SUMMARY OF OIG INVESTIGATIVE FINDINGS REGARDING THE DETENTION BY THE DRUG ENFORCEMENT ADMINISTRATION OF DANIEL CHONG

U.S. Department of Justice
Office of the Inspector General
July 2014

SUMMARY OF OIG INVESTIGATIVE FINDINGS

Based on an anonymous telephone call received on April 27, 2012, the Office of the Inspector General (OIG) initiated an investigation into allegations that the Drug Enforcement Administration (DEA) San Diego Field Division (SDFD) had detained an individual, and then left him in a holding cell for days. The caller said the individual had not been charged with any offense, and when he was discovered by DEA, he had to be hospitalized in an Intensive Care Unit. The caller alleged that the DEA "was trying to contain this matter locally." Shortly thereafter, the OIG also received hotline complaints from citizens citing news stories reporting on DEA's alleged illegal detention of Daniel Chong.

In the ensuing investigation, the OIG learned that on April 21, 2012, DEA SDFD conducted a narcotic enforcement operation that resulted in the arrest or detention of Chong and several others. After being detained and transported to the SDFD, Chong was questioned about his involvement in narcotics trafficking. After the interview, the case agents informed him he would be released. Chong was then returned to a holding cell where he remained, in handcuffs behind his back, and without food or water, for 5 days. The OIG concluded from the evidence that Chong found and ingested methamphetamine in the holding cell while detained, drank his own urine to avoid dehydration, and used his broken glasses to cut himself.

As part of our investigation, the OIG attempted to determine which DEA employees may have come into contact with Chong during his detention for 5 days at SDFD and how a detainee could be left in a holding cell and forgotten about for so long. The OIG concluded that the SDFD holding cell area lacked any recordkeeping methods to track detainee movements. Additionally, although there was video coverage of the holding cell area, the individual cells did not contain cameras, and the single video camera that was present could only be monitored by an employee not in the holding cell area, and that employee was not assigned solely to holding cell duties and had many other responsibilities. There also was no official DEA policy or training regarding the operation of the holding cell area, and no requirement that DEA personnel check the holding cells at the end of a day to ensure that all detainees had been properly processed, either for arrest or release. Moreover, DEA personnel were not required to sign-in and sign-out of the detention area, and there were no reliable electronic entry records for the relevant period because the door locking mechanism at the entrance to the detention area was not functioning properly. Accordingly, the OIG was not able to identify from electronic entry records or logs DEA personnel that entered the holding cell area during Chong's detention.

We were able to identify four employees who had seen or heard Chong during the period of his detention. However, the employees told us there was nothing unusual about their encounters with Chong in the detention cell. Additionally, all four employees told us they assumed that whoever had placed Chong in the cell would return shortly to process him.

On April 25, 2012, several DEA personnel who had not been involved in the operation that resulted in Chong's detention discovered Chong in the holding cell. He was immediately transported by San Diego paramedics to Sharp Memorial Hospital, suffering from serious medical conditions. He was hospitalized until April 29, 2012. Last year, the Department of Justice entered into a settlement with Chong in which it agreed to pay him $4.1 million.

The OIG investigation concluded that the three case agents -- one DEA employee and two DEA task force officers -- who were involved in the April 21 operation were responsible for the safe handling and welfare of all the individuals detained during that operation, including Chong. Their failure to ensure that Chong was released from custody after deciding that he would not be charged resulted in Chong's unjustified incarceration from April 21 to April 25, and his need for significant medical treatment.

The OIG concluded that in addition to the three case agents, a DEA supervisor was responsible for the safe handling and welfare of all detainees during the narcotic enforcement operation on April 21, and was also accountable for Chong's extended detention. As the on-scene commander in the holding and detention area, the supervisor should have ensured that all detainees, including Chong, were either released or charged at the conclusion of the investigative operation on April 21. His failure to do so resulted in Chong's unjustified detention and his need for significant medical treatment.

We further found that this same DEA supervisor violated DEA policy and showed poor judgment by initiating an investigation of the incident without management's approval in the immediate aftermath of Chong being discovered in the holding cell, and by assigning two of the case agents -- the two task force officers -- to conduct the processing of Chong's holding cell for evidence. This action was a violation of DEA policy that requires field divisions to notify DEA's Office of Professional Responsibility (OPR) of alleged misconduct so that the OIG can determine whether OIG or DEA OPR will investigate the allegations. This policy is particularly important when an incident involves conduct that could be subject to criminal prosecution, as this incident could have been, because an investigation by management could be construed as compelling employees' cooperation, thereby adversely affecting the admissibility of statements gathered under such circumstances. Moreover, the two case agents had a clear conflict of interest because they were among those whose conduct contributed to the improper detention of Chong and whose conduct was, therefore, subject to scrutiny.

The OIG also concluded that DEA management in the field and at headquarters improperly initiated a review of the incident before notifying the OIG. This action was contrary to Department of Justice and DEA policy, resulted in a delay of the OIG's investigation, and could have caused harm to a potential criminal prosecution. Prosecution was declined by appropriate authorities. In view of all the facts and circumstances, the OIG found the decision to decline prosecution to be reasonable.

The OIG investigation identified several systemic deficiencies in the operation of the detention area that caused Chong's improper detention. For example, as noted above, DEA had no methods or procedures in place to keep track of detainees. If such methods and procedures had been in place, the risk of Chong or any other detainee being left in a locked holding cell for 5 days, handcuffed, and without food and water, would have been reduced substantially or eliminated.

The OIG has completed its investigation and has provided a full report of its investigation to the DEA for appropriate action. In addition, the OIG has made several recommendations to the

DEA to improve procedures in its detention facilities to reduce the risk that the failures in this case are repeated in the future.