Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

January–June 2015

Volume II

September 2015

Fairness ◆ Integrity ◆ Respect ◆ Service ◆ Transparency

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September 2015

FOREWORD

This 21st Semi-Annual Report covers the time period January through June 2015. In addition to its oversight of CDCR's employee discipline process, 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 and CDCR's adherence to its contraband surveillance watch policy. 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 within CDCR. The OIG reports these monitoring activities here to reduce the overall need for separate reports, and also to give the reader a wider view of OIG-monitored activities in one place.

The OIG maintains response capability 24 hours per day, seven days per week, for any critical incident occurring within the prison system. OIG staff responds to the scene (when timely notified) to assess the department's handling of incidents that pose a high risk for the State, staff, or inmates. The factors leading up to each incident, the department's response to the incident, and the outcome of the incident are all assessed and reported; then, if appropriate, the OIG makes recommendations. To provide transparency into the incidents, these cases are reported in Appendix E.

The highest monitoring priority among critical incidents is the use of deadly force. For this reason, these cases are reported separately and processed by the department and the OIG with a higher level of scrutiny. That scrutiny includes both criminal and administrative investigations opened by CDCR's Office of Internal Affairs' Deadly Force Investigation Team, which are monitored by the OIG due to the seriousness of the event, but not necessarily because misconduct is suspected.

Historically, the OIG has also monitored and reported on use-of-force incidents and CDCR's subsequent review process. The OIG's reports in this area can also be found in Volume II. As noted above, deadly force incidents are a subset of use of force and are also categorized as critical incidents. These are reported separately in Appendix D.

Finally, the reader will find a report of the department's use of contraband surveillance watch for this reporting period. These cases are contained in Appendix F.

MONITORING 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 an immediate response by the department, 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 to an individual in the custody or control of the department, excluding lawful executions[1];
3. Any death or serious injury to any parolee if the death or injury occurs while involved with department staff;
4. Any on duty death of a department staff member;
5. Any off duty death of a department staff member when the death has a nexus to the employee's duties at the department;
6. Any suicide by an adult individual in the custody or control of the department and any suicide or attempted suicide by a juvenile ward in the custody or control of the department;
7. 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;
8. Any time an inmate is placed on or removed from contraband surveillance watch;
9. 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;
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.

The OIG maintains a 24-hour contact number in each region to receive notifications. After notification, the OIG monitors the department's management of the incident, either by responding to the site of the incident or by obtaining the incident reports and following up at the scene at a later time. More specifically, the OIG evaluates what caused the incident and the department's immediate response to it. The OIG may make recommendations as a result of its review 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. If the Office of Internal Affairs opens an investigation, the OIG may monitor the ensuing investigation. Critical incidents are customarily reported in the Semi-Annual Report that follows the incident occurrence. However, if an investigation is initiated, a report may be held at the discretion of the Inspector General until the completion of the investigation if reporting it would potentially negatively impact the integrity of that internal investigation.

During this reporting period, the OIG completed assessments of 124 critical incidents (Appendices D and E). It is important to note that the number of critical incidents within any period is dependent upon the events taking place within the department. This report does not

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

directly correlate to incidents that occurred within this time frame, but rather reflects the number of incidents the OIG has assessed and closed for the time period. There were 66 insufficient ratings overall, 27 of which were insufficient due to late notification. In order to monitor an incident on scene, the OIG relies on the department to provide timely notification that a critical incident has occurred. However, even when notification is untimely, the OIG still remotely monitors the event by collecting reports and conducting follow-up reviews.

For cases reported during this period, the department failed to provide timely notification for 31 percent of the critical incidents being reported. This is a 3 percent decline in timely notifications compared to the previous reporting period. Delays in notification impact the OIG's ability to provide real-time, on-site monitoring and transparency for critical incidents.

MONITORING DEADLY FORCE INCIDENTS

The OIG monitors all deadly force incidents. The Office of Internal Affairs conducts both an administrative and a criminal investigation for deadly force investigations, the only exception being when the force occurs outside the institution and an outside law enforcement agency conducts the criminal investigation. Appendix D contains each case involving the use of deadly force closed in this reporting period, regardless of whether the Office of Internal Affairs was involved.

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.

CDCR policy mandates that deadly force investigations be conducted by the Office of Internal Affairs' Deadly Force Investigation Team. The OIG also monitors any use of force involving a head strike by custody staff with any instrument on an inmate, and any warning shots.

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.

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 is required to review Deadly Force Investigation Team incidents. An OIG representative participates as a non-voting member of this body. The Deadly Force Review Board reviews those cases to which the Office of Internal Affairs sends a Deadly Force Investigation Team. The Deadly Force Review Board is an independent body consisting of outside law enforcement experts and a CDCR executive officer. Generally, after the administrative investigation is complete, the investigative report is presented 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 43 potentially deadly force incidents. The incidents included the intentional use of lethal weapons, unintentional strikes 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 that the OIG monitored but the Office of Internal Affairs did not respond to are reported in Appendix D1. There are nine such cases for this period. Cases that were investigated by the Office of Internal Affairs and monitored by the OIG are reported in Appendix D2. There are 34 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 34 cases being reported in Appendix D2, the Office of Internal Affairs responded to the scene in 21 cases, including ten cases where a full Deadly Force Investigation Team responded. In one case, outside law enforcement conducted the criminal investigation, while the Deadly Force Investigation Team conducted the administrative investigation. The case involved an off-duty incident where an officer used his personal firearm to fire two warning shots into the ground on his property to scare away a trespasser.

On January 16, 2014, in response to the OIG's recommendation, the Office of Internal Affairs instituted a pilot project requiring an on-scene response for any incident involving any strike to the head with a baton or impact munition, regardless of injury. On February 12, 2015, the Office of Internal Affairs terminated the pilot project, citing the major expenditure of resources. The OIG consulted with the Office of Internal Affairs regarding the pilot project and agreed that the pilot project did not produce results justifying the increased use of Office of Internal Affairs resources involved in implementation of the pilot project. However, there are 15 pilot project cases that are being reported for this period because the incidents occurred before the project was terminated. The Office of Internal Affairs responded to 13 of those incidents and failed to respond to the remaining two. None of the 15 incidents resulted in serious injury or death. In all 15 cases, the Office of Internal Affairs determined the incidents did not meet the requirements for a full deadly force investigation and the investigations were terminated. The OIG concurred with all of these determinations.

While none of the incidents that transpired during the pilot project resulted in serious injury or death or subjected the department to major liability, the potential for this type of outcome warranted the pilot program. The OIG will continue responding and monitoring incidents involving the use of potentially deadly force as it has done in the past, and will recommend a Deadly Force Investigation Team be sent by the Office of Internal Affairs on a case-by-case basis if deemed necessary.

A recent troubling issue has arisen regarding the Office of Internal Affairs failure to respond to potentially negligent firearm discharges both on institution grounds and in the community. The Department Operations Manual, Chapter 5, Section 51020.4 and Title 15, California Code of

Regulations, Section 3268(a)(8) clearly define "any discharge of a firearm" as "deadly force," requiring a Deadly Force Investigation Team response. On July 28, 2015, an off-duty parole agent discharged his department issued firearm in his home. On August 18, 2015, an officer discharged a department firearm while conducting inventory inside of an institution. In both cases, the Office of Internal Affairs determined that the incidents need not be investigated by the Deadly Force Investigation Team. Therefore, the Office of Internal Affairs did not immediately respond nor will the Deadly Force Review Board review the incidents. The Office of Internal Affairs should comply with the Department Operations Manual and Title 15. The OIG is concerned about the apparent backsliding by the Office of Internal Affairs in the treatment of deadly force incidents, especially those cases where there is a high probability of mishandling of firearms.

MONITORING USE OF FORCE

The OIG monitors the department's evaluation of the force used by staff and reports its findings semi-annually. The monitoring process includes attending Institutional Executive Review Committee (IERC) meetings, where every use of force incident is reviewed and evaluated for compliance with policy.[2] The department is tasked with maintaining the safety and security of staff members, inmates, visitors, and the public. At times, this responsibility requires the use of reasonable force by sworn correctional officers. In doing so, officers are authorized 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." 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."[3]

Departmental policy requires that, whenever possible, verbal persuasion or orders be attempted 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.

Per departmental policy, use-of-force options include, but are not limited to, the following:

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).

[2] See "*Pilot Program for Institutional Use-of-Force Reviews*" later in this section for the exception to this policy.
[3] Department Operations Manual, Chapter 5, Article 2.

Force that utilizes techniques or instruments that are 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; 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. After the report is submitted, a multi-tiered review process begins. As part of its oversight process, the OIG reviews each of the reports, including the entire multi-tiered process. The OIG also provides oversight and makes recommendations to the department in the development of new use-of-force policies and procedures.

When appropriate, the OIG recommends an incident be referred to CDCR's Office of Internal Affairs for investigation (or approval to take disciplinary action based on the information already available). In the event the OIG does not concur with the decision made by the local hiring authority, i.e., the warden or parole administrator, the OIG may confer with higher level department managers. If the OIG recommends investigation of a case, the department's response is monitored and reported.

The OIG attends as many use-of-force committee meetings that 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 that it held 853 use-of-force committee meetings. Of those, the OIG attended 388.

Future Use of Force Monitoring Efforts

Beginning July 1, 2015, the OIG implemented a new use of force monitoring tool. The new tool was designed to give the OIG the ability to more accurately track and report on types and frequency of force and injuries, and capture very specific information from which data can be extracted to identify pertinent or troubling trends and to provide more valuable feedback to the department and its public safety stakeholders.

Use-of-Force Meetings Attended and Incidents Reviewed

During this reporting period, the OIG monitored and evaluated 1,260 unique use-of-force incidents and 82 allegation reviews.[4] In addition, 383 incidents were reviewed, but had to be deferred due to the cases not being fully prepared upon first review by the IERC. This data is derived from those incidents that were reviewed from January 1 through June 30, 2015.

In preparation for a use-of-force meeting, the OIG evaluates all departmental reviews completed prior to the meeting. At each level of review, the reviewer is tasked with evaluating reports, requesting necessary clarifications, identifying deviations from policy, and determining whether the use of force was within policies, regulations, and applicable laws. The levels of review are the initial review conducted by the incident commander; the first level management review conducted by a captain; the second level management review conducted by an associate warden; and the final level of review where the incident is reviewed by the use-of-force review

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

committee, with the ultimate determination made by the institution head or designee. During the meeting, the OIG observes the review process and engages in contemporaneous oversight by raising concerns about the incidents when appropriate, asking for clarifications if reports are inconsistent or incomplete, and engaging in discussions with the committee about the incidents. Through this process the OIG draws an independent conclusion about whether the force used was in compliance with policies, procedures, and applicable laws and whether the review process was thorough and meaningful. Table 1 illustrates the OIG-monitored incidents by the division within CDCR.

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

Division	Number of Incidents Reviewed
Division of Adult Institutions	1,134
Division of Juvenile Justice	96
Division of Parole Operations	24
Office of Correctional Safety	6
Total	**1,260**

Through involvement at the use-of-force meetings, the OIG influenced the department's decision to prescribe additional training, pursue employee discipline, obtain additional factual clarifications, or make policy changes in 92 individual cases.

In the adult institution cases monitored by the OIG, CDCR found the force used was within policy 97 percent of the time, while the OIG found the force used was within policy 96 percent of the time. In the juvenile facility cases, both CDCR and the OIG found the force used was within policy 98 percent of the time. For parole, both CDCR and the OIG found the force used was within policy 96 percent of the time, and for the Office of Correctional Safety (OCS), CDCR and the OIG found the use of force to be in compliance in all of the cases reviewed. These numbers are consistent with prior reporting periods and show that of the cases fully prepared for review, the department is able to take meaningful and appropriate action. As noted in previous reports, the department has struggled with timeliness, thorough evaluations, and fact gathering by first and second-level reviewers, specifically in the adult institutions. In this reporting period, 383 of the cases monitored by the OIG had to be deferred because they were not ready for complete review when they were brought to the use-of-force committee. From these reviews and prior reports, it is apparent that the department should continue efforts to achieve timely reviews.

Department Executive Review Committee (DERC)

Pursuant to California Code of Regulations, Title 15, Section 3268(a)(18) 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 also assigns a Deputy Inspector General to monitor DERC reviews.

During this reporting period, two of the four missions held DERC reviews; the General Population mission reviewed two incidents and the Reception Center mission reviewed six incidents. For each of these incidents, the DERC found the actual use of force to be within policy, but notified the respective wardens of several administrative findings where training needed to be provided. The OIG concurred with the DERC's findings.

The remaining two missions, High Security and Female Offender Programs and Services, Special Housing, have not reported conducting any DERC reviews in the past two reporting periods. While the OIG has identified incidents that may have met the criteria for DERC review, there are no timeframes or formal procedures for the various missions to track, schedule, or record the outcome of DERC reviews, which makes it difficult to ensure that these important reviews are conducted in a timely manner, if at all. The OIG recommends that the department review its procedures pertaining to DERC reviews and adopt a formal procedure for tracking, scheduling, and recording the outcomes for them.

Types of Force

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

The department also distinguishes between immediate and controlled use of force. Immediate use of force is defined in departmental policy as the force used to respond without delay to inmate behavior that constitutes an imminent threat to institution/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/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. All controlled use-of-force situations require the authorization and the presence of a first- or second-level manager or an Administrative Officer of the Day (AOD) during non-business hours. Staff must make every effort to identify disabilities, to include mental health concerns, and to note any accommodations that may need to be considered when preparing for a controlled use of force.

The types of force used in incidents are always examined by the use-of-force review committees, but the officer has discretion in determining the level of force required in each situation. In the vast majority of cases, the type of force used is appropriate for the situation and does not become an issue of discussion. The primary focus of committee review is to evaluate whether the use-of-force policy and other policies, such as decontamination of inmates, video-recorded interviews, escort of inmates post-incident, completion of log entries, etc., were followed.

During this reporting period, staff contributed to the need for force in 41 of the 1,260 incidents reviewed. While there were varying reasons staff contributed to the need for the use of force, five major reasons were the following:

1) Opening a cell door or otherwise allowing inmates access to unauthorized areas (8 incidents);

2) Using force when no imminent threat was present (7 incidents);

3) Restraint equipment (such as handcuffs) being inappropriately applied or not applied when required (7 incidents);

4) Staff making inappropriate or violence-inciting statements, resulting in an escalation of the incident (5 incidents); and

5) Failing to sound an alarm during an incident, which may have negated the need for force (3 incidents).

In all of these 41 incidents, the department took appropriate action, which varied from staff training to disciplinary action.

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

Division	Incidents
Division of Adult Institutions	35
Division of Juvenile Justice	3
Division of Adult Parole	2
Office of Correctional Safety	1
Total	**41**

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/special housing (FOPS/SH).[5] As of June 30, 2015, the department housed 117,342[6] in-state inmates.[7]

Of the 1,260 total use-of-force incidents the OIG reviewed this period, 1,134 (90 percent) occurred within the DAI. The OIG found the reports adequately articulated the justification for using force and adequately described the force used in 96 percent of the incidents. The remaining

[5] The full name of this mission is "female offender programs and services, special housing" (FOPS/SH). 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.

[6] This number includes the 2,129 inmates housed at the California City Correctional Facility, which is a leased facility within the high security mission. The department additionally contracts to house over 7,000 inmates in out-of-state facilities and nearly 4,000 in in-state contract beds. The OIG does not monitor those facilities unless there is a deadly force incident.

[7] CDCR data is derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1412.pdf.

4 percent of incidents reviewed had inadequate justification for the use of force. In the majority of the incidents, the department provided training to involved staff; however, others generated counseling or referrals for internal investigations. The OIG concurred with each of the findings.

The following table reflects the number of incidents reviewed by the OIG within the adult institutions during this reporting period. In addition, the table breaks down the applications of force. Note that "applications of force," as used in this report, corresponds to the type of force used on each inmate during an incident. For example, if two inmates are fighting and OC pepper spray is used on each inmate, OC pepper spray will be counted twice for the one incident. However, if two applications of OC pepper spray are used on one inmate, it is only counted as one application of force.

