. The last issue the OIG would like to address is the transport, by the DPS, of his wife from the accident scene to the hospital in his official vehicle. The OIG could not find any documented authority or policy that covered this issue. As has been noted in the media, and by the DPS, he was not going to go home and switch out cars to take his wife to the hospital. The elimination of the position of Director of Public Safety may render this as a moot point but the OIG believes this issue merits being reviewed and considered.


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