Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

July–December 2016

Volume II

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Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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Foreword

This 24th Semi-Annual Report covers the time period of July through December 2016. 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. The OIG has also been tracking attempted suicides for the female institutions, as well as suicides, within the department. This report summarizes the OIG's monitoring and tracking activities to provide the reader an overview of OIG monitoring activities, as well as to summarize the monitored incidents in the Appendices attached hereto. This 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 July through December 2016 reporting period.

The OIG maintains a 24-hour contact number in each region to receive notifications and 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.

The highest monitoring priority among critical incidents is use of deadly force. 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.

When CDCR suspects an inmate has secreted contraband, the department may place the inmate on contraband surveillance watch. As outlined below, 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 is reporting 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, either by responding to the scene of the incident or by obtaining incident reports and following up at the scene at a later time. The OIG evaluates what may have caused the incident, the department's response to it, and whether there may be 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 upcoming Semi-Annual Report. However, if an investigation is initiated, the Inspector General may decide to withhold a report until the investigation is completed if reporting could jeopardize the investigation.

During this reporting period, the OIG completed assessments of 107 critical incidents, reported in Appendices D and E. Sixteen of these incidents involved full investigations of use of deadly force. Those 16 incidents are not included in the critical incident statistics, but the OIG's assessments are in Appendix D2.

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 and each incident may be sufficient or insufficient in more than one phase. Of the 91 cases reported in Appendices D1 and E, 20 cases pertain to attempted suicide incidents within female institutions. These cases are reported only for informational purposes. The OIG does not presume to assess the department's mental health care, which is currently under a federal court-appointed special master. Of the remaining 71 cases, the OIG assessed 52 percent as insufficient in at least one of the assessment ratings. In two cases, the department's actions were insufficient in all three phases, before, during, and after the incident. The details regarding the assessments are found in the Appendices.

In order to monitor an incident at the scene, the OIG relies on the department to provide timely notification of the critical incident. However, even when notification is untimely, the OIG still monitors the event by collecting reports and conducting follow-up reviews. For cases reported during this period in Appendices D1 and E, the department failed to provide timely notification of 16 of the 91 critical incidents, which is 18 percent. This is a slight improvement over the delayed notifications reported during the prior reporting period, during which time 20 percent were deemed untimely. Four of the cases with untimely notification were still assessed as sufficient for all three assessment ratings. Two of the sixteen cases involving delayed notification involved discharge of a firearm, including one in which the department provided the OIG with inaccurate information regarding the incident location. The OIG deemed this case insufficient partially due to this misinformation. CDCR administration previously agreed to emphasize timely notification. The improvement is a positive trend, which we look forward to continuing.

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 or more difficult cases.

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

PRISON RAPE ELIMINATION ACT (PREA) 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 an investigation or, if there were criminal allegations, to refer the case to a district attorney's office. There was no mechanism for the institution to perform a preliminary inquiry into the allegation. Institutional staff referred cases to the Office of Internal Affairs, which then 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 regarding preventing, detecting, responding to, and investigating offender sexual violence, staff sexual misconduct, and sexual harassment, with additional training for staff who perform specialized roles in the PREA process. Institutions are required to take specified preventative measures to minimize staff 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 and the policy provides methods for inmates, staff, and third parties to report sexual abuse and harassment by other inmates or staff.

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 the information gathered indicates a reasonable belief that staff misconduct occurred, the hiring authority refers the matter to the Office of Internal Affairs for an investigation.

Alleged victims are entitled to a victim advocate and a victim support person. A victim advocate is a trained person typically employed by a rape crisis center whose primary purpose is to give advice and assistance to sexual assault victims. A victim support person is any person of the alleged victim's choosing. The victim advocate and victim support person may be present during

any medical examinations and interviews, with some restrictions. The department also performs a suicide risk assessment and offers the alleged victim mental health treatment in accordance with detailed policies.

The policy provides additional guidance for handling parolee reports of alleged sexual misconduct by other parolees or staff. The policy contains additional protections to guard against retaliation against inmates or parolees who report sexual violence or staff sexual misconduct. Each institution must have a PREA Compliance Manager who coordinates efforts to comply with the CDCR Prison Rape Elimination Policy. Hiring authorities must also review allegations that have been substantiated.

There are also additional requirements for internal and external audits of the process. In 2016, external audits were completed at the following institutions: Wasco State Prison; Mule Creek State Prison; North Kern State Prison; and Folsom State Prison. All were found to be in compliance with PREA standards. The department also entered into a multi-state memorandum of understanding that allows department PREA-certified auditors to conduct PREA audits at other state facilities. Additional information regarding these audits can be found at http://www.cdcr.ca.gov/PREA/Reports-Audits.html.

As reported in the January through June 2016 Semi-Annual Report, additional changes were expected to expand the rights of inmates who allege staff sexual misconduct. As anticipated, effective October 20, 2016, Title 15 of the California Code of Regulations, Sections 3084.8, 3084.9, 3323, 3335, and 3401.5 were revised to expand protections for inmates who are alleged victims of sexual misconduct. The changes include expanding the definition of sexual misconduct to now include when staff members expose themselves in front of an inmate, as well as voyeurism. There is also a new provision to Section 3084.8 that there shall be no time limit for an inmate to submit an appeal alleging sexual violence or staff sexual misconduct. In addition, Section 3084.9 now provides that allegations of sexual violence or staff sexual misconduct shall be processed as an emergency appeal. Previously, this section was void of any reference to sexual misconduct allegations.

As part of its duties, the OIG monitors cases involving alleged staff against inmate sexual misconduct. During this reporting period, the OIG is reporting two such incidents, the details of which are in Appendix E.

FEMALE SUICIDES AND ATTEMPTED SUICIDES

When the department notifies the OIG that a female inmate attempted or committed suicide, the OIG opens a case for monitoring. The OIG reviews documents the institution prepared in connection with the incident and evaluates the department's response to the emergency. The OIG consults with the chief of mental health at the institution to determine whether, after a mental health evaluation of the inmate, the department continued to classify the inmate's actions as a suicide attempt or whether the inmate's actions were reclassified. The OIG also discusses with the chief of mental health whether the department identified any mental health care deficiencies prior to or after the incident. The OIG does not independently evaluate the determinations the

department's mental health staff made, but will ask for clarification or raise potential issues with departmental staff.

Female attempted suicide cases the OIG closed during the July through December 2016 reporting period are reported in Appendix E and are titled "Other Significant Incident." The OIG is reporting only the facts and dispositions for these cases rather than any assessments since the OIG is currently not staffed for assessing the sufficiency of the department's handling of such incidents.

As of June 27, 2016, 41 percent of inmates at the Central California Women's Facility (CCWF) were in the Mental Health Services Delivery System (MHSDS).[3] At the California Institution for Women (CIW), 48 percent of inmates were in the MHSDS, and 38 percent of inmates at Folsom Women's Facility (FWF) were in the MHSDS. Between January and June 2016, there were 17 attempted suicides by 16 female inmates: 13 at CIW and 4 at CCWF. Of the four at CCWF, two were made by the same inmate on the same day. There were no attempted suicides at FWF.

As of December 27, 2016, 46 percent of inmates at CCWF were in the MHSDS. At CIW, 48 percent of inmates were in the MHSDS, and at FWF, 46 percent were in the MHSDS. Between July and December 2016, there were 30 attempted suicides by 26 female inmates, a significant increase over the 17 attempted suicides reported during the past reporting period. Of these attempts, two inmates made multiple suicide attempts. One of these inmates attempted suicide four times, each time on a different day. The second inmate made two attempts within hours of each other. Of the total amount, 12 occurred at CIW and 18 occurred at CCWF. There were none reported for FWF. The number of attempted suicides at CCWF is also a significant increase over the four attempts reported during the first half of 2016. The department has not yet provided possible reasons for the increased attempts at CCWF.

The youngest female inmate to attempt suicide in the second half of 2016 was 21 years old and the oldest was 60 years old. The average age at the time of attempt was 34. Eight of the thirty inmates who attempted suicide were white, seven were Hispanic, five were black, two were Mexican, and the others identified as American Indian, Puerto Rican, and "other."

Although all of the inmates who attempted suicide were approved to be housed with other inmates, 15 were housed alone at the time of the suicide attempt. Two were in a cell with another inmate and nine were in a dormitory setting. The most common method used to attempt suicide was hanging, which was used 17 times. In one instance, the inmate used both cutting and hanging, whereas there were six incidents of cutting as the only method. Another method used was medication ingestion. In two instances, the inmate placed a bag over her head, and in one instance, the inmate hit her head against a wall.

[3] The department's MHSDS provides mental health services to inmates with a serious mental disorder or who meet medical necessity criteria. The MHSDS is designed to provide an appropriate level of treatment and to promote individual functioning within the least clinically restrictive environment. Mental health care is provided by clinical social workers, psychologists, and psychiatrists. CDCR 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/index.html.

Twenty of the inmates who attempted suicide were serving determinate sentences. Of these, 15 were serving terms of less than 10 years while the other 5 were serving between 10 and 25 years. Five inmates were serving sentences of life with the possibility of parole and one inmate was serving life without the possibility of parole. Of the inmates with determinate sentences, the shortest incarceration before the suicide attempt was one month and 24 days and the longest was nearly 13 years of a term of 22 years and 4 months.

All of the 26 female inmates who attempted suicide in this reporting period of July through December 2016 were participants in the MHSDS at the Correctional Clinical Case Management System (CCCMS) level of care or above at the time of the attempted suicide.

During this reporting period, psychiatrists ultimately reclassified four of the suicide attempts as not suicide attempts. One inmate's behavior of cutting both arms was reportedly precipitated by environmental stressors and the inmate was a participant in the Enhanced Outpatient Program (EOP) for ongoing mental health issues. She had three prior attempts, in 1996, 2001, and 2006.

In a second case, a physician reclassified the attempt as a means to secure an officer's attention. This inmate had prior attempts in 2012 and 2014. A third inmate whose attempt was reclassified claimed she did not feel safe being assigned to the CCCMS yard after being assigned to administrative segregation for safety concerns. She had two prior attempts.

The fourth inmate whose actions were reclassified reportedly acted out as a means to be moved out of the administrative segregation unit. She had a prior hanging attempt in 2014 and injurious behavior previously in 2016.

In addition, there were two actual female inmate suicides between July and December 2016, one at CCWF and one at CIW. In addition to monitoring attempted suicides, the OIG is monitoring the two suicides. However, the monitoring of these cases has not concluded. Appendix E contains only those cases that have come to a conclusion during this reporting period. The remaining cases will be reported in a subsequent Semi-Annual Report.

The inmate who committed suicide at CCWF was a 40-year-old black female who was in the CCCMS level of care and hanged herself. The inmate who committed suicide at CIW was 55 years old of Asian descent who also committed suicide by hanging. She was in the EOP level of care and was incarcerated for stabbing her daughter to death. She was close to being released on parole. However, she had recently learned her husband was filing for divorce.

According to a report published in December 2016 by the Vera Institute, some of the recommended steps for decreasing suicide and self-harm in a correctional setting include gathering a multi-disciplinary team, creating a time line of the event, identifying contributing factors, identifying the root cause or causes, and developing an action plan.[4] Since the January through June 2016 reporting period, the department has taken similar steps toward identifying causes and solutions for the high rate of attempted suicides at female institutions.

[4] Pope and Delany-Brumsey, Creating a Culture of Safety (undated) Vera Institute of Justice https://www.vera.org/publications/culture-of-safety-sentinel-event-suicide-self-harm-correctional-facilities [as of December 2016].

Based on information a department executive provided to the OIG, the department is working with outside organizations and experts to assist staff with having a better understanding of the female population and gender-based issues, such as being away from their children and being victims of verbal and physical abuse.

At CIW, the department is modifying the cells in the EOP unit to replace the ceiling vents with mesh so they can no longer be used to tie a noose. The department is also replacing porcelain plumbing fixtures with stainless steel to prevent breakage, which could enable inmates to make sharp implements used to harm themselves. The institution is also conducting peer counseling for inmates wherein inmates are trained to alert officers of concerns regarding other inmates. As of December 2016, there are mandatory tier inspections in the support care unit, requiring officers to confirm that inmates are alive at the time of the inspections. These inspections are conducted either every 30 minutes or hourly depending on the shift. Officers are trained to look for warning signs, such as crying or harmful behaviors.

Beginning January 30, 2017, CIW implemented a crisis intervention team pilot program involving custody, medical, and mental health staff to collaborate with inmates to help identify root problems that could lead to suicide attempts. The department is also considering implementing this program at CCWF, but the final decision is pending. In response to a request from inmates, CIW also plans to establish an open-line clinic for general population inmates with mental health concerns. This clinic will enable inmates to seek assistance yet avoid the stigma and concern of being labeled as a mental health inmate.

Both CIW and CCWF are conducting regular town-hall meetings to facilitate communication. Additionally, CIW, CCWF, and FWF, are all using drug and contraband interdiction strategies, including low-dose x-rays to better locate and remove contraband that could be used for suicide purposes.

MALE SUICIDES

Between July 1, 2016, and December 31, 2016, nine male inmates committed suicide. All but one of these inmates were in the CCCMS level of mental health care or above. Of the nine suicides, two occurred at each of the following institutions: California State Prison Sacramento (SAC); Kern Valley State Prison (KVSP); and California Men's Colony (CMC). One suicide occurred at each of the following: California State Prison Los Angeles County (LAC); Pleasant Valley State Prison (PVSP); and California Health Care Facility (CHCF).

In response to the number of suicides that had previously occurred at Salinas Valley State Prison (SVSP), the hiring authority at SVSP took similar steps as those the department has taken at CCWF and CIW, as discussed above. Some of the specific steps include establishing a crisis intervention team to help identify whether suicide threats or attempts are genuine, as well as the cause of the threat or attempt. Through this process, custody and medical staff have been able to identify inmates who are threatening or attempting suicide in order to be placed on suicide watch and, therefore, removed from what might otherwise be a threatening environment. As mentioned above, none of the nine male suicides that occurred between July 1, 2016, and December 31, 2016, took place at SVSP, which could indicate the steps SVSP has taken are being effective.

SUMMARY OF SUICIDES AND ATTEMPTED SUICIDES

Overall, as demonstrated above, rather than being obdurate, the department is taking a proactive approach to help identify suicide risk and respond to help decrease the number of attempted and completed suicides. The mental health system within the department has been under federal court monitoring by a special master. In 1995, as a result of a lawsuit mentally ill inmates filed, the United States District Court for the Eastern District of California ordered the appointment of the special master and experts to oversee the establishment of corrective policies and procedures after finding the department was not providing appropriate medical care to mentally ill inmates.[5] The OIG reporting is for transparency in our critical incident monitoring role. It is the purview of the federal special master to create a solution with the department.

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."[6] 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 OIG notes that, even for warning shots, the justification for use of deadly force must be present. Any time CDCR staff use deadly force, the department is required to promptly notify the OIG. When the OIG receives timely notice of a deadly force incident, a Special Assistant Inspector General immediately responds to the incident scene to evaluate the department's management of the incident and 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 manager participates as a non-voting member of this body. The Deadly Force Review Board is an independent body consisting of outside law enforcement experts and a CDCR executive

[5] *Coleman v Wilson (Brown)* 912 F.Supp. 1282 (E.D. Cal. 1995).
[6] Title 15, California Code of Regulations, Section 3268(a)(9).

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 needed.

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 34 potentially deadly force incidents. These include intentional use 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. Cases the OIG monitored but the Office of Internal Affairs did not respond to are reported in Appendix D1, mentioned previously. There are 18 such cases for this period. Cases that the Office of Internal Affairs investigated and the OIG monitored are reported in Appendix D2. There are 16 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 16 cases being reported in Appendix D2, the Office of Internal Affairs responded to the scene in ten cases. In eight of the ten cases, as well as in three cases 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 15 of the 16 Deadly Force Investigation Team cases reported in Appendix D2.

NEGLIGENT FIREARM DISCHARGE INCIDENTS

The OIG has noticed an alarming number of incidents involving unintentional discharges of a lethal weapon. During this reporting period, the OIG is reporting 13 cases involving unintentional discharges, plus one case involving discharge of a weapon in an unsafe area. These cases are reported in Appendices D1 and D2. In addition, the OIG is currently monitoring at least two other incidents involving similar facts, but those cases have not yet come to conclusion. During the January through June 2016 reporting period, the OIG reported nine such cases.

Nine of the cases currently being reported involved discharges that occurred either during training or while the involved staff member was trying to make the weapon safe. Some of the incidents occurred while at a training range while others occurred indoors.

Two incidents currently being reported involved conducting a "press-check" maneuver. The OIG reported the same type of incident in the January through June 2016 reporting period. The department trains its peace officers to use this maneuver to determine whether a weapon is loaded. The maneuver 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.

In one such case currently reported, an officer shot himself in the hand while conducting the "press-check" during a firearms training course. The officer had previously failed the course and received one-on-one training before being admitted to subsequent training. The officer claimed that while performing the "press-check," his hands were sweaty and his trigger finger slipped.

In the second case, an officer discharged a weapon inside an observation area, with a second officer present, overlooking a dining hall where several inmates were eating. The second officer was struck in the head with an unknown projectile. The discharge occurred because the officer could not recall whether the weapon was loaded so he conducted a "press-check" maneuver to determine whether the weapon was loaded. The officer conducted this maneuver in the unsafe area rather than in a loading station used for checking whether weapons are loaded. Although the department provided firearms training which the officer completed successfully, the training did not include use of the loading station to check the weapon. Moreover, the officer claimed that he was specifically taught to use the "press-check" maneuver to determine whether the weapon was loaded.

A similar incident involved an officer who, after completing qualification training, cleaned the weapon and then 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.

Another incident involved a parole agent who was struck in the thigh with a bullet. The OIG reported a similar incident during the past reporting period. In one of the currently reported cases that occurred indoors, a round ricocheted and embedded in a wall. Another incident took place inside a classroom with several other people present. The OIG also reported a similar case in the prior reporting period.

The recurring cause of these incidents appears to be prematurely and inappropriately placing the index finger on the trigger. Fortunately, there were no deaths as a result of these incidents. However, it is ironic that the majority of these negligent discharge incidents occurred while the staff member was trying to make the weapon safe or during training. The department's Deadly Force Review Board, which consists primarily of former outside law enforcement executives who are retained to consult with the department regarding the use of deadly force cases, has encouraged the department to examine the appropriateness of the press-check practice.

The Office of the Inspector General for the County of Los Angeles issued a report in December 2015 addressing a similar problem in the Los Angeles County Sheriff's Department.[7] The Office of the Inspector General for the County of Los Angeles conducted a study and found a substantial increase in unintended discharges between 2012 and 2015. During this time frame, the Sheriff's 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. However, the Office 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.

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

As a result of the study, the Office of the Inspector General for the County of Los Angeles made several recommendations, some of which could apply to CDCR, to decrease the number of negligent discharge incidents. Some of these recommendations are:

1. Strengthen training procedures;
2. Incorporate follow-up training to ensure that the new safety practices are retained;
3. Develop a product evaluations manual and documented testing and evaluation procedures for all critical equipment selections;
4. Establish a robust and consistent system for tracking, investigating, evaluating, and responding to unintended discharges;
5. Establish more accountability for those involved in such incidents; and
6. Have the Office of Internal Affairs investigate all such incidents.

Based on the cases the OIG is reporting, the department may be lacking in training, including remedial training, for peace officers regarding the proper safe handling of a lethal weapon, especially keeping the index finger off of the trigger until ready to actually fire at a target. For this reason, the OIG recommends the department take action to remedy this problem before serious injury or death results, and consider instituting some or all of the same safeguards recommended to the Los Angeles County Sheriff's Department.

PUBLIC SAFETY STATEMENTS

Pursuant to the Department Operations Manual Section 51020.17.5 and Title 15 California Code of Regulations Section 3268.1(b)(2)(A), when there has been a use of deadly force, the on-duty supervisor shall, among other things, ask the employee who used deadly force to provide a public safety statement *immediately* after the incident. This statement is obtained orally and helps determine the general circumstances of the incident, including the need for resources, the need for and location of a perimeter, whether anyone was injured, and the nature of evidence to be sought. The statement shall also provide other basic information such as the number of persons involved in the incident, any injuries, number of inmates not yet in custody, and the number and direction of shots fired. The purpose of the statement includes identifying possible danger to involved employees and alleviating any such danger. In the general public setting, the statement also assists in determining whether any possible suspects are still at large, as well as any unaccounted for weapons or ammunition. The statement also enables responding officers to rescue any persons in danger and protect human life. As such, it is critical that the statement be obtained as promptly as possible following an incident.

The OIG has noticed that the department is not consistently obtaining public safety statements, thereby placing employees and potentially the general public in danger following a use-of-deadly force incident. During this reporting period, the OIG is reporting four cases wherein the department failed to timely obtain public safety statements. Three of the cases involved warning shots and in two of those cases, there was a 90-minute delay obtaining the statement. In the third case, the department failed to obtain the statement until the officer was relieved from his post and was able to confer with a union representative. The fourth case involved an unintentional discharge and also involved a 90-minute delay.

The OIG is also currently monitoring a fifth case involving a delayed public safety statement. In this case, an officer shot himself in the leg during training. The department failed to obtain the statement until six days later and at the officer's home. By the time the department obtained the statement, any exigency had long since passed, eliminating the need to even take the statement.

Based on these case examples, the OIG believes the department must take action to close this gap in obtaining public safety statements. To that end, the OIG recommends the department provide better training to supervisors regarding the rationale, requirements, and process for obtaining public safety statements, as well as the dangers in failing to do so.

Use of Force

HISTORICAL PERSPECTIVE

On January 10, 1995, the federal court found that officers were using excessive and unnecessary force.[8] On June 24, 2004, the federal court's special master found that department officials demonstrated a failure of leadership and an unwillingness and inability to investigate and discipline officers' abuses of force. The special master also found that a sergeant from the department's training center was inappropriately providing opinions in disciplinary cases. The federal court found that the special master's report, in vivid and damning detail, documented the department's system for investigating and disciplining officers was broken to the core and not only dysfunctional from a managerial standpoint, but subject to interference and obstruction from the union.

As a result, the department revised its use-of-force policy and the OIG began monitoring disciplinary investigations and disciplinary actions, as well as the review of use-of-force policy compliance at each institution. The OIG now strives to review 100 percent of use-of-force incidents at all institutions.

UNDERSTANDING THE DEPARTMENT'S POLICY

The general department policy is that the Division of Adult Institutions (DAI) is to accomplish custodial and correctional functions with minimal reliance on the use of force.[9] Employees may use reasonable force as required but shall not use unnecessary or excessive force. A recent opinion from the Ninth Circuit Court of Appeals, once again, provides clear guidance on how the department should evaluate the use of force.[10] First, the three factors from *Graham v. Connor*[11] are to be considered. They include: (1) the severity of the crime at issue; (2) whether the suspect poses an immediate threat to the safety of the officers or others; and (3) whether he is actively resisting arrest or attempting to evade arrest by flight. These factors are to be judged from the perspective of the reasonable officer on the scene, rather than with the 20/20 vision of hindsight.

The most important factor under *Graham* is whether the suspect posed an immediate threat to the safety of officers or third parties. The department's policy incorporates this element when it says immediate force is the force used to respond to a situation or circumstances that constitute an *imminent threat* to security or the safety of persons. The department's policy defines an imminent threat as any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, *requiring immediate action to stop the threat.*

The recent Ninth Circuit opinion clearly says the factors identified in *Graham* are not exclusive. When assessing an officer's conduct, the totality of the circumstances must be considered,

[8] *Madrid v. Gomez*, 889 F.Supp. 1146 (N.D. Cal. 1995).
[9] Department Operations Manual, Chapter 5, Article 2.
[10] *Hughes v. Kisela*, 841 F.3d 1081 (2016).
[11] *Graham v. Connor*, 490 U.S. 386 (1989).

including any specific factors that may be appropriate in a particular case, whether or not listed in *Graham*. Other relevant factors may include the availability of less intrusive force, whether proper warnings were given, and whether it should have been apparent to the officer that the subject of the force used was mentally disabled. The totality of the circumstances analysis also requires that the reasonableness of officer conduct preceding the use of force be considered. In other words, the analysis must consider whether inappropriate officer conduct caused the need for force.

Policy requires that, whenever possible, officers attempt verbal persuasion or orders before resorting to the use of force. In situations where verbal persuasion fails to achieve desired results, a variety of force options are available. The department's policy does not require these options be employed in any predetermined sequence. Rather, officers select the force option they reasonably believe is necessary to stop the perceived threat or gain compliance.

Additionally, accurate and thorough report writing is a critical requirement of the department's use-of-force policy. The recent Ninth Circuit opinion in *Hughes* made it clear, once again, that an officer's simple statement that he fears for his safety or the safety of others is not enough to justify a use of force. Instead, there must be objective factors articulated to justify such a concern. Furthermore, a desire to quickly resolve a potentially dangerous situation, standing alone, does not justify the use of force, nor does simply reporting a conclusion that conduct could result in injury. An officer must articulate all of the facts supporting the conclusion that immediate action was required to stop the threat.

Pursuant to the department's policy, use-of-force options available to department employees include, but are not limited to:

a) Chemical agents, such as pepper spray and tear gas;
b) Hand-held batons;
c) Physical force, such as control holds and controlled take downs;
d) Less-lethal weapons (weapons not intended to cause death when used in a prescribed manner), including the following: 37mm or 40mm launchers used to fire rubber, foam, or wooden projectiles, and electronic control devices; and
e) Lethal (deadly) force. This includes any use of force that is likely to result in death, and any discharge of a firearm (other than during weapons training).

Force that utilizes techniques or instruments not specifically authorized in policy, procedures, or training is defined in policy as "non-conventional force." Depending on the circumstances, non-conventional force can be necessary and reasonable, but it can also be unnecessary or excessive.

Any department 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. As mentioned above, the accuracy and completeness of the report is crucial because the department conducts a multi-tiered review process of the submitted reports.

OIG 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, where hiring authorities review and evaluate every use-of-force incident for compliance with policy. The department must maintain the safety and security of staff members, inmates, visitors, and the public. At times, this responsibility requires officers to use reasonable force, defined as "the force that an objective, trained, and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order."[12] The use of greater force than justified by this standard is deemed "excessive force," while using any force not required or appropriate in the circumstances is "unnecessary force." Both unauthorized types of force are categorized as "unreasonable." As part of its oversight process, the OIG reviews the reports and the review process, and may make recommendations to the department regarding use-of-force policies and procedures.

As part of its monitoring, the OIG has identified problems regarding a lack of proper training. Some case examples highlight these problems. On April 23, 2016, an officer fired three warning shots and prepared a report that failed to adequately explain his use of deadly force. The report set forth little more than conclusions that great bodily injury *could* occur as a result of multiple fights. During the review process, a lieutenant, captain, and associate warden did not recognize the failure to adequately describe the need for deadly force. The associate warden even wrote that the threat of "serious bodily injury" justified the use of deadly force. Nowhere does the department's policy permit the use of deadly force when there is a threat of "serious bodily injury." Policy clearly requires a *likely risk* of great bodily injury or death. Policy also permits warning shots in the institutions only when deadly force is warranted.

In a second case, on April 28, 2016, two special agents from the Office of Internal Affairs interviewed the two subjects of the investigation and three witnesses regarding alleged unreasonable force against an inmate. A third special agent and a department attorney were also present. The special agent insisted the interviews take place on a day the special agent knew the OIG could not be present. Neither the special agents nor department attorney asked the subjects of the investigation or the witnesses any questions regarding the use-of-force policy, compliance with the policy, or how the policy governs and limits the use of force in the case under investigation. The agents and department attorney were not aware of the use-of-force concerns that resulted in the investigation.