Table 3: Incidents Reviewed and Frequency of Force within the Division of Adult Institutions

Adult Institutions									
Institution Initialism	**Institution Name**	**Incidents Reviewed**	**Applications of Force**	**Chemical Agents**	**Physical Force**	**Less-Lethal Force**	**Expandable Baton**	**Other/Non-Conventional**	**Lethal Force, Including Warning Shots**
ASP	Avenal State Prison	15	36	97%	3%	0%	0%	0%	0%
CAC	California City Correctional Facility	5	9	78%	22%	0%	0%	0%	0%
CAL	Calipatria State Prison	9	29	38%	21%	28%	10%	0%	3%
CCC	California Correctional Center	40	107	76%	12%	5%	7%	0%	0%
CCI	California Correctional Institution	14	26	81%	8%	12%	0%	0%	0%
CCWF	Central California Women's Facility	17	33	85%	12%	0%	3%	0%	0%
CEN	Centinela State Prison	29	68	75%	6%	13%	6%	0%	0%
CHCF	California Health Care Facility	41	48	21%	67%	0%	4%	8%	0%
CIM	California Institution for Men	22	38	68%	18%	5%	3%	5%	0%
CIW	California Institution for Women	41	61	61%	36%	3%	0%	0%	0%
CMC	California Men's Colony	28	47	62%	30%	2%	6%	0%	0%
CMF	California Medical Facility	19	31	52%	42%	0%	6%	0%	0%
COR	California State Prison, Corcoran	30	52	63%	23%	8%	6%	0%	0%
CRC	California Rehabilitation Center	19	30	80%	20%	0%	0%	0%	0%
CTF	Correctional Training Facility	12	24	63%	17%	0%	21%	0%	0%
CVSP	Chuckawalla Valley State Prison	6	12	75%	8%	0%	8%	8%	0%
DVI	Deuel Vocational Institution	15	27	33%	41%	0%	26%	0%	0%
FSP	Folsom State Prison	20	50	74%	16%	2%	8%	0%	0%
HDSP	High Desert State Prison	80	185	68%	11%	18%	3%	0%	1%
ISP	Ironwood State Prison	24	62	68%	5%	11%	16%	0%	0%
KVSP	Kern Valley State Prison	46	117	67%	9%	22%	1%	0%	2%
LAC	California State Prison, Los Angeles County	92	207	62%	14%	15%	9%	0%	0%
MCSP	Mule Creek State Prison	69	131	53%	15%	15%	17%	1%	0%
NKSP	North Kern State Prison	33	86	65%	9%	17%	1%	0%	7%
PBSP	Pelican Bay State Prison	13	40	65%	13%	15%	8%	0%	0%
PVSP	Pleasant Valley State Prison	19	262	0%	0%	3%	97%	0%	0%
RJD	Richard J. Donovan Correctional Facility	44	72	53%	32%	6%	6%	4%	0%
SAC	California State Prison, Sacramento	108	197	55%	25%	8%	11%	1%	0%
SATF	Substance Abuse Treatment Facility & State Prison at Corcoran	18	35	51%	14%	23%	9%	3%	0%
SCC	Sierra Conservation Center	21	42	71%	24%	2%	2%	0%	0%
SOL	California State Prison, Solano	22	52	73%	4%	15%	8%	0%	0%
SQ	California State Prison, San Quentin	19	47	57%	17%	11%	13%	0%	2%
SVSP	Salinas Valley State Prison	85	176	66%	16%	15%	1%	0%	1%
VSP	Valley State Prison	6	10	50%	50%	0%	0%	0%	0%
WSP	Wasco State Prison	53	117	68%	9%	18%	6%	0%	0%
TOTAL		**1,134 Incidents**	**2,566 Applications**	**64% Overall Average**	**21% Overall Average**	**8% Overall Average**	**7% Overall Average**	**1% Overall Average**	**<1% Overall Average**

CDCR Missions:	Reception Center	High Security	General Population	Female Offender/Special Programs

Use of Force on Mental Health Inmates

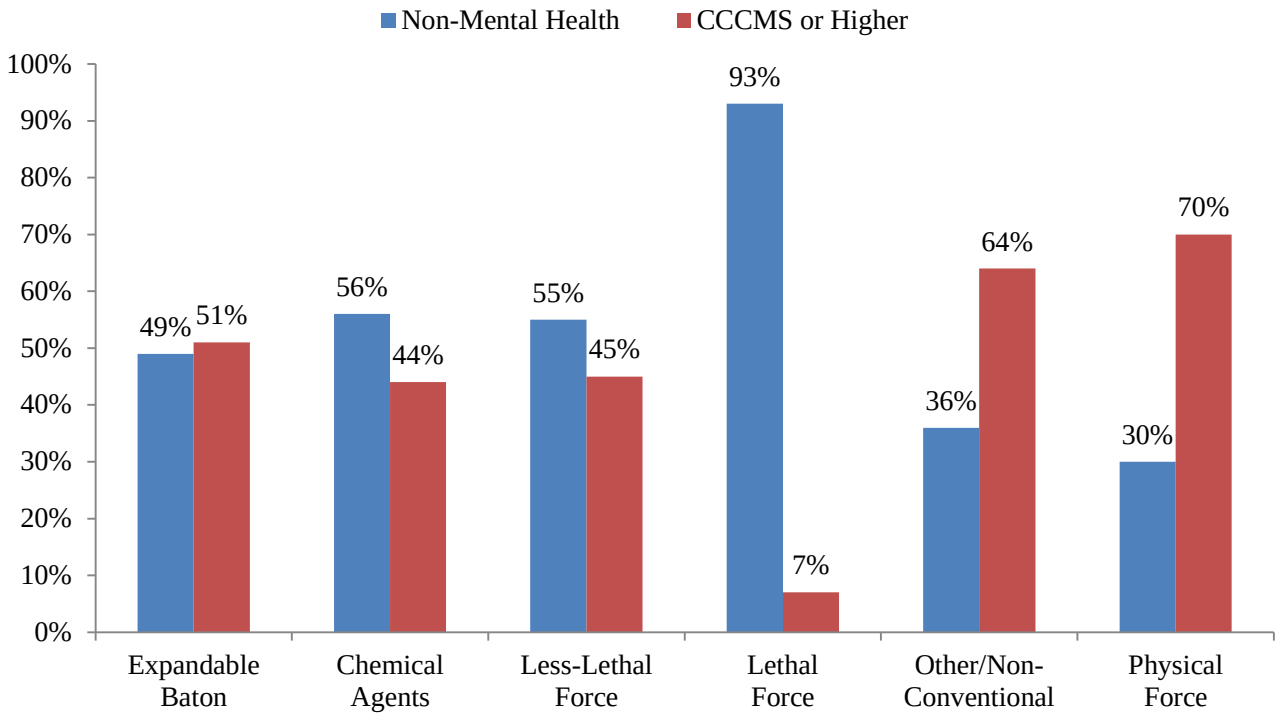
The department reports that during this reporting period about 28.6 percent of its in-custody inmate population were mentally ill inmates participating in the department's mental health services delivery system at the Correctional Clinical Case Management System (CCCMS) level of care or above. Nearly half (48 percent) of the total uses of force within the Division of Adult Institutions reviewed this reporting period were on inmates at the CCCMS level or above.[8,9]

Table 4: Use of Force, by Mental Health Status

MH Code:	Non-Mental Health	CCCMS	EOP	MHCB	DMH
Percentage:	52%	31%	14%	2%	1%
		48%			

Percentages are rounded to the nearest whole number so may not total exactly 100.

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



[8] 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.

[9] 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: CCCMS, Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), and Department of Mental Health (DMH). 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/DCHCS/index.html.

Table 5: Frequency of Force by Type, Grouped by Mental Health Status

	Chemical Agents			Physical Force			Less-Lethal Force			Baton		
	Number	%		Number	%		Number	%		Number	%	
Non-MH	965	56%		120	30%		148	55%		74	49%	
CCMS	523	30%	44%	114	29%	70%	95	35%	45%	51	34%	51%
EOP	211	12%		118	30%		27	10%		24	16%	
MHCB	10	1%		26	6%		0	0%		3	1%	
DMH	8	1%		20	5%		1	<1%		0	0%	
Total	1,717	100%		398	100%		271	100%		152	100%	

	Other/Non-Conventional			Lethal Force		Total		
	Number	%		Number	%	Number	%	
Non-MH	5	36%		13	93%	1,325	52%	
CCMS	5	36%	64%	1	7%	789	31%	48%
EOP	1	7%		0		381	15%	
MHCB	2	145		0		41	1%	
DMH	1	7%		0		30	1%	
Total	14	100%		14	100%	2,566	100%	

Percentages are rounded to the nearest whole number so may not total exactly 100.

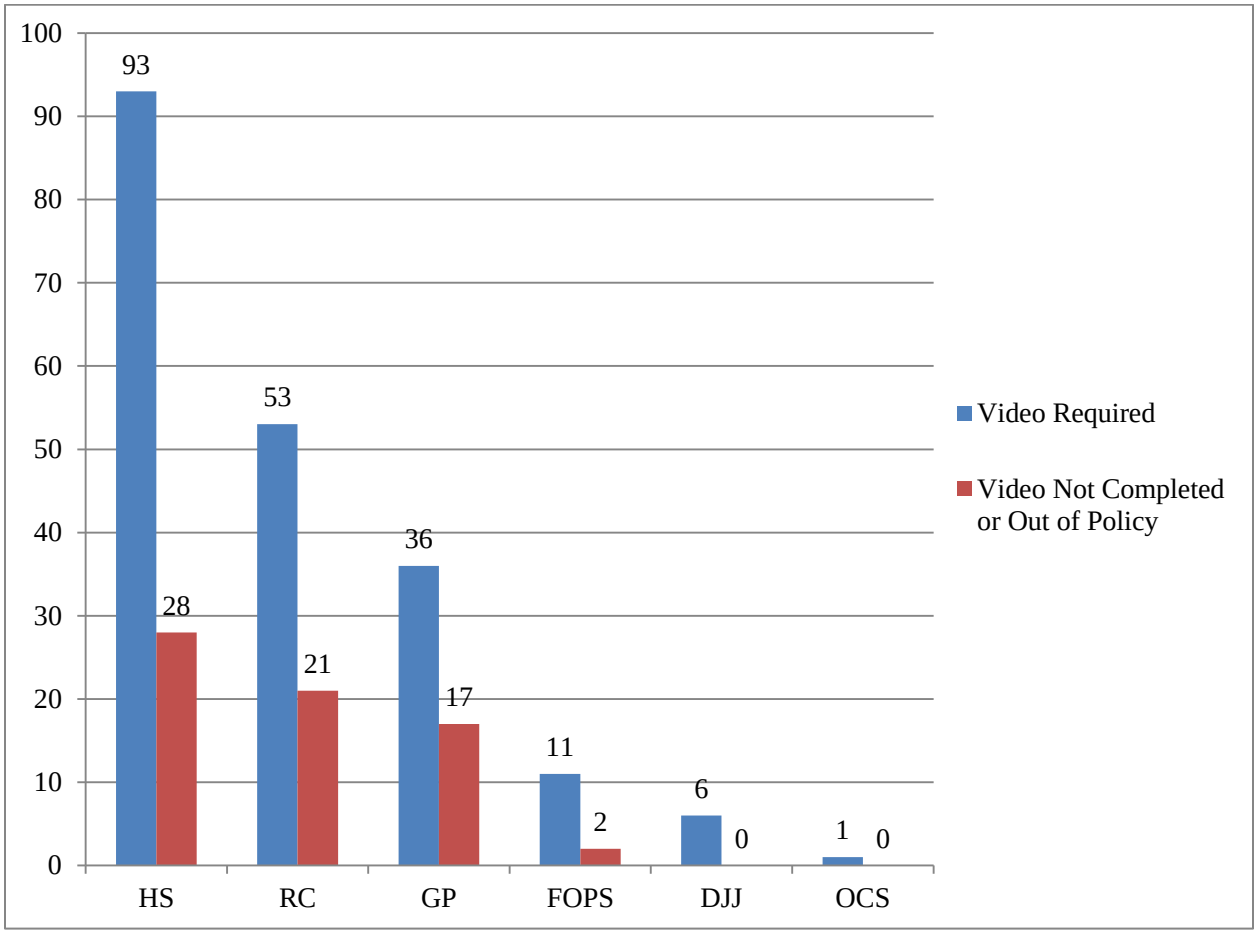
Even though nearly half of the total uses of force within the Division of Adult Institutions were on inmates at the CCCMS level or above, it appears there is an effort to use physical restraint on mentally ill inmates, as opposed to more severe use-of-force methods. The data shows that while the use of physical force and chemical agents is proportionately greater, there is a lower proportionate percentage of use of batons, 40mm direct-impact rounds, and lethal force on the mentally ill inmate population. As noted in the OIG Semi-Annual Report for the July through December 2014 reporting period, the OIG will continue to monitor the department's use of force on mentally ill inmates. To that end, the OIG is developing a new use-of-force monitoring tool which will allow OIG staff to track more detailed statistics and identify trends regarding use of force on all inmates, including mentally ill inmates. Some of the data which will be collected will include frequency of specific inmates being involved in uses of force, frequency of specific officers being involved in uses of force, and the classification level of inmates involved in use-of-force incidents. In addition, the OIG will also be researching best practices utilized by other jurisdictions and states regarding utilization of force on the mentally ill population.

Video-Recorded Interviews

The department's use-of-force policy requires video-recorded interviews if an inmate alleges unreasonable force or has sustained serious or great bodily injury that could have been caused by the use of force. The video recording should be conducted within 48 hours of discovery of the injury or allegation. If the inmate refuses to be video-recorded, CDCR policy requires staff to record the inmate confirming his or her refusal to be interviewed. However, the actual process for conducting video-recorded interviews of inmates involved in a use-of-force incident is inconsistent among the adult institutions, as some institutions are not following the policy, with the most common deviations listed below.

Two hundred of the incidents reviewed by the OIG required video-recorded interviews. Of those, 132 incidents had the video-recorded interview conducted within policy, while in 68 incidents the video-recorded interview was either not completed or was not completed according to policy. This results in a policy compliance rate of only 66 percent. The errors that were found included not conducting an interview when one was required, interviewers not adequately identifying themselves or interviewers not adequately identifying the inmate's injuries. The OIG has reported these concerns in prior reports, yet the policy compliance rate remains below 70 percent.

Chart 2: Video Recordings, by Mission/Division



Pilot Program for Institutional Use-of-Force Reviews

At the OIG's urging, in 2012 the department began developing a streamlined process for reviewing use-of-force incidents in which there were no issues after review of the incident reports. At the time, the department was having difficulty meeting its 30-day timeline for use-of-force review in some institutions due to the volume of cases, a challenge that still exists. The new process provides the means by which certain use-of-force incident reports can be placed on a "consent calendar" based on the decisions reached in the first three levels of review. The OIG recommended a process whereby each stakeholder would review the incident reports, and if no issues were found, the incident could be forwarded to the warden for final disposition without having to be formally heard at the Institutional Executive Review Committee. The recommendation included a provision that if any of the stakeholders, including the OIG, had questions about any of the incidents, those incidents would be heard at committee. The original purpose of a streamlined review process was to provide time for more thorough reviews of incidents most likely to have issues. The initial indications in this pilot show this type of review is more appropriate at institutions with lower security and non-mental-health designations.

In order to be considered for "consent" and to bypass a formal IERC review, the incident must *not* include any of the following circumstances:

- Allegations of unnecessary/excessive use of force;
- Serious bodily injury or great bodily injury likely caused by staff use of force;
- Controlled use of force;
- Extraction;
- Use of force possibly out of compliance with policy before, during, or following the incident;
- Discharge of warning shot;
- Involvement of any inmate who is a participant in the Mental Health Services Delivery System (MHSDS) at any level of care.

This change to policy required approval by the Office of Administrative Law, and late in this reporting period the department implemented the new use-of-force review process at three institutions (High Desert State Prison in Susanville; Kern Valley State Prison in Delano; and California State Prison, Los Angeles County, in Lancaster) on a 24-month pilot basis.[10]

When this change was first recommended, the pilot institutions were chosen based only on the number of use-of force incidents at that institution. One institution was chosen in each of the three regions. The IERC process is defined in California Code of Regulations, Title 15, Section 3268(a)(17), and because the process is defined in regulation, a review by the Office of Administrative Law was required before the pilot program could be implemented. This led to a long lead time for implementation. Immediately prior to implementation of the pilot program, it was recognized that any use of force on a participant in the Mental Health Services Delivery System required increased scrutiny and would be an inappropriate case for the pilot program, so due to the high number of mental health inmates at these pilot institutions, very few incidents met the requirements for consent review. As a result, as noted above, use of force against an

[10] Details of the pilot program can be found in California Code of Regulations, Title 15, Section 3999.16 (operative February 11, 2014, pursuant to Penal Code Section 5058.1(c)).

inmate who was a participant in the MHSDS would receive full review through the IERC. It was discovered that the institutions identified early in the process that had large numbers of uses of force and that might benefit from this program also had a large population of inmates participating in the MHSDS. To better determine if this process will provide efficiencies worth implementing, the department added Calipatria State Prison to the pilot program, as it has a low population of inmates receiving mental health care.

During this reporting period, the department reviewed 164 incidents as a part of the pilot program. Of these, the OIG agreed with the conclusion of 160 of the incidents and the determinations made on them by the department.

Table 6: Number of Pilot Incidents Reviewed

Institution	Cases CDCR Referred for Consent	Cases OIG Concurred with Consent	Difference
Calipatria State Prison	105	105	0
High Desert State Prison	16	15	1
Kern Valley State Prison	13	13	0
California State Prison, Los Angeles County	30	27	3
Total	**164**	**160**	**4**

As the table above illustrates, Calipatria State Prison, an institution with few inmates receiving mental health care, referred three times as many cases to consent as any other prison in the pilot. It is expected that the pilot will prove beneficial at institutions with similar populations as Calipatria State Prison.

Division of Juvenile Justice

During this reporting period the Division of Juvenile Justice (DJJ) consisted of three facilities and one conservation camp and was responsible for supervising 681 juvenile wards.[11] The OIG reviewed 96 use-of-force incidents occurring throughout the three juvenile facilities. There were no incidents in the juvenile conservation camp this reporting period.

Among the 96 incidents reviewed, 41 were at N.A. Chaderjian Youth Correctional Facility (NACYCF), 37 were at O.H. Close Youth Correctional Facility, and 18 were at Ventura Youth Correctional Facility. The OIG found the reports adequately articulated the justification for using force and adequately described the force used in all but two of the incidents, which both occurred at NACYCF. In those two incidents where the OIG found that the reports did not adequately articulate the justification for the use-of-force and did not adequately describe the force, one resulted in staff training and one resulted in staff counseling. The OIG commends the department on its willingness to identify and appropriately resolve use-of-force issues in the DJJ.

[11] Data derived from: http://www.cdcr.ca.gov/Reports_Research/docs/research/Characteristics/06_2015_Characteristics.pdf.

Division of Adult Parole Operations

During this reporting period, the Division of Adult Parole Operations (DAPO) consisted of two parole regions and was responsible for supervising over 45,000 parolees.[12] The OIG reviewed 24 use-of-force incidents: 14 in the north parole region and 10 in the south parole region. Of those incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all but one case, which occurred in the north region and resulted in staff training.

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 conducted reviews of six use-of-force incidents involving seven uses of force by OCS employees; there were four uses of physical force, and three uses of a Taser. Of those six incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all cases.

MONITORING 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 if it is imposed punitively. 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*

[12] Data derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1506.pdf

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. The OIG collects all relevant data, including the name of the inmate, the reason the inmate was placed on contraband surveillance watch, what contraband, if any, was found, and the dates and times the department put the inmate on and off watch. The OIG responds to the scene to formally monitor any contraband surveillance watch where a significant medical problem occurs, regardless of the time 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 condition of the inmate and all logs and records, ensuring the department is following its policy. This on-scene response is repeated every 72 hours until the inmate is removed from contraband surveillance watch. Any serious breaches of policy are immediately discussed with institution managers while on scene. The OIG formally assesses the sufficiency of how the department conducts each contraband surveillance watch that exceeds 72 hours.

During this reporting period, the OIG was notified of 155 contraband surveillance watch cases, including cases reported from out-of-state facilities. Of these 155 cases, inmates were kept on contraband surveillance watch longer than 72 hours but less than 144 hours in 37 cases and five cases involved inmates placed on watch for 144 to 216 hours. No cases extended beyond 216 hours during this reporting period. This report assesses the 42 cases that extended beyond 72 hour as well as four of the cases that did not extend beyond 72 hours as they involved special circumstances that warrant attention. In two of the four cases, the inmates required medical attention at an outside hospital. In the other two cases, the OIG had concerns over whether there were legitimate reasons for placing the inmates on contraband surveillance watch. There were 113 cases that did not extend beyond 72 hours, and in 43 percent of these cases (49 cases), contraband was recovered. Contraband was found in 90 percent of the contraband surveillance watch cases that extended beyond 72 hours. This is up from 47 percent during the last reporting period. The increase suggests the department has become more careful in determining when to keep an inmate on contraband surveillance watch for longer than 72 hours and is doing so only when there is sufficient probable cause to justify the extended watch.

