Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

January–June 2017

Volume II

August 2017

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

Office of the Inspector General

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Foreword

This 25th Semi-Annual Report covers the time period of January through June 2017. In addition to its oversight of the employee discipline process within the California Department of Corrections and Rehabilitation (CDCR or the department), the OIG also uses a real-time monitoring model to provide oversight and transparency in several other areas within the state prison system. The OIG publishes the Semi-Annual Report in a two-volume format to allow readers to more easily distinguish the various categories of oversight activity.

Volume II is a summary of the OIG's monitoring and assessment of the department's handling of critical incidents, including those involving deadly force. It also reports on the department's use-of-force reviews, CDCR's adherence to its contraband surveillance watch policy, and the department's response to the OIG's field inquiries. Since each of these activities is monitored on an ongoing basis, they are combined into one report that is published every six months in this two-volume Semi-Annual Report.

We encourage feedback from our readers and strive to publish reports that meet our statutory mandates, as well as offer all concerned parties a useful tool for improvement. For more information about the Office of the Inspector General, including all reports, please visit our website at www.oig.ca.gov.

— **ROBERT A. BARTON, INSPECTOR GENERAL**

VOLUME II

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Summary of Other Monitoring Activities

In addition to the Office of the Inspector General's monitoring of the employee discipline process within the California Department of Corrections and Rehabilitation (CDCR or the department) reported in Volume I, the Office of the Inspector General (OIG) also monitors critical incidents, use-of-force incidents, and contraband surveillance watch cases, and conducts field inquiries. This report summarizes the OIG's monitoring and tracking activities to provide the reader an overview of OIG monitoring activities, and summarizes the monitored incidents in the Appendices attached hereto. The report does not directly correlate to the number of incidents that occurred within this time frame, but rather reflects the number of incidents the OIG assessed and closed for the January through June 2017 reporting period.

The OIG maintains a 24-hour contact number in each region to receive notifications. The OIG is able to respond to any critical incident occurring within the prison system 24 hours per day, seven days per week. When timely notified, Special Assistant Inspectors General respond to the scene to assess the department's handling of incidents that pose a high risk for the state, staff, or inmates. Sometimes a Special Assistant Inspector General will respond to the scene even when the department's notification was untimely if the OIG believes the nature of the incident warrants a response.

Use of deadly force is the highest monitoring priority among critical incidents. For this reason, the department and the OIG handle these cases with a higher level of scrutiny that includes both criminal and administrative investigations the Office of Internal Affairs' Deadly Force Investigation Team opens. The OIG monitors these incidents due to the seriousness of the event, but not necessarily because misconduct is suspected. These cases are reported in Appendix D2 of this Volume of the Semi-Annual Report. The OIG also monitors use of deadly force incidents that the Office of Internal Affairs does not investigate and reports these cases in Appendix D1.

The OIG also assesses and reports factors leading up to other critical incidents, including the department's response to the incident and the outcome. If appropriate, the OIG makes recommendations. These cases are reported in Appendix E.

The department may place an inmate on contraband surveillance watch when suspecting an inmate secreted contraband. The department is required to notify the OIG when placing an inmate on contraband surveillance watch. The OIG monitors the department's use and handling of contraband surveillance watch, with special focus on cases exceeding 72 hours, and reports these cases in Appendix F.

Finally, the OIG also provides a process for inmates, CDCR staff, and the public to report misconduct or lodge complaints. The OIG examines complaints and assigns staff members to address field inquiries regarding the complaints. These cases are reported in Appendix G.

Critical Incidents

The department is required to notify the OIG of any critical incident immediately following the event. Critical incidents include serious events that require the department to respond immediately, such as riots, homicides, escapes, uses of deadly force, and unexpected inmate deaths. The following critical incidents require OIG notification:

1. Any use of deadly force, including warning shots or strikes to the head with a baton and/or impact munitions;
2. Any death or any serious injury that creates a substantial risk of death or results in loss of consciousness, concussion, protracted loss or impairment of function of any bodily member or organ, or disfigurement to an individual in the custody or control of the department;[1]
3. Any death or serious injury to a department employee if it occurs on-duty or has a nexus to the employee's duties;
4. Any death or serious injury to a parolee or citizen if the death or injury occurs while involved with department staff;
5. Any suicide by an adult individual in the custody or control of the department and any suicide or attempted suicide by a juvenile ward or female inmate in the custody or control of the department;
6. All allegations of rape or sexual assault as defined by the Prison Rape Elimination Act made by an individual in the legal custody or physical control of the department, including alleged staff involvement;
7. Any time an inmate is placed on or removed from contraband surveillance watch or any time an inmate on contraband surveillance watch is transported to a hospital outside of an institution;
8. Any riot or disturbance within an institution or facility that requires a significant number of department staff to respond or mutual aid from an outside law enforcement agency;
9. Any time an inmate is on a hunger strike for more than ten consecutive days, an inmate on hunger strike has lost more than 10 percent of his or her body weight, or when an inmate on hunger strike is transported to a hospital outside of an institution;
10. Any incident of notoriety or significant interest to the public; and
11. Any other significant incident identified by the OIG after proper notification to the department.

After notification, the OIG monitors the department's management of the incident. The OIG may respond to the scene or obtain incident reports and follow up at the scene at a later time, depending on the circumstances. The OIG evaluates potential causes of the incident, the department's response, and whether there is possible misconduct or negligence involved. The OIG may make recommendations regarding training, policy, or referral for further investigation of potential negligence or misconduct. If the OIG believes the hiring authority should refer the incident to the Office of Internal Affairs, the OIG monitors the hiring authority's decision. The OIG may monitor an investigation the Office of Internal Affairs opens. Generally, the OIG

[1] As used herein, an individual within the custody and control of the department does not include a parolee.

reports critical incidents in the current Semi-Annual Report unless reporting the incident could jeopardize the investigation. In those instances, the Inspector General may decide to withhold a report until the investigation is completed.

In conjunction with monitoring incidents involving inmate deaths, the OIG typically also reviews the department's Death Review Committee reports. The committee is comprised of department nurses and physicians who review and analyze medical records regarding every inmate who died while in the department's custody. The committee determines, among other things, the cause of the death, whether the death was preventable, deficiencies in clinical care, and systemic concerns and opportunities for improvement.[2] The assigned OIG monitor reviews the Death Review Committee's report to assist in determining whether the department's actions in response to the death were sufficient and appropriate. The OIG's Medical Inspection Unit members also evaluate the timeliness of the reporting and provide valuable input to the OIG monitor regarding questions on more difficult cases.

During this reporting period, the OIG completed assessments of 117 critical incidents, reported in Appendices D and E. Twenty-six of these incidents involved full investigations of use of deadly force. Those 26 incidents are not included in the critical incident statistics, but the OIG's assessments of these incidents are in Appendix D2. The remaining 91 cases pertain to uninvestigated deadly force and other critical incidents the OIG monitored, such as warning shots.

The OIG's rating system considers the department's actions prior to, during, and after a critical incident. The OIG rates each incident on all three phases. Each incident may be sufficient or insufficient in more than one phase. Of the 91 critical incident cases, the OIG assessed 42 cases as insufficient in at least one of the assessment ratings. In three cases, the department's actions were insufficient in all three phases, before, during, and after the incident. And, 49 cases were sufficient in all three phases. The details regarding the assessments are found in the Appendices.

The OIG relies on the department to provide timely notification of the critical incident so that the OIG can timely respond to the scene and properly monitor an incident at the scene. However, even when notification is untimely, the OIG still monitors the event by collecting reports and conducting follow-up reviews. For cases currently reported in Appendices D1 and E, the department failed to provide timely notification of 9 of the 91 critical incidents, which is 10 percent. Only one of the cases with untimely notification was still assessed as sufficient for all three assessment ratings. Two of the nine cases involving delayed notification involved discharge of a firearm. In one of these cases, the department delayed two days before notifying the OIG that the officer's neglect of leaving a loaded firearm on a bed at home resulted in the shooting and killing of the officer's one-year-old child. In the second case, an officer allegedly negligently discharged a firearm in an observation booth. The department failed to notify the OIG until the day after the incident, preventing the OIG from providing real-time monitoring of the case.

[2] California Correctional Healthcare Services, Inmate Medical Services Policies and Procedures, Volume I, Chapters 29.1 and 29.2.

The percentage of delayed notifications has improved during the past two reporting periods. During the January through June and July through December 2016 reporting periods, the department did not provide timely notification to the OIG in 20 percent and 18 percent of the cases, respectively. The department's administration previously agreed to emphasize timely notification, and this action seems to be having a positive impact. The OIG looks forward to a continuation of this positive trend in timely notifications.

CRIME-SCENE PRESERVATION FOLLOWING INMATE DEATHS

During this reporting period, the OIG noted situations wherein staff members prematurely moved inmates' dead bodies, prompting the OIG to make a new recommendation to the department. California Government Code Section 27491.2 provides:

> a) The coroner or the coroner's appointed deputy, on being informed of a death and finding it to fall into the classification of deaths requiring his or her inquiry, may immediately proceed to where the body lies, examine the body, make identification, make inquiry into the circumstances, manner, and means of death, and, as circumstances warrant, either order its removal for further investigation or disposition or release the body to the next of kin.
> (b) For purposes of inquiry, the body of one who is known to be dead from any of the causes or under any of the circumstances described in Section 27491 shall not be disturbed or moved from the position or place of death without permission of the coroner or the coroner's appointed deputy. Any violation of this subdivision is a misdemeanor.

Three of the cases the OIG is reporting for January through June 2017 were deemed insufficient because staff members moved an inmate's dead body before the coroner's authorization to do so, thereby compromising the preservation of potentially critical evidence and potentially subjecting those involved to misdemeanor criminal charges. In one of these cases, an officer discovered an unresponsive inmate in a cell, and officers and nurses initiated life-saving measures without success. After a physician declared the inmate dead but before the coroner arrived, a lieutenant ordered a nurse to move the inmate's body to the triage and treatment area. The OIG recognized that the department inappropriately moved the inmate's body before the coroner authorized the movement, and the hiring authority provided training to the lieutenant who gave the order.

In a second case, another officer found an unresponsive inmate in a cell. This inmate's lips were blue, his body was cold to touch, and he exhibited obvious signs of rigor mortis and lividity to the extent that both arms were frozen in an upward position away from his body. However, officers and nurses initiated life-saving measures, following which they transported the inmate to the correctional treatment center. The OIG again identified that officers moved the inmate's body and searched the cell without the coroner's authorization. The OIG addressed this issue with the hiring authority and, although the hiring authority did not agree there was any staff misconduct, the hiring authority contacted the coroner and district attorney's office to coordinate future expectations.

The third case involved another officer who found an unresponsive inmate with a towel wrapped tightly around his neck and the cellmate standing in the cell covered in blood. In this case, not

only did officers move the deceased inmate's body without the coroner's consent, but an officer did not adequately control who entered the crime scene, again thereby compromising the integrity of any investigation.

The OIG recommends the department provide training to all custody and medical staff regarding the removal of dead bodies without a coroner's authorization.

PRISON RAPE ELIMINATION ACT INCIDENTS

In 2003, the United States Congress passed the Prison Rape Elimination Act (PREA), aimed at preventing sexual violence in prison. The California legislature followed suit with the Sexual Abuse in Detention Elimination Act in 2005 and the department instituted a PREA policy in 2006.

Before July 1, 2015, if an inmate alleged sexual misconduct or assault by a staff member, the department's PREA policy required institutional staff to refer the case to the Office of Internal Affairs for investigation. If there were criminal allegations, the department was to refer the case to a district attorney's office. There was no procedure for the institution to perform a preliminary inquiry into the allegation. Despite an institution's referral of an allegation to the Office of Internal Affairs, the Office of Internal Affairs routinely denied investigation requests based on its belief there was no corroborating evidence or reasonable belief of misconduct. As a result of the policy, there were cases in which neither the institution nor the Office of Internal Affairs investigated an inmate's allegations of PREA violations by staff.

In 2012, the United States Department of Justice issued a final rule in accordance with PREA that set national standards for protecting inmates. In order to conform to the national standards, the department amended Department Operations Manual Sections 31060, et. seq., 51030.3, 52050.16.4 through 52050.16.6, and 54040, et. seq., effective July 1, 2015.

The new policies the department enacted in July 2015 restrict hiring and promoting staff members who engaged in sexual violence or sexual misconduct with an inmate and require employees to report sexual violence allegations made against them. The department also added restrictions to clothed and unclothed body searches. The policies require the department to train all staff members regarding preventing, detecting, responding to, and investigating offender sexual violence, staff sexual misconduct, and sexual harassment, with additional training for staff members who perform specialized roles in the PREA process. Institutions are required to take specified preventative measures to minimize staff members incidentally viewing inmates' breasts, buttocks, or genitalia. The policy further requires documentation of any cross-gender unclothed body searches. Institutions must more rigorously review inmate housing assignments. The policy also provides methods for inmates, staff members, and third parties to report sexual abuse and harassment by other inmates or staff members.

When an inmate reports alleged sexual misconduct, employees are required to respond with sensitivity while still taking steps to preserve evidence. The hiring authority will assign a Locally Designated Investigator (LDI) to conduct an inquiry. LDIs undergo special training for the role. Currently, all institutions have trained LDIs. If information obtained indicates a reasonable belief

that staff misconduct occurred, the hiring authority refers the matter to the Office of Internal Affairs for investigation. As part of its duties, the OIG monitors cases involving alleged staff-against-inmate sexual misconduct. During this reporting period, the OIG has no cases to report.

There are additional requirements for internal and external audits of the process. In the July through December 2016 Semi-Annual Report, the OIG reported the findings of audits conducted at Wasco State Prison, Mule Creek State Prison, North Kern State Prison, and Folsom State Prison. All were found to comply with PREA standards. Pursuant to a multi-state memorandum of understanding allowing department PREA-certified auditors to conduct PREA audits, audits were also completed at Chuckawalla Valley State Prison and Ironwood State Prison. In January 2017, the reports issued, reporting both prisons met PREA standards.[3]

DEADLY FORCE INCIDENTS

CDCR policy mandates that the Office of Internal Affairs' Deadly Force Investigation Team conduct deadly force investigations. Deadly force is "[a]ny use of force that is likely to result in death. Any discharge of a firearm other than the lawful discharge during weapons qualification, firearms training, or legal recreational use of a firearm, is deadly force."[4] Use of less-lethal force methods, such as impact munitions or expandable batons in ways likely to result in death, may constitute deadly force. Examples include intentional blows to the head or unintentional blows that cause great bodily injury. The Office of Internal Affairs' Deadly Force Investigation Team is described and regulated by Title 15, California Code of Regulations, Section 3268(a)(20), which specifically states the Deadly Force Investigation Team need not respond to warning shots that cause no injury. Therefore, the Office of Internal Affairs conducts both administrative and criminal investigations for deadly force incidents except for warning shots. The Office of Internal Affairs will not conduct criminal investigations if an outside law enforcement agency conducts the criminal investigation.

The OIG, however, monitors all deadly force incidents, including warning shots. The justification for use of deadly force must be present even for warning shots. The department is required to promptly notify the OIG any time CDCR staff use deadly force. When the OIG receives timely notice of a deadly force incident, a Special Assistant Inspector General (SAIG) immediately responds to the incident scene to evaluate the department's management of the incident. The SAIG also monitors the department's subsequent deadly force investigation, if initiated. The OIG believes on-scene response is an essential element of its oversight role and will continue responding to critical incidents involving all potentially deadly uses of force whenever feasible. The very nature of such an incident warrants additional scrutiny and review, regardless of whether any misconduct is suspected or whether the ultimate result of the force is great bodily injury or death.

The Deadly Force Review Board reviews Deadly Force Investigation Team incidents. An OIG representative participates as a non-voting member of this body. The Deadly Force Review

[3] Additional information regarding these audits can be found at http://www.cdcr.ca.gov/PREA/Reports-Audits.html.
[4] Title 15, California Code of Regulations, Section 3268(a)(9).

Board is an independent body consisting of outside law enforcement experts and a CDCR executive officer. Generally, after the administrative investigation is complete, an Office of Internal Affairs' special agent presents the case to the Deadly Force Review Board. The Deadly Force Review Board examines the incident to determine the extent to which the use of force complied with departmental policies and procedures, and to determine the need for modifications to CDCR policy, training, or equipment. The Deadly Force Review Board's findings are presented to the CDCR Undersecretary of Operations, who determines whether further action is warranted.

The OIG has always given the highest level of scrutiny to the department's use of deadly force due to the serious implications involved. During this reporting period, the OIG closed a total of 45 potentially deadly force incidents. These include intentional uses of lethal weapons, unintentional blows to the head, warning shots, and other uses of force that could have or did result in great bodily injury or death. Each incident is summarized in Appendix D, which is broken into two categories. Appendix D1 contains cases the OIG monitored but to which the Office of Internal Affairs did not respond. There are 19 such cases for this period. Cases that the Office of Internal Affairs investigated and the OIG monitored are reported in Appendix D2. There are 26 such cases for this reporting period. The number of cases being reported does not correlate with the actual number of times the Office of Internal Affairs responded to the scene during this reporting period as the OIG only reports a case once all activity is completed.

Of the 26 cases being reported in Appendix D2, the Office of Internal Affairs responded to the scene in 19 cases. In 17 of the 19 cases, as well as in one case where the Office of Internal Affairs did not respond to the scene, the Deadly Force Investigation Team conducted both criminal and administrative investigations.

The department timely and adequately notified the OIG in all but one of the Deadly Force Investigation Team cases reported in Appendix D2.

NEGLIGENT FIREARM DISCHARGE INCIDENTS

The OIG previously reported concerns regarding an alarming number of incidents involving unintentional discharges of a lethal weapon. During the January through June 2016 and July through December 2016 reporting periods, the OIG reported 9 and 14 cases, respectively.

During the January through June 2017 reporting period, the OIG is reporting 16 such cases, the details of which are in Appendices D1 and D2.

Nine of the sixteen cases currently being reported involve discharges that occurred during weapons safety checks or while attempting to otherwise make the weapon safe, such as attempting to clear or secure the weapon. Two of these nine incidents occurred during training, one of which involved remedial training. Some of these incidents occurred while at a training range while others occurred indoors. The other seven incidents involved negligent discharges at times other than during weapons safety checks.

During the July through December 2016 reporting period, the OIG reported two incidents involving the "press-check" maneuver, which consists of inserting an ammunition magazine into the weapon and pulling back on the slide to visually and physically inspect the chamber for the presence of ammunition. During the January through June 2017 reporting period, the OIG is once again reporting two such incidents, both of which are included in the nine incidents referenced above.

In one such case, an officer errantly placed his finger on the trigger of a semi-automatic handgun and negligently fired a round inside an observation booth. The round penetrated a wooden rack, struck a Mini-14 rifle that was inside the rack, and came to rest at a steel wall behind the rack. Fortunately, there were no injuries.

In the second case being reported, a sergeant dropped a semi-automatic handgun and tried to grab the weapon as it was falling. As the sergeant caught the weapon, the sergeant discharged a round, which struck the cement and fragmented. The incident occurred at the armory and again, there were no injuries.

In the July through December 2016 report, the OIG reported an incident involving an officer who, after completing qualification training, cleaned the weapon and realized he had not conducted a proper check of the weapon. Not realizing he had inserted a loaded magazine into the weapon, the officer pulled the trigger, causing the weapon to discharge into the ground. The OIG is once again reporting a similar incident wherein a sergeant failed to notice she inserted a magazine into the weapon after cleaning it during remedial training. The sergeant shot herself but fortunately sustained only minor injury.

Another incident involved a control booth officer who discharged a Mini-14 rifle in a control booth while practicing sight alignment with a loaded weapon. Yet another incident occurred when an officer discharged a handgun in an observation area overlooking a dining facility where inmates were eating. The OIG reported a similar incident in the July through December 2016 reporting period involving a firearm discharge inside a classroom with several other people present.

In 9 of the 16 cases being reported in the January through June 2017 report, the Office of Internal Affairs conducted an administrative investigation. In all nine cases, the hiring authority sustained the allegations pertaining to negligent discharge. The penalties ranged from a letter of instruction to dismissal. In the case in which the officer was dismissed, there was other misconduct alleged, including dishonesty. In two cases, the hiring authority issued letters of reprimand, and in one case, the hiring authority issued a letter of instruction. In three cases, the hiring authority issued salary reductions, and in two cases, suspensions.

In the July through December 2016 report, the OIG referenced a report The Office of the Inspector General for the County of Los Angeles issued in December 2015 addressing a similar problem in the Los Angeles County Sheriff's Department.[5] The Office of the Inspector General for the County of Los Angeles conducted a study and found a substantial increase in unintended

[5] Walter Katz, Deputy Inspector General, Assessing the Rise in Unintended Discharges Following the Sheriff's Department's Conversion to a New Handgun (December 2015).

discharges between 2012 and 2015, during which time the department transitioned to a new weapon. The Office of the Inspector General for the County of Los Angeles found the Sheriff's Department training inadequate but also found that, despite training, some of the discharges were attributable to officers failing to follow basic training to keep the index finger off the trigger until ready to fire. Another reason was the lack of a safety mechanism on the new weapons.

Although there were some injuries, it is extremely fortunate that there were no deaths as a result of the incidents the OIG is currently reporting. Several incidents occurred either during training, including remedial training, or while the staff member was trying to make the weapon safe. The department's Deadly Force Review Board previously encouraged the department to examine the appropriateness of the press-check practice. Since not all of the incidents the OIG is currently reporting involved the press-check maneuver, it appears there are other possible problems that need to be addressed.

In its July through December 2016 report, the OIG recommended the department take action to address the high rate of negligent discharge incidents. As is being reported in the Volume II Recommendations section at the end of this report, in response to the OIG's recommendation, the department is taking steps to address the problem of negligent firearm discharges. The cases the OIG is currently reporting reinforce the need for these actions. The OIG is encouraged by the department's response to the OIG's recommendations and, due to the potential serious consequences, urges the department to expeditiously follow through with its plan.

Use-of-Force Monitoring

The OIG monitors the department's evaluation of staff uses of force and reports its findings semi-annually. The OIG's monitoring process includes attending Institutional Executive Review Committee (IERC) meetings at the Division of Adult Institutions and Institutional Force Review Committee (IFRC) meetings at the Division of Juvenile Justice, where hiring authorities review and evaluate every use-of-force incident for compliance with policy. As part of its oversight process, the OIG analyzes the department's reports and its reviews, and may make recommendations to the department regarding use-of-force policies and procedures.

Any departmental employee who uses force, or who observes another employee use force, is required to report the incident to a supervisor and submit a written report prior to being released from duty. The accuracy and completeness of the report is crucial because the department conducts a multi-tiered review process of the submitted reports.

A Deputy Inspector General reviews reports and other evidence related to a use-of-force incident and attends the review committee meetings at all institutions. The OIG developed and designed a monitoring tool to enable the OIG to more accurately track and report on types and frequency of force and injuries, as well as to identify pertinent or troubling trends and to provide more valuable feedback to the department and its public safety stakeholders. This tool enables the OIG to collect more detailed information regarding force used, injuries resulting from the use of force, inmate allegations of unreasonable force, and the review committee meeting itself. The OIG monitors the department's compliance with policies and procedures regarding the use of force, as well as subsequent activities, including the review process.

The OIG attends as many use-of-force committee meetings as resources allow, but no less than one meeting each month at each prison, juvenile facility, and parole region. During this reporting period, the department reported conducting 861 use-of-force review committee meetings. Of those, the OIG attended 822 review committee meetings, which is 95 percent. In addition, the OIG attended 19 Department Executive Review Committee meetings and 2 Division Force Review Committee meetings, which are discussed below. The OIG is striving for 100 percent attendance at all use-of-force review committee meetings.

When appropriate, the OIG recommends the hiring authority refer an incident to the Office of Internal Affairs for investigation or approval to take disciplinary action without an investigation if there is sufficient evidence already available. If the OIG does not agree with the hiring authority's decision, the OIG may confer with higher level department managers. If the OIG recommends an investigation, the OIG monitors and reports the department's response.

USE-OF-FORCE MEETINGS ATTENDED AND INCIDENTS REVIEWED

During this reporting period, the OIG monitored and closed 3,936 unique use-of-force incidents and allegation reviews.[6] All of the incidents discussed in the sections that follow pertain solely to those cases the OIG closed during this reporting period. In some instances, the review committee may decide to defer a case for further information or clarification. The information contained in this report does not include deferred cases since there are no final determinations for such cases.

Before attending a use-of-force meeting, the OIG reviews and evaluates all departmental reports and reviews completed. Department reviewers at each level of review are tasked with evaluating reports, requesting clarifications, identifying policy deviations, and determining whether the use of force was within applicable policies, procedures, and laws. The levels of review are: (1) the initial review the incident commander conducts; (2) the first level management review a captain conducts; (3) the second level management review an associate warden conducts; and (4) the final review where the use-of-force review committee reviews the matter, with the warden, superintendent, chief, or regional parole administrator, or designee, making the ultimate determination. The OIG monitors the review process and raises concerns, if any. The OIG may recommend clarification if reports are inconsistent or incomplete, and confers with the committee. Through this process, the OIG independently concludes whether the force used complied with policies and procedures, and whether the review process was thorough and meaningful. Table 1 illustrates the cases the OIG closed, by division within CDCR.

Table 1: ***Number of Separate Use-of-Force Incidents Reviewed, by Division***

Division	Number of Incidents Reviewed
Division of Adult Institutions	3,651
Division of Juvenile Justice	255
Division of Parole Operations	26
Office of Correctional Safety	4
Total	**3,936**

Through involvement at the use-of-force meetings, the department followed OIG recommendations to prescribe additional training, pursue employee discipline, obtain additional factual clarifications, or make policy changes in 336 individual cases (9 percent).

[6] Allegation reviews involve reviews of inmate allegations of unnecessary or excessive use of force, by inmate appeal or statements to staff members, that are not directly connected with an incident and, therefore, do not have an incident number assigned. The IERC is required to review the allegations.

DEPARTMENT EXECUTIVE REVIEW COMMITTEE

Pursuant to California Code of Regulations, Title 15, Section 3268(a)(19) and the Department Operations Manual, Sections 51020.4 and 51020.19.6, the Department Executive Review Committee (DERC) is a committee of staff selected by and including the Associate Director of the respective mission-based group of institutions. The DERC has oversight responsibility and final review authority over the Institution Executive Review Committees. The DERC is required to convene and review the following use-of-force incidents:

- Any use of deadly force;
- Every serious injury or great bodily injury;
- Any death.

The DERC also reviews those incidents referred to the DERC by the IERC Chairperson or otherwise requested by the DERC. In the past, the DERC has also reviewed incidents referred by the OIG. The OIG assigns a Deputy Inspector General to monitor DERC reviews.

CDCR's Division of Adult Institutions comprises four mission-based disciplines: Reception Centers; High Security; General Population; and Female Offender Programs and Services/Special Housing.[7] During this reporting period, all four missions held a total of 19 DERC meetings during which they reviewed 48 incidents. The number of incidents reviewed by mission is:

- High Security – 20 incidents
- Reception Center – 12
- General Population – 2
- Female Offender Programs and Services/Special Housing – 14

In addition, the Division of Juvenile Justice conducted two Division Force Review Committee (DFRC) meetings during which they reviewed ten incidents. The DFRC is similar to the Division of Adult Institutions DERC because they also have oversight responsibility and final review authority of the institutional level force review committees at all Division of Juvenile Justice facilities. The OIG attended 19 DERC and 2 DFRC meetings.

During this reporting period, the OIG found that an additional 41 cases met the criteria for DERC review but the department did not conduct the review: 24 in the High Security mission; 8 in the General Population mission; 7 in the Reception Center mission; and 2 in the Female Offender Programs and Services/Special Housing mission. The Female Offender Programs and Services/Special Housing mission includes the Community Correctional Facilities. The OIG recommended the DERC review an additional 29 incidents where inmates suffered serious injury or great bodily injury, including 1 case where deadly force was used. The case involving the use of deadly force involved a three-on-one inmate attack with inmate-manufactured weapons. The attack stopped after a counselor deployed a grenade and an officer fired one shot for effect from

[7] All of the female institutions are part of this mission, as well as the California Medical Facility, the California Health Care Facility, Folsom State Prison, and the Community Correctional Facilities.

a Mini-14 rifle. There were no injuries as a result of the incident. The use of force was found to comply with policy, and the OIG concurred.

TYPES OF FORCE

A single incident may involve different types of force and more than one use of force depending on the circumstances. For example, during a riot, officers may use chemical agents, expandable batons, less-lethal force, and lethal force to address varying threats as the riot progresses.

The department also distinguishes between immediate and controlled use of force. Departmental policy defines immediate use of force as the force used to respond without delay when there is an imminent threat to institution or facility security or the safety of persons. Employees may use immediate force without prior authorization from a higher official. Controlled use of force is the force used in an institution or facility setting when an inmate's presence or conduct poses a threat to safety or security and the inmate is located in an area that can be controlled or isolated. Controlled uses of force must also be video recorded. These situations do not normally involve the immediate threat of loss of life or immediate threat to institution security. In January 2016, the department revised its policy to require the use of controlled force if the sole purpose of using force is to gain compliance with a lawful order. All controlled use-of-force situations require the authorization and presence of a first- or second-level manager or, during non-business hours, an Administrative Officer of the Day (AOD). Staff must make every effort to identify disabilities, including mental health concerns, and note any accommodations that may need to be considered when preparing for a controlled use of force.

Use-of-force review committees evaluate the types of force used and whether involved staff members complied with use-of-force and related policies. Some of the factors evaluated include the decontamination of inmates following pepper spray exposure, video-recorded interviews, inmate escorts post-incident, and completion of documentation. In the vast majority of cases, the type of force used is appropriate for the situation and does not become an issue for discussion.

During this reporting period, staff contributed to the need for force in 65 of the 3,936 incidents closed, which is approximately 2 percent of the cases. While there were varying reasons staff contributed to the need for the use of force, the main reasons were:[8]

1. Initiating an immediate use of force when there was no threat or when a controlled use of force was appropriate (27 incidents);
2. Improperly opening or failing to secure a cell door or food port, or releasing an inmate (15 incidents); and
3. Failing to de-escalate a situation (8 incidents).

In four incidents, staff members initiated the incident. In one case, a visual recording captured an officer verbally challenging an inmate. In a second incident, an officer argued with and used profanity toward an inmate. In a third case, an officer grabbed an inmate's wrist before verbally ordering the inmate to submit to handcuffs. In the fourth case, an officer reopened a cell door

[8] Staff may have contributed to the need for the use of force for more than one reason in the same incident.

after an inmate made a comment to him as he was being let into his cell. Some other reasons staff contributed to the need for force included ordering an inmate to submit to a medical examination that was not required, failing to listen to an inmate's complaint of pain, or not allowing the inmate to eat for the proper length of time.

Table 2 reflects the numbers of cases where staff contributed to the need for force.

Table 2: *Staff Contribution to the Need for Force, by Division*

Division	Total Use-of-Force Incidents	Incidents Where Staff Contributed to the Need for Force	Percentage
Division of Adult Institutions	3,651	57	1.6%
Division of Juvenile Justice	255	6	2.4%
Division of Adult Parole	26	2	7.7%
Office of Correctional Safety	4	0	0%
Total	**3,936**	**65**	**1.7%**

In nine cases, the department imposed disciplinary action, and in one case, the hiring authority referred the matter to the Office of Internal Affairs. The OIG concurred with these determinations. The department provided training or counseling in 50 cases, and the OIG concurred. The hiring authority did not take any action in five cases, and the OIG disagreed in all five. In four of those cases, the OIG disagreed with the hiring authority's finding that the actual use of force complied with policy. In the fifth case, the hiring authority found the actions prior to the use of force to comply, but the OIG disagreed. Overall, the OIG concurred in over 92 percent of the cases.

Inmates alleged staff violated policies and procedures, or made statements that could be interpreted as allegations of staff misconduct, in 656 of the 3,936 cases the OIG closed during this reporting period, which is 17 percent. This is an increase over the 14 percent reported during the last reporting period.

Apart from inmate allegations, the OIG found that staff used immediate force when no force was justified in 70 of the 3,936 incidents, which is less than 2 percent. The vast majority of these incidents involved the use of physical force or pepper spray when there was no imminent threat or when a controlled use of force should have been initiated. Three cases involved accidental discharge of pepper spray. In one case, an officer fired a pepper ball launcher when there was no threat and in another case, an officer fired a less-lethal round instead of initiating a controlled use of force. Table 3 on the following page outlines the number of cases by division where immediate force was not justified.

Table 3: *Immediate Force Not Justified, by Division*

Division	Total Use-of-Force Incidents	Incidents Where Immediate Force Not Justified	Percentage
Division of Adult Institutions	3,651	56	1.5%
Division of Juvenile Justice	255	14	5.5%
Division of Adult Parole	26	0	0%
Office of Correctional Safety	4	0	0%
Total	**3,936**	**70**	**1.8%**

FREQUENCY OF USE OF FORCE AS AN EARLY-WARNING SYSTEM

The OIG provides wardens with regular reports that show the frequency of force in specific locations and with specific staff. For example, during the January through June 2017 reporting period, the OIG identified 14 officers at 7 different institutions who were involved in ten or more use-of-force incidents. The highest number of incidents in which any officer was involved was 14 incidents. Two officers were each involved in 14 incidents, each officer at a different institution. All 14 incidents at each institution occurred on the same facility. One of these officers was also involved in 19 use-of-force incidents reported in the July through December 2016 reporting period. Although the number of incidents involving the same officers is less than reported during the July through December 2016 reporting period, there are still several officers involved in multiple use-of-force incidents, and many of them are involved in the same incidents. While there could be many explanations for officers to be involved in multiple uses of force, this report is primarily used as a tool for the wardens to determine if there are potential areas for improvement or to identify risks as it relates to use of force.