At a May 2016 hearing contesting disciplinary action, an attorney representing the department before the State Personnel Board failed to articulate and demonstrate even a basic understanding of the applicable Fourth Amendment reasonableness standard governing the use of force when the disciplined employee's attorney misrepresented the law.

On December 9, 2016, an institution was told it would be required to inform its mission headquarters of its pending use-of-force reviews and that personnel from headquarters would

[12] Department Operations Manual, Chapter 5, Article 2.

provide oversight during institutional use-of-force reviews to ensure appropriate evaluations of the department's use-of-force policy prior to, during, and following the use of force at that institution. This action resulted from inadequate use-of-force reviews by the warden, chief deputy warden, associate wardens, captains, and lieutenants.

The OIG also noted at an institution where use-of-force incidents are numerous and serious, the warden rarely, if ever, attended use-of-force review meetings. The reviews the warden's subordinates conducted were too often inadequate and did not always ensure compliance with policy. The OIG raised the issue and the warden now attends the meetings.

Beginning January 1, 2016, the OIG implemented a new use-of-force monitoring tool. As in the past, a Deputy Inspector General or Special Assistant Inspector General reviews reports and other evidence related to a use-of-force incident and attends the IERC meetings at all institutions. Previously, the OIG collected only basic information regarding incidents it monitored. With the new monitoring tool, the OIG collects more detailed information regarding force used, injuries resulting from the use of force, inmate allegations of unreasonable force, and the IERC 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 developed and designed the new 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. As with the prior report, the use-of-force data in this Semi-Annual Report was gathered with this monitoring tool.

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 836 use-of-force committee meetings. Of those, the OIG attended 775 Institutional Executive Review Committee meetings, which is 93 percent. The OIG is striving for 100 percent attendance and since the last reporting period, increased its attendance rate from 81 percent. In addition, the OIG attended 12 Department Executive Review Committee meetings, which are discussed below. Based on this increased attendance, the data the OIG is reporting herein is more comprehensive than in the past.

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. In the event 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 3,637 unique use-of-force incidents and allegation reviews.[13] All of the incidents discussed in the sections that follow pertain solely to those cases the OIG closed during this reporting period.

Prior to attending a use-of-force meeting, the OIG evaluates all departmental 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 observes the review process and raises concerns, if any. The OIG may ask for 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	3,414
Division of Juvenile Justice	197
Division of Parole Operations	24
Office of Correctional Safety	2
Total	**3,637**

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 285 individual cases (8 percent).

[13] Allegation reviews involve reviews of inmate allegations of unnecessary or excessive use of force (by inmate appeal or statements to staff). The IERC is required to review the allegations.

DEPARTMENT EXECUTIVE REVIEW COMMITTEE (DERC)

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 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.

During this reporting period, two of the four missions held a total of six DERC reviews during which they reviewed seven incidents: the Reception Center mission reviewed two incidents and the High Security mission reviewed five incidents. In addition, the Division of Juvenile Justice conducted six DERC reviews during which they reviewed 12 incidents. The OIG attended 12 DERC meetings, including six at Division of Juvenile Justice facilities.

During this reporting period, the OIG found that an additional 51 cases met the criteria for DERC review but the department did not conduct the review: 18 in the Reception Center mission; 5 in the General Population mission; 20 in the High Security mission; 6 in the Female Offender Programs and Services, Special Housing mission; and 2 in the Division of Juvenile Justice. The DERC did not review 35 cases where inmates suffered serious injury or great bodily injury and did not review 1 case where deadly force was used. The case involving the use of deadly force involved a three-on-one inmate attempted homicide resulting in a warning shot from a Mini-14 rifle. There were no injuries as a result of the incident and the use of force was found to be within policy; 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. These situations do not normally involve the immediate threat of loss of life or immediate threat to

institution security. In addition, the department revised its policy in January 2016 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 the 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, include mental health concerns, and note any accommodations that may need to be considered when preparing for a controlled use of force.

The 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 106 of the 3,637 incidents closed, which is approximately 3 percent of the cases. While there were varying reasons staff contributed to the need for the use of force, the main reasons were:[14]

1. Opening the wrong cell door or otherwise allowing inmates access to unauthorized areas (12 incidents);
2. Lack of proper back-up or failure to notify a supervisor (10 incidents);
3. Improperly opening a door or food port (7 incidents); and
4. Accidental pepper spray discharge (6 incidents).

Some other reasons staff contributed to the need for force included improperly keeping an inmate's property, searching an inmate in an unsecure area, and handcuffing an inmate in the front rather than the back, thereby enabling the inmate to attempt to assault staff. In addition, in some cases, force may not have been necessary at all if staff members had followed proper policy initially. Table 2 below 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	3,414	100	2.9%
Division of Juvenile Justice	197	5	2.5%
Division of Adult Parole	24	1	4.2%
Office of Correctional Safety	2	0	0%
Total	**3,637**	**106**	**2.9%**

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

In 24 cases, the department submitted the matter to the Office of Internal Affairs for possible investigation. The OIG concurred with all of the referrals. In one case, the Office of Internal Affairs referred the matter back to the institution for further inquiry. The investigative services unit conducted the inquiry and recommended the hiring authority resubmit the matter to the Office of Internal Affairs for investigation and the OIG agreed. However, the hiring authority refused to resubmit the matter.

The department provided training or counseling in 77 cases and in one case, the hiring authority decided to change the local policy in response to the incident. In ten incidents, the hiring authority did not take any action. The OIG agreed with this decision in five cases and disagreed in five. In some cases, the hiring authority took more than one kind of action. 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 517 of the 3,637 cases the OIG closed during this reporting period, which is 14 percent. This is an increase over the 9 percent reported during the last reporting period. These consist of allegations that staff unnecessarily used force or used excessive force and does not include other non-use-of-force allegations, such as allegedly improperly confiscating or damaging an inmate's property. Apart from inmate allegations, the OIG found that staff used immediate force when no force was justified in 70 of the 3,637 incidents, which is less than 2 percent.

The majority of these incidents involved the use of physical force when there was no imminent threat, whereas others involved immediate force when a controlled use of force should have been initiated. In nine cases, officers accidentally discharged pepper spray. In four cases, officers used physical force in an attempt to prevent inmates from either swallowing or destroying contraband. Below is a table outlining 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	3,414	64	1.9%
Division of Juvenile Justice	197	4	2%
Division of Adult Parole	24	2	8.3%
Office of Correctional Safety	2	0	0%
Total	**3,637**	**70**	**1.9%**

FREQUENCY OF USE OF FORCE AS AN EARLY-WARNING SYSTEM

For cases the OIG closed during this reporting period, the OIG identified 11 officers at six different institutions who were involved in ten or more use-of-force incidents. The highest number of incidents in which one officer was involved was 26 incidents. In all 26 incidents, the officer used physical force or chemical agents, and all occurred on the same yard and involved officers who were also involved in multiple use-of-force incidents. The department found all incidents to comply with policy and the OIG agreed.

The second highest number of incidents involving the same officer was 19 incidents, followed by a third officer involved in 15 incidents, and a fourth officer involved in 14 incidents. All of these incidents occurred at the same institution and on the same yard as the first officer discussed above, except for three incidents, two of which occurred on a different yard and one that occurred in a housing unit. All incidents also involved physical force or chemical agents and all were found to comply with policy, with OIG concurrence.

Another officer at a different institution was involved in 12 incidents, 11 of which occurred on the same yard. These incidents involved physical force, chemical agents, and one baton. Again, all were found in compliance with policy and the OIG concurred. Six other officers were involved in ten use-of-force incidents at six institutions. One of these institutions is the same institution with the highest number of incidents discussed in the first paragraph above. In one of these incidents, the institution determined that officers should have used a controlled use of force, but the force used was found in compliance with policy and the OIG concurred. None of the incidents resulted in any serious injuries.

There could be many reasons for an officer to be involved in multiple uses of force. The officer could be working with a difficult or mentally challenged inmate population. The majority of the 26 incidents discussed above that took place on the same yard occurred during second watch. The inmate population on this yard is in the Enhanced Outpatient Program (EOP). The OIG met with the hiring authority at this institution regarding the large number of incidents involving the same officers. The hiring authority acknowledged being aware that one officer was involved in the most incidents. The OIG will continue to share this type of information with the department to assist in determining whether a particular post or person is potentially at risk, and if harm to staff or inmates can be avoided.

DIVISION OF ADULT INSTITUTIONS

CDCR's Division of Adult Institutions (DAI) comprises four mission-based disciplines: reception centers (RC), high security (HS), general population (GP), and female offender programs and services/special housing (FOPS/SH).[15] As of December 31, 2016, 124,721 inmates were under the

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

department's in-state supervision.[16] Of the 3,637 total use-of-force incidents the OIG closed this period, 3,414 occurred within the DAI.

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 Contract Beds Unit and Table 4C shows the total numbers. The numbers listed in the column titled "Applications of Force" reflect the numbers 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, Kern Valley State Prison (KVSP) had the highest number of incidents during this reporting period, with 292 incidents reviewed and 1,130 applications of force in conjunction with those incidents.[17] Salinas Valley State Prison (SVSP) had the second highest number, with 268 incidents reviewed and 857 applications of force.

On the other hand, Chuckawalla Valley State Prison (CVSP) had the fewest number of incidents involving the use of force, with four incidents reviewed and ten applications of force. The second fewest incidents occurred at California City Correctional Facility (CAC), where the OIG reviewed seven incidents involving 15 applications of force.

There are many variables involved in any use-of-force incident. Therefore, any conclusions drawn based on this information should be weighed carefully. Variables 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.

[16] CDCR data is derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1612.pdf.

[17] CORRECTION: In the prior Semi-Annual Report, the OIG incorrectly reported in the narrative that CIW had the fifth highest uses of force, with 391 uses of force during 117 incidents. However, the actual number of incidents was 104, with 261 applications of force. Table 6 on page 23 lists these numbers correctly. The OIG apologizes for this error and any confusion.

Table 4A: *Incidents Reviewed and Frequency of Force within the Division of Adult Institutions*[18]

Institution Initialism	Institution	Incidents Reviewed	Applications of Force	Chemical Agents	Physical	Less-Lethal Force	Expandable Baton	Other/Non-Conventional[19]	Lethal Force, Including Warning Shots
CCC	California Correctional Center	46	125	29%	59%	2%	6%	2%	1%
CIM	California Institution for Men	45	83	41%	43%	11%	5%	0%	0%
CMC	California Men's Colony	144	435	34%	57%	1%	6%	2%	0%
CRC	California Rehabilitation Center	31	57	40%	56%	0%	4%	0%	0%
DVI	Deuel Vocational Institution	35	69	23%	68%	0%	9%	0%	0%
NKSP	North Kern State Prison	106	161	42%	32%	19%	6%	0%	1%
RJD	R. J. Donovan Correctional Facility	159	397	32%	54%	6%	7%	1%	0%
SQ	San Quentin State Prison	57	109	48%	21%	19%	12%	0%	0%
SCC	Sierra Conservation Center	29	55	51%	38%	5%	5%	0%	0%
WSP	Wasco State Prison	132	248	42%	39%	10%	8%	0%	1%
CAC	California City Correctional Facility	7	15	80%	13%	0%	7%	0%	0%
CCI	California Correctional Institution	167	411	61%	23%	7%	9%	0%	0%
COR	California State Prison - Corcoran	216	535	33%	55%	5%	7%	1%	0%
LAC	California State Prison - Los Angeles County	200	623	39%	45%	5%	10%	0%	0%
SAC	California State Prison - Sacramento	263	637	44%	43%	7%	4%	1%	0%
SATF	California Substance Abuse Treatment Facility	94	240	35%	46%	10%	8%	0%	1%
HDSP	High Desert State Prison	132	353	47%	32%	13%	7%	0%	1%
KVSP	Kern Valley State Prison	292	1130	61%	20%	16%	2%	1%	0%
PBSP	Pelican Bay State Prison	53	238	35%	43%	11%	11%	1%	0%
SVSP	Salinas Valley State Prison	268	857	69%	18%	12%	0%	0%	0%
ASP	Avenal State Prison	9	11	73%	27%	0%	0%	0%	0%
SOL	California State Prison - Solano	48	107	54%	37%	6%	3%	0%	0%
CAL	Calipatria State Prison	115	254	71%	6%	22%	1%	0%	0%
CEN	Centinela State Prison	69	148	57%	30%	8%	5%	0%	0%
CVSP	Chuckawalla Valley State Prison	4	10	10%	90%	0%	0%	0%	0%
CTF	Correctional Training Facility	15	44	18%	70%	0%	7%	5%	0%
ISP	Ironwood State Prison	40	90	56%	21%	10%	13%	0%	0%
MCSP	Mule Creek State Prison	127	277	44%	42%	6%	7%	1%	0%
PVSP	Pleasant Valley State Prison	45	112	65%	24%	4%	6%	0%	0%
VSP	Valley State Prison	13	30	37%	60%	0%	3%	0%	0%
CHCF	California Health Care Facility	162	506	14%	79%	0%	3%	4%	0%
CIW	California Institution for Women	71	144	27%	64%	0%	3%	6%	0%
CMF	California Medical Facility	52	129	27%	68%	0%	5%	0%	0%
CCWF	Central California Women's Facility	88	229	30%	64%	0%	2%	4%	0%
FSP	Folsom State Prison	19	57	63%	21%	7%	9%	0%	0%
Total		**3,353 Incidents**	**8,926 Applications**	**44% Average**	**43% Average**	**6% Average**	**6% Average**	**1% Average**	**0% Average**
CDCR Mission:	**Reception Center**	**High Security**		**General Population**		**Female Offender/Special Housing**			

[18] This data is based upon the number of use-of-force incidents the OIG closed during this reporting period.
[19] 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 (CBU)*[20]

Institution Initialism	Institution	Incidents Reviewed	Applications of Force	Chemical Agents	Physical	Less-Lethal Force	Expandable Baton	Other/Non-Conventional	Lethal Force, Including Warning Shots
DMCCF	Delano Modified Community Correctional Facility	11	16	75%	13%	6%	6%	0%	0%
DVMCCF	Desert View Modified Community Correctional Facility	1	3	33%	33%	0%	33%	0%	0%
LPCC	La Palma Correctional Center	17	31	68%	32%	0%	0%	0%	0%
FCRF	McFarland Female Community Reentry Facility	4	5	40%	40%	0%	20%	0%	0%
SMCCF	Shafter Modified Community Correctional Facility	2	4	25%	75%	0%	0%	0%	0%
TMCCF	Taft Modified Community Correctional Facility	2	7	14%	86%	0%	0%	0%	0%
TCCF	Tallahatchie County Correctional Facility	24	57	95%	5%	0%	0%	0%	0%
Total		**61 Incidents**	**123 Applications**	**50% Average**	**41% Average**	**1% Average**	**8% Average**	**0% Average**	**0% Average**

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

Institution Initialism	Institution	Incidents Reviewed	Applications of Force	Chemical Agents	Physical	Less-Lethal Force	Expandable Baton	Other/Non-Conventional	Lethal Force, Including Warning Shots
Total		**3,414 Incidents**	**9,049 Applications**	**45% Average**	**43% Average**	**5% Average**	**6% 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. Eighteen locations statewide had between 20 and 47 use-of-force incidents, with six of these locations having between 30 and 46 incidents. Twelve of these "hotspot" locations were yards and two were housing units, one of which was a level IV housing unit. One of the locations was an administrative segregation unit, which had 34 incidents.

Additionally, the program type with the highest number of incidents was the Sensitive Needs Yard program at four institutions.[21] A reception center at one institution had the third highest number of incidents, followed by general population inmates at two institutions. All of these location program types had 100 or more incidents, with the highest number being 162.

[20] The OIG started monitoring the Contract Beds Unit use-of-force incidents on September 13, 2016.
[21] 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 bodily injury or great bodily injury[22] as a result of force. Of the 3,637 incidents the OIG closed during this reporting period, 45 incidents resulted in serious bodily injury, one resulted in great bodily injury, and one inmate died following the incident. In this incident, officers used physical force to subdue a combative inmate. The inmate did not have any documented injuries. However, the hiring authority referred the matter to the Office of Internal Affairs for investigation due to the death and the OIG is monitoring the case.

The incident involving great bodily injury involved an attempted homicide wherein two inmates repeatedly stabbed a third inmate. An officer fired two shots for effect from a Mini-14 rifle and one of the rounds struck one of the assailants in the hip. The department determined the use of deadly 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 285 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,[23] 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 improperly completed medical assessments.

Apart From Actual Force

For cases the OIG closed during this reporting period, the department found 2,167 incidents within policy for conduct the OIG deems "Apart from Actual Force." This is 60 percent of the total incidents reported. The department found 22 incidents involved a reasonable deviation from policy. The department took action on 32 inmate allegations against staff and determined not to take action on 125 inmate allegations. The department conducted one internal inquiry and, in 385 cases, deferred making a decision to a later meeting pending further information. For incidents

[22] 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.
[23] Department Operations Manual, Chapter 5, Article 2.

deemed out of policy, the department took adverse action in 11 cases, provided training in 822 cases, and issued counseling in 51 cases. The hiring authority referred 21 cases to the Office of Internal Affairs. The OIG concurred with the department's determinations in 3,476 cases, including all cases referred to the Office of Internal Affairs, and disagreed in 161 cases.

Actual Force Used

For conduct deemed "Actual Force Used," the department assessed 2,915, or 80 percent, of the incidents within policy. The OIG concurred with this assessment in all but seven cases. Two of the cases with which the OIG did not concur involved physical force. In both cases, the Office of Internal Affairs conducted investigations. In one case, the Office of Internal Affairs returned the matter to the institution for an inquiry, which the investigative services unit conducted. The investigative services unit recommended referring the matter back to the Office of Internal Affairs but the hiring authority refused. In the second case, the hiring authority did not sustain the allegations.

Another example of a case with which the OIG did not concur involved physical force and a baton. The Office of Internal Affairs conducted an investigation but the hiring authority did not sustain any allegations. The OIG did not agree but did not seek a higher level of review because the deadline to take disciplinary action was about to expire. In yet a fourth case, an officer intentionally closed a food port door on an inmate's hand and the hiring authority found this action to comply with policy. The OIG did not concur based on the plain language in the policy.

A fifth example of the cases where the OIG did not concur involved an officer punching an inmate in the face multiple times in response to an inmate attack on a second officer. The OIG believed the first officer should have assessed the situation before continuing to strike the inmate. The hiring authority disagreed because the officer claimed his vision was impaired due to pepper spray exposure.

The department found 61 incidents involved a reasonable deviation from policy and the OIG concurred with all but one decision. The department decided to take action on three inmate allegations of staff misconduct and the OIG concurred. The department decided not to take action on 157 inmate allegations of staff misconduct and the OIG concurred with all but one. The department conducted an internal inquiry in one case and, in 390 cases, deferred making a decision to a later meeting pending further information. The department also referred 21 cases to the Office of Internal Affairs. For the remaining cases deemed to be out of compliance with policy, the department took adverse action in 18 cases, provided training in 55 cases, and issued counseling in 16 cases. The OIG concurred with all of these decisions except three cases involving training.

Non Use of Force

The department assessed 2,553 of the incidents within policy for conduct the OIG deems "Non Use of Force," which is 70 percent of these cases. The OIG concurred in all but nine. The department found four incidents involved a reasonable deviation from "Non Use of Force" policies. The department decided to take action on nine inmate allegations of staff misconduct

and decided not to take action on 150 inmate allegations. The OIG concurred in all but one case where the hiring authority decided not to take action. The department conducted an internal inquiry in one case and deferred 384 cases. Of the cases found to be out of policy, the hiring authority took adverse action in 14 cases, provided training in 477 cases, and issued counseling in 24 cases. The OIG did not concur with two cases involving counseling. In one of these cases, the OIG thought the hiring authority should impose discipline and in the second case, the OIG disagreed with the decision to not provide training or corrective action. In a third case, the hiring authority provided training to a sergeant, lieutenant, and captain, but the OIG also thought the hiring authority should have issued some form of training or action against the involved officers.

USE OF FORCE ON MENTAL HEALTH INMATES

The department reports during this reporting period approximately 30.5 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. 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.[24, 25]

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 below outlines the use of force at each institution, broken down by mental health status of the inmate on whom the force was used.

[24] 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.
[25] See footnote 4, page 6, regarding the department's MHSDS and levels of care provided by CDCR.

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

			Mental Health Code				
		Institution	Non-Mental Health	CCCMS	EOP	MHCB	DSH
CDCR Mission	Reception Center	CCC	100%	0%	0%	0%	0%
		CIM	71%	17%	5%	8%	0%
		CMC	27%	25%	44%	4%	0%
		CRC	54%	39%	0%	6%	1%
		DVI	55%	18%	15%	11%	0%
		NKSP	56%	36%	6%	2%	0%
		RJD	11%	37%	43%	9%	0%
		SQ	69%	24%	3%	4%	0%
		SCC	77%	21%	0%	2%	0%
		WSP	55%	34%	10%	1%	0%
	High Security	CAC	100%	0%	0%	0%	0%
		CCI	57%	43%	0%	0%	0%
		COR	34%	38%	21%	7%	0%
		LAC	28%	36%	36%	1%	0%
		SAC	18%	21%	57%	4%	0%
		SATF	37%	35%	19%	10%	0%
		HDSP	50%	48%	0%	2%	0%
		KVSP	55%	40%	3%	1%	0%
		PBSP	42%	29%	24%	6%	0%
		SVSP	31%	28%	35%	2%	4%
	General Population	ASP	60%	40%	0%	0%	0%
		SOL	59%	40%	1%	0%	0%
		CAL	98%	2%	0%	0%	0%
		CEN	99%	1%	0%	0%	0%
		CVSP	91%	9%	0%	0%	0%
		CTF	54%	46%	0%	0%	0%
		ISP	96%	1%	3%	0%	0%
		MCSP	23%	30%	47%	0%	0%
		PVSP	83%	16%	0%	0%	0%
		VSP	0%	13%	84%	3%	0%
	Female Offender/ Special Housing	CHCF	5%	6%	32%	21%	36%
		CIW	9%	48%	22%	16%	5%
		CMF	16%	16%	49%	19%	1%
		CCWF	30%	47%	11%	12%	0%
		FSP	88%	12%	0%	0%	0%
		Average	**60%**	**21%**	**14%**	**4%**	**1%**
				40%			

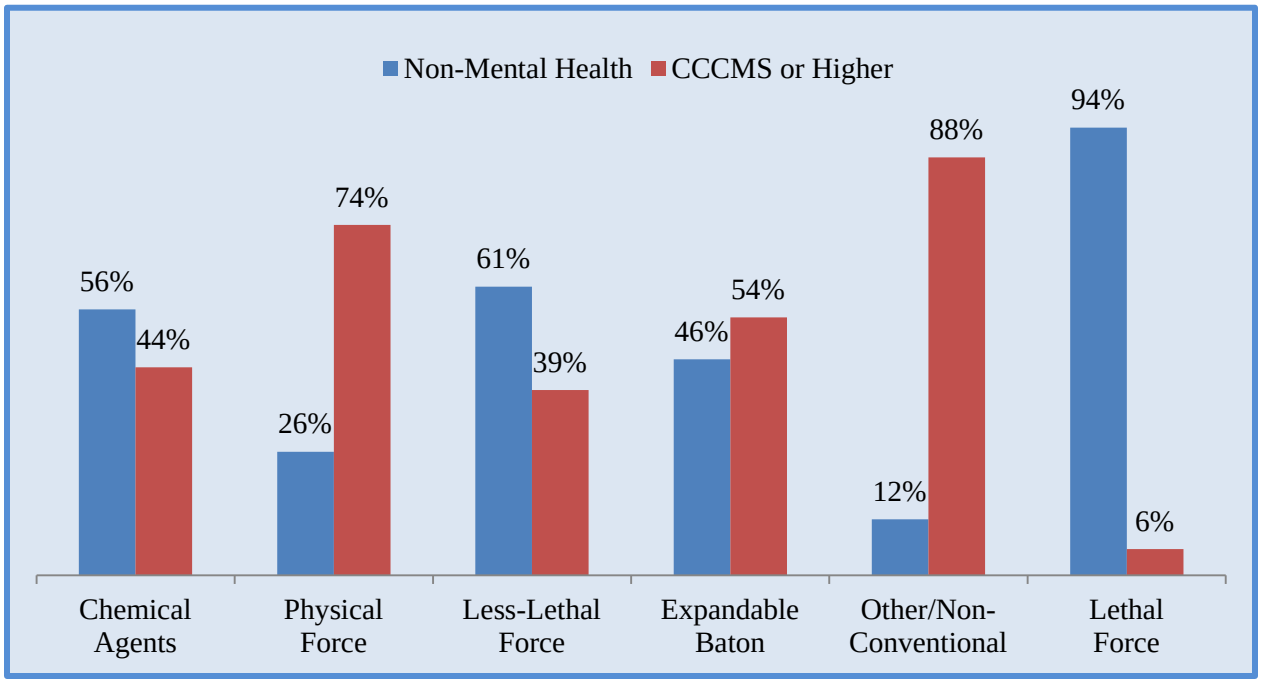
*Percentages are rounded to the nearest whole number.

In addition to these general statistics, the OIG identified 9 inmates and 17 wards who were involved in four or more use-of-force incidents during this reporting period.[26] All of the wards were participants in the Wards with Disabilities Program (WDP),[27] which includes wards with mental illness as well as other disabilities. One of these wards was involved in ten incidents and a second ward was involved in nine incidents.

Of the nine inmates involved in four or more incidents, four inmates were in the CCCMS level of care. One of these four inmates was involved in six incidents. Four other inmates were in the Enhanced Outpatient Program (EOP) level of care, one was a Department of State Hospitals (DSH) inmate, and one was in a Mental Health Crisis Bed level of care. Based on these statistics, mental health inmates and wards are more likely to be involved in repeated use-of-force incidents.

Chart 1 below reflects the frequency of force used by type for the 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.

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



[26] 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 reviewed by the OIG at IERC meetings or during the consent process. The OIG attended 93 percent of the IERC meetings statewide.

[27] 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.

As the chart reflects, the department appears to make an effort to limit the use of more severe use-of-force methods, including lethal force, and instead uses physical and non-conventional force on mentally ill inmates. The information collected during this reporting period shows that non-conventional and physical force were the type of force most often used. Mental health inmates were involved in 6 percent of the total uses of lethal force.

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 individual uses of force based on type of force and the number of times the force was used on an individual inmate during an 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**	**Total**
Chemical Agents	2,725	1,277	46	63	**4,111**
Physical Force	957	1,198	453	180	**2,788**
Less-Lethal Force	281	106	0	6	**393**
Expandable Baton	163	112	11	4	**290**
Other/Non-Conventional	19	34	19	10	**82**
Lethal Force	1	0	0	0	**1**
Total	**4,146**	**2,727**	**529**	**263**	**7,665**

Of the 4,146 uses of force on CCCMS inmates during 947 incidents, the OIG found immediate force was not justified in 15 incidents. The actual force used on CCCMS inmates was out of policy in a total of 40 incidents. The department referred four of those cases to the Office of Internal Affairs. In addition, the department imposed disciplinary action in five cases, trained staff in seven cases, and issued counseling in four cases. The department also found policy deviations in 20 cases, but found the deviations reasonable. Of the 947 incidents reviewed, the OIG concurred in all but eight of the decisions. In four of these eight incidents, the hiring authority found the use of force to comply with policy. A fifth involved an allegation but no action taken. In this case, an inmate alleged an officer used excessive force by kicking a food port closed after the inmate threw a tray through the food port and was grabbing another tray. The OIG did not concur with the department's finding that kicking the food port was not a use of force, but did concur that the officer's actions were reasonable. One incident was found to be out of compliance with policy but the hiring authority only provided training, and the other two were deferred.