There was one case during this reporting period where the OIG responded to the scene as a result of medical concerns. In that case, the inmate was taken to the triage and treatment area after exhibiting signs of a drug overdose. He was then transported to an outside hospital where an x-ray revealed a sack in the inmate's rectal area. The inmate reported swallowing a sack of methamphetamine. After three days, the inmate returned to the institution but the department never recovered the sack.

Chart 3: Duration of Contraband Surveillance Watch Cases

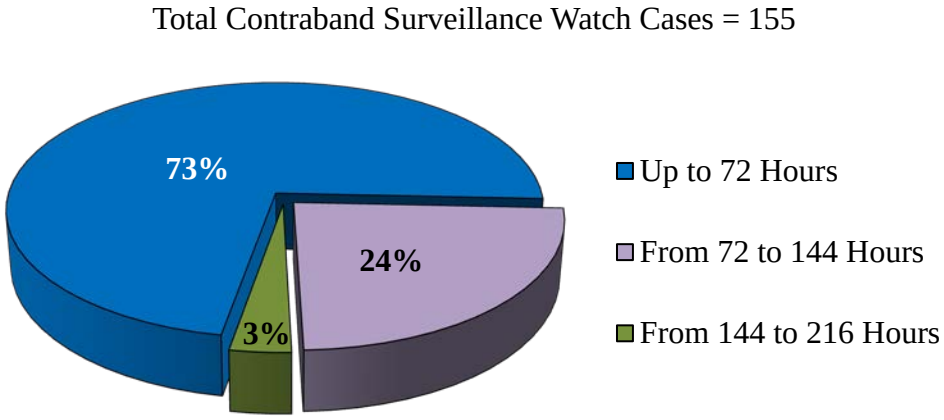


Chart 4: Contraband Found in Cases Extending Beyond 72 Hours

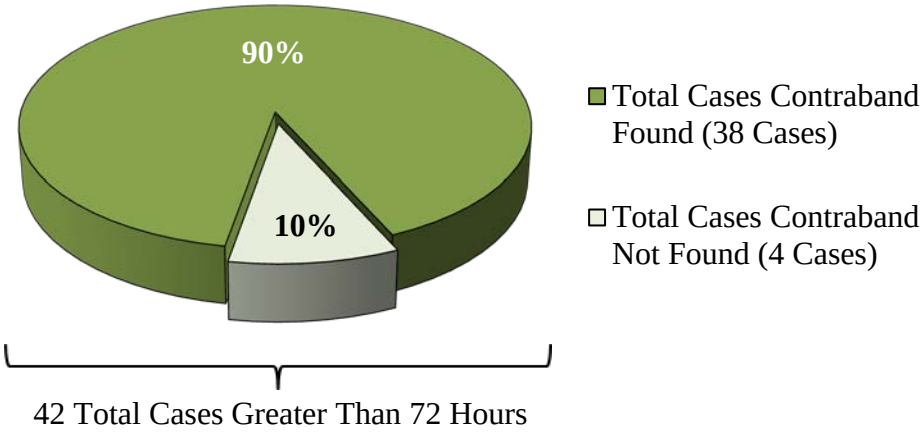


Chart 5: Contraband Found in Cases Lasting Less Than 72

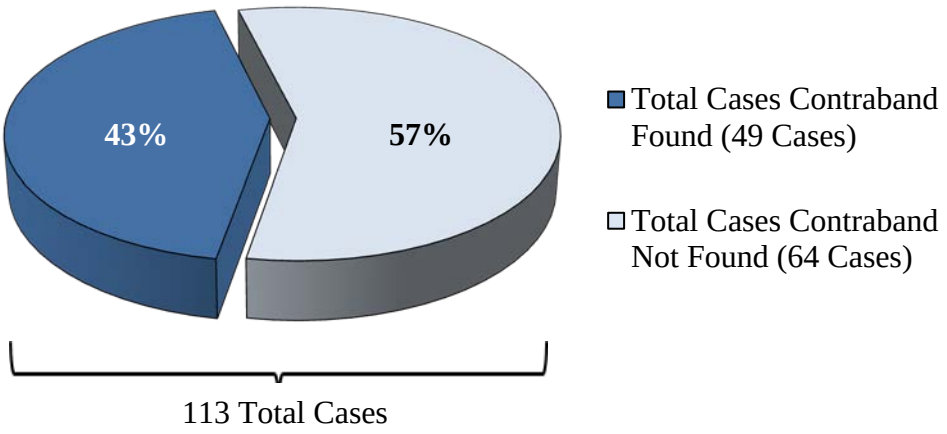
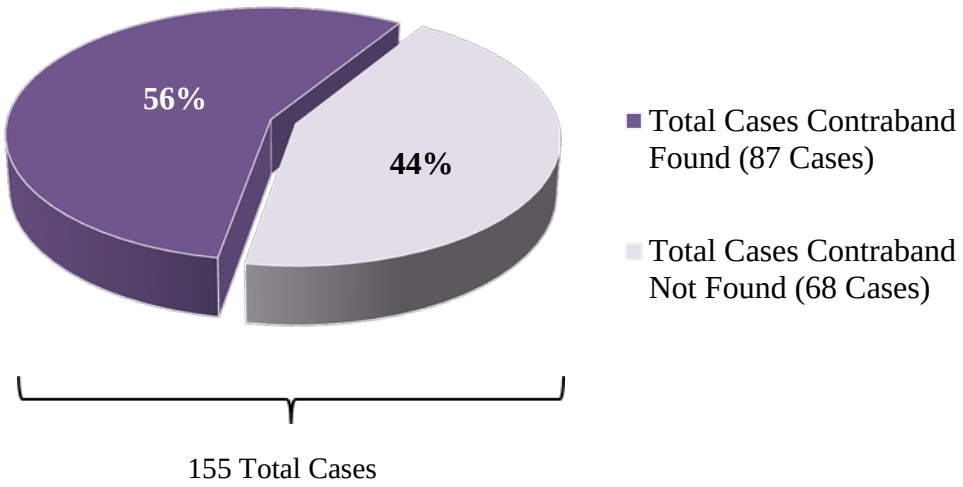


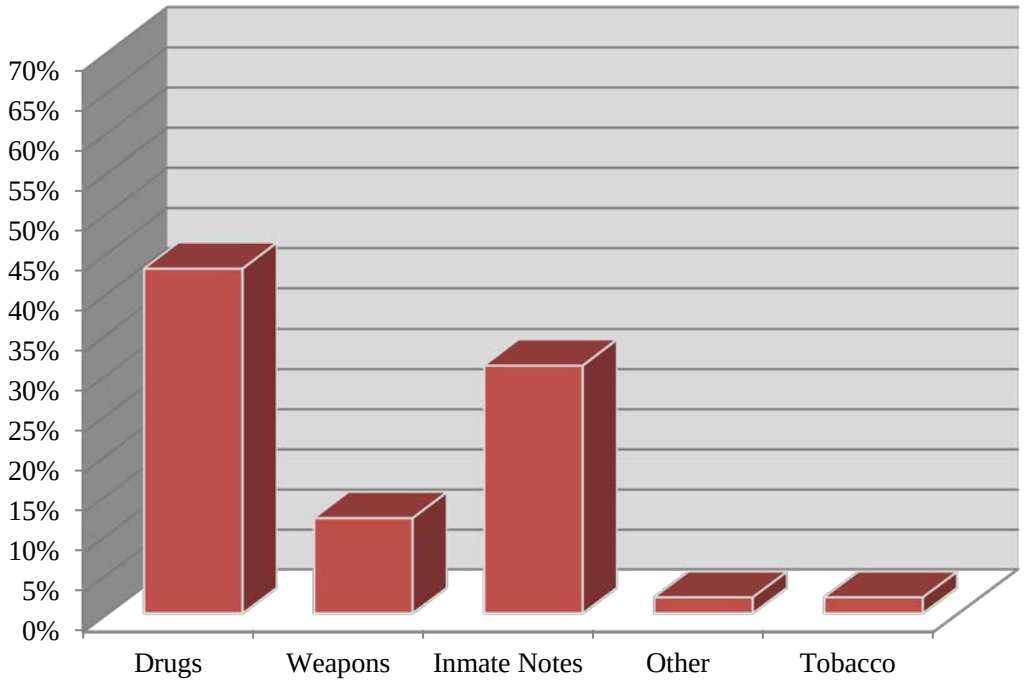
Chart 6: Contraband Found in All Contraband Surveillance Watch Cases



As previously noted, this report covers in detail those 42 contraband surveillance watch cases that extended beyond 72 hours. Contraband was found in 38 cases that extended beyond 72 hours. Drugs were recovered in 43 percent of the cases where contraband was found, while the remaining recovered contraband primarily consisted of weapons, inmate notes, and other contraband.

Chart 7: Contraband Type and Frequency in Cases Extending Beyond 72 Hours

During this reporting period, the OIG rated the department on the adequacy of its management of contraband surveillance watch cases monitored by the OIG. Of the 42 cases that exceeded 72 hours, the OIG found that the department sufficiently managed the contraband surveillance watch process in 30 cases (71 percent) and was insufficient in its management of 12 contraband



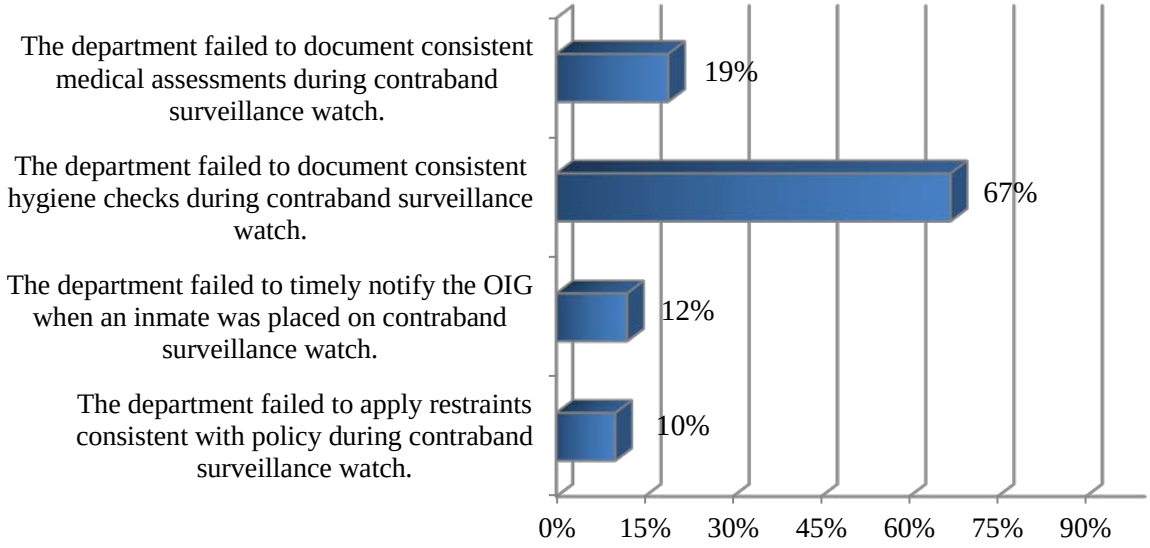
surveillance watch cases (29 percent). In those cases where deficiencies were noted, the department took corrective action mainly via staff training. While the OIG concurs that the majority of deficiencies could be appropriately addressed through additional staff training, the same issues are continuing to occur over and over again. The OIG previously recommended that the department review its contraband surveillance watch training policies and determine where improvements can be made. The OIG suggests the department develop an on-the-job training component for custody staff newly assigned to a contraband surveillance watch case. For staff who consistently fail to follow contraband surveillance watch policy, the OIG recommends the department take corrective action beyond training, up to and including disciplinary action.

In this reporting period, the department placed significantly fewer inmates on contraband surveillance watch compared to the four previous reporting periods (155 in this period compared to 206, 192, 246, and 293 for the four prior reporting periods). Also, the number of inmates kept on contraband surveillance watch beyond 72 hours dropped (42 in this period, compared to 59, 48, 75, and 92 in the four prior reporting periods). Finally, there were no contraband surveillance watch cases exceeding 216 hours in this reporting period, compared to 4, 2, 11, and 8 in the four prior periods. This signifies positive progress in the curtailment of lengthy watches.

While the department's decision for placing an inmate on contraband surveillance watch cases exceeding 72 hours was within policy in 37 of the 42 cases, 35 cases had subsequent minor

policy violations, with many cases having multiple policy violations during the time the inmate was on contraband surveillance watch.

Chart 8: Policy Violations in Contraband Surveillance Watch Cases



In the 42 contraband surveillance watch cases that extended beyond 72 hours, the majority of process violations involved failures to complete appropriate documentation, failures to provide timely notification to the OIG, and failures to document consistent hygiene checks.

It should be noted that in 28 cases of contraband surveillance watch cases exceeding 72 hours (nearly 67 percent), the department failed to complete appropriate documentation concerning inmate hygiene (up from 49 percent from the last reporting period which was up from 46 percent the reporting period before that). Given the importance of inmate hygiene and the concerning upward trend in policy violations pertaining to inmate hygiene, the OIG recommends the department provide training to both custody and medical staff on Department Operations Manual section 52050.23.5 to ensure that staff are complying with this policy.

In 12 percent of cases, the department failed to timely notify the OIG when an inmate was placed on contraband surveillance watch. The department has significantly improved in the timely reporting of contraband surveillance watch placements since the last reporting period at which time 25 percent of cases were not timely reported to the OIG.

In eight of the 42 contraband surveillance watch cases that extended beyond 72 hours (19 percent), medical staff failed to note required medical checks in the inmate's medical record, as required by policy. Although this is an improvement over the last period when there were failures in documentation of required medical checks in nearly 53% of the cases, the OIG recommends that the department work with California Correctional Health Care Services (CCHCS) to ensure medical staff is trained on and familiar with CCHCS Policy 4.33, Contraband Surveillance Watch to continue to improve in this area.

California Correctional Center had eight cases with at least one policy violation; California Rehabilitation Center had five cases with at least one policy violation; and Richard J. Donovan Correctional Facility had four cases with at least one policy violation. Five institutions are to be commended which had cases extending beyond 72 hours with no policy violations: Mule Creek State Prison, California Substance Abuse Treatment Facility, Pleasant Valley State Prison, Folsom State Prison, and the N.A. Chaderjian Youth Correctional Facility.

When failures to comply with policies and procedures are identified, those responsible should be held accountable through the department's disciplinary process if neglect or misconduct is reasonably believed to have occurred. Without accountability, remediation is unlikely. The OIG is committed to monitoring this process to avoid abuses and accomplish the legitimate goals of contraband surveillance watch. It is therefore vital that the department continue its positive efforts at notifying the OIG in a timely manner to ensure transparency and eliminate the repeated policy violations to achieve successful outcomes.

The following table details the total number of contraband surveillance watch cases that occurred during this reporting period at each institution.

Table 7: Contraband Surveillance Watch Cases, by Institution, January–June 2015

Institution	Number of CSW Cases by Institution	Less Than 72 Hours	72 to Less Than 144 Hours	144 to Less Than 216 Hours	Number of Cases Over 72 Hours Rated Sufficient	Number of Cases Over 72 Hours Rated Insufficient
ASP	2	1	1	0	1	0
CAL	6	6	0	0	0	0
CCC	19	11	7	1	7	1
CCI	4	4	0	0	N/A	N/A
CCWF	1	1	0	0	N/A	N/A
CEN	9	6	3	0	2	1
CIM	1	1	0	0	N/A	N/A
CIW	1	1	0	0	N/A	N/A
COCF	1	1	0	0	N/A	N/A
COCF-LPCC	2	2	0	0	N/A	N/A
COR	5	5	0	0	N/A	N/A
CRC	20	15	5	0	2	3
CTF	1	1	0	0	N/A	N/A
CVSP	1	1	0	0	N/A	N/A
DVI	2	1	1	0	0	1
HDSP	6	4	2	0	2	0
ISP	3	3	0	0	N/A	N/A
KVSP	7	5	2	0	1	1
LAC	6	6	0	0	N/A	N/A
MCSP	4	2	2	0	2	0
NACYCF	2	2	0	0	N/A	N/A
NKSP	1	1	0	0	N/A	N/A
PBSP	12	11	1	0	0	1
PVSP	2	2	0	0	N/A	N/A
RJD	6	2	3	1	2	2
SAC	5	0	4	1	5	0
SATF	4	3	0	1	1	0
SCC	3	3	0	0	N/A	N/A
SOL	8	5	3	0	3	0
SQ	3	1	2	0	1	1
SVSP	5	3	1	1	1	1
VSP	1	1	0	0	N/A	N/A
VYCF	1	1	0	0	N/A	N/A
WSP	1	1	0	0	N/A	N/A
Total CSW Cases	155	113	37	5	30	12
		Contraband Recovered: 49 Cases = 43%	**Contraband Recovered: 33 Cases = 89%**	**Contraband Recovered: 5 Cases = 100%**	**Sufficient = 71%**	**Insufficient = 29%**

VOLUME II CONCLUSION

The goal of publishing the OIG's Semi-Annual Report in two volumes is to allow the reader to easily focus on specific areas of monitoring conducted by the OIG. 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. In all of the monitoring activities, the OIG alerts the department to potential risks or problem areas and makes recommendations for improvement. It is the goal of the OIG that this monitoring will help avoid potential abuse, costly litigation, and expensive federal oversight.

Critical incidents as described within this report have the potential for serious consequences for staff, inmates, and the taxpayers at large. As such, OIG oversight provides independent assessment on how the incidents occur, how they are handled, and their outcomes. A 3 percent decline in timely notification compared to the previous reporting period, after a 20 percent decline from the period before, prevents the performance of this oversight role. CDCR management values the OIG role in this area and has pledged to improve notifications. It is believed that many of the failures are due to the recent rapid turnover of senior staff within the department.

The OIG attended 388 use-of-force meetings throughout the State and evaluated a total of 1,260 unique incidents. In the overwhelming number of reviews, the committee took appropriate action. The department and the OIG noted improvement is needed in following the video recording policies. The OIG is also specifically monitoring the use of force on mentally ill inmates, and will continue to do so.

The OIG's monitoring of contraband surveillance watch continues to evolve. If departmental staff do not follow documentation and observation policies, serious medical issues could occur. If the process does not maintain policy integrity, there may also be a waste of departmental resources. Overall, the OIG found the department has improved in its adherence to departmental policy on contraband surveillance watch with 71 percent of the cases that exceeded 72 hours being rated sufficient as compared to only 53 percent last period. This percentage could be improved by focusing on poor documentation which is a primary concern. With the department's new focus on drug interdiction, OIG oversight will continue to be important in this area. Overall, the department has improved significantly since OIG monitoring began.