Another example of how this report and communication with the wardens has benefited the institutions is illustrated when OIG reported that three officers with the highest number of incidents at the same institution were working on the same facility. The facility, which has an inmate population in the Enhanced Outpatient Program (EOP), tended to have frequent inmate fights, resulting in the need for force. The OIG met with the hiring authority at this institution regarding the large number of incidents involving the same officers. The hiring authority was aware of the concerns but still appreciated the report and communication. It is important to note that the uses of force were found to comply with policy and, in the majority of cases, the OIG concurred with the department's review. The OIG maintains an open dialogue with the department to communicate concerns and trends, and to assist in determining whether a particular post or person is potentially at risk.

DIVISION OF ADULT INSTITUTIONS

Within the four mission-based disciplines under the Division of Adult Institutions, 126,848 inmates were under the department's in-state supervision as of June 30, 2017.[9] Of the 3,936 total use-of-force incidents the OIG closed this period, 3,651 occurred within the Division of Adult Institutions.

Table 4A on the next page reflects the number of incidents the OIG closed within the adult institutions during this reporting period. In addition, Table 4B is a separate table for the Community Correctional and Out-of-State Facilities, and Table 4C shows the total numbers. The numbers listed in the column titled "Applications of Force" reflect the numbers of types of uses of force per incident rather than the total number of applications of force. For example, if pepper spray is used three times in one incident, the table only reflects the use of pepper spray once. However, if multiple types of force are used, such as a baton and pepper spray, those applications are reflected as separate applications.

As the table reflects, California State Prison, Corcoran had the highest number of incidents and applications of force during this reporting period, with 283 incidents reviewed and 379 applications of force in conjunction with those incidents. California State Prison, Sacramento also reviewed 283 incidents, but with 349 applications of force. California State Prison, Los Angeles County had the second highest number of incidents reviewed, with 247 incidents reviewed, and the second highest applications of force, with 375 applications of force.

On the other hand, Chuckawalla Valley State Prison had the fewest number of incidents involving the use of force, with four incidents reviewed and four applications of force. The second fewest incidents occurred at California City Correctional Facility, where the OIG reviewed seven incidents involving nine applications of force.

Many variables and conditions can impact any use-of-force incident and, therefore, any conclusions drawn based on this information should be weighed carefully. Factors include the mission, level, and population of the prison, the number of participants, number of responders, accuracy and efficacy of certain force choices, and even weather conditions, since wind may make chemical agents ineffective. This information may be useful, however, in evaluating the possible need for training at particular prisons or identifying areas that may need closer scrutiny so that frequent uses of force do not become commonplace and, consequently, ignored to the detriment of officers or inmates in need of assistance.

[9] CDCR data is derived from: *http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1706.pdf.*

Table 4A: *Incidents Reviewed and Frequency of Force within the Division of Adult Institutions*[10]

Institution Identifier	Institution	Incidents Reviewed	Applications of Force	Chemical Agents	Physical	Less-Lethal Force	Expandable Baton	Other/Non-Conventional[11]	Lethal Force, Including Warning Shots
RJD	R. J. Donovan Correctional Facility	143	157	46%	35%	11%	8%	0%	0%
WSP	Wasco State Prison	134	184	60%	24%	11%	4%	0%	0%
NKSP	North Kern State Prison	114	140	52%	19%	24%	5%	1%	0%
CMC	California Men's Colony	95	87	44%	52%	0%	5%	0%	0%
SQ	San Quentin State Prison	95	163	47%	15%	27%	10%	1%	1%
CCC	California Correctional Center	63	81	40%	32%	10%	17%	0%	1%
DVI	Deuel Vocational Institution	44	62	50%	29%	0%	21%	0%	0%
CIM	California Institution for Men	40	52	54%	27%	12%	6%	2%	0%
SCC	Sierra Conservation Center	38	51	76%	18%	4%	2%	0%	0%
CRC	California Rehabilitation Center	23	28	57%	39%	0%	4%	0%	0%
COR	California State Prison, Corcoran	283	379	43%	32%	13%	7%	4%	0%
SAC	California State Prison, Sacramento	283	349	47%	34%	11%	6%	2%	0%
LAC	California State Prison, Los Angeles County	247	375	50%	21%	19%	8%	1%	0%
KVSP	Kern Valley State Prison	215	335	65%	13%	19%	3%	0%	0%
SVSP	Salinas Valley State Prison	209	276	56%	21%	20%	3%	0%	0%
CCI	California Correctional Institution	159	256	70%	11%	13%	6%	1%	0%
HDSP	High Desert State Prison	125	188	57%	20%	14%	5%	2%	3%
SATF	California Substance Abuse Treatment Facility	122	163	46%	24%	25%	4%	1%	1%
PBSP	Pelican Bay State Prison	50	73	42%	25%	21%	11%	1%	0%
CAC	California City Correctional Facility	7	9	33%	44%	0%	22%	0%	0%
MCSP	Mule Creek State Prison	176	220	50%	37%	7%	5%	0%	0%
CAL	Calipatria State Prison	126	160	55%	9%	33%	3%	1%	0%
SOL	California State Prison, Solano	73	90	51%	36%	9%	4%	0%	0%
CEN	Centinela State Prison	64	87	57%	17%	14%	9%	1%	1%
PVSP	Pleasant Valley State Prison	49	71	61%	25%	10%	4%	0%	0%
ISP	Ironwood State Prison	32	39	49%	21%	15%	13%	3%	0%
ASP	Avenal State Prison	20	26	73%	15%	0%	8%	4%	0%
CTF	Correctional Training Facility	18	21	52%	38%	0%	10%	0%	0%
VSP	Valley State Prison	12	14	21%	71%	0%	0%	7%	0%
CVSP	Chuckawalla Valley State Prison	4	4	75%	0%	0%	25%	0%	0%
CCWF	Central California Women's Facility	144	189	47%	47%	2%	3%	2%	0%
CHCF	California Health Care Facility	131	157	18%	71%	0%	7%	4%	0%
CMF	California Medical Facility	94	115	55%	32%	0%	12%	1%	0%
CIW	California Institution for Women	61	64	25%	61%	0%	8%	6%	0%
FSP	Folsom State Prison	37	60	55%	18%	18%	8%	0%	0%
Total		**3,530 Incidents**	**4,725 Applications**	**51% Average**	**30% Average**	**10% Average**	**8% Average**	**1% Average**	**0% Average**
CDCR Mission:	**Reception Center**	**High Security**	**General Population**	**Female Offender/Special Housing**					

[10] This data is based upon the number of use-of-force incidents the OIG closed during this reporting period.
[11] Other/Non-conventional Force includes hand-to-hand combat, use of a shield to apply force, use of an available force tool in an unconventional manner (for example, striking with a chemical agent canister), or other force that utilizes techniques or instruments not specifically authorized in policy, procedure, or training.

Table 4B: ***Incidents Reviewed and Frequency of Force within the Division of Adult Institutions (Community Correctional Facilities and Out-of-State Facilities)***[12]

Institution Identifier	Institution	Incidents Reviewed	Applications of Force	Chemical Agents	Physical	Less-Lethal Force	Expandable Baton	Other/Non-Conventional	Lethal Force, Including Warning Shots
TCCF	Tallahatchie County Correctional Facility	44	48	85%	6%	8%	0%	0%	0%
LPCC	La Palma Correctional Center	39	43	70%	23%	5%	0%	2%	0%
DMCCF	Delano Modified Community Correctional Facility	22	26	46%	19%	23%	12%	0%	0%
SMCCF	Shafter Modified Community Correctional Facility	7	7	86%	14%	0%	0%	0%	0%
FCRF	McFarland Female Community Reentry Facility	6	6	33%	67%	0%	0%	0%	0%
TMCCF	Taft Modified Community Correctional Facility	3	4	25%	75%	0%	0%	0%	0%
DVMCCF	Desert View Modified Community Correctional Facility	0	0	0%	0%	0%	0%	0%	0%
Total		**121 Incidents**	**134 Applications**	**49% Average**	**29% Average**	**5% Average**	**2% Average**	**0% Average**	**0% Average**

Table 4C: ***Incidents Reviewed and Frequency of Force within the Division of Adult Institutions (Total Division of Adult Institutions)***

Incidents Reviewed	Applications of Force	Chemical Agents	Physical	Less-Lethal Force	Expandable Baton	Other/Non-Conventional	Lethal Force, Including Warning Shots
3,651 Total Incidents	**4,859 Total Applications**	**52% Average**	**30% Average**	**10% Average**	**7% Average**	**1% Average**	**0% Average**

In addition to tracking types of force, the OIG now also tracks common locations where use-of-force incidents occurred at each institution. Twenty-seven locations statewide had between 20 and 51 use-of-force incidents. The location with 51 incidents was a school area at a juvenile facility. One institution had 42 incidents on the same yard, and a second institution had 30 incidents on the same yard. A total of 17 of the "hotspot" locations were yards and 7 were in housing units, including 1 administrative segregation unit, which had 27 incidents.

Additionally, the program type with the highest number of incidents was the Sensitive Needs Yard program at three institutions.[13] The two highest numbers of incidents occurred at institutions with level I–IV Sensitive Needs Yard programs. The third highest number of incidents occurred at an institution with level III and IV Sensitive Needs Yard programs. The fourth highest number of incidents was in the general population at one institution, with the fifth highest number of incidents at a juvenile facility. The number of incidents for all of these location program types ranged from 107 to 147 incidents.

[12] The OIG started monitoring the Community Correctional Facilities use-of-force incidents on September 13, 2016.
[13] Sensitive Needs Yards house inmates with protective custody needs, such as inmates who have been victims of attack, sex offenders, inmates with drug debts, or inmates seeking safety during their incarceration. More information can be found at http://www.cdcr.ca.gov/Blueprint-Update-2016/An-Update-to-the-Future-of-California-Corrections-January-2016.pdf .

The OIG also monitors when inmates die or suffer serious or great bodily injury[14] as a result of force used. Of the 3,936 incidents the OIG closed between January and June 2017, 58 incidents resulted in serious bodily injury, 1 incident resulted in great bodily injury, and one inmate died following the incident. The incident resulting in great bodily injury involved a two-on-one inmate attempted homicide. Officers used chemical, less-lethal, and lethal force. The officer who used lethal force fired two shots for effect, striking one of the attacking inmates in the hip. The actual uses of force were found to be in compliance with policy. The OIG concurred.

The incident involving an inmate death consisted of a large-scale riot in which four warning shots and one shot for effect were fired. The shot for effect struck one of the inmates in the chest resulting in the inmate's death. Other than a chemical agent being used in an improper location, the other uses of force complied with policy, and the OIG concurred.

COMPLIANCE WITH THE USE-OF-FORCE POLICY

The OIG use-of-force monitoring tool allows the OIG to collect information about whether force used complied with policies and procedures, including whether the department complied with policies and procedures "Apart from Actual Force," "Actual Force Used," and "Non Use of Force." The OIG defines these categories as outlined below. The OIG assesses each incident in all three categories. Therefore, one incident could be discussed in one or more of the three sections addressed below. Overall, the department followed the OIG's recommendations in 336 of the cases the OIG closed during this reporting period.

- **Apart from Actual Force** refers to the department's policies and procedures encompassed within the use-of-force policy,[15] excluding the use of force itself. Examples include whether a medical assessment of the inmate was completed after a use of force, whether reports were thorough and submitted timely, and whether protocols were violated that may have led up to the use of force.
- **Actual Force Used** refers to the force itself.
- **Non Use of Force** refers to activities related to the use of force but not directly within the policy, such as holding cell procedures, escorts, and properly completed medical assessments.

Apart From Actual Force

For cases the OIG closed during this reporting period, the department found 2,667 out of 3,936 incidents within policy for conduct the OIG deems "Apart from Actual Force." This is 68 percent of the total incidents reported and includes 170 incidents in which the department determined not to take action on inmate allegations against staff.

[14] As used herein, serious bodily injury refers to injury which results in loss of consciousness, concussion, protracted loss or impairment of function of any bodily member or organ, or disfigurement to an individual in the custody or control of the department. Great bodily injury refers to injury that creates a substantial risk of death.
[15] Department Operations Manual, Chapter 5, Article 2.

The department conducted two internal inquiries. The hiring authority referred 21 cases to the Office of Internal Affairs.

For incidents deemed out of policy, the department took disciplinary action in 8 cases, issued counseling in 59 cases, and provided training in 1,057 cases. The department took action on 102 inmate allegations against staff and found 20 incidents involved a reasonable deviation from policy.

The OIG concurred with the department's determinations in 3,827 cases, including all cases referred to the Office of Internal Affairs, and disagreed in 109, or 3 percent of cases.

Actual Force Used

For conduct deemed "Actual Force Used," the department assessed 3,746 of 3,936, or 95 percent, of the incidents within policy. This includes 274 incidents in which the department determined not to take action on inmate allegations against staff. The OIG concurred with the determinations in all but 11 cases, or less than 1 percent.

In eight of the cases in which the OIG did not concur with the finding that the use of force complied with policy, the OIG did not believe there was an imminent threat. In another case, the OIG found an officer used a non-approved chemical agent, and in another case, a sergeant failed to give an inmate an order to submit to handcuffs before touching the inmate during a search. In the last case, there were inconsistent reports regarding who placed a spit mask on the inmate. The hiring authority found the use of force to comply with policy but referred the case to the Office of Internal Affairs for an investigation. Although the OIG agreed with the referral, the OIG did not concur with the finding that the use of force complied with policy because the OIG recommended the hiring authority wait for the outcome of the investigation.

The department conducted an internal inquiry in 2 cases and referred 21 cases to the Office of Internal Affairs. The OIG concurred with all of these determinations. The department found 73 incidents involved a reasonable deviation from policy.

For the remaining cases deemed to be out of compliance with policy, the department took disciplinary action in 7 cases, issued counseling in 18 cases, and provided training in 68 cases. The department decided to take action on one inmate allegation of staff misconduct. The OIG concurred with all of these decisions.

Non Use of Force

The department assessed 3,312 of 3,936 of the incidents within policy for conduct the OIG deems "Non Use of Force," which is 84 percent of incidents. This includes 249 incidents wherein inmates made allegations of staff misconduct and the department did not take any action. The OIG concurred in all but six of these incidents found to be within policy.

The department conducted 3 internal inquiries and referred 21 cases to the Office of Internal Affairs. The department found two incidents involved a reasonable deviation from "Non Use of Force" policies.

Of the cases found to be out of policy, the hiring authority took disciplinary action in 9 cases, issued counseling in 20 cases, and provided training in 542 cases. The OIG concurred with all of these determinations except for three (or less than 1 percent) cases involving training. The department decided to take action on 27 inmate allegations of staff misconduct where the non use of force was out of policy, and the OIG concurred with all.

ALLEGATION INQUIRIES

Department Operations Manual Section 51020.18.2 sets forth specific required actions after an inmate raises an allegation of unreasonable use of force. The requirements include having the inmate medically evaluated, completing a medical report, obtaining and reviewing reports from inmate witnesses, if any, and obtaining a video-recorded interview of the inmate, including recording any injuries. If an inmate makes an allegation during a medical evaluation that staff used unreasonable force, the medical staff member is required to document the inmate's allegation. During its use-of-force review activities, the OIG has identified that the department is not consistent in determining whether an inmate's statement constitutes an allegation of unreasonable force.

In one such case, an inmate was repeatedly banging his head on the side of the cell, causing a head injury. The inmate refused orders to stop the self-injurious behavior, and the officer used pepper spray to stop the inmate's actions. The nurse who examined the inmate documented that the inmate alleged the officer used pepper spray for no reason. The IERC determined the inmate's statement did not constitute an allegation of unreasonable force. The OIG disagreed and raised the matter to department executives who agreed with the institution.

Clearly, an allegation that an officer used pepper spray "for no reason" is an allegation that the force used was unreasonable. There can be no other logical interpretation. However, based on the department's response to this incident, the OIG recommends the department establish clear guidelines for analyzing inmates' statements related to use-of-force incidents, including accepting an inmate's plain language complaint as a legitimate allegation of unreasonable force to initiate a proper inquiry or investigation. The OIG also recommends the department provide training to all supervisors and managers to ensure inmate allegations are processed according to policy.

DECONTAMINATION AFTER PEPPER SPRAY EXPOSURE

During the January through June 2017 reporting period, the OIG also noted a lack of consistent documentation when providing inmates with clean clothing as part of the decontamination process. Department Operations Manual Section 51020.15.5 describes the decontamination process, which includes providing clean clothing, and section 51020.17.1 further requires officers to include in their reports their observations of the decontamination process.

The OIG is reporting 16 incidents where staff members did not document providing inmates with clean clothing as part of the decontamination process. Eight incidents occurred at each of two institutions. Although some institutions require officers to document offering clean clothing, either in an incident report or holding cell log, the department overall takes the position that policy does not require documenting an offer of clean clothing after decontamination.

Some institutions also interpret policy to not require any report documenting an offer of clean clothing if an inmate is taken for a medical evaluation or placed in administrative segregation. This interpretation is based on the theory that neither the institution's medical services nor administrative segregation will accept an inmate with contaminated clothing.

The OIG raised concerns regarding this lack of documentation with the hiring authorities at each of the institutions referenced above, and ultimately discussed these concerns with departmental executives. Despite the OIG's feedback, the department believes policy does not require staff members to document providing clean clothing to inmates following decontamination. The OIG recommends the department clarify its policy to require staff members to document providing inmates with clean clothing as part of the decontamination process, and to document the time clothing is provided to the inmate.

THE APPLICATION OF SPIT HOODS OR MASKS

Pursuant to Department Operations Manual Section 51020.16, a spit hood or mask may be applied when staff members believe there is a verbal or physical intent by the inmate to contaminate others with spit or other bodily fluids from the nose or mouth, the inmate is not able to control expelling fluids from the nose or mouth (with the exception of vomit), or the inmate is on authorized security precautions according to the procedures of the unit where the inmate is housed. During the January through June 2017 reporting period, the OIG is reporting nine cases wherein the OIG disagreed with the department's findings that the application of a spit mask or hood complied with policy. A few case examples illustrate the issue.

One case involved an inmate who kicked an officer, resulting in the use of physical force. As a result of the force, the inmate was bleeding from an injury above his eye. A sergeant ordered the application of a spit mask even though there were no fluids coming from the inmate's nose or mouth and, therefore, the incident did not meet the criteria for applying a spit mask.

Five other incidents occurred at another institution. In one of these incidents, officers used physical force and an expandable baton to subdue a resistive inmate. An officer placed a spit mask over the inmate's face solely to prevent further attempts to assault the officers. A similar incident involved application of a spit mask to prevent blood from an inmate's head wounds, rather than the nose or mouth, from contaminating officers. In the other three cases, officers applied a spit mask because the inmate was agitated, resistive, or acting erratically. In all five cases, the hiring authority disagreed with the OIG's opinion that application of the spit mask did not comply with policy, stating that officers have full discretion for using a spit mask.

In addition, the OIG reviewed eight other incidents where the department agreed that application of spit masks was not appropriate because the criteria outlined above were not met. In all eight incidents, the department provided training to involved staff members.

Additionally, Department Operations Manual Section 51020.16 provides in part that if a spit hood or mask is applied to an inmate, it is imperative to maintain constant supervision of the inmate to watch for signs of respiratory distress. Policy requires removing a spit mask if an inmate loses consciousness, begins seizing or vomiting, or when any sign of respiratory distress is observed. Absent constant observation, officers cannot adequately monitor for these medical emergencies. During the January through June 2017 reporting period, the OIG identified ten cases in which the department applied spit masks but did not document removing them, preventing the ability to determine whether officers maintained constant observation of the inmates while the spit masks were in place. In six of these incidents, the department provided training to the involved staff members. The department requested and obtained clarifying reports in the remaining four incidents.

Until recently, some wardens believed the department's position was that the requirement to maintain constant supervision *only* applied if an inmate in a spit mask was exposed to pepper spray. However, based on OIG input, the department has clarified the policy to require constant supervision of an inmate once a spit mask has been applied since application of a spit mask can cause respiratory distress regardless of other factors, such as pepper spray exposure. In addition, application of a spit mask can contribute to positional asphyxia when an inmate is placed on his stomach. Serious injuries and death have occurred in the past, which called for the creation of these policies. Failure to require adherence could have fatal results. The OIG recommends the department provide training to reinforce the importance of ensuring the application of spit masks or hoods meets the criteria set forth in the Department Operations Manual. The OIG also recommends the department clarify criteria regarding the monitoring of inmates after a spit mask or hood has been applied.

USE OF FORCE ON MENTAL HEALTH INMATES

The department reports during this reporting period approximately 31 percent of its in-custody inmate population were mentally ill inmates participating in the department's Mental Health Services Delivery System at the Correctional Clinical Case Management System (CCCMS) level of care or above.[16] During this reporting period, 40 percent of the total uses of force within the Division of Adult Institutions the OIG closed were on inmates at the CCCMS level or above.[17]

[16] The department's Mental Health Services Delivery System (MHSDS) provides mental health services to inmates with serious mental disorders or inmates who meet the necessity criteria. The MHSDS is designed to provide an appropriate level of treatment and promote individual functioning within the least clinically restrictive environment. Mental health care is provided by clinical social workers, psychologists, and psychiatrists. The department provides four different levels of care: Correctional Clinical Case Management System (CCCMS); Enhanced Outpatient Program (EOP); Mental Health Crisis Bed (MHCB); and Department of Mental Health (DMH) Inpatient Hospital Care. A detailed description of the mental health services levels of care can be found on the department's website at http://www.cdcr.ca.gov/DHCS/Mental_Health_Program.html.

[17] Multiple types of force can be used on a single inmate and an inmate could have been involved in more than one incident during this reporting period. In addition, the inmate's mental health status can change between incidents.

The OIG's use-of-force monitoring tool allows the OIG to track more detailed statistics and identify trends regarding use of force on all inmates, including mentally ill inmates. Some of the data collected includes frequency of specific inmates being involved in uses of force, the classification level of inmates involved in use-of-force incidents, and the locations of use-of-force incidents. The following table outlines the use of force at each institution, broken down by mental health status of the inmate on whom the force was used.

Table 5: ***Use of Force, by Mental Health Status, by Institution***

			Mental Health Code					
		Institution	CCCMS	EOP	MHCB	DSH	Total Mental Health	Non-Mental Health
CDCR Mission	Reception Center	CCC	0%	0%	0%	0%	0%	100%
		CIM	25%	12%	27%	0%	65%	35%
		CMC	15%	37%	8%	0%	61%	39%
		CRC	28%	0%	0%	8%	36%	64%
		DVI	37%	2%	0%	0%	39%	61%
		NKSP	35%	4%	7%	0%	46%	54%
		RJD	17%	58%	3%	0%	78%	22%
		SQ	34%	5%	4%	0%	42%	58%
		SCC	24%	0%	0%	0%	24%	76%
		WSP	33%	7%	4%	0%	43%	57%
	High Security	CAC	4%	0%	0%	0%	4%	96%
		CCI	52%	0%	0%	0%	53%	47%
		COR	30%	34%	3%	0%	68%	32%
		LAC	29%	45%	1%	0%	75%	25%
		SAC	21%	58%	2%	0%	81%	19%
		SATF	24%	14%	8%	0%	46%	54%
		HDSP	38%	2%	2%	0%	41%	59%
		KVSP	36%	7%	2%	0%	44%	56%
		PBSP	19%	10%	2%	0%	31%	69%
		SVSP	24%	32%	1%	2%	59%	41%
	General Population	ASP	48%	0%	11%	0%	60%	40%
		SOL	37%	0%	6%	0%	43%	57%
		CAL	0%	0%	0%	0%	0%	100%
		CEN	0%	0%	0%	0%	0%	100%
		CVSP	0%	0%	0%	0%	0%	100%
		CTF	45%	0%	0%	0%	45%	55%
		ISP	1%	0%	4%	0%	5%	95%
		MCSP	31%	50%	2%	0%	82%	18%
		PVSP	19%	0%	10%	0%	29%	71%
		VSP	27%	30%	40%	0%	97%	3%
	Female Offender/ Special Housing	CHCF	2%	32%	15%	48%	97%	3%
		CIW	64%	17%	3%	6%	91%	9%
		CMF	26%	26%	5%	1%	59%	41%
		CCWF	46%	19%	7%	0%	73%	27%
		FSP	28%	2%	8%	0%	38%	62%
		Average	22%	12%	5%	2%	40%	60%

*Percentages are rounded to the nearest whole number.

In addition to these general statistics, the OIG identified five inmates who were involved in five use-of-force incidents and ten wards who were involved in five or more incidents during this reporting period.[18] All of the wards were participants in the Wards with Disabilities Program (WDP),[19] which includes wards with mental illness as well as other disabilities. One of these wards was involved in 13 incidents, and a second ward was involved in 9 incidents. Of these 22 combined incidents, 19 incidents consisted of wards fighting. In one incident, a ward was hanging onto a sprinkler, and in another incident, wards attacked staff members. Nineteen incidents involved the use of physical force and pepper spray. Two of the remaining incidents involved less-lethal force and chemical agents, and the third involved pepper spray, physical force, and an expandable baton. In all of these incidents, the department found the uses of force to be justified and to comply with policy, and the OIG agreed.

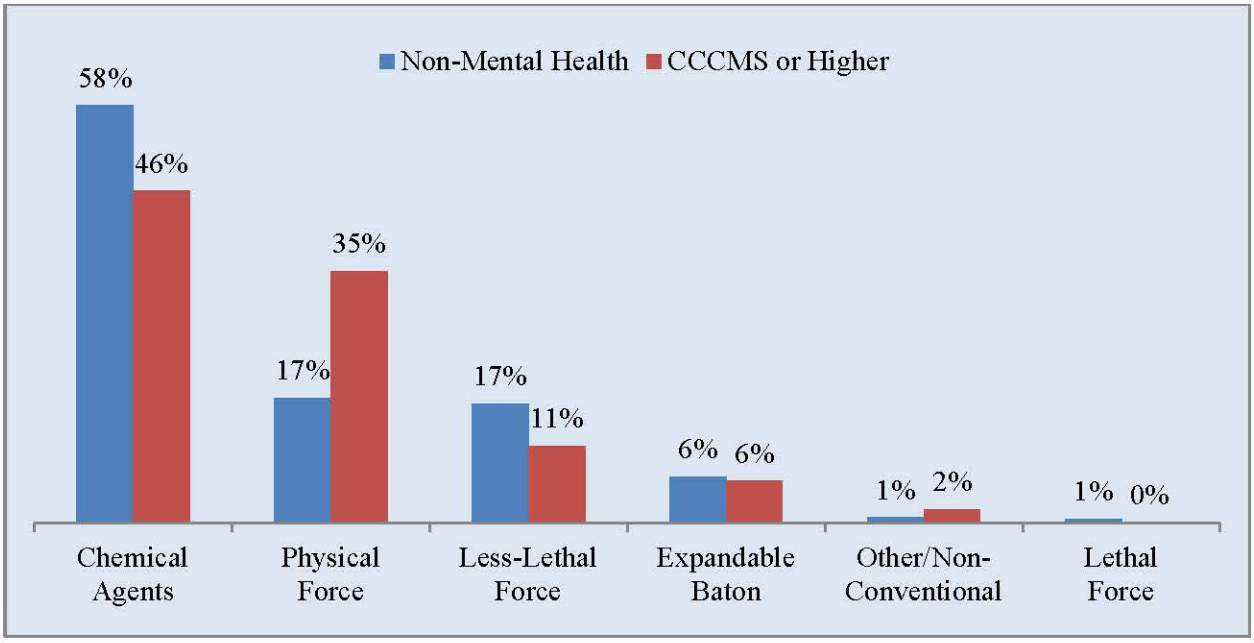
An inmate's mental health status may change between incidents. Of the five inmates involved in five incidents, one of the inmates was in the CCCMS level of care at the time of all five incidents. A second inmate's mental health status varied between CCCMS and Mental Health Crisis Bed (MHCB) levels of care, and a third inmate's status varied between the Enhanced Outpatient Program (EOP) and MHCB levels of care. The remaining two inmates involved in five incidents were in the MHCB, Enhanced Outpatient Program (EOP), and Department of State Hospitals (DSH) at various times. The majority of all of these incidents involved the use of physical force and pepper spray. Five incidents involved physical force and expandable batons, and in one incident, officers used less-lethal force. The department found all of these uses of force were justified and complied with policy, and the OIG agreed.

Chart 1 reflects the frequency of force used by type for both the mental health and non-mental health population. The percentages are based on the numbers of distinct types of force per incident rather than the total numbers of force used per incident. For example, if one officer uses pepper spray and physical force in the same incident, the forces count as two uses of force, whereas if one officer uses pepper spray twice in the same incident, the applications of pepper spray count as one use of force.

[18] The ward or inmate may have been involved in additional uses of force in addition to those reported here, since this report only provides data regarding incidents the OIG reviewed and closed during this reporting period. The OIG attended 95 percent of the review committee meetings statewide.

[19] A more detailed description of the criteria for designating wards in the Wards with Disabilities Program can be found in the Wards with Disabilities Remedial Plan at http://www.cdcr.ca.gov/juvenile_justice/docs/adaplan.pdf.

Chart 1: ***Frequency of Force by Type for Mental Health Population***



As Chart 1 reflects, the department uses chemical and physical force on mentally ill inmates more than more severe methods, such as lethal force. Mental health inmates were involved in less than 1 percent of the total uses of lethal force, including warning shots.

Table 6 below reflects the frequencies of force used per incident, broken down by type of force and grouped by mental health status. The numbers reported are numbers of types of uses of force per incident. For example, if one officer uses both pepper spray and physical force on the same inmate, these uses of force are counted as two uses of force. However, if one officer applies pepper spray multiple times on one inmate during one incident, those uses only counted as one use of force.

Table 6: ***Frequency of Force by Type, Grouped by Mental Health Status***

	Mental Health Status						
Force Type	**CCCMS**	**EOP**	**MHCB**	**DSH**	**Sub Total**	**Non Mental Health**	**Total**
Chemical Agents	815	441	28	17	**1,301**	1,216	**2,517**
Physical Force	349	448	120	71	**988**	363	**1,351**
Less-Lethal Force	194	108	0	0	**302**	347	**649**
Expandable Baton	80	73	6	5	**164**	135	**299**
Other/Non-Conventional	15	21	14	3	**53**	15	**68**
Lethal Force	1	0	0	0	**1**	11	**12**
Total	**1,454**	**1,091**	**168**	**96**	**2,809**	**2,087**	**4,896**

Of the 912 incidents involving CCCMS inmates, the OIG found immediate force was not justified in 8 incidents. The department identified 21 incidents involving CCCMS inmates where actual force used was out of policy. The department referred five of those cases to the Office of Internal Affairs. In addition, the department imposed disciplinary action in 3 cases, issued counseling in 2 cases, and provided training in 11 cases. The department also found policy deviations in 24 cases, but found the deviations reasonable. The OIG concurred with the department's findings in all of these cases.

Of the 869 incidents involving EOP inmates, the OIG found immediate force was not justified in ten incidents. The actual force used on EOP inmates was out of policy in 22 incidents. The department referred four of those cases to the Office of Internal Affairs. The department imposed disciplinary action in 2 cases, issued counseling in 5 cases, and trained staff in 11 cases. The department found policy deviations in 23 cases, but found the deviations reasonable. The OIG concurred with all of the decisions except for three the department found to comply with policy.

In the first case, the inmate refused to allow staff to lock the food port. Officers then used immediate force and sprayed the inmate with pepper spray. During decontamination in the cell, the 15-minute checks took place over a period of only 30 minutes when policy requires a minimum of 45 minutes. Finally, the officers sprayed pepper spray at a distance of less than three feet without having an imminent threat to justify the deviation from policy.

In the second case, officers used physical force to remove an inmate from a committee room when no imminent threat was identified. Officers then used non-conventional force when they tied a sheet around the inmate to secure him to a wheelchair during the escort.

In the third case, two officers used physical force to subdue an inmate without articulating the imminent threat. The committee agreed that one officer could have summoned a supervisor, used verbal de-escalation, or summoned assistance. They provided on the job training but still did not find the officer acted out of policy.

Of the 136 incidents involving MHCB inmates, the OIG found immediate force was not justified in 2 incidents. The actual force used was out of policy in four incidents. Of those, the department referred two cases to the Office of Internal Affairs, imposed disciplinary action in one case, and provided training in one case. The department found reasonable deviations in two cases. The OIG concurred with all of these determinations except for one in which the department found the use of force complied with policy. That case involved an inmate who became resistive during an escort and used his shoulder to hit an officer in the chest. Four officers used physical force to subdue the inmate. Based on the visual recording, it was not clear when the inmate lunged at the officer. The officer reported the inmate struck him in the chest with his shoulder after they entered the cell, which was not captured on the visual recording. The OIG did not concur with the finding that the use of force complied with policy because it appeared on the visual recording that the officer used physical force when he placed the inmate against the wall and then pushed the inmate into the cell. There was no evidence to justify the use of force before entering the cell.

Of the 79 incidents involving DSH patients, there were no incidents where immediate force was not justified. The department found two incidents in which the actual use of force did not comply

with policy and referred one of these to the Office of Internal Affairs and provided training in the second. The OIG concurred with all of these decisions.