For EOP inmates, of the 2,727 uses of force during 798 incidents, the OIG found immediate force was not justified in seven incidents. The actual force used on EOP inmates was out of policy in 35 incidents. The department referred eight of those cases to the Office of Internal Affairs. The department also imposed disciplinary action in four cases, trained staff in eight cases, and issued counseling in three cases. The department found policy deviations in 12 cases,

but found the deviations reasonable. The OIG concurred with all of the decisions except for one found to be in compliance with policy and ten that were deferred.

Of the 529 uses of force during 144 incidents involving MHCB inmates, the OIG found immediate force was not justified in 3 incidents. The actual force used was out of policy in 13 incidents. Of those, the department referred one case to the Office of Internal Affairs. The department also imposed disciplinary action in one case, provided training in four cases, and found reasonable deviations in seven cases. The OIG concurred with all but three decisions. Of the three decisions with which the OIG did not concur, one involved the provision of training and one involved a deviation that was determined to be reasonable. The third was deferred.

Of the 263 uses of force on DSH patients during 80 incidents, the OIG found immediate force not justified in one incident. The department also referred one case to the Office of Internal Affairs for a policy violation and found two others with reasonable deviations from policy. The OIG concurred with all of these decisions except one incident that was deferred.

For incidents in which hiring authorities found that the actual use of force did not comply with policy, the OIG concurred with the hiring authority's determinations in all but one case. In that case, the OIG disagreed with the hiring authority's decision to not provide training to a sergeant who did not articulate the distance from which he deployed chemical agents.

VIDEO-RECORDED INTERVIEWS

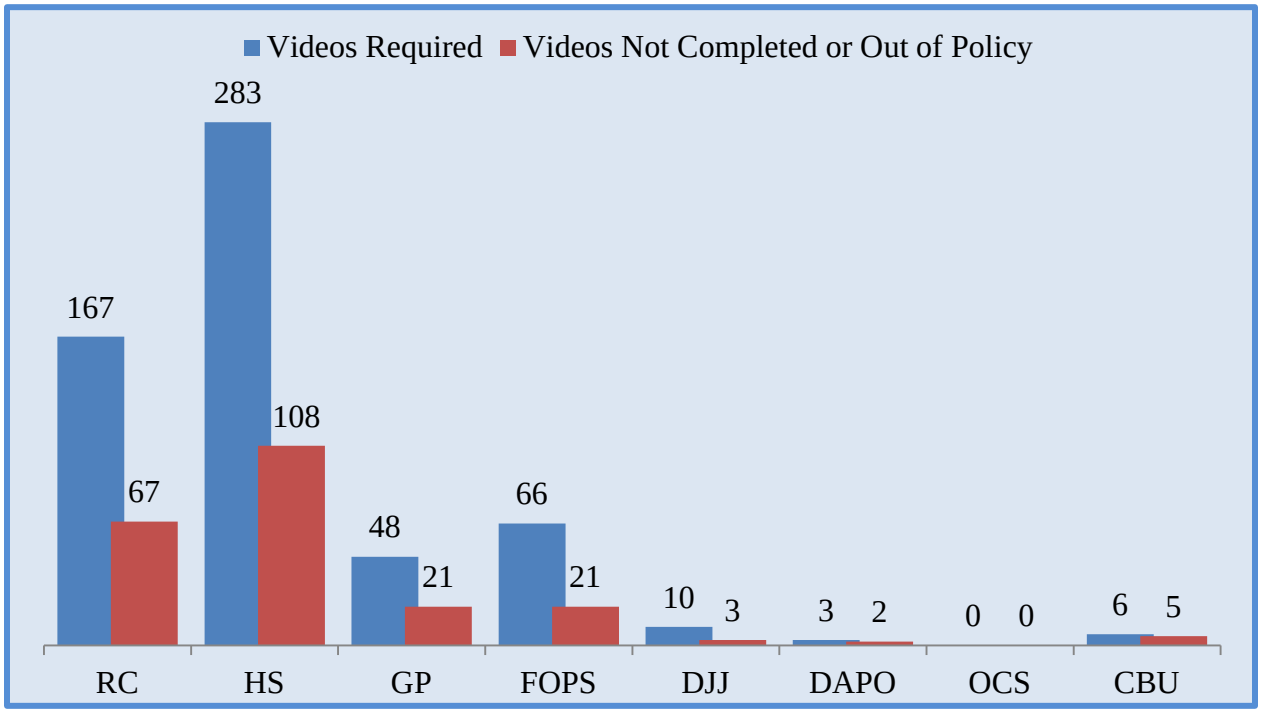
The department's use-of-force policy requires the department to video-record an interview with any inmate who alleged unreasonable force or sustained serious or great bodily injury possibly due to a use of force.[28] The video recording should be conducted within 48 hours of discovery of the injury or 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 583 incidents that required video-recorded interviews. Of those, 356 were conducted within policy and in 227 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 61 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. In addition, during this reporting period, the OIG noted seven cases wherein the department potentially intimidated an inmate during the recorded interview. In one of those cases, the interviewing lieutenant was involved in the incident and, therefore, should not have conducted the interview. In addition, the interview took place in front of the inmate's cell as opposed to a private area and the lieutenant failed to record the inmate's injuries. The hiring authority provided training to the lieutenant and the OIG concurred.

[28] Department Operations Manual, Chapter 5, Article 2, Section 51020.17.3.

A second case involved an interview that took place in front of the inmate's cell but the hiring authority did not take any action. The OIG did not concur. In a third case, the interviewing sergeant took an aggressive tone toward the inmate, repeatedly interrupted the inmate, and repeated questions. The hiring authority referred the matter to the Office of Internal Affairs for possible misconduct and the OIG concurred. Despite the OIG previously reporting similar failures, the department continues to fail in this area, with a compliance rate of only 61percent. 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 (DJJ) consisted of three facilities[29] and one conservation camp, and was responsible for supervising 692 juvenile wards as of December 31, 2016.[30] DJJ has its own policy governing the use of force, including the need for video-recorded interviews under certain circumstances.[31] The OIG assess DJJ's compliance with its own policy.

Between July 1, 2016, and December 31, 2016, the OIG reviewed 197 use-of-force incidents that occurred at the three juvenile facilities. There were no incidents in the juvenile conservation

[29] O. H. Close Youth Correctional Facility (OHC) and N. A. Chaderjian Youth Correctional Facility (NAC) are co-located in Stockton.
[30] Data derived from: *http://www.cdcr.ca.gov/Juvenile_Justice/docs/DJJ_ADP_Monthly_Report_2016/ADP_MONTHLY_REPORT_2016.12.pdf*
[31] Division of Juvenile Justice, Crisis Prevention and Management, Use of Force, April 8, 2013.

camp this reporting period. The OIG attended 88 percent of the meetings held at all three DJJ facilities.

Among the 197 incidents reviewed, 74 were at N.A. Chaderjian Youth Correctional Facility (NAC), 66 were at O.H. Close Youth Correctional Facility (OHC), and 57 were at Ventura Youth Correctional Facility (VYCF). The OIG found the actual force used complied with policy in all but six incidents, two at NAC, two at VYCF, and two at OHC. In addition, the OIG found one incident at OHC where the use of force deviated from policy but the deviation was deemed reasonable. In that case, a ward refused to return to his room and was threatening the officer with clenched fists. The officer used pepper spray from a closer distance than allowed, but this was deemed reasonable because the officer did not have sufficient room to retreat.

In two of the incidents where the use of force was found out of policy, officers should have used controlled uses of force rather than immediate force. In both cases, officers used physical force. In a third incident, an officer used pepper spray at too close of a distance and in two incidents, officers used foam rounds. In one of those incidents, the officer fired a foam round as a warning shot and in the second incident, the officer fired the round without sufficient back-up and into a dark room. In all cases, the department provided training or counseling and the OIG concurred.

Three of the incidents the OIG reviewed at DJJ facilities involved allegations that staff members used unreasonable force. In one case, a ward claimed a counselor used excessive force to move his arm out of the way when he reached around the counselor to retrieve an item from another ward. The hiring authority found the ward's allegation to be unfounded and that the force was appropriate, and the OIG concurred. In the second case, a ward claimed staff members beat him. The department found the use of force to comply with policy and the OIG concurred. In the third case, the ward claimed an officer failed to warn him before using pepper spray. The hiring authority found the officer failed to provide a warning and issued counseling to the officer. The OIG also concurred with this determination, as well as all cases the OIG closed during this reporting period.

DIVISION OF ADULT PAROLE OPERATIONS

During this reporting period, the Division of Adult Parole Operations (DAPO) consisted of two parole regions. As of December 31, 2016, DAPO was responsible for supervising 44,161 parolees.[32] The OIG reviewed 24 use-of-force incidents: eight in the northern parole region and 16 in the southern parole region. The OIG attended 92 percent of the DAPO use-of-force meetings held statewide during this reporting period. Of the incidents reviewed, the OIG found one incident out of policy. In this incident, the OIG identified that the parole agent used pepper spray closer than policy allows. The department provided training and the OIG concurred.

[32] *Data derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/PAROLE/PAROLEd1612.pdf.*

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 (OCS). The Office of Correctional Safety is the primary departmental link with allied law enforcement agencies and the California Emergency Management Agency. Major responsibilities of OCS 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 reporting period, the OIG attended the two use-of-force meetings the Office of Correctional Safety conducted. There were only two incidents, each involving physical force. In both incidents, the force was deemed to comply with policy.

Contraband Surveillance Watch

In 2012, citing concerns by the Legislature that CDCR's contraband surveillance watch process was not being applied consistently, the OIG developed a contraband surveillance watch monitoring program. Contraband surveillance watch is a significant budget driver for CDCR because it requires additional staffing for one-on-one observations. 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.

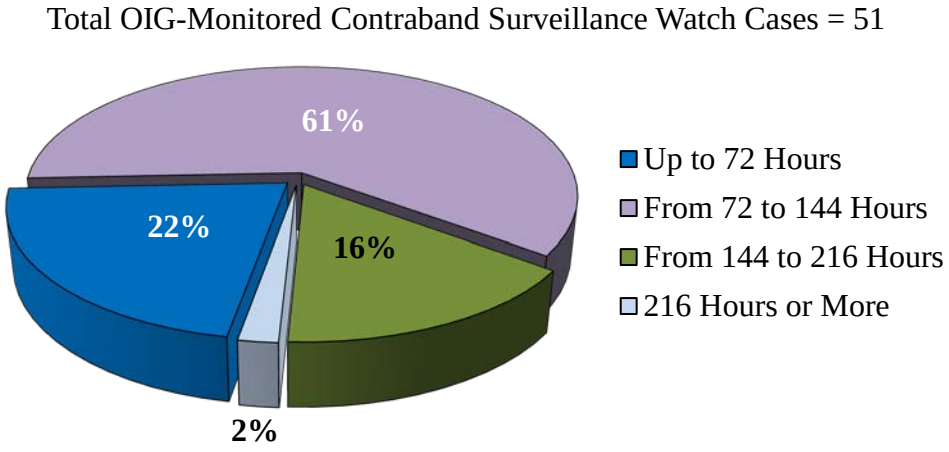
The department is required to notify the OIG every time an inmate is placed on contraband surveillance watch and when the department transfers an inmate to an outside hospital while on contraband surveillance watch. The OIG collects all relevant data, including the inmate's name, reason for placing the 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 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.

During this reporting period, the department notified the OIG of 121 contraband surveillance watch cases, slightly fewer contraband surveillance watch cases compared to the five previous reporting periods. In the five prior reporting periods, the department notified the OIG of inmates placed on contraband surveillance watch 128, 135, 155, 206, and 192 times respectively. 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.[33] Normally, the department should retain an inmate on contraband surveillance watch for no more than 72 hours.

During this reporting period, the OIG is reporting 51 monitored cases in Appendix F. These 51 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 31 cases. In eight cases, the department kept inmates on contraband surveillance watch between 144 and 216 hours, and in only one case did the department keep an inmate on contraband surveillance watch longer than 216 hours. In this case, the department placed the inmate on contraband surveillance because the inmate swallowed unknown items a visitor had provided. While on contraband surveillance watch, the department recovered several bindles of heroin from the inmate. In addition, other than minor documentation issues, the department sufficiently complied with policies during the watch in all 51 cases. Chart 3 below depicts the percentages of cases by duration for cases the OIG monitored.

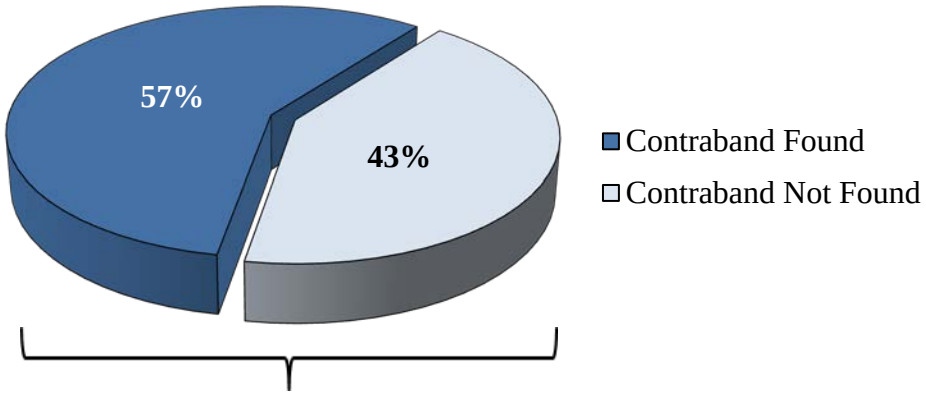
Chart 3: *Duration of OIG-Monitored Contraband Surveillance Watch Cases*



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

Of the 121 total cases reported to the OIG from July 1, 2016, through December 31, 2016, the department recovered contraband in 62 percent of the total cases for all durations of contraband surveillance watch. The department recovered contraband in 57 percent of the total cases reported to the OIG that did not extend beyond 72 hours. Chart 4 below reflects the percentages for cases reported to the OIG lasting less than 72 hours.

Chart 4: *Contraband Found in Total Cases Reported to the OIG Lasting Less Than 72 Hours*



For cases the OIG monitored and is reporting currently, the department recovered contraband in 78 percent of cases that extended beyond 72 hours, including the one case that extended beyond 216 hours. This is a fairly significant increase from the 68 percent recovery rate during the last reporting period. Chart 5 below reflects the percentages of contraband found per case duration.

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

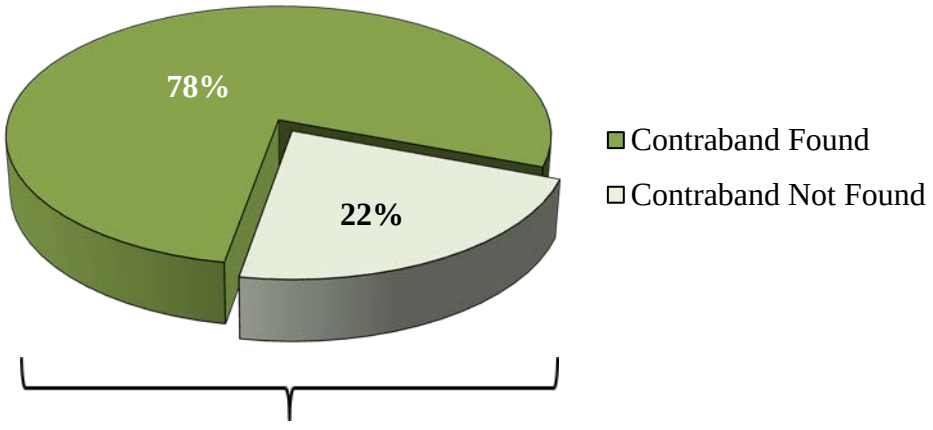


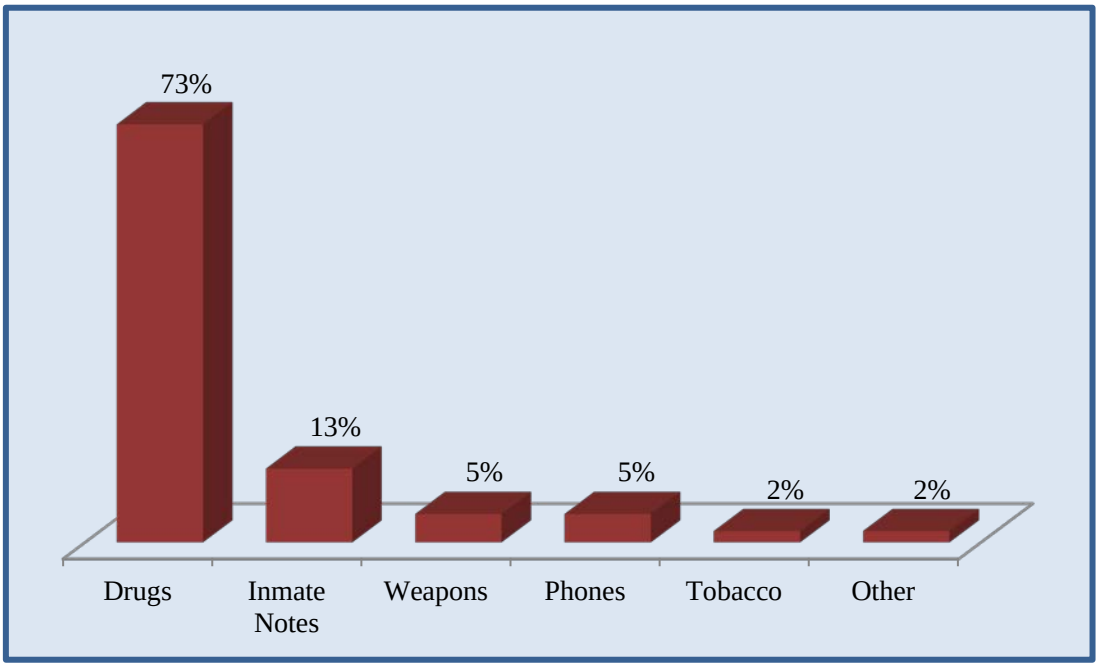
Table 7 below shows a comparison of the percentages of cases where the department recovered contraband between January 2014 and December 2016 for those cases extending beyond 72 hours.

Table 7: *Contraband Found in Cases Extending Beyond 72 Hours, 2014 to 2016*

Reporting Period	Cases Over 72 Hours	Contraband Found	Percentage
January–June 2014	48	17	35%
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%

As previously noted, this report covers in detail those cases in which contraband surveillance watch extended beyond 72 hours, as well as those cases where the department transported inmates to outside hospitals. Chart 6 below reflects the types of contraband found for those incidents. In some cases, the department recovered more than one type of contraband.

Chart 6: *Contraband Type and Frequency in Cases Extending Beyond 72 Hours*



The OIG rated the department on the adequacy of its management of contraband surveillance watch. Of the 51 cases the OIG monitored, the department sufficiently managed the contraband surveillance watch process in 28 cases, or 55 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 the majority of insufficient cases, the department provided training, and in some instances, written counseling.

However, in two insufficient cases, the department failed to adequately monitor the inmate during contraband surveillance watch, enabling the inmate to re-ingest contraband. In another case that bears mention, the department removed an inmate from contraband surveillance watch only two hours after being placed on contraband surveillance watch despite a drug-sniffing dog's indication the inmate might possess drugs and the inmate's voluntary relinquishment of an inmate-manufactured weapon. The OIG expressed concerns about the early removal since the inmate could distribute concealed drugs, but the hiring authority disagreed and granted removal.

The department's decision to place inmates on contraband surveillance watch complied with policy in all but one case the OIG monitored. In the one case, the department waited more than eight hours after the inmate failed a metal detector and admitted to swallowing metal security bits before placing the inmate on contraband surveillance watch.

The department did not timely notify the OIG when an inmate was placed on contraband surveillance watch in two cases. During the last reporting period, the department failed to notify the OIG when placing the inmate on contraband surveillance watch in three monitored cases. In addition, during this reporting period, the department failed to notify the OIG when inmates were transferred to an outside hospital in three of the eleven cases involving hospital placement.

Table 8 on the following page details the total number of contraband surveillance watch cases that occurred during this reporting period at each institution.

Table 8: *Contraband Surveillance Watch Cases, by Institution, July–December 2016*

Institution	Less Than 72 Hours *Includes 11 cases the OIG monitored	72 to Less Than 144 Hours *All OIG monitored	144 to Less Than 216 Hours *All OIG monitored	216 Hours or More *OIG monitored	Number of Cases Rated Sufficient	Number of Cases Rated Insufficient
ASP	0	0	0	0	N/A	N/A
CAC	1	0	0	0	N/A	N/A
CAL	4	1	0	0	1	4
CCC	11	7	1	0	8	2
CCI	0	0	0	0	N/A	N/A
CCWF	0	0	0	0	N/A	N/A
CEN	6	4	1	0	2	3
CHCF	0	0	0	0	N/A	N/A
CIM	2	1	0	0	0	1
CIW	1	0	0	0	N/A	N/A
CMC	1	0	0	0	N/A	N/A
CMF	0	0	0	0	N/A	N/A
COCF	0	0	0	0	N/A	N/A
COCF-LPCC	0	0	0	0	N/A	N/A
COCF-NFCF	0	0	0	0	N/A	N/A
COCF-TCCF	0	0	0	0	N/A	N/A
COR	1	1	0	0	1	0
CRC	0	0	0	0	N/A	N/A
CTF	0	0	0	0	N/A	N/A
CVSP	0	0	0	0	N/A	N/A
DVI	1	0	0	0	N/A	N/A
FSP	1	2	2	0	4	1
HDSP	6	2	0	0	1	2
ISP	0	0	1	0	0	1
KVSP	2	1	0	0	1	0
LAC	6	2	0	0	2	2
MCSP	1	2	0	0	0	2
NKSP	0	0	0	0	N/A	N/A
NCYCC	3	0	0	0	N/A	N/A
NYCRC	0	0	0	0	N/A	N/A
OHC	0	0	0	0	N/A	N/A
PBSP	6	2	0	0	1	1
PVSP	3	1	0	0	1	0
RJD	2	1	0	0	0	2
SAC	2	0	1	1	2	0
SATF	2	1	1	0	1	1
SCC	3	0	0	0	N/A	N/A
SOL	7	1	1	0	2	0
SQ	4	1	0	0	0	1
SVSP	2	1	0	0	1	0
VSP	1	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	79	31	8	1	28	23
	Contraband Recovered: 45 Cases = 57%	Contraband Recovered: 22 Cases = 71%	Contraband Recovered: 8 Cases = 100%	Contraband Recovered: 1 Cases = 100%	Sufficient = 55%	Insufficient = 45%

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 now requires that, before mechanical restraints are used, 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 prior 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.

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. On July 1, 2015, the OIG began collecting data regarding the department's response to OIG's inquiries for inclusion in the Semi-Annual Report. As part of the monitoring duties, the OIG assigns staff members to address field inquiries regarding selected complaints. 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. In this reporting period, the OIG completed the collection of data for 32 inquiries referred to the OIG.

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.

In this reporting period, the OIG concluded 32 inquiries at 17 institutions. Of the 32 cases, the department sufficiently addressed the OIG's inquiry in 27 cases (84 percent). Two of the five insufficient cases involved possible disclosure of confidential inmate information. In one of the cases, another inmate was in possession of the information. In both cases, the hiring authority appropriately referred the matter to the Office of Internal Affairs. However, the Office of Internal Affairs declined to open investigations despite the OIG's recommendations to investigate both cases.

In a third case, an inmate alleged the department mishandled an investigation into alleged sexual assault by an officer. The Office of Internal Affairs again refused to conduct an investigation. The OIG elevated the matter to an Office of Internal Affairs executive, who also rejected the recommendation for an investigation. In the fourth case, three inmates alleged the institution was delaying their legal mail. The hiring authority did not adequately cooperate with the OIG's requests for information, resulting in the insufficient assessment. Finally, the fifth case involved a complaint submitted by a supervising nurse claiming a psychiatric technician used Family Medical Leave time to pursue a second job and that a nurse left work before being relieved. Again, part of the insufficient assessment was inadequate cooperation with the OIG. In addition, the hiring authority delayed in submitting the matter to the Office of Internal Affairs for investigation into the possible misconduct.

Overall, the percentage of sufficient assessments has declined since the prior reporting period when the department sufficiently addressed 94 percent of the inquiries. The OIG will continue to examine all complaints and allegations received to help ensure appropriate resolution.

Volume II Conclusion

The OIG publishes the Semi-Annual Report in two volumes to allow the reader to more easily focus on specific areas of the OIG's monitoring. All areas of monitoring require transparent oversight in order to ensure public trust, proper adherence to policy, best practices, safety and security of staff and inmates, and accountability to the taxpayer. During all 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 for 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 82 percent of critical incident cases reported in Appendices D1 and E. This is a slight improvement over the prior reporting period when the department timely notified the OIG in 80 percent of cases. In addition, the department timely notified the OIG of 94 percent of Deadly Force Investigation Team cases, which is consistent with the last reporting period.

In an effort to meet its goal of attending 100 percent of the statewide use-of-force meetings, the OIG increased its attendance from 638 use-of-force meetings attended during the prior reporting period to 775 meetings during this reporting period. In addition, the OIG evaluated and closed 3,637 unique incidents. Overall, the committees took appropriate action. As mentioned, the OIG's new use-of-force monitoring tool allows the OIG to report more detailed data regarding use-of-force incidents, compliance with policies and procedures, and areas of potential improvement. Review of this information indicates that the department could improve its practices in complying with policies regarding the actual use of force since the OIG found only 80 percent of the uses of force in compliance with policy during this reporting period. In addition, the department can improve in other areas, such as report-writing, holding cell procedures, and the use of video recordings.

The OIG also continues to monitor and report on the department's handling of contraband surveillance watch. If department staff members do not follow policies, serious medical issues may occur. During this reporting period, the department again demonstrated a mediocre rate of compliance with contraband surveillance watch policies, with 55 percent of the cases rated sufficient. During the prior reporting period, the compliance rate was 53 percent. Similar to prior reporting periods, documentation is still the weakest area of compliance. However, it should be noted that the need for contraband surveillance watch has diminished and the department is still not keeping inmates on contraband surveillance watch for unreasonable lengths of time.

This report also includes the department's response to the OIG's complaint intake process. The OIG headquarters intake personnel resolve 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 84 percent of the field inquiry cases during this reporting period

and the OIG continues to view this as value added in providing legitimacy to the complaint process.

Because the report details those cases where there is a violation of policy, or the OIG does not concur with the department's action, it is easy to form false perceptions. There are definitely areas for the department to improve, and we have highlighted some emergent issues, such as the frequency of negligent discharge incidents. But the current administration has so far made sincere efforts to discuss and act on the majority of OIG recommendations.

Oversight is a critical element for the transparency of the California corrections system. As this Semi-Annual Report reflects, the OIG continues to provide 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 commends the department for implementing prior recommendations and continues to encourage CDCR to implement those that remain. The OIG recommends the department implement the following recommendations from Volume II of this 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.

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.

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, January through June 2016.