Of particular concern this reporting period is the department's compliance with its policy on emergency medical responses. While the department's policy requires staff to immediately provide life-saving measures and to summon outside emergency medical services when necessary, there were seven cases this period in which responding staff failed to adequately provide emergency medical assistance. In one case, after an inmate appeared to be having a seizure and stopped breathing, custody staff failed to monitor the inmate and provide life-saving measures when it became necessary. In another case, after staff discovered an inmate hanging from a bed sheet in his cell, the responding nurse failed to bring an automated external defibrillator to the cell. In a third case, custody staff delayed 90 minutes before transporting an inmate to an outside hospital after the inmate was discovered vomiting in his cell after swallowing a large amount of pills. In yet another case, after staff discovered an inmate lying unresponsive in his cell, there was a 24-minute time lapse between the time life-saving measures

were initiated and when an ambulance was summoned. In three other cases, custody staff failed to initiate life-saving measures on unresponsive inmates, instead waiting for medical staff to do so. It should be noted that in the majority of cases the emergency medical response is very good and in several instances has saved lives. Nevertheless, even one instance of preventable death would be worth mention, and in all of these cases the OIG recommended better training or accountability for the failures.

Another area of concern is crime-scene preservation. In March 2005, the OIG highlighted the importance of crime-scene preservation in its *Special Report into the Death of Correctional Officer Manuel A. Gonzalez, Jr. on January 10, 2005 at the California Institution for Men*. In that report, the OIG made numerous recommendations to the department to improve upon crime-scene preservation practices. Despite this, there were five cases during this reporting period in which the department failed to adequately preserve crime scenes. In one case, after an inmate stabbed two officers, the emergency responders failed to preserve and collect the suspect inmate's clothing as evidence. The institution's 2008 training syllabus provided instruction for collecting the victim's clothing as evidence, but failed to address collecting the suspect's clothing as evidence.

Other instances of failures in crime-scene preservation include a case in which custody staff removed inmates in the area of a deadly force shooting without their locations being photographed and marked. Therefore, it was impossible for the Office of Internal Affairs to determine where all of the inmates were located at the time of the shooting. Officers also picked up shell casings immediately after the incident without taking any photographs of where the casings were discovered. In another case, after an in-cell fight, a sergeant directed an officer to only photograph the crime scene. The officer did not use evidence markers and failed to collect a bloody fan and broken pieces of the fan as potential evidence. Reports did not indicate the crime scene was searched for additional evidence or weapons and lead cards were not used to identify inmate photographs. In yet another case, after an inmate fight, the investigative services unit photographed the crime scene; however, they did not conduct a search for weapons or secure the crime scene. In the last case, after an inmate was found being lowered by other inmates from a hanging position in her cell, the investigative services unit failed to take clear, adequate photos of the scene. Photos of the noose had to be retaken using an evidence placard since no evidence placards were used in the initial photos. In addition, no photos of the sink area below where the inmate was found hanging nor photos of the covering of the door window were taken. Finally, prior to the investigative services unit arriving on scene, custody staff had allowed many inmates in and out of the cell.

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 the department's processes continuing to improve. The OIG is committed to monitoring the vital areas of critical incidents, use of force, and contraband surveillance watch and to providing transparency to the California correctional system.

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, January–June 2015.

Recommendation 2.1 The OIG recommends that the department ensure that its custody and health care staff are trained to immediately recognize the need for life-saving measures, that all staff trained in life-saving measures have a responsibility to immediately assess the need for and provide life-saving measures, and that its custody and health care staff initiate life-saving measures without delay, when required by the circumstances.

Recommendation 2.2 The OIG recommends that the department ensure that its investigative services unit officers and all custody staff with a rank of sergeant or above receive training in the identification and securing of crime scenes, as well as the identification, preservation and collection of all evidence that has potential forensic value. The OIG further recommends that the department re-commit itself to its instructional curriculum concerning crime scene preservation and evidence collection that was adopted following the fatal stabbing of a correctional officer ten years ago.

VOLUME II RECOMMENDATIONS FROM PRIOR REPORTING PERIODS

The OIG recommended the department implement the following recommendations from Volume II of the prior Semi-Annual Report, July–December 2014.

Recommendation 2.1 The OIG recommends the department develop a consistent statewide policy for threat assessments when an inmate attacks a line staff member, such as an officer.

CDCR Response: Partially Implemented. The department has partnered with the Office of Correctional Safety to draft a consistent statewide policy that would include criteria for when a warden should request assistance from the Office of Correctional Safety to provide a thorough assessment of a threat against staff. The department anticipates the policy will be implemented in July 2016. [13]

Recommendation 2.2 The OIG recommends that the department develop a clear policy for inmates who swallow foreign objects such as razor blades. The OIG further recommends that the department ensure its position is known to all institutions to avoid inconsistent application of contraband surveillance watch policy.

CDCR Response: Fully Implemented. On September 9, 2015, the department issued a memorandum to all wardens clarifying the actions to be taken when an inmate is suspected of having swallowed contraband that could cause physical harm such as razor blades.

Recommendation 2.3 The OIG recommends that the department evaluate the concurrent monitoring when an inmate is simultaneously placed on suicide watch and contraband surveillance watch.

CDCR Response: Fully Implemented. On September 9, 2015, the department issued a memorandum to all wardens clarifying that licensed health care staff has responsibility for monitoring an inmate who is on both suicide watch and contraband surveillance watch while the inmate is in any health care setting. Outside of a health care setting, custody staff can cover both functions of suicide watch and contraband surveillance watch.

[13] On August 14, 2015, Governor Brown signed a bill enacting Penal Code section 5004.7, which requires the department to establish a statewide policy on operational procedures for the handling of threats made by inmates or wards, and threats made by family members of inmates or wards, against department staff.

The OIG recommended the department implement the following recommendations from Volume II of the prior Semi-Annual Report, January–June 2014.

Recommendation 2.1 The OIG recommends the department revise *CDCR Form 3013, Inmate Interview Guidelines* to clearly include the following instructions:

- The video recording shall be conducted by persons uninvolved in the incident.
- The interview shall be conducted in a location conducive to acquiring a clear recording of the interview, free of outside noise or distractions.
- The video recording should be made within 48 hours of discovery of the injury or allegation.
- The inmate shall be told, on camera, the reason for the interview, i.e., "You made an allegation of unnecessary or excessive use of force," or "You sustained an injury during the incident."
- The interviewer shall not interfere with the inmate's ability to be interviewed.

CDCR Response: Substantially Implemented. On July 21, 2015, the department conducted statewide training on revised use-of-force review forms, including a separate form for interviewing inmates with great or serious bodily injury (CDCR Form 3013-1) and a form for interviewing inmates who have made allegations of unnecessary or excessive force (CDCR Form 3013-2). The OIG expects that with the implementation of these new forms and the statewide training, the rate of compliance with the policies and procedures related to visually-recorded inmate interviews should greatly increase. If not, hiring authorities should be taking corrective action to remedy the policy violations.

Recommendation 2.2 The OIG recommends the department review and revise its current policies regarding cellmate placement and double celling on sensitive needs yards. Implementation steps should include the following:

- Institute compatibility guidelines requiring the completion of *CDCR Form 1882-A, General Population Double Cell Review* and completion of the *CDCR Form 1882-B, Administrative Segregation Unit/Security Housing Unit Double Cell Review* to help ensure that inmates are properly housed with compatible cellmates.
- Require potential cellmates to document their agreement to house together.
- Provide clear guidelines for transitioning single-cell-designated inmates to double-cell status on sensitive needs yards.
- Require that central files of inmates on sensitive needs yards are reviewed for propensity for violence and prior assaultive behavior before double celling (part of the *CDCR Form 1882-A* process).

CDCR Response: Partially Implemented. The department is developing a classification system to identify inmates that are at risk of being assaulted and to identify inmates that are likely to assault other inmates. With this new system, they will be able to make sure inmates from these two groups are not celled together. The new classification system is expected to be implemented in early 2016.

TABLE OF CHARTS

APPENDICES

APPENDIX D1 9
MONITORED DEADLY FORCE INCIDENTS
Central Region

Incident Date: 2014-08-14	Deadly Force Incident

Incident Summary

OIG Case Number: **14-2004-RO**

On August 14, 2014, an officer shot himself in the foot, sustaining serious bodily injury, while on the range. The Office of Internal Affairs failed to respond to the scene. The OIG responded to the scene.

Disposition

After the OIG intervened, the hiring authority referred the matter to the Office of Internal Affairs for an investigation to determine why and how the firearm discharged. OIA Central Intake returned the case to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate. The Office of Internal Affairs failed to respond to the incident despite an officer being seriously injured by the discharge of a firearm. The hiring authority delayed nine months in referring the matter for investigation. Once a request for investigation was submitted, OIA Central Intake failed to approve an interview of the officer.

Assessment Questions

- Did the OIA adequately respond to the incident?

  The deadly force investigation team failed to respond to the scene.

- Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?

  The OIG identified the need to conduct an investigation to determine how the firearm discharged a round while the officer was holstering his weapon.

- 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 August 14, 2014, but the hiring authority did not refer the matter to the Office of Internal Affairs until April 9, 2015, almost eight months after the date of discovery.

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

  The hiring authority failed to refer the matter to the Office of Internal Affairs in a timely manner and only did so after the OIG sought a higher level of review.

- Did the OIA make an appropriate initial determination regarding the case?

  The Office of Internal Affairs failed to approve an interview of the officer to determine how and why the firearm discharged.

Central Region

Incident Date: 2014-09-05	Deadly Force Incident

Incident Summary

OIG Case Number: **14-2127-RO**

On September 5, 2014, multiple inmates participated in a riot on the exercise yard. The inmates failed to comply with orders to stop fighting. Officers utilized chemical agents and less-lethal rounds in an attempt to stop the fighting. Two inmates were struck in the head with less-lethal rounds. One inmate had a small, red spot on his head. The other inmate had a circular injury with swelling on the left side of his head. Both inmates were transported to an outside hospital for evaluation and returned to the institution. The OIG responded to the scene. The Office of Internal Affairs did not respond to the scene.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate because the institution failed to notify the Office of Internal Affairs. Once notified by the OIG, the Office of Internal Affairs deadly force investigation team failed to respond on scene despite the potentially lethal injuries caused by the use of less-lethal force. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Did the hiring authority timely notify the Office of Internal Affairs of the incident?

  The institution failed to notify the Office of Internal Affairs. The Office of Internal Affairs was notified by the OIG.

- Did the OIA adequately respond to the incident?

  Upon notification, the Office of Internal Affairs failed to respond to the incident.

Incident Date: 2014-11-17	Deadly Force Incident

Incident Summary

OIG Case Number: **14-2848-RO**

On November 17, 2014, two inmates attacked a third inmate with inmate-manufactured weapons. A control booth officer fired two warning shots from his Mini-14 rifle but the inmates continued their attack. The inmates ceased their attack after additional officers arrived and deployed pepper spray and utilized a baton strike. The injured inmate was treated at the institution for multiple puncture wounds. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Assessment

Rating: **Sufficient**

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

Central Region

Incident Date: 2014-11-06	Deadly Force Incident

Incident Summary

OIG Case Number: **15-0137-RO**

On November 6, 2014, over 200 inmates participated in a riot on the exercise yard. Officers used chemical agents, 51 less-lethal rounds, and two warning shots from a Mini-14 rifle to stop the riot. One inmate was transported to an outside hospital via ambulance for multiple head injuries caused by other inmates and returned to the institution later the same day. There were no serious injuries caused by the use of force. The OIG responded to the scene.

Disposition

The institution's executive review committee determined the use of force was consistent with departmental policy; however, the video-taped interviews had minor deviations from policy. Therefore, training was provided. The OIG concurred with the committee's decision. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.

Incident Assessment

Rating: **Sufficient**

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

Incident Date: 2015-02-09	Deadly Force Incident

Incident Summary

OIG Case Number: **15-0337-RO**

On February 9, 2015, three inmates attacked a fourth inmate on an exercise yard. The inmates ignored orders to stop the attack. The fourth inmate collapsed to the ground motionless as the other inmates punched and kicked him. The observation officer fired two warning shots from a Mini-14 rifle, which stopped the attack. The injured inmate was transported to an outside hospital via ambulance and returned three days later after receiving treatment for his injuries.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Incident Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Central Region

Incident Date: 2015-02-11	Deadly Force Incident

Incident Summary

OIG Case Number: **15-0352-RO**

On February 11, 2015, approximately 15 inmates participated in a riot on the exercise yard. After the inmates stopped fighting, a second fight erupted. An observation officer fired a warning shot from his Mini-14 rifle. After additional officers arrived, the fighting stopped. One inmate suffered puncture wounds during the fight and was treated at the institution.

Disposition

Potential staff misconduct was identified related to the failure to provide timely notice that lethal force was used; 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.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate because the institution failed to timely notify the OIG thereby preventing the OIG from real-time monitoring of the case. The officer who fired the warning shot failed to articulate sufficient justification for the use of lethal force. The hiring authority failed to timely determine that lethal force was used, failed to timely request an investigation, and failed to properly identify all issues to be investigated.

Assessment Questions

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

  The observation officer failed to report his use of lethal force to supervisors. Supervisors failed to determine lethal force had been used for two hours after the warning shot was fired.

- Did the hiring authority timely notify the Office of Internal Affairs of the incident?

  The hiring authority failed to notify the Office of Internal Affairs that lethal force had been used until almost two and one-half hours after the incident.

- Was the OIG promptly informed of the critical incident?

  The hiring authority failed to notify the OIG that lethal force had been used until almost two and one-half hours after the incident.

- Was the hiring authority's response to the critical incident appropriate?

  The officer who fired a warning shot failed to articulate sufficient justification for the use of lethal force and failed to promptly inform his supervisors that lethal force had been used. Supervisors failed to determine that lethal force had been used until two hours after the incident.

- Was the critical incident adequately documented?

  The officer who fired a warning shot failed to articulate sufficient justification for using lethal 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 determined that the observation officer failed to articulate sufficient justification for using lethal force and failed to provide timely notice that he fired a warning shot.

- 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 February 11, 2015, but the hiring authority did not refer the matter to the Office of Internal Affairs until May 12, 2015, three months after the date of discovery.

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

  While the hiring authority appropriately determined that the failure to timely report the use of lethal force should be referred to the Office of Internal Affairs, the hiring authority failed to determine that the failure to articulate a sufficient justification for the use of lethal force should also be referred to the Office of Internal Affairs.

North Region

Incident Date: 2014-10-23	Deadly Force Incident

Incident Summary

OIG Case Number: **14-2520-RO**

On October 23, 2014, approximately nine inmates began fighting on an exercise yard. An officer fired a warning shot from a Mini-14 rifle, which struck a wall several feet off the ground. Another officer deployed a pepper spray grenade and a third officer deployed pepper spray toward the fighting inmates. The inmates stopped fighting. Nurses treated multiple inmates for puncture wounds and slashes. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Assessment

Rating: **Sufficient**

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

Incident Date: 2015-03-31	Deadly Force Incident

Incident Summary

OIG Case Number: **15-0647-RO**

On March 31, 2015, over 70 inmates participated in a riot on the exercise yard. An officer deployed one chemical grenade and another deployed pepper spray to stop the incident; however, the inmates continued to fight. An observation officer observed an inmate on the ground being kicked in the head by several inmates. The officer fired two warning shots from a Mini-14 rifle. The second warning shot stopped the attack. There were no staff injuries. Four inmates were transported to an outside hospital for treatment, following which they were returned to the institution or another institution. The OIG responded to the scene.

Disposition

The institution's executive review committee found that the use of force was in compliance with departmental policy but identified deficiencies based on the untimely submission and review of reports, inaccurate medical reports of injuries, and a clarification that was not adequately memorialized. The hiring authority did not refer the matter to the Office of Internal Affairs for investigation but provided training and corrective action. The OIG concurred with the hiring authority's determination.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate because use-of-force reports were not submitted and reviewed in a timely manner, medical reports of injuries were not correctly completed, and a clarification to a report was not adequately memorialized.

Assessment Questions

- Was the hiring authority's response to the critical incident appropriate?

  Reports were not submitted and reviewed in a timely manner and medical reports of injuries were not accurately completed.

- Was the critical incident adequately documented?

  Reports documenting the incident were not timely submitted, a clarification to a report was not adequately memorialized, and medical reports of injuries were not correctly completed.

South Region

Incident Date: 2015-03-03	Deadly Force Incident

Incident Summary

OIG Case Number: **15-0459-RO**

On March 3, 2015, three inmates attacked a fourth inmate on the exercise yard. The fourth inmate was observed lying motionless on the ground while the other three inmates continued to hit and punch the fourth inmate in the head. The observation officer fired one lethal round from a Mini-14 rifle as a warning shot. The inmates stopped their assault. None of the inmates were seriously injured. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. However, the department provided training regarding the proper completion of the medical evaluation form. The OIG concurred.

Incident Assessment

Rating: **Sufficient**

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

APPENDIX D2 34
INVESTIGATED AND MONITORED DEADLY FORCE CASES
Central Region

Incident Date: 2014-08-26	Deadly Force Incident

Incident Summary

On August 26, 2014, three inmates engaged in a fight. An observation officer fired two less-lethal rounds which ultimately stopped the fight. One inmate was struck on the jaw with a less-lethal round. The inmate who was struck with the less-lethal round was treated at the institution. The Office of Internal Affairs and the OIG both responded to the scene.

Administrative Investigation	OIG Case Number: **14-2118-IR**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to notify the OIG of the institution's executive review committee meeting which prevented the OIG from real-time monitoring of the meeting. The Office of Internal Affairs failed to provide a draft copy of the investigative report to the OIG for review.

Assessment Questions

- 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?

  A draft copy of the investigative report was not forwarded to the OIG to allow for feedback before it was forwarded to the hiring authority.

- Did the HA cooperate with and provide continual real-time consultation with the OIG throughout the pre-disciplinary/investigative phase?

  The hiring authority failed to notify the OIG of the institution's executive review committee meeting.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined the discharge of the less-lethal round was in compliance with the department's use-of-force policy. The OIG concurred with the determination.