As previously mentioned, one inmate can be involved in multiple use-of-force incidents and an inmate's mental health status can change from incident to incident. Therefore, the statistics outlined above pertain solely to the numbers of incidents rather than numbers of inmates.

VIDEO-RECORDED INTERVIEWS

The department's use-of-force policy requires the department to video record an interview with any inmate who alleged unreasonable force or sustained serious or great bodily injury possibly due to a use of force.[20] The video recording should be conducted within 48 hours of discovering the injury or allegation. If the inmate refuses, policy requires that the refusal be recorded. However, the actual process for conducting these interviews is inconsistent among the adult institutions. The most common deviations are listed below.

The OIG reviewed 705 incidents that required video-recorded interviews. Of those, 409 were conducted within policy and in 296 incidents, the video-recorded interview was either not completed or was not completed according to policy. This equates to a policy compliance rate of only 58 percent. The errors included failure to timely conduct interviews, failure of interviewers to adequately identify themselves or describe the inmates' injuries, failure to conduct a required interview, and failure to video record inmates' refusals to be interviewed.

During this reporting period, the OIG also noted four cases wherein the department potentially intimidated an inmate during the recorded interview. In two of those cases, the interviewing sergeant provided the inmate with a *Miranda*[21] admonishment even though the department was not pursuing criminal charges, and in one of those cases, a sergeant interrupted the inmate while the inmate was trying to describe what happened. The hiring authority provided training in both cases.

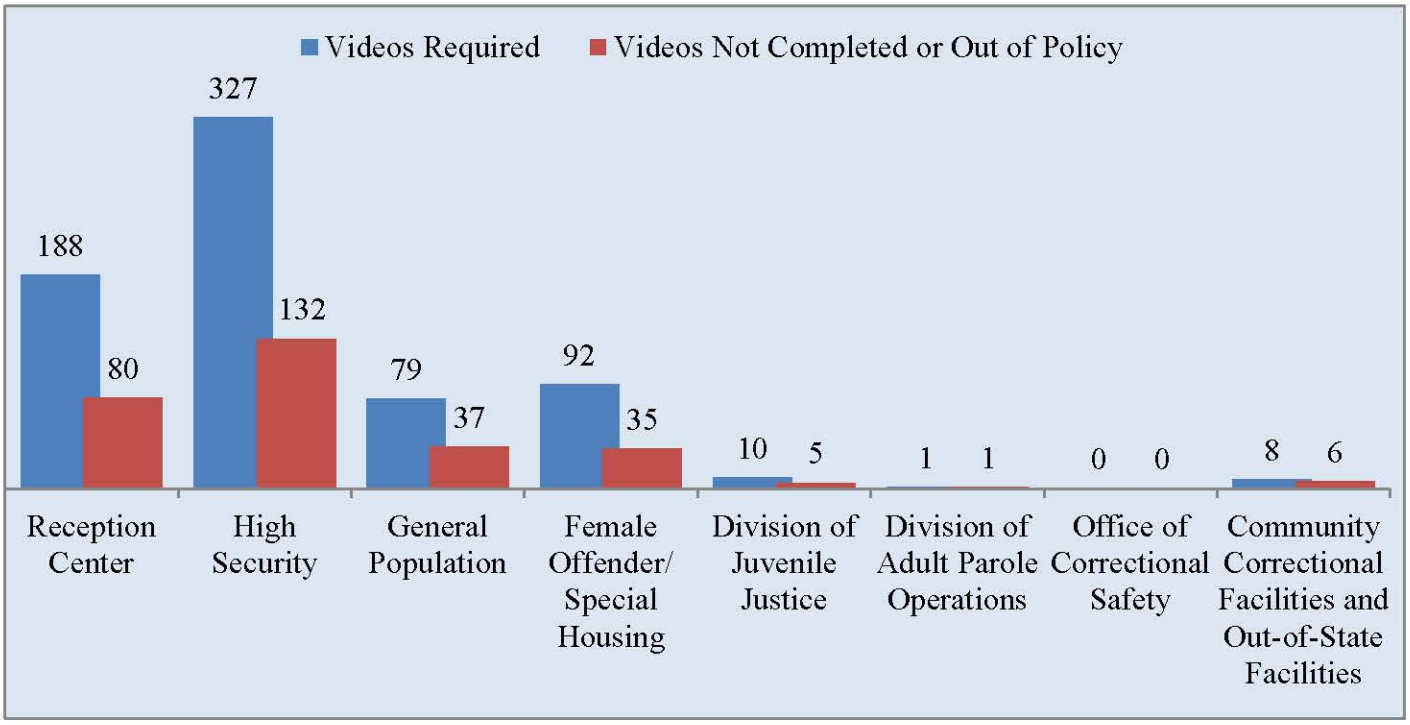
In a third case, the lieutenant conducting the interview did not adequately explain the purpose of the interview. In addition, although a sergeant was also present, the lieutenant allowed an officer also to be present, over the inmate's objection. The lieutenant told the inmate he had battered a staff member and the lieutenant did not feel safe even though a sergeant was also present. The hiring authority provided training to the lieutenant for allowing the officer to be present during the interview.

In a fourth case, the interviewing lieutenant was involved in the incident and should not have conducted the interview. Also, the lieutenant conducted the interview in front of the inmate's cell, which provided no degree of privacy from other inmates and possibly contributed to the inmate's refusal to be interviewed. The hiring authority provided training to the lieutenant.

[20] Department Operations Manual, Chapter 5, Article 2, Section 51020.17.3.
[21] *Miranda v Arizona* (1966) 384 U.S. 486.

Based on the OIG's review, the department continues to demonstrate a low rate of complying with policies regarding video-recorded interviews despite the OIG's prior reporting of similar issues. The 58 percent compliance rate is less than the 61 percent compliance rate reported during the July through December 2016 reporting period. Chart 2 reflects the percentages of failures by mission.

Chart 2: ***Video Recordings, by Mission/Division***



DIVISION OF JUVENILE JUSTICE

During this reporting period, the Division of Juvenile Justice consisted of three facilities[22] and one conservation camp, and was responsible for supervising 636 juvenile wards as of June 30, 2017.[23] The Division of Juvenile Justice has its own policy governing the use of force, including the need for video-recorded interviews under certain circumstances.[24] The OIG assesses the Division of Juvenile Justice's compliance with its own policy.

Between January and June 2017, the OIG reviewed 255 use-of-force incidents that occurred at the three juvenile facilities. Consistent with the July through December 2016 reporting period, there were no incidents at the juvenile conservation camp. The OIG attended 95 percent of the

[22] O. H. Close Youth Correctional Facility (OHC) and N. A. Chaderjian Youth Correctional Facility (NAC) are co-located in Stockton.
[23] CDCR data is derived from: *http://www.cdcr.ca.gov/Juvenile_Justice/docs/DJJ_ADP_Monthly_Report_2017/ADP_MONTHLY_REPORT_2017.06.pdf.*
[24] Division of Juvenile Justice, Crisis Prevention and Management, Use of Force, April 8, 2013.

meetings held at all three Division of Juvenile Justice facilities, an increase over the 88 percent attendance rate during the July through December 2016 reporting period.

Of the 255 incidents reviewed, 107 were at N.A. Chaderjian Youth Correctional Facility (NAC), 98 were at O.H. Close Youth Correctional Facility (OHC), and 50 were at Ventura Youth Correctional Facility (VYCF). The OIG agreed with the department that actual force used complied with policy in all but 12 incidents, 7 at VYCF, 3 at NAC, and 2 at OHC. In addition, the OIG agreed with the department that there was one incident at NAC where the use of force deviated from policy but the deviation was deemed reasonable. In that case, two wards were fighting, and an officer used pepper spray from a closer distance than allowed.

In eight of the incidents where the use of force was found out of policy, either there was no imminent threat to justify the use of force or officers should have used controlled uses of force rather than immediate force. In all of these eight incidents, officers used physical force or chemical agents. In a ninth case, a counselor attempted to handcuff a ward by himself after the ward had been involved in a fight and was agitated. The department concluded the counselor might have avoided the need for force if he had waited for responding staff members. In another case, an officer did not reassess the need to use a pepper ball launcher between deployments, and in another case, a counselor should have placed the ward in a control hold rather than dragging the ward. Another case involved the failure to give the ward sufficient time to comply with orders before spraying the ward with pepper spray. The last incident involved a riot where counselors and officers used physical force, pepper spray, less-lethal rounds, and a baton. One of the counselors dragged a ward who was refusing to get up instead of placing the ward in a control hold. In all of these cases, the department provided training or counseling, and the OIG concurred.

During this reporting period, there were three cases where the OIG did not agree with the department's conclusion that the use of force complied with policy. All three incidents occurred at NAC. In one of these cases, a counselor deployed pepper spray on a ward who was on suicide watch because the ward said he was going to harm himself by trying to scratch an injection site. The OIG raised the fact that the counselor could have contacted a mental health clinician or another counselor to help determine whether the ward was actually harming himself. In a second incident, multiple fights were occurring in the day room, and officers and counselors used pepper spray and other chemical agents, but one of the officers did not articulate an imminent threat before firing a pepper ball launcher within a few seconds of opening the door. In the third incident, a ward refused to leave his room, and an officer used physical force to remove the ward. The OIG believed the officer should not have entered the room as there was no imminent threat or need for immediate force.

During the January through June 2017 reporting period, only one of the incidents the OIG reviewed at Division of Juvenile Justice facilities involved an allegation that an officer used unreasonable force. In this incident, a team was escorting a ward for an unclothed body search when the ward turned toward the escorting officer. The officer used physical force to place the ward against the wall. During a counseling session, the ward claimed the officer placed him against the wall for no reason. The facility's review committee found the use of force to comply with policy, and the OIG concurred.

DIVISION OF ADULT PAROLE OPERATIONS

The Division of Adult Parole Operations consists of two parole regions, northern and southern. As of June 30, 2017, the Division of Adult Parole Operations was responsible for supervising 45,261 parolees.[25] The OIG reviewed 26 use-of-force incidents: 12 in the northern parole region and 14 in the southern parole region. The OIG attended 94 percent of the Division of Adult Parole Operations use-of-force meetings held statewide during this reporting period. Of the incidents reviewed, the department found that the force used complied with policy in all but one incident. In that one incident, a parolee barricaded himself inside a motor home. Parole agents entered the vehicle and used a taser in an effort to persuade the parolee to come down from an upper bunk. The parolee resisted efforts to apply handcuffs, and agents used physical force. The department determined the agents did not need to immediately enter the motor home to apprehend the parolee and that the agents should have established a perimeter and called for assistance. However, the department also determined the force the agents used after entering the motor home was reasonable. The department provided training to the parole agent who used the taser and training to all involved agents regarding proper protocol for handling parolees barricaded inside a structure. The OIG concurred with the department's determinations.

OFFICE OF CORRECTIONAL SAFETY

In addition to monitoring use-of-force incidents involving personnel at correctional institutions and in the parole system, the OIG also monitors such incidents involving employees of the department's Office of Correctional Safety. The Office of Correctional Safety is the primary departmental link with allied law enforcement agencies and the California Emergency Management Agency. Major responsibilities of the Office of Correctional Safety include criminal apprehension efforts of prison escapees and parolees wanted for serious and violent felonies, gang-related investigations of inmates and parolees suspected of criminal gang activity, and oversight of special departmental operations such as special transports, hostage rescue, riot suppression, critical incident response, and joint task force operations with local law enforcement.

During the January through June 2017 reporting period, the OIG attended the two use-of-force meetings the Office of Correctional Safety conducted. There were four total incidents involving the Office of Correctional Safety. Two of these incidents involved only physical force, the third involved physical force and pepper spray, and the fourth involved the use of a taser and physical force. The department found all of the uses of force to comply with policy, and the OIG agreed.

[25] CDCR data is derived from: *http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1706.pdf.*

Contraband Surveillance Watch

In 2012, the OIG developed a contraband surveillance watch monitoring program due to concerns the Legislature raised regarding CDCR's contraband surveillance watch process. The Legislature was concerned the department was not applying its policy in a consistent manner. Contraband surveillance watch requires additional staffing for one-on-one observations and is a significant budget driver for CDCR. Additionally, contraband surveillance watch can subject the state to significant liability if abuses occur or inmate health is at risk. On July 1, 2012, the OIG began its formal monitoring of this process. The department's policy for placing an inmate on contraband surveillance watch is found in the Department Operations Manual, Section 52050.23:

> When it becomes apparent through medical examination, direct observation, or there is reasonable suspicion that an inmate has concealed contraband in their body, either physically or ingested, and the inmate cannot or will not voluntarily remove and surrender the contraband, or when a physician has determined that the physical removal of contraband may be hazardous to the health and safety of the inmate, the inmate may be placed in a controlled isolated setting on [contraband surveillance watch] under constant visual observation until the contraband can be retrieved through natural means, or is voluntarily surrendered by the inmate.

The department is required to notify the OIG every time an inmate is placed on contraband surveillance watch and when the department transfers an inmate to an outside hospital while on contraband surveillance watch. The OIG collects all relevant data, including the inmate's name, reason for placing the inmate on contraband surveillance watch, dates and times the department places an inmate on and removes an inmate from watch, and what contraband, if any, was found. The OIG responds to the scene and monitors any contraband surveillance watch case where a significant medical problem occurs, regardless of how long the inmate has been on watch, and in all cases where the watch extends beyond 72 hours. While at the scene, the OIG inspects the inmate's condition along with documentation to determine whether the department is following policy. This on-scene response is repeated every 72 hours until the department removes the inmate from contraband surveillance watch. The OIG discusses any serious policy breaches with institution managers while at the scene. The OIG also formally assesses the sufficiency of how the department conducts each contraband surveillance watch that exceeds 72 hours, as well as select cases that do not exceed 72 hours. Examples of such cases include cases when the department transfers an inmate to an outside hospital or an inmate is suffering serious medical conditions that could be related to the contraband surveillance watch.

Table 7: ***All Contraband Surveillance Watch Cases Reported to the OIG, by Institution, January – June 2017***

Institution	All Cases Reported to the OIG between January and June 2017 by Institution
ASP	0
CAC	1
CAL	9
CCC	6
CCI	5
CCWF	0
CEN	15
CHCF	0
CIM	0
CIW	3
CMC	1
CMF	1
COCF-CCF[26]	0
LPCC	1
TCCF	0
COR	1
CRC	1
CTF	2
CVSP	0
DVI	2
FSP	3
HDSP	3
ISP	8
KVSP	3
LAC	2
MCSP	1
NKSP	1
NCYCC	1
PBSP	11
PVSP	6
RJD	1
SAC	4
SATF	4
SCC	3
SOL	13
SQ	0
SVSP	9
VSP	2
VYCF	1
WSP	3
Total CSW Cases	127

During this reporting period, the department notified the OIG of 127 contraband surveillance watch cases, slightly fewer contraband surveillance watch cases compared to four of the five previous reporting periods. In the five prior reporting periods, the department notified the OIG of inmates placed on contraband surveillance watch 121, 128, 135, 155, and 206 times respectively. Table 7 contains the number of cases the department reported to the OIG by institution between January 1, 2017, and June 30, 2017. This number does not directly correlate with the number of cases the OIG is reporting in this Semi-Annual Report since the OIG only assesses and reports those cases where contraband surveillance watch extends beyond 72 hours, where the department transfers an inmate to an outside hospital, or in other circumstances warranting an assessment.

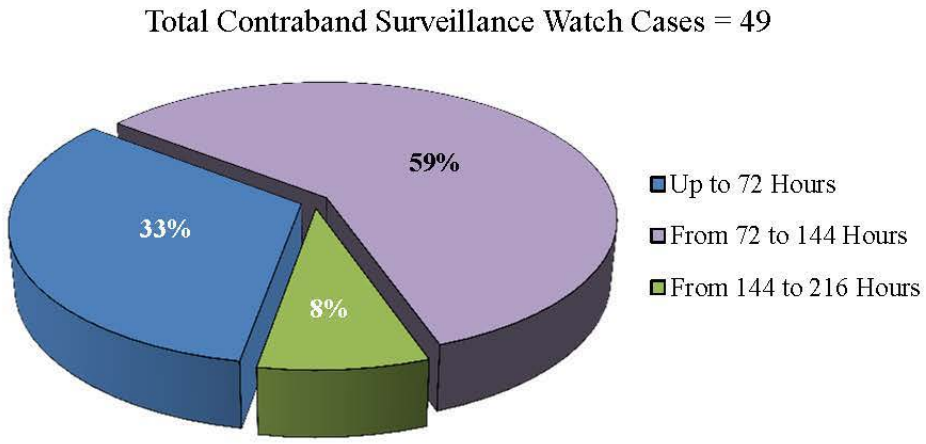
The department may remove an inmate from contraband surveillance watch when the department reasonably believes the inmate has relinquished the contraband or the department determines the inmate is contraband free.[27] Normally, the department should retain an inmate on contraband surveillance watch for no more than 72 hours.

[26] Community Correctional Facilities operated by the California Out-of-State Correctional Facility Program.

[27] Department Operations Manual, Title 15, Chapter 2, Section 52050.23.8.

For the January through June 2017 reporting period, the OIG is reporting 49 monitored cases in Appendix F. These 49 cases include 8 cases involving inmates who required medical attention at an outside hospital but where the contraband surveillance watch did not extend beyond 72 hours. The department kept inmates on contraband surveillance watch longer than 72 hours but less than 144 hours in 29 cases. In four cases, the department kept inmates on contraband surveillance watch between 144 and 216 hours. During this reporting period, the department did not keep any inmates on contraband surveillance watch longer than 216 hours (9 days). In addition, other than minor documentation issues, the department sufficiently complied with policies during the watch in all 49 cases. Chart 3 below depicts the percentages of cases by duration for cases the OIG monitored.

Chart 3: *Duration of OIG-Monitored Contraband Surveillance Watch* Cases

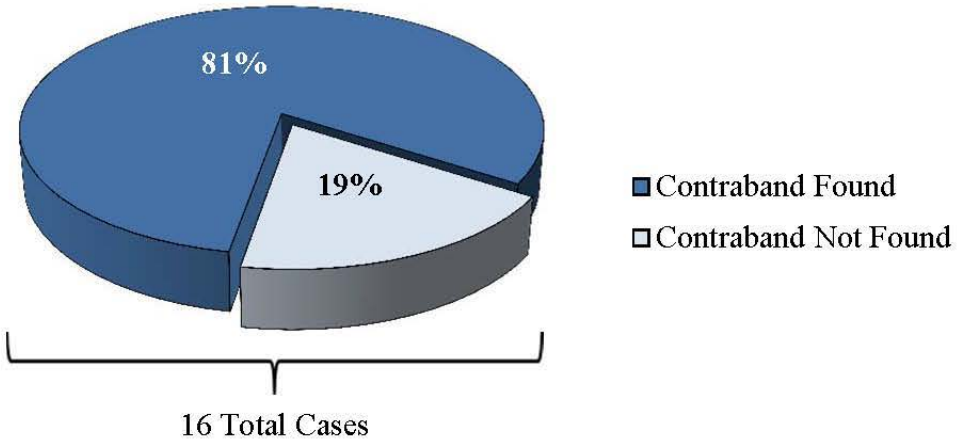


For the January through June 2017 reporting period, "contraband found" includes any contraband the department obtained that led to placing an inmate on contraband surveillance watch. For example, if officers discovered mobile phones or marijuana in an inmate's cell during a cell search and subsequently placed the inmate on contraband surveillance watch, the mobile phone and marijuana would count as "contraband found" to be consistent with the department's practice. However, in the upcoming July through December 2017 reporting period, the OIG will no longer consider "contraband found" to include contraband that led to placing an inmate on contraband surveillance watch. Instead, the OIG will only report contraband found as a direct result of placing an inmate on contraband surveillance watch to ensure there is no abuse during the contraband surveillance watch process.

Of the 127 total cases reported to the OIG from January 1, 2017, through July 31, 2017, the department recovered contraband in 46 percent of the total cases for all durations of contraband surveillance watch. The department recovered contraband in 37 percent of the total cases reported to the OIG that did not extend beyond 72 hours. This is less than the 57 percent recovery rate for cases lasting less than 72 hours reported to the OIG during the July through December 2016 reporting period.

Chart 4 below reflects the percentages of contraband found for cases monitored by the OIG between January and June 2017 lasting less than 72 hours, including contraband discovered prior to actually placing the inmate on contraband surveillance watch.

Chart 4: *Contraband Found in OIG-Monitored Cases Lasting Less Than 72 Hours*



For cases the OIG monitored and is reporting currently, the department recovered contraband in 70 percent of cases that extended beyond 72 hours, which is a slight decrease from the 78 percent of cases in which contraband was found from July through December 2016. Chart 5 below reflects the percentages of contraband found for OIG-monitored cases extending beyond 72 hours.

Chart 5: *Contraband Found in OIG-Monitored Cases Extending Beyond 72 Hours*

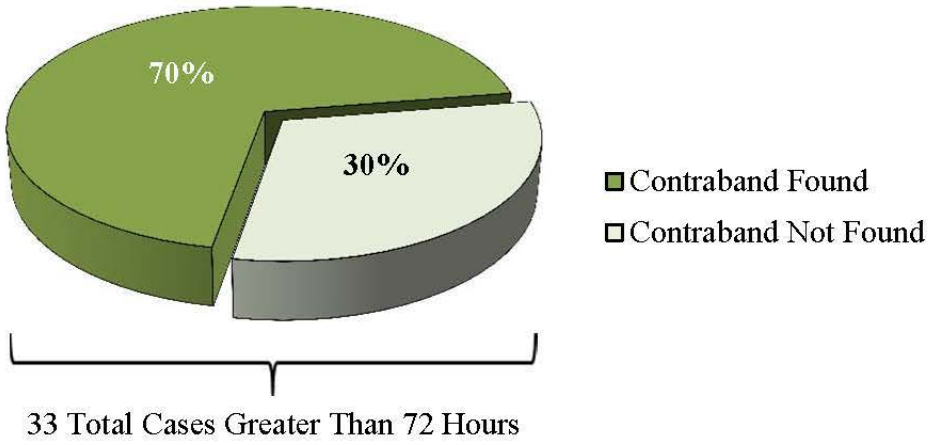


Table 8 below shows a comparison of the percentages of OIG-monitored cases where the department recovered contraband between July 2014 and June 2017 for those cases extending beyond 72 hours.

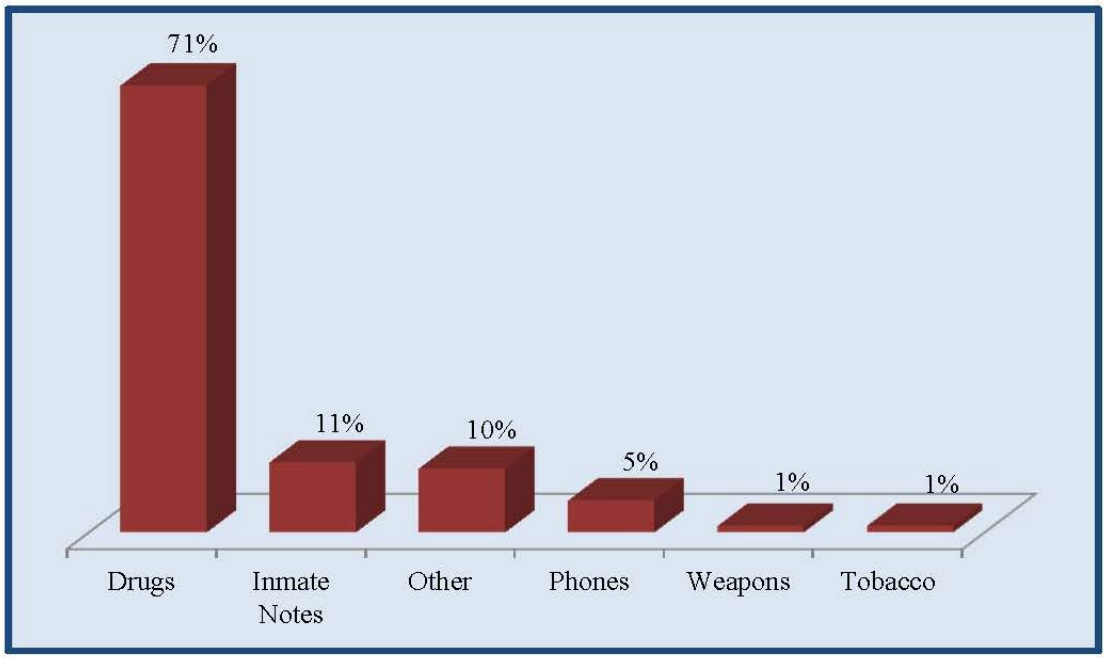
Table 8: *Contraband Found in Cases Extending Beyond 72 Hours, July 2014 – June 2017*

Reporting Period	Cases Over 72 Hours	Contraband Found	Percentage
July–December 2014	59	28	53%
January–June 2015	42	38	90%
July–December 2015	39	27	69%
January–June 2016	43	28	65%
July-December 2016	40	31	78%
January-June 2017	33	23	70%

For the total cases the OIG monitored and is reporting for the January through June 2017 reporting period, the department recovered contraband in 73 percent of the cases. Again, though, this includes contraband discovered prior to placing an inmate on contraband surveillance watch, such as items found during a cell search.

As previously noted, this report discusses in detail those cases the OIG monitored in which contraband surveillance watch extended beyond 72 hours, as well as cases where the department transported inmates to outside hospitals. Chart 6 below reflects the types of contraband found for all OIG-monitored incidents for the January through June 2017 reporting period. In some cases, the department recovered more than one type of contraband.

Chart 6: *Contraband Type and Frequency in All OIG-Monitored Cases*



The OIG rated the department on the adequacy of its management of contraband surveillance watch. Of the 49 cases the OIG monitored, the department sufficiently managed the contraband surveillance watch process in 25 cases, or 51 percent. The details regarding the sufficiency assessments are found in Appendix F. As the individual cases reflect, consistent with the prior reporting period, the main reasons for insufficient assessments are inadequate documentation and failure to perform consistent hygiene checks. In addition, the OIG noted a fairly consistent failure to allow range of motion while inmates were restrained.

Some other insufficiencies are also worthy of mention for cases monitored during the January through June 2017 reporting period. In three cases, the department placed the inmate in hand isolation devices without proper authorization. In one of the cases, the department identified the error approximately two hours later and removed the devices. However, the department also failed to place the inmate on contraband surveillance watch until more than one hour after officers saw the inmate swallow an unknown object. Additionally, the hiring authority prematurely authorized removing this inmate from contraband surveillance watch within 24 hours, after conceding the delayed initial placement on contraband surveillance watch may have allowed the inmate to discard the contraband.

In another insufficient case, the department failed to adequately monitor the inmate during contraband surveillance watch, enabling the inmate to re-ingest contraband. The department recovered concentrated cannabis from the inmate three days after placement on contraband surveillance watch. The department also failed to timely notify the OIG when transferring the inmate to an outside hospital and when removing the inmate from contraband surveillance watch. A final case worth noting is a case where the department placed an inmate in leg restraints for 13 hours without authorization.

In the majority of insufficient cases, the department provided training. In some cases, the hiring authority revised local procedures or provided written counseling to those involved.

The department's decision to place inmates on contraband surveillance watch complied with policy in all but four cases the OIG monitored. In the one of these cases, the department waited almost one hour after observing the inmate appear to swallow suspected drugs before placing the inmate on contraband surveillance watch, and in a second case, officers did not tape the inmate's jumpsuit in a timely manner after placing the inmate on contraband surveillance watch. In the third case, officers did not conduct an initial unclothed body search, and in the fourth case, the department did not document placing the inmate on contraband surveillance watch.

For cases the OIG is reporting for January through June 2017, the department timely notified the OIG when placing an inmate on contraband surveillance watch in all but two cases. During the July through December 2016 reporting period, the department also failed to notify the OIG when placing the inmate on contraband surveillance watch in two monitored cases. In addition, during the January through June 2017 reporting period, the department failed to notify the OIG when inmates were transferred to an outside hospital in 5 of the 17 cases where inmates were transferred to an outside hospital, compared to insufficient notification in 3 of 11 cases during the July through December 2016 reporting period. Table 9 on the following page details the total

number of contraband surveillance watch cases the OIG assessed for the January through June 2017 reporting period at each institution.

Table 9: ***Contraband Surveillance Watch Cases, by Institution, January – June 2017***

Institution	Cases Less than 72 Hours *Reported January–June 2017	Cases Between 72 and 144 Hours *Reported January–June 2017	Cases Between 144 and 216 Hours *Reported January–June 2017	216 Hours or More	Number of Cases Rated Sufficient	Number of Cases Rated Insufficient
ASP	0	0	0	0	N/A	N/A
CAC	2	0	0	0	0	2
CAL	5	1	0	0	3	3
CCC	1	0	0	0	0	1
CCI	2	1	0	0	0	3
CCWF	0	0	0	0	N/A	N/A
CEN	0	6	0	0	5	1
CHCF	0	0	0	0	N/A	N/A
CIM	0	0	0	0	N/A	N/A
CIW	1	0	0	0	0	1
CMC	0	0	0	0	N/A	N/A
CMF	0	0	0	0	N/A	N/A
COCF-CCF	0	0	0	0	N/A	N/A
LPCC	0	0	0	0	N/A	N/A
TCCF	0	0	0	0	N/A	N/A
COR	0	0	0	0	N/A	N/A
CRC	1	2	0	0	0	3
CTF	0	0	0	0	N/A	N/A
CVSP	0	0	0	0	N/A	N/A
DVI	1	0	0	0	1	0
FSP	0	0	0	0	N/A	N/A
HDSP	0	0	1	0	0	1
ISP	0	3	1	0	1	3
KVSP	0	2	0	0	1	1
LAC	0	0	0	0	N/A	N/A
MCSP	0	0	0	0	N/A	N/A
NKSP	0	0	0	0	N/A	N/A
NCYCC	0	0	0	0	N/A	N/A
PBSP	0	2	0	0	1	1
PVSP	1	1	1	0	1	2
RJD	0	1	0	0	1	0
SAC	1	0	0	0	1	0
SATF	1	1	0	0	0	2
SCC	0	0	0	0	N/A	N/A
SOL	0	6	1	0	7	0
SQ	0	0	0	0	N/A	N/A
SVSP	0	3	0	0	3	0
VSP	0	0	0	0	N/A	N/A
VYCF	0	0	0	0	N/A	N/A
WSP	0	0	0	0	N/A	N/A
Total CSW Cases	16	29	4	0	25	24
	Contraband Recovered: 13 Cases = 81%	Contraband Recovered: 19 Cases = 66%	Contraband Recovered: 4 Cases = 100%	Contraband Recovered: N/A	Sufficient = 51%	Insufficient = 49%

Typically, the department uses waist restraints on inmates placed on contraband surveillance watch in order to prevent destruction or re-ingestion of contraband. On May 2, 2016, the department began a trial period of unrestrained contraband surveillance watch at three institutions: California Rehabilitation Center; Kern Valley State Prison; and Calipatria State Prison. The policy for these institutions requires that, before using mechanical restraints, the institution must document a specific safety and security need beyond simply the recovery of contraband, and a captain or higher authority must approve the use of the restraints. The criteria for using such restraints is met if it appeared an inmate was concealing a weapon, razor blades, or any item that would pose an immediate risk to the safety and security of inmates or staff. Inmates who attempt to defeat the contraband surveillance watch process would also be subject to the application of restraints. Unrestrained inmates are still monitored according to the remainder of the contraband surveillance watch polices. As in the July through December 2016 reporting period, the OIG continued to assess the department's compliance with policies and procedures at these three trial period institutions pursuant to the revised policy for contraband surveillance watch cases.

Use of Low-Dose Body Scans as Reason for Placement on Contraband Surveillance Watch

Although the OIG assessed the department's decision to place inmates on contraband surveillance watch as sufficient in a large majority of cases, the OIG noticed a possible trend in using low-dose body scans as the only basis to justify contraband surveillance watch. Therefore, in addition to routine monitoring, between July 1, 2016, and April 10, 2017, the OIG also reviewed 183 contraband surveillance watch cases to evaluate the department's use of low-dose body scans as a basis for placing inmates on contraband surveillance watch.

As a result of the review, the OIG found 32 incidents where the department used a low-dose body scan as a basis for placing inmates on contraband surveillance watch. Of these 32 cases, the department recovered contraband from inmates in only 12 cases, which is 38 percent of the cases using a low-dose body scan. However, the OIG found a higher recovery rate in those instances where there was a secondary indicator of contraband, such as failure to clear a metal detector or the discovery of contraband during a cell search. In 8 of the 12 cases where the department recovered contraband after using a low-dose body scanner, there were also secondary sources such as direct observation or failure to clear a metal detector. As a result of this review, the OIG recommends the department attempt to obtain a secondary indicator, such as direct observation, failure to clear a metal detector, or contraband found during a cell search, before placing an inmate on contraband surveillance watch based only on a lose-dose body scan. Otherwise, inmates could be unnecessarily subjected to contraband surveillance watch.

Field Inquiries

Since its inception, the OIG has provided a process by which inmates, CDCR staff, and the public can report misconduct or lodge complaints. The OIG receives 250-300 complaints monthly, which go through a screening process. Many are returned because existing administrative remedies have not been exhausted, and many more are resolved informally through correspondence or phone calls with the institution. There are five to ten more serious or unresolved complaints each month that are referred out to regional OIG staff to directly follow up on the department's response. The OIG staff members examine complaints, review the entire case and reports, appear at the scene as appropriate, confer with the department, and determine whether the department's response was appropriate overall. During the January through June 2017 reporting period, the OIG completed the collection of data for 29 monitored complaints.