Recommendation 2.1: The OIG recommends the department amend DOM 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: Not Implemented

The Division of Adult Institutions will revise DOM Section 51020.19.5. This revision will add specific language relative to the Institutional Executive Review Committee reviewing video capturing immediate use-of-force when video footage is available. To be completed by April 2017.

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

CDCR Response: Not Implemented

The Division of Adult Institutions will revise DOM to incorporate the Division of Adult Institutions' existing expectation that the Department Executive Review Committee reviews required use-of-force incidents within 60 days of completion by the Institution Executive Review Committee. To be completed by April 2017.

The OIG recommended the department implement the following recommendation from Volume II of the Semi-Annual Report, July through December 2015.

Recommendation 2.1: The OIG recommends the department amend Title 15, DOM, and Form 115 Part C to require individuals who serve Form 115 Part C to attest to actual service and effective communication. Form 115 Part C should include an attestation clause that the person who signed the form personally served the Rules Violation Report and ensured effective communication. The form should also include a section for the inmate's signature acknowledging receipt of the form or refused service.

CDCR Response: Not Implemented

CDCR has determined it will not implement this recommendation. The current SOMS technology does not have the ability to allow inmates to electronically sign RVRs. Other means of meeting this request are not feasible due to the number of staff that would be required for this proposed recommendation.

Appendices

APPENDIX D1 18
MONITORED DEADLY FORCE INCIDENT CASE SUMMARIES
Central Region

Incident Summary
OIG Case Number: **16-1092-RO**

On April 11, 2016, an officer allegedly negligently fired one round from a firearm while attempting to make the weapon safe. The OIG responded to the scene.

Incident Date: 2016-04-11	Deadly Force Incident

Disposition
The institution's executive review committee determined the discharge was not within departmental policy but was accidental and noted that the hiring authority provided training. The OIG did not concur.

Incident Assessment
The department's actions during the incident were not adequate because an officer allegedly unintentionally discharged a firearm. The department's response was not adequate because the hiring authority did not request an investigation or determine how the unintended discharge occurred, the Office of Internal Affairs did not investigate the matter, and the officer did not adequately document the matter.

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

Assessment Questions
- Were the department's actions prior to, during, and after the critical incident appropriate?

  The officer allegedly negligently discharged a firearm and the hiring authority never determined how the officer chambered a live round after being told to make the handgun safe and failed to submit the matter to the Office of Internal Affairs. The Office of Internal Affairs did not initiate an investigation.

- Was the critical incident adequately documented?

  The officer did not explain in his report how he chambered a live round if he was making the handgun safe.

- 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 determined that the hiring authority never discovered why or how the officer chambered a round when he should have made the handgun safe and that the hiring authority failed to refer the matter to the Office of Internal Affairs.

- Did the hiring authority appropriately determine whether to refer any conduct to the OIA related to the critical incident?

  The hiring authority should have referred the matter to the Office of Internal Affairs to determine why and how the officer fired his handgun after being told to make it safe.

Central Region

Incident Summary

OIG Case Number: **16-1232-RO**

On April 23, 2016, approximately 40 inmates attacked another inmate on the exercise yard. Officers used chemical agents and deployed six less-lethal rounds. An officer fired three warning shots from a Mini-14 rifle, stopping the attack. The attacked inmate sustained minor injuries and was treated at the institution. The OIG responded to the scene.

Incident Date: 2016-04-23	Deadly Force Incident

Disposition

The institution's executive review committee determined that the officer's use of force complied with departmental policy and the hiring authority did not identify any staff misconduct. The OIG did not concur because the officer did not sufficiently document the justification for his use of deadly force and the institution's executive review committee neglected to identify this failure. The Office of Internal Affairs conducted an inquiry to interview the officer, at which time the officer described the circumstances leading to his use of deadly force. The Office of Internal Affairs decided no further action needed to be taken. The OIG concurred.

Incident Assessment

The department's response following the incident was not adequate because the officer did not adequately describe the justification for using deadly force, the institution's executive review committee did not identify the officer's failure, and the hiring authority delayed referring the matter to the Office of Internal Affairs.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The officer's written report failed to adequately describe the need to use deadly force.

- Was the critical incident adequately documented?

  The officer's justification for the use of deadly force was not adequately documented.

- Did the use-of-force review committee adequately review and respond to the incident?

  The institution's executive review committee failed to identify that the officer did not adequately document the justification for using deadly force.

- 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 the officer's failure to adequately articulate the need to use deadly force and the institution's executive review committee's failure to deem the officer's report inadequate.

- 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 23, 2016, but the hiring authority did not refer the matter to the Office of Internal Affairs until June 9, 2016, 47 days after the date of discovery.

Central Region

Incident Summary

OIG Case Number: **16-1382-RO**

On May 9, 2016, an officer saw two inmates pull a third inmate from a wheelchair and begin stabbing and hitting him. The officer fired one warning shot from a Mini-14 rifle and three less-lethal rounds, stopping the attack. The third inmate resisted officers and an officer struck him once with a baton and used physical force to subdue him. The third inmate sustained puncture wounds to his neck, chest, and back, and the department transported him to an outside hospital and he returned to the institution the next day. The OIG responded to the scene.

Incident Date: 2016-05-09	Deadly Force Incident

Disposition

The institution's executive review committee determined that the officer's use of lethal force was in compliance with departmental policy, the officer's use of three less-lethal rounds did not comply with policy, and a lieutenant failed to timely obtain a public safety statement. The OIG concurred. The hiring authority provided training to the officer and lieutenant.

Incident Assessment

The department's response was not adequate because an officer discharged three less-lethal rounds from an ineffective distance and a lieutenant failed to timely obtain a public safety statement.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  An officer discharged three less-lethal rounds from a location that was far beyond the effective range for the weapon and a lieutenant failed to timely obtain a public safety statement.

Central Region

Incident Summary

OIG Case Number: **16-1473-RO**

On May 12, 2016, an officer allegedly negligently discharged a firearm during a tactical reloading drill during training.

Incident Date: 2016-05-12	Deadly Force Incident

Disposition

The hiring authority did not identify any staff misconduct, but provided range safety training to the officer and developed and implemented a written procedure for responding to unintended discharges on the range, including timely notification to the OIG.

Incident Assessment

The department's actions prior to the incident were not adequate because the hiring authority had no established procedures for addressing such incidents. The department's actions during the incident were not adequate because an officer allegedly negligently discharged a firearm. The department's actions following the incident 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 incident. The investigative services unit did not respond to the scene and the hiring authority did not request an investigation or review the matter, appropriately preserve evidence, or take a public safety statement. The Office of Internal Affairs also neglected to initiate an investigation.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Insufficient	**Insufficient**	**Insufficient**

Assessment Questions

- Did the department timely notify the OIG regarding the critical incident?

  The department delayed notifying the OIG for almost two hours after the incident, preventing the OIG from responding to the scene.

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The officer allegedly negligently discharged a weapon. The hiring authority had no established procedures for responding to or reviewing unintended firearm discharges during range training and failed to initiate an investigation, establish a crime scene, take a public safety statement, and secure the weapon for testing. The Office of Internal Affairs also failed to initiate an investigation.

- Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?

  The investigative services unit did not respond to the scene.

- Did the use-of-force review committee adequately review and respond to the incident?

  The institution's executive review committee did not review 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 the need to refer the alleged negligent discharge of a firearm to the Office of Internal Affairs for investigation.

- Did the hiring authority appropriately determine whether to refer any conduct to the OIA related to the critical incident?

  The hiring authority refused to refer the matter to the Office of Internal Affairs for investigation.

Central Region

Incident Summary

OIG Case Number: **16-1466-RO**

On May 16, 2016, an officer saw two inmates punching a third inmate and fired a less-lethal round at the back of an attacking inmate's leg, striking him in the head instead. The inmates stopped fighting. The department transported the inmate struck in the head to an outside hospital. The inmate suffered a skull fracture and intracranial bleeding and returned to the institution two days later.

Incident Date: 2016-05-16	Deadly Force Incident

Disposition

The institution's executive review committee determined that the officer's use of force was in compliance with departmental 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Summary

OIG Case Number: **16-1723-RO**

On June 3, 2016, after observing one inmate attack another inmate, an officer fired three less-lethal rounds, one of which struck the attacking inmate in the face. The inmates stopped fighting. The department transported the attacking inmate to an outside hospital where he was diagnosed with a fractured skull and returned to the institution.

Incident Date: 2016-06-03	Deadly Force Incident

Disposition

The institution's executive review committee determined the use of force was in compliance with departmental policy. The OIG concurred. The hiring authority identified potential staff misconduct based on the failure of a lieutenant to properly document injuries and the failure of a sergeant and officer to properly document a public safety statement, and provided training.

Incident Assessment

The department's actions following the incident were not adequate because the department did not properly document the incident.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  After the incident, a lieutenant did not completely document the inmate's injuries when conducting the video-recorded interview and a sergeant and officer did not properly document a public safety statement.

- Was the critical incident adequately documented?

  Neither the officer that provided the public safety statement nor the sergeant that took the public safety statement documented the public safety statement in their incident reports. The lieutenant did not completely 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 lieutenant did not properly document the inmate's injuries.

Central Region

Incident Summary

OIG Case Number: **16-1819-RO**

On July 26, 2016, an officer allegedly negligently discharged a round from a handgun as she attempted to clear the chamber. The round struck the floor, deflected, and embedded in a wall.

Incident Date: 2016-07-26	Deadly Force Incident

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 during the incident were not adequate because an officer allegedly negligently discharged a firearm. The department's actions following the incident were not adequate because a sergeant allegedly failed to obtain a timely and legally appropriate public safety statement and the hiring authority did not timely refer the matter to the Office of Internal Affairs. An officer allegedly negligently discharged a firearm.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The officer allegedly negligently discharged a firearm. The department obtained a public statement only after a sergeant requested and the officer agreed to provide the statement, 90 minutes after the incident, and the public safety statement contained irrelevant and inappropriate information.

- 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 the failure to obtain a timely and legally appropriate public safety statement.

- 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 July 26, 2016, but the hiring authority did not refer the matter to the Office of Internal Affairs until September 12, 2016, 48 days after the date of discovery.

Central Region

Incident Summary

OIG Case Number: **16-1996-RO**

On October 20, 2016, approximately 50 inmates attacked 20 inmates on the exercise yard. Officers deployed chemical agents and less-lethal rounds and an officer fired one warning shot from a Mini-14 rifle, which stopped the attack. The department transported one inmate to an outside hospital for injuries consistent with the attack. The inmate returned to the institution the next day. The OIG responded to the scene.

Incident Date: 2016-10-20	Deadly Force Incident

Disposition

The institution's executive review committee determined that the officer's use of force was in compliance with departmental 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

North Region

Incident Summary

OIG Case Number: **15-2085-RO**

On October 12, 2015, over 100 inmates engaged in three separate riots on two exercise yards and in a classroom. Officers deployed pepper spray, 38 less-lethal rounds, and 17 pepper spray grenades. One officer fired two warning shots from a Mini-14 rifle and another officer fired one warning shot from a Mini-14 rifle. Two inmates reported being struck in the head with the less-lethal rounds. Three inmates were transported to an outside hospital for stab wounds and returned to the institution the same day. The OIG responded to the scene.

Incident Date: 2015-10-12	Deadly Force Incident

Disposition

The institution's executive review committee determined that an officer did not aim at the proper target when he fired a less-lethal round and another officer deployed pepper spray from a distance closer than the recommended minimum distance. The OIG concurred. The hiring authority ordered training for the officers.

Incident Assessment

The department's response was not adequate because the department did not adequately cooperate with the OIG, timely review the incident, or make a timely decision regarding whether to refer any conduct to the Office of Internal Affairs. Also, officers did not use force in the proper manner.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  An officer failed to aim at the proper target when he fired a less-lethal round and another officer deployed pepper spray from a distance closer than the recommended range.

- Did the use-of-force review committee adequately review and respond to the incident?

  The institution's executive review committee did not review the incident until December 18, 2015, 67 days after the incident.

- Did the department adequately consult with the OIG regarding the critical incident?

  The department did not timely provide the OIG with copies of reports upon the OIG's request.

- 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 12, 2015, but the hiring authority did not make a decision regarding whether to refer the matter to the Office of Internal Affairs until December 18, 2015, 67 days after the date of discovery.

North Region

Incident Summary	OIG Case Number: **16-1648-RO**
On May 26, 2016, approximately 170 inmates engaged in a riot on the exercise yard. A lieutenant fired one round from a Mini-14 rifle into the ground as a warning shot, stopping the fight. The department transported one inmate to an outside hospital for a head injury suffered as a result of fighting with other inmates. The inmate returned to the institution the same day. The OIG responded to the scene.	
Incident Date: 2016-05-26	Deadly Force Incident

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.

Incident Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Summary	OIG Case Number: **16-1720-RO**
On June 7, 2016, two inmates attacked a third inmate on the exercise yard. Officers used less-lethal force and one officer fired a warning shot from a Mini-14 rifle, stopping the attack. The department transported the attacked inmate to an outside hospital where he died from stab wounds sustained during the attack. The department also transported one of the attacking inmates to an outside hospital for a broken arm. The OIG responded to the scene.	
Incident Date: 2016-06-07	Deadly Force Incident

Disposition

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

Incident Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

North Region

Incident Summary	OIG Case Number: **16-1761-RO**
On June 28, 2016, three inmates attacked a fourth inmate with an inmate-manufactured weapon on the exercise yard. An officer fired one warning shot from a Mini-14 rifle at a wall in an area with no inmates, stopping the attack. The department transported the fourth inmate to an outside hospital and he returned to the institution two days later. The OIG responded to the scene.	
Incident Date: 2016-06-28	Deadly Force Incident

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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Summary	OIG Case Number: **16-1955-RO**
On September 17, 2016, a sergeant returned home to find an intruder inside. The intruder advanced toward the sergeant and the sergeant attempted to fire his off-duty weapon at the intruder. However, the weapon did not fire and the intruder fled. Outside law enforcement responded to the scene and subsequently apprehended the intruder.	
Incident Date: 2016-09-17	Deadly Force Incident

Disposition

The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was satisfactory in all critical respects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

North Region

Incident Summary

OIG Case Number: **16-1979-RO**

On October 17, 2016, an officer allegedly negligently discharged a firearm at an institution's gun range. The round struck the ground and no one sustained injuries.

Incident Date: 2016-10-17	Deadly Force Incident

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. 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 response was not adequate because the officer allegedly negligently discharged his firearm. The department did not timely provide the OIG accurate information regarding the location of the incident.

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

Assessment Questions

- Did the department timely notify the OIG regarding the critical incident?

  The department did not provide the OIG with accurate information about the location of the incident until nearly three hours after the incident occurred.

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The officer allegedly negligently discharged a firearm.

South Region

Incident Summary

OIG Case Number: **15-2729-RO**

On December 10, 2015, approximately 100 inmates participated in a riot on the exercise yard. An officer fired three warning shots from a Mini-14 rifle, which stopped the riot. Several inmates were treated at the institution for injuries consistent with fighting and returned to their cells. The OIG responded to the scene.

Incident Date: 2015-12-10	Deadly Force Incident

Disposition

The institution's executive review committee determined that the officer's use of force was in compliance with departmental policy. The OIG concurred. The hiring authority identified multiple errors and provided training to an officer, a sergeant, and two lieutenants regarding the completion of documentation, to a lieutenant regarding video-recorded interviews, and to all responding officers and supervisors regarding the submission of reports.

Incident Assessment

The department's action's following the incident were not adequate because nurses did not adequately complete medical evaluations, an officer, a sergeant, and two lieutenants did not adequately complete holding cell documentation, a lieutenant did not timely conduct video-recorded interviews, and responding officers and supervisors did not timely submit their reports.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  After the incident, nurses did not adequately complete medical evaluations, an officer, a sergeant, and two lieutenants failed to adequately complete holding cell documentation, a lieutenant did not timely conduct video-recorded interviews, and responding officers and supervisors failed to timely submit their reports.

South Region

Incident Summary

OIG Case Number: **16-1126-RO**

On April 13, 2016, an officer allegedly negligently discharged one round from a firearm during training. The OIG responded to the scene.

Incident Date: 2016-04-13	Deadly Force Incident

Disposition

The institution's executive review committee determined that the use of force did not comply with policy. The OIG concurred. The hiring authority did not refer the matter to the Office of Internal Affairs, but provided training to the officer.

Incident Assessment

The department's actions during the incident were not adequate because an officer allegedly negligently discharged a firearm. The department's actions following the incident were not adequate because the hiring authority did not refer the matter to the Office of Internal Affairs.

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

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 hiring authority appropriately determine whether to refer any conduct to the OIA related to the critical incident?

  Although the use of force did not comply with policy, the hiring authority failed to refer the matter to the Office of Internal Affairs, contrary to the OIG's recommendations.

Incident Summary

OIG Case Number: **16-1953-RO**

On September 29, 2016, an officer allegedly negligently discharged a Mini-14 rifle inside a housing unit control booth. The OIG responded to the scene.

Incident Date: 2016-09-29	Deadly Force Incident

Disposition

The hiring authority identified potential staff misconduct based on the officer's unintentional discharge of a firearm in an unsafe area; therefore, the hiring authority referred the case to the Office of Internal Affairs. 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 during the incident were not adequate because an officer allegedly discharged a firearm in an unsafe area.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The officer allegedly inappropriately discharged a lethal weapon in an unsafe area.

South Region

Incident Summary	OIG Case Number: **16-2079-RO**
On November 15, 2016, an inmate attacked another inmate and then ran toward an officer. Two officers deployed pepper spray, but the inmate continued running toward one of the officers. That officer struck the inmate in the back of the head with a pepper spray can, stopping the inmate's impending attack. The inmate suffered a minor injury and was treated at the institution.	
Incident Date: 2016-11-15	Deadly Force Incident

Disposition

The institution's executive review committee determined that the officer's use of force was in compliance with departmental 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

APPENDIX D2 16
INVESTIGATED AND MONITORED DEADLY FORCE INCIDENT CASE SUMMARIES

Central Region

Incident Date: 2015-07-30	Deadly Force Incident

Incident Summary

On July 30, 2015, an officer allegedly negligently discharged a firearm while in a classroom in the presence of several other staff members. The OIG responded to the scene. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. 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 also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **15-1730-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Discharge of Lethal Weapon**	1. **Sustained**	**Salary Reduction**	**Salary Reduction**

Disposition

The Deadly Force Review Board found that the officer was negligent and the unintentional discharge was not in compliance with the department's use-of-force policy. The hiring authority imposed a 10 percent salary reduction for 12 months. The OIG concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.

Disciplinary Assessment	Procedural Rating: **Sufficient** Substantive Rating: **Sufficient**

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

Central Region

Incident Date: 2015-08-24	Deadly Force Incident

Incident Summary

On August 24, 2015, a sergeant conducting firearms training allegedly negligently discharged a round from his unauthorized personal firearm using State ammunition. An officer was allegedly aware the sergeant was using the unauthorized personal firearm and did not report it. 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.

Administrative Investigation	OIG Case Number: **15-1722-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Contraband** 2. **Weapons** 3. **Misuse of State Equipment or Property** 4. **Neglect of Duty**	1. **Sustained** 2. **Sustained** 3. **Sustained** 4. **Not Sustained**	**Salary Reduction**	**Salary Reduction**

Disposition

The hiring authority sustained the allegations against the sergeant and imposed a 5 percent salary reduction for 13 months. The OIG concurred with the investigative findings, but not the penalty, but did not seek a higher level of review because the penalty was within departmental guidelines. The sergeant filed an appeal with the State Personnel Board but later withdrew the appeal. The hiring authority found insufficient evidence to sustain the allegations against the officer. The OIG concurred.

Disciplinary Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Insufficient**

The department did not comply with policies and procedures governing the disciplinary process because the hiring authority did not timely conduct the disciplinary findings conference or select the appropriate penalty.

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 Office of Internal Affairs returned the case to the hiring authority on March 24, 2016. However, the hiring authority did not consult with the OIG and the department attorney regarding the disciplinary determinations until April 18, 2016, 25 days thereafter.

- Did the HA who participated in the disciplinary conference select the appropriate penalty?

  The hiring authority imposed a lower penalty than was appropriate since the sergeant's actions could have resulted in more serious consequences.

- Was the disciplinary phase conducted with due diligence by the department?

  The department did not conduct the disciplinary findings conference in a timely manner.

Central Region

Incident Date: 2015-11-05	Deadly Force Incident

Incident Summary

On November 5, 2015, an officer fired two rounds from a Mini-14 rifle at two inmates who were attacking and stabbing another inmate with an inmate-manufactured weapon on the exercise yard. One of the rounds struck one of the attacking inmates in the hip. The inmates stopped fighting. Officers transported the inmate who had been shot and the inmate who had been stabbed to an outside hospital for treatment. Both inmates 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 department policy, it referred the matter to the district attorney's office. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **15-2359-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

Procedural Rating: **Sufficient**
Substantive Rating: **Sufficient**

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

Disposition

The Deadly Force Review Board found that the officer's use of deadly force was in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officer and the OIG concurred.

Central Region

Incident Date: 2015-11-13	Deadly Force Incident

Incident Summary

On November 13, 2015, approximately 70 inmates participated in a riot on the exercise yard. An officer saw one inmate hitting and kicking an unresponsive inmate. The officer fired a single round from a Mini-14 rifle, striking the attacking inmate in the thigh. The department transported the inmate with the gunshot wound and an inmate with a fractured arm to an outside hospital. The first inmate returned to the institution the same day and the second inmate returned the next day. A third inmate received treatment at the institution for a laceration. 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	OIG Case Number: **15-2411-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Discharge of Lethal Weapon**	1. **Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Sufficient**

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 special agent did not enter critical interview information into the case management system.

Assessment Questions

- Did the special agent appropriately enter case activity in the case management system?

  The special agent did not enter a summary in the case management system indicating whether the officer supported, refuted, denied, or admitted the allegations.

- Did the department conduct the pre-disciplinary/investigative phase with due diligence?

  On November 13, 2015, the Office of Internal Affairs assigned a special agent to conduct the deadly force investigation. The Office of Internal Affairs did not complete the investigation until April 29, 2016, more than five months thereafter.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force was in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officer and the OIG concurred.

Central Region

Incident Date: 2016-02-29	Deadly Force Incident

Incident Summary

On February 29, 2016, an officer allegedly negligently discharged a firearm and shot himself in the hand while participating in a training course on a firearms range while firearms instructors and other students were present.

Administrative Investigation	OIG Case Number: **16-0666-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Weapons**	1. **Sustained**	**Suspension**	**Suspension**

Predisciplinary Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Insufficient**

The department did not comply with policies and procedures governing the pre-disciplinary process because the Office of Internal Affairs did not make an appropriate initial determination, the department attorney did not correctly assess the deadline for taking disciplinary action and did not appropriately consult with the OIG, and the special agent did not prepare thorough investigative reports.

Assessment Questions

- Did the Office of Internal Affairs make an appropriate initial determination regarding the case?

  The OIG disagreed with the Office of Internal Affairs' decision not to assign a deadly force investigation team to investigate the incident based on the discharge of a lethal weapon.

- 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 incorrectly assessed the deadline for taking disciplinary action as February 7, 2017, when the deadline was actually March 1, 2017.

- 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 the OIG with written confirmation summarizing his review of the investigative report until requested by OIG.

- Was the investigative draft report provided to the OIG for review thorough and appropriately drafted?

  The draft investigative report failed to include the officer's public safety statement as an exhibit.

- Was the final investigative report thorough and appropriately drafted?

  The final investigative report failed to include the officer's public safety statement as an exhibit.

Disposition

The hiring authority sustained the allegation and imposed a two-working-day suspension. The OIG did not concur with the level of penalty, but did not seek a higher level of review because the officer retired before the disciplinary action took effect. The hiring authority placed a letter in the officer's official personnel file indicating he retired pending disciplinary action.

Disciplinary Assessment

Procedural Rating: **Sufficient**
Substantive Rating: **Insufficient**

The department's handling of the disciplinary process was substantively insufficient because the department attorney did not provide appropriate legal consultation to the hiring authority and the hiring authority did not select appropriate causes for discipline or the appropriate penalty.

Assessment Questions

- Did the department attorney provide appropriate legal consultation to the HA regarding disciplinary determinations?

  The department attorney inappropriately advised the hiring authority the officer's misconduct was only careless and not grossly negligent and, therefore, did not recommend the appropriate charges and causes for discipline.

Central Region

- 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 more appropriate and serious charge and cause for discipline of gross negligence in handling a duty weapon.

- Did the HA who participated in the disciplinary conference select the appropriate penalty?

  Because the hiring authority considered the officer's misconduct as careless and not grossly negligent, she imposed only a two-working-day suspension when a greater suspension was more appropriate for the misconduct.

Incident Date: 2016-08-04	Deadly Force Incident

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.

Criminal Investigation	OIG Case Number: **16-1838-IR**	Allegation: **Criminal Act Involving Unreasonable Use of Force**

Investigation Assessment	Procedural Rating: **Insufficient** Substantive Rating: **Sufficient**

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

Assessment Questions

- Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours?

  The department did not attempt to interview the special agent until August 15, 2016, two weeks after the incident.

- Did the department conduct the pre-disciplinary/investigative phase with due diligence?

  The Office of Internal Affairs assigned a special agent on August 3, 2016, but the special agent did not complete the investigation until November 23, 2016, 112 days after assignment.

North Region

Incident Date: 2014-03-21	Deadly Force Incident

Incident Summary

On March 21, 2014, an off-duty officer was driving home after picking up his son from school when another vehicle passed him, driving recklessly. The other vehicle eventually crashed in front of him. The officer stopped and exited his vehicle. The officer claimed that after he exited his vehicle, the vehicle that crashed came toward him as if to run over him. The officer discharged two lethal rounds from his off-duty weapon at the vehicle but the rounds missed. The Office of Internal Affairs and the OIG were notified and both responded on scene.

Administrative Investigation	OIG Case Number: **14-0771-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Dishonesty** 2. **Use of Deadly Force**	1. **Sustained** 2. **Sustained**	**Dismissal**	**No Penalty Imposed**

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 that the officer violated the department's use-of-force policy and added and sustained allegations that the officer was dishonest in a written memorandum to the department, dishonest to local law enforcement, and dishonest during the internal affairs investigation. The hiring authority dismissed the officer. The OIG concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Prior to the hearing, the hiring authority intended to settle the case and amend the disciplinary action to omit that the officer violated policy. The OIG did not agree and elevated the matter to the hiring authority's supervisor. At the higher level of review, the hiring authority's supervisor determined the disciplinary action and penalty would remain the same. Following an evidentiary hearing, the State Personnel Board revoked the disciplinary action in its entirety. The administrative law judge made a credibility determination that the officer and his son were credible and the other witnesses offered weak testimony. The department filed a petition for rehearing, which the State Personnel Board denied. The department filed a Writ of Administrative Mandamus, which the Superior Court denied.

Disciplinary Assessment

Procedural Rating:	**Sufficient**
Substantive Rating:	**Insufficient**

The department 's handling of the disciplinary process was substantively insufficient because the assistant chief counsel and hiring authority intended to settle the case and amend the disciplinary action contrary to the Deadly Force Review Board findings.

Assessment Questions

- If an executive review was invoked in the case, did OIG request the executive review?

  The OIG sought a higher level of review because the OIG disagreed with the hiring authority's inappropriate decision to settle the case and amend the disciplinary action to omit the officer's violation of the department's use-of-force policy, based on the assistant chief counsel's inappropriate advice and contrary to the Department's Deadly Force Review Board's finding.