Incident Date: 2014-04-26	Deadly Force Incident

Incident Summary

On April 26, 2014, numerous inmates participated in a riot on an exercise yard. The inmates refused orders to stop fighting. An observation booth officer fired a warning shot from a Mini-14 rifle but three inmates continued fighting. The observation booth officer fired a second warning shot from the Mini-14 rifle and the inmates stopped fighting. The OIG responded to the scene. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Central Region

Criminal Investigation	OIG Case Number: **14-2314-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: Insufficient

The department failed to comply with policies and procedures governing the investigative process. The deadly force investigation team did not perform the preliminary tasks and did not complete the interviews within 72 hours. The Office of Internal Affairs failed to protect compelled statements obtained in the administrative case from being improperly used in the criminal case.

Assessment Questions

- Upon arrival at the scene, did the Deadly Force Investigation Team special agent adequately perform the required preliminary tasks?

  The Office of Internal Affairs failed to respond to the incident even though there were concerns about the propriety of the officer's use of deadly force.

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

  The special agent assigned to conduct the criminal investigation did not conduct all interviews within 72 hours.

- Did the OIA adequately consult with the OIG, department attorney (if designated), and the appropriate prosecuting agency to determine if an administrative investigation should be conducted concurrently with the criminal investigation?

  The Office of Internal Affairs did not consult with the OIG or the district attorney's office regarding whether to conduct the administrative investigation concurrently with the criminal investigation.

- Did OIA appropriately protect compelled statements obtained in the administrative case from being improperly used in a criminal case?

  Immediately after the officer invoked his Fifth Amendment right against self incrimination, the Office of Internal Affairs obtained compelled statements from him. The special agent who obtained the compelled statements provided a verbal and written summary of the officer's interview to the senior special agent in charge of criminal investigations, who then requested that the special agent in-charge approve opening a criminal investigation against the officer. The Office of Internal Affairs documented these events and the nature of the compelled statements in the case management system related to the criminal case which were accessible by the special agent assigned to investigate the criminal case. A criminal investigation was opened as a result of the compelled statements. The failure to protect the compelled statements jeopardized potential criminal prosecution.

Incident Date: 2014-11-23	Deadly Force Incident

Incident Summary

On November 23, 2014, multiple inmates participated in a riot. A control booth officer fired a less-lethal round at the lower extremities of one of the aggressor inmates. The round missed its intended target and struck the inmate in the head. The inmate was treated at the institution and received three sutures. The OIG responded to the scene. The Office of Internal Affairs failed to respond to the scene.

Central Region

Administrative Investigation	OIG Case Number: **14-2825-IR**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Internal Affairs failed to respond to the incident and failed to provide a draft investigative report to the OIG for review. OIA Central Intake failed to take timely action on the case.

Assessment Questions

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs failed to respond to the scene because efforts by the institution and the OIG to contact the Office of Internal Affairs were unsuccessful.

- Did OIA Central Intake make a determination regarding the case within 30 calendar days?

  OIA Central Intake received the request for investigation on November 25, 2014, but did not take action until January 21, 2015, 57 days after receipt of the request.

- 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 failed to timely forward a draft copy of the investigative report to the OIG for review before it was forwarded to OIA Central Intake for a decision regarding whether to conduct a full investigation.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  OIA Central Intake failed to timely take action on the case.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred. The institution's executive review committee determined that the use of force was in compliance with departmental policy and the OIG concurred.

Incident Date: 2015-01-09	Deadly Force Incident

Incident Summary

On January 9, 2015, officers observed two inmates attacking another inmate on the exercise yard. The inmates did not comply with orders to stop fighting. The control booth officer fired six less-lethal rounds, one of which struck an inmate in the head. Another officer deployed a pepper spray grenade. The inmates stopped fighting. The inmate who was struck in the head was transported to an outside hospital for a medical evaluation and later returned to the institution. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation	OIG Case Number: **15-0159-IR**

Predisciplinary Assessment

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

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

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred. The institution's executive review committee determined that the officer's use of force complied with the department's use-of-force policy. The OIG concurred with the determination.

Incident Date: 2015-01-16	Deadly Force Incident

Central Region

Incident Summary

On January 16, 2015, three inmates began to attack a fourth inmate. The control booth officer ordered the inmates to get down but the three inmates ignored the orders. The control booth officer fired one less-lethal round at the buttocks of one of the attacking inmates but did not know where the round struck. The control booth officer again ordered the inmates to get down. Two of the attackers got down, but one attacker continued to attack the fourth inmate. Responding custody staff arrived and the final attacker stopped fighting and got down. The less-lethal round struck one of the attacking inmates in the face, resulting in a cut over his eye. That inmate was taken to an outside hospital for a bone fracture and later returned to the institution. The Office of Internal Affairs and the OIG both responded to the scene.

Administrative Investigation	OIG Case Number: **15-0207-IR**

Predisciplinary Assessment

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

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

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined the use of force was in compliance with departmental policy. The OIG concurred with the determination.

Incident Date: 2015-02-09	Deadly Force Incident

Incident Summary

On February 9, 2015, two inmates attacked a third inmate on the exercise yard. An observation officer fired a less-lethal round at the inmates, but the fighting continued. The officer fired three additional less-lethal rounds, one of which struck an inmate on his right ear. While the first fight continued, two other inmates attacked another inmate. A second observation officer fired two less-lethal rounds at the second group. Those rounds did not strike the intended targets. Another officer fired a less-lethal round which also did not strike any inmates. However, the fighting finally ended. The inmate struck by a less-lethal round was treated at the institution and received 12 sutures to his ear. The other inmates sustained minor injuries. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation	OIG Case Number: **15-0338-IR**

Predisciplinary Assessment

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

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

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet the criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the officer's use of force complied with departmental policy. The OIG concurred with the determination.

Incident Date: 2015-01-31	Deadly Force Incident

Incident Summary

On January 31, 2015, an officer saw a woman run from a residence with a man chasing her. When the woman fell, the man straddled and punched the woman. The officer fired a warning shot from his personal handgun into the ground. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. No criminal conduct was identified and the matter was not referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Central Region

Criminal Investigation	OIG Case Number: **15-0387-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: Insufficient

The department failed to comply with policies and procedures governing the investigative process. The institution failed to timely notify the Office of Internal Affairs. The department also failed to timely notify the OIG thereby preventing the OIG from real-time monitoring of the case. The Office of Internal Affairs failed to complete all interviews within 72 hours and failed to refer the matter to the district attorney's office as required by departmental policy for all deadly force criminal investigations.

Assessment Questions

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

  The Office of Internal Affairs was not notified until four hours after the incident.

- Was the OIG promptly informed of the critical incident?

  The institution failed to make adequate, timely notification by telephone. The OIG received e-mail notification of the incident almost four hours after the institution was notified.

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

  The deadly force investigation team did not conduct all interviews within 72 hours of the incident.

- Did OIA appropriately determine whether there was probable cause to believe a crime was committed and, if probable cause existed, was the investigation referred to the appropriate agency for prosecution?

  The Office of Internal Affairs failed to refer the matter to the district attorney's office as required by departmental policy for all deadly force criminal investigations.

Incident Date: 2014-01-16	Deadly Force Incident

Incident Summary

On January 16, 2014, a sergeant was driving home with his wife when he heard gunshots. Upon approaching the area, the sergeant encountered an armed suspect who had already killed one man, wounded two others, and was attempting to shoot and carjack another man with a young child. The sergeant discharged four lethal rounds from his off-duty weapon that struck the suspect. The suspect later died from injuries related to crashing the vehicle he had stolen. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation	OIG Case Number: **14-0232-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Discharge of Lethal Weapon**	1. **Exonerated**	**No Penalty Imposed**	**No Change**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to provide the OIG with a copy of the CDCR Form 402, the form documenting the investigative findings.

Assessment Questions

- Did the HA cooperate with and provide continual real-time consultation with the OIG throughout the pre-disciplinary/investigative phase?

  The department failed to provide the OIG with a copy of the CDCR Form 402, the form documenting the investigative findings.

Disposition

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

North Region

Incident Date: 2014-10-09	Deadly Force Incident

Incident Summary

On October 9, 2014, a parole agent discharged his weapon at a pit bull that ran towards him. No one was struck by the round. The OIG and the Office of Internal Affairs responded to the scene. The Office of Internal Affairs conducted a criminal investigation. Although no criminal misconduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **14-2404-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

Incident Date: 2013-08-28	Deadly Force Incident

Incident Summary

On August 28, 2013, an Office of Correctional Safety special agent discharged her assigned firearm while in pursuit of a fleeing parolee. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred 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: **13-1978-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

Incident Date: 2014-03-07	Deadly Force Incident

Incident Summary

On March 7, 2014, officers observed two inmates attacking a third inmate on the exercise yard. Officers gave multiple orders for the inmates to stop their attack, but the inmates continued fighting. The third inmate appeared lifeless and unable to defend himself. An officer fired a warning shot from a Mini-14 rifle, but the fighting continued. The officer fired a second round from the Mini-14 rifle. The round struck one of the attacking inmates in the hand, causing the inmates to stop fighting. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **14-0635-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

North Region

Administrative Investigation	OIG Case Number: **14-0623-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Change**

Predisciplinary Assessment

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

The Office of Internal Affairs failed to comply with policies and procedures governing the pre-disciplinary process. The investigation was not timely completed and the Office of Internal Affairs failed to provide the department attorney sufficient time to review the investigative report.

Assessment Questions

- Did the special agent and department attorney cooperate and provide real-time consultation with each other throughout the pre-disciplinary phase?

  The Office of Internal Affairs closed its investigation without giving the department attorney sufficient time to review and provide feedback regarding the investigative report.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The deadly force investigation was assigned to a special agent on March 17, 2014. The investigation was not completed until June 25, 2014, 100 days after assignment.

Disposition

The Deadly Force Review Board found that the discharges of the lethal rounds were in compliance with departmental policy and the hiring authority subsequently exonerated the officer. The OIG concurred.

Incident Date: 2014-04-03	Deadly Force Incident

Incident Summary

On April 3, 2014, a lieutenant fired a warning shot from his personal firearm after a trespasser came onto his property. Outside law enforcement arrived and arrested the trespasser who was placed on a 72-hour mental health hold for evaluation. The trespasser did not sustain any serious injuries during the incident. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. No criminal conduct was identified; therefore, the matter was not referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **14-0924-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

North Region

Administrative Investigation	OIG Case Number: **14-0923-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. Sustained**	**Letter of Instruction**	**No Change**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Internal Affairs failed to respond to the scene of a use of deadly force.

Assessment Questions

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs failed to respond to the scene.

Disposition

The Deadly Force Review Board found that the discharge of the round was not in compliance with the department's use-of-force policy. The case was referred to the hiring authority for further action. The hiring authority issued the lieutenant a letter of instruction. The OIG concurred with the hiring authority's determination.

Disciplinary Assessment

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

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

Incident Date: 2014-04-06	Deadly Force Incident

Incident Summary

On April 6, 2014, an officer observed an inmate making stabbing motions toward another inmate while they were fighting on the ground. Despite being ordered to do so, the inmates refused to stop fighting. An officer fired two warning shots from his Mini-14 rifle. The officer then aimed his Mini-14 rifle at the attacking inmate and fired but missed the intended target. Other officers deployed pepper spray. An officer utilizing a baton to strike one of the inmate's legs. Neither inmate sustained serious injuries. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **14-0926-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department failed to comply with policies and procedures governing the investigative process. The department failed to adequately protect the crime scene and process evidence.

Assessment Questions

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

  Custody staff failed to properly preserve the crime scene. Inmates in the area of the attack were removed from the exercise yard without their locations being photographed and marked. Therefore, it was impossible for the special agent to determine exactly where all of the inmates were located at the time of the shooting. Shell casings were picked up by officers and handed to a sergeant immediately after the incident without taking any photographs of where the casings were discovered.

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

  The investigative services unit failed to ensure that the scene was preserved until the deadly force investigation team arrived.

North Region

Administrative Investigation	OIG Case Number: **14-0925-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Change**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority's response to the incident was not appropriate, the department attorney failed to contact the special agent within 21 days of being assigned to the case, and the Office of Internal Affairs failed to conduct the investigation with due diligence and failed to consult with the department attorney prior to completing the investigative report.

Assessment Questions

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

  Custody staff failed to properly preserve the scene. Inmates in the area of the attack were removed from the exercise yard without their locations being photographed and marked. Therefore, it was impossible for the special agent to determine exactly where all of the inmates were located at the time of the shooting. Shell casings were picked up by officers and handed to a sergeant immediately after the incident without taking photographs of where the casings were discovered.

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

  The investigative services unit failed to ensure that the scene was preserved until the deadly force investigation team arrived.

- No later than 21 calendar days following assignment of the case, did the department attorney contact the assigned special agent and the monitor to discuss the elements of a thorough investigation of the alleged misconduct?

  The department attorney failed to contact the assigned special agent within 21 days of being assigned to the case.

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

  The special agent failed to forward a copy of the draft report to the department attorney to allow for feedback.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The last interview occurred on May 20, 2014, but the investigative report was not completed until December 15, 2014, more than six months later.

Disposition

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

Incident Date: 2014-06-09	Deadly Force Incident

Incident Summary

On June 9, 2014, a parole agent and members of outside law enforcement agencies went to an encampment to obtain information about a parolee at large. As the team approached a campsite, a large dog ran towards the parole agent in an aggressive manner. After yelling for the dog to stop, it continued to advance. The agent then drew his handgun and shot at the dog but missed. However, the dog stopped and withdrew. The bullet struck the ground and no one was injured. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **14-1349-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

North Region

Administrative Investigation	OIG Case Number: **14-1351-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Change**

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 discharge of the lethal round was in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officer and the OIG concurred.

Incident Date: 2014-09-27	Deadly Force Incident

Incident Summary

On September 27, 2014, officers observed two inmates fighting and making stabbing motions. Officers deployed pepper spray and utilized expandable batons to stop the attack. One inmate was allegedly struck twice in the head with a baton. An officer was also allegedly struck in the back of the head. A second officer suffered a wrist injury. Both inmates were sent to an outside hospital for treatment of multiple abrasions, lacerations, and puncture wounds and were later returned to the institution. Both officers were sent to an outside hospital. One officer received five staples to close the laceration to his scalp and the second officer was treated for the wrist injury and released. The OIG and the Office of Internal Affairs responded to the scene.

Administrative Investigation	OIG Case Number: **14-2470-IR**

Predisciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the pre-disciplinary process. OIA Central Intake failed to make a timely determination regarding the request for investigation and the Office of Internal Affairs failed to provide the OIG with a draft copy of the investigative report.

Assessment Questions

- Did OIA Central Intake make a determination regarding the case within 30 calendar days?

  OIA Central Intake received the request for investigation on September 30, 2014, but did not make a determination regarding the request until December 3, 2014, 64 days later.

- 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 did not send a draft copy of the investigative report to the OIG.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The Office of Internal Affairs failed to make a timely determination regarding the request for investigation.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the use of force was in compliance with departmental policy. The OIG concurred.

Incident Date: 2015-01-03	Deadly Force Incident

North Region

Incident Summary

On January 3, 2015, approximately eight inmates participated in a riot in the dining facility. An observation officer fired one less-lethal round, which failed to stop the riot. The observation officer attempted to fire a second less-lethal round but the weapon misfired. A second officer deployed a chemical vapor grenade but the grenade failed to detonate. A third officer then deployed pepper spray three times, which ultimately stopped the riot. The less-lethal round struck an inmate in the head and resulted in a laceration. The inmate was provided medical treatment at the institution. The OIG and Office of Internal Affairs responded to the scene.

Administrative Investigation

OIG Case Number: **15-0141-IR**

Predisciplinary Assessment

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

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

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined the use of force was in compliance with departmental policy. The OIG concurred with the determination.

Incident Date: 2015-01-08 — Deadly Force Incident

Incident Summary

On January 8, 2015, officers deployed three less-lethal rounds at two inmates who were fighting on a tier of a housing unit. One inmate was struck on the forehead with one of the less-lethal rounds and was treated by medical staff at the institution. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation

OIG Case Number: **15-0296-IR**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Internal Affairs failed to provide the OIG with a draft of the special agent's report.

Assessment Questions

- 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 failed to provide the OIG with a draft of the special agent's report.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the discharges of the less-lethal rounds were in compliance with the department's use-of-force policy. The OIG concurred.

Incident Date: 2014-06-05 — Deadly Force Incident

Incident Summary

On June 5, 2014, two inmates attacked another inmate with an inmate-manufactured weapon on the exercise yard. An officer ordered the inmates to stop fighting but they refused to comply. The officer fired a Mini-14 rifle for effect and struck one of the inmates in the abdomen. The inmate continued to attack the third inmate with the inmate-manufactured weapon until another officer arrived and deployed chemical agents. The inmate who was attacked and the inmate who was struck by the Mini-14 rifle round were transported to an outside hospital for treatment and returned to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

North Region

Criminal Investigation	OIG Case Number: **14-1348-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

Administrative Investigation	OIG Case Number: **14-1352-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Change**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. After becoming aware of new information in the case, the Office of Internal Affairs failed to timely complete a supplemental investigation. The department attorney failed to document his review of the investigative reports, provide substantive feedback to the agent, or complete written confirmation summarizing critical discussions regarding the investigative reports.

Assessment Questions

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

  The Office of Internal Affairs failed to provide a copy of the supplemental investigative report to the department attorney until four days before the deadline to take disciplinary action.

- Within 21 calendar days following receipt of the investigative report, did the department attorney review the report and provide appropriate substantive feedback addressing the thoroughness and clarity of the report?

  The department attorney did not document in the case management system that the reports were reviewed and did not provide appropriate substantive feedback addressing the thoroughness and clarity of the reports.

- Did the department attorney provide written confirmation summarizing all critical discussions about the investigative report to the special agent with a copy to the OIG?

  The department attorney did not provide written confirmation summarizing all critical discussions about the investigative reports to the special agent with a copy to the OIG.

- Was the investigation or subject-only interview completed at least 14 days before the deadline to take disciplinary action or the deadline for a prosecuting agency to file charges?

  The deadline to take disciplinary action was June 5, 2015. The investigation was completed on June 1, 2015, four days before the deadline to take disciplinary action.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The Office of Internal Affairs delayed completing the investigation until four days before the deadline to take disciplinary action.

Disposition

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

South Region

Incident Date: 2015-02-08	Deadly Force Incident

Incident Summary

On February 8, 2015, an inmate attacked an officer with an inmate-manufactured weapon. The inmate and officer struggled and the inmate was knocked to the ground. The inmate got up and lunged at the officer with the weapon. The officer used his expandable baton and intentionally struck the inmate's head. The inmate attempted to lunge at the officer again and the officer delivered a second intentional strike to the inmate's head. The inmate sustained a cut to his head and was transported to an outside hospital. The inmate was later returned to the institution without serious injury. The officer suffered abrasions. The Office of Internal Affairs was timely notified but did not respond to the scene until the day after the incident.