The OIG assesses whether the department takes appropriate action to investigate or address the issue, rather than whether underlying complaints or allegations are substantiated. The assessment includes whether the department developed and maintained sufficient documentation and adequately consulted with the OIG, as well as whether the hiring authority appropriately referred allegations of misconduct to the Office of Internal Affairs and whether the Office of Internal Affairs made appropriate determinations regarding the referrals.

Of the 29 cases the OIG concluded between January 1, 2017, and June 30, 2017, the department sufficiently addressed the OIG's inquiry in 26 cases, which is 90 percent. The three insufficient cases involved alleged sexual assault by officers against inmates. The hiring authority did not identify staff misconduct in any of the three insufficient cases. However, in one of the cases, the OIG identified concerns regarding the incident reports and recommended custody and medical staff write objective reports without demeaning comments. The hiring authority agreed and provided training. In a second case, the hiring authority conducted an inquiry regarding the allegations, made a staffing change, and provided locally designated investigator training to the investigative services unit. And in the third case, the hiring authority provided Prison Rape Elimination Act training to a lieutenant, provided locally designated investigation training to all investigative services unit staff, and also made staffing changes.

The percentage of sufficient assessments improved from the 87 percent sufficiency rating during the July through December 2016 reporting period. The OIG will continue to examine all complaints and allegations received to help ensure appropriate resolution.

Volume II Conclusion

The OIG publishes two volumes of its Semi-Annual Report to allow the reader to more easily focus on specific areas of the OIG's monitoring. All areas the OIG monitors require transparent oversight to ensure public trust, proper adherence to policy, best practices, safety and security of staff and inmates, and accountability to the taxpayer. Throughout its monitoring activities, the OIG alerts the department to potential risks or problem areas and makes recommendations for improvement. The OIG monitoring helps prevent abuses, potential harm to staff members and inmates, costly litigation, and federal oversight.

Critical incidents as described herein have the potential for serious consequences to staff, inmates, and the taxpayers at large. As such, OIG oversight provides independent assessments of how incidents occur, the department's response, and the outcomes. During this reporting period, the department timely notified the OIG of 90 percent of critical incident cases reported in Appendices D1 and E, which is a continued improvement over the 82 percent timely reporting rate during the July through December 2016 reporting period. In addition, the department timely notified the OIG in all but one of the Deadly Force Investigation Team cases, which is consistent with the last reporting period.

While monitoring critical incidents, the OIG identified a new area of concern, which consists of staff members potentially destroying critical crime-scene evidence by moving an inmate's body before the coroner's office authorizes the staff member to do so. The OIG provides a new recommendation, listed on page 43, based on this concern.

During this reporting period, the OIG attended 822 review committee meetings, and 19 Department Executive Review Committee and 2 Division Force Review Committee meetings, and continues to strive for a 100 percent attendance rate. In addition, the OIG evaluated and closed 3,936 unique incidents. Overall, the committees took appropriate action, and the OIG concurred with the vast majority of the department's determinations regarding use of force, including actual force. However, the OIG also noticed some new areas of potential concern, including inappropriate use of spit masks or hoods and inadequate documentation regarding the decontamination process following application of chemical agents. We are pleased that after bringing the spit mask concerns to the department, leaders took immediate action to clarify policy. The OIG is making new recommendations based on these findings. These recommendations are also on page 43.

The OIG also continues to monitor and report on the department's handling of contraband surveillance watch incidents. If department staff members do not follow policies, serious medical issues may occur. During this reporting period, the department again demonstrated a mediocre compliance rate with contraband surveillance watch policies, with 51 percent of the cases deemed sufficient compared with 55 percent during the July through December 2016 reporting period. Lack of documentation continues to be a problem, although the basis for contraband surveillance watch appears to remain fairly consistent since the last reporting period. However, the department's rate of recovering contraband in those cases where it placed an inmate on contraband surveillance watch solely based on the results of a low-dose body scan is a possible

indicator that the department needs to consider using secondary indicators before unnecessarily subjecting an inmate to contraband surveillance watch. At the same time, the department is not keeping inmates on contraband surveillance watch for unreasonable lengths of time and, during the January through June 2017 reporting period, did not keep any inmates on contraband surveillance watch longer than 216 hours. The OIG is making a final recommendation based on the use of low-dose body scanners as a basis for placing inmates on contraband surveillance watch.

This report once again contains the department's response to the OIG's complaint intake process. The OIG headquarters intake personnel are able to address most of these complaints informally and return others to the complainant to exhaust administrative remedies. However, the OIG may reach out to institutions to address more serious or unresolved concerns. The department sufficiently addressed the OIG's inquiry in 90 percent of the field inquiry cases during this reporting period, compared with 84 percent in the July through December 2016 reporting period. The OIG believes this is value added in providing legitimacy to the complaint process.

There continue to be areas for the department to improve. The OIG continues to highlight areas of concern, including the continued high frequency of negligent discharge incidents. However, the department continues to be receptive to the OIG's input and meets with the OIG routinely to discuss concerns and possible actions in response to the OIG's recommendations.

The OIG believes oversight continues to be crucial to help ensure the transparency of the California corrections system. As in the past, the OIG provides recommendations to the department with the goal of continuing the improvement of the department's processes. The OIG is committed to being an external outlet to resolve complaints when other processes within the system fail. We also remain focused on monitoring the vital areas of critical incidents, use of force, and contraband surveillance watch and providing transparency to the public in these areas.

Volume II Recommendations

The OIG recommends the department implement the following recommendations from Volume II of this Semi-Annual Report, January through June 2017.

Recommendation 1.1: The OIG recommends the department provide training to all custody and medical staff regarding the removal of dead bodies without a coroner's authorization.

Recommendation 1.2: The OIG recommends the department establish clear guidelines for analyzing inmates' statements related to use-of-force incidents, including accepting an inmate's plain language complaint as a legitimate allegation of unreasonable force, to initiate a proper inquiry or investigation. The OIG also recommends the department provide training to all supervisors and managers to ensure inmate allegations are processed according to policy.

Recommendation 1.3: The OIG recommends the department clarify its policy to require staff members to document providing inmates with clean clothing as part of the chemical agent decontamination process, and to document the time clothing is provided to the inmate.

Recommendation 1.4: The OIG recommends the department provide training to reinforce the importance of ensuring the application of spit masks or hoods meets the criteria set forth in the Department Operations Manual. The OIG also recommends the department clarify criteria regarding the monitoring of inmates after a spit mask or hood has been applied.

CDCR Response: Partially Implemented.

The department has clarified the policy to require constant supervision of an inmate once a spit mask has been applied since application of a spit mask can cause respiratory distress regardless of other factors, such as pepper spray exposure.

Recommendation 1.5: The OIG recommends the department attempt to obtain a secondary indicator, such as direct observation, failure to clear a metal detector, or contraband found during a cell search, before placing an inmate on contraband surveillance watch based only on a lose-dose body scan.

Volume II Recommendations from Prior Reporting Periods

The OIG recommended the department implement the following recommendations from Volume II of the prior Semi-Annual Report, July through December 2016.

Recommendation 2.1: The OIG recommends the department develop procedures for and implement better training for safe firearms handling, including addressing negligent discharges with appropriate follow-up to include training or discipline as appropriate.

CDCR Response: Partially Implemented.

The department does not agree with the OIG that there is a failure to conduct adequate follow-up after negligent discharge incidents. However, the Division of Adult Institutions, Division of Adult Parole Operations, Office of Correctional Safety, and Office of Internal Affairs established a workgroup to review the use-of-force policy and is incorporating language to include appropriate follow-up such as training or discipline. The department's Office of Correctional Safety developed a training approach in an effort to decrease negligent discharges. The department stopped using the phrase "press check" when referring to the act of verifying the whether a firearm is loaded. The technique is referred to as a "chamber check" and changes were made to instructor course presentations, including a new range master lesson plan to reflect the changes. In addition, the department developed options for reducing or eliminating extensive manipulation of a handgun for armed post weapons exchanges while still allowing an officer to safely determine whether a firearm is loaded. The department is providing training during the 2017 firearms qualification sessions. The department also mandated the use of "dummy rounds" to be used during training regarding how to address malfunctions. The department prepared a new 80-hour range master certification lesson plan, which is currently pending approval by the Office of Training and Professional Development. The plan will include enhanced firearms safety during testing and side bar instructor notes to address areas of concern.

Recommendation 2.2: The OIG recommends the department provide training to supervisors regarding the procedures and processes for obtaining timely and appropriate public safety statements.

CDCR Response: Not Implemented.

The department reviewed the case examples and does not agree the examples present a systemic problem and believes existing regulations regarding public safety statements are clear. The department states it is committed to enforcing the regulations through the progressive discipline process on a case-by-case basis.

The OIG recommended the department implement the following recommendations from Volume II of the prior Semi-Annual Report, January through June 2016.

Recommendation 2.1: The OIG recommends the department amend Department Operations Manual Section 51020.19.5 to require the Institutional Executive Review Committee to view all available exercise yard or housing unit video recordings as part of the incident review process.

CDCR Response: Fully Implemented

On March 7, 2017, the Division of Adult Institutions revised Department Operations Manual Section 51020.19.5 to require the Institutional Executive Review Committee chairperson to personally review all video recordings arising from controlled use-of-force incidents and any portion of video recordings capturing an immediate use of force.

Recommendation 2.2: The OIG recommends the department amend Department Operations Manual Sections 51020.4 and 51020.19.6 to require the Department Executive Review Committee to review use-of-force incidents within 60 days of Institutional Executive Review Committee completion in accordance with recent guidance promulgated by senior CDCR management.

CDCR Response: Fully Implemented

On March 7, 2017, the Division of Adult Institutions revised Department Operations Manual Section 51020.19.6 to require the Department Executive Review Committee to review required use-of-force incidents within 60 days of completion by the Institution Executive Review Committee.

Appendices

Appendix D1 contains the assessments for 19 deadly force incidents the OIG monitored during the reporting period but the Office of Internal Affairs did not investigate, listed by geographical region. **Page 47**

Appendix D2 contains the assessments for 26 deadly force cases the Office of Internal Affairs investigated and the OIG monitored during the reporting period, listed by geographical region. **Page 57**

Appendix E contains the assessments for 72 critical incidents the OIG monitored during the reporting period, listed by geographical region. **Page 81**

Appendix F contains the results and outcomes of 49 contraband surveillance watch cases the OIG monitored during the reporting period, listed by the date the department placed the inmate on contraband surveillance watch. **Page 113**

Appendix G contains the 29 field inquiries the OIG concluded during the reporting period, listed by geographical region. **Page 138**

Appendix D1
Monitored Deadly Force Incident Cases

Central

Incident Date	OIG Case Number	Case Type
2016-09-29	16-0001951-RO	Use of Deadly Force

Incident Summary

On September 29, 2016, an officer observed three inmates beating another inmate who appeared to be defenseless and unconscious. The officer fired a warning shot from a Mini-14 rifle, stopping the fight. The injured inmate received medical treatment at the institution. The OIG responded to the scene.

Disposition

The institution's executive review committee determined the officer's use of force complied with policy. The OIG concurred. The hiring authority provided training to officers regarding crime scene and evidence preservation.

Incident Assessment

The department's actions following the incident were not adequate because officers did not secure the crime scene.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Responding officers neglected to maintain the security of the crime scene prior to removing the inmates from the area.

Incident Date	OIG Case Number	Case Type
2017-01-11	17-0000112-RO	Use of Deadly Force

Incident Summary

On January 11, 2017, an officer allegedly left a loaded handgun on a bed at home. The officer's three-year old daughter picked up and discharged the handgun, killing the officer's one-year-old son.

Disposition

The hiring authority identified potential staff misconduct based on the officer's alleged child endangerment and unlawful storage of a firearm and referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Incident Assessment

The department's actions were not adequate because the department failed to properly notify the OIG and the Office of Internal Affairs and an officer allegedly left a loaded firearm unattended in the presence of a minor.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Did the hiring authority timely notify the Office of Internal Affairs of the incident?**
  The institution did not notify the Office of Internal Affairs.
- **Did the department timely notify the OIG regarding the critical incident?**
  The department learned of the incident on January 11, 2017, but did not notify the OIG until January 13, 2017, two days later.
- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's actions were not adequate because an officer allegedly negligently left a loaded firearm unattended in the presence of a minor.

North

Incident Date	OIG Case Number	Case Type
2015-05-23	15-0001051-RO	Use of Deadly Force

Incident Summary

On May 23, 2015, approximately 100 inmates engaged in a riot on the exercise yard. An officer deployed a gas grenade. A second officer fired six less-lethal rounds, striking an inmate in the back with one round. The second officer also fired a warning shot from a Mini-14 rifle, stopping the fighting. One inmate sustained injuries caused by an inmate-manufactured weapon and was treated at the institution. The inmate who was shot in the back with the less-lethal round sustained minor injuries and returned to a cell. The OIG responded to the scene.

Disposition

The institution's executive review committee determined the officers' use of force complied with policy but recommended training for officers who did not timely submit reports, nurses for incomplete medical assessments, and managers for failing to complete timely reviews. The OIG concurred.

Incident Assessment

The department's response was not adequate because nurses did not sufficiently complete medical assessments, officers did not sufficiently conduct checks on inmates or timely submit reports, the captain and associate warden did not timely review the incident, and the institution's executive review committee did not timely review the incident.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Was the critical incident adequately documented?**
  Nurses did not properly document medical assessments or complete a medical assessment on one inmate. Officers failed to conduct 15-minute checks on several inmates and failed to submit incident reports prior to the end of their shift. The captain and associate warden did not timely review the incident.

- **Did the use-of-force review committee adequately review and respond to the incident?**
  The institution's executive review committee did not complete its review until 19 months after the incident. The department failed to complete training documentation for incomplete documentation and late reports.

Incident Date	OIG Case Number	Case Type
2016-08-14	16-0001852-RO	Use of Deadly Force

Incident Summary

On August 14, 2016, two inmates attacked a third inmate on the exercise yard, repeatedly kicking the inmate in the head. An officer fired one warning shot from a Mini-14 rifle, stopping the attack. The department treated the third inmate at the institution. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-12-12	16-0002130-RO	Use of Deadly Force

Incident Summary

On December 12, 2016, two inmates attacked a third inmate with inmate-manufactured weapons on the exercise yard. An officer deployed a pepper spray grenade, and two other officers fired three warning shots from Mini-14 rifles, stopping the attack. The inmate who was attacked was air-lifted to an outside hospital with serious injuries. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-12-16	16-0002148-RO	Use of Deadly Force

Incident Summary

On December 16, 2016, two inmates repeatedly punched and kicked a third inmate. An officer attempted to fire less-lethal rounds, but improperly operated the less-lethal launcher and was unable to fire any less-lethal rounds. The inmates continued attacking the third inmate. The officer fired one warning shot from a Mini-14 rifle, stopping the attack. Two of the three inmates were treated at the institution for injuries and released. One inmate refused treatment.

Disposition

The institution's executive review committee determined the use of force complied with policy. However, the committee determined the officer improperly used the less-lethal launcher, causing it to malfunction. The institution's executive review committee also determined a different officer untimely submitted a report, a nurse did not adequately document the inmate's injuries, and a lieutenant failed to complete required documentation, ensure the interview was properly conducted, or ensure another medical evaluation was completed. The OIG concurred with the executive review committee's determinations. The hiring authority provided training to address all identified issues.

Incident Assessment

The department's actions during and after the incident were not adequate because the officer caused the less-lethal launcher to malfunction. Also, the department did not timely or properly conduct the inmate's interview, a lieutenant did not ensure a medical evaluation was completed, an officer submitted an untimely report, and a nurse did not adequately document the inmate's injuries.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  An officer improperly used the less-lethal launcher causing it to malfunction. The inmate complaint office did not ensure the inmate was interviewed timely. The lieutenant who conducted the interview failed to complete required documentation, ensure the interview was conducted in an area free from noise and distraction, or ensure another medical evaluation was completed of the injuries identified during the interview. An officer untimely submitted a report and a nurse did not adequately document the inmate's injuries.

- **Was the critical incident adequately documented?**
  The lieutenant who conducted the interview failed to complete required documentation, and a nurse did not adequately document the inmate's injuries.

- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified that the department did not timely interview the inmate.

Incident Date	OIG Case Number	Case Type
2016-12-26	16-0002162-RO	Use of Deadly Force

Incident Summary

On December 26, 2016, an officer allegedly negligently discharged a round from a firearm during a weapons check inside an observation booth.

Disposition

The hiring authority identified potential staff misconduct based on the officer's alleged negligent discharge of a firearm. Therefore, the hiring authority referred the matter to the Office of Internal Affairs. The Office of Internal Affairs returned the matter to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Incident Assessment

The department's actions were not adequate because an officer allegedly negligently discharged a firearm and the department did not notify the OIG in a timely and sufficient manner.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Did the department timely notify the OIG regarding the critical incident?**
  The department learned of the incident on December 26, 2016, but did not notify the OIG until December 27, 2016, thereby preventing the OIG from real-time monitoring.

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  An officer allegedly negligently discharged a firearm.

Incident Date	OIG Case Number	Case Type
2017-01-09	17-0000097-RO	Use of Deadly Force

Incident Summary

On January 9, 2017, approximately 30 inmates participated in a riot on the exercise yard. Officers deployed approximately six pepper spray grenades. Two officers fired warning shots from Mini-14 rifles, stopping the attack. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officers' use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-01-17	17-0000113-RO	Use of Deadly Force

Incident Summary

On January 17, 2017, two inmates attacked a third inmate on the exercise yard. An officer fired one less-lethal round, and other officers deployed pepper spray grenades. A third officer fired one warning shot from a Mini-14 rifle, stopping the attack. The inmate who was attacked sustained puncture wounds, and the department transported him to an outside hospital. The inmate returned to the institution four days later. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the use of force complied with policy. The OIG concurred. The hiring authority did not identify staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-02-16	17-0021814-RO	Use of Deadly Force

Incident Summary

On February 16, 2017, two inmates attacked and stabbed another inmate on the exercise yard. Three officers deployed pepper spray to stop the attack. One of the officers also used a tear-gas grenade. The second and third officers joined two other officers and struck one of the attacking inmates 18 times with their batons. A sixth officer struck the same attacking inmate one time in the head with a baton, which stopped the attack. The inmate who was stuck in the head and the inmate who was stabbed were taken to an outside hospital and returned the same day. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-02-18	17-0021832-RO	Use of Deadly Force

Incident Summary

On February 18, 2017, an officer allegedly negligently discharged a handgun while conducting a weapon safety check. The round struck the tower window facing an unmanned tower and open hillside. The OIG responded to the scene.

Disposition

The hiring authority identified potential staff misconduct based on the officer's alleged negligent discharge of a firearm. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the case to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Incident Assessment

The department's actions were not adequate because an officer allegedly negligently discharged a firearm.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's actions were not appropriate because an officer allegedly negligently discharged a firearm.

Incident Date	OIG Case Number	Case Type
2017-02-25	17-0021881-RO	Use of Deadly Force

Incident Summary

On February 25, 2017, three inmates repeatedly punched and kicked a fourth inmate on the exercise yard. An officer deployed a pepper spray grenade and then fired one warning shot from a Mini-14 rifle, but the attack continued until two other officers and a sergeant deployed pepper spray. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the use of force complied with policy. However, the committee also determined the first officer's action of reloading a round into the Mini-14 rifle violated policy. The OIG concurred. The hiring authority provided training to the officer.

Incident Assessment

The department's actions after the incident were not adequate because the first officer reloaded a round into the Mini-14 after the incident in violation of policy.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The officer reloaded a round into the Mini-14 rifle after the incident in violation of policy.

Incident Date	OIG Case Number	Case Type
2017-03-15	17-0022086-RO	Use of Deadly Force

Incident Summary

On March 15, 2017, three inmates attacked a fourth inmate on the exercise yard. An officer fired one warning shot from a Mini-14 rifle, which stopped the attack. Two of the inmates suffered injuries consistent with fighting and were transported to an outside hospital. The inmates returned to the institution the same day. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct but provided training to the nurses regarding report writing.

Incident Assessment

The department's actions following the incident were not adequate because nurses did not adequately complete required documentation.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Nurses did not adequately complete required documentation.

- **Was the critical incident adequately documented?**
  Nurses did not adequately complete required documentation.

Incident Date	OIG Case Number	Case Type
2017-04-04	17-0022241-RO	Use of Deadly Force

Incident Summary

On April 4, 2017, a sergeant allegedly negligently discharged a firearm when trying to catch the firearm as it slipped from his hand during a weapons check. The OIG responded to the scene.

Disposition

The hiring authority identified potential staff misconduct based the officer's alleged negligent discharge of a firearm and referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the case to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Incident Assessment

The department's actions were not adequate because a sergeant allegedly negligently discharged a firearm and the department did not obtain a public safety statement.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  A sergeant allegedly negligently discharged a firearm and the department did not obtain a public safety statement from the sergeant.

Incident Date	OIG Case Number	Case Type
2017-04-19	17-0022396-RO	Use of Deadly Force

Incident Summary

On April 19, 2017, two inmates attacked a third inmate with an inmate-manufactured weapon on the exercise yard. Eight officers deployed pepper spray and pepper spray grenades. A ninth officer fired one warning shot from a Mini-14 rifle, stopping the attack. The third inmate sustained puncture wounds. The department transported the third inmate to an outside hospital and he returned to the institution the same day. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-05-07	17-0022590-RO	Use of Deadly Force

Incident Summary

On May 7, 2017, an officer allegedly negligently discharged a handgun while performing a weapons safety check in a dining room where nobody else was present. The OIG responded to the scene.

Disposition

The hiring authority identified potential staff misconduct based on the officer's alleged negligent discharge of a firearm. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the case to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Incident Assessment

The department's actions were not adequate because an officer allegedly negligently discharged a handgun, and the department did not obtain a public safety statement.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's actions were not adequate because an officer allegedly negligently discharged a handgun, and the department did not obtain a public safety statement from the officer.

South

Incident Date	OIG Case Number	Case Type
2017-02-11	17-0021773-RO	Use of Deadly Force

Incident Summary

On February 11, 2017, an officer allegedly negligently discharged his personal firearm into a clearing barrel. The OIG responded to the scene.

Disposition

The hiring authority identified potential staff misconduct because the officer allegedly negligently discharged a firearm. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Incident Assessment

The department's actions were not adequate because an officer allegedly negligently discharged a firearm.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  An officer allegedly negligently discharged a firearm.

- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified that the negligent discharge did not comply with the department's use-of-force policy.

Incident Date	OIG Case Number	Case Type
2017-02-15	17-0021815-RO	Use of Deadly Force

Incident Summary

On February 15, 2017, two inmates attacked a third inmate on the exercise yard. An officer fired two warning shots from a Mini-14 rifle, but the attack continued until a second officer deployed pepper spray. The department transported the inmate who was attacked to an outside hospital and the inmate returned the same day. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-04-03	17-0022226-RO	Use of Deadly Force

Incident Summary

On April 3, 2017, a sergeant allegedly negligently discharged a handgun while attempting to clear the firearm in an office, and the bullet struck a computer speaker. The OIG responded to the scene.

Disposition

The hiring authority identified potential staff misconduct based on the alleged negligent discharge of a firearm. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Incident Assessment

The department's actions were not adequate because a sergeant allegedly negligently discharged a firearm.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's actions were not appropriate because the sergeant allegedly discharged a firearm in an office, striking a computer speaker.

INVESTIGATED AND MONITORED DEADLY FORCE INCIDENT CASE SUMMARIES

Central

Incident Date	OIG Case Number	Case Type
2016-01-06	16-0000139-IR	Use of Deadly Force Administrative

Incident Summary

On January 6, 2016, an officer, while handling and securing a firearm, allegedly unintentionally discharged one round from the firearm into the weapons storage locker. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Sustained	Salary Reduction	Salary Reduction

Disposition

The Deadly Force Review Board found that the officer's use of deadly force did not comply with policy, and the hiring authority imposed a 5 percent salary reduction for three months. The OIG concurred. After the *Skelly* hearing, the hiring authority decided to reduce the penalty to a one-working-day suspension. The OIG did not concur and elevated the matter to the hiring authority's supervisor. Before the hiring authority's supervisor could consider the matter, the hiring authority rescinded the decision to modify the penalty and reinstated the 5 percent salary reduction for three months. The officer did not file an appeal with the State Personnel Board.

Disciplinary Assessment

The department did not comply with procedures governing the disciplinary process because the department did not timely conduct the disciplinary findings conference or properly conduct the *Skelly* hearing. The department attorney did not prepare an adequate disciplinary action or adequately cooperate with the OIG.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the HA timely consult with the OIG and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision?**
  The Deadly Force Review Board returned the case to the hiring authority on November 3, 2016. However, the hiring authority did not consult with the OIG and the department attorney regarding the disciplinary determinations until December 6, 2016, 33 days thereafter.
- **Was the draft disciplinary action provided to the OIG for review appropriately drafted as described in the DOM?**
  The draft disciplinary action did not accurately cite legal authority governing peace officer confidentiality or inform the officer of his right to respond to an uninvolved manager.
- **Was the disciplinary action served on the subject (s) appropriately drafted as described in the DOM?**
  The disciplinary action served on the officer did not accurately cite legal authority governing peace officer confidentiality or inform the officer of his right to respond to an uninvolved manager.
- **If there was a Skelly hearing, was it conducted pursuant to DOM?**
  The Skelly officer inappropriately conducted her own investigation after the Skelly hearing.
- **If an executive review was invoked in the case, did OIG request the executive review?**
  The OIG sought a higher level of review when the hiring authority decided to accept the Skelly officer's recommendation to ignore the Deadly Force Review Board finding that the officer was negligent in violating the department's use-of-force policy and to reduce the penalty to a one-working-day suspension.
- **Did the department attorney or employee relations officer cooperate with and provide continual real-time consultation with the OIG throughout the disciplinary phase?**
  The department attorney did not provide the OIG a reasonable amount of time to review the draft disciplinary action.
- **Was the disciplinary phase conducted with due diligence by the department?**
  The delay is addressed in a prior question.

Incident Date	OIG Case Number	Case Type
2016-07-30	16-0001833-IR	Use of Deadly Force Administrative

Incident Summary

On July 30, 2016, an Office of Correctional Safety special agent allegedly shot and killed an injured deer. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. Although the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with policies and procedures governing the pre-disciplinary process because the hiring authority did not adequately or timely respond to or document the incident, and the special agent did not adequately consult with the department attorney or the OIG or conduct a timely and thorough investigation. The department attorney did not timely assess the deadline for taking disciplinary action, adequately consult with the special agent or the OIG, and provided poor legal advice to the hiring authority, and the hiring authority incorrectly found the investigation sufficient. As a result of the failures, witnesses had difficulty remembering the incident, and the Office of Internal Affairs did not collect and preserve crucial evidence or thoroughly investigate the incident.

Procedural Rating	Substantive Rating
Insufficient	Insufficient

Assessment Questions

- **Did the HA timely respond to the critical incident?**
  The hiring authority learned of the incident on July 30, 2016, but did not begin to review the incident until August 1, 2016, two days later.
- **Did the institution timely notify the Office of Internal Affairs of the incident?**
  The hiring authority learned of the incident on July 30, 2016, but failed to notify the Office of Internal Affairs until August 2, 2016, three days later.
- **Did the department timely notify OIG of the critical incident?**
  The hiring authority learned of the incident on July 30, 2016, but failed to notify the OIG until August 2, 2016, three days later.
- **Was the HA's response to the critical incident appropriate?**
  The hiring authority did not timely notify the Office of Internal Affairs or collect and preserve the firearm.
- **Was the critical incident adequately documented?**
  The department did not adequately document the location of or witnesses to the incident.
- **Did the special agent adequately confer with the OIG upon case initiation and prior to finalizing the investigative plan?**
  The special agent did not consult with the OIG before formulating the investigative plan and did not provide the OIG with a completed investigative plan.
- **Did the special agent adequately confer with the department attorney upon case initiation and prior to finalizing the investigative plan?**
  The special agent did not consult with the department attorney before formulating the investigative plan.
- **Within 21 calendar days, did the department attorney or employee relations officer correctly assess the deadline for taking disciplinary action and make an entry into the case management system confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time?**
  The department attorney was assigned August 26, 2016, but did not make an entry into the case management system regarding the deadline for taking disciplinary action until April 25, 2017, eight months thereafter.
- **No later than 21 calendar days following assignment of the case, did the department attorney contact the assigned special agent and the monitor to discuss the elements of a thorough investigation of the alleged misconduct?**
  The department attorney never contacted the assigned special agent or the OIG to discuss the elements of a thorough investigation.
- **Was the investigation thorough and appropriately conducted?**
  The Office of Internal Affairs did not thoroughly inspect or test the firearm, make appropriate efforts to contact percipient witnesses, or adequately investigate whether the special agent allegedly dissuaded witnesses from cooperating with the investigation.
- **Did the HA properly deem the Office of Internal Affairs investigation sufficient or insufficient?**
  The hiring authority deemed the investigation sufficient despite the OIG's recommendation that the Office of Internal Affairs make additional efforts to interview percipient witnesses to determine whether the special agent dissuaded them from cooperating with the investigation.
- **Did the HA properly determine whether additional investigation was necessary?**
  The hiring authority improperly determined the Office of Internal Affairs conducted a sufficient investigation even though the Office of Internal Affairs did not take sufficient steps to interview percipient witnesses.

- **Did the department attorney provide appropriate legal consultation to the HA regarding the sufficiency of the investigation and investigative findings?**
  The department attorney did not advise the hiring authority that additional investigation was necessary to determine whether the special agent dissuaded percipient witnesses from cooperating with the investigation.

- **Did the special agent and department attorney cooperate and provide real-time consultation with each other throughout the pre-disciplinary phase?**
  The special agent and the department attorney did not consult with each other upon case initiation and prior to finalizing the investigative plan.

- **Did the HA cooperate with and provide continual real-time consultation with the OIG throughout the pre-disciplinary/investigative phase?**
  The hiring authority did not provide the OIG with the form documenting the investigative findings.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The delays are addressed in prior questions.

Disposition

The Deadly Force Review Board found that the special agent's use of deadly force complied with policy. The hiring authority subsequently exonerated the special agent, and the OIG concurred, based on the state of the investigation provided by the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2017-01-05	17-0021802-IR	Use of Deadly Force Administrative

Incident Summary

On January 5, 2017, an officer allegedly negligently discharged a handgun, shooting himself in the foot during training. The OIG responded to the scene.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Sustained	Letter of Reprimand	Letter of Reprimand

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the Office of Internal Affairs did not respond to the incident or open a deadly force investigation.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the Office of Internal Affairs adequately respond to the incident?**
  The Office of Internal Affairs did not respond.
- **Did the Office of Internal Affairs make an appropriate initial determination regarding the case?**
  The Office of Internal Affairs did not open a deadly force investigation despite the use of deadly force causing an injury.
- **Did the Office of Internal Affairs properly determine whether the case should be opened as a Deadly Force Investigation Team investigation?**
  The Office of Internal Affairs did not open a deadly force investigation.

Disposition

The hiring authority sustained the allegation and issued a letter of reprimand. The OIG did not concur with the penalty but did not seek a higher level of review due to conflicting evidence regarding the seriousness of the alleged misconduct. The officer did not file an appeal with the State Personnel Board.

Disciplinary Assessment

The department did not comply with policies and procedures governing the disciplinary process because the department attorney provided poor legal advice and prepared an insufficient disciplinary action, and the hiring authority imposed an inappropriate penalty.

Procedural Rating	Substantive Rating
Insufficient	Insufficient

Assessment Questions

- **Did the department attorney provide appropriate legal consultation to the HA regarding disciplinary determinations?**
  The department attorney provided poor legal advice by failing to recommend the appropriate disciplinary matrix section, contributing to the hiring authority issuing a letter of reprimand instead of a more appropriate penalty of a salary reduction.
- **Did the HA who participated in the disciplinary conference select the appropriate Employee Disciplinary Matrix charges and causes for discipline?**
  The hiring authority did not select the matrix charge most consistent with gross negligence in handling a firearm despite evidence of negligence.
- **Did the HA who participated in the disciplinary conference select the appropriate penalty?**
  The hiring authority issued a letter of reprimand instead of a penalty more consistent with gross negligence in handling a firearm.
- **Was the draft disciplinary action provided to the OIG for review appropriately drafted as described in the DOM?**
  The draft disciplinary action did not cite the correct law governing peace officer confidentiality, reference all necessary documents, or advise the officer of his right to respond to an uninvolved manager in accordance with policy.
- **Was the disciplinary action served on the subject (s) appropriately drafted as described in the DOM?**
  The final disciplinary action did not cite the correct law governing peace officer confidentiality or advise the officer of his right to respond to an uninvolved manager in accordance with policy.

North

Incident Date	OIG Case Number	Case Type
2016-03-09	16-0001204-IR	Use of Deadly Force Administrative

Incident Summary

On March 9, 2016, an officer allegedly negligently discharged a round from a handgun during an armory inventory, failed to timely report the negligent discharge, removed the discharged bullet casing from the scene and discarded it at home, and was allegedly dishonest to responding officers when he told them nothing had happened. On March 10, 2016, the officer allegedly completed a false armory inventory and was dishonest to another officer regarding the inventory, and on March 12, 2016, allegedly submitted a false memorandum regarding the incident.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Dishonesty	1. Sustained	Dismissal	Resignation in Lieu of Termination
2. Weapons	2. Sustained		
3. Failure to Report	3. Sustained		
4. Dishonesty	4. Not Sustained		

Disposition

The hiring authority sustained the allegations, except that the officer submitted a false memorandum, and dismissed the officer. The OIG concurred with the hiring authority's determinations except for the decision to not sustain the allegation regarding the false memorandum. The OIG did not seek a higher level of review because the other allegations were sustained and the correct penalty imposed. The officer filed an appeal with the State Personnel Board. However, pursuant to a settlement agreement, the officer resigned in lieu of dismissal and agreed to never seek employment with the department in the future. The OIG concurred because the ultimate goal of ensuring the officer did not work for the department was achieved.