North Region

Incident Date: 2015-08-18	Deadly Force Incident

Incident Summary

On August 18, 2015, an officer allegedly negligently discharged a firearm while inside the complex control area of the institution. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. The Office of Internal Affairs did not refer the case 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

OIG Case Number: **15-1715-IR**

	Findings	Initial Penalty	Final Penalty
1. **Discharge of Lethal Weapon**	1. **Sustained**	**Letter of Reprimand**	**Letter of Reprimand**

Disposition

The Deadly Force Review Board found that the officer's use of deadly force was not in compliance with the department's use-of-force policy. The hiring authority sustained the allegation and issued the officer a letter of reprimand. The OIG concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.

Disciplinary Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Sufficient**

The department did not comply with procedures governing the disciplinary process because the department attorney did not provide the hiring authority and the OIG with written confirmation of penalty discussions and did not send the OIG a draft of the disciplinary action.

Assessment Questions

- Did the department attorney provide to the HA and OIG written confirmation of penalty discussions?

  The department attorney did not provide written confirmation of penalty discussions.

- Did the department attorney or employee relations officer provide the OIG with a copy of the draft disciplinary action and consult with the OIG?

  The department attorney provided the disciplinary action to the hiring authority without first providing a draft to the OIG.

- 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 provided the disciplinary action to the hiring authority without first providing a draft to the OIG.

North Region

Incident Date: 2016-02-18	Deadly Force Incident

Incident Summary

On February 18, 2016, an officer allegedly negligently discharged a firearm inside the armory during a weapon safety check. 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 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

OIG Case Number: **16-0580-IR**

	Findings	Initial Penalty	Final Penalty
1. **Discharge of Lethal Weapon**	1. **Sustained**	**Letter of Instruction**	**Letter of Instruction**

Predisciplinary Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Sufficient**

The department did not comply with procedures governing the pre-disciplinary process because the special agent did not complete the investigation in a timely manner. The special agent did not make all appropriate entries in the case management system.

Assessment Questions

- Did the special agent appropriately enter case activity in the case management system?

  The special agent did not enter a summary in the case management system indicating whether the officer supported, refuted, denied, or admitted the allegation.

- Did the department conduct the pre-disciplinary/investigative phase with due diligence?

  The Office of Internal Affairs assigned a special agent on February 19, 2016, but the special agent did not complete the investigation until July 1, 2016, 133 days after being assigned.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force was not in compliance with the department's use-of-force policy. The hiring authority issued the officer a letter of instruction. The OIG concurred with the hiring authority's determinations.

Disciplinary Assessment

Procedural Rating: **Sufficient**
Substantive Rating: **Sufficient**

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

North Region

Incident Date: 2016-02-27	Deadly Force Incident

Incident Summary

On February 27, 2016, a sergeant allegedly failed to provide her handgun to an officer when she left the control booth and then dropped the handgun while conducting a weapons check. The sergeant allegedly discharged one round into the wall. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation	OIG Case Number: **16-0681-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Weapons** 2. **Neglect of Duty** 3. **Misuse of State Equipment or Property**	1. **Sustained** 2. **Sustained** 3. **Not Sustained**	**Letter of Reprimand**	**Letter of Reprimand**

Disposition

The hiring authority sustained the allegations, except for one that was improperly worded, and issued a letter of reprimand. The OIG concurred with the hiring authority's determinations. The sergeant did not file an appeal with the State Personnel Board.

Disciplinary Assessment

Procedural Rating: **Sufficient**
Substantive Rating: **Sufficient**

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

North Region

Incident Date: 2016-05-16	Deadly Force Incident

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.

Criminal Investigation	OIG Case Number: **16-1457-IR**	Allegation: **Criminal Act Involving Unreasonable Use of Force**

Investigation Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Insufficient**

The department did not comply with policies and procedures governing the investigative process because the investigative services unit did not properly preserve evidence and the Office of Internal Affairs failed to properly consult with OIG and did not refer the case to the district attorney's office, as required by policy, until the OIG raised the issue to Office of Internal Affairs management.

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.

- Upon completion of the investigation, was a draft copy of the investigative report timely forwarded to the OIG to allow for feedback before it was forwarded to the HA or prosecuting agency?

  The Office of Internal Affairs neglected to consult with the OIG before consulting with the district attorney's office about the need to submit the investigative report to the district attorney's office, and failed to submit the investigative report to the district attorney's office until the OIG recommended that it do so and elevated the matter to Office of Internal Affairs management.

- Did the special agent cooperate with and provide continual real-time consultation with the OIG?

  The special agent did not notify the OIG about the firearms testing or consult with the OIG before contacting the district attorney's office.

North Region

Incident Date: 2016-05-27	Deadly Force Incident

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 riot. The department transported nine inmates to outside hospitals for injuries. Seven inmates returned to the institution the same day and 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.

Criminal Investigation	OIG Case Number: **16-1664-IR**	Allegation: **Criminal Act Involving Unreasonable Use of Force**

Investigation Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Sufficient**

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

Assessment Questions

- Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours?

  The incident occurred on May 27, 2016, but the special agent did not complete all interviews until June 17, 2016, 21 days later.

- Did the department conduct the pre-disciplinary/investigative phase with due diligence?

  The Office of Internal Affairs assigned a special agent on May 27, 2016, but the special agent did not complete the investigation until November 1, 2016, 158 days later.

Incident Date: 2016-06-09	Deadly Force Incident

Incident Summary

On June 9, 2016, an officer allegedly brandished a firearm and then discharged one round into the air. The Office of Internal Affairs did not respond to the scene. Outside law enforcement conducted a criminal investigation and referred the matter to the district attorney's office. The Office of Internal Affairs opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **16-1739-IR**	Allegation: **Criminal Act Involving Unreasonable Use of Force**

Investigation Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Sufficient**

The department did not comply with procedures governing the investigative process because the special agent spent an inordinate amount of time preparing an investigative report.

Assessment Questions

- Was the investigation thorough and appropriately conducted?

  The special agent spent 39 hours preparing a 13-page investigative report that only cited the applicable law, quoted four reports independently prepared by outside law enforcement, and listed witnesses identified in those reports. The special agent attached the reports as exhibits to his own report.

South Region

Incident Date: 2015-07-27	Deadly Force Incident

Incident Summary

On July 27, 2015, while participating in a timed live-fire training exercise, a parole agent allegedly negligently discharged his firearm while moving the firearm in the holster. A bullet struck the parole agent in his thigh, causing an injury requiring sutures. 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 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	OIG Case Number: **15-1788-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Discharge of Lethal Weapon**	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 did not concur but did not seek a higher level of review because the department's investigation did not address the parole agent's defenses. The parole agent filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the parole agent reducing the penalty to a 5 percent salary reduction for nine months and agreeing to remove the disciplinary action from the parole agent's official personnel file in 12 months because of the parole agent's unrefuted claims that his State-issued holster was faulty and he was denied additional training before the incident. The OIG concurred because the Office of Internal Affairs' investigation failed to address the parole agent's claims and the penalty was within departmental guidelines.

Disciplinary Assessment

Procedural Rating: **Sufficient**
Substantive Rating: **Insufficient**

The department's handling of the disciplinary process was substantively insufficient because the department attorney did not provide appropriate legal advice to the hiring authority and the hiring authority was not adequately prepared and did not select the appropriate cause for discipline.

Assessment Questions

- If the HA consulted with the OIG concerning the disciplinary determinations, was the HA adequately prepared?

  The hiring authority did not know the parole agent received prior disciplinary action for similar misconduct.

- Did the department attorney provide appropriate legal consultation to the HA regarding disciplinary determinations?

  Since the department attorney did not know the parole agent was previously disciplined for similar misconduct, the department attorney did not advise the hiring authority of the prior discipline. The department attorney also neglected to advise the hiring authority to use gross negligence in the handling of a weapon as a cause for discipline and instead recommended careless handling of a weapon.

- Did the HA who participated in the disciplinary conference select the appropriate Employee Disciplinary Matrix charges and causes for discipline?

  The hiring authority inappropriately selected careless handling of a weapon as a cause for discipline.

- Did the HA who participated in the disciplinary conference select the appropriate penalty?

  By neglecting to select the appropriate cause for discipline, the hiring authority selected a lower penalty than the circumstances warranted.

South Region

Incident Date: 2015-09-21	Deadly Force Incident

Incident Summary

On September 21, 2015, a parole agent allegedly discharged a round from his firearm at a dog running toward him. The Office of Internal Affairs did not respond to the scene.

Administrative Investigation

OIG Case Number: **15-2323-IR**

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

Predisciplinary Assessment

Procedural Rating: **Insufficient**
Substantive Rating: **Insufficient**

The department did not comply with policies and procedures governing the pre-disciplinary process because the hiring authority did not obtain a public safety statement from the parole agent and neglected to notify the Office of Internal Affairs and the OIG regarding the incident, preventing both from responding to the scene.

Assessment Questions

- Did the institution timely notify the Office of Internal Affairs of the incident?

  The hiring authority did not notify the Office of Internal Affairs of the incident.

- Did the department timely notify OIG of the critical incident?

  The hiring authority did not notify the OIG of the incident.

- Was the HA's response to the critical incident appropriate?

  The hiring authority neglected to obtain a public safety statement from the parole agent and did not notify the OIG and the Office of Internal Affairs of the incident.

- Did the department conduct the pre-disciplinary/investigative phase with due diligence?

  The hiring authority failed to notify the Office of Internal Affairs and the OIG of the incident.

Disposition

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

South Region

Incident Date: 2016-05-24	Deadly Force Incident

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.

Criminal Investigation	OIG Case Number: **16-1656-IR**	Allegation: **Criminal Act Involving Unreasonable Use of Force**

Investigation Assessment

Procedural Rating: **Sufficient**
Substantive Rating: **Insufficient**

The department's handling of the investigative process was substantively insufficient because the investigative services unit neglected to take photographs and the Office of Internal Affairs did not utilize proper investigative techniques to measure the scene. The special agent did not make all required entries in the case management system.

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 Office of Internal Affairs adequately respond to the incident?

  The Office of Internal Affairs did not utilize proper investigative techniques to measure the scene.

- Did the special agent appropriately enter case activity in the case management system?

  The special agent did not enter a summary in the case management system indicating whether the officer invoked his Fifth Amendment rights against self incrimination or supported, refuted, denied, or admitted the allegations.

APPENDIX E
NON-DEADLY FORCE
CRITICAL INCIDENT CASE SUMMARIES

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CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-11-09	**15-2358-RO**	**In-Custody Inmate Death**

Incident Summary

On November 9, 2015, after an inmate reported to officers that he had killed his cellmate, officers found the unresponsive cellmate with a shirt wrapped around his neck. A physician pronounced the cellmate dead.

Disposition

The coroner determined the cause of death was asphyxiation by strangulation and the manner of death was homicide. The department's Death Review Committee concluded the cause of death was assault by strangulation and suffocation and the death was not preventable. The hiring authority identified potential staff misconduct based on an officer's failure to conduct a proper count and a sergeant's initial refusal to permit responding nurses access to the inmate. The department provided training to the sergeant and the officer.

Overall Assessment

The department's actions prior to the incident were not adequate because an officer did not conduct an appropriate inmate count. During the incident, a sergeant initially refused to allow responding nurses access to the cell. The department's actions following the incident were not adequate because the hiring authority did not refer the officer's misconduct to the Office of Internal Affairs and delayed in making the decision not to refer the case.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Insufficient	**Insufficient**	**Insufficient**

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  An officer failed to conduct a proper count before discovering the dead inmate and a sergeant initially refused to allow responding nurses access to the cell. The hiring authority did not refer the officer's misconduct to the Office of Internal Affairs and delayed in making the decision not to do 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 November 12, 2015, but the hiring authority did not decide whether to refer the matter to the Office of Internal Affairs until March 16, 2016, four months thereafter.

- Did the hiring authority appropriately determine whether to refer any conduct to the OIA related to the critical incident?

  The hiring authority inappropriately decided to not refer the matter to the Office of Internal Affairs when there was evidence indicating the inmate was dead when an officer counted the inmate as alive.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-11-25	**15-2547-RO**	**In-Custody Inmate Death**

Incident Summary

On November 25, 2015, an officer found an unresponsive inmate slumped over in a cell. A sergeant and two officers removed the inmate from the cell and an officer began life-saving measures until two nurses arrived and assisted. Paramedics continued life-saving measures and transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

The coroner determined the manner of death was accidental and the cause was fentanyl intoxication. The department's Death Review Committee determined the death was not preventable. The hiring authority provided training regarding crime scene preservation to seven officers, a sergeant, and a lieutenant.

Overall Assessment

The department's actions prior to the incident were not adequate because the department did not establish a crime scene following an earlier incident also involving a possible drug overdose.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department failed to establish a crime scene after the cellmate sustained a previous possible drug overdose, thereby failing to adequately search the cell and secure the inmate who later died of a suspected overdose.

- Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?

  The department failed to establish a crime scene after the cellmate sustained a previous possible drug overdose, thereby failing to adequately search the cell and secure the inmate who later died of a suspected overdose.

- 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 failed to establish a crime scene after the cellmate sustained a previous possible drug overdose, thereby failing to adequately search the cell and secure the inmate who later died of a suspected overdose.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-12-01	**15-2574-RO**	**In-Custody Inmate Death**

Incident Summary

On December 1, 2015, officers found an inmate face down on the floor of his cell with his hands and feet tied together behind his back, a walking cane protruding from his rectum, and a pen and pencil in his ears. A nurse initiated life-saving measures and the department transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

The autopsy report stated the inmate's cause of death was strangulation and the manner of death was homicide. The department's review determined that the inmates were housed together in accordance with policy and the homicide was not preventable. However, the hiring authority identified potential staff misconduct based on the failure to immediately initiate life-saving measures; 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

The department's actions during the incident were not adequate because sergeants, officers, and a nurse allegedly failed to timely initiate life-saving measures.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  Two sergeants, five officers, and a nurse allegedly failed to initiate life-saving measures in a timely manner.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-01-08	**16-0145-RO**	**In-Custody Inmate Death**

Incident Summary

On January 8, 2016, inmates informed officers of an unresponsive cellmate. Officers moved the cellmate to a mattress on the floor and initiated life-saving measures. Another officer and a nurse continued life-saving measures until paramedics pronounced the inmate dead.

Disposition

The coroner determined the death to be natural, unexpected, and due to a tear of the inmate's aorta. The department's emergency medical response review committee identified that officers and nurses performed life-saving measures on a soft surface and a physician gave an inappropriate medication order. The hiring authority for the physician and nurses provided training to nurses and the physician, and provided statewide training regarding the use of an epinephrine auto-injector. The hiring authority for the officers also provided training.

Overall Assessment

The department's response was not adequate because nurses and officers performed life-saving measures on a soft surface and a physician gave an inappropriate medication order.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department's action during the incident were not adequate because nurses and officers performed life-saving measures on a soft surface for over ten minutes and a physician ordered a nurse to administer an epinephrine auto-injector in the absence of an intravenous line.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-01-13	**16-0206-RO**	**Suicide**

Incident Summary

On January 13, 2016, an officer discovered a cell door window was covered and requested assistance. A sergeant and nurse opened the cell door and found an unresponsive inmate with a noose tied around his neck. The sergeant and nurse initiated life-saving measures and the inmate was transported to an outside hospital where a physician pronounced him dead.

Disposition

The coroner concluded the cause of death was asphyxia by hanging and the manner of death was suicide. The department's Death Review Committee determined that the inmate's death was possibly preventable. The department's suicide report found the suicide to be foreseeable and preventable. The hiring authority revised its policy on recognizing the risk of suicide and provided all psychiatric technicians with training regarding the revised policy. The hiring authority also provided training to the nurse regarding the preparation of appropriate medical documentation.

Overall Assessment

The department's actions prior to the incident were not adequate because a psychiatric technician did not recognize the inmate was at risk for suicide. The department's actions following the incident were not adequate because a nurse did not accurately complete medical records.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  In an assessment seven hours before the suicide took place, a psychiatric technician did not recognize the risk of suicide and believed the inmate was suffering from depression.

- Was the critical incident adequately documented?

  A nurse did not accurately document the manner in which the inmate was transported to the medical clinic.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-02-20	**16-0574-RO**	**In-Custody Inmate Death**

Incident Summary

On February 20, 2016, after an inmate informed an officer that his cellmate was unresponsive, a sergeant removed the unresponsive inmate from the cell and a nurse initiated life-saving measures. The department transported the unresponsive inmate to an outside hospital where a physician pronounced him dead.

Disposition

The coroner determined the cause of death was narcotic intoxication. The department's Death Review Committee concluded the cause of death was an overdose of codeine and morphine and not preventable. The hiring authority identified potential staff misconduct based on an officer's alleged failure to sound an immediate alarm, a sergeant's alleged failure to initiate timely life-saving measures and preserve evidence, and a nurse's alleged failure to initiate timely life-saving measures; 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

The department's response was not adequate because an officer allegedly did not timely sound an alarm, a sergeant and nurse allegedly failed to timely initiate life-saving measures, and the sergeant also allegedly failed to preserve evidence.

Prior to Incident Rating	During the Incident Rating	After the 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 immediately sound an alarm after discovering the unresponsive inmate. A sergeant and nurse allegedly failed to timely initiate life-saving measures and the sergeant allegedly failed to preserve evidence.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-03-05	**16-0705-RO**	**In-Custody Inmate Death**

Incident Summary

On March 5, 2016, after an inmate notified an officer that his cellmate was dead, officers attempted to rouse the cellmate. A nurse determined the cellmate's body was rigid, cold, and discolored and did not initiate life-saving measures. A physician pronounced the cellmate dead.

Disposition

The autopsy report stated the cause of death was acute fentanyl intoxication and the department's Death Review Committee determined the death was unexpected and not preventable. The hiring authority identified potential staff misconduct based on an officer's alleged failure to conduct an adequate inmate count. 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 prior to the incident were not adequate because an officer allegedly counted the cellmate as alive one hour before other officers found the cellmate dead with rigor mortis and dependent lividity.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  An officer allegedly counted the cellmate as alive one hour before officers found the inmate dead with rigor mortis and dependent lividity.

- 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 determined an officer may have failed to conduct an appropriate count and recommended the matter be referred to the Office of Internal Affairs for investigation.

Incident Date	OIG Case Number	Case Type
2016-03-17	**16-1220-RO**	**Other Significant Incident**

Incident Summary

On March 17, 2016, officers saw an inmate punch a cellmate in the face. The inmate refused orders to leave the cell and used a bed sheet to tie the door shut. The officers noticed wounds on the inmate's forearms, forced the door open, and transported the inmate to the triage and treatment area and then to an outside hospital. The inmate returned to the institution the following day.

Disposition

The institution's executive review committee identified a 24-minute delay in calling for a medical response. The OIG concurred. The hiring authority provided training to six officers and a sergeant for this delay.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-04-06	**16-1067-RO**	**In-Custody Inmate Death**

Incident Summary

On April 6, 2016, an officer discovered an unresponsive inmate face down on the floor of his cell. A sergeant, additional officers, and a nurse removed the inmate from the cell. The nurse and an officer initiated life-saving measures. The department transported the inmate to an outside hospital where he was pronounced dead.

Disposition

The coroner determined the manner of death was homicide and the cause of death was ligature strangulation. The department's Death Review Committee determined that the death was not preventable. The hiring authority identified potential staff misconduct based on a failure to timely initiate life-saving measures; therefore, the hiring authority referred the case of 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 response was not adequate because officers allegedly delayed six minutes before initiating life-saving measures and the hiring authority did not timely refer potential staff misconduct to the Office of Internal Affairs.

Prior to Incident Rating	During the Incident Rating	After the 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 initiate life-saving measures when they first arrived, resulting in a six-minute delay until a nurse initiated life-saving measures. On initial review, the hiring authority did not identify this failure.

- 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 potential six-minute delay in initiating life-saving measures after officers first arrived.

- Did the hiring authority make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?

  On May 3, 2016, the emergency medical response review committee determined that officers did not initiate timely life-saving measures but the hiring authority did not refer the matter to the Office of Internal Affairs until June 29, 2016, 57 days thereafter.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-05-20	**16-1545-RO**	**In-Custody Inmate Death**

Incident Summary

On May 20, 2016, an officer found an unresponsive inmate on a bathroom floor. Officers, a nurse, 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 coronary artery disease. The department's Death Review Committee concluded the death was due to atherosclerotic coronary artery disease and was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-06-03	**16-1799-RO**	**Hunger Strike**

Incident Summary

On June 3, 2016, an inmate initiated a hunger strike because the inmate wanted a transfer to a different institution. On July 18, 2016, the department transported the inmate to an outside hospital to reintroduce food. On July 24, 2016, the inmate returned to the institution. The inmate lost approximately 16 percent of body weight during the hunger strike.

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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-06-17	**16-1750-RO**	**Suicide**

Incident Summary

On June 17, 2016, an officer discovered an inmate hanging from a noose. Officers entered the cell and lowered the inmate. A sergeant and a psychiatric technician began life-saving measures, which continued as they transported the inmate to the triage and treatment area. A paramedic pronounced the inmate dead after consulting with a physician at an outside hospital.

Disposition

The coroner determined the cause of death was hanging and the manner of death was suicide. The department's Death Review Committee concluded the death was self-inflicted, unexpected, and not preventable. The department's suicide report concluded that the suicide was not preventable or foreseeable, but that responding officers did not respond with all the equipment to remove the noose, but the failure did not compromise the response. The hiring authority updated the suicide prevention procedures to standardize the equipment contents and require custody staff to respond with required equipment, and provided training regarding the updated procedures.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-06-20	**16-1769-RO**	**Other Significant Incident**

Incident Summary

On June 20, 2016, an inmate alerted an officer that there was a medical emergency. The officer observed blood on the inmate's arm and called for medical assistance. The inmate suffered three self-inflicted superficial cuts to the arm.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-06-20	**16-1770-RO**	**Other Significant Incident**

Incident Summary

On June 20, 2016, a certified nursing assistant observed an inmate actively bleeding from the wrist and called for medical assistance. The inmate suffered a cut to one arm and scratches to both arms.

Disposition

The hiring authority did not identify any staff misconduct.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-07-02	**16-1776-RO**	**Other Significant Incident**

Incident Summary

On July 2, 2016, an officer observed an inmate actively bleeding from the wrist and leg and called for medical assistance. The inmate suffered multiple superficial cuts to one arm and leg.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-07-29	**16-1835-RO**	**Hunger Strike**

Incident Summary

On July 29, 2016, an inmate initiated a hunger strike alleging inadequate medical care and false disciplinary charges. The department transported the inmate to an outside hospital once for dehydration and once to reintroduce food. On September 12, 2016, the inmate returned to the institution but had lost approximately 20 percent of his body weight. On September 13, 2016, the inmate initiated another hunger strike for the same reasons. On September 15, 2016, the inmate requested food and the department transported him to an outside hospital to reintroduce food. On September 20, 2016, the inmate returned to the institution but initiated another hunger strike because he was unhappy with custody and medical staff. On October 3, 2016, the inmate ended his hunger strike and the department transported him to an outside hospital to reintroduce food. The inmate returned to the institution on October 5, 2016.

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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-08-08	**16-1864-RO**	**Hunger Strike**

Incident Summary

On August 8, 2016, an inmate initiated a hunger strike due to depression. On August 18, 2016, due to the inmate's dehydration, the department transported the inmate to an outside hospital. The inmate ended his hunger strike the same day and returned to the institution on August 22, 2016.

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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-08-19	**16-1880-RO**	**Hunger Strike**

Incident Summary

On August 19, 2016, an inmate began a hunger strike because his approved transfer to another institution was delayed due to lack of housing. On August 31, 2016, when housing at the other institution became available, the department transported the inmate to an outside hospital to reintroduce food. The inmate returned to the institution the same day and ended the hunger strike so he could be transferred. The inmate lost 11 pounds.

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 respects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-09-07	**16-1912-RO**	**Other Significant Incident**

Incident Summary

On September 7, 2016, an inmate struck her head against a holding cell while speaking with a psychologist. The inmate complied with orders to stop and officers removed her from the cell and transported her for a mental health evaluation.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-09-08	**16-1940-RO**	**Hunger Strike**

Incident Summary

On September 8, 2016, an inmate initiated a hunger strike because he did not want to be in the institution any longer. On September 25, 2016, the department transported the inmate to an outside hospital because he appeared dehydrated; however, the inmate refused medical treatment and returned to the institution the same day. On September 26, 2016, the inmate ended his hunger and agreed to be transported to an outside hospital to reintroduce food.

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. The department adequately notified and consulted with the OIG regarding this incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-09-22	16-1950-RO	Other Significant Incident

Incident Summary

On September 22, 2016, officers responded to an inmate banging on the cell door and determined the cellmate swallowed 50 naproxen tablets. The department transported the cellmate to an outside hospital, following which the cellmate returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-09-27	16-1949-RO	Other Significant Incident

Incident Summary

On September 27, 2016, an inmate covered the cell window and did not respond when an officer ordered the inmate to remove the covering. Officers entered the cell and removed a torn sheet that the inmate had tied around her neck. On October 18, 2016, the inmate tied a piece of paper clothing around her neck, which officers removed.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-10-21	16-2004-RO	Other Significant Incident

Incident Summary

On October 21, 2016, officers saw an inmate tie a noose around her neck, tie the other end to a bunk, and sit down in an apparent suicide attempt. Officers removed the noose and transported the inmate to the correctional treatment center.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-11-24	16-2098-RO	Hunger Strike

Incident Summary

On November 24, 2016, an inmate initiated a hunger strike, demanding his personal property and a specific nutritional drink. On November 28, 2016, the inmate fell in his cell, sustaining injuries, and was taken to an outside hospital. The inmate ended his hunger strike later that day 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. The department adequately notified and consulted with the OIG regarding the incident.

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-07-08	**15-1388-RO**	**Other Significant Incident**

Incident Summary

On July 8, 2015, an inmate escaped from his handcuffs during an escort and attacked an officer and an inmate with an inmate-manufactured weapon. The officer and three additional officers used physical force to restrain the first inmate. The second inmate sustained minor injuries due to the attack and was treated at the institution. The first officer and two of the responding officers were treated at an outside hospital, released the same day, and subsequently returned to work. The department referred the case against the first inmate to the district attorney's office.

Disposition

The institution's executive review committee determined that the use of force complied with policy and the OIG concurred. The hiring authority identified potential staff misconduct based on officers' alleged failure to properly search the inmate before the escort; 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

The department's actions were not adequate because officers allegedly did not adequately search the inmate before the escort and the department did not adequately notify or cooperate with the OIG.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  Officers allegedly failed to conduct an unclothed body search of the inmate or inspect him with a hand-held metal detector before the escort.

- Did the department adequately consult with the OIG regarding the critical incident?

  After the incident, the department did not notify the OIG of critical facts, such as the nature and extent of the attack and the injuries sustained. In addition, the department failed to timely provide the OIG with a copy of the incident reports until 86 days after the incident.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-08-18	**15-1638-RO**	**Other Significant Incident**

Incident Summary

On August 18, 2015, an officer allegedly improperly released an inmate from his cell. The inmate exited the cell and slashed the officer's face with an inmate-manufactured weapon. The officer punched the inmate, fled the unit, and secured the unit door. The inmate remained out of his cell with access to the unit for several hours, during which time he smashed multiple cell door windows and attempted to open other inmates' cell doors. The institution's crisis response team deployed two flash grenades and restrained the inmate. The department transported the officer to an outside hospital and he was released the same day.