Administrative Investigation	OIG Case Number: **15-0340-IR**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Internal Affairs failed to timely respond to the incident, failed to identify the incident as use of deadly force, and failed to open the case for an investigation.

Assessment Questions

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs was notified timely but made a decision not to respond to the scene until the following day.

- Did OIA Central Intake make an appropriate initial determination regarding the case?

  Even though the officer used deadly force, OIA Central Intake failed to open an investigation because the inmate did not suffer great bodily injury.

- Did the OIA properly determine whether the case should be opened as a Deadly Force Investigation Team investigation?

  The intentional use of a baton to the head is a use of deadly force regardless of the extent of the resulting injury and regardless of whether that level of force might be justified. However, the Office of Internal Affairs refused to open a full investigation into the use of deadly force.

- Upon arrival at the scene, did the Deadly Force Investigation Team special agent adequately perform the required preliminary tasks?

  The special agent did not conduct any interviews or investigation once he determined the inmate did not suffer great bodily injury.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The Office of Internal Affairs incorrectly determined no deadly force was used based on the lack of great bodily injury and not based on the actual force intended and used. The OIG did not concur with the determination because the officer intentionally struck the inmate's head with a baton, which is force likely to cause great bodily injury. The institution's executive review committee determined the use of force was in compliance with departmental policy. The OIG concurred with the determination.

Incident Date: 2013-08-13	Deadly Force Incident

Incident Summary

On August 13, 2013, while attempting to apprehend a parolee in a residential neighborhood, a parole agent allegedly fired a warning shot at a dog. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **13-1657-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

Incident Date: 2013-08-24	Deadly Force Incident

South Region

Incident Summary

On August 24, 2013, upon being notified that a stranger was loitering around his property, an officer allegedly grabbed a firearm, ran out of his house, and fired two warning shots into the ground. As the stranger ran away, the officer allegedly followed him with the firearm to intimidate and apprehend the stranger. Outside law enforcement arrested the officer for negligent discharge of a firearm. The officer was allegedly not properly certified to carry the firearm. The Office of Internal Affairs did not respond to the scene.

South Region

Administrative Investigation	OIG Case Number: **13-1823-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Threat/Intimidation**	1. **Sustained**	**Suspension**	**Letter of Reprimand**
2. **Neglect of Duty**	2. **Sustained**		
3. **Other Failure of Good Behavior**	3. **Sustained**		
4. **Discharge of Lethal Weapon**	4. **Not Sustained**		
5. **Weapons**	5. **Not Sustained**		

Predisciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to timely notify the Office of Internal Affairs and the OIG. Therefore, the OIG was prevented from real-time monitoring of the incident. The hiring authority failed to timely consult regarding the sufficiency of the investigation and the investigative findings.

Assessment Questions

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

  The Office of Internal Affairs was not notified of the incident until August 25, 2013, the day after the incident.

- Was the OIG promptly informed of the critical incident?

  The incident occurred on August 24, 2013; however, the OIG was not notified until August 26, 2013.

- Did the HA timely consult with the OIG and department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?

  The hiring authority received the Deadly Force Review Board findings on June 5, 2014; however, the consultation concerning the sufficiency of the investigation and the investigative findings did not take place until July 9, 2014, 34 days thereafter.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The hiring authority failed to timely consult regarding the sufficiency of the investigation and the investigative findings.

Disposition

The Deadly Force Review Board found the discharge of the lethal rounds did not comply with the department's use-of-force policy. The hiring authority subsequently sustained allegations that the officer intimidated a private citizen, neglected his duty, and engaged in other failure of good behavior, but not the remaining allegations. The hiring authority imposed a 60-working-day suspension. The OIG concurred. The officer filed an appeal with the State Personnel Board. The hiring authority entered into a settlement agreement with the officer wherein the suspension was reduced to a letter of reprimand with a waiver of back pay. In exchange, the officer agreed to withdraw his appeal. At the time of the settlement, the officer had already served the 60-working-day suspension.

Disciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the disciplinary process. The hiring authority failed to timely consult regarding the disciplinary determinations. The department attorney failed to provide the hiring authority and the OIG written confirmation of penalty discussions and failed to properly complete a case settlement report.

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 hiring authority received the findings of the Deadly Force Review Board on June 5, 2014; however, the consultation concerning the disciplinary determinations did not take place until July 9, 2014, 34 days thereafter.

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

  The department attorney did not provide either the hiring authority or the OIG with written confirmation of penalty discussions.

- If the case settled, did the department attorney or employee relations officer properly complete the CDC Form 3021?

  The department attorney did not provide the OIG with a copy of a case settlement report.

South Region

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

  The hiring authority failed to timely consult regarding the disciplinary determinations.

Incident Date: 2014-03-11	Deadly Force Incident

Incident Summary

On March 11, 2014, approximately 250 inmates participated in a riot on the exercise yard. The inmates did not comply with orders to stop fighting. Officers deployed pepper spray, chemical agent grenades, and less-lethal rounds, all of which failed to stop the fighting. Three officers fired a total of 12 warning shots from their Mini-14 rifles. The inmates stopped fighting after the warning shots were issued. Three inmates who alleged head injuries from strikes by less-lethal rounds were treated and none sustained life-threatening injuries. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **14-0614-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department failed to comply with policies and procedures governing the investigative process. The Office of Internal Affairs failed to timely conduct all interviews.

Assessment Questions

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

  The incident occurred on March 11, 2014; however, the last interviews were not conducted until March 18, 2014, seven days later.

South Region

Administrative Investigation	OIG Case Number: **14-0789-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force** 2. **Use of Deadly Force** 3. **Discharge of Lethal Weapon**	1. **Not Sustained** 2. **Exonerated** 3. **Exonerated**	**No Penalty Imposed**	**No Change**

Predisciplinary Assessment

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

The Office of Internal Affairs and department attorney failed to comply with policies and procedures governing the pre-disciplinary process. The Office of Internal Affairs failed to complete the investigation in a timely manner. The department attorney failed to document assessing the deadline to take disciplinary action.

Assessment Questions

- Within 21 calendar days, did the department attorney or employee relations officer make an entry into the case management system accurately 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 did not make an entry into the case management system confirming critical dates.

- No later than 21 calendar days following assignment of the case, did the department attorney contact the assigned special agent and the monitor to discuss the elements of a thorough investigation of the alleged misconduct?

  The department attorney did not contact the special agent and the OIG to discuss the elements of a thorough investigation.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The Office of Internal Affairs did not complete the investigation until August 18, 2014, over five months after the incident.

Disposition

The Deadly Force Review Board found the discharge of the lethal rounds was in compliance with the department's use-of-force policy. The institution's executive review committee determined that all other force used by staff complied with departmental policy except for one officer who fired a less-lethal round at a greater distance than recommended. The hiring authority subsequently exonerated all officers except the officer who fired the less-lethal round from too far away. The hiring authority determined there was insufficient evidence to sustain an allegation against that officer but provided training. The OIG concurred with all of the hiring authority's determinations.

Incident Date: 2014-05-27	Deadly Force Incident

Incident Summary

On May 27, 2014, more than 350 inmates participated in a riot on an exercise yard. Six officers fired 26 warning shots from Mini-14 rifles. Other officers fired more than 179 less-lethal rounds. Two inmates were struck in the head with less-lethal rounds. One of the inmates was flown to an outside hospital for medical care for non-life-threatening injuries and later returned to the institution. The second inmate was treated at the institution and returned to his cell with a minor injury. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

South Region

Criminal Investigation	OIG Case Number: **14-1256-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: Insufficient

The department failed to comply with policies and procedures governing the investigative process. The Office of Internal Affairs failed to timely complete all interviews.

Assessment Questions

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

  The incident occurred on May 27, 2014, but the final interviews were not conducted until August 15, 2014, 80 days after the incident.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The incident occurred on May 27, 2014, but the final interviews were not conducted until August 15, 2014, 80 days after the incident.

Administrative Investigation	OIG Case Number: **14-1426-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. Exonerated**	**No Penalty Imposed**	**No Change**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority did not timely conduct the findings conference.

Assessment Questions

- Did the HA timely consult with the OIG and department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings?

  The case was returned to the hiring authority on March 25, 2015; however, the consultation with the department attorney and the OIG regarding the sufficiency of the investigation and the investigative findings did not occur until May 22, 2015, 58 days thereafter.

- Was the pre-disciplinary/investigative phase conducted with due diligence?

  The hiring authority delayed in conducting the findings conference.

Disposition

The Deadly Force Review Board found the discharge of the lethal rounds by each officer to be in compliance with the department's use-of-force policy. The institution's executive review committee determined that the officer who discharged the less-lethal round which inadvertently struck the inmate in the head also complied with the department's use-of-force policy. The hiring authority subsequently exonerated the seven officers and the OIG concurred.

Incident Date: 2014-06-20	Deadly Force Incident

Incident Summary

On June 20, 2014, an inmate in a contained exercise yard refused an order to return to his housing unit and resisted officers during a controlled yard extraction. Officers deployed pepper spray and used batons and physical force to gain compliance. An officer allegedly struck the inmate on the head with a baton causing an injury that required sutures. The Office of Internal Affairs and the OIG both responded to the scene.

South Region

Administrative Investigation	OIG Case Number: **14-1511-IR**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The hiring authority failed to timely notify the OIG of the incident. The Office of Internal Affairs failed to open a full investigation thereby foreclosing a complete and thorough review of the incident to determine whether the officer's use of the baton complied with the department's use-of-force policy.

Assessment Questions

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

  The hiring authority failed to notify the Office of Internal Affairs until two hours after the incident.

- Was the OIG promptly informed of the critical incident?

  The hiring authority failed to notify the OIG until two hours after the incident.

- Did OIA Central Intake make an appropriate initial determination regarding the case?

  The OIG recommended that an investigation be opened because the evidence was unclear regarding the number of strikes to the inmate's head and whether they were intentional. Despite the OIG's recommendation, OIA Central Intake did not open an investigation.

- Did the OIA properly determine whether the case should be opened as a Deadly Force Investigation Team investigation?

  The OIG recommended that an investigation be opened because the evidence was unclear regarding the number of strikes to the inmate's head and whether they were intentional. Despite the OIG's recommendation, OIA Central Intake did not open a deadly force investigation.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG did not concur because, without an interview of the officer who struck the inmate with the baton, it could not be known with sufficient certainty whether the inmate was struck more than once and whether the strikes were intentional. The institution's executive review committee determined the use of force was within departmental policy. Based on the information available to the committee, the OIG concurred.

Incident Date: 2014-08-27	Deadly Force Incident

Incident Summary

On August 27, 2014, multiple inmates engaged in a riot on the exercise yard. Officers deployed pepper spray. Six officers fired 13 less-lethal rounds to stop the riot. One inmate claimed he was hit in the eye with one of the less-lethal rounds. The inmate suffered serious injury to his face and was taken to an outside hospital for medical treatment. The OIG and the Office of Internal Affairs both responded to the scene.

Administrative Investigation	OIG Case Number: **14-2197-IR**

Predisciplinary Assessment

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

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

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee found the use of force complied with the department's use-of-force policy. The OIG concurred.

Incident Date: 2014-12-09	Deadly Force Incident

South Region

Incident Summary

On December 9, 2014, two inmates began fighting and refused orders to stop. An officer deployed pepper spray but the inmates continued fighting. The officer pulled his baton and inadvertently struck one of the inmates on the head with his baton as the inmate was still fighting. The inmate sustained a bump and redness to his face and was evaluated at an outside hospital before returning to the institution later that evening. The Office of Internal Affairs and the OIG both responded to the scene.

Administrative Investigation	OIG Case Number: **14-2822-IR**

Predisciplinary Assessment

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

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

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined the use of force complied with departmental policy. The OIG concurred with the determination.

Incident Date: 2015-01-13	Deadly Force Incident

Incident Summary

On January 13, 2015, multiple inmates participated in a riot on the top tier of a housing unit. The inmates refused orders to stop fighting. A control booth officer fired three less-lethal rounds, all of which hit the railing and missed the intended targets. Another officer fired two less-lethal rounds, one of which grazed an inmate in the face. The inmate suffered minor injuries and refused treatment by medical staff at the institution. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation	OIG Case Number: **15-0172-IR**

Predisciplinary Assessment

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

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

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined the use of force complied with departmental policy. The OIG concurred with the determination.

APPENDIX E 81
CRITICAL INCIDENT CASE SUMMARIES
CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-04-19	**14-0941-RO**	**In-Custody Inmate Death**

Incident Summary

On April 19, 2014, an inmate returning from an exercise yard appeared to be having a seizure while lying on his bunk in a dormitory. Two inmates requested assistance and two officers responded. One officer announced a medical emergency while both floor officers began clearing the area of inmates. The inmate stopped breathing and two inmates started life-saving efforts. Additional custody, medical, and fire staff responded and took over life-saving measures. The unresponsive inmate was transported to an outside hospital where he was later pronounced dead.

Disposition

An autopsy determined the inmate died of natural causes due to severe coronary artery disease. The department's Death Review Committee concluded that the death was not preventable but identified opportunities for improvement specific to life-saving efforts. Potential staff misconduct was identified based on the two floor officers' failure to provide direct observation of an inmate during a man-down emergency so life-saving measures could be started. Therefore, the hiring authority referred the matter to the Office of Internal Affairs. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was insufficient because the hiring authority did not timely address the failure of custody staff to monitor the inmate and provide life-saving measures when it became necessary. After the OIG presented the facts to the hiring authority, the case was submitted to the Office of Internal Affairs, but the referral was not timely. In addition, the department failed to adequately consult with the OIG. The OIG concurred with the decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The department delayed reviewing the incident. Therefore, the department did not discover the alleged misconduct until December 10, 2014. The hiring authority did not refer the matter to the Office of Internal Affairs until January 30, 2015, 51 days after the date of discovery.

- 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 of custody staff to monitor the inmate and provide life-saving measures when it became necessary. After the OIG presented the facts to the hiring authority, the case was submitted to the Office of Internal Affairs.

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

  Despite the OIG's requests, the department did not provide the OIG with the emergency medical response review committee minutes until November 21, 2014, thereby preventing the OIG from completing a timely review of the incident.

- Was the hiring authority's response to the critical incident appropriate?

  The institution's emergency medical response review committee failed to address custody staff's failure to monitor the inmate's breathing and provide life-saving measures when it became necessary.

Incident Date	OIG Case Number	Case Type
2014-08-28	**14-2073-RO**	**In-Custody Inmate Death**

Incident Summary

On August 28, 2014, an officer responded to a cell in response to a medical alarm and was told by an inmate that her cellmate was unresponsive. Officers and a nurse responded and initiated life-saving measures. Despite these life-saving efforts, the inmate was pronounced dead.

CENTRAL REGION

Disposition

The autopsy determined the inmate died of a heart attack due to heart disease. The department's Death Review Committee concluded the inmate's death was unexpected and not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-08-31	**14-2114-RO**	**Other Significant Incident**

Incident Summary

On August 31, 2014, an officer ordered an inmate to exit his cell for a random cell search. The officer activated her alarm after the inmate became argumentative and refused orders to sit down. As the officer removed the pepper spray from its holster, the inmate ran into his cell, quickly returned, and began striking her in the head and stabbing her in the neck until she collapsed and lost consciousness. A second officer responded and used physical force to stop the inmate's attack. The inmate then began stabbing the second officer in the upper torso. The first officer regained consciousness and struck the inmate with her baton in an attempt to stop the attack on the second officer. Additional officers responded and used batons, pepper spray, and physical force to subdue the inmate. The two officers were transported to an outside hospital for treatment of non-life-threatening injuries. The inmate was also transported to an outside hospital for treatment of a broken rib and injuries to his face and returned to the institution the following day.

Disposition

The OIG informed the institution's executive review committee that the video-taped interview was not conducted according to policy guidelines. The committee agreed and ensured that a follow-up video was completed and training provided to the incident commander. Training was also ordered for the officer who failed to collect the clothing of the attacking inmate into evidence. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was not adequate because the institution failed to keep the OIG timely informed as new information became available during the on-scene monitoring of the incident. In addition, the clothing worn by the attacking inmate was not collected as evidence and the video-recorded interview did not address the purpose of the interview or record the inmate's injuries. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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?

  Although the officer who escorted and searched the attacking inmate had received training on collecting and preserving evidence, the training directs staff to collect and process the victim's clothing but does not direct staff to collect a suspect's clothing as potential evidence.

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

  Although the OIG responded on scene, the institution did not provide an adequate initial briefing nor did it keep the OIG timely informed as new information became available.

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

  The investigative services unit failed to ensure that the attacking inmate's clothing was placed into evidence and the video-taped interview did not address the purpose of the interview or record the inmate's injuries.

- Was the hiring authority's response to the critical incident appropriate?

  The officer that escorted the inmate to a holding cell failed to collect and retain the attacking inmate's clothing as evidence.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-09-05	**14-2202-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 5, 2014, two officers were escorting a handcuffed inmate when he allegedly kicked an officer. An officer reported the inmate hit his head on the floor when the officer intentionally swept the inmate's leg from underneath him, forcing the inmate to the ground. A second officer hit the inmate in the leg with his baton. After the inmate was placed in leg restraints, the officers began walking the inmate out of the housing unit before calling medical staff to evaluate the inmate. When the inmate was unable to walk any further, a nurse responded and the inmate was transported to an outside hospital where he was treated for three skull fractures and a broken knee. The inmate returned to the institution five days later.

Disposition

Potential staff misconduct was identified based on the officers' alleged unreasonable use of force. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate. The officers failed to account for the inmate's injuries in their written reports and failed to summon medical assistance after using force. After the inmate received medical care at the outside hospital, medical staff and custody staff failed to adequately and timely determine the seriousness of the inmate's injuries due to the use of force. The institution's emergency medical response review committee failed to complete a review of the incident. The hiring authority delayed more than four months before referring the matter to the Office of Internal Affairs and did so only after the OIG recommended that the matter be referred.

Assessment Questions

- 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 September 26, 2014, but the hiring authority did not refer the matter to the Office of Internal Affairs until February 6, 2015, more than four months after the date of discovery.

- 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 potential staff misconduct based on the officers' alleged unreasonable use of force and recommended that the matter be referred to the Office of Internal Affairs. The OIG also recommended that the hiring authority implement a tracking system whereby custody staff would follow-up and confirm with medical staff the nature and extent of inmate injuries resulting from use of force.

- Was the critical incident adequately documented?