Disciplinary Assessment

Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-03-19	16-0000928-IR	Use of Deadly Force Administrative

Incident Summary

On March 19, 2016, an Office of Internal Affairs special agent fired two rounds at and killed a pit bull that ran toward him outside his residence. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Discharge of Lethal Weapon	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the department delayed completing the investigation.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The Office of Internal Affairs did not complete the deadly force investigation within 90 days of the incident date pursuant to the department's guidelines. The incident took place on March 19, 2016, but the Office of Internal Affairs did not complete the investigation until June 27, 2016, 100 days thereafter.

Disposition

The Deadly Force Review Board found that the special agent's use of deadly force complied with the department's use-of-force policy. The hiring authority subsequently exonerated the special agent, and the OIG concurred.

Incident Date	OIG Case Number	Case Type
2016-05-16	16-0001456-IR	Use of Deadly Force Administrative

Incident Summary

On May 16, 2016, three inmates stabbed a fourth inmate with inmate-manufactured weapons on the exercise yard. An officer fired one round from a Mini-14 rifle, striking one of the attacking inmates and stopping the attack. The department transported the inmate who was shot and the inmate who was stabbed to outside hospitals, following which both inmates returned to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with policies and procedures governing the pre-disciplinary process because the investigative services unit did not handle evidence appropriately and the special agent did not timely complete the investigation. The special agent did not make complete entries in the case management system.

Procedural Rating	Substantive Rating
Insufficient	Insufficient

Assessment Questions

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit inappropriately collected crime-scene evidence, consisting of blood-stained clothing the inmates wore, and hung the clothing on a clothesline on the patio outside of the investigative services unit, contrary to appropriate practice for preserving evidence.

- **Did the special agent appropriately enter case activity in the case management system?**
  The special agent did not make an entry regarding the tasks performed on the day of the incident.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The Office of Internal Affairs did not complete the deadly force investigation within 90 days of the incident date pursuant to the department's guidelines. The incident took place May 16, 2016, but the Office of Internal Affairs did not complete the investigation until August 19, 2016, 95 days thereafter.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force complied with policy, and the hiring authority subsequently exonerated the officer. The OIG concurred.

Incident Date	OIG Case Number	Case Type
2016-05-27	16-0001665-IR	Use of Deadly Force Administrative

Incident Summary

On May 27, 2016, approximately 40 inmates attacked ten inmates on the exercise yard. An officer fired two warning shots from a Mini-14 rifle, stopping the riot. Approximately 50 other inmates attacked eight inmates on an adjacent exercise yard. Two other officers fired two rounds each, and a fourth officer fired three warning shots from Mini-14 rifles, stopping the fight. The department transported nine inmates to outside hospitals for injuries. Seven inmates returned to the institution the same day. The other two inmates returned later. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the Office of Internal Affairs did not timely complete the investigation. The department attorney did not review the draft investigative report in a timely manner.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Within 21 calendar days following receipt of the investigative report, did the department attorney review the report and provide appropriate substantive feedback addressing the thoroughness and clarity of the report?**
  The Office of Internal Affairs provided the draft report to the department attorney on September 19, 2016. However, the department attorney did not document review of the report in the case management system or provide appropriate substantive feedback addressing the thoroughness and clarity of the report until October 12, 2016, 22 days after receipt.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The Office of Internal Affairs did not complete the deadly force investigation within 90 days of the incident date pursuant to the department's guidelines. The incident took place May 27, 2016, but the Office of Internal Affairs did not complete the investigation until October 17, 2016, over four months later.

Disposition

The Deadly Force Review Board found that the officers' uses of deadly force complied with the department's use-of-force policy. The hiring authority exonerated the officers. The OIG concurred.

Incident Date	OIG Case Number	Case Type
2016-07-28	16-0001828-IR	Use of Deadly Force Administrative

Incident Summary

On July 28, 2016, an officer saw a man brandish a knife at numerous persons in and outside of a store. The man refused to surrender the knife and behaved erratically, swinging the knife at bystanders and lunging at the officer. The officer fired one round from his weapon, striking the man in the chest, causing him to fall and drop the knife. Outside law enforcement responded to the scene. An ambulance transported the man to an outside hospital where he was placed in a medically-induced coma. The hospital removed the man from the medically-induced coma on August 2, 2016, and placed him in intensive care. The department timely notified the OIG. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the department attorney did not timely provide feedback regarding the investigative report and the hiring authority delayed conducting the investigative findings conference.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Within 21 calendar days following receipt of the investigative report, did the department attorney review the report and provide appropriate substantive feedback addressing the thoroughness and clarity of the report?**
  The Office of Internal Affairs provided the draft report to the department attorney on October 14, 2016, but the department attorney neglected to provide feedback regarding the report until November 10, 2016, 27 days thereafter.

- **Did the department attorney provide written confirmation summarizing all critical discussions about the investigative report to the special agent with a copy to the OIG?**
  The department attorney did not provide written confirmation to the OIG summarizing critical discussions about the investigative report.

- **Did the HA timely consult with the OIG and department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?**
  The Office of Internal Affairs returned the case to the hiring authority on April 14, 2017. However, the hiring authority did not consult with the OIG and the department attorney regarding the sufficiency of the investigation and the investigative findings until 32 days thereafter.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The delays are addressed in prior questions.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force complied with policy. The hiring authority subsequently exonerated the officer, and the OIG concurred.

Incident Date	OIG Case Number	Case Type
2016-08-06	16-0001841-IR	Use of Deadly Force Administrative

Incident Summary

On August 6, 2016, an inmate attacked a second inmate with an inmate-manufactured weapon on the exercise yard. Officers fired seven less-lethal rounds and deployed two pepper spray grenades, but the inmates kept fighting. An officer fired one round from a Mini-14 rifle at the first inmate and missed, but the inmates stopped fighting. The first inmate sustained minor injuries. The department sent the second inmate to an outside hospital for treatment of stab wounds, and he returned to the institution the next morning. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs did not identify criminal misconduct but did not refer the matter to the district attorney's office for review as required by departmental policy. The Office of Internal Affairs opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because officers allowed inmates to walk through the crime scene, the investigative services unit inappropriately cleared the crime scene, and the department attorney did not note the exception to the deadline to take disciplinary action.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Was the HA's response to the critical incident appropriate?**
  Officers allowed inmates to walk through the crime scene to return to their buildings. The investigative services unit cleared the crime scene before special agents from the deadly force investigation team arrived at the institution.

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit cleared the crime scene before the special agents from the deadly force investigation team arrived at the institution.

- **Within 21 calendar days, did the department attorney or employee relations officer correctly assess the deadline for taking disciplinary action and make an entry into the case management system confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time?**
  The department attorney assessed the deadline for taking disciplinary action without noting the criminal investigation as an applicable exception.

Disposition

The Deadly Force Review Board found the officer's use of force complied with policy. The hiring authority subsequently exonerated the officer. The OIG concurred.

Incident Date	OIG Case Number	Case Type
2016-08-06	16-0001842-IR	Use of Deadly Force Criminal

Incident Summary

On August 6, 2016, an inmate attacked a second inmate with an inmate-manufactured weapon on the exercise yard. Officers fired seven less-lethal rounds and deployed two pepper spray grenades, but the inmates kept fighting. An officer fired one round from a Mini-14 rifle at the first inmate and missed, but the inmates stopped fighting. The first inmate sustained minor injuries. The department sent the second inmate to an outside hospital for treatment of stab wounds, and he returned to the institution the next morning. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs did not identify criminal misconduct but did not refer the matter to the district attorney's office for review as required by departmental policy. The Office of Internal Affairs opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department did not comply with policies and procedures governing the investigative process because the investigative services unit did not properly preserve the crime scene, the Office of Internal Affairs did not timely conduct the investigation, and the Office of Internal Affairs did not refer the matter to the district attorney's office as required by departmental policy.

Procedural Rating	Substantive Rating
Insufficient	Insufficient

Assessment Questions

- **Was the HA's response to the critical incident appropriate?**
  Officers allowed inmates to walk through the crime scene to return to their buildings. The investigative services unit cleared the crime scene before the special agents arrived at the institution.

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit cleared the crime scene before the special agents arrived at the institution.

- **Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours?**
  The special agent did not conduct all interviews within 72 hours.

- **Did the Office of Internal Affairs appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution?**
  The Office of Internal Affairs did not refer the matter to the district attorney's office as required by policy.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The special agent spent more than 90 hours preparing and completing the 34-page draft investigative report.

Incident Date	OIG Case Number	Case Type
2016-10-12	16-0001975-IR	Use of Deadly Force Administrative

Incident Summary

On October 12, 2016, two inmates stabbed a third inmate with inmate-manufactured weapons. An officer fired one round from a Mini-14 rifle at one of the attacking inmates but missed. The inmates stopped fighting. Officers transported the stabbed inmate to an outside hospital and later returned the inmate to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs did not identify criminal conduct but did not refer the matter to the district attorney's office as required by departmental policy. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the investigative services unit did not timely provide evidence to the Office of Internal Affairs and the department attorney did not timely note one of the exceptions to the deadline to take disciplinary action.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit did not provide requested evidence to the Office of Internal Affairs until eight weeks after the incident and initial request.

- **Within 21 calendar days, did the department attorney or employee relations officer correctly assess the deadline for taking disciplinary action and make an entry into the case management system confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time?**
  The department attorney was assigned on November 3, 2016, but did not assess one of the exceptions to the deadline to take disciplinary action until May 23, 2017, six months after assignment.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force complied with policy. The hiring authority exonerated the officer. The OIG concurred.

Incident Date	OIG Case Number	Case Type
2016-10-12	16-0001976-IR	Use of Deadly Force Criminal

Incident Summary

On October 12, 2016, two inmates stabbed a third inmate with inmate-manufactured weapons. An officer fired one round from a Mini-14 rifle at one of the attacking inmates but missed. The inmates stopped fighting. Officers transported the stabbed inmate to an outside hospital and later returned the inmate to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs did not identify any criminal conduct but did not refer the matter to the district attorney's office for review as required by departmental policy. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department did not comply with procedures governing the investigative process because the Office of Internal Affairs did not timely complete the investigation or refer the matter to the district attorney's office.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the Office of Internal Affairs appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution?**
  The Office of Internal Affairs did not refer the matter to the district attorney's office as policy requires.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The incident took place on October 12, 2016, but the Office of Internal Affairs did not complete the investigation until February 2, 2017, 113 days after the incident.

Incident Date	OIG Case Number	Case Type
2016-10-17	16-0002116-IR	Use of Deadly Force Administrative

Incident Summary

On October 17, 2016, an officer allegedly negligently discharged his duty weapon while conducting a weapons check at a range, and the bullet struck the ground.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Sustained	Letter of Instruction	Letter of Instruction

Pre-disciplinary Assessment

The department sufficiently complied with policies and procedures governing the pre-disciplinary process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Disposition

The hiring authority sustained the allegation and issued the officer a letter of instruction. The OIG did not concur with the penalty but did not seek a higher level of review.

Disciplinary Assessment

The department did not comply with procedures governing the disciplinary process because the department attorney provided flawed legal advice to the hiring authority and the hiring authority did not impose any discipline.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the department attorney provide appropriate legal consultation to the HA regarding disciplinary determinations?**
  The department attorney advised the hiring authority the officer's misconduct was unintentional and accidental and, therefore, formal discipline was not warranted. However, the officer's actions were grossly negligent and his intent was therefore immaterial.

- **Did the HA who participated in the disciplinary conference select the appropriate Employee Disciplinary Matrix charges and causes for discipline?**
  The hiring authority did not select the appropriate allegation that the officer failed to observe and perform within the scope of training, reasoning that since the incident occurred at the firing range on the same day as the training, the officer was not yet trained. However, the incident occurred after the officer received training.

- **Did the HA who participated in the disciplinary conference select the appropriate penalty?**
  The hiring authority took corrective action rather than impose formal discipline.

Incident Date	OIG Case Number	Case Type
2016-11-30	16-0002106-IR	Use of Deadly Force Administrative

Incident Summary

On November 30, 2016, an officer fired one round from a Mini-14 rifle at an inmate who was attacking a second inmate with an inmate-manufactured weapon on the exercise yard. The round did not strike its intended target, but the inmates stopped fighting. The second inmate sustained stab wounds, and the department transported him to an outside hospital. The inmate returned to the institution within one week. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs did not identify any criminal conduct but did not refer the matter to the district attorney's office for review as policy requires. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Exonerated	No Penalty Imposed	No Penalty Imposed

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the investigative services unit prematurely processed and cleared the crime scene and the department attorney did not timely assess an exception to the deadline to take disciplinary action. The special agent did not include a relevant exhibit in the draft investigative report.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit processed and cleared the crime scene before the deadly force investigation team viewed the scene.

- **Within 21 calendar days, did the department attorney or employee relations officer correctly assess the deadline for taking disciplinary action and make an entry into the case management system confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time?**
  The department attorney was assigned on December 19, 2016, but did not assess an exception to the deadline for taking disciplinary action known at the time until May 22, 2017, five months after assignment.

- **Was the investigative draft report provided to the OIG for review thorough and appropriately drafted?**
  The draft report did not include the video recording of the incident as an exhibit.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force complied with policy. The hiring authority subsequently exonerated the officer, and the OIG concurred.

Incident Date	OIG Case Number	Case Type
2016-11-30	16-0002107-IR	Use of Deadly Force Criminal

Incident Summary

On November 30, 2016, an officer fired one round from a Mini-14 rifle at an inmate who was attacking a second inmate with an inmate-manufactured weapon on the exercise yard. The round did not strike its intended target, but the inmates stopped fighting. The second inmate sustained stab wounds, and the department transported him to an outside hospital. The inmate returned to the institution within one week. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department did not comply with procedures governing the investigative process because the investigative services unit prematurely cleared the crime scene and the Office of Internal Affairs did not timely complete the investigation.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit processed and cleared the crime scene before the deadly force investigation team viewed the scene.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The Office of Internal Affairs did not complete the deadly force investigation within 90 days of the incident date pursuant to the department's guidelines. The incident took place on November 30, 2016, but the Office of Internal Affairs did not complete the investigation until May 24, 2017, 175 days thereafter.

Incident Date	OIG Case Number	Case Type
2016-12-14	16-0002142-IR	Use of Deadly Force Criminal

Incident Summary

On December 14, 2016, two inmates attacked a third inmate with stabbing motions on the exercise yard. The third inmate was on his back and appeared unable to defend himself. An officer fired one warning shot from a Mini-14 rifle, but the inmates continued fighting. The officer fired two more rounds at the two inmates but missed. Six officers deployed pepper spray grenades. One of the officers used a chemical agent grenade, stopping the attack. Officers discovered two inmate-manufactured weapons. The inmate who was attacked sustained 75 puncture wounds and was transported to an outside hospital and subsequently returned to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department did not comply with the procedures governing the investigative process because the Office of Internal Affairs did not timely complete the interviews or the investigation.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours?**
  The incident occurred on December 14, 2016, but the Office of Internal Affairs did not complete all interviews until December 20, 2016.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The Office of Internal Affairs assigned a special agent on December 14, 2016, but the special agent did not complete the investigation until April 6, 2017, 113 days thereafter.

Incident Date	OIG Case Number	Case Type
2016-12-20	16-0002153-IR	Use of Deadly Force Criminal

Incident Summary

On December 20, 2016, nearly 100 inmates participated in a riot on the exercise yard. Officers deployed pepper spray, pepper spray grenades, and less-lethal rounds. The inmates continued fighting, and two officers each fired one warning shot from Mini-14 rifles. One of the officers fired a second round, striking an inmate who was kicking another inmate in the head. The department transported the inmate who was kicked in the head and an inmate who sustained loss of consciousness to an outside hospital. Both inmates returned to the institution the next day. The department transported the inmate struck by the Mini-14 round to an outside hospital, following which he also returned to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded . Although the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department sufficiently complied with policies and procedures governing the investigative process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-01-24	17-0000126-IR	Use of Deadly Force Criminal

Incident Summary

On January 24, 2017, two inmates attacked a third inmate with stabbing motions on the exercise yard. The third inmate was on the ground and bleeding profusely. An officer fired one round from a Mini-14 rifle, stopping the attack. The department transported the third inmate to an outside hospital. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department sufficiently complied with policies and procedures governing the investigative process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-02-11	17-0021810-IR	Use of Deadly Force Criminal

Incident Summary

On February 11, 2017, two inmates repeatedly punched a third inmate on the exercise yard. An officer fired one less-lethal round but missed. The officer fired a second less-lethal round, hitting one of the attacking inmates on the head. The officer fired a third less-lethal round at the second attacking inmate, hitting the inmate on the knee. The inmate who was hit on the head lost consciousness and the department transported him to an outside hospital. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department did not comply with procedures governing the investigative process because the special agent never interviewed two key witnesses.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours?**
  The special agent did not interview two inmates involved in the incident within 72 hours.
- **Were all of the interviews thorough and appropriately conducted?**
  The special agent never interviewed one of the attacking inmates or the attacked inmate.
- **Was the investigation thorough and appropriately conducted?**
  The special agent never interviewed one of the attacking inmates or the attacked inmate.

Incident Date	OIG Case Number	Case Type
2017-03-09	17-0022034-IR	Use of Deadly Force Criminal

Incident Summary

On March 9, 2017, two inmates attacked a third inmate on the exercise yard. An officer fired one shot from a Mini-14 rifle, striking one of the attacking inmates in the arm, stopping that inmate's attack. The second inmate continued his attack. The officer fired a second shot from the Mini-14 rifle but missed the intended target. A second officer deployed a pepper spray grenade, but the attack continued. A third officer struck the second inmate once with a baton, stopping the attack. The department transferred the inmate who was struck by the Mini-14 round to an outside hospital where he underwent surgery. The inmate returned to the institution on March 16, 2017. The other inmates were treated at the institution for injuries related to the attack. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department sufficiently complied with policies and procedures governing the investigative process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

South

Incident Date	OIG Case Number	Case Type
2015-12-30	15-0002925-IR	Use of Deadly Force Administrative

Incident Summary

On December 30, 2015, a sergeant allegedly discharged a firearm and shot herself during remedial firearms training. The department transported the sergeant to an outside hospital where she was treated for a minor injury and released. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Sustained	Letter of Reprimand	Letter of Reprimand
2. Weapons	2. Unfounded		
3. Neglect of Duty	3. Unfounded		
4. Misuse of State Equipment or Property	4. Unfounded		

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the hiring authority did not timely conduct the investigative findings conference, the department attorney did not provide written confirmation regarding the investigative report, and the employee relations officer erroneously added allegations.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the department attorney provide written confirmation summarizing all critical discussions about the investigative report to the special agent with a copy to the OIG?**
  The department attorney did not provide written confirmation to the OIG summarizing critical discussions about the investigative report.

- **Did the HA timely consult with the OIG and department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?**
  The Office of Internal Affairs referred the matter to the hiring authority on July 26, 2016. However, the hiring authority did not consult with the OIG and department attorney regarding the sufficiency of the investigation and the investigative findings until August 24, 2016, 30 days thereafter.

- **Was the CDCR Form 402 documenting the findings properly completed?**
  The employee relations officer erroneously added numerous allegations in the case management system that the hiring authority did not address at the investigative findings conference but had to be documented on the form documenting the investigative findings.

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The delay is addressed in a prior question.

Disposition

The Deadly Force Review Board found that the sergeant's use of deadly force did not comply with policy. The hiring authority sustained an allegation of negligent discharge of a firearm and imposed a letter of reprimand. The hiring authority found that additional allegations had been added in error and, therefore, determined the investigation conclusively proved the alleged misconduct did not occur. The OIG did not concur with the penalty but did not seek a higher level of review because the penalty was within the disciplinary guidelines. The officer filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the officer agreeing to remove the letter of reprimand from the officer's official personnel file after one year. The OIG did not concur because the department did not identify any new evidence, flaws, or risks justifying the modification, but the OIG did not seek a higher level of review because the reduction was minor and did not significantly change the overall penalty.

Disciplinary Assessment

The department did not comply with procedures governing the disciplinary process because the hiring authority did not conduct the disciplinary findings conference in a timely manner or adequately consult with the OIG and modified the penalty without sufficient justification. The department attorney did not adequately consult with the OIG.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the HA timely consult with the OIG and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision?**

The Deadly Force Review Board completed its investigation and referred the matter to the hiring authority on June 30, 2016. However, the hiring authority did not consult with the OIG and the department attorney regarding the disciplinary determinations until August 24, 2016, 55 days thereafter.

- **If there was a settlement agreement, was the settlement consistent with the DOM factors?**
  The department did not identify any new evidence, flaws, or risks justifying the modification.

- **Did the HA consult with the OIG and department attorney (if applicable) before modifying the penalty or agreeing to a settlement?**
  The hiring authority did not consult with the OIG before agreeing to a settlement.

- **If the penalty was modified by department action or a settlement agreement, did OIG concur with the modification?**
  The OIG did not concur with the penalty modification because the department did not identify any new evidence, flaws, or risks justifying the modification.

- **Did the department attorney or employee relations officer cooperate with and provide continual real-time consultation with the OIG throughout the disciplinary phase?**
  The department attorney did not provide the OIG with a draft of the settlement agreement for review.

- **Did the HA cooperate with and provide continual real-time consultation with the OIG throughout the disciplinary phase?**
  The hiring authority did not consult with the OIG prior to agreeing to the settlement.

- **Was the disciplinary phase conducted with due diligence by the department?**
  The delay is addressed in a prior question.

Incident Date	OIG Case Number	Case Type
2016-05-20	16-0001700-IR	Use of Deadly Force Administrative

Incident Summary

On May 20, 2016, an officer allegedly unintentionally discharged his personal firearm inside an institutional firearm storage locker and was allegedly dishonest in his report regarding the incident.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Discharge of Lethal Weapon 2. Dishonesty	1. Sustained 2. Not Sustained	Suspension	Suspension

Disposition

The hiring authority sustained the allegation the officer negligently discharged a firearm, but not that the officer was dishonest, and imposed a two-working-day suspension. The OIG concurred. The officer filed an appeal with the State Personnel Board. Prior to State Personnel Board proceedings, the department entered into a settlement agreement with the officer agreeing to remove the disciplinary action from the officer's official personnel file after 12 months. The OIG did not concur. However, the settlement terms did not merit a higher level of review because the penalty was within the appropriate range for the misconduct.

Disciplinary Assessment

Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-05-24	16-0001654-IR	Use of Deadly Force Administrative

Incident Summary

On May 24, 2016, an officer allegedly discharged his firearm in an observation area which overlooked the dining facility where several inmates were eating, with a second officer present. An unknown projectile struck the second officer in the back of the head. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Sustained	Salary Reduction	Salary Reduction

Pre-disciplinary Assessment

The department did not comply with procedures governing the pre-disciplinary process because the investigative services unit neglected to photograph the scene and the Office of Internal Affairs did not timely conduct the investigation.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit neglected to photograph the scene.
- **Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours?**
  The deadly force investigation team did not interview the officer until May 31, 2016, seven days after the incident.
- **Was the investigation thorough and appropriately conducted?**
  The investigative services unit did not photograph the scene.
- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The Office of Internal Affairs did not complete the deadly force investigation within 90 days of the incident date pursuant to the department's guidelines. The incident occurred on May 24, 2016, but the Office of Internal Affairs did not complete the investigation until September 12, 2016, 111 days thereafter.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force did not comply with policy. The hiring authority sustained the allegation and imposed a 5 percent salary reduction for 13 months. The OIG concurred. The officer filed an appeal with the State Personnel Board but withdrew his appeal.

Disciplinary Assessment

The department sufficiently complied with policies and procedures governing the disciplinary process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-07-01	16-0001889-IR	Use of Deadly Force Administrative

Incident Summary

On July 1, 2016, a sergeant allegedly negligently discharged a firearm into a nearby residence.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Neglect of Duty	1. Sustained	Salary Reduction	Modified Salary Reduction

Disposition

The hiring authority sustained the allegation and imposed a 5 percent salary reduction for 12 months. The OIG concurred. The sergeant filed an appeal with the State Personnel Board. Prior to State Personnel Board proceedings, the department entered into a settlement agreement with the sergeant reducing the penalty to a 5 percent salary reduction for ten months. The OIG concurred because the sergeant showed remorse and paid restitution.

Disciplinary Assessment

Overall, the department sufficiently complied with policies and procedures governing the disciplinary process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-09-29	16-0002081-IR	Use of Deadly Force Administrative

Incident Summary

On September 29, 2016, an officer allegedly negligently discharged a round from a Mini-14 rifle in a control booth while practicing sight alignment with the rifle.

Administrative Investigation

Allegations	Findings	Initial Penalty	Final Penalty
1. Weapons	1. Sustained	Suspension	Suspension
2. Weapons	2. Not Sustained		

Pre-disciplinary Assessment

The department's handling of the pre-disciplinary process was substantively insufficient because the department attorney did not attend the initial investigative findings conference and the hiring authority did not add appropriate allegations.

Procedural Rating	Substantive Rating
Sufficient	Insufficient

Assessment Questions

- **Did the department attorney provide appropriate legal consultation to the HA regarding the sufficiency of the investigation and investigative findings?**
  The department attorney did not attend the initial investigative findings conference, making a second investigative findings conference necessary.

- **Did the HA who participated in the findings conference appropriately determine the investigative findings for each allegation?**
  The hiring authority did not add allegations regarding the officer's failure to maintain the Mini-14 rifle according to policy despite the OIG's recommendation and evidence supporting the allegations.

Disposition

The hiring authority sustained an allegation of gross negligence in handling a duty weapon, but not a careless handling of a weapon allegation, and imposed a 50-working-day suspension. The OIG concurred. The officer filed an appeal with the State Personnel Board that he later withdrew.

Disciplinary Assessment

The department sufficiently complied with policies and procedures governing the disciplinary process.

Procedural Rating	Substantive Rating
Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-01-30	17-0000139-IR	Use of Deadly Force Criminal

Incident Summary

On January 30, 2017, two inmates attacked a third inmate with inmate-manufactured weapons on the exercise yard. Two officers deployed pepper spray grenades but the attack continued. An officer fired one round from a Mini-14 rifle for effect at the attacking inmate, striking him in the abdomen. A fourth inmate joined the attack on the inmate being stabbed. A second officer fired one warning shot from a Mini-14 rifle, but the attack continued. The first officer fired three additional warning shots, stopping the attack. The inmate who was shot and the inmate who was stabbed were taken to an outside hospital. The inmate who was stabbed returned to the institution the same day, and the inmate who was shot returned on February 2, 2017. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

Investigative Assessment

The department did not comply with procedures governing the investigative process because the Office of Internal Affairs did not timely complete the investigation.

Procedural Rating	Substantive Rating
Insufficient	Sufficient

Assessment Questions

- **Did the department conduct the pre-disciplinary/investigative phase with due diligence?**
  The Office of Internal Affairs did not complete the deadly force investigation within 90 days of the incident date pursuant to the department's guidelines. The incident took place on January 30, 2017, but the Office of Internal Affairs did not complete the investigation until June 12, 2017, 133 days thereafter.

Appendix E
Critical Incident Cases

Central

Incident Date	OIG Case Number	Case Type
2016-05-25	16-0001636-RO	Suicide

Incident Summary

On May 25, 2016, an officer found an inmate hanging from a noose in his cell. Officers cut the noose, and officers, nurses, and paramedics performed life-saving measures but were unsuccessful, and a paramedic pronounced the inmate dead.

Disposition

The coroner determined the cause of death was hanging and the manner of death was suicide. The department's Suicide Case Review Committee determined the suicide was not foreseeable but was preventable. The hiring authority identified potential staff misconduct based on three officers' alleged failure to relieve pressure on the inmate's airway. The hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the matter to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Overall Assessment

The department's actions were not adequate because officers allegedly failed to relieve pressure on the inmate's airway before cutting the noose, and the Office of Internal Affairs did not make appropriate determinations.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Officers allegedly failed to relieve pressure on the inmate's airway before cutting the noose.
- **Did the OIA make an appropriate initial determination regarding the case?**
  The Office of Internal Affairs did not open an investigation or interview the officers although there were questions regarding where officers found the inmate and the training the officers received.
- **If the hiring authority submitted a request for reconsideration to the OIA, was an appropriate decision made regarding the request?**
  The Office of Internal Affairs refused the hiring authority's request to interview the officers to determine whether they colluded when drafting their reports despite indications they had.

Incident Date	OIG Case Number	Case Type
2016-06-04	16-0001722-RO	In-Custody Inmate Death

Incident Summary

On June 4, 2016, an officer found an inmate on the floor of his cell alert, but unable to stand up. The department transported the inmate to an outside hospital where he died on June 8, 2016.

Disposition

The coroner determined the cause of death was multiple organ failure caused by diltiazem intoxication and the manner of death was accidental. The department's emergency medical response review committee identified that nurses did not arrive with appropriate transport equipment or adequately document the incident. The hiring authority provided training to three nurses. The department's Death Review Committee found that nurses did not timely notify the physician on-call or contact the outside law enforcement emergency number. As a result of this review, the department updated its local emergency response policies and procedures to include specific language regarding contacting the outside law enforcement emergency number and provided training to 30 medical staff to include nurses and psychiatric technicians.

Overall Assessment

The department's actions were not adequate because nurses did not respond with appropriate transport equipment, adequately document the incident, or timely contact the physician on-call or the outside law enforcement emergency number.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Did the hiring authority timely respond to the critical incident?**
  A nurse failed to respond to the scene with proper transport equipment, causing a delay in transporting the inmate to the triage and treatment area. Nurses neglected to contact the outside law enforcement emergency number or the physician on-call for more than 15 minutes after it was determined the inmate required a higher level of care.

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  A nurse failed to respond to the scene with proper transport equipment. Also, nurses did not timely contact the outside law enforcement emergency number or adequately document the incident date and time or the inmate's initial medical assessment when arriving to the triage and treatment area.

- **Was the critical incident adequately documented?**
  Nurses did not adequately document the incident date and time or the inmate's initial medical assessment.

Incident Date	OIG Case Number	Case Type
2016-06-11	16-0001734-RO	Suicide

Incident Summary

On June 11, 2016, an officer found an inmate hanging from a noose in his cell. Officers entered the cell, and two officers began life-saving measures. A nurse arrived and assisted four officers with life-saving measures which continued during transport of the inmate to the triage and treatment area where a physician pronounced the inmate dead.

Disposition

The coroner reported the cause of death was asphyxia due to hanging. The department's Death Review Committee determined the death was not preventable. The department's Suicide Case Review Committee found the inmate's suicide was not foreseeable and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-06-28	16-0001766-RO	In-Custody Inmate Death

Incident Summary

On June 28, 2016, an officer found an unresponsive inmate in a cell. Three officers, two psychiatric technicians, and a nurse initiated life-saving measures and transported the inmate to the triage and treatment area where a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death was opiate overdose and the manner of death was accidental, self-induced overdose. The department's Death Review Committee found the cause of death was a narcotic overdose and the death was not preventable. The investigative services unit sufficiently investigated the source of the drugs but did not determine the source or locate additional drugs. The hiring authority contacted the coroner and district attorney's office to coordinate future expectations.

Overall Assessment

The department's actions following the incident were not adequate because officers moved the inmate's body and searched the cell without proper authorization.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  Officers moved the inmate's body and searched his cell before the coroner's authorization.

- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified that officers moved the inmate's body and searched the cell before obtaining the coroner's authorization and recommended corrective action to ensure statutory compliance in the future.

Incident Date	OIG Case Number	Case Type
2016-06-28	16-0001768-RO	In-Custody Inmate Death

Incident Summary

On June 28, 2016, an inmate complained of difficulty breathing, then vomited and lost consciousness while being taken to the triage and treatment area, where he became unresponsive. Nurses performed life-saving measures and a paramedic pronounced the inmate dead after consulting with a physician at an outside hospital.

Disposition

The coroner determined the cause of death was heart disease and the manner of death was natural. The department's death review committee determined the cause of death was myocardial infarction and not preventable. The hiring authority identified potential staff misconduct based on a nurse's alleged delay in calling an ambulance and provided training to the nurse.

Overall Assessment

The department's actions during the incident were not adequate because a nurse allegedly delayed calling an ambulance.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  A nurse allegedly delayed approximately eight minutes before calling an ambulance.

Incident Date	OIG Case Number	Case Type
2016-07-12	16-0001789-RO	In-Custody Inmate Death

Incident Summary

On July 12, 2016, an officer found an unresponsive inmate on the floor of his cell. A nurse responded but did not initiate life-saving measures due to obvious signs of rigor mortis and dependent lividity. Nurses transported the inmate to the triage and treatment area where a physician pronounced him dead.

Disposition

The coroner determined the inmate died of heart disease and the manner of death was natural. The emergency medical response review committee determined a nurse did not adequately document why she did not initiate life-saving measures, and a second nurse did not document when she arrived and left the scene. The hiring authority for the nurses provided training.