Disposition

The institution's executive review committee determined that the crisis response team's response should have been video recorded. The OIG concurred. The hiring authority identified potential staff misconduct because an officer allegedly opened the cell door without proper coverage and was dishonest and the crisis response team allegedly failed to video record its response. 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 prior to and during the incident were not adequate because an officer allegedly improperly released the inmate from the cell and falsely denied releasing the inmate and the crisis response team allegedly did not video record its response.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  An officer allegedly inappropriately released an inmate from his cell and falsely denied opening the door and the crisis response team allegedly failed to video record its response.

Incident Date	OIG Case Number	Case Type
2015-08-26	**15-1731-RO**	**In-Custody Inmate Death**

Incident Summary

On August 26, 2015, an officer discovered an unresponsive inmate alone in his cell. Two sergeants and another officer responded, removed the inmate from his cell, and began life-saving measures. Two nurses assisted and life-saving measures continued while transporting the inmate to the triage and treatment area. Paramedics arrived and continued life-saving measures until a physician pronounced the inmate dead.

Disposition

The coroner determined the inmate died of starvation. The department's Death Review Committee disagreed and noted the inconsistency between the coroner's findings and the description of the body as well-nourished. The Death Review Committee determined the cause of death to be unknown and concluded it was natural, unexpected, and not preventable. The hiring authority did not identify any staff misconduct. An OIG physician independently determined the inmate did not die of starvation.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-11-30	**15-2589-RO**	**In-Custody Inmate Death**

Incident Summary

On November 30, 2015, an inmate alerted an officer that his cellmate was unresponsive. Officers and nurses initiated life-saving measures and transported the inmate to the triage and treatment area. The department transported the inmate to an outside hospital where he was placed on a ventilator. On December 2, 2015, a physician pronounced the inmate dead.

Disposition

The coroner determined the cause of death was a fentanyl overdose. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2015-12-17	**15-2778-RO**	**Suicide**

Incident Summary

On December 17, 2015, an officer found an inmate lying in his cell face down with strips of a sheet tied around his neck. The officer, three nurses, and two psychiatric technicians performed life-saving measures until paramedics arrived, who continued life-saving measures until a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the cause of death to be asphyxiation. The department's suicide report indicated the suicide was neither preventable nor foreseeable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department’s response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-01-10	**16-0150-RO**	**In-Custody Inmate Death**

Incident Summary

On January 10, 2016, officers discovered an unresponsive inmate on the floor. Officers and nurses initiated life-saving measures and transported the inmate to the triage and treatment area. Officers, nurses, paramedics, and institutional firefighters continued life-saving measures until a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee determined that the cause of death was a cardiac event and that the death was not preventable. The hiring authority identified potential staff misconduct based on the nurse's failure to immediately refer the inmate to the triage and treatment area; 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 did not accept for monitoring. The hiring authority provided training to the second nurse who failed to obtain the inmate's blood sugar level during the emergency response.

Overall Assessment

The department's actions prior to and during the incident were not adequate because a nurse allegedly did not refer the inmate to the triage and treatment area when appropriate and a second nurse did not obtain the inmate's blood sugar level during the emergency response.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The day before the inmate's death, a nurse allegedly did not immediately refer him to the triage and treatment area after the inmate complained that he was having trouble breathing. During the emergency response, a second nurse did not obtain the inmate's blood sugar level.

Incident Date	OIG Case Number	Case Type
2016-02-15	**16-0496-RO**	**In-Custody Inmate Death**

Incident Summary

On February 15, 2016, an officer observed an inmate standing in a cell and the inmate's cellmate lying on the floor in a pool of blood. Four officers and a sergeant handcuffed the first inmate. A nurse detected the cellmate had a faint pulse and the nurse, sergeant, and officers performed life-saving measures. The department transported the cellmate to the triage and treatment area where a physician pronounced him dead. Outside law enforcement responded and initiated a criminal investigation.

Disposition

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

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-02-17	**16-1003-RO**	**PREA**

Incident Summary

On February 17, 2016, a dentist allegedly sexually assaulted an inmate.

Disposition

The hiring authority determined that the inmate's allegation was unfounded but found that a dentist and a chief support executive failed to timely implement Prison Rape Elimination Act protocols. The hiring authority provided training regarding identifying cases that would fall under the Act.

Overall Assessment

The department's actions following the incident were not adequate because the department did not timely implement Prison Rape Elimination Act Protocols, timely refer the matter to the investigative services unit, timely refer the matter to the Office of Internal Affairs, or timely notify the OIG.

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

Assessment Questions

- Did the hiring authority timely respond to the critical incident?

  On March 4, 2016, the inmate reported that he had been sexually assaulted but the hiring authority did not follow the Prison Rape Elimination Act protocols until March 30, 2016.

- Did the department timely notify the OIG regarding the critical incident?

  On March 4, 2016, the inmate reported that he had been sexually assaulted him but the hiring authority did not notify the OIG until March 30, 2016.

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department did not timely initiate Prison Rape Elimination Act protocols or timely refer the matter to the investigative services unit for investigation.

- Did the hiring authority make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?

  On March 4, 2016, the inmate alleged that he had been sexually assaulted but the hiring authority did not make a decision regarding whether to refer any conduct to the Office of Internal Affairs until May 11, 2016, 68 days thereafter.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-03-17	**16-0852-RO**	**Suicide**

Incident Summary

On March 17, 2016, an officer discovered an inmate hanging from a noose in his cell. Six officers, two captains, three nurses, and a psychiatric technician performed life-saving measures but they were unsuccessful and a physician pronounced the inmate dead.

Disposition

The coroner determined the manner of death was suicide and the cause of death was asphyxia due to hanging by ligature. The department conducted a suicide review and determined the suicide was not foreseeable or preventable. However, the report identified a failure by the two captains, six officers, and a nurse to timely call the outside law enforcement emergency number and a psychiatric technician's failure to record medical intervention provided to the inmate. The department provided training to the captains, officers, nurse, and psychiatric technician. The report also identified a lack of suicide prevention resources available to inmate families. The department created a work group to develop strategies to make these resources accessible to inmate families.

Overall Assessment

The department's actions prior to and during the incident were not adequate because the department did not make suicide prevention resources readily available to inmate families and responders did not timely contact the outside law enforcement emergency number or complete adequate documentation.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Insufficient	**Insufficient**	**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 provide the inmate's family with suicide prevention resources. During the incident, two captains, six officers, and a nurse did not timely call the outside law enforcement emergency number or complete an emergency responder form and a psychiatric technician failed to document medical intervention.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-03-24	**16-0947-RO**	**In-Custody Inmate Death**

Incident Summary

On March 24, 2016, an inmate informed officers that his cellmate did not look well. Officers discovered the cellmate unresponsive and initiated life-saving measures and a physician pronounced the cellmate dead.

Disposition

The coroner determined the cellmate's death was accidental due to acute heroin intoxication. The department's Death Review Committee concluded the cellmate'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 department did not timely notify the OIG of the cellmate's death or investigate how the cellmate obtained heroin.

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

Assessment Questions

- Did the department timely notify the OIG regarding the critical incident?

  The department did not notify the OIG until more than eight hours after the cellmate was pronounced dead.

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department did not investigate the source of the heroin that led to the cellmate's death.

Incident Date	OIG Case Number	Case Type
2016-04-01	**16-1016-RO**	**Suicide**

Incident Summary

On April 1, 2016, an officer discovered an inmate hanging from a noose in his cell. Officers cut the noose and lowered the inmate to the floor. The officers performed life-saving measures until paramedics arrived and continued life-saving measures until pronouncing the inmate dead.

Disposition

The coroner determined that the manner of death was suicide. The department's Death Review Committee determined that the cause of death was asphyxia due to hanging. The department's suicide report stated that the 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-04-02	**16-1017-RO**	**Suicide**

Incident Summary

On April 2, 2016, officers found an inmate hanging from a noose inside the cell. Officers cut the noose and lowered the inmate to the floor. Officers and nurses performed life-saving measures. Paramedics arrived, performed life-saving measures, and pronounced the inmate dead.

Disposition

The coroner determined that the cause of death was asphyxia by hanging and the manner of death was suicide. The department's suicide report determined the death was foreseeable and preventable. The hiring authority provided training to the psychiatrist who evaluated the cellmate the day before the suicide and counseled and provided training to the physician who failed to document the cellmate's clinical visits. The hiring authority also provided training to all clinicians to improve critical analysis while conducting suicide risk evaluations, changed the evaluation forms, and provided additional training to five psychiatrists. The hiring authority amended the procedures and documentation for conducting welfare checks and changed the meeting schedule to ensure the presence of sufficient clinical staff at meetings to discuss the medical and mental health care of inmates. The hiring authority also committed to performing random audits in the future to confirm and assess compliance with the changes.

Overall Assessment

The department's actions prior to the incident were not adequate because the department did not adequately conduct clinical visits, complete documentation, have an interpreter available, or have sufficient nurses or physicians at a meeting to discuss the cellmate's treatment. Also, officers did not perform all necessary welfare checks prior to the cellmate's suicide.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  Prior the incident, the department failed to have sufficient nurses or physicians at a meeting to discuss the cellmate's treatment, failed to have an interpreter at all of the consultations with the cellmate, and failed to ensure the appropriate number of clinical visits were completed and documented. Psychiatrists failed to properly complete assessment forms. Officers did not perform all of the necessary welfare checks on the cellmate just prior to the cellmate's suicide.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-04-02	**16-1021-RO**	**PREA**

Incident Summary

On April 2, 2016, an officer allegedly committed sexual misconduct on an inmate during a search.

Disposition

The hiring authority determined that the inmate's allegation was unfounded. The hiring authority provided training to a sergeant about identifying allegations that fall under the Prison Rape Elimination Act.

Overall Assessment

The department's actions following the incident were not adequate because the department did not timely implement the Prison Rape Elimination Act protocols or timely notify the OIG.

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

Assessment Questions

- Did the hiring authority timely respond to the critical incident?

  A sergeant became aware of the inmate's allegation on April 2, 2016, but the department did not implement the Prison Rape Elimination Act protocols until April 4, 2016.

- Did the department timely notify the OIG regarding the critical incident?

  The department was aware of the allegation on April 2, 2016, but did not notify the OIG until April 4, 2016.

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department did not timely implement protocols under the Prison Rape Elimination Act.

- 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 sergeant failed to initiate protocols under the Prison Rape Elimination Act.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-05-28	**16-1666-RO**	**Suicide**

Incident Summary

On May 28, 2016, officers found an inmate hanging from a noose tied to the ceiling in his cell and initiated life-saving measures. Nurses responded and continued life-saving measures until paramedics arrived and stopped life-saving measures. The coroner pronounced the inmate dead.

Disposition

The coroner determined the cause of death was asphyxia due to hanging. The department's Death Review Committee also identified the cause of death as asphyxia due to hanging, determined the death was not preventable, and identified that a psychiatrist should have completed suicide risk evaluations during the inmate's visit prior to his death. The hiring authority for the psychiatrist provided training. The hiring authority for the officers identified potential staff misconduct because the inmate's body was in rigor mortis when found and welfare check records reflected that 30-minute welfare checks had been completed; 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 prior to the incident were not adequate because officers allegedly failed to conduct welfare checks and falsified welfare check records and a psychiatrist failed to complete suicide risk evaluations.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department's actions prior to the incident were not adequate because the inmate's body was in rigor mortis when paramedics attempted life-saving measures and welfare check records indicated officers conducted 30-minute welfare checks prior to discovering the inmate. A psychiatrist failed to complete suicide risk evaluations during the inmate's visit prior to his death.

Incident Date	OIG Case Number	Case Type
2016-06-03	**16-1732-RO**	**In-Custody Inmate Death**

Incident Summary

On June 3, 2016, officers responded to a request for assistance and found an inmate unresponsive but still breathing in his cell. A sergeant and a nurse transported the inmate to the triage and treatment area. The department transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

The coroner determined the cause of death was accidental acute fentanyl intoxication. 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-06-16	**16-1751-RO**	**In-Custody Inmate Death**

Incident Summary

On June 16, 2016, an officer discovered an unresponsive inmate in a cell and responding nurses began life-saving measures. Paramedics relieved the nurses and a paramedic pronounced the inmate dead.

Disposition

The coroner determined the inmate died of cardiac dysrhythmia. The department's Death Review Committee concluded the inmate's death was natural, unexpected, and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-06-17	**16-1775-RO**	**Hunger Strike**

Incident Summary

On June 17, 2016, an inmate began a hunger strike because he was concerned he was not receiving proper medication. On June 30, 2016, the institution transported him to an outside hospital for complications related to his mental health and blood pressure. The inmate returned to the institution on July 1, 2016, and ended the hunger strike on July 8, 2016.

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 following the incident were not adequate because the department failed to notify the OIG when the inmate was sent to an outside hospital.

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

Assessment Questions

- Did the department timely notify the OIG regarding the critical incident?

  The department failed to notify the OIG that the inmate had been taken to an outside hospital while on a hunger strike.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-07-07	**16-1784-RO**	**In-Custody Inmate Death**

Incident Summary

On July 7, 2016, two inmates attacked a third inmate with an inmate-manufactured weapon on the exercise yard. Officers used less-lethal rounds and chemical agents to stop the attack. Officers and nurses performed life-saving measures on the third inmate but efforts were unsuccessful and a physician pronounced the inmate dead. The hiring authority referred the case against the inmates to the district attorney's office.

Disposition

The institution's executive review committee determined that the use of force complied with policy. The department's Death Review Committee determined the cause of death to be stab wounds to the chest and back and the death was unexpected and not preventable. The OIG concurred. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-08-02	**16-1840-RO**	**Suicide**

Incident Summary

On August 2, 2016, a nurse discovered an unresponsive inmate in his cell. Two officers and a sergeant entered the cell and removed two unknown objects from the inmate's mouth. Three officers and a nurse performed life-saving measures. Paramedics transported the inmate to an outside hospital where a physician pronounced him dead four days later.

Disposition

The department's Death Review Committee found the inmate died of anoxic brain injury due to asphyxia. The hiring authority identified potential staff misconduct based on a nurse allegedly sleeping on duty; 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 did not accept for monitoring.

Overall Assessment

The department's actions prior to the incident were not adequate because a nurse allegedly did not adequately monitor the inmate.

Prior to Incident Rating	During the Incident Rating	After the 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, a nurse was allegedly asleep for nearly three hours and did not perform required inmate welfare checks before another nurse found the inmate unresponsive.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-08-10	**16-1867-RO**	**Hunger Strike**

Incident Summary

On August 10, 2016, an inmate began a hunger strike because he objected to his medical treatment. On August 18, 2016, the institution transported him to an outside hospital for complications related to mental health and blood pressure. The inmate returned to the institution on August 20, 2016, and ended his hunger strike the next 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 actions following the incident were not adequate because the department failed to notify the OIG when the inmate was transported to an outside hospital.

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

Assessment Questions

- Did the department timely notify the OIG regarding the critical incident?

  The department failed to notify the OIG that the inmate, while on hunger strike, was transported to an outside hospital.

Incident Date	OIG Case Number	Case Type
2016-08-17	**16-1891-RO**	**Hunger Strike**

Incident Summary

On August 17, 2016, an inmate initiated a hunger strike due to safety concerns he had at another institution and because he believed his food was poisoned. On September 3, 2016, the department transported the inmate to an outside hospital due to dehydration and the inmate returned to the institution the next day. On September 7, 2016, the inmate ended the hunger strike but had lost 11 percent of his body weight.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority addressed the failure to timely notify the OIG by sending a memorandum with a description of this incident and instructions on notification requirements for hunger strikes to managers and watch commanders. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was not adequate because the department did not notify the OIG in a timely and sufficient manner and thus delayed the OIG's real-time monitoring of the case.

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

Assessment Questions

- Did the department timely notify the OIG regarding the critical incident?

  The hiring authority neglected to notify the OIG when the inmate had been on a hunger strike for ten days or when the inmate lost 10 percent of his body weight, and only notified the OIG after transporting the inmate to an outside hospital.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-08-22	**16-1868-RO**	**In-Custody Inmate Death**

Incident Summary

On August 22, 2016, an inmate stabbed a second inmate numerous times with an inmate-manufactured weapon. An officer discovered the second inmate in a pool of blood. Four nurses and a supervising nurse performed life-saving measures and a physician pronounced the second inmate dead. The institution conducted an investigation, determined three inmates were potentially involved, and referred the matter against the three inmates to the district attorney's office.

Disposition

The coroner determined that the manner of death was homicide and the cause of death was blunt and sharp force injury to the head. The hiring authority identified potential staff misconduct based on an officer's alleged failure to adequately supervise the inmates and to adequately respond during the incident; 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

The department's actions prior to and during the incident were not adequate because an officer allegedly did not adequately supervise the inmates or timely respond to the incident.

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

Assessment Questions

- Did the hiring authority timely respond to the critical incident?

  An officer allegedly failed to timely respond to the fight that resulted in the inmate's death.

- Were the department's actions prior to, during, and after the critical incident appropriate?

  An officer allegedly did not adequately supervise the inmates prior to or during the incident and failed to adequately respond during the incident.

Incident Date	OIG Case Number	Case Type
2016-09-15	**16-1919-RO**	**In-Custody Inmate Death**

Incident Summary

On September 15, 2016, two inmates stabbed a third inmate with inmate-manufactured weapons on the exercise yard. Officers deployed pepper spray blast grenades to stop the attack. The third inmate suffered multiple stab wounds and was taken to an outside hospital where a physician pronounced the inmate dead.

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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-09-17	**16-2001-RO**	**Hunger Strike**

Incident Summary

On September 17, 2016, an inmate began a hunger strike because he believed he was not receiving proper mental health treatment. On November 3, 2016, 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.

Overall Assessment

The department's actions during the incident were not adequate because the department did not adequately monitor the inmate's access to food.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department allowed the inmate to continue working as a porter and to be housed with an inmate who was not on hunger strike, thereby allowing the inmate unmonitored access to food during the hunger strike.

Incident Date	OIG Case Number	Case Type
2016-09-20	**16-2000-RO**	**Hunger Strike**

Incident Summary

On September 20, 2016, an inmate began a hunger strike to protest being found guilty of a rules violation. On October 21, 2016, the inmate was unresponsive and the department transported him to an outside hospital. The inmate returned to the institution the same day and continued the hunger strike. On November 23, 2016, the inmate agreed to end the hunger strike and was transported to an outside hospital to begin reintroducing food. The inmate had lost 29 percent of his body weight.

Disposition

The department made reasonable attempts to address the inmate's concerns. The hiring authority addressed the failure to timely notify the OIG by providing training to administrative officers of the day on notification requirements for hunger strikes and assigning his administrative assistant to coordinate hunger strike notification to the OIG.

Overall Assessment

The department's response was not adequate because the department did not notify the OIG in a timely and sufficient manner and thus delayed the OIG's real-time monitoring of the case.

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

Assessment Questions

- Did the department timely notify the OIG regarding the critical incident?

  The hiring authority neglected to notify the OIG when the inmate had been on hunger strike for ten days or when the inmate lost 10 percent of his body weight, and only notified the OIG when the inmate was sent to an outside hospital.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-09-22	**16-1961-RO**	**Hunger Strike**

Incident Summary

On September 22, 2016, an inmate began a hunger strike, stating he was not receiving proper medical care and was denied his due process rights. On October 30, 2016, the inmate ended his hunger strike. During the hunger strike, the inmate lost over 10 percent of his body weight and was transported to an outside hospital twice.

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 not adequate because nurses did not timely provide the inmate with critical information or adequately complete documentation.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  Nurses did not provide the inmate documentation pertaining to facts and risks associated with not eating, timely complete a critical form pertaining to the inmate's request to life-sustaining treatment, consistently document the inmate's weight, or document that nutritional supplements were offered to the inmate and refused.

- Was the critical incident adequately documented?

  Nurses did not adequately document that nutritional supplements were offered to the inmate and refused, timely complete a critical form indicating the inmate's desires regarding life-sustaining treatment, or consistently document the inmate's weight.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-02-06	**16-0456-RO**	**In-Custody Inmate Death**

Incident Summary

On February 6, 2016, an officer saw an inmate with blood on his face and found the cellmate unresponsive with an inmate-manufactured weapon tied to his hand. Officers and nurses performed life-saving measures and paramedics subsequently pronounced the cellmate dead. Outside law enforcement initiated a criminal investigation.

Disposition

An autopsy determined the cause of death was strangulation. The department's Death Review Committee concluded the inmate's death was unexpected and medically non-preventable. The department conducted an in-cell assault review and determined the institution complied with departmental policies when housing the two involved inmates. The department provided training and counseled the involved officers regarding timely notification responsibilities.

Overall Assessment

The department's response during the incident was not adequate because officers failed to timely notify the outside law enforcement emergency number.

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

Assessment Questions

- Were the department's actions prior to, during, and after the critical incident appropriate?

  The department did not timely notify the outside law enforcement emergency number.

Incident Date	OIG Case Number	Case Type
2016-04-21	**16-1219-RO**	**Other Significant Incident**

Incident Summary

On April 21, 2016, an officer found an inmate on a shower floor with a noose around the inmate's neck. The officer removed the noose and the department transported the inmate to an outside hospital, following which the inmate returned to the institution.

Disposition

The hiring authority did not identify any staff misconduct.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-05-02	**16-1300-RO**	**In-Custody Inmate Death**

Incident Summary

On May 02, 2016, officers discovered an unresponsive inmate in his cell, removed the inmate from the cell, and initiated life-saving measures. A nurse arrived and continued life-saving efforts. Paramedics arrived at the scene and pronounced the inmate dead.

Disposition

The coroner determined the cause of death was acute opiate and methamphetamine intoxication. The department's Death Review Committee concluded the cause of death was a drug overdose and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-05-02	**16-1394-RO**	**Other Significant Incident**

Incident Summary

On May 2, 2016, officers found an inmate with cut wrists. The department transported the inmate to an outside hospital and the inmate returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-05-10	**16-1435-RO**	**Other Significant Incident**

Incident Summary

On May 10, 2016, an inmate reported swallowing half of a sharpened toothbrush as an attempt to commit suicide.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-05-26	**16-1652-RO**	**Other Significant Incident**

Incident Summary

On May 26, 2016, officers discovered an inmate standing on a chair in the cell with one end of a noose tied around the inmate's neck and the other end tied to a conduit in the ceiling. As officers attempted to remove the inmate from the chair, the noose broke and the inmate fell into two officers' arms. The department transported the inmate to an outside hospital. The inmate returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-05-29	16-1699-RO	Other Significant Incident

Incident Summary

On May 29, 2016, officers found an inmate with a noose tied around the inmate's neck, but not tied to anything else, removed the noose, and transported the inmate to the correctional treatment center. A nurse found no significant injuries and officers returned the inmate to the cell.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-06-16	16-1785-RO	Hunger Strike

Incident Summary

On June 16, 2016, an inmate began a hunger strike because he did not want to be in a cell with another inmate. On July 8, 2016, the department transported the inmate to an outside hospital because he had lost more than 10 percent of his body weight. The inmate returned to the institution on July 10, 2016, and ended the hunger strike on July 14, 2016.

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. The department adequately notified and consulted with the OIG regarding the incident.

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

Incident Date	OIG Case Number	Case Type
2016-06-24	16-1759-RO	In-Custody Inmate Death

Incident Summary

On June 24, 2016, an inmate alerted officers that his cellmate was on the floor and not breathing. Officers removed the cellmate from the cell and began life-saving measures until paramedics arrived. The department transported the cellmate to the triage and treatment area where a physician pronounced him dead.

Disposition

The coroner's report indicated the cause of death appeared to be a heart attack. The department's Death Review Committee report concluded the cause of death was 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. The department adequately notified and consulted with the OIG regarding the incident.

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-06-26	**16-1760-RO**	**Other Significant Incident**

Incident Summary

On June 26, 2016, a psychiatric technician found an inmate on the floor of her cell with blood on her shirt and a laceration on her arm. The department transported the inmate to an outside hospital and she returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-07-08	**16-1787-RO**	**Other Significant Incident**

Incident Summary

On July 8, 2016, an officer found an unresponsive inmate in a cell with cuts to her neck. The department transported the inmate to an outside hospital and she returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-07-10	**16-1786-RO**	**In-Custody Inmate Death**

Incident Summary

On July 10, 2016, multiple inmates stabbed another inmate numerous times with inmate-manufactured weapons on the exercise yard. Officers and a fire captain performed life-saving measures but they were unsuccessful and a physician pronounced the inmate dead. The hiring authority referred the case against the attacking inmates to the district attorney's office.

Disposition

The coroner determined that the inmate died of multiple stab wounds. 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-07-11	**16-1790-RO**	**Hunger Strike**

Incident Summary

On July 11, 2016, an inmate began a second hunger strike to protest his conviction shortly after ending an earlier hunger strike. As of July 12, 2016, the inmate had lost over 24 percent of his body weight since the start of his first hunger strike. On July 20, 2016, 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.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-07-20	**16-1804-RO**	**Other Significant Incident**

Incident Summary

On July 20, 2016, an officer discovered an inmate hanging from a noose in a cell. The officer heard a thud from inside the cell and opened the cell door, finding the inmate on the floor having what appeared to be a seizure. The department transported the inmate to an outside hospital, following which the inmate returned to the institution and was placed in a mental health crisis bed.

Disposition

The hiring authority did not identify any staff misconduct.

Incident Date	OIG Case Number	Case Type
2016-07-30	**16-1824-RO**	**Other Significant Incident**

Incident Summary

On July 30, 2016, officers discovered an inmate sitting on the floor in a cell with a noose around the inmate’s neck and attached to the upper bunk. Officers removed the noose and the department transported the inmate to an outside hospital. The inmate returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-08-17	**16-1866-RO**	**In-Custody Inmate Death**

Incident Summary

On August 17, 2016, an officer found an unresponsive inmate near his bunk. Officers, nurses, and paramedics initiated life-saving measures and transported the inmate to an outside hospital where he died on August 19, 2016.

Disposition

The coroner determined the inmate died of methamphetamine toxicity and 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-08-18	**16-1893-RO**	**Hunger Strike**

Incident Summary

On August 18, 2016, an inmate began a hunger strike because he wanted to be transferred to another institution, the institution had reduced his medication, and he had not received some of his property. As of September 7, 2016, the inmate had lost 12 percent of his body weight. On October 3, 2016 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.

Overall Assessment

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

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-08-20	**16-1869-RO**	**Other Significant Incident**

Incident Summary

On August 20, 2016, an officer discovered an inmate sitting on a lower bunk with a noose tied around the inmate’s neck and the other end affixed to the upper bunk. Officers cut the noose and noted the inmate was breathing but unresponsive. The department transported the inmate to an outside hospital. The inmate returned to the institution the following day and the department placed the inmate in a mental health crisis bed.

Disposition

The hiring authority did not identify any staff misconduct.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-09-21	**16-1980-RO**	**Hunger Strike**

Incident Summary

On September 21, 2016, an inmate began a hunger strike because he received several rules violation reports for failing to provide urine samples for controlled substance testing. On October 26, 2016, the inmate ended the hunger strike.

Disposition

The hiring authority 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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-09-22	**16-1952-RO**	**Hunger Strike**

Incident Summary

On September 22, 2016, an inmate began a hunger strike due to a loss of appetite. As of September 30, 2016, the inmate had lost 10 percent of her body weight. On October 2, 2016, the inmate ended the hunger strike.