  Officers failed to document the inmate's injuries in their reports.

- Was the hiring authority's response to the critical incident appropriate?

  After using force, the officers failed to summon medical staff to evaluate the inmate's injuries before attempting to escort him out of the housing unit. After the inmate received medical care at the outside hospital, medical staff and custody staff failed to adequately and timely determine the seriousness of the inmate's injuries due to the use of force. The institution's emergency medical response review committee failed to complete a review of the incident.

Incident Date	OIG Case Number	Case Type
2014-09-06	**14-2203-RO**	**Suicide**

Incident Summary

On September 6, 2014, an officer responded to a cell after he heard an inmate yelling. The inmate told the officer that his cellmate hung himself. The officer saw the cellmate hanging from a light fixture by a noose. Officers pulled the cellmate out of the cell and began life-saving measures. A nurse arrived and assisted the officers with life-saving efforts. The injured inmate was transported to the triage and treatment area. The inmate's pulse and blood pressure were restored following advanced life-saving measures. The inmate was air-lifted to an outside hospital and was removed from life-support two days later after physicians determined he was brain-dead.

CENTRAL REGION

Disposition

An autopsy concluded that the inmate died from ligature strangulation. The department's Statewide Mental Health Program suicide report called for an evaluation to determine whether the institution was completing required clinical assessments in the timeframe departmental policy specified. The evaluation identified systemic problems related to incomplete documentation, suicide risk evaluations, and document scanning. The department provided seven hours of suicide risk assessment training to 18 mental health clinicians and one hour of training to 61 mental health employees. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's actions leading up to the incident were not adequate because the required mental health evaluation was not completed and the suicide risk evaluations were not thorough. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the hiring authority's response to the critical incident appropriate?

  The department failed to conduct the required mental health evaluation and the suicide risk evaluations were not thorough.

Incident Date	OIG Case Number	Case Type
2014-09-11	**14-2222-RO**	**PREA**

Incident Summary

On September 11, 2014, an inmate reported to a clinical social worker that his cellmate had raped him. The clinical social worker attempted to notify his supervisor several times that day, without success. The following day, the clinical social worker contacted his supervisor who instructed him to report the matter to the sergeant. Thereafter, officers interviewed each inmate separately. The inmate admitted to raping his cellmate, but refused to continue the interview without an attorney present. The other inmate confirmed he was raped by his cellmate. Both inmates were transported to an outside center for sexual assault examinations.

Disposition

During a cell search, the officers found a letter from one of the inmates indicating the rape allegation was fabricated so single-cell status could be obtained. The investigative services unit interviewed the inmates separately and they each admitted the rape did not occur. After the OIG identified the clinical social worker's failure to timely contact the watch commander, the hiring authority provided training for the clinical social worker regarding proper handling and reporting of sexual assault incidents. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was not satisfactory because the clinical social worker failed to immediately notify the watch commander of the alleged rape as required by the Prison Rape Elimination Act policy. The hiring authority provided training to the clinical social worker because he was new and made several attempts to timely notify his supervisor, but was unaware of the additional requirement to notify the watch commander. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 clinical social worker's failure to follow policy by not notifying the watch commander immediately after not being able to contact his supervisor.

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

  The clinical social worker who first became aware of the allegation made several attempts to contact his supervisor, but was unsuccessful until the following day. The clinical social worker failed to notify the watch commander as required by departmental policy.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-09-14	**14-2233-RO**	**In-Custody Inmate Death**

Incident Summary

On September 14, 2014, officers discovered an inmate vomiting in his cell after he swallowed a large amount of pills. Officers escorted the inmate to the triage and treatment area where a nurse assessed the inmate. The inmate was conscious, talking, and able to walk. The nurse reported the inmate's condition to a physician who ordered the inmate be transported to an outside hospital. The inmate left the institution approximately 90 minutes after being discovered. While at the outside hospital, the inmate's condition worsened due to the drug overdose and he was pronounced dead on September 19, 2014.

Disposition

An autopsy determined the inmate died from a drug overdose. Potential staff misconduct was identified based on the alleged failure to timely transport the inmate; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it delayed in transporting the inmate to an outside hospital. Additionally, custody staff, without the assistance of any medical personnel, transported an inmate to an outside hospital for emergency medical care for a potentially life-threatening event. The investigative services unit failed to timely interview the inmate's cellmate. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The investigative services unit initially failed to interview the inmate's cellmate regarding the incident before the cellmate was transferred to another institution. The cellmate was eventually interviewed at the other institution.

- Was the hiring authority's response to the critical incident appropriate?

  Custody staff transported the inmate to an outside hospital for emergency medical care for a potentially life-threatening event without the assistance or presence of medical staff. There was a 90-minute delay in transporting the inmate to an outside hospital.

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

  There was a 90-minute delay in transporting the inmate to an outside hospital for a potentially life-threatening event.

Incident Date	OIG Case Number	Case Type
2014-09-20	**14-2254-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 20, 2014, officers observed two inmates knock a third inmate to the ground and begin stabbing him multiple times in the upper torso. The inmates stopped their attack as responding officers arrived. The injured inmate was transported to an outside hospital via ambulance with life-threatening stab wounds to his chest and returned to the institution three days later. Two days earlier, the injured inmate's cellmate had also sustained life-threatening stab wounds to the chest.

Disposition

The emergency medical response review committee identified incomplete documentation and provided training to the nurse that completed the assessment. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the decision not to refer the matter to the Office of Internal Affairs.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-10-07	**14-2384-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On October 7, 2014, an officer went to investigate noises coming from a cell. The officer observed blood on both inmates. The inmates were removed from the cell. One of the inmates had multiple stab wounds on his upper torso, arms, and legs. The injured inmate was transported to an outside hospital via ambulance with life-threatening injuries and returned to the institution four days later. An inmate-manufactured stabbing weapon was recovered from the toilet in the cell. The cellmate was placed in administrative segregation pending investigation.

Disposition

The department completed an in-cell assault review and concluded the inmates were appropriately housed together prior to the incident. The OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-10-19	**14-2493-RO**	**In-Custody Inmate Death**

Incident Summary

On October 19, 2014, an officer discovered an unresponsive inmate on the floor of his cell between the bunks. Officers entered the cell, removed the inmate, found he was not breathing, and initiated life-saving measures which continued while the inmate was taken to the institution's hospital. Despite life-saving efforts, the inmate was pronounced dead approximately 30 minutes later. The presence of early rigor mortis made life-saving measures difficult.

Disposition

The cause of death was determined to be a probable heart attack caused by years of drug abuse. Potential staff misconduct was identified based on an officer's alleged failure to conduct an appropriate welfare check; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because there was a delay in conducting a welfare check. The presence of rigor mortis at the time life-saving measures were attempted suggested the inmate may not have been alive when an officer reported the inmate was alive. There was a five-month delay in referring the matter for investigation. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 19, 2014, but the hiring authority did not refer the matter to the Office of Internal Affairs until March 22, 2015, five months after the date of discovery and only after the OIG recommended the referral.

- 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 potential staff misconduct and recommended the hiring authority refer the matter to the Office of Internal Affairs.

- Was the hiring authority's response to the critical incident appropriate?

  The department failed to comply with departmental policy requiring welfare checks two times every hour, not to exceed 35 minutes between welfare checks. The inmate was noted to have signs of rigor mortis 11 minutes after being found unresponsive, suggesting the inmate was not alive when last checked approximately 45 minutes before being found unresponsive.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-10-31	14-2571-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On October 31, 2014, an inmate refused to move to another cell as officers ordered. The inmate was asked whether he had enemy concerns but refused to explain why he would not accept his assigned housing. A medical evaluation was completed because of placement in administrative segregation for refusal to accept a cell assignment. During the medical evaluation, it was discovered that the inmate had a fractured jaw.

Disposition

The institution's investigative services unit interviewed the inmate to identify the source of his safety concern. The inmate refused to provide specific information other than claiming that the attack occurred on the facility where he was previously housed. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Although the OIG was not notified of the incident, the department's response to the incident was otherwise sufficient. The OIG concurred with the decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-10-31	14-2603-RO	Other Significant Incident

Incident Summary

On October 31, 2014, an inmate in a minimum security facility jumped the fence. A fire captain saw the inmate pick up a bag that was thrown from a car traveling at a high rate of speed. After picking up the bag, the inmate appeared to be returning to the facility. As the inmate approached the facility, he saw the fire captain driving toward him. The inmate changed direction and disappeared into an orchard. The observation officer saw the inmate running across the field and alerted the institution of a possible escape. An emergency count confirmed that an inmate was missing. The institution initiated emergency escape procedures, including requesting outside law enforcement assistance. The department's Special Services Unit apprehended the inmate two days later.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department’s response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority’s decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-10-31	14-2642-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On October 31, 2014, officers responded to a request for assistance and observed an inmate on the cell floor with a laceration above his right eye. The injured inmate and his cellmate were removed without incident. The injured inmate told officers he was not assaulted by his cellmate. The injured inmate was transported to an outside hospital for treatment and returned the same day. After returning to the institution, the inmate fell out of the gurney and was hospitalized for five days because of an orbital fracture and lacerations to his head. The inmate received a new cell assignment upon returning to the institution.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Although the department failed to timely notify the OIG, the department's response to the incident was otherwise sufficient. The OIG concurred with the hiring authorities decision not to refer the matter to the Office of Internal Affairs.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-11-13	**14-2643-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On November 13, 2014, officers opened a cell door and saw an inmate with blood on his face. The cellmate exited the cell, but the injured inmate remained. The injured inmate was transported to an outside hospital for treatment of a head injury, broken jaw, nose, and finger and returned to the institution eight days later.

Disposition

The in-cell assault review determined that the double-cell status of both inmates complied with departmental guidelines. The cellmate received a rules violation for battery on an inmate and remained in administrative segregation. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to complete an in-cell assault review in a timely manner. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs. The department is developing a process to better classify and ensure compatibility of inmates housed on facilities designed for inmates with sensitive needs.

Assessment Questions

- 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 in-cell assault review was not completed until six months after the incident occurred. Departmental policy requires the in-cell assault review to be completed within two weeks of the incident. Inmates are placed on sensitive needs facilities primarily for their safety. In this case, both inmates were from rival gangs with an extensive history of violence against each other, which current policy permits on sensitive needs yards.

Incident Date	OIG Case Number	Case Type
2014-11-21	**14-2877-RO**	**Hunger Strike**

Incident Summary

On November 21, 2014, an inmate initiated a hunger strike because he disagreed with a physician's decision to confiscate his wheelchair. The inmate was transferred to the institution's correctional treatment center. On December 23, 2014, the inmate was transported to an outside hospital after he fell and injured his head. The inmate ended his hunger strike by consuming a meal while monitored by medical staff and he returned to the institution the following day.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-11-30	**14-2760-RO**	**Suicide**

Incident Summary

On November 30, 2014, as an inmate was returning from an exercise yard, he discovered his cellmate hanging in the cell and immediately alerted officers. Officers arrived and began life-saving efforts. Two nurses arrived and relieved the officers. Paramedics responded and pronounced the inmate dead after life-saving efforts failed.

Disposition

The autopsy determined the cause of death was suicide by hanging. The department's Forensic Psychological Autopsy review recommended training for mental health clinicians regarding the importance of documenting gaps in treatment or changes in treatment plans. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

CENTRAL REGION

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department adequately notified and consulted with the OIG. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-12-03	**14-2761-RO**	**In-Custody Inmate Death**

Incident Summary

On December 3, 2014, two officers discovered an unresponsive inmate lying on his bunk in a dormitory. Officers began life-saving efforts until relieved by two licensed vocational nurses. The inmate was transported to an outside hospital via ambulance. The inmate was pronounced dead two hours later after life-saving efforts failed.

Disposition

The coroner concluded that the cause of death was related to chronic heart disease. The department's Death Review Committee determined the death was not preventable. The Emergency Medical Response Review Committee provided nurses with training to improve documentation of ambulance responses. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response to the incident was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-12-16	**14-2863-RO**	**In-Custody Inmate Death**

Incident Summary

On December 16, 2014, officers responded to an inmate choking on food. The officers began life-saving measures and called an ambulance after the inmate stopped breathing. Paramedics pronounced the inmate dead after life-saving efforts failed.

Disposition

The coroner determined the cause of death was an accidental drug overdose. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner, thus preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified of the inmate death until the day after the incident.

Incident Date	OIG Case Number	Case Type
2014-12-23	**14-2883-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On December 23, 2014, an inmate attacked a second inmate with a weapon on an exercise yard. Both inmates were recently released from a security housing unit. The inmates stopped fighting after being ordered to do so by officers. The injured inmate was air-lifted to an outside hospital for treatment of a punctured lung and numerous stab wounds to his upper torso and head. The inmate returned to the institution after four days of treatment.

CENTRAL REGION

Disposition

The hiring authority informed the OIG that there is a statewide shortage of appropriate housing and a backlog of classifying inmates. The hiring authority indicated it would not be appropriate to retain inmates in the security housing unit pending transfer beyond their prescribed term. The hiring authority agreed with the OIG that a statewide housing guideline would be helpful. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response to this incident was not adequate. The hiring authority did not address the lack of guidelines for appropriately housing inmates pending transfer. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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?

  There is a practice of releasing inmates from security housing units and placing them on facilities where classification factors restrict them from placement.

- Was the hiring authority's response to the critical incident appropriate?

  The involved inmates were released to a facility designed for lower risk inmates due to unavailable bed space. The inmate that was injured and one of the attackers were restricted from placement on that facility. The hiring authority said this problem is not unique to his institution and he would welcome statewide guidelines.

Incident Date	OIG Case Number	Case Type
2014-12-27	**14-2900-RO**	**In-Custody Inmate Death**

Incident Summary

On December 27, 2014, an officer responding to a request for assistance found an inmate lying face down on the floor of his cell. The inmate was breathing but unresponsive. Four nurses responded and transported him to the medical clinic. Shortly after arrival in the clinic, a nurse determined the inmate had no pulse and nurses initiated life-saving measures. The inmate was transported to an outside hospital and, shortly after his arrival, was pronounced dead by a physician.

Disposition

An autopsy determined the death was natural and caused by chronic heart disease. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical respects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-01-07	**15-0211-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On January 7, 2015, two officers deployed pepper spray to stop two inmates from fighting. One inmate stopped fighting but the second inmate continued to advance toward the first inmate. One officer used physical force to take the second inmate to the ground. The second inmate suffered a head injury and was transported via ambulance to an outside hospital. The inmate received 24 sutures, following which he returned to the institution.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy; however, the video-taped interview failed to adequately show the inmate's injuries. Training was provided to the camera operator. The OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

CENTRAL REGION

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-01-14	**15-0552-RO**	**Hunger Strike**

Incident Summary

On January 14, 2015, an inmate initiated a hunger strike after alleging he did not have adequate access to haircuts, mailing envelopes, and the law library. On March 12, 2015, the inmate was transported to an outside hospital for five days due to dehydration. The inmate ended his hunger strike while at the outside hospital. The inmate renewed his hunger strike two additional times over a five-month period which resulted in ten admissions to an outside hospital for non-life-threatening conditions. The inmate lost a total of 43 pounds, which was 25 percent of his body weight.

Disposition

The department made reasonable attempts to address the inmate's concerns. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-01-28	**15-0700-RO**	**Suicide**

Incident Summary

On January 28, 2015, an inmate jumped over a second tier rail and landed headfirst on the cement floor of the first tier. Nurses responded and provided emergency care. The inmate was air-lifted to an outside hospital and placed on life-support. The inmate died nine days later.

Disposition

The coroner determined the cause of death was suicide due to blunt force trauma to the head. The Emergency Medical Response Review Committee found that the emergency response was adequate. The Forensic Psychological Autopsy found that the suicide was not preventable; however, they did find opportunities for improvement related to consistency, continuity, and follow-through related to documentation. Training was provided to mental health clinicians to improve mental health care at the institution. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner, thus preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The department failed to notify the OIG of the death.

Incident Date	OIG Case Number	Case Type
2015-02-02	**15-0310-RO**	**PREA**

Incident Summary

On February 2, 2015, a non-departmental officer in a private contract facility allegedly made inappropriate sexual comments to an inmate.

CENTRAL REGION

Disposition

The private contract facility completed an inquiry and determined that the inmate's allegation was not substantiated.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2015-02-09	**15-0341-RO**	**In-Custody Inmate Death**

Incident Summary

On February 9, 2015, an officer observed an inmate lying on his bunk with blood on his face and the bed linen. The officer activated the alarm, placed the cellmate in handcuffs, and removed him from the cell. As a nurse arrived, the injured inmate lost consciousness. The injured inmate was air-lifted to an outside hospital due to a life-threatening head injury. Both of the inmate's eyes were dislodged from their sockets. The inmate died at the outside hospital 19 days later.

Disposition

The autopsy determined that the inmate died of multiple blunt force trauma injuries. The manner of death was homicide. The department completed an in-cell assault review and concluded that the inmates were compatible at the time they were placed together and their cell assignment followed departmental policy. The emergency medical response review committee identified an opportunity for improvement regarding the use of a backboard and log-rolling technique. The nurses that responded to the incident received training. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-02-13	**15-0370-RO**	**In-Custody Inmate Death**

Incident Summary

On February 13, 2015, officers responded to a request for assistance and found an unresponsive inmate lying on the floor of his cell. Officers requested an emergency medical response. As two licensed vocational nurses arrived, the inmate stopped breathing and the two nurses initiated life-saving measures. The inmate was transported to an outside hospital via ambulance where the inmate was pronounced dead by a physician.

Disposition

The coroner determined that the inmate died of a methamphetamine overdose. The department's Death Review Committee determined the death was not preventable. The emergency medical response review committee found that custody staff and medical staff both assumed the other called for an ambulance. Therefore, the hiring authority provided training to officers, sergeants, lieutenants, captains, licensed vocational nurses, registered nurses, and senior registered nurses to ensure an ambulance is summoned immediately when life-saving measures are initiated.

Overall Assessment

Rating: **Insufficient**

The department's response to this incident was not adequate. There was a 24-minute time lapse between the time life-saving measures were initiated and when the ambulance was summoned. The OIG concurred with the decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  There was a 24-minute gap between the time life-saving measures were initiated and when the ambulance was summoned.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-02-20	**15-0417-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On February 20, 2015, two officers observed an inmate standing at the door of his cell, covered in blood and bleeding profusely from his face. The cellmate was standing behind him, also covered in blood. Both inmates were placed in restraints and removed from the cell. The first inmate was transported to an outside hospital via ambulance after a physician determined the inmate lost consciousness and required sutures. The inmate returned to the institution the following day. The cellmate was treated at the institution for a bone fracture and a wound requiring sutures.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the investigative services unit was not notified and the crime scene was not adequately processed. The department failed to notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 deficient processing of the crime scene, poor documentation, and the missing control booth officer's report, and informed the hiring authority.