Overall Assessment

The department's response was not adequate because two nurses did not adequately document the medical emergency.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's actions after the incident were not appropriate because two nurses did not adequately document their observations.

- **Was the critical incident adequately documented?**
  The emergency medical response review committee determined a nurse did not adequately document why she did not initiate life-saving measures and a second nurse did not document when she arrived and left the scene.

Incident Date	OIG Case Number	Case Type
2016-07-21	16-0001805-RO	In-Custody Inmate Death

Incident Summary

On July 21, 2016, an officer discovered an unresponsive and bloody inmate on the cell floor with a towel wrapped tightly around his neck. Officers removed the cellmate, who was standing in the cell covered in blood. Three officers and two nurses removed the towel and initiated life-saving measures but were unsuccessful, and a paramedic pronounced the inmate dead. The investigative services unit conducted an investigation, and the department referred the matter to the district attorney's office.

Disposition

The coroner reported the cause of death as neck compression and the manner of death as homicide. The department's Death Review Committee described the cause of death as severe neck compression with blunt injuries and the death was not preventable. The department's in-cell assault review determined the inmates were properly housed together in compliance with departmental guidelines. The hiring authority determined the inmate's body was moved without the coroner's authorization and an officer did not adequately control and document the crime scene. The hiring authority provided training to address both issues.

Overall Assessment

The department's response was not adequate because the department did not timely notify the OIG and the inmate's body was moved without the coroner's consent. The department's action following the incident were not adequate because an officer did not adequately control and document entry into the crime scene.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Did the department timely notify the OIG regarding the critical incident?**
  The department delayed one hour and 13 minutes before notifying the OIG of the inmate's death.

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The inmate's body was moved without prior authorization from the coroner, and access to the crime scene was not adequately controlled and documented.

- **Was the critical incident adequately documented?**
  An officer did not document his escort of medical personnel to the crime scene.

- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified that the body was moved without the coroner's authorization and an officer failed to document entry into the crime scene by medical staff.

Incident Date	OIG Case Number	Case Type
2016-07-25	16-0001806-RO	Suicide

Incident Summary

On July 25, 2016, an officer discovered an inmate hanging from a noose in a cell. Two officers cut the noose and lowered the inmate. A third officer began life-saving measures. Three nurses continued life-saving measures while transporting the inmate to the triage and treatment area. During transport to an outside hospital, a paramedic pronounced the inmate dead after consulting with a physician.

Disposition

The coroner and the department's Death Review Committee determined the cause of death was suffocation and the manner of death was suicide. The department's Suicide Case Review Committee determined the suicide was not foreseeable but was preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-10-08	16-0001964-RO	Suicide

Incident Summary

On October 8, 2016, an officer discovered an inmate with a noose around his neck. Officers removed the noose and initiated life-saving measures which continued during transport of the inmate to the institution's emergency room where a physician pronounced the inmate dead.

Disposition

The coroner and the department's Death Review Committee determined the cause of death was suffocation and the manner of death was accidental. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-10-10	16-0001974-RO	Suicide

Incident Summary

On October 10, 2016, officers found an inmate hanging from a noose. Officers removed the noose and a sergeant, officer, and three nurses initiated life-saving measures. The department transported the inmate to an outside hospital where the inmate died on October 14, 2016.

Disposition

The coroner and the department's Death Review Committee determined the inmate's cause of death was suffocation by hanging and the manner was death was suicide. The department's Suicide Case Review Committee determined the suicide to be foreseeable and preventable. The hiring authority identified potential staff misconduct based on an officer allegedly not securing a cell during an emergency medical response and later submitting a false report. The hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions were not adequate because an officer allegedly failed to properly secure a cell and allegedly submitted a false report.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  An officer allegedly failed to properly secure a cell during a medical emergency and submitted a false report report regarding the incident.

Incident Date	OIG Case Number	Case Type
2016-10-28	16-0002021-RO	In-Custody Inmate Death

Incident Summary

On October 28, 2016, an inmate fell in the dayroom and complained of not feeling well. An officer and three nurses responded, and one nurse initiated life-saving measures. The department transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

The coroner determined the cause of death to be probable heart attack resulting from coronary artery disease and the manner of death to be natural. The department's Death Review Committee also determined the cause of death was a heart attack secondary to coronary artery disease and the death was not preventable. The hiring authority for the nurses identified potential staff misconduct based on the alleged failure to timely initiate life-saving measures and failure to timely prepare reports. Therefore, the hiring authority for the nurses referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG did not accept for monitoring. The hiring authority for the officers did not identify any staff misconduct.

Overall Assessment

The department's actions were not adequate because nurses allegedly did not initiate life-saving measures in a timely manner and failed to prepare timely reports, and the hiring authority for the nurses did not timely refer the matter to the Office of Internal Affairs.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Two nurses allegedly delayed initiating life-saving measures and failed to timely complete reports regarding the incident.
- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified a delay in initiating life-saving measures.
- **Did the hiring authority make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?**
  The department learned of the alleged misconduct on October 10, 2016, but the hiring authority for the nurses did not refer the matter to the Office of Internal Affairs until December 30, 2016, 81 days after the date of discovery.

Incident Date	OIG Case Number	Case Type
2016-11-29	16-0002100-RO	In-Custody Inmate Death

Incident Summary

On November 29, 2016, an officer found an unresponsive inmate in a cell. Officers and nurses initiated life-saving measures. A paramedic pronounced the inmate dead.

Disposition

The coroner determined the cause of death was heroin and methamphetamine intoxication. The department's Death Review Committee concluded the cause of death was a drug overdose and not preventable. The investigative services unit sufficiently investigated the source of the drugs but did not determine the source. The hiring authority did not identify any staff misconduct but provided training to the lieutenant regarding crime scene preservation.

Overall Assessment

The department's actions during the incident were not adequate because a lieutenant ordered a nurse to move the inmate's body before the coroner arrived.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  A lieutenant incorrectly ordered a nurse to transport the inmate's body to the triage and treatment area before the coroner arrived.
- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified that a lieutenant erred in ordering a nurse to transport the inmate's body to the triage and treatment area before the coroner arrived.

Incident Date	OIG Case Number	Case Type
2016-12-14	17-0000062-RO	Hunger Strike

Incident Summary

On December 14, 2016, an inmate began a hunger strike and did not state the reason for not eating. On December 31, 2016, and January 11, 2017, the department transferred the inmate to an outside hospital due to low vital signs. The inmate returned to the institution on January 16, 2017, and ended the hunger strike on January 17, 2017.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions were not adequate because the department did not notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Did the department timely notify the OIG regarding the critical incident?**
  The department did not notify the OIG the inmate was sent to an outside hospital.

Incident Date	OIG Case Number	Case Type
2017-01-01	17-0000059-RO	In-Custody Inmate Death

Incident Summary

On January 1, 2017, an officer discovered an unresponsive inmate in his cell. Four officers, a sergeant, and a psychiatric technician performed life-saving measures. A nurse continued the life-saving measures. The department transported the inmate to an outside hospital where a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death was heroin intoxication and the manner of death was accidental. The investigative services unit investigated but could not determine the source of the heroin. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-04-30	17-0022560-RO	Hunger Strike

Incident Summary

On April 30, 2017, an inmate initiated a hunger strike because of a perceived due process violation. On May 3, 2017, the department transported the inmate to an outside hospital because the inmate claimed he lost consciousness. On May 4, 2017, the inmate ended the hunger strike and returned to the institution.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

North

Incident Date	OIG Case Number	Case Type
2015-08-09	15-0001566-RO	In-Custody Inmate Death

Incident Summary

On August 9, 2015, three officers found an inmate attempting to self-induce vomiting. Moments later, the inmate collapsed. Three officers began life-saving measures, and a sergeant, three additional officers, and two nurses assisted, but were unsuccessful. A physician pronounced the inmate dead.

Disposition

The coroner determined the manner of death was accidental and the cause of death was methamphetamine overdose. The department's Death Review Committee concluded the inmate died of a drug overdose and the death was not preventable. The investigative services unit sufficiently investigated the source of the drugs but did not determine the source or locate additional drugs. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response during and after the incident was insufficient because responding officers and nurses did not timely assess or provide life-saving measures to the inmate or complete adequate documentation.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Officers and nurses did not timely assess whether the inmate required immediate life-saving measures and failed to adequately document the incident by omitting when they assessed the inmate. Officers waited 12 minutes after the incident began and seven minutes after nurses arrived before providing life-saving measures.

- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified that officers and nurses failed to timely assess and provide life-saving measures to the inmate and complete adequate documentation.

- **Did the hiring authority appropriately determine whether to refer any conduct to the OIA related to the critical incident?**
  The hiring authority disagreed with the OIG's determination that officers and nurses submitted inadequate documentation and failed to timely assess the inmate and provide medical care. Therefore, the hiring authority did not refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-11-02	15-0002298-RO	In-Custody Inmate Death

Incident Summary

On November 2, 2015, an officer discovered an unresponsive inmate in his cell. Two other officers, a sergeant, and two nurses began life-saving measures, which continued during transport to the correctional treatment center. A physician subsequently pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the case of death was methamphetamine and heroin overdose and the death was not preventable. The investigative services unit sufficiently investigated the source of the drugs but did not determine the source or locate additional drugs. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2015-11-24	16-0001762-RO	In-Custody Inmate Death

Incident Summary

On November 24, 2015, an inmate jumped from the second tier onto the ground below. On March 4, 2016, the inmate died of his injuries at an outside hospital.

Disposition

The inmate died due to medical complications related to jumping from the tier. The department's Suicide Case Review Committee found the death was foreseeable and preventable and found multiple failures by mental health clinicians to properly assess the suicide risk. The department reviewed mental health clinicians' records and provided training. The department referred the nursing issues to the department's Nursing Professional Practice Committee. The department also modified training for mental health clinicians to discuss communicating the reasons for placing inmates on or removing them from mental health crisis bed or suicide watch status. The department also created a policy that when a mental health clinician becomes aware that an inmate previously attempted suicide by jumping off a tier, the mental health clinician must consult with a medical physician and recommend the inmate for first floor housing.

Overall Assessment

The department's actions prior to the incident were not adequate because the institution inappropriately housed the inmate and nurses and physicians did not provide sufficient medical care. The department's response was not adequate because nurses did not make timely emergency notification or urge appropriate medical transport of the inmate and failed to complete adequate documentation.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Prior to the incident, the institution housed the inmate in a second tier cell after the inmate told a psychiatrist he had thoughts of jumping off the second tier, nurses failed to stagger their 15-minute rounds, and psychiatrists did not properly assess the suicide risk. During the incident, nurses did not immediately call the law enforcement emergency number after learning the inmate fell from the second tier, nursing records contained conflicting information, and a nurse failed to urge transferring the inmate by ambulance. After the incident, nurses did not document notifying a physician when the inmate lost significant weight, stagger their 15-minute rounds, weigh the inmate twice weekly, or document the amount of food the inmate ate.

Incident Date	OIG Case Number	Case Type
2016-01-14	16-0000225-RO	Suicide

Incident Summary

On January 14, 2016, an officer discovered an inmate hanging from a noose in his cell. Officers cut the noose, lowered the inmate, and initiated life-saving measures. Two nurses continued life-saving measures until paramedics arrived and pronounced the inmate dead.

Disposition

The coroner determined the cause of death was asphyxia due to hanging. The department's Death Review Committee determined the cause of death was suicide due to asphyxiation by hanging. The department's Suicide Case Review Committee found the inmate's suicide was foreseeable and preventable. The committee questioned the decision to reduce the inmate's mental health level of care prior to his death and a cross-discipline concern that information regarding the inmate's recent court appearance had not been relayed to mental health clinicians. The department implemented procedures to change documentation requirements to improve the continuity of care and implemented a process for inmates' attorneys to contact the department to report concerns regarding their clients' mental health status following court appearances. The department also provided training to 19 mental health clinicians regarding the new documentation requirements.

Overall Assessment

The departments response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-02-06	16-0000421-RO	In-Custody Inmate Death

Incident Summary

On February 6, 2016, an inmate collapsed in the chapel. Officers and nurses initiated life-saving measures and transported the inmate to the triage and treatment area where life-saving efforts continued. The inmate regained a pulse and respiration but stopped breathing during transport to an outside hospital where a physician pronounced the inmate dead.

Disposition

The coroner determined the inmate's death was accidental due to a ruptured intracranial aneurysm contributed to by methamphetamine toxicity. The department's Death Review Committee determined the cause of death was cardiovascular disease and the death was not preventable. The investigative services unit sufficiently investigated the source of the drugs but did not determine the source or locate additional drugs. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-03-05	16-0000703-RO	Suicide

Incident Summary

On March 5, 2016, a nurse discovered an unresponsive inmate face down on a bunk. A sergeant and five officers entered the cell and removed a noose from the inmate's neck. Three nurses and three officers performed life-saving measures until a physician pronounced the inmate dead.

Disposition

The department's Suicide Case Review Committee concluded the cause of death was asphyxiation by hanging, the manner of death was suicide, and that the death was foreseeable and preventable. The department provided instruction to clinicians, physicians, and nurses regarding classifying and documenting inmate self-harm events, reviewed local policies and procedures regarding preparation of incident reports for inmate self-harm incidents, added clinical staff and provided training to clinicians regarding discharge requirements, documenting interdisciplinary treatment team meetings, and reminding clinicians to include inmates in the treatment planning process. The department also provided training to clinicians regarding properly documenting treatment and evaluating chronic risk for suicide. The department also revised its procedures for submitting psychiatry-related documentation.

Overall Assessment

The department's actions prior to the incident were not adequate because the department did not adequately complete assessments or documentation and failed to ensure the inmate attended important treatment meetings.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Sufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Prior to the incident, the department did not properly or timely document or assess the inmate's suicide attempts, prepare incident reports after the inmate's suicide attempts, timely complete the inmate's treatment plan and discharge documents when he was released from a mental health crisis bed, document that the inmate attended interdisciplinary treatment team meetings, or that there was a treatment plan for the inmate while he was in a mental health crisis bed, ensure the inmate attended interdisciplinary treatment team meetings, or accurately document the inmate's medication. Additionally, the department prescribed new psychotropic medications for the inmate but failed to document that a psychiatrist met with the inmate for a new evaluation, used outdated mental health forms, and poorly documented the inmate's suicide risk evaluations.

Incident Date	OIG Case Number	Case Type
2016-04-26	16-0001299-RO	Suicide

Incident Summary

On April 26, 2016, officers observed an inmate jump from the fifth tier of a housing unit. Nurses provided life-saving measures and transported the inmate to the triage and treatment area. Paramedics arrived and transported the inmate to an outside hospital. On April 30, 2016, a physician pronounced the inmate dead.

Disposition

The coroner reported the cause of death was complication from blunt force injuries and the manner of death was suicide. The department's Death Review Committee determined the inmate's death was not medically preventable but nursing documentation and the activation of emergency medical response could be improved. The hiring authority referred the matter to the Nursing Professional Practice Committee. The department's Suicide Case Review Committee concluded the suicide was not foreseeable or preventable.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-05-02	16-0001307-RO	In-Custody Inmate Death

Incident Summary

On May 2, 2016, an officer found an unresponsive inmate on the floor in his cell after other inmates informed officers the inmate had been calling for help for almost 30 minutes. Officers removed the cellmate from the cell, and an officer and nurse initiated life-saving measures. The department transferred the inmate to an outside hospital where a physician pronounced the inmate dead. The department referred the case against the cellmate to the district attorney's office.

Disposition

The department's Death Review Committee determined the cause of death was traumatic brain injury with severe head trauma and the manner of death was homicide. The hiring authority identified potential staff misconduct based on three officers' alleged failure to ensure the inmate's well-being. The hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions were not adequate because three officers allegedly did not ensure the inmate's well-being and delayed responding and the department did not timely notify the OIG.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Insufficient	Sufficient

Assessment Questions

- **Did the department timely notify the OIG regarding the critical incident?**
  The department notified the OIG of the inmate's death by email message instead of by telephone and did not notify the OIG until nearly one and one-half hours after the inmate's death.

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's action prior to the incident were not adequate because three officers allegedly failed to ensure the inmate's well-being and during the incident, the officers allegedly delayed responding after inmates notified them of the incident.

Incident Date	OIG Case Number	Case Type
2016-05-05	16-0001349-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On May 5, 2016, two officers used physical force to control a resisting inmate and the inmate's head struck a gate and the ground. The inmate received treatment at the institution, following which the department transported the inmate to an outside hospital. The inmate returned to the institution the same day.

Disposition

The institution's executive review committee determined the use of force complied with policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-05-23	16-0001635-RO	In-Custody Inmate Death

Incident Summary

On May 23, 2016, an inmate informed officers a second inmate hit him in the face with a cup. Officers escorted the first inmate to the triage and treatment area, following which the first inmate returned to the cell. The first inmate subsequently returned to the triage and treatment area and became unconscious. The department air-lifted the first inmate to an outside hospital where a physician pronounced the inmate dead two days later. The investigative services unit investigated the incident and referred the case to the district attorney's office.

Disposition

The coroner determined the cause of death was blunt force injury and the manner of death was homicide. The department's Death Review Committee concluded the inmate's death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-05-27	16-0001669-RO	In-Custody Inmate Death

Incident Summary

On May 27, 2016, an inmate alerted an officer that his cellmate was having a seizure. Nurses initiated life-saving measures and transported the inmate to the triage and treatment area where a physician pronounced him dead.

Disposition

The coroner determined pathology and toxicology results did not reveal a definite cause of death. The department's Death Review Committee did not identify a cause of death or whether it was preventable. The hiring authority for the nurse provided training to the nurse regarding report writing.

Overall Assessment

The department's actions following the incident were not adequate because the department failed to timely notify the OIG, the investigative services unit failed to take pictures of the deceased inmate's cellmate, and a nurse did not complete adequate documentation.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Did the department timely notify the OIG regarding the critical incident?**
  The department notified the OIG two hours after a physician pronounced the inmate dead.
- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit did not take pictures of the deceased inmate's cellmate to document injuries or lack thereof.
- **Was the critical incident adequately documented?**
  A nurse did not adequately complete a medical assessment form.

Incident Date	OIG Case Number	Case Type
2016-05-29	16-0001680-RO	In-Custody Inmate Death

Incident Summary

On May 29, 2016, an inmate reported having chest pains and not feeling well. The department transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

The coroner determined an autopsy was not required because the inmate died of natural causes. The department's Death Review Committee determined the death was possibly preventable due to a delay transporting the inmate to an outside hospital. The emergency medical response review committee determined that nurses delayed calling emergency medical services. The hiring authority provided training to the nurses.

Overall Assessment

The department's actions during the incident were not adequate because nurses did not administer required medication or make timely notifications.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Nurses did not administer sublingual nitroglycerin according to protocol, timely notify the on-call physician of the emergency, or timely contact emergency medical services to transport the inmate to an outside hospital.

Incident Date	OIG Case Number	Case Type
2016-08-31	16-0001939-RO	In-Custody Inmate Death

Incident Summary

On August 31, 2016, an officer discovered an inmate in his cell covered with blood and unresponsive. Officers removed the cellmate from the cell, and officers and nurses transported the inmate to the triage and treatment area. The department transported the inmate to an outside hospital where he died on September 21, 2016. The department referred the matter to the district attorney's office for prosecution.

Disposition

The coroner concluded the inmate died of complications from blunt force injury to the head. The department's Death Review Committee determined the death was not medically preventable. The department conducted an in-cell assault review and concluded the inmates were appropriately housed. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-09-01	16-0001886-RO	Suicide

Incident Summary

On September 1, 2016, an officer found an inmate hanging from a noose in his cell. Officers entered the cell and lowered the inmate, and four officers began life-saving measures. A nurse continued life-saving measures as officers transported the inmate to the triage and treatment area where life-saving measures continued until a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the inmate died from suffocation by hanging and the death was not preventable. The Suicide Case Review Committee found the suicide was not foreseeable or preventable, but the report identified concerns regarding follow-up consultations, suicide risk assessments, and documentation. In response to the report, the department revised its operating procedures regarding follow-up assessments, provided training to more than 60 staff members regarding suicide risk assessments, and counseled the psychologist who incorrectly filed patient information.

Overall Assessment

The department's actions prior to and after the incident were inadequate because the the department did not conduct a timely assessment of the inmate, properly conduct and document suicide risk assessments, or correctly file inmate information. The department did not adequately consult with the OIG.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Sufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's handling of the incident prior to and after the incident was inadequate because the the department did not conduct a timely follow-up assessment with the inmate, properly conduct and document the inmate's suicide risk, and a psychologist progress notes contained information pertaining to another patient.

- **Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?**
  The investigative services unit neglected to notify the OIG of the autopsy date and time preventing the OIG from real-time monitoring of the autopsy.

- **Did the department adequately consult with the OIG regarding the critical incident?**
  The department did not sufficiently consult with the OIG by neglecting to notify the OIG of the date and time of the autopsy.

Incident Date	OIG Case Number	Case Type
2016-09-09	16-0001908-RO	In-Custody Inmate Death

Incident Summary

On September 9, 2016, two officers found an inmate unresponsive on the floor of a cell after his cellmate reported killing the inmate. Officers and nurses performed life-saving measures. The department transferred the inmate to an outside hospital where a physician pronounced him dead three days later. The department referred the case against the cellmate to the district attorney's office.

Disposition

The institution's death review determined the primary cause of death was brain injury due to strangulation. The department's Death Review Committee determined the death was not medically preventable. The department conducted an in-cell assault review and determined the inmates were housed together in compliance with policy. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-09-10	16-0001909-RO	In-Custody Inmate Death

Incident Summary

On September 10, 2016, an inmate informed officers his cellmate was unresponsive. An officer and a nurse initiated life-saving measures and transported the inmate to the triage and treatment area. Three additional officers and two other nurses took over life-saving measures until paramedics arrived and, after consulting a physician, pronounced the inmate dead.

Disposition

The coroner determined the cause of death was cardio-respiratory failure with sepsis from abdominal inflammation and the manner of death was accidental due to high levels of methamphetamine and hydromorphone. The department's Death Review Committee determined the cause of death was sepsis and not preventable, and found no death-related departures from the standard of care. The investigative services unit made reasonable efforts to determine whether the inmate had drugs in his cell. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-09-14	16-0001947-RO	Hunger Strike

Incident Summary

On September 14, 2016, an inmate began a hunger strike because of housing issues, damaged and lost personal property, and the department's refusal to provide an ankle brace. On September 26, 2016, the department transported the inmate to an outside hospital due to hunger strike-related medical concerns. The inmate returned to the institution the same day and ended his hunger strike on October 11, 2016.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify staff misconduct.

Overall Assessment

The department did not timely notify the OIG after transferring the inmate to an outside hospital. The department's action following the incident were not adequate because the department delayed conducting an inquiry into the inmate's allegations of potential staff misconduct.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Did the department timely notify the OIG regarding the critical incident?**
  The department did not notify the OIG that the department transferred the inmate to an outside hospital until the following day.

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department did not notify the OIG the inmate was transported to an outside hospital while on hunger strike or conduct a timely inquiry into allegations of potential staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-09-18	16-0001920-RO	In-Custody Inmate Death

Incident Summary

On September 18, 2016, an inmate began shaking uncontrollably and sweating profusely in the visiting area. An officer and nurse transported the inmate to the triage and treatment area where a nurse administered an antidote for opiate overdose, but the inmate's heart and breathing stopped. A nurse began life-saving measures until a paramedic took over, and a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death was methamphetamine overdose and the department's Death Review Committee determined the death was unexpected and not preventable. The investigative services unit adequately investigated the source of the drugs but did not determine the source or recover additional drugs. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-09-20	16-0002120-RO	Hunger Strike

Incident Summary

From September 20, 2016, through November 23, 2016, an inmate engaged in a hunger strike because he disagreed with a guilty finding on a rules violation report. On December 5, 2016, the inmate renewed the hunger strike because he disagreed with the department's determinations regarding his housing and classification. On December 7, 2016, the institution transported the inmate to an outside hospital where he continued the hunger strike. On December 29, 2016, the inmate ended the hunger strike but remained at the hospital to begin reintroducing food. The inmate lost a total of 32 percent of his body weight during the hunger strikes. On January 13, 2017, the inmate was released from the hospital and transferred to a different institution.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-10-11	16-0001969-RO	In-Custody Inmate Death

Incident Summary

On October 11, 2016, an officer found an inmate unresponsive after his cellmate reported strangling the inmate. A nurse responded but did not initiate life-saving measures due to obvious signs of death, rigor mortis, and lividity. Officers transported the inmate to the triage and treatment area where a physician pronounced him dead. The hiring authority referred the case against the cellmate to the district attorney's office.

Disposition

The coroner concluded the cause of death was ligature strangulation. The department's Death Review Committee determined the death was not preventable. The department's in-cell assault review concluded the department housed the inmates in compliance with policy. However, during the review, the department noted documentation discrepancies regarding the inmates' case factors. Since the errors were minor and remote in time, they did not change the classification. One of the lieutenants who made an error no longer worked for the department and the other no longer worked at the institution. Therefore, the hiring authority decided not to provide training. After the OIG identified potential staff misconduct, the hiring authority submitted a request for investigation to the Office of Internal Affairs for an officer's alleged failure to conduct the required inmate count and for falsely documenting having done so. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions were not adequate because documentation contained errors, an officer allegedly failed to conduct a proper inmate count and was dishonest, and the hiring authority did not timely refer the matter to the Office of Internal Affairs.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Sufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Documentation regarding the inmates' classification contained discrepancies. An officer allegedly failed to conduct proper counts and falsely documented doing so.
- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG independently identified that an officer allegedly failed to conduct proper counts and falsely documented doing so.
- **Did the hiring authority make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?**
  The department learned of the alleged misconduct on October 11, 2016, but the hiring authority did not refer the matter to the Office of Internal Affairs until May 3, 2017, more than six months after the date of discovery.

Incident Date	OIG Case Number	Case Type
2016-10-11	16-0001970-RO	In-Custody Inmate Death

Incident Summary

On October 11, 2016, an officer and nurse found an unresponsive inmate in his cell. The officer and nurse did not initiate life-saving measures due to obvious signs of death, rigor mortis, and lividity. Officers transported the inmate to the triage and treatment area where a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death was heart attack. The department's Death Review Committee determined the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-10-15	16-0001977-RO	In-Custody Inmate Death

Incident Summary

On October 15, 2016, an officer saw an inmate being stabbed by a second inmate with an inmate-manufactured weapon. The attacking inmate complied with orders to stop. Nurses initiated life-saving measures on the attacked inmate and transported him to the triage and treatment area where a physician pronounced him dead. The department referred the matter to the district attorney's office.

Disposition

The coroner determined the cause of death was multiple stab wounds to the torso. The department's Death Review Committee concluded the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-10-26	16-0002016-RO	In-Custody Inmate Death

Incident Summary

On October 26, 2016, a nurse discovered an inmate having a seizure in his cell and transported the inmate to the infirmary where the inmate stopped breathing. Nurses performed life-saving measures and an ambulance transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

The department's Death Review Committee determined the primary cause of death was ventricular arrhythmia and the inmate's death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions following the incident were not adequate because the hiring authority did not timely consult with the OIG.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Did the department adequately consult with the OIG regarding the critical incident?**
  The hiring authority did not timely respond to the OIG's inquiries and telephone calls.

Incident Date	OIG Case Number	Case Type
2016-10-30	16-0002020-RO	In-Custody Inmate Death

Incident Summary

On October 30, 2016, officers found an inmate unresponsive in his cell and initiated life-saving measures. Nurses continued life-saving measures and transported the inmate to the institution's emergency room where a physician pronounced the inmate dead.

Disposition

The coroner determined the inmate died of a heroin overdose. The department's Death Review Committee determined the death was not preventable but also found that nurses did not administer a heroin antidote and could have directed officers to take over life-saving measures so they could administer the antidote. The Death Review Committee referred the matter to the department's Nursing Professional Practice Committee. The hiring authority investigated the source of the heroin but was unable to identify the source.

Overall Assessment

The department's actions during the incident were not adequate because nurses did not adequately respond to the incident.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The department's actions during the incident were not adequate because nurses did not administer medication to counteract the potential life-threatening effects of a drug overdose and did not direct officers to take over live-saving measures so they could administer the medication.

Incident Date	OIG Case Number	Case Type
2016-11-02	16-0002024-RO	In-Custody Inmate Death

Incident Summary

On November 2, 2016, two officers, a counselor, and a nurse responded to a call for assistance and discovered an unresponsive inmate in his cell with his cellmate hunched over him. The nurse initiated life-saving measures. Officers and nurses transported the inmate to the triage and treatment area where a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death to be acute methamphetamine intoxication. The department's Death Review Committee determined the inmate's death was not preventable. The OIG identified that officers had a reasonable suspicion that the inmate and his cellmate possessed drugs but did not place the inmate on contraband surveillance watch. The hiring authority provided training to the officers regarding contraband surveillance watch.

Overall Assessment

The department's actions prior to the incident were not adequate because the department failed to place the inmate on contraband surveillance watch.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Sufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Prior to the incident, the department failed to place the inmate on contraband surveillance watch despite a reasonable suspicion the inmate and his cellmate possessed drugs.

- **Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?**
  The OIG identified that based on information a reliable source provided to the investigative services unit and the inmate's behavior during a search for contraband on the day the inmate died, officers should have placed the inmate on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2016-12-06	16-0002113-RO	In-Custody Inmate Death

Incident Summary

On December 6, 2016, an officer observed an unresponsive inmate on the floor in a cell. The officer and nurses performed life-saving measures until a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death to be severe heart disease. The department's Death Review Committee determined the death was natural and unexpected and the emergency medical response was appropriate. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-12-25	16-0002161-RO	In-Custody Inmate Death

Incident Summary

On December 25, 2016, an officer saw an inmate in front of a cell with blood coming from his nose and mouth. The inmate collapsed and became unresponsive. Two other officers and a nurse initiated life-saving measures. Paramedics arrived and continued life-saving efforts until a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death was aspiration related to lung cancer. The department's Death Review Committee determined the death was not medically preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-12-27	16-0002160-RO	In-Custody Inmate Death

Incident Summary

On December 27, 2016, an officer found an unresponsive inmate on his bed. Two officers and two nurses performed life-saving measures and transported the inmate to the triage and treatment area where life-saving measures continued until a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the inmate died from a sudden heart attack and the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-12-28	17-0000110-RO	Hunger Strike

Incident Summary

On December 28, 2016, an inmate initiated a hunger strike claiming his housing needs were not being met. The inmate ended the hunger strike on January 20, 2017.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-01-05	17-0000101-RO	Hunger Strike

Incident Summary

On January 5, 2017, an inmate began a hunger strike due to safety concerns. On January 9, 2017, the inmate fell and the department transported him to an outside hospital. The inmate returned to the institution the same day. On January 12, 2017, the inmate became unresponsive, and the department transported the inmate to an outside hospital again. On the same day, the inmate ended his hunger strike and returned to the institution.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-01-20	17-0000141-RO	In-Custody Inmate Death

Incident Summary

On January 20, 2017, the department sent the inmate to an outside hospital for treatment where he died on January 26, 2017.

Disposition

The department's Death Review Committee determined the inmate died due to influenza and pneumonia and the death was not preventable. The hiring authority provided training to the lieutenant regarding report writing.

Overall Assessment

The department's actions following the incident were not adequate because a lieutenant did not adequately document the incident.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Was the critical incident adequately documented?**
  A lieutenant did not include a clear and concise timeline of events or timeline of required notifications in his report.

Incident Date	OIG Case Number	Case Type
2017-01-25	17-0000143-RO	Hunger Strike

Incident Summary

On January 25, 2017, an inmate initiated a hunger strike due to denial of law library documents, program restriction, and housing status. On January 29, 2017, the inmate fell, injuring his leg, and the department transported him to an outside hospital. The inmate returned to the institution the same day. On February 21, 2017, the inmate ended his hunger strike.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct but provided training to management and supervisory staff regarding timely notification to the OIG.

Overall Assessment

The department's actions were not adequate because the department did not notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Sufficient

Assessment Questions

- **Did the department timely notify the OIG regarding the critical incident?**
  The department did not notify the OIG the inmate was transported to an outside hospital while on hunger strike.

Incident Date	OIG Case Number	Case Type
2017-01-30	17-0000135-RO	In-Custody Inmate Death

Incident Summary

On January 30, 2017, an officer discovered an unresponsive inmate on the floor of a cell he shared with a cellmate. The inmate had cuts on his face and blood on his shorts and legs. A sergeant, three officers, and two nurses performed life-saving measures. The department transported the inmate to an ambulance where a paramedic pronounced the inmate dead. The department referred the matter to the district attorney's office.

Disposition

The coroner concluded the cause of death was asphyxia due to external compression of the neck with blunt force trauma to the head and chest. The department's Death Review Committee determined the death was not preventable. The institution's in-cell assault review concluded the inmates were housed within departmental guidelines. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-02-11	17-0021834-RO	Hunger Strike

Incident Summary

On February 11, 2017, an inmate began a hunger strike because he was not allowed to possess personal property. On February 17, 2017, the department transferred the inmate to an outside hospital for treatment of a prior injury. The inmate ended his hunger strike at the hospital and returned to the institution the same day.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-02-28	17-0021895-RO	In-Custody Inmate Death

Incident Summary

On February 28, 2017, an officer found an unresponsive inmate on the floor of a cell. Officers and a nurse performed life-saving measures. Paramedics arrived and continued life-saving measures until a paramedic pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the cause of death was lung cancer and the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-03-11	17-0022290-RO	Hunger Strike

Incident Summary

On March 11, 2017, an inmate initiated a hunger strike because he wanted protective frames for his glasses. The inmate ended his hunger strike on April 10, 2017.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct. However, to improve the reliability of information regarding an inmate's weight while on hunger strike, the hiring authority instituted a practice requiring documentation regarding whether the inmate is wearing a medical device while being weighed while on hunger strike.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-03-15	17-0022102-RO	Other Significant Incident

Incident Summary

On March 15, 2017, approximately 30 inmates attacked four officers in a dining hall. Officers used physical force, pepper spray, and two less-lethal rounds to stop the attack. The officers sustained minor injuries and a responding counselor suffered a broken thumb. An inmate sustained an orbital fracture. The department transported the injured inmate to an outside hospital and the inmate returned to the institution the same day.