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. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

Incident Date	OIG Case Number	Case Type
2016-09-29	**16-1946-RO**	**Other Significant Incident**

Incident Summary

On September 29, 2016, a nurse found an inmate in a cell with a noose around the inmate’s neck. The inmate complied with orders to remove the noose and a sergeant and an officer transported the inmate to the correctional treatment center, following which the inmate returned to the cell.

Disposition

The hiring authority did not identify any staff misconduct.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-10-02	**16-1956-RO**	**Other Significant Incident**

Incident Summary

On October 2, 2016, an officer observed an inmate in a cell with a plastic bag over the inmate's head. Another officer removed the bag from the inmate's head and officers transported the inmate to the triage and treatment area for evaluation, following which the department placed the inmate on suicide watch and contraband surveillance watch.

Disposition

The hiring authority identified potential staff misconduct based on a captain's alleged failure to notify the OIG of the incident. The hiring authority provided training to the captain regarding reporting requirements.

Incident Date	OIG Case Number	Case Type
2016-11-25	**16-2111-RO**	**Hunger Strike**

Incident Summary

On November 25, 2016, an inmate initiated a hunger strike because of matters related to his criminal trial and the department's refusal to provide pain medication. As of December 5, 2016, the inmate had lost more than 10 percent of his body weight. On December 8, 2016, 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.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.

Prior to Incident Rating	During the Incident Rating	After the Incident Rating
Sufficient	**Sufficient**	**Sufficient**

APPENDIX F 51
CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-06-15	**2016-06-18**	**Suspected Weapons**	**Weapons**

Incident Summary

16-15329-CWRM

On June 15, 2016, the department placed an inmate on contraband surveillance watch after the inmate complained of stomach pains and an x-ray revealed a foreign object secreted in his anal cavity. The department transported the inmate to an outside hospital where he had surgery to remove the object. The department removed the inmate from contraband surveillance watch on June 18, 2016, three days later. During that time, the department recovered a weapon 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 complete required documentation. The department provided training to the supervisors and officers to address the deficiencies.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  The officers did not consistently document the inmate had the opportunity for proper hygiene.

- Did the department complete appropriate documentation?

  The documentation specific to the inmate's activities was not recorded on a consistent basis.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not consistently document hygiene, supervisory checks, and range of motion and did not record any information on some of the shifts.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified discrepancies and provided training to the supervisors and officers involved.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-14	**2016-08-21**	**Suspicious Activity**	**Tobacco**

Incident Summary

16-15368-CWRM

On August 14, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate place an unknown object into his mouth and swallow it during a visit. The department removed the inmate from contraband surveillance watch on August 21, 2016, seven days later. During that time, the department recovered tobacco from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-21	**2016-08-24**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15377-CWRM

On August 21, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate place an unknown object into his mouth during a visit. The department obtained a search warrant on August 24, 2016, for an x-ray that revealed three bindles containing an unknown substance. The department removed the inmate from contraband surveillance watch on August 24, 2016, three days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Sufficient

The department sufficiently comply with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-10-24	**2016-10-28**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15423-CWRM

On October 24, 2016, the department placed an inmate on contraband surveillance watch after officers heard the inmate admit to swallowing drugs while on a monitored phone call. On October 27, 2016, officers discovered the inmate unresponsive in his cell, while under constant observation, and transported the inmate to an outside hospital where he remained on contraband surveillance watch. The department removed the inmate from contraband surveillance watch the same day, after the inmate returned to the institution. During that time, the department recovered drugs 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
2016-12-03	**2016-12-09**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15445-CWRM

On December 3, 2016, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow unknown objects an inmate's visitor placed into a bag. The department removed the inmate from contraband surveillance watch on December 9, 2016, six days later. During that time, the department recovered methamphetamine from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-02-05	**2016-02-09**	**Suspicious Activity**	**Drugs**

Incident Summary

16-15240-CWRM

On February 5, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow a bindle. The department removed the inmate from contraband surveillance watch on February 9, 2016, four days later. During that time, the department recovered marijuana from the inmate.

Incident Assessment

Insufficient

The department did not comply with policies and procedures governing contraband surveillance watch. The department did not adequately provide the inmate with opportunities for range of motion and handwashing. In addition, a supervisor did not consistently check on the inmate. The department provided training to all involved officers and supervisors.

Assessment Questions

- Did application of restraints comply with CSW policies and procedures?

  Officers did not document providing the inmate with range of motion on four occasions.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not provide the inmate the opportunity to wash his hands on multiple occasions.

- Did the department complete appropriate documentation?

  Supervisors did not consistently conduct or document inmate checks.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately provide the inmate with range of motion and the opportunity to wash his hands as required and supervisors did not conduct a welfare check of the inmate on three occasions.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not adequately provide range of motion and give the inmate an opportunity to wash his hands. Supervisors did not conduct a welfare check on three occasions. The department provided training to the officers and supervisors.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-06-14	**2016-06-17**	**Suspicious Activity**	**Drugs**

Incident Summary

16-15328-CWRM

On June 14, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an unknown object during an unclothed body search. The department removed the inmate from contraband surveillance watch on June 17, 2016, three days later. During that time, the department recovered methamphetamines from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-06-18	**2016-06-26**	**Suspected Drugs**	**1. Drugs** **2. Inmate Note** **3. Weapons**

Incident Summary

16-15333-CWRM

On June 18, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate spit out a bindle of drugs during an unclothed body search and swallow a second bindle. The department removed the inmate from contraband surveillance watch on June 26, 2016, eight days later. During that time, the department recovered heroin, a weapon, and inmate notes 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
2016-07-19	**2016-07-24**	**Suspected Drugs**	**Nothing**

Incident Summary

16-15347-CWRM

On July 19, 2016, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow an unknown object during an unclothed body search and the inmate admitted to ingesting marijuana. The department removed the inmate from contraband surveillance watch on July 24, 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 consistently document providing the inmate with hand hygiene and did not fully document observations during two shifts. The department provided training to the involved officers, sergeants, lieutenants, and captains.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hand hygiene.

- Did the department complete appropriate documentation?

  Officers did not fully document activities during two shifts.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not consistently document inmate hygiene and did not fully document activities during two shifts.

- 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 document cell inspections, trash removal, and inmate hygiene. Additionally, officers did not fully document observations during two shifts. The hiring authority provided training to the involved officers, sergeants, lieutenants, and captains.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-20	**2016-07-25**	**Suspected Drugs**	**Inmate Note**

Incident Summary

16-15348-CWRM

On July 20, 2016, the department placed an inmate on contraband surveillance watch after a drug-sniffing dog signaled possible drugs on the inmate. The department removed the inmate from contraband surveillance watch on July 25, 2016, five days later. During that time, the department recovered inmate notes.

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
2016-07-20	**2016-07-25**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15349-CWRM

On July 20, 2016, the department placed an inmate on contraband surveillance watch after a drug-sniffing dog alerted to possible narcotics on the inmate. On July 21, 2016, an officer saw the inmate chewing an unknown item. The inmate admitted retrieving and then destroying inmate notes by chewing and swallowing them. The department removed the inmate from contraband surveillance watch on July 25, 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. An officer either did not provide constant observation of the inmate or did not recognize that the inmate's movements were consistent with retrieving contraband. This resulted in the inmate re-ingesting and destroying some of the contraband. In addition, officers did not consistently document cell inspections and opportunities for hygiene. The department provided training to address these deficiencies.

Assessment Questions

- Overall, did the department substantially comply with CSW policies and procedures?

  An officer did not provide constant visual observation of the inmate while he was on contraband surveillance watch or did not alert supervisors when the inmate made movements consistent with attempting to retrieve contraband. This resulted in the inmate obtaining and re-ingesting the contraband.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified that an officer did not not alert supervisors of his observations when he saw the inmate make movements consistent with retrieving contraband. The hiring authority also identified that officers did not consistently document hygiene, cell searches, or the inmate's actions. The hiring authority provided training to the officers.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-25	**2016-07-30**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15351-CWRM

On July 25, 2016, the department placed an inmate on contraband surveillance watch after officers observed him swallow several unknown items while being removed from his cell for a cell search. While on contraband surveillance watch, the inmate retrieved and re-ingested suspected drugs on two separate occasions. The department removed the inmate from contraband surveillance watch on July 30, 2016, five days later. 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. An officer did not continually monitor the inmate, resulting in the inmate retrieving and re-ingesting the contraband. The department did not adequately notify the OIG. Sergeants did not adequately document supervisory checks and officers did not consistently provide the inmate with the opportunity for hand hygiene. The department provided written counseling to the officer who did not provide constant observation of the inmate and provided training to sergeants and officers to address the other deficiencies.

Assessment Questions

- Did the department complete appropriate documentation?

  Officers did not consistently document providing the inmate with opportunities for hand hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not notify the OIG when it transported the inmate to an outside hospital because of a medical emergency associated with the inmate re-ingesting the contraband. An officer did not provide constant visual observation of the inmate's hands and actions resulting in the inmate retrieving and re-ingesting the contraband. Officers did not consistently document providing the inmate with the opportunity for hand hygiene. Supervisors did not consistently conduct supervisory checks.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The institution did not notify the OIG when the inmate was transported to an outside hospital.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified that supervisory checks, hand hygiene, and range of motion were not consistently documented. An officer did not provide constant visual observation of the inmate during contraband surveillance watch. The hiring authority provided training and written counseling to address these deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-29	**2016-08-01**	**Suspected Drugs**	**Mobile Phone**

Incident Summary

16-15354-CWRM

On July 29, 2016, the department placed an inmate on contraband surveillance watch after officers received confidential information that the inmate's cell was one of several containing drugs. A drug-sniffing dog alerted to drugs on the inmate and officers observed lubricant around the inmate's rectum during an unclothed body search. The department removed the inmate from contraband surveillance watch on August 1, 2016, three days later. During that time, the department recovered a mobile phone and charger from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-29	**2016-08-01**	**Suspected Drugs**	**1. Drugs** **2. Inmate Note**

Incident Summary

16-15355-CWRM

On July 29, 2016, the department placed an inmate on contraband surveillance watch after a drug-sniffing dog signaled possible drugs on the inmate. The department removed the inmate from contraband surveillance watch on August 1, 2016, three days later. During that time, the department recovered heroin and inmate notes from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers and a sergeant did not properly complete required documentation. The hiring authority provided training to the sergeant and issued employee counseling records to two officers 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 opportunities for hand hygiene.

- Did application of restraints comply with CSW policies and procedures?

  Officers did not consistently document providing the inmate with range of motion.

- Did the department complete appropriate documentation?

  A sergeant did not document a supervisory check and officers did not consistently document providing the inmate with range of motion or the opportunity for hand hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  A sergeant did not conduct a supervisory check and officers did not consistently provide the inmate access to proper hygiene and range of motion.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified that a sergeant did not conduct a supervisory check and officers did not consistently provide the inmate access to proper hygiene and range of motion. The hiring authority provided training to the sergeant and issued employee counseling records to the officers to address these deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-31	**2016-08-05**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15356-CWRM

On July 31, 2016, the department placed an inmate on contraband surveillance watch after receiving information the inmate was planning to smuggle drugs. The department removed the inmate from contraband surveillance watch on August 5, 2016, five days later. During that time, the department recovered heroin from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-31	**2016-08-06**	**Suspected Drugs**	**1. Drugs** **2. Other**

Incident Summary

16-15358-CWRM

On July 31, 2016, the department placed an inmate on contraband surveillance watch after an officer observed an unknown object being transferred between the inmate and his visitor during a kiss. The department removed the inmate from contraband surveillance watch on August 6, 2016, six days later. During that time, the department recovered marijuana, methamphetamine, and money 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
2016-08-03	**2016-08-03**	**Suspected Drugs**	**Weapons**

Incident Summary

16-15362-CW

On August 3, 2016, the department placed an inmate on contraband surveillance watch after a drug-sniffing dog signaled possible drugs on the inmate. The department removed the inmate from contraband surveillance watch the same day, approximately two hours after placement. During that time, the department recovered an inmate-manufactured weapon from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The hiring authority prematurely removed the inmate from contraband surveillance watch.

Assessment Questions

- Did the department comply with policies and procedures governing the inmate's removal from CSW?

  The hiring authority authorized the removal of the inmate from contraband surveillance watch within two hours of placement after the inmate voluntarily relinquished an inmate-manufactured weapon. However, since the drug-sniffing dog only signals to possible drugs, the department prematurely removed the inmate from contraband surveillance watch.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department removed the inmate from contraband surveillance watch prior to establishing a reasonable belief that the inmate was free of contraband.

- 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 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.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-03	**2016-08-07**	**Suspected Drugs**	**Nothing**

Incident Summary — 16-15364-CWRM

On August 3, 2016, the department placed an inmate on contraband surveillance watch after a drug-sniffing dog signaled possible drugs on the inmate. The department removed the inmate from contraband surveillance watch on August 7, 2016, four 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
2016-08-14	**2016-08-26**	**Suspicious Activity**	**Drugs**

Incident Summary — 16-15372-CWRM

On August 14, 2016, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow unknown objects the inmate's visitor placed into a bag. The department removed the inmate from contraband surveillance watch on August 26, 2016, 12 days later. During that time, the department recovered several bindles of 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
2016-08-20	**2016-08-27**	**Suspected Drugs**	**1. Drugs** **2. Tobacco**

Incident Summary — 16-15375-CWRM

On August 20, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow suspected contraband during visiting and found contraband on the inmate's visitor. The department removed the inmate from contraband surveillance watch on August 27, 2016, seven days later. During that time, the department recovered 19 bindles of marijuana and tobacco 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
2016-08-21	**2016-08-28**	**Suspected Drugs**	**1. Drugs** **2. Inmate Note**

Incident Summary — 16-15376-CWRM

On August 21, 2016, the department placed an inmate on contraband surveillance watch after officers observed the inmate ingesting possible contraband from a bag during visiting. The department removed the inmate from contraband surveillance watch on August 28, 2016, seven days later. During that time, the department recovered marijuana and an inmate note from the inmate.

Incident Assessment — Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-30	**2016-09-05**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15384-CWRM

On August 30, 2016, the department placed an inmate on contraband surveillance watch after receiving information that the inmate was in possession of drugs and an x-ray confirmed the presence of a foreign object in his colon. While on contraband surveillance watch, officers found heroin, marijuana, and cocaine in the inmate's cell. The department removed the inmate from contraband surveillance watch on September 5, 2016, six 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. Officers did not consistently complete required documentation. A lieutenant did not ensure an initial medical assessment was completed. The institution retained the inmate on contraband surveillance watch one day longer than necessary without justification. The hiring authority provided training to the involved lieutenants, sergeants, and officers for all identified deficiencies, and to all administrative officers on the timely removal of inmates from contraband surveillance watch.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hygiene checks.

- Did the department conduct required medical assessments?

  The watch commander did not ensure that an initial medical assessment of the inmate was completed.

- Did the department complete appropriate documentation?

  Officers did not consistently document hand hygiene, restraint checks, cell inspections, and mattress and blanket issuance and removal.

- Did the department comply with policies and procedures governing the inmate's removal from CSW?

  The department retained the inmate on contraband surveillance watch for one day longer than necessary without justification.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the contraband surveillance watch, the watch commander did not ensure that a medical assessment was completed, and the institution retained the inmate on contraband surveillance watch for one day longer than necessary without justification.

- 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 watch commander did not ensure an initial medical assessment was completed.

- 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 document hand hygiene, restraint checks, and hygiene, cell inspections, and mattress and blanket issuance and removal. The institution retained the inmate on contraband surveillance watch one day longer than necessary without justification. The hiring authority provided training to the involved lieutenants, sergeants, and officers for all identified deficiencies and to all administrative officers on the timely removal of inmates from contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-09-03	**2016-09-12**	**Suspected Inmate Note**	**Inmate Note**

Incident Summary

16-15389-CWRM

On September 3, 2016, the department placed an inmate on contraband surveillance watch after officers observed him take an unknown item from his waistband and place it in his mouth during a random cell search. The department removed the inmate from contraband surveillance watch on September 12, 2016, nine days later. During that time, the department recovered inmate notes 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
2016-09-10	**2016-09-15**	**Suspicious Activity**	**Nothing**

Incident Summary

16-15394-CWRM

On September 10, 2016, 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 September 15, 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. The department did not obtain authorization from the warden or chief deputy warden to apply hand isolation devices because the institution has a local operating procedure that allows for the administrative officer-of-the day to authorize the use of hand isolation devices. The OIG recommended the hiring authority change the local operating procedure to correlate with the department's policy but the hiring authority declined.

Assessment Questions

- Did application of Hand Isolation Devices comply with CSW policies and procedures?

  The department placed the inmate in hand isolation devices without proper authorization from the warden or chief deputy warden.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department placed the inmate in hand isolation devices without proper authorization.

- Did the OIG make a recommendation to the hiring authority?

  The OIG recommended the hiring authority change its local operating procedure which allows for the administrative officer-of-the-day to authorize the use of hand isolation devices.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  The hiring authority declined to change the local operating procedure to comport with the department's policy.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-10-06	**2016-10-12**	**Suspected Drugs**	**Inmate Note**

Incident Summary

16-15406-CWRM

On October 6, 2016, the department placed an inmate on contraband surveillance watch after an officer smelled marijuana coming from the inmate's cell and observed lubricant around the inmate's rectum during an unclothed body search. The department removed the inmate from contraband surveillance watch on October 12, 2016, six days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-10-07	**2016-10-10**	**Suspicious Activity**	**Nothing**

Incident Summary

16-15407-CWRM

On October 7, 2016, the department placed an inmate on contraband surveillance watch after receiving information that the inmate may be in possession of controlled substances and an x-ray showed an anomaly in the inmate's abdomen. The department removed the inmate from contraband surveillance watch on October 10, 2016, three 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 timely notify the OIG of the inmate's initial placement on contraband surveillance watch and did not obtain the proper authorization to extend the inmate on contraband surveillance watch beyond 72 hours. The department did not complete required documentation. The department provided training to address these 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 approximately four hours after placing the inmate on contraband surveillance watch.

- Did the department comply with policies and procedures when the inmate's placement on CSW was extended beyond the initial 72 hours?

  The department did not obtain the proper authorization to extend the inmate's placement on contraband surveillance watch beyond 72 hours.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document providing the inmate with opportunities for hand hygiene.

- Did the department complete appropriate documentation?

  Officers did not consistently document range of motion, restraint checks, hand hygiene, trash removal, and mattress and blanket removal.

- Did the department comply with policies and procedures governing the inmate's removal from CSW?

  The department extended the contraband surveillance watch beyond 72 hours without the warden's authorization and the extension was not justified. The associate warden did not timely complete an internal audit document.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not timely notify the OIG when placing the inmate on contraband surveillance watch and did not obtain the proper authorization to extend contraband surveillance watch beyond 72 hours. Officers did not consistently document restraint checks, hand hygiene, mattress removal, trash removal, blanket removal, and range of motion. A supervisor did not conduct a supervisory check. The associate warden did not timely complete an internal audit document.

- 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 did not timely notify the OIG of the inmate's initial placement on contraband surveillance watch and did not obtain the proper authorization to extend the inmate on contraband surveillance watch beyond 72 hours. A supervisor did not complete a supervisory check. An associate warden did not timely complete an internal audit document.

- 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 document restraint checks, hand hygiene, mattress removal, trash removal, blanket removal, and range of motion. The hiring authority provided training to the involved associate warden, captain, lieutenants, sergeants and officers.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-10-20	**2016-10-24**	**Suspicious Activity**	**Nothing**

Incident Summary 16-15418-CWRM

On October 20, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallowing what appeared to be two bindles. The department removed the inmate from contraband surveillance watch on October 24, 2016, four 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
2016-10-23	**2016-10-24**	**Suspicious Activity**	**Drugs**

Incident Summary 16-15422-CW

On October 23, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow a bindle a visitor provided. Officers discovered another bindle containing methamphetamine in the visitor's possession. The department transported the inmate to an outside hospital after the inmate exhibited signs of being under the influence of drugs and removed the inmate from contraband surveillance watch on October 24, 2016, one day later. During that time, the department recovered methamphetamine and heroin from the inmate. The inmate returned to the institution on October 25, 2016.

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
2016-10-29	**2016-11-02**	**Suspicious Activity**	**Drugs**

Incident Summary 16-15424-CWRM

On October 29, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate reach into a visitor's pockets and then swallow unknown objects. The department removed the inmate from contraband surveillance watch on November 2, 2016, four days later. During that time, the department recovered heroin, synthetic cannabinoids, and prescription drugs 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
2016-10-31	**2016-11-03**	**Suspicious Activity**	**Drugs**

Incident Summary 16-15425-CW

On October 31, 2016, the department placed an inmate on contraband surveillance watch after officers received information that the inmate was in possession of contraband. On November 1, 2016, the department transferred the inmate to an outside hospital after a medical assessment revealed that a bindle may have burst. The inmate returned to the institution the same day. The department removed the inmate from contraband surveillance watch on November 3, 2016, two days later. During that time, the department recovered methamphetamines and synthetic cannabinoid from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-10-31	**2016-11-01**	**Suspicious Activity**	**1. Drugs** **2. Mobile Phone**

Incident Summary 16-15426-CW

On October 31, 2016, the department placed an inmate on contraband surveillance watch after he admitted placing contraband in his rectum. The department transferred the inmate to an outside hospital after medical staff determined that a bindle may burst. Physicians at the outside hospital removed the contraband from the inmate and the department removed the inmate from contraband surveillance watch on November 1, 2016, one day later. During that time, the department recovered marijuana and two mobile phones 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
2016-11-05	**2016-11-12**	**Suspicious Activity**	**Drugs**

Incident Summary 16-15428-CWRM

On November 5, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate's visitor pass an unknown object to the inmate during a kiss. The department removed the inmate from contraband surveillance watch on November 12, 2016, seven days later. During that time, the department recovered 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
2016-11-21	**2016-11-25**	**Suspicious Activity**	**1. Drugs** **2. Inmate Note** **3. Mobile Phone**

Incident Summary 16-15435-CWRM

On November 21, 2016, the department placed an inmate on contraband surveillance watch after officers observed lubricant around the inmate's rectal area during an unclothed body search. The department removed the inmate from contraband surveillance watch on November 25, 2016, four days later. During that time, the department recovered drugs, inmate notes, and a mobile phone from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-04-29	**2016-05-04**	**Suspicious Activity**	**Nothing**

Incident Summary

16-15298-CWRM

On April 29, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow a bindle of suspected drugs. The department removed the inmate from contraband surveillance watch on May 4, 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. The department did not adequately document inmate observations, supervisory checks, range of motion, blanket removal, and hygiene. The hiring authority provided training to involved supervisors and officers.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was afforded the opportunity to wash his hands prior to meals and after using the restroom.

- Did application of restraints comply with CSW policies and procedures?

  Officers did not adequately document that the inmate was allowed free movement of each arm during required times.

- Did the department complete appropriate documentation?

  Officers did not adequately document the incident.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document hand hygiene, supervisory checks, blanket issuance and removal, and range of motion. The hiring authority did not identify any deficiencies in the documentation of 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 documentation deficiencies in hand hygiene, supervisory checks, blanket issuance and removal, and range of motion. The hiring authority provided training to involved supervisors and officers.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-06-18	**2016-06-23**	**Suspected Weapons**	**Nothing**

Incident Summary

16-15332-CWRM

On June 18, 2016, the department placed an inmate on contraband surveillance watch after the inmate told officers that he swallowed razor blades and he was going to use them to assault staff. The department removed the inmate from contraband surveillance watch on June 23, 2016, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not sufficiently complete documentation. The hiring authority provided training to the officers.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals.

- Did the department complete appropriate documentation?

  Officers did not adequately document inmate hygiene, range of motion, or the results of the inmate's bowel movement.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document inmate hygiene, range of motion, or the results of the inmate's bowel movement.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not adequately document the incident. The hiring authority provided training to the officers.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-08	**2016-07-13**	**Suspected Drugs**	**Nothing**

Incident Summary

16-15342-CWRM

On July 8, 2016, the department placed an inmate on contraband surveillance watch after a medical procedure at an outside hospital revealed he had suspected drugs in his stomach. The department removed the inmate from contraband surveillance watch on July 13, 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 document the incident. The hiring authority provided training to sergeants and officers.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was afforded the opportunity to wash his hands prior to meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not adequately document inmate hygiene, supervisor reviews, range of motion, or the medical procedures conducted at the outside hospital.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident.

- 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 for inadequate documentation.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-18	**2016-07-20**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15346-CW

On July 18, 2016, the department transported an inmate to an outside hospital for a suspected drug overdose and placed the inmate on contraband surveillance watch after an examination revealed three bindles of suspected drugs in the inmate's abdomen. The department removed the inmate from contraband surveillance watch on July 20, 2016, two days later and returned the inmate to the institution. 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. The department did not property complete required documentation. The hiring authority provided training to lieutenants, sergeants, and officers to address the deficiencies.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  An officer did not document hand hygiene on one occasion during the incident and officers did not consistently document restraint hygiene.

- Did the department complete appropriate documentation?

  An officer did not document that the inmate was afforded hand hygiene, an officer did not document the disposition of recovered contraband, and forms contained incorrect dates and a missing time. Officers did not consistently document restraint hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  An officer did not document that the inmate was afforded hand hygiene, an officer did not document the disposition of recovered contraband, and forms contained incorrect dates and a missing time. Officers did not consistently document restraint hygiene.

- 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 regarding documentation errors and omissions.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-07-27	**2016-07-31**	**Suspected Drugs**	**Inmate Note**

Incident Summary

16-15352-CWRM

On July 27, 2016, the department placed an inmate on contraband surveillance watch after receiving information that the inmate was concealing narcotics and an x-ray revealed a foreign object in his anal cavity. The department removed the inmate from contraband surveillance watch on July 31, 2016, four days later. During that time, the department recovered an inmate note 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 hand hygiene or range of motion and nurses did not conduct required checks and assessments. The hiring authority provided training to address the deficiencies.

Assessment Questions

- Did the department conduct required medical assessments?

  Nurses did not complete required medical assessments.

- Did the department complete appropriate documentation?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom and did not consistently document range of motion.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document hand hygiene and range of motion releases and nurses did not conduct required assessments.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not adequately document range of motion and hand hygiene. Nurses did not 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 an officer for not documenting the issuance of a meal.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-14	**2016-08-16**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15369-CW

On August 14, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallowing items from a bag that a visitor gave him and the inmate told an officer that he swallowed bindles of heroin. On August 15, 2016, the department transported the inmate to an outside hospital where he remained on contraband surveillance watch. The department removed the inmate from contraband surveillance watch on August 16, 2016, two days after placement. During that time, the department recovered heroin from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-16	**2016-08-19**	**Suspected Weapons**	**Nothing**

Incident Summary

16-15373-CW

On August 16, 2016, the department placed an inmate on contraband surveillance watch after an x-ray revealed the inmate had swallowed objects believed to be razor blades. On August 17, 2016, the department transported the inmate to an outside hospital where the inmate remained on contraband surveillance watch. The inmate returned to the institution on August 18, 2016, and the department removed the inmate from contraband surveillance watch on August 19, 2016, three 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. Officers did not consistently document hand hygiene and range of motion releases. The hiring authority provided training to the officers. A manager did not complete the required documentation following the termination of the contraband surveillance watch.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not consistently document dates, times, and range of motion releases. A manager did not complete the required documentation after terminating contraband surveillance watch.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not consistently document dates, times, hand hygiene, and range of motion releases. A manager did not complete the required documentation after terminating contraband surveillance watch.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  Officers did not consistently document hand hygiene and range of motion releases. The hiring authority provided training to eight officers.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-16	**2016-08-24**	**Suspected Weapons**	**Other**

Incident Summary

16-15374-CWRM

On August 16, 2016, the department placed an inmate on contraband surveillance watch when he was unable to clear the metal detector and admitted to ingesting two security bits. The department transported the inmate to an outside hospital for a higher level of care twice during the contraband surveillance watch, on August 17, 2016, and August 18, 2016. On both occasions, the inmate returned to the institution the same day. The department removed the inmate from contraband surveillance watch on August 24, 2016, eight days after placement. During that time, the department recovered two security bits 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 until more than eight hours after he did not pass the metal detector and admitted to ingesting contraband. The department did not notify the OIG when transferring the inmate to an outside hospital. Officers did not adequately document cell searches, hand hygiene, blanket issuance and removal, and range of motion releases. The hiring authority issued counseling and provided training to the officers to address the documentation 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 more than eight hours after he did not pass a metal detector and admitted swallowing metal security bits.