- Was the critical incident adequately documented?

  The captain and lieutenant initially failed to obtain a report from the control booth officer who did not submit a report but was operating the cell door when the incident was discovered. Documentation did not provide a clear chain of custody of the video recorder that was used to document the crime scene. Documentation of crime scene photographs only included one of the inmates. There was no documentation to establish what precipitated the incident and what transpired during the incident to support the dismissal of the rules violation report for one of the inmates later designated as the victim.

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

  Officers did not adequately process the crime scene. The sergeant directed an officer to only photograph the crime scene. No evidence markers were used. A bloody fan and broken pieces of the fan were photographed within the crime scene; however, the items were not collected as potential evidence. Reports did not indicate the crime scene was searched for additional evidence or weapons. Lead cards were not used to identify inmate photographs.

- Was the hiring authority's response to the critical incident appropriate?

  The investigative services unit was not notified of the incident and did not process the evidence. The incident was initially considered a simple fistfight. Several weeks following the incident, as a result of the rules violation process, the incident was discovered to be an in-cell battery with serious injury.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until four hours after the incident.

Incident Date	OIG Case Number	Case Type
2015-02-25	**15-0448-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On February 25, 2015, an officer observed an inmate with a shiny object in his hand run toward a second inmate in the dayroom. The second inmate retrieved a broken cane from his pant leg and attempted to stab the approaching inmate. The inmates refused orders to stop fighting. An officer fired six less-lethal rounds to stop the fight. The second inmate was transported to an outside hospital for treatment of a head injury that may have been caused by a less-lethal round.

CENTRAL REGION

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the institution provided training to the administrative officers of the day regarding notification requirements.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG preventing the OIG from real-time monitoring of the case. The department also failed to notify the Office of Internal Affairs. The incident commander failed to advise that an inmate may have been hit in the head by a less-lethal round and the institution inappropriately determined the inmate was not hit in the head. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 failure to provide prompt notice of the incident as a basis for corrective action.

- Was the hiring authority's response to the critical incident appropriate?

  The incident commander failed to notify his superiors that an inmate may have been hit in the head by a less-lethal round. The institution inappropriately determined that an inmate was not hit in the head by a less-lethal round despite strong evidence to the contrary.

- Was the OIG promptly informed of the critical incident?

  The hiring authority failed to notify the OIG of the incident.

- Did the hiring authority timely notify the Office of Internal Affairs of the incident?

  The hiring authority failed to notify the Office of Internal Affairs of the incident despite the potential lethal injury caused by the use of less-lethal force.

Incident Date	OIG Case Number	Case Type
2015-02-28	**15-0566-RO**	**Contraband Watch**

Incident Summary

On February 28, 2015, the department placed an inmate on contraband surveillance watch after the inmate told an officer that he swallowed a methamphetamine bindle and that it may have burst. The inmate was taken to an outside hospital for a suspected drug overdose. A CT scan revealed a dense area in the stomach that appeared to represent drugs, but did not reveal any other foreign object. After three days, the inmate was removed from contraband surveillance watch and returned to the institution. The department recovered no contraband from the inmate.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was adequate in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-04-16	**15-0762-RO**	**Contraband Watch**

Incident Summary

On April 16, 2015, an inmate on contraband surveillance watch exhibited symptoms consistent with a drug overdose. The inmate was transported to an outside hospital where officers discovered a rip in the inmate's jumpsuit and pieces of what appeared to be a torn bindle. After it was determined that he did not suffer a drug overdose, officers returned the inmate to the institution the same day. The inmate remained on contraband surveillance watch an additional three days during which time he produced several bindles that tested presumptively positive for drugs. The inmate was removed from contraband surveillance watch after a CT scan revealed no additional foreign objects.

CENTRAL REGION

Disposition

The investigative services unit determined that a non-sworn staff member may have introduced drugs into the prison. Potential staff misconduct was identified. Therefore, the case was referred to the Office of Internal Affairs for an investigation. An investigation was opened, which the OIG did not accept for monitoring.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-02-23	14-0455-RO	In-Custody Inmate Death

Incident Summary

On February 23, 2014, officers observed an unresponsive inmate in a cell. The officers removed the cellmate from the cell and observed that the unresponsive inmate had a pulse. The officers transported the unresponsive inmate to the triage and treatment area where he lost vital signs. Medical staff began life-saving measures but the inmate was pronounced dead. There were no signs of a struggle in the cell and no obvious injuries on the inmate or his cellmate. The cellmate was placed in administrative segregation pending the investigation which later determined that he was not involved in causing the inmate's death.

Disposition

The coroner determined that the inmate died from a methamphetamine overdose. Multiple balloons filled with drugs were found in the inmate's esophagus and stomach during the autopsy. Some of the balloons had ruptured. The department's Death Review Committee determined that staff responded appropriately during the response to the medical emergency. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-04-25	14-0993-RO	In-Custody Inmate Death

Incident Summary

On April 25, 2014, officers observed an unresponsive inmate on the lower bunk of his cell and his cellmate asleep on the upper bunk. Officers activated an alarm, entered the cell, removed the cellmate, and initiated life-saving measures. Nurses responded and continued life-saving measures while an ambulance was called. A physician pronounced the inmate dead after life-saving measures failed.

Disposition

An autopsy that included toxicology results determined that the death was accidental and caused by toxic levels of phenytoin, a medication used to control seizures. The department's Death Review Committee determined that the death was unexpected and possibly preventable. The committee identified instances of systemic concerns where there was a failure in provider-to-provider communication concerning abnormal blood levels which were referred for corrective action. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the institution failed to timely notify the OIG preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was notified nearly four hours after the inmate was pronounced dead.

Incident Date	OIG Case Number	Case Type
2014-05-19	14-1171-RO	In-Custody Inmate Death

Incident Summary

On May 19, 2014, an inmate in a vocational class suddenly collapsed in a classroom. Two other inmates immediately reported the emergency to a vocational instructor who alerted custody staff. Officers immediately initiated life-saving measures and transported the inmate to the correctional treatment center. Life-saving efforts were unsuccessful and the inmate was pronounced dead.

Disposition

The autopsy determined that the cause of death was chlorodifluoromethane intoxication. As a result of this incident, the institution implemented corrective action plans for better security, accountability, and training related to toxic substances. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

NORTH REGION

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to provide timely notification to the OIG thereby preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until three hours after the inmate was pronounced dead.

Incident Date	OIG Case Number	Case Type
2014-05-27	**14-1219-RO**	**In-Custody Inmate Death**

Incident Summary

On May 27, 2014, an inmate collapsed in the shower. Officers and nurses responded but did not start life-saving measures until a physician arrived and assessed the inmate. Nurses and physicians then initiated and continued life-saving measures until the inmate was pronounced dead.

Disposition

The department's Death Review Committee determined the cause of death was end-stage liver disease. Potential staff misconduct was identified because officers and nurses allegedly failed to immediately provide life-saving measures. The hiring authority referred the matter to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because officers and nurses failed to immediately assess the inmate and initiate life-saving measures, the incident reports were incomplete, and the hiring authority failed to make a timely decision regarding whether to refer the matter to the Office of Internal Affairs. The OIG concurred with the hiring authority's decision to submit the matter to the Office of Internal Affairs.

Assessment Questions

- 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 potential misconduct on May 29, 2014, but the hiring authority did not refer the matter to the Office of Internal Affairs until July 23, 2014, 55 days after the date of discovery.

- Was the critical incident adequately documented?

  The incident reports failed to adequately explain the delay in the administration of life-saving measures.

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

  Officers and nurses failed to immediately assess the inmate and initiate life-saving measures.

Incident Date	OIG Case Number	Case Type
2014-05-28	**14-1240-RO**	**Suicide**

Incident Summary

On May 28, 2014, officers found an inmate unresponsive in his cell with a sheet tied around his neck and the other end attached to an air vent. Officers entered the cell and initiated life-saving measures. The inmate was transported to an outside hospital where he was pronounced dead on May 31, 2014.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG in a timely manner. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

NORTH REGION

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The department delayed notifying the OIG for almost two hours

Incident Date	OIG Case Number	Case Type
2014-05-31	**14-1259-RO**	**In-Custody Inmate Death**

Incident Summary

On May 31, 2014, an officer discovered an inmate unresponsive in his cell. Nurses initiated life-saving measures which continued while the inmate was transported to the triage and treatment area. Paramedics arrived and continued life-saving measures; however, these attempts failed and the inmate was pronounced dead by a physician from an outside hospital.

Disposition

The autopsy report revealed the inmate died from a heart attack. The department's Death Review Committee concluded that the inmate's death was unexpected and possibly preventable due to a failure to recognize signs and symptoms of acute coronary syndrome. Training was provided to medical staff to address this issue. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was not adequate because the department found that a nurse should have informed a physician of the inmate's recurring chest pain in the hours prior to his death. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the hiring authority's response to the critical incident appropriate?

  A nurse failed to inform a physician of the inmate's second visit to the triage and treatment area for recurring chest pains in the hours before his death.

Incident Date	OIG Case Number	Case Type
2014-06-02	**14-1526-RO**	**Contraband Watch**

Incident Summary

On June 2, 2014, an inmate on contraband surveillance watch was transported to an outside hospital after officers observed him re-ingest suspected drugs. The inmate tested positive for methamphetamine and was returned to the institution.

Disposition

Potential staff misconduct was identified because officers allegedly failed to prevent the inmate from retrieving and re-ingesting contraband. Further, after the inmate was removed from the contraband surveillance watch cell, cellophane material was found in the cell when the cell should have been cleared of all contraband. The hiring authority declined to refer the matter to the Office of Internal Affairs.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case. The department also failed to adequately document the incident and refer the matter to the Office of Internal Affairs. The OIG did not concur with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

NORTH REGION

Assessment Questions

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

  While on contraband surveillance watch, the inmate accessed contraband without being detected and then re-ingested the contraband. Further, two items of cellophane material were found in the inmate's contraband surveillance watch cell which should have been cleared of all contraband. However, the hiring authority determined the officers adequately documented the incident and that no misconduct occurred.

- Was the critical incident adequately documented?

  The incident report did not adequately describe the actions of the inmate before he was seen placing contraband in his mouth.

- Was the OIG promptly informed of the critical incident?

  The department failed to notify the OIG when the inmate was transported to an outside hospital.

Incident Date	OIG Case Number	Case Type
2014-06-25	**14-1494-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On June 25, 2014, officers observed two inmates arguing on the second tier of a housing unit. Both inmates were grabbing and pulling at each other's clothing and ignored orders to get down. As an officer activated the alarm, one inmate pushed the other inmate toward the stairs, causing the inmate to fall backwards down the stairs. Nurses responded to the housing unit and provided emergency medical treatment to the inmate. The inmate was air-lifted to an outside hospital for treatment of lacerations and a puncture wound. The inmate returned to the institution later the same day.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the investigative services unit failed to follow crime scene preservation and evidence collection protocols after establishing control of the incident. Training on crime scene preservation was provided to the involved custody staff. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 department failed to follow its crime scene preservation and evidence collection protocols. The department provided training to the involved officers.

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

  The investigative services unit failed to conduct a search for weapons or establish a crime scene.

- Was the hiring authority's response to the critical incident appropriate?

  The investigative services unit photographed the crime scene; however, they did not conduct a search for weapons or secure the crime scene.

Incident Date	OIG Case Number	Case Type
2014-06-27	**14-1527-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On June 27, 2014, officers responded to a cell after hearing loud noises consistent with a fight. The officers observed an inmate battering his cellmate. An officer activated his alarm and additional custody staff responded. Both inmates complied with orders to separate and were examined by medical staff. One of the inmates was taken to the triage and treatment area and later transported to a local hospital for a higher level of care. The inmate was treated for facial fractures, internal bleeding, bleeding on the brain, and the loss of four teeth. The inmate returned to the institution five days later.

NORTH REGION

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-09-02	**14-2085-RO**	**Suicide**

Incident Summary

On September 2, 2014, officers discovered an inmate hanging from a bed sheet attached to the upper bunk in his cell. Officers, a senior registered nurse, and a registered nurse performed life-saving measures but were unsuccessful and a physician pronounced the inmate dead at the scene.

Disposition

The autopsy determined the cause of death was asphyxia due to hanging. The department's Death Review Committee identified concerns that the registered nurse initially responded to the cell without an automated external defibrillator and the senior registered nurse experienced difficulty using a resuscitator bag and stabilizing the inmate's body while performing care. In addition, the Death Review Committee noted a lieutenant's failure to timely notify outside law enforcement that the inmate had died. Finally, a more thorough assessment in response to the inmate's previous suicidal ideation should have been conducted by mental health staff. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation. However, on the job training was provided to all involved custody and medical staff.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the registered nurse initially responded without proper medical equipment, the senior registered nurse experienced difficulty using equipment, outside law enforcement was not timely notified of the inmate's death, and a more thorough mental health assessment should have been conducted. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the hiring authority's response to the critical incident appropriate?

  The registered nurse failed to bring an automated external defibrillator to the cell, the senior registered nurse experienced difficulty using a resuscitator bag, and a lieutenant failed to timely notify outside law enforcement that the inmate had died. In addition, the mental health staff failed to conduct a thorough assessment in response to the inmate's previous suicidal ideation.

Incident Date	OIG Case Number	Case Type
2014-09-07	**14-2129-RO**	**In-Custody Inmate Death**

Incident Summary

On September 7, 2014, officers found an unresponsive inmate in the shower. Officers and nurses provided life-saving measures until an ambulance transported the inmate to an outside hospital. Shortly after arriving at the outside hospital, the inmate was pronounced dead.

Disposition

The autopsy established the cause of death to be hypertensive and atherosclerotic cardiovascular disease. The department's Death Review Committee determined that the inmate's death was possibly preventable, noting that the institution's medical providers did not follow the primary care model in treating the inmate for chronic health conditions. Therefore, the hiring authority provided training to all medical providers as it relates to following the primary care model on chronic care patients.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was not adequate because the department failed to notify the OIG in a timely and sufficient manner thereby preventing the OIG from real-time monitoring of the case. Additionally, the department did not provide a complete incident report to the OIG for more than two months after the incident. Finally, the department's Death Review Committee determined that the inmate's death was possibly preventable, noting that the institution's medical providers did not follow the primary care model in treating the inmate for chronic health conditions. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

NORTH REGION

Assessment Questions

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

  The institution did not provide incident reports to the OIG until two months after the incident, despite multiple requests from the OIG.

- Was the hiring authority's response to the critical incident appropriate?

  The institution's medical providers failed to follow the primary care model in treating the inmate for chronic health conditions.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until over two hours after the inmate died.

Incident Date	OIG Case Number	Case Type
2014-09-07	**14-2132-RO**	**Suicide**

Incident Summary

On September 7, 2014, officers found an unresponsive inmate hanging from the top bunk of his cell. Officers detected a pulse and summoned medical assistance. Nurses arrived and initiated life-saving measures which were unsuccessful. The inmate was pronounced dead.

Disposition

The county medical examiner determined that the death was due to hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for Investigation.

Overall Assessment

Rating: **Sufficient**

Although the department failed to timely notify the OIG, the department's response to the incident was otherwise sufficient. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-10-18	**14-2490-RO**	**Suicide**

Incident Summary

On October 18, 2014, an officer observed an inmate lying on his bunk with a towel draped over his bunk. The inmate was not responsive. The officer activated an alarm and additional officers responded. The inmate was unresponsive with a plastic bag tightly wrapped over his head. Officers and nurses initiated life-saving measures but the inmate was pronounced dead at the scene.

Disposition

The coroner determined the cause of death was suicide by asphyxia. Potential staff misconduct was identified based on the preliminary autopsy report indicating that there was insufficient evidence to determine the manner of death; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-10-25	**14-2528-RO**	**Contraband Watch**

Incident Summary

On October 25, 2014, the department placed an inmate on contraband surveillance watch after he told officers that he swallowed razor blades. After a medical evaluation, a physician ordered the inmate to be transported to an outside hospital for an x-ray to verify the presence of a foreign body. Medical staff at the outside hospital confirmed the presence of a foreign body and admitted the inmate for possible surgery to remove the object. The inmate returned to the institution on October 28, 2014, after it was determined that surgery was not necessary. Upon return to the institution, the inmate passed the razor blade and was removed from contraband surveillance watch.

NORTH REGION

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

Except for failure to timely notify the OIG, the department's response was otherwise satisfactory in all critical aspects. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-10-26	**14-2526-RO**	**In-Custody Inmate Death**

Incident Summary

On October 26, 2014, an officer saw an inmate packing his personal property but could not see his cellmate because he was completely covered on the bottom bunk. The inmate told the officer that his cellmate was dead. The officer instructed the inmate to pull back the covers from his cellmate and when he did, the officer observed the cellmate was unresponsive and had a bloody shirt. A sergeant and two additional officers responded and removed the first inmate from the cell. Two officers then moved the unresponsive inmate from the cell and initiated life-saving measures. The inmate had visible cuts to his throat and puncture wounds to his chest and stomach area. The inmate was pronounced dead after life-saving efforts failed.

Disposition

The coroner determined the manner of death was homicide and the cause of death was multiple sharp force injuries. The department conducted a review of the in-cell homicide which revealed that the inmates were appropriately housed in compliance with departmental policy. The department's Death Review Committee determined the death was not preventable. The department evaluated the medical response to the emergency and determined that the response was adequate. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-11-02	**14-2563-RO**	**Suicide**

Incident Summary

On November 2, 2014, as an inmate returned to his cell, he yelled that his cellmate was hanging in their cell. An officer responded and found the second inmate with an inmate-manufactured noose around his neck and tied to a vent. Officers entered the cell, cut the noose from the vent, moved the second inmate to the tier, and began life-saving measures which continued upon arrival of medical staff. The inmate was transported to the triage and treatment area where a physician pronounced the inmate dead.

Disposition

The autopsy determined the cause of death was asphyxiation due to hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-11-03	**14-2575-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On November 3, 2014, an inmate physically assaulted an officer in his assigned housing unit. The officer used physical force in an attempt to stop the inmate's assault; however, the inmate continued striking the officer. The inmate failed to comply with responding officers' orders to get down and assumed a combative stance. Officers deployed pepper spray and struck the inmate's leg once with a baton. The officer who was assaulted sustained facial injuries requiring treatment at an outside hospital. The inmate sustained a laceration on his head that required sutures.