Disposition

The institution's executive review committee determined the use of force was within policy. The OIG concurred. The hiring authority did not identify any staff misconduct

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-03-26	17-0022231-RO	Hunger Strike

Incident Summary

On March 26, 2017, an inmate initiated a hunger strike due to the possibility of being transferred to another institution. On March 30, 2017, the department transported the inmate to an outside hospital for dehydration, high blood pressure, and risk of stroke. The inmate remained in the outside hospital until he ended the hunger strike on April 29, 2017.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-04-21	17-0022437-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On April 21, 2017, an officer allegedly failed to secure two housing unit doors, allowing an inmate to leave his housing unit, enter another housing unit, and attack a second officer with two inmate-manufactured weapons. The second officer used pepper spray and physical force, and two other officers used physical force to subdue the inmate. The second officer suffered puncture wounds and a laceration to his ear. A sergeant transported the second officer to an outside hospital and he was released the same day. The department transported the inmate to an outside hospital for possible head and rib injuries. The inmate also returned to the institution the same day.

Disposition

The hiring authority identified potential staff misconduct based on an officer's alleged failure to secure the two doors. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs agreed to interview the officer. The OIG accepted the case for monitoring.

Overall Assessment

The department's actions prior to the incident were not adequate because an officer allegedly failed to secure two doors, allowing the inmate to attack another officer.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Sufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  An officer allegedly left two doors open, allowing an inmate to exit one section and enter a second section where he attacked another officer.

Incident Date	OIG Case Number	Case Type
2017-05-02	17-0022537-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On May 2, 2017, an inmate hit an officer with a cane, and three officers used physical force to restrain the inmate. The department transported the inmate to an outside hospital. The inmate suffered a serious injury.

Disposition

The hiring authority identified potential staff misconduct based on officers' alleged unreasonable use of force and failure to accurately report use of force. Therefore, the hiring authority referred the case to the Office of Internal Affairs for an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions were not adequate because officers allegedly used unreasonable force on an inmate, resulting in serious injury to the inmate, and failed to accurately report the use of force. Also, an officer failed to complete adequate documentation, and the Office of Internal Affairs did not add a dishonesty allegation.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Officers allegedly used unreasonable force resulting in serious injury to an inmate, failed to accurately report the use of force, and an officer failed to adequately document a holding cell log.

- **Was the critical incident adequately documented?**
  Officers allegedly failed to accurately report the use use of force and an officer failed to adequately document a holding cell log.

- **Did the OIA make an appropriate initial determination regarding the case?**
  The Office of Internal Affairs did not add a dishonesty allegation for each officer despite information suggesting the officers lied in reporting the force used and witnessed.

Incident Date	OIG Case Number	Case Type
2017-05-25	17-0022825-RO	Hunger Strike

Incident Summary

On May 25, 2017, 74 inmates in an administrative segregation unit declared hunger strikes because they wanted exercise equipment in the administrative segregation unit exercise yard, cleaner exercise yards, cleaning supplies, access to law clerks and more access to the law library, rehabilitative programs and education, and the same privileges as inmates in security housing units. The inmates also complained that some officers were too loud while conducting security checks. As of June 1, 2017, the inmates ended their hunger strikes.

Disposition

The department made reasonable attempts to address the inmates' concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

South

Incident Date	OIG Case Number	Case Type
2016-02-15	16-0000758-RO	In-Custody Inmate Death

Incident Summary

On February 15, 2016, officers found an unresponsive inmate bleeding from his head and nose. The department transported the inmate to an outside hospital where he died on March 9, 2016. The hiring authority referred the matter to the district attorney's office to investigate possible homicide by another inmate.

Disposition

The coroner determined the cause of death was blunt force head trauma. The department's Death Review Committee concluded that the death was not medically preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-03-18	16-0000866-RO	In-Custody Inmate Death

Incident Summary

On March 18, 2016, officers discovered an unresponsive inmate in his cell. The officers removed the cellmate and initiated life-saving measures on the inmate. Outside firefighters arrived and pronounced the inmate dead.

Disposition

The coroner reported the cause of death as mixed drug toxicity but the manner of death, based on evidence of blunt force trauma, is undetermined. The investigative services unit took reasonable steps to identify the source of the drugs and outside law enforcement is investigating. The department's Death Review Committee concluded the death was not medically preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-04-03	16-0001014-RO	In-Custody Inmate Death

Incident Summary

On April 3, 2016, officers discovered an unresponsive inmate covered in blood in a cell. Officers and nurses performed life-saving measures until a physician pronounced the inmate dead. Outside law enforcement is investigating the incident.

Disposition

The coroner concluded the cause of death was homicide. The department conducted an in-cell assault review and determined the institution complied with policies when housing the two involved inmates. The department's Death Review Committee concluded the inmate's death was unexpected and medically not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-04-14	16-0001147-RO	In-Custody Inmate Death

Incident Summary

On April 14, 2016, an officer found an inmate hanging from a noose in the cell. Two officers, three nurses, and paramedics performed life-saving measures but were unsuccessful. A paramedic pronounced the inmate dead.

Disposition

The coroner determined the cause of death to be asphyxiation by hanging and the department's Suicide Case Review Committee reported the death as foreseeable and preventable suicide. The hiring authority identified potential staff misconduct based on the officer's alleged failure to perform a proper security check, entering the cell without notifying a sergeant, and failure to timely submit an incident report. Therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions were not adequate because an officer allegedly failed to adequately conduct a security check, entered the inmate's cell prior to notifying a supervisor, and failed to timely complete an incident report. The hiring authority did not timely refer the matter to the Office of Internal Affairs.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Prior to the incident, an officer allegedly did not discover the inmate had a noose around her neck during a security check. During the incident, the officer allegedly entered the inmate's cell prior to notifying a supervisor. After the incident, the officer allegedly did not complete an incident report before going off duty.

- **Was the critical incident adequately documented?**
  The officer allegedly failed to complete an incident report before going off duty.

- **Did the hiring authority make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?**
  The department learned of the alleged misconduct on April 14, 2016, but the hiring authority did not refer the matter to the Office of Internal Affairs until January 18, 2017, 279 days after the date of discovery.

Incident Date	OIG Case Number	Case Type
2016-05-13	16-0001455-RO	In-Custody Inmate Death

Incident Summary

On May 13, 2016, an inmate complained of stomach pains and vomiting. The department transported the inmate to an outside hospital where the inmate was found to have a bindle of marijuana in his intestine. A physician surgically removed the bindle, but the inmate suffered surgical complications. A physician pronounced the inmate dead on May 14, 2016.

Disposition

The coroner concluded the cause of death was hypertrophic cardiomyopathy. The department's Death Review Committee concluded the cause of death was medically non-preventable cardiovascular disease. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-05-30	16-0001667-RO	In-Custody Inmate Death

Incident Summary

On May 30, 2016, an inmate collapsed while working in the kitchen. Officers and nurses performed life-saving measures that were unsuccessful, and a physician pronounced the inmate dead.

Disposition

The coroner determined the inmate died of methamphetamine toxicity. The department's Death Review Committee found that the death was not medically preventable. The department unsuccessfully attempted to locate the source of the drugs. The hiring authority did not identify any staff misconduct

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-06-08	16-0001721-RO	In-Custody Inmate Death

Incident Summary

On June 8, 2016, an officer found an unresponsive inmate in a cell. Officers and nurses performed life-saving measures but they were unsuccessful, and a physician pronounced the inmate dead.

Disposition

The coroner concluded the inmate sustained heart poisoning due to acute fentanyl intoxication. The department's Death Review Committee determined the inmate's death was not medically preventable. The investigative services unit found fentanyl in the cell. The department took appropriate steps to identify the source of the drugs and provided training to custody staff regarding fentanyl.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-06-15	16-0001737-RO	In-Custody Inmate Death

Incident Summary

On June 15, 2016, officers found an unresponsive inmate in his cell. The officers and nurses attempted life-saving measures but were not successful. After consulting a physician, a paramedic pronounced the inmate dead.

Disposition

The coroner determined the inmate died of heroin intoxication. The department's Death Review Committee found the death was not medically preventable. The department unsuccessfully attempted to locate the source of the drugs. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-08-14	16-0001853-RO	In-Custody Inmate Death

Incident Summary

On August 14, 2016, officers found an unresponsive inmate face down on the floor of a cell. Officers and a nurse initiated life-saving measures and transported the inmate to the triage and treatment area. Paramedics arrived and took over life-saving measures until a physician pronounced the inmate dead.

Disposition

The coroner indicated the inmate died of acute methamphetamine and opiate intoxication. The department's Death Review Committee determined the death was not medically preventable. The hiring authority took steps to investigate the source of the drugs. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-09-16	16-0001921-RO	In-Custody Inmate Death

Incident Summary

On September 16, 2016, an officer found an unresponsive inmate. Two officers and two nurses initiated life-saving measures. The department transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

The coroner determined the cause of death was heroin and methamphetamine toxicity and manner of death was accidental. The department's Death Review Committee also concluded the cause of death was heroin and methamphetamine toxicity and the death was not medically preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions following the incident were not adequate because the institution did not investigate the source of the drugs.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  The institution failed to investigate the source of the drugs that caused the inmate's death.

Incident Date	OIG Case Number	Case Type
2016-11-20	16-0002080-RO	Suicide

Incident Summary

On November 20, 2016, an officer found an unresponsive inmate in a cell with a bag over his head and a strip of torn shirt securing the bag to his neck. Officers and paramedics performed life-saving measures but were unsuccessful, and a paramedic pronounced the inmate dead.

Disposition

The coroner determined the manner of death was suicide and cause of death was suffocation. The department's Suicide Case Review Committee determined the death was foreseeable but not preventable. The department's Death Review Committee concluded the death was a non-preventable suicide. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-12-02	16-0002112-RO	In-Custody Inmate Death

Incident Summary

On December 2, 2016, officers discovered an unresponsive inmate in his cell. Officers removed the inmate from the cell and initiated life-saving measures. Four nurses arrived and continued life-saving efforts until paramedics arrived, and a physician at an outside hospital pronounced the inmate dead.

Disposition

The coroner identified the cause of death as heart disease. The department's Death Review Committee concluded the death was possibly medically preventable. The hiring authority identified potential staff misconduct based on the transporting officers' alleged failure to contact emergency medical services after learning the inmate was having a diabetic emergency during transport. The hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to the incident were not adequate because officers allegedly did not adequately provide medical assistance to the inmate and the hiring authority delayed referring the matter to the Office of Internal Affairs.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Sufficient	Sufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Officers transporting the inmate allegedly failed to contact emergency medical services when learning the inmate was having a diabetic emergency during transport.

- **Did the hiring authority make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?**
  The department learned of the alleged misconduct on December 2, 2016, but the hiring authority did not refer the matter to the Office of Internal Affairs until January 17, 2017, 46 days after the date of discovery.

Incident Date	OIG Case Number	Case Type
2016-12-10	16-0002129-RO	In-Custody Inmate Death

Incident Summary

On December 10, 2016, officers found an unresponsive inmate in a cell after his cellmate called for help. Officers, a nurse, and paramedics performed life-saving measures that were unsuccessful, and a physician pronounced the inmate dead. Outside law enforcement is conducting a homicide investigation.

Disposition

The coroner determined the inmate died of a blood clot in the lungs partially due to an earlier injury from a fight with another inmate. The department's Death Review Committee determined the death was not medically preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2016-12-31	17-0000122-RO	Hunger Strike

Incident Summary

On December 31, 2016, an inmate began a hunger strike because his personal property had been confiscated. On January 27, 2017, the inmate ended his hunger strike but on February 6, 2016, resumed the hunger strike due to dissatisfaction with replacement property and being denied appliances necessary to cope with his disabilities. As of March 19, 2017, the inmate lost 31 percent of his original body weight. On March 20, 2017, the department transferred the inmate to an outside hospital. The inmate returned to the institution on March 21, 2017, and ended the hunger strike on March 23, 2017.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-02-06	17-0021707-RO	In-Custody Inmate Death

Incident Summary

On February 6, 2017, an officer discovered an unresponsive inmate in his cell. Two officers and a nurse performed life-saving measures until paramedics arrived and pronounced the inmate dead.

Disposition

The coroner determined the cause of death to be a heroin overdose. The department's Death Review Committee determined the death was not medically preventable. The department attempted to identify the source of the heroin but was unsuccessful. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Sufficient	Sufficient	Sufficient

Incident Date	OIG Case Number	Case Type
2017-04-24	17-0022463-RO	In-Custody Inmate Death

Incident Summary

On April 24, 2017, an officer discovered a non-responsive inmate in his cell. The officer performed life-saving measures, which were not successful because the inmate had been dead for several days.

Disposition

The hiring authority identified potential staff misconduct based on several officers alleged failure to conduct proper inmate counts, licensed psychiatric technicians alleged failure to administer and monitor the inmate's medications, and alleged false reporting regarding contact with the inmate after his death. The hiring authority referred the matter to the Office of Internal Affairs. The Office of Internal Affairs opened an investigation to address allegations against eight officers, two licensed psychiatric technicians, and one teacher. The OIG accepted the case for monitoring.

Overall Assessment

The department's response was not adequate because officers and licensed psychiatric technicians allegedly failed to properly monitor the inmate before he died and detect the inmate was dead. Also, the department did not adequately notify the OIG and the Office of Internal Affairs did not approve an investigation into alleged misconduct by four additional officers and three additional licensed psychiatric technicians even though the allegations are supported by evidence.

Prior to Incident Rating	During Incident Rating	After Incident Rating
Insufficient	Insufficient	Insufficient

Assessment Questions

- **Were the department's actions prior to, during, and after the critical incident appropriate?**
  Officers and licensed psychiatric technicians allegedly failed to properly monitor the inmate and detect the inmate was dead for three days. The department failed to notify the OIG of the date and time of the autopsy.

- **Did the OIA make an appropriate initial determination regarding the case?**
  The Office of Internal Affairs refused to investigate similar alleged misconduct by four additional officers and three additional licensed psychiatric technicians when there was sufficient evidence the inmate was dead for as long as three days, and the officers and licensed psychiatric technicians should have discovered the inmate.

Appendix F
Contraband Surveillance Watch Cases

Central

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-04	2016-12-04	1. Drugs	1. Drugs

Incident Summary **16-15446-CW**

On December 4, 2016, the department placed an inmate on contraband surveillance watch after officers saw the inmate swallow an unknown object. Officers searched the inmate's cell and found a bindle of suspected heroin. The department transported the inmate to an outside hospital where the inmate remained on contraband surveillance watch. An imaging scan showed no additional bindles or foreign objects inside the inmate. The department removed the inmate from contraband surveillance watch and returned the inmate to the institution the same day. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch during the four hours of the contraband surveillance watch. The department did not apply restraints, provide the inmate with hygiene opportunities, or complete required documentation. The hiring authority provided training to address the documentation deficiencies.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  The department did not apply restraints.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not provide the inmate access to proper hygiene.
- **Did the department complete appropriate documentation?**
  Officers did not document applying restraints or the inmate's activities for the duration of the inmate's placement on contraband surveillance watch.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not properly document the incident.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority trained the officers who failed to document the inmate's activities while on contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-17	2016-12-22	1. Drugs	1. Drugs

Incident Summary **16-15455-CWRM**

On December 17, 2016, the department placed an inmate on contraband surveillance watch because an officer saw the inmate swallow an unknown object. The department removed the inmate from contraband surveillance watch on December 22, 2016, five days later. During that time, the department recovered heroin from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Sergeants did not consistently complete required supervisory checks, and officers did not complete required documentation or consistently provide the inmate proper hand hygiene. The department provided training to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide the inmate with hand-washing opportunities prior to meals and after using the restroom.
- **Did the department complete appropriate documentation?**
  Officers did not consistently document that required medical assessments were completed.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Sergeants did not consistently conduct supervisory checks, and officers did not consistently document that required medical assessments were completed or that the inmate was provided proper hand hygiene.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to officers and sergeants to address the deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-01-08	2017-01-16	1. Drugs	1. Drugs

Incident Summary **17-15464-CWRM**

On January 8, 2017, the department placed an inmate on contraband surveillance watch because an officer saw the inmate swallow an unknown object from a milk carton during visiting. The department removed the inmate from contraband surveillance watch on January 16, 2017, eight days later after recovering heroin from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-01-15	2017-01-18	1. Suspicious Activity	1. Drugs

Incident Summary **17-15468-CW**

On January 15, 2017, the department transported an inmate to an outside hospital because an officer saw him swallow a suspected drug bindle during visiting. The inmate refused all medical assessments, and the department returned the inmate to the institution and placed him on contraband surveillance watch the same day. On January 17, 2017, the inmate retrieved and re-ingested the suspected drug bindle. The department returned the inmate to an outside hospital where he remained on contraband surveillance watch. The department removed the inmate from contraband surveillance watch and returned him to the institution on January 18, 2017, three days after placement, after recovering concentrated cannabis from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not adequately notify the OIG, an officer did not continually monitor the inmate, and a sergeant did not assign two officers while the inmate was unrestrained. Sergeants and officers did not consistently complete required documentation and supervisory checks. The department provided counseling and training to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide the inmate the opportunity to wash his hands prior to meals and after using the restroom.

- **Did the department comply with policies and procedures governing the inmate's removal from CSW?**
  The department did not notify the OIG when removing the inmate from contraband surveillance watch.

- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not notify the OIG when transferring the inmate to an outside hospital or when removing the inmate from contraband surveillance watch. An officer did not continually monitor the inmate, and a sergeant did not assign two officers during unrestrained times, resulting in the inmate retrieving and re-ingesting the contraband. Officers did not consistently conduct required security checks of the inmate's jumpsuit or provide the inmate proper hand hygiene. Sergeants did not consistently complete required supervisory checks.

- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The department did not notify the OIG when transferring the inmate to an outside hospital or removing the inmate from contraband surveillance watch. The department provided training to managers to address the deficiencies.

- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority identified that the administrative officer of the day did not make required notifications, an officer did not continually monitor the inmate, and a sergeant did not assign two officers during unrestrained times. The hiring authority also identified that officers did not consistently conduct required security checks of the inmate's jumpsuit or provide the inmate proper hand hygiene. Sergeants did not consistently complete required supervisory checks. The department provided counseling to the sergeant and officer who did not provide constant observation, and provided training to managers and officers to address the other deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-13	2017-02-14	1. Drugs	1. Nothing

Incident Summary **17-15489-CW**

On February 13, 2017, the department placed an inmate on contraband surveillance watch after an officer observed him place an unknown item in his mouth during a random cell search. The department removed the inmate from contraband surveillance watch on February 14, 2017, one day later, after an x-ray revealed no foreign object. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department prematurely removed the inmate from contraband surveillance watch, neglected to timely notify the OIG of the inmate's removal, and did not consistently provide the inmate with proper hygiene or range of motion opportunities. A nurse did not conduct a required medical assessment. The hiring authority provided training to an associate warden, captain, sergeants, officers, and administrative officers of the day to address some deficiencies. The hiring authority decided not to take action in response to the nurse's failure, deeming it an issue for sergeants and officers.

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide the inmate with the opportunity to wash his hands prior to meals and after using the restroom, or remove trash from the cell.

- **Did the department conduct required medical assessments?**
  A nurse did not complete a required medical assessment prior to the inmate's placement on contraband surveillance watch.

- **Did the department comply with policies and procedures governing the inmate's removal from CSW?**
  The hiring authority prematurely authorized removing the inmate from contraband surveillance watch within one day of placement after an x-ray revealed no foreign object and did not timely notify the OIG of the removal.

- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department neglected to timely notify the OIG when removing the inmate from contraband surveillance watch and removed the inmate before establishing a reasonable belief the inmate was free of contraband. Officers did not consistently provide the inmate with proper hygiene or range of motion opportunities, and a nurse did not conduct a required medical assessment.

- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The OIG identified the department prematurely removed the inmate from contraband surveillance watch and did not timely notify the OIG of the inmate's removal. The hiring authority implemented new policies and provided training to an associate warden, captain, four sergeants, two officers, and administrative officers of the day to address these deficiencies.

- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority identified that officers did not consistently provide the inmate hygiene or range of motion opportunities, and that a nurse did not complete an initial medical assessment. The hiring authority provided training to an associate warden, captain, sergeants, and officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-24	2017-02-28	1. Drugs	1. Nothing

Incident Summary **17-15497-CWRM**

On February 24, 2017, the department placed an inmate on contraband surveillance watch after an x-ray at an outside hospital revealed a bindle of suspected drugs in the inmate's abdomen. The inmate returned the institution the same day. The department removed the inmate from contraband surveillance watch on February 28, 2017, four days after placement. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not consistently provide the inmate proper hygiene or range of motion opportunities, or conduct required medical assessments. The hiring authority provided training to address some deficiencies. The hiring authority decided not to take action in response to the nurses' failures, deeming it an issue for sergeants and officers.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  Officers did not provide all required range of motion opportunities.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide the inmate access to hand hygiene after using the restroom and prior to meals on multiple occasions.
- **Did the department conduct required medical assessments?**
  Nurses did not conduct required medical assessments while on contraband surveillance watch.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not consistently provide the inmate proper hygiene or range of motion opportunities, or conduct required medical assessments.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to the involved captain, lieutenants, sergeants, and officers to to address the deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-28	2017-03-01	1. Drugs	1. Nothing

Incident Summary **17-15499-CW**

On February 28, 2017, the department placed an inmate on contraband surveillance watch after officers observed the inmate place an unknown object in his mouth and appear to have swallowed it. The department removed the inmate from contraband surveillance watch on March 1, 2017, one day later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not place the inmate on contraband surveillance watch in a timely manner and prematurely removed the inmate from contraband surveillance watch, neglected to obtain authorization to apply hand isolation devices, and did not consistently complete required documentation or provide the inmate with access to hand hygiene. The hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures when the inmate was placed on CSW?**
  The department placed the inmate on contraband surveillance watch almost one hour after officers observed the inmate appear to swallow suspected drugs.
- **Did application of Hand Isolation Devices comply with CSW policies and procedures?**
  The department placed the inmate in hand isolation devices without justification or the warden's or chief deputy warden's approval. The department identified the error and removed the hand isolation devices approximately two hours later.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide the inmate access to hand hygiene prior to meals and after using the restroom.
- **Did the department complete appropriate documentation?**
  Officers did not document the type of restraints used.
- **Did the department comply with policies and procedures governing the inmate's removal from CSW?**
  The hiring authority prematurely authorized removing the inmate from contraband surveillance watch within 24 hours of placement after noting the delayed placement may have allowed the inmate time to discard the contraband.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department delayed placing the inmate on contraband surveillance watch, did not complete adequate documentation, placed the inmate in hand isolation devices without approval, and removed the inmate from contraband surveillance watch before establishing a reasonable belief the inmate was contraband-free.
- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The department prematurely removed the inmate from contraband surveillance watch.
- **If the OIG identified a policy violation or issue that resulted in, or should have resulted in, corrective action, including training, did the department take corrective action or provide training?**
  The hiring authority did not agree that the department prematurely removed the inmate from contraband surveillance watch.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority identified the delayed placement on contraband surveillance watch and that officers did not adequately complete required documentation. The hiring authority provided training to lieutenants, sergeants, and officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-03-05	2017-03-09	1. Suspicious Activity	1. Drugs

Incident Summary **17-15506-CWRM**

On March 5, 2017, the department placed an inmate on contraband surveillance watch after officers observed the inmate place multiple unknown objects into his mouth and swallow them during a visit. While under constant observation, the inmate retrieved and re-ingested the suspected drugs. On March 8, 2017, the department transported the inmate to an outside hospital where the inmate remained on contraband surveillance watch and refused treatment. The department obtained a search warrant and physicians induced multiple bowel movements which revealed seven bindles and one empty bindle of suspected drugs. An x-ray revealed additional foreign objects. The inmate remained at the hospital and two additional bindles of suspected drugs were recovered. The department returned the inmate to the institution and removed him from contraband surveillance watch on March 9, 2017, four days after placement. During that time, the department recovered heroin from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-04-16	2017-04-19	1. Drugs	1. Drugs 2. Inmate Note

Incident Summary **17-15528-CW**

On April 16, 2017, the department placed an inmate on contraband surveillance watch because a body scan showed an object in the inmate's anal cavity and a sergeant recovered a bindle of methamphetamine and inmate notes from the inmate's mouth. The department removed the inmate from contraband surveillance watch on April 19, 2017, three days later. During that time, the department recovered no additional contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department retained the inmate on contraband surveillance watch longer than justified and did not consistently provide the inmate with range of motion opportunities, hand hygiene, or conduct required medical assessments. The hiring authority provided training to a captain, lieutenants, sergeants, and officers to address the deficiencies. The hiring authority decided not to take action in response to the nurses' failures, deeming it an issue for sergeants and officers.

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide the inmate with hygiene opportunities after restroom use and before meals.

- **Did the department conduct required medical assessments?**
  Nurses did not complete required medical assessments.

- **Did the department comply with policies and procedures governing the inmate's removal from CSW?**
  The department did not assess the inmate until after the fourth bowel movement instead of after the third bowel movement as policy requires.

- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not timely assess the inmate after bowel movements, causing the inmate to be on contraband surveillance watch one day longer than necessary. Officers did not consistently provide the inmate with range of motion opportunities or hand hygiene, and nurses neglected to conduct required medical assessments.

- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The OIG identified that the department retained the inmate on contraband surveillance watch longer than reasonably necessary. The hiring authority provided training to the involved captain, lieutenants, sergeants, and officers to address removal criteria.

- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority identified that officers did not adequately complete required documentation and provided training to sergeants and officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-04-23	2017-04-26	1. Suspicious Activity	1. Drugs

Incident Summary **17-15537-CW**

On April 23, 2017, the department placed an inmate on contraband surveillance watch after officers observed an unknown object fall from the inmates rectal area during an an unclothed body search. The department removed the inmate from contraband surveillance watch on April 26, 2017, three days later. During that time, the department recovered no additional contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not apply restraints, complete required documentation, or provide the inmate with proper hygiene. The department updated its local policies and procedures, and the hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures when the inmate was placed on CSW?**
  The department did not document placing the inmate on contraband surveillance watch.
- **Did application of restraints comply with CSW policies and procedures?**
  The department did not apply restraints.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not provide the inmate with proper hand hygiene or trash removal.
- **Did the department complete appropriate documentation?**
  Officers did not document application of restraints, that the inmate received required medical assessments, the inmate's activities for the duration of contraband surveillance watch, or placing the inmate on contraband surveillance watch.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not adequately document the incident.
- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The hiring authority updated its local operating procedures to include documentation requirements and expectations. The hiring authority also provided training to the chief deputy warden, associate wardens, captains, lieutenants, sergeants, and officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-04-30	2017-05-04	1. Drugs	1. Drugs

Incident Summary **17-15539-CWRM**

On April 30, 2017, the department placed an inmate on contraband surveillance watch after officers observed unknown objects being transferred between the inmate and his visitor during a kiss. On May 3, 2017, the department transported the inmate to an outside hospital, where the inmate remained on contraband surveillance watch, and obtained a search warrant. Physicians induced multiple bowel movements, and the department recovered bindles containing methamphetamine, marijuana, and heroin. On May 4, 2017, after an imaging scan showed no contraband, the department returned the inmate to the institution and removed him from contraband surveillance watch, four days after placement.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not notify the OIG of the inmate's removal from contraband surveillance watch or complete adequate documentation. The hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did the department complete appropriate documentation?**
  Officers did not document providing the inmate with trash removal and hand hygiene during two shifts.
- **Did the department comply with policies and procedures governing the inmate's removal from CSW?**
  The department did not notify the OIG when removing the inmate from contraband surveillance watch.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not notify the OIG when removing the inmate from contraband surveillance watch or complete adequate documentation.
- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The department did not notify the OIG when removing the inmate from contraband surveillance watch. The hiring authority provided training to the lieutenant.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The department identified that officers did not complete adequate documentation. The hiring authority provided training to officers and sergeants.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-04	2017-05-09	1. Suspicious Activity	1. Nothing

Incident Summary **17-15542-CWRM**

On May 4, 2017, the department placed an inmate on contraband surveillance watch after the inmate refused to submit to a metal detector and body search. The department removed the inmate from contraband surveillance watch on May 9, 2017, five days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not consistently provide the inmate proper hand hygiene, conduct cell inspections, restraint checks, and required searches, or document required medical assessments. The department provided training to address the deficiencies

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently afford the inmate the opportunity to wash his hands prior to meals and after using the restroom.
- **Did the department complete appropriate documentation?**
  The officers did not consistently document the inmate received required medical assessments.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not consistently provide the inmate proper hand hygiene, consistently conduct restraint checks, cell inspections, and required searches, or consistently document medical assessments.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to involved sergeants and officers to address the deficiencies.

North

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-11-30	2016-12-02	1. Suspicious Activity	1. Drugs 2. Other

Incident Summary **16-15443-CW**

On November 30, 2016, the department placed an inmate on contraband surveillance watch after an officer observed a clear lubricant around the inmate's anal cavity during an unclothed body search. On December 1, 2016, officers discovered three pieces of broken latex in the inmate's bowel movement and requested a medical evaluation. The department transported the inmate to an outside hospital after a nurse determined the inmate needed a higher level of care. The inmate returned to the institution the following day and remained on contraband surveillance watch until December 2, 2016. During that time, the department recovered synthetic cannabinoid from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not adequately notify the OIG when transferring the inmate to an outside hospital. The hiring authority provided training to administrative officers of the day to address this deficiency and provided training to officers to ensure that required documentation is completed.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  Officers did not provide the inmate with range of motion once out of four required times.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not provide the inmate with hand hygiene once out of four required times.
- **Did the department complete appropriate documentation?**
  Officers did not document providing the inmate with range of motion one time, hand hygiene one time, cell inspections, restraint checks, and 15-minute checks.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not notify the OIG when the department transferred the inmate to an outside hospital while on contraband surveillance watch.
- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The department did not notify the OIG when transferring the inmate to an outside hospital. The department provided training to administrative officers of the day to ensure proper notification is made to the OIG when the department transfers an inmate to an outside hospital.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The department provided training to officers to ensure that required documentation is completed.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-13	2016-12-17	1. Mobile Phone	1. Mobile Phone 2. Other

Incident Summary **16-15454-CWRM**

On December 13, 2016, the department placed an inmate on contraband surveillance watch after a metal detector indicated the presence of metal inside the inmate. The department removed the inmate from contraband surveillance watch on December 17, 2016, four days later after recovering a mobile phone, a phone adapter, and a charging cable from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-24	2016-12-28	1. Suspicious Activity	1. Nothing

Incident Summary **16-15460-CWRM**

On December 24, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an unknown object. The department removed the inmate from contraband surveillance watch on December 28, 2016, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-01-09	2017-01-14	1. Drugs	1. Nothing

Incident Summary **17-15466-CWRM**

On January 9, 2017, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow a bindle containing a white substance during a clothed body search. The department removed the inmate from contraband surveillance watch on January 14, 2017, five days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Sufficient**

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-08	2017-02-15	1. Suspicious Activity	1. Weapons 2. Drugs 3. Inmate Note

Incident Summary **17-15484-CWRM**

On February 8, 2017, the department placed an inmate on contraband surveillance watch after officers observed him swallow a suspected drug bindle during a cell search. The department removed the inmate from contraband surveillance watch on February 15, 2017, seven days later. During that time, the department recovered a weapon, methamphetamine, and inmate notes from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-14	2017-02-16	1. Drugs	1. Nothing

Incident Summary **17-15491-CW**

On February 14, 2017, the department placed an inmate on contraband surveillance after officers observed the inmate having convulsions. Officers transported the inmate to the triage and treatment area where the inmate admitted ingesting five bindles of methamphetamine. The department transported the inmate to an outside hospital where the inmate remained on contraband surveillance watch. The department removed the inmate from contraband surveillance watch on February 16, 2017, two days after placement, and the inmate returned from the outside hospital on February 17, 2017. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-22	2017-02-25	1. Suspicious Activity	1. Mobile Phone 2. Drugs

Incident Summary **17-15495-CWRM**

On February 22, 2017, the department placed an inmate on contraband surveillance watch because a metal detector indicated the presence of metal inside the inmate. The department removed the inmate from contraband surveillance watch on February 25, 2017, three days later. During that time, the department recovered marijuana and a mobile phone from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-03-03	2017-03-06	1. Suspicious Activity	1. Nothing

Incident Summary **17-15502-CWRM**

On March 3, 2017, the department placed an inmate on contraband surveillance watch after he made a spontaneous statement to the registered nurse stating that he was experiencing abdominal pains because he had secreted contraband in his rectum. The department removed the inmate from contraband surveillance watch on March 6, 2017, three days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-03-16	2017-03-19	1. Mobile Phone	1. Mobile Phone 2. Other

Incident Summary **17-15512-CWRM**

On March 16, 2017, the department placed an inmate on contraband surveillance because a metal detector indicated the presence of metal inside the inmate. The department removed the inmate from contraband surveillance watch on March 19, 2017, three days later. During that time, the department recovered a mobile phone and a phone charger from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-03-17	2017-03-23	1. Suspicious Activity	1. Inmate Note

Incident Summary **17-15514-CWRM**

On March 17, 2017, the department placed an inmate on contraband surveillance watch after an officer observed lubrication around the inmate's rectum and a low dose body scan showed a foreign object in the inmate's pelvic region. The department removed the inmate from contraband surveillance watch on March 23, 2017, six days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-04-20	2017-04-25	1. Suspicious Activity	1. Inmate Note

Incident Summary **17-15534-CWRM**

On April 20, 2017, the department placed an inmate on contraband surveillance watch after a low dose body scan revealed an object in his abdomen. The department removed the inmate from contraband surveillance watch on April 25, 2017, five days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers placed the inmate in leg restraints without authorization. The hiring authority provided training to address the deficiency.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  Officers placed the inmate in leg restraints for 13 hours without authorization.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Officers placed the inmate in leg restraints without authorization.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority identified that officers placed leg restraints on the inmate without authorization and provided training to the officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-04-22	2017-04-26	1. Suspicious Activity	1. Drugs

Incident Summary **17-15535-CWRM**

On April 22, 2017, the department placed an inmate on contraband surveillance watch after officers observed lubricant in the inmate's rectal area during an unclothed body search. The department removed the inmate from contraband surveillance watch on April 26, 2017, four days later. During that time, the department recovered two bindles of amphetamine and opiates from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-01	2017-05-08	1. Suspicious Activity	1. Other

Incident Summary **17-15541-CWRM**

On May 1, 2017, the department placed an inmate on contraband surveillance watch after officers observed the inmate place unknown objects into his rectal area. The department removed the inmate from contraband surveillance watch on May 8, 2017, seven days later. During that time, the department recovered a label from a mobile-phone data card from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not consistently provide the inmate the opportunity for hand hygiene, conduct inmate welfare checks, or complete adequate documentation. The department provided training to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not provide the inmate hand hygiene opportunity before meals on 8 of the required 21 times.
- **Did the department complete appropriate documentation?**
  Officers did not document providing the inmate hand hygiene opportunity before meals on 8 of the required 21 times. Sergeants did not document conducting inmate welfare checks on 5 of the required 21 times.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Officers did not provide the inmate adequate opportunity for hand hygiene and did not document the issuance and removal of a mattress and blanket on one occasion. Sergeants did not conduct inmate welfare checks on 5 of the required 21 times.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority identified that officers did not document inmate hygiene, trash removal, and the issuance and removal of a mattress and blanket. Additionally, sergeants did not conduct required inmate welfare checks. The hiring authority provided training to the involved lieutenants, sergeants, and officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-09	2017-05-14	1. Drugs	1. Drugs

Incident Summary **17-15549-CWRM**

On May 9, 2017, the department placed an inmate on contraband surveillance watch after officers discovered heroin during a cell search. Officers attempted to conduct an unclothed body search but the inmate refused to lift his tongue and was observed swallowing. The inmate remained on contraband surveillance watch until May 14, 2017, five days later. During that time, the department recovered additional heroin from the inmate.