- Did application of restraints comply with CSW policies and procedures?

  The department did not obtain proper authorization to place the inmate in leg restraints.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was afforded the opportunity to wash his hands prior to meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not adequately document hand hygiene, cell searches, range of motion releases, and blanket issuance and removal.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department placed the inmate on contraband surveillance watch more than eight hours after the inmate did not clear the metal detector and admitted to swallowing contraband. The department failed to notify the OIG when transferring the inmate to an outside hospital. Officers did not adequately document hand hygiene, cell searches, range of motion releases, and blanket issuance and removal.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The department placed the inmate on contraband surveillance watch more than eight hours after he did not clear the metal detector and admitted to swallowing contraband.

- 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 declined to take any action related to the delay in placing the inmate on contraband surveillance watch.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided counseling and training to officers for inadequate documentation of the incident.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-21	**2016-08-26**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15378-CWRM

On August 21, 2016, the department placed an inmate on contraband surveillance watch after a sergeant observed the inmate attempting to insert contraband into his rectum. During an unclothed body search, the department recovered heroin from the inmate. The department removed the inmate from contraband surveillance watch on August 26, 2016, five 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. Nurses did not complete required medical assessments and officers did not adequately document hand hygiene. The hiring authority provided training to a lieutenant, sergeants, and officers to address the deficiencies.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom.

- Did the department conduct required medical assessments?

  Nurses did not complete all of the required medical assessments.

- Overall, did the department substantially comply with CSW policies and procedures?

  Nurses did not complete required medical checks and officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Nurses did not complete all of the 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 officers regarding the lack of hand hygiene documentation.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-08-21	**2016-08-26**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15379-CWRM

On August 21, 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 August 26, 2016, five 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. Officers did not adequately document hand hygiene and nurses did not complete all of the required medical assessments. 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 adequately document that hand hygiene was offered prior to meals or after using the restroom.

- Did the department conduct required medical assessments?

  Nurses did not complete all of the required medical assessments.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document hand hygiene and nurses did not 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?

  Nurses did not complete all of the 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 officers for inadequate hand hygiene documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-09-03	**2016-09-03**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15386-CW

On September 3, 2016, an officer observed an inmate in visiting swallow bindles of suspected drugs. The officer recovered a bindle of suspected heroin on the floor near the inmate and his visitor. The department transported the inmate to an outside hospital and placed the inmate on contraband surveillance watch after the inmate told a nurse that he swallowed bindles of heroin. The same day, doctors at the outside hospital removed three bindles of suspected heroin from the inmate's stomach and the department removed the inmate from contraband surveillance watch.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-09-04	**2016-09-08**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15387-CWRM

On September 4, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an object he received from his visitor and the inmate admitted swallowing bindles of drugs. The department removed the inmate from contraband surveillance watch on September 8, 2016, four 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 adequately document hand hygiene and did not adequately complete required documentation. The hiring authority provided training to a captain, sergeants, and officers to address the deficiencies.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not adequately document required hand hygiene.

- Did the department complete appropriate documentation?

  Officers did not document affording the inmate proper hygiene and did not adequately complete required forms.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not consistently document required hand hygiene and did not adequately complete required forms.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to a captain, sergeants, and officers regarding documentation requirements.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-09-07	**2016-09-15**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15391-CWRM

On September 7, 2016, the department placed an inmate on contraband surveillance watch after officers saw him swallow several bindles of suspected drugs during a search. The department removed the inmate from contraband surveillance watch on September 15, 2016, eight days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Insufficient

The department did not comply with policies and procedures governing contraband surveillance watch. Officers did not adequately document hand hygiene, the issuance and removal of the mattress, searches, range of motion, and the sufficiency of each bowel movement. The department did not obtain proper authorization to extend the contraband surveillance watch beyond the initial 72 hours. The hiring authority provided counseling and training to managers and officers to address the deficiencies.

Assessment Questions

- Did the department comply with policies and procedures when the inmate's placement on CSW was extended beyond the initial 72 hours?

  The department did not obtain proper authorization to extend the contraband surveillance watch beyond the initial 72 hours.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not adequately document hand hygiene, the issuance and removal of a mattress, searches, range of motion, and the sufficiency of each bowel movement.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident. The department did not obtain proper authorization to extend the contraband surveillance watch beyond the initial 72 hours.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided counseling and training to sergeants and officers related to the inadequate documentation and training to managers regarding contraband surveillance watch extensions.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-11-12	**2016-11-13**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15431-CW

On November 12, 2016, the department placed an inmate on contraband surveillance watch after officers saw the inmate swallow an unknown item during visiting and officers discovered four bindles of heroin during a search of the inmate. The department removed the inmate from contraband surveillance watch on November 13, 2016, one day later. On November 13, 2016, the department recovered heroin from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not complete adequate documentation. The hiring authority provided training to a sergeant and officers to address these deficiencies.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document the inmate had the opportunity to wash his hands after bowel movements.

- Did the department complete appropriate documentation?

  A sergeant did not adequately complete required tracking documents and officers did not consistently document the opportunity for proper hygiene or adequately document the results of the inmate's bowel movements.

- Overall, did the department substantially comply with CSW policies and procedures?

  A sergeant did not adequately complete required tracking documents and officers did not consistently document the opportunity for proper hygiene or adequately document the results of the inmate's bowel movements.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to a sergeant and officers regarding documentation procedures.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-11-19	**2016-11-20**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15434-CW

On November 19, 2016, the department placed an inmate on contraband surveillance watch after they observed him place an unknown object in his rectum during visiting. The department removed the inmate from contraband surveillance watch on November 20, 2016, one day later. During that time, the department recovered heroin from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-11-22	**2016-11-26**	**Suspected Drugs**	**Nothing**

Incident Summary

16-15436-CWRM

On November 22, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow a bindle of suspected drugs. The department removed the inmate from contraband surveillance watch on November 26, 2016, four 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
2016-12-01	**2016-12-05**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15444-CWRM

On December 1, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate breaking a mobile phone and observed lubrication around the inmate's anal cavity during an unclothed body search. The department removed the inmate from contraband surveillance watch on December 5, 2016, four days later. During that time, the department recovered heroin from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-12-04	**2016-12-07**	**Suspected Drugs**	**Nothing**

Incident Summary

16-15447-CW

On December 4, 2016, the department placed an inmate on contraband surveillance watch after they observed him reach into his visitor's boot and place suspected contraband in his rectum. After the initial medical evaluation on December 4, 2016, the department transported the inmate to an outside hospital, where the inmate refused treatment, and returned him to the institution the same day. The department removed the inmate from contraband surveillance watch on December 7, 2016, three 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 notify the OIG when the inmate was transported to an outside hospital. Officers did not adequately document the inmate's hand hygiene, and sergeants and officers did not properly complete required documentation of the incident. The hiring authority provided training to the sergeants and officers.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document affording the inmate proper hygiene.

- Did the department complete appropriate documentation?

  Officers did not consistently document hand hygiene and officers and sergeants did not properly complete required forms.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not notify the OIG that the inmate was transported to an outside hospital.

- 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 regarding inmate hygiene and proper completion of the required documentation. The hiring authority provided training to the sergeants and officers.

APPENDIX G 32
FIELD INQUIRY CASE SUMMARIES
CENTRAL REGION

Contact Date	OIG Case Number	Case Type
2015-09-02	**16-0011902-FI**	**Field Inquiry**

Incident Summary
On September 2, 2015, an inmate submitted a complaint to the OIG alleging the department did nothing when the inmate reported that an officer opened a food port and grabbed the inmate's buttocks.

Disposition
The hiring authority determined that Prison Rape Elimination Act protocols had not been initiated in response to the inmate's initial complaint, but did not identify any potential staff misconduct. The OIG reminded the hiring authority of the importance of following the Prison Rape Elimination Act protocols and the hiring authority provided training to lieutenants to ensure compliance.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2015-12-07	**15-0002765-FI**	**Field Inquiry**

Incident Summary
On December 7, 2015, an inmate submitted a complaint to the OIG alleging the department refused to adequately investigate a sexual assault allegation against another inmate.

Disposition
The department sufficiently investigated and resolved the inmate's allegation of sexual assault.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

CENTRAL REGION

Contact Date	OIG Case Number	Case Type
2016-01-26	**16-0000306-FI**	**Field Inquiry**

Incident Summary

On January 26, 2016, the OIG received a complaint on behalf of three inmates alleging an institution was significantly delaying their legal mail.

Disposition

The hiring authority determined the mailbox into which the three inmates deposited their legal mail was previously inaccessible to inmates and therefore, had not been checked for a long period of time. The hiring authority reported it now has a practice of checking the mailbox on a regular basis.

Overall Assessment

Rating: **Insufficient**

The department did not sufficiently address the matter because the hiring authority did not adequately consult with the OIG or provide sufficient documentation regarding the inquiry.

Assessment Questions

- **Did the department adequately consult with the OIG regarding the field inquiry?**

  The hiring authority repeatedly failed to respond to requests for information from the OIG.

- **Was the department's overall response to the OIG's field inquiry appropriate?**

  The hiring authority's failure to respond to OIG inquiries was not appropriate.

Contact Date	OIG Case Number	Case Type
2016-02-22	**16-0000696-FI**	**Field Inquiry**

Incident Summary

On February 22, 2016, an inmate submitted a complaint to the OIG alleging the department did not investigate his allegation that an officer grabbed his buttocks.

Disposition

The hiring authority conducted an inquiry regarding the inmate's sexual misconduct allegation 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
2016-06-22	**16-0011838-FI**	**Field Inquiry**

Incident Summary

On June 22, 2016, an inmate submitted a complaint to the OIG alleging a sergeant investigated the inmate's allegation of misconduct even though the sergeant was identified as a witness to the alleged misconduct.

Disposition

The hiring authority reopened an inquiry into the inmate's allegation of misconduct and provided training to the sergeant, facility lieutenant, and the appeals assignment coordinator regarding the proper assignment of inmate allegations of misconduct.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

CENTRAL REGION

Contact Date	OIG Case Number	Case Type
2016-07-07	16-0012027-FI	Field Inquiry

Incident Summary

On July 7, 2016, an inmate submitted a complaint to the OIG alleging the department ignored his request for a cell transfer because he was afraid of his cellmate, who later attempted to kill the inmate.

Disposition

The institution updated the inmates' records to document that they are enemies to prevent them from being cellmates in the future.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-07-18	16-0011888-FI	Field Inquiry

Incident Summary

On July 18, 2016, an inmate submitted a complaint to the OIG alleging the department's failure to properly compute his credits prevented him from being released on parole.

Disposition

The department determined the district attorney's office failed to provide the reports necessary to determine whether the inmate was entitled to the credits. The department requested the information from the district attorney's office.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-08-10	16-0012035-FI	Field Inquiry

Incident Summary

On August 10, 2016, an inmate submitted a complaint to the OIG alleging that inmates were tampering with his food and that officers were sexually assaulting him while he was sleeping.

Disposition

The department investigated and resolved the inmate's allegations.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-08-15	16-0012022-FI	Field Inquiry

Incident Summary

On August 15, 2016, an inmate submitted a complaint to the OIG alleging officers used excessive force, four officers submitted false reports, and the department conducted an inadequate video-recorded interview.

Disposition

The institution's executive review committee determined the use of force complied with policy. The department conducted an inquiry regarding the inmate's allegations and determined there was insufficient evidence to support the allegations, but provided training to a lieutenant for not complying with video-recording requirements. The OIG concurred with the department's determinations.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

CENTRAL REGION

Contact Date	OIG Case Number	Case Type
2016-08-18	**16-0011900-FI**	**Field Inquiry**

Incident Summary

On August 18, 2016, an inmate submitted a complaint to the OIG alleging officers had assaulted two inmates causing serious injuries and that he was falsely charged with battery on a peace officer when he reported the matter to the investigative services unit.

Disposition

The hiring authority identified potential staff misconduct involving the use of force and the failure to report the use of force. 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
2016-09-16	**16-0012211-FI**	**Field Inquiry**

Incident Summary

On September 16, 2016, an inmate submitted a complaint to the OIG alleging the department refused to initiate hunger strike protocols when he was on a hunger strike, denied administrative remedies, and inappropriately removed him from mental health treatment. He also alleged that he was a victim of racism, reprisal, and sexual harassment.

Disposition

The department agreed to provide training to ensure the hunger strike protocols are followed. The hiring authority determined the other allegations were unfounded. The OIG concurred.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

NORTH REGION

Contact Date	OIG Case Number	Case Type
2015-02-06	15-0000316-FI	Field Inquiry

Incident Summary

On February 6, 2015, an inmate submitted a complaint to the OIG alleging he was not given the opportunity for time out of his cell.

Disposition

In response to the complaint, the institution changed its procedures to ensure all records in administrative segregation are appropriately maintained. The OIG independently evaluated the housing records and spoke with custody supervisors who confirmed that a segregated housing pilot project which may provide increased yard time for inmates in segregated housing is still under development.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2015-04-01	15-0000675-FI	Field Inquiry

Incident Summary

On April 1, 2015, an inmate submitted a complaint to the OIG alleging he was placed in administrative segregation for possession of an inmate-manufactured weapon belonging to his cellmate.

Disposition

The hiring authority identified potential staff misconduct based on the officer's inaccurate reporting of who possessed the weapon, officers' failures to provide the inmate with photographs indicating where the weapon was found, and the lieutenant's failure to discover the inconsistencies in the report during a rules violation hearing. The hiring authority was unable to refer the matter to the Office of Internal Affairs because the deadline to take disciplinary action had already expired. The hiring authority addressed the deficiencies with the lieutenant and discussed performance expectations in handling future hearings. The department provided training to the officer regarding evidence collection and preservation.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2015-07-28	15-0001494-FI	Field Inquiry

Incident Summary

On July 28, 2015, the OIG received a complaint alleging the department refused to process an inmate's appeal wherein the inmate alleged that an officer made repeated derogatory sexual comments to the inmate.

Disposition

The hiring authority identified potential staff misconduct based upon the appeals analyst's failure to process the inmate's appeal as a staff complaint and a lieutenant's failure to submit a timely memorandum to the hiring authority and adequately document the allegations. The hiring authority did not refer the case to the Office of Internal Affairs for investigation, but instead assigned the inmate's appeal as a staff complaint, reassigned the appeals analyst, and provided counseling to the lieutenant.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

NORTH REGION

Contact Date	OIG Case Number	Case Type
2016-01-25	**16-0000358-FI**	**Field Inquiry**

Incident Summary

On January 25, 2016, an inmate submitted a complaint to the OIG alleging his cellmate sexually assaulted him.

Disposition

The hiring authority provided training to a lieutenant and an officer regarding the appropriate handling of sexual assault complaints.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-05-02	**16-0001368-FI**	**Field Inquiry**

Incident Summary

On May 2, 2016, a supervising nurse submitted a complaint to the OIG alleging a psychiatric technician used leave granted pursuant to the Family Medical Leave Act to perform duties for her secondary employer and that a nurse left his shift early before his relief arrived.

Disposition

The hiring authority identified potential staff misconduct based on the psychiatric technician allegedly abusing leave granted under the Family Medical Leave Act. However, the hiring authority delayed referring the matter to the Office of Internal Affairs for disciplinary action and the psychiatric technician retired before any disciplinary action could be taken. The hiring authority also referred the nurse's potential misconduct to the Office of Internal Affairs. The Office of Internal Affairs returned the cases to the hiring authority to take action without an investigation. The OIG did not accept the cases for monitoring.

Overall Assessment

Rating: **Insufficient**

The department did not sufficiently address the matter because the hiring authority did not adequately consult with the OIG and neglected to timely act on the OIG's recommendation to refer potential staff misconduct for disciplinary action and referred the nurse's potential misconduct almost three months after being contacted by the OIG.

Assessment Questions

- **Did the hiring authority appropriately determine whether to refer any alleged misconduct related to the OIG's field inquiry to the Office of Internal Affairs?**

  The hiring authority knew the psychiatric technician used leave granted pursuant to the Family Medical Leave Act to perform duties for her secondary employer, but incorrectly believed that the approved medical leave precluded the department from imposing discipline on the employee for the misconduct.

- **Did the department adequately consult with the OIG regarding the field inquiry?**

  The hiring authority did not timely return telephone calls and neglected to timely act on the OIG's recommendations to refer potential staff misconduct for disciplinary action. The psychiatric technician retired before discipline could be imposed.

- **Was the department's overall response to the OIG's field inquiry appropriate?**

  The hiring authority incorrectly believed the psychiatric technician could not be disciplined when she had approved medical leave for the date she was absent. The hiring authority's failure to timely refer the potential staff misconduct for disciplinary action resulted in the psychiatric technician retiring before disciplinary action could be imposed. The hiring authority was aware of the nurse's potential misconduct, but did not refer the matter Office of Internal Affairs until almost three months after being contacted by the OIG.

NORTH REGION

Contact Date	OIG Case Number	Case Type
2016-05-06	16-0011637-FI	Field Inquiry

Incident Summary

On May 6, 2016, an inmate submitted a complaint to the OIG alleging the department did not accommodate his medical needs for being transported.

Disposition

The department determined the procedures used to prepare for the inmate's transportation were appropriate and complied with the inmate's medical needs.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-06-15	16-0011441-FI	Field Inquiry

Incident Summary

On June 15, 2016, an inmate submitted a complaint to the OIG with a photograph of an alleged officer holding a photograph of what appeared to be an inmate with a bullet hole in the inmate's forehead.

Disposition

The hiring authority conducted an inquiry and determined the person pictured in the photograph retired from the department over four years earlier.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-06-17	16-0011762-FI	Field Inquiry

Incident Summary

On June 17, 2016, an inmate submitted a complaint to the OIG alleging sexual harassment by a psychiatric technician.

Disposition

The department determined that there was no staff misconduct.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-07-07	16-0011617-FI	Field Inquiry

Incident Summary

On July 7, 2016, an inmate submitted a complaint to the OIG alleging that the department delayed his release from administrative segregation in retaliation for reporting staff misconduct.

Disposition

The department provided information that the inmate remained in administrative segregation to maintain the integrity and confidentiality of an ongoing investigation involving potential staff misconduct, not retaliation.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addresses the OIG's field inquiry.

NORTH REGION

Contact Date	OIG Case Number	Case Type
2016-07-07	16-0011618-FI	Field Inquiry

Incident Summary

On July 7, 2016, an inmate submitted a complaint to the OIG alleging an investigative services unit lieutenant and sergeant arranged for a second inmate to possess a mobile phone to assist in its inquiry concerning an officer's alleged misconduct. The second inmate's father allegedly sent the phone to the investigative services unit, which arranged to deliver the phone to the inmate. The second inmate's father is allegedly a personal friend of a warden at another institution and the second inmate was allowed to transfer to that institution.

Disposition

The department conducted an inquiry and determined there was no reasonable belief that the sergeant, lieutenant, or warden committed misconduct. The hiring authority had previously identified the potential staff misconduct based on the officer allegedly introducing mobile phones into the institution. 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
2016-08-17	16-0011871-FI	Field Inquiry

Incident Summary

On August 17, 2016, the OIG received a complaint on behalf of an inmate who alleged that a second inmate obtained a copy of an email message a licensed clinical psychologist and a counselor exchanged that contained discourteous statements and confidential information about the first inmate.

Disposition

The hiring authority identified potential staff misconduct because the licensed clinical psychologist and counselor sent and received an email message containing discourteous information about an inmate and the licensed clinical psychologist failed to maintain control of the message. 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, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department did not sufficiently address the OIG's field inquiry because the Office of Internal Affairs declined to open an investigation to determine how the inmate obtained the email message.

Assessment Questions

- **Did the Office of Internal Affairs make an appropriate determination regarding the case?**

  The Office of Internal Affairs declined to open an investigation to determine how the inmate obtained the email message.

- **Did the department follow the recommendation(s) of the OIG?**

  The Office of Internal Affairs did not follow the OIG's recommendation to open an investigation to determine how an inmate obtained the email message.

- **Was the department's overall response to the OIG's field inquiry appropriate?**

  Prior to the OIG's intervention, the hiring authority did not request an investigation or take appropriate steps to impose disciplinary action. The Office of Internal Affairs did not open an investigation into the alleged misconduct.

NORTH REGION

Contact Date	OIG Case Number	Case Type
2016-08-31	**16-0012139-FI**	**Field Inquiry**

Incident Summary

On August 31, 2016, an inmate reported that while at the county jail, he was the victim of a sexual assault by county correctional officers and that he had notified the institution several months later of the alleged assault. The institution did not notify the OIG.

Disposition

The department agreed to ensure managers and the investigative services unit recognize sexual misconduct allegations and timely report them to the OIG.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry and the untimely notification to the OIG.

Contact Date	OIG Case Number	Case Type
2016-09-19	**16-0012149-FI**	**Field Inquiry**

Incident Summary

On September 19, 2016, an officer submitted a complaint to the OIG alleging another officer inappropriately accessed an inmate's confidential information, including medical records.

Disposition

The hiring authority identified potential staff misconduct based on the officer's alleged inappropriate access of inmate custody and medical records. 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, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department did not sufficiently address the matter because the Office of Internal Affairs neglected to open an administrative investigation as the OIG recommended.

Assessment Questions

- **Did the Office of Internal Affairs make an appropriate determination regarding the case?**

  The Office of Internal Affairs improperly declined to open an administrative investigation.

- **Did the department follow the recommendation(s) of the OIG?**

  The Office of Internal Affairs rejected the OIG's recommendation to open an administrative investigation.

- **Was the department's overall response to the OIG's field inquiry appropriate?**

  The Office of Internal Affairs declined to open an administrative investigation.

SOUTH REGION

Contact Date	OIG Case Number	Case Type
2015-09-29	**15-0001987-FI**	**Field Inquiry**

Incident Summary

On September 29, 2015, an inmate and the inmate's sister submitted a complaint to the OIG alleging the department identified an incorrect release date for the inmate.

Disposition

The department identified errors in the award and calculation of credits toward the inmate that affected his release date. Once the department identified and corrected the errors, the department addressed the restrictions in the inmate's confidential departmental file and appropriately released the inmate. The department identified potential staff misconduct based on a counselor's alleged failure to prepare documentation to support the restoration of credits, a committee chairman for allegedly approving the restoration of credits, and an analyst for allegedly failing to identify missing documentation during a pre-release audit. The counselor and the committee chairman retired before the hiring authority identified potential misconduct. The hiring authority provided corrective action to the analyst.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-02-26	**16-0000730-FI**	**Field Inquiry**

Incident Summary

On February 26, 2016, an inmate submitted a complaint to the OIG alleging that the department did not provide him with a form to request further chemical analysis of the results of his positive drug test per departmental policy and the department failed to timely process paperwork related to his possible appeal of a rules violation report.

Disposition

The department provided training to custody staff involved in rules violation reports to ensure that proper forms are made available to inmates and to document providing the forms. The department increased staffing to eliminate a backlog in processing inmate appeals and provided training to appeals staff regarding proper timelines for processing appeals-related paperwork.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SOUTH REGION

Contact Date	OIG Case Number	Case Type
2016-05-02	**16-0011628-FI**	**Field Inquiry**

Incident Summary

On May 2, 2016, an inmate submitted a complaint to the OIG alleging the department mishandled an investigation involving a sexual assault allegation the inmate made against an officer.

Disposition

The Office of Internal Affairs previously rejected a request for investigation regarding the allegation. The OIG elevated the issue to an Office of Internal Affairs executive who concurred with the earlier decision not to open an investigation.

Overall Assessment

Rating: **Insufficient**

The department did not sufficiently address the matter because the Office of Internal Affairs did not properly consider forensic evidence that supported the inmate's allegation and instead rejected the request for investigation.

Assessment Questions

- **Did the Office of Internal Affairs make an appropriate determination regarding the case?**

  Despite the existence of forensic evidence supporting the inmate's sexual assault allegation, the Office of Internal Affairs did not open an investigation.

- **Did the department follow the recommendation(s) of the OIG?**

  Despite the existence of forensic evidence supporting the inmate's sexual assault allegation, the Office of Internal Affairs did not open an investigation.

- **Was the department's overall response to the OIG's field inquiry appropriate?**

  The Office of Internal Affairs inappropriately rejected a request for investigation. Furthermore, when reviewing the the hiring authority's request for investigation, the special agent did not consider the forensic evidence that supported the inmate's allegation. When the OIG raised this issue with an Office of Internal Affairs manager, the manager likewise did not address the issue of the corroborating forensic evidence.

Contact Date	OIG Case Number	Case Type
2016-05-09	**16-0012467-FI**	**Field Inquiry**

Incident Summary

On May 9, 2016, an inmate alleged that a sergeant had his pants down and would not allow the inmate to go to the mental health department unless the inmate orally copulated the sergeant.

Disposition

The department determined the Prison Rape Elimination Act team misidentified the alleged conduct as sexual harassment rather than sexual misconduct. The department provided training to the team regarding the proper identification of sexual misconduct.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SOUTH REGION

Contact Date	OIG Case Number	Case Type
2016-05-26	16-0011518-FI	Field Inquiry

Incident Summary

On May 26, 2016, an institution's appeals office reported to the OIG that the department is allegedly providing inmates with outdated complaint forms containing an unconstitutional admonishment.

Disposition

In response to the complaint, the hiring authority removed and destroyed the outdated complaint forms containing the unconstitutional admonishment.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-07-20	16-0012466-FI	Field Inquiry

Incident Summary

On July 20, 2016, an inmate submitted a complaint to the department alleging an officer touched his genitals during a clothed body search.

Disposition

The department determined the Prison Rape Elimination Act team misidentified the alleged conduct as sexual harassment rather than sexual misconduct. The department provided training to the team regarding the proper identification of sexual misconduct.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Contact Date	OIG Case Number	Case Type
2016-08-15	16-0012204-FI	Field Inquiry

Incident Summary

On August 15, 2016, an inmate submitted a complaint to the OIG alleging two inmates were inappropriately removed from his confidential enemy list.

Disposition

The two enemy inmates were not previously on the inmate's enemy list. The department added the two enemy inmates to the list.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SOUTH REGION

Contact Date	OIG Case Number	Case Type
2016-08-18	**16-0012021-FI**	**Field Inquiry**

Incident Summary

On August 18, 2016, an inmate submitted a complaint to the OIG alleging the institution detained him beyond his commitment and failed to transport him to court on two occasions.

Disposition

In response to the complaint, the institution reevaluated and expedited an update of the inmate's legal status summary and he was immediately released on parole. The institution determined the error in transporting the inmate to court was caused by a miscommunication between the court and outside law enforcement.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SEMI-ANNUAL REPORT

July–December 2016

Volume II

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STATE OF CALIFORNIA
March 2017