Incident Assessment **Sufficient**

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-10	2017-05-11	1. Drugs	1. Drugs

Incident Summary **17-15552-CW**

On May 4, 2017, the department transported an inmate to an outside hospital after the inmate admitted to an officer swallowing two bindles of methamphetamine. On May 10, 2017, the department placed the inmate on contraband surveillance watch while at the outside hospital after an x-ray confirmed the presence of a foreign object. The department removed the inmate from contraband surveillance watch and returned the inmate to the institution on May 11, 2017, one day later. During that time, the department recovered two bindles of suspected methamphetamine from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-24	2017-05-29	1. Suspicious Activity	1. Inmate Note

Incident Summary **17-15560-CWRM**

On May 24, 2017, the department placed an inmate on contraband surveillance watch after the inmate failed to pass a metal detector. The department removed the inmate from contraband surveillance watch on May 29, 2017, five days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

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Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-11-18	2016-11-22	1. Drugs	1. Drugs

Incident Summary **16-15433-CWRM**

On November 17, 2016, an inmate reported swallowing heroin and having chest pains. The department transported the inmate to an outside hospital. On November 18, 2016, an x-ray revealed a foreign object in the inmate's abdomen and the department placed the inmate on contraband surveillance watch. The inmate returned to the institution on November 21, 2016, and the department removed him from contraband surveillance watch on November 22, 2016. During that time, the department recovered methamphetamine from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-11-26	2016-12-01	1. Drugs	1. Nothing

Incident Summary **16-15437-CWRM**

On November 26, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate with lubricant around his anal cavity during an unclothed body search. The department removed the inmate from contraband surveillance watch on December 1, 2016, five days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately provide or document hand hygiene. The hiring authority provided training and issued a memorandum to all custody staff to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers provided the inmate with hand hygiene prior to meals or after using the restroom 10 of the 17 required times.
- **Did the department complete appropriate documentation?**
  Officers did not adequately document hand hygiene.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Officers did not adequately provide hand hygiene.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to lieutenants and sergeants and issued a memorandum to all custody staff regarding documentation requirements.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-11-27	2016-12-03	1. Drugs	1. Nothing

Incident Summary **16-15439-CWRM**

On November 27, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate with lubricant around his anal cavity during an unclothed body search. The department removed the inmate from contraband surveillance watch on December 3, 2016, six days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately provide or document range of motion releases or hand hygiene. The hiring authority provided training and issued a memorandum to all custody staff to address the deficiencies.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  Officers provided the inmate with range of motion releases 9 of the 11 required times and did not document the duration of the release four times.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers provided the inmate with hand hygiene before meals or after using the restroom 17 of the 28 required times.
- **Did the department complete appropriate documentation?**
  Officers did not adequately document hand hygiene or range of motion releases.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Officers did not adequately provide range of motion or hand hygiene.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to lieutenants and sergeants and issued a memorandum to all custody staff regarding requirements for hygiene and range of motion releases.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-12	2016-12-16	1. Drugs	1. Nothing

Incident Summary **16-15453-CWRM**

On December 12, 2016, the department placed an inmate on contraband surveillance watch after the inmate told a nurse that he swallowed a bindle containing possible narcotics and had stomach pains. The department removed the inmate from contraband surveillance watch on December 16, 2016, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-18	2016-12-24	1. Drugs	1. Drugs

Incident Summary **16-15457-CWRM**

On December 18, 2016, the department placed an inmate on contraband surveillance watch after officers saw the inmate swallow suspected drug bindles during visiting. The department removed the inmate from contraband surveillance watch on December 24, 2016, six days later after recovering marijuana from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-31	2017-01-04	1. Drugs	1. Nothing

Incident Summary **16-15462-CWRM**

On December 31, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate reach into his pants, place something in his mouth, and swallow. The department removed the inmate from contraband surveillance watch on January 4, 2017, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-01-01	2017-01-10	1. Drugs	1. Drugs

Incident Summary **17-15463-CWRM**

On January 1, 2017, the department placed an inmate on contraband surveillance watch because an officer saw the inmate swallow an unknown item from a bag during visiting. The department removed the inmate from contraband surveillance watch on January 10, 2017, nine days later. During that time, the department recovered heroin from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not consistently provide range of motion releases or hand hygiene and did not complete adequate documentation. The hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  Officers did not consistently provide range of motion releases.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide the inmate the opportunity to wash his hands after using the restroom and before meals.
- **Did the department complete appropriate documentation?**
  Officers did not adequately document the results of bowel movements, hand hygiene, range of motion, or blanket issuance and removal.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Officers did not consistently provide range of motion releases or hand hygiene and did not complete adequate documentation.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to officers regarding hygiene, range of motion, bowel movement results, and blanket issuance.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-01-22	2017-01-25	1. Drugs	1. Drugs

Incident Summary **17-15472-CWRM**

On January 22, 2017, the department placed an inmate on contraband surveillance watch after an officer discovered the inmate with a bag containing 17 bindles of suspected drugs. The inmate later complained of stomach pain, and the department transported him to an outside hospital, where the inmate remained on contraband surveillance watch. On January 25, 2017, the inmate returned to the institution, and the department removed him from contraband surveillance watch. During that time, the department recovered heroin and methamphetamine from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately provide or document hygiene or range of motion. The department provided training to address the deficiencies.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  Officers provided the inmate with range of motion releases only four of the required seven times.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers provided the inmate with hand hygiene before meals or after using the restroom 35 of the required 53 times.
- **Did the department complete appropriate documentation?**
  Officers did not adequately document range of motion or hand hygiene.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Officers did not adequately provide range of motion or hand hygiene.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to officers regarding range of motion and inmate hygiene and provided training to a sergeant for not communicating the status of the inmate to the watch commander during one shift.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-01-28	2017-02-02	1. Suspicious Activity	1. Nothing

Incident Summary **17-15475-CWRM**

On January 28, 2017, the department placed an inmate on contraband surveillance watch after the inmate told officers he swallowed razor blades, and an x-ray at an outside hospital revealed a foreign object in the inmate's abdomen. On January 29, 2017, the inmate returned to the institution and remained on contraband surveillance watch. On February 2, 2017, the department transported the inmate to an outside hospital and removed the inmate from contraband surveillance watch after a negative x-ray. The department recovered no contraband from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-05	2017-02-10	1. Drugs	1. Drugs

Incident Summary **17-15481-CWRM**

On February 5, 2017, the department placed an inmate on contraband surveillance watch after officers discovered bindles of drugs in a bag from which the inmate was eating in the visiting room. On February 7, 2017, the department transported the inmate to an outside hospital, where the inmate remained on contraband surveillance watch, after the inmate complained of stomach pain. The department returned the inmate to the institution on February 9, 2017, and removed the inmate from contraband surveillance watch on February 10, 2017. During that time, the department recovered marijuana from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not consistently provide range of motion or hand hygiene, remove trash, or issue a blanket, and did not complete adequate documentation. The hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  Officers provided the inmate with range of motion releases only six of the required ten times.
- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers provided the inmate with hand hygiene before meals or after using the restroom only 24 of the required 39 times.
- **Did the department complete appropriate documentation?**
  Officers did not adequately document hand hygiene, range of motion, trash removal, or blanket issuance.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  Officers did not consistently provide range of motion releases or hand hygiene, remove trash, or issue and remove the inmate's blanket.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to sergeants and officers regarding the requirements for hand hygiene, range of motion, trash removal, and blanket issuance.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-21	2017-02-24	1. Drugs	1. Drugs

Incident Summary **17-15492-CWRM**

On February 21, 2017, the department placed an inmate on contraband surveillance watch after officers found a substance on the inmate's hands and buttocks during an unclothed body search. The department removed the inmate from contraband surveillance watch on February 24, 2017, three days later. During that time, the department recovered three bindles with an unknown substance from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch because the department did not timely notify the OIG when placing the inmate on contraband surveillance watch. The department provided training to a lieutenant to address the late notification.

Assessment Questions

- **Did the department timely notify the OIG Regional AOD when the inmate was placed on CSW?**
  The department did not notify the OIG until two hours and ten minutes after placing the inmate on contraband surveillance watch.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not timely notify the OIG.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to a lieutenant regarding notification protocols.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-02-24	2017-02-24	1. Drugs	1. Drugs 2. Other 3. Mobile Phone 4. Tobacco

Incident Summary **17-15496-CW**

On February 23, 2017, officers discovered tobacco, heroin, a mobile phone, a phone charger, mobile-phone data cards, and syringes during a cell search. The department transported the inmate to an outside hospital after a body scan revealed a foreign object in the inmate's abdomen. While at the outside hospital, the inmate voluntarily relinquished one bindle of tobacco. On February 24, 2017, the department returned the inmate to the institution and placed the inmate on contraband surveillance watch after an x-ray revealed an additional foreign object. While on contraband surveillance watch, the department returned the inmate to the outside hospital, where a physician removed plastic material from the inmate. The department removed the inmate from contraband surveillance watch at the hospital and returned the inmate to the institution the same day. The department recovered no additional contraband from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not adequately notify the OIG. Officers applied hand isolation devices without proper authorization and did not consistently provide the inmate with hand hygiene or complete adequate documentation. The hiring authority provided training to address some of the deficiencies.

Assessment Questions

- **Did the department timely notify the OIG Regional AOD when the inmate was placed on CSW?**
  The department did not notify the OIG until three hours after placing the inmate on contraband surveillance watch.
- **Did the department comply with policies and procedures when the inmate was placed on CSW?**
  Officers did not conduct an initial unclothed body search.
- **Did application of Hand Isolation Devices comply with CSW policies and procedures?**
  The department placed the inmate in hand isolation devices without proper authorization.
- **Did the department complete appropriate documentation?**
  Officers did not document an initial unclothed body search or adequately document hand hygiene or supervisory checks.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not timely notify the OIG of the placement on contraband surveillance watch and failed to notify the OIG after transporting the inmate to an outside hospital. Officers placed the inmate in hand isolation devices without authorization and did not conduct an initial unclothed body search, consistently provide inmate hygiene, or adequately document the incident.
- **Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?**
  The OIG identified deficiencies in hand hygiene and supervisory checks.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to an associate warden for not obtaining authorization from the warden or chief deputy warden prior to placing the inmate in hand isolation devices.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-03-19	2017-03-22	1. Drugs	1. Drugs

Incident Summary **17-15517-CWRM**

On March 19, 2017, the department placed an inmate on contraband surveillance watch after officers observed an unknown object protruding from the inmate's rectum during an unclothed body search. On March 20, 2017, the department transported the inmate to an outside hospital after the inmate complained of abdominal pain. The department removed the inmate from contraband surveillance watch on March 22, 2017, and returned the inmate to the institution on March 23, 2017. During that time, the department recovered marijuana from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately document the incident, and the department did not timely inform officers of the decision to remove the inmate from contraband surveillance watch. The hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures governing hygiene requirements?**
  Officers did not consistently provide hand and restraint hygiene.
- **Did the department complete appropriate documentation?**
  Officers did not consistently complete the required activity log or adequately document hand and restraint hygiene.
- **Did the department comply with policies and procedures governing the inmate's removal from CSW?**
  The department did not inform officers monitoring the inmate at the outside hospital until eight hours after a captain authorized ending the contraband surveillance watch.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department transported the inmate to an outside hospital without notifying the OIG and did not timely inform officers of the authorization to end contraband surveillance watch. Officers did not adequately complete required documentation.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to lieutenants, sergeants, and officers to address the documentation deficiencies and lack of communication regarding the termination of contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-03-25	2017-03-25	1. Drugs	1. Drugs

Incident Summary **17-15518-CW**

On March 25, 2017, the department placed an inmate on contraband surveillance watch after officers observed the inmate retrieve an unknown item from his visitor and place it in his pants. The department removed the inmate from contraband surveillance watch the same day and recovered heroin and marijuana from the inmate.

Incident Assessment **Sufficient**

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-04-15	2017-04-15	1. Drugs	1. Other

Incident Summary **17-15527-CW**

On April 15, 2017, the department placed an inmate on contraband surveillance watch after officers observed an object concealed in the inmate's buttocks during an unclothed body search. The department removed the inmate from contraband surveillance watch the same day, after recovering a syringe from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not obtain proper authorization for using hand isolation devices, complete adequate documentation, or timely tape the inmate's jumpsuit. The hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did the department comply with policies and procedures when the inmate was placed on CSW?**
  Officers did not tape the inmate's jumpsuit in a timely manner after suspecting the inmate possessed contraband.
- **Did application of Hand Isolation Devices comply with CSW policies and procedures?**
  Neither the warden nor chief deputy warden approved the application of hand isolation devices. Instead, the administrative officer of the day approved application of the devices.
- **Did the department complete appropriate documentation?**
  Officers did not document the incident on all required forms.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not adequately notify the OIG, officers did not timely tape the inmate's jumpsuit, and the department failed to obtain proper authorization for using hand isolation devices.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to an associate warden regarding the proper authorization for hand isolation devices and to a sergeant and officers regarding the timely application of tape and proper documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-04-16	2017-04-18	1. Drugs	1. Drugs

Incident Summary **17-15526-CW**

On April 16, 2017, the department placed an inmate on contraband surveillance watch after officers observed an inmate receive an unknown item from his visitor while kissing. The department removed the inmate from contraband surveillance watch on April 18, 2017, two days later. During that time, the department recovered marijuana from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-05	2017-05-09	1. Suspicious Activity	1. Drugs 2. Inmate Note

Incident Summary **17-15544-CWRM**

On May 5, 2017, the department placed an inmate on contraband surveillance watch after the inmate refused to pass through the low-dose scanner and a subsequent unclothed body search revealed the inmate had an enlarged rectum. On May 6, 2017, the department transported the inmate to an outside hospital after the inmate complained of abdominal pain and nausea. The inmate returned to the institution the same day, and the department removed the inmate from contraband surveillance watch on May 9, 2017. During that time, the department recovered two inmate notes and heroin from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-06	2017-05-11	1. Drugs	1. Drugs

Incident Summary **17-15545-CWRM**

On May 6, 2017, the department placed an inmate on contraband surveillance watch after officers found bindles of suspected drugs in a bag from which the inmate was eating during a visit. The department removed the inmate from contraband surveillance watch on May 11, 2017, five days later. During that time, the department recovered marijuana from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-14	2017-05-16	1. Drugs	1. Drugs

Incident Summary **17-15554-CW**

On May 14, 2017, the department placed an inmate on contraband surveillance watch after officers observed a visitor pass a bindle to the inmate during a kiss. The department transported the inmate to an outside hospital the same day for observation. On May 16, 2017, the department removed the inmate from contraband surveillance watch and returned the inmate to the institution. During that time, the department recovered heroin from the inmate.

Incident Assessment **Sufficient**

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-20	2017-05-22	1. Drugs	1. Drugs

Incident Summary **17-15558-CW**

On May 20, 2017, the department placed an inmate on contraband surveillance watch after officers discovered the inmate's visitor with bindles of suspected drugs and an x-ray revealed a foreign object in the inmate's abdominal area. The department transported the inmate to an outside hospital and returned the inmate to the institution the same day. The inmate remained on contraband surveillance watch until May 22, 2017. During that time, the department recovered marijuana from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not notify the OIG when transferring the inmate to an outside hospital, and officers did not adequately complete required forms. The hiring authority provided training to officers to regarding documentation requirements.

Assessment Questions

- **Did the department complete appropriate documentation?**
  Officers did not thoroughly document inmate activities on the new form pertaining to unrestrained contraband surveillance watch.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department did not notify the OIG when transferring the inmate to an outside hospital, and officers did not completely document the incident on required forms.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to officers regarding documentation requirements.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2017-05-28	2017-05-30	1. Drugs	1. Drugs

Incident Summary **17-15562-CW**

On May 28, 2017, the department placed an inmate on contraband surveillance watch after an x-ray showed a foreign object in the inmate's abdominal area and the inmate told officers he swallowed drugs. The department removed the inmate from contraband surveillance watch on May 30, 2017, two days later. During that time, the department recovered methamphetamine from the inmate.

Incident Assessment **Insufficient**

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department placed the inmate in mechanical restraints without proper authorization and did not document the justification. The hiring authority provided training to address the deficiencies.

Assessment Questions

- **Did application of restraints comply with CSW policies and procedures?**
  The department did not obtain proper authorization to place the inmate in restraints.
- **Did the department complete appropriate documentation?**
  The department did not document the justification to place the inmate in restraints.
- **Overall, did the department substantially comply with CSW policies and procedures?**
  The department placed the inmate in restraints without proper authorization and did not document the justification.
- **Did the hiring authority identify a policy violation or issue and take corrective action, including training?**
  The hiring authority provided training to an associate warden, a captain, and a lieutenant regarding restraint procedures.

Appendix G
Field Inquiry Cases

Central

Contact Date	OIG Case Number	Case Type
2016-03-29	16-0011711-FI	Field Inquiry

Incident Summary
On March 29, 2016, an inmate's mother submitted a complaint to the OIG alleging an officer sexually assaulted her son on March 22, 2016. She also alleged the department retaliated against the inmate when he attempted to report the alleged sexual assault.

Disposition
The hiring authority conducted an inquiry and did not identify any staff misconduct. The OIG identified concerns regarding the incident reports and recommended custody and medical staff write objective reports without demeaning comments. The hiring authority agreed and provided training. The OIG also recommended replacing an outdated inmate complaint form with the current form. The institution agreed and changed its policy to require the use of appropriate forms. The hiring authority also agreed that all future sexual assault allegations will be timely reported to the OIG.

Overall Assessment **Rating: Insufficient**
The department did not sufficiently address the matter because it did not timely respond to the OIG's request for an inquiry.

Contact Date	OIG Case Number	Case Type
2016-08-15	16-0012414-FI	Field Inquiry

Incident Summary
On August 15, 2016, an inmate submitted a complaint to the OIG alleging another inmate and an officer engaged in an overly familiar relationship.

Disposition
The hiring authority conducted an inquiry and did not identify any staff misconduct.

Overall Assessment **Rating: Sufficient**
The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-11-03	16-0012465-FI	Field Inquiry

Incident Summary
On November 3, 2016, an inmate submitted a complaint to the OIG alleging that officers were overly intrusive while conducting random drug testing.

Disposition
The hiring authority conducted an inquiry and did not identify any staff misconduct.

Overall Assessment **Rating: Sufficient**
The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-11-17	16-0012593-FI	Field Inquiry

Incident Summary

On November 17, 2016, an inmate submitted a complaint to the OIG alleging a lieutenant was providing confidential sexual assault investigation information to other inmates.

Disposition

The hiring authority identified potential staff misconduct based on the lieutenant's alleged providing of confidential sexual assault investigation information to inmates. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-12-14	17-0021684-FI	Field Inquiry

Incident Summary

On December 14, 2016, an inmate submitted a complaint to the OIG alleging an appeals coordinator failed to respond to three complaints the inmate submitted and rejected a fourth complaint the inmate submitted against the same appeals coordinator.

Disposition

The hiring authority initiated an inquiry and determined the inmate complaint against the appeals coordinator was previously forwarded to the hiring authority who determined there was no misconduct. The hiring authority directed that custody staff receive training regarding the timely handling of inmate complaints against staff.

Overall Assessment **Rating: Sufficient**

Overall, the department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2017-02-17	17-0021909-FI	Field Inquiry

Incident Summary

On February 17, 2017, an inmate submitted a complaint to the OIG raising concerns for his safety if he were transferred from the administrative segregation unit to the general population, claiming the institution did not address his concerns during a classification review.

Disposition

The hiring authority determined the inmate's safety concerns may not have been previously considered and took steps to ensure the information was considered at the inmate's next classification review.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2017-02-24	17-0022213-FI	Field Inquiry

Incident Summary

On February 24, 2017, an inmate submitted a complaint to the OIG alleging that inmate complaint forms were not available in the housing unit.

Disposition

The OIG conducted an unannounced visit to the inmate's housing unit and found that inmate complaint forms are located on the unit. However, the forms are kept in an office where inmates are not permitted. Policy requires complaint forms to be readily available. In response to the complaint, the institution changed its procedures to ensure all inmate complaint forms are moved to an area readily accessible to inmates in each housing unit.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

North

Contact Date	OIG Case Number	Case Type
2015-03-19	15-0000597-FI	Field Inquiry

Incident Summary
On March 19, 2015, an inmate submitted a complaint to the OIG alleging the department falsely identified him as an associate of a security threat group.

Disposition
The hiring authority conducted an inquiry and determined the department never validated the inmate as an associate of a security threat group. The hiring authority did not identify any staff misconduct.

Overall Assessment **Rating: Sufficient**
The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-07-25	16-0011869-FI	Field Inquiry

Incident Summary
On July 25, 2016, an inmate submitted a complaint to the OIG alleging an officer used unreasonable force on him.

Disposition
The OIG identified that the department did not acknowledge or act upon the inmate's written request to postpone a rules violation hearing, and the hearing officer may not have properly considered the inmate's mental health status. The department provided the inmate with an additional rules violation hearing and a mental health assessment. The hiring authority did not identify any staff misconduct.

Overall Assessment **Rating: Sufficient**
The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-08-23	16-0012023-FI	Field Inquiry

Incident Summary
On August 23, 2016, a lieutenant submitted a complaint to the OIG alleging another lieutenant was harassing him.

Disposition
The hiring authority took appropriate managerial action to address the lieutenant's concerns.

Overall Assessment **Rating: Sufficient**
The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-08-25	16-0012020-FI	Field Inquiry

Incident Summary

On August 25, 2016, a legislative staff member submitted a complaint to the OIG because a ward's mother alleged her son was attacked three times in school, the facility was not addressing his safety concerns, and he was being retaliated against for not attending school by being forced to sit in the bathroom while school was in session.

Disposition

Prior to the OIG's inquiry, the hiring authority conducted an inquiry into the concerns expressed by the ward's mother. The hiring authority also ended the practice of temporarily placing wards in the bathroom.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-08-26	16-0012029-FI	Field Inquiry

Incident Summary

On August 26, 2016, a foreign consulate submitted a complaint to the OIG regarding an inmate's allegation that officers assaulted him during a use-of-force incident.

Disposition

The institution's executive review committee determined the use of force complied with policy. At the OIG's recommendation, the department attempted to interview the inmate, but the inmate refused. The OIG concurred with the hiring authority's actions.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-09-21	16-0012293-FI	Field Inquiry

Incident Summary

On September 21, 2016, an inmate submitted a complaint to the OIG alleging the hiring authority failed to investigate allegations of sexual misconduct by an officer perpetrated against him and other inmates.

Disposition

The department provided Prison Rape Elimination Act training to the lieutenant, provided locally designated investigation training to all investigative services unit staff, and made staffing changes.

Overall Assessment **Rating: Insufficient**

The department failed to sufficiently resolve the matter because the department did not initiate a Prison Rape Elimination Act inquiry and complete the review in a timely manner.

Contact Date	OIG Case Number	Case Type
2016-09-28	16-0012294-FI	Field Inquiry

Incident Summary

On September 28, 2016, an inmate's mother submitted a complaint to the OIG alleging an officer kicked her son several times in the head after he fell on the floor.

Disposition

The hiring authority conducted an inquiry and did not identify any staff misconduct.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-10-17	16-0012756-FI	Field Inquiry

Incident Summary

On October 17, 2016, an inmate submitted a complaint to the OIG alleging the department failed to investigate his allegations of sexual harassment by officers.

Disposition

The hiring authority conducted an inquiry regarding the allegations, made a staffing change, and provided locally designated investigator training to the investigative services unit. The hiring authority did not identify any staff misconduct.

Overall Assessment **Rating: Insufficient**

The department did not sufficiently address the matter because the institution delayed referring the matter to the investigative services unit to implement Prison Rape Elimination Act policies and procedures.

Contact Date	OIG Case Number	Case Type
2016-12-09	17-0012906-FI	Field Inquiry

Incident Summary

On December 9, 2016, an inmate's mother submitted a complaint to the OIG alleging the department harassed and racially discriminated against the inmate and improperly placed him in the administrative segregation unit after food he threw near a trash can splattered on an officer.

Disposition

The OIG identified that an officer, sergeant, lieutenant, and appeals coordinator who participated in processing the rules violation report may have failed to identify that the inmate complained of unreasonable use of force and rejected the inmate's appeals for lack of documentation without clearly identifying missing documents or actions the inmate needed to take to have the appeal processed. The OIG also identified that the institution placed the inmate in the administrative segregation unit for a seemingly excessive term after the food splattered on the officer. In response to the OIG's field inquiry, the hiring authority conducted an inquiry and found the lieutenant had identified the inmate's unreasonable use-of-force allegation and conducted a video-recorded interview of the inmate. However, the interview was untimely and the documentation not appropriately processed. The hiring authority provided training to the officer, lieutenant, appeals coordinator, and a captain.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-12-20	16-0012840-FI	Field Inquiry

Incident Summary

On December 20, 2016, an inmate's spouse submitted a complaint to the OIG alleging an officer engaged in a sexual relationship with the inmate.

Disposition

The hiring authority conducted an inquiry pursuant to the Prison Rape Elimination Act and determined the allegation was unfounded.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-12-20	17-0012907-FI	Field Inquiry

Incident Summary

On December 20, 2016, an inmate submitted a complaint to the OIG alleging officers were bringing contraband into the institution for inmates and allowing inmates to steal from the supply closet with the knowledge of psychologists.

Disposition

The hiring authority conducted an inquiry and did not identify any staff misconduct.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-12-21	17-0013062-FI	Field Inquiry

Incident Summary

On December 21, 2016, an inmate submitted a complaint to the OIG alleging that inmate complaint forms were not available in the administrative segregation unit.

Disposition

The OIG conducted an unannounced visit to the administrative segregation unit and found that inmate complaint forms were available on the unit.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2017-01-18	17-0013064-FI	Field Inquiry

Incident Summary

On January 18, 2017, an anonymous individual submitted a complaint to the OIG alleging a teacher was committing fraud by taking a leave of absence during the ten-month period in which his teaching credential was suspended and that both the warden and education supervisor approved the leave of absence even though they were aware the teacher was being suspended for the same period. Furthermore, even though the teacher's credential was suspended, the teacher allegedly continued teaching at the institution.

Disposition

The OIG discovered the department hired the teacher even though a prior employer suspended him for improper contact with a student and, at the time of hire with the department, the teacher was subject to another pending investigation regarding similar alleged misconduct. The department terminated the teacher's leave of absence, following which the teacher resigned. The department also established procedures to ensure it maintains accurate information regarding the status of its teachers' credentials to prevent hiring individuals without valid credentials and to appropriately address those teachers whose credentials are suspended after hire.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2017-02-23	17-0022217-FI	Field Inquiry

Incident Summary

On February 23, 2017, an attorney submitted a complaint to the OIG alleging the department was not processing an inmate's legal mail.

Disposition

The hiring authority determined that the department's mail procedure was being followed.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2017-03-20	17-0022339-FI	Field Inquiry

Incident Summary

On March 20, 2017, an inmate submitted a complaint to the OIG alleging an officer denied inmates access to cleaning supplies which placed the inmates at risk for colds and an influenza outbreak.

Disposition

The department verified inmates were provided disinfectant to clean their cells and inmate porters cleaned the building.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIGs field inquiry.

South

Contact Date	OIG Case Number	Case Type
2015-05-18	17-0022341-FI	Field Inquiry

Incident Summary

On May 18, 2015, an inmate submitted a complaint to the OIG alleging two officers were using unnecessary force on inmates, being discourteous, and violating the Prison Rape Elimination Act.

Disposition

The hiring authority conducted an inquiry and found insufficient evidence to support the allegations.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-05-23	17-0013061-FI	Field Inquiry

Incident Summary

On May 23, 2016, an inmate's mother submitted a complaint to the OIG alleging officers failed to provide the inmate a receipt for property confiscated during a cell search, officers did not issue a rules violation report to the cellmate, and the inmate was denied the right to call witnesses during the rules violation hearing.

Disposition

In response to the OIG's inquiry, the hiring authority reviewed the matter and determined the inmate received a receipt for confiscated property in the form of the rules violation report, the inmate was allowed to call witnesses to testify, and forensic examination of the mobile phone supported the rules violation report against the inmate, not the cellmate.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-06-30	16-0011634-FI	Field Inquiry

Incident Summary

On June 30, 2016, an inmate submitted a complaint to the OIG alleging a substance abuse counselor brought contraband into the institution, engaged in sexual relations with another inmate, threatened to have other inmates kill him if he reported the misconduct, and that the other inmates falsely accused him of making threats, which resulted in his placement in the administrative segregation unit.

Disposition

The hiring authority conducted an inquiry and did not identify any staff misconduct.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-07-20	16-0012028-FI	Field Inquiry

Incident Summary

On July 20, 2016, an inmate submitted a complaint to the OIG alleging an officer worked in the inmate's housing unit in violation of a staff separation alert and the institution took no action on the inmate's complaint against the officer.

Disposition

The hiring authority conducted an inquiry and determined the officer had no contact with the inmate and there was no violation of the separation protocol.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-09-12	16-0012292-FI	Field Inquiry

Incident Summary

On September 12, 2016, an advocacy group submitted a complaint alleging that an inmate suffered serious bodily injury after she was assaulted by another inmate and, therefore, the matter should have been referred to the district attorney's office for possible prosecution.

Disposition

The investigative services unit investigated the matter and referred the case to the district attorney's office, which declined to prosecute.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-11-28	17-0021903-FI	Field Inquiry

Incident Summary

On November 28, 2016, an inmate submitted a complaint to the OIG alleging personnel in the inmate appeals office rejected his complaints as untimely without considering delays caused by departmental mail processing and because his complaints were against personnel in the inmate appeals office.

Disposition

The institution changed its policy to require notification to the hiring authority before rejecting appeals as untimely and to require complaints about appeals office personnel to be routed to the hiring authority for resolution.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-12-21	16-0012848-FI	Field Inquiry

Incident Summary

On December 21, 2016, an anonymous individual submitted a complaint to the OIG alleging an officer is introducing mobile phones and other contraband into an institution.

Disposition

The hiring authority conducted an inquiry and was unable to verify any of the information.

Overall Assessment **Rating: Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SEMI-ANNUAL REPORT

January – June 2017

Volume II

OFFICE OF THE INSPECTOR GENERAL

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STATE OF CALIFORNIA
August 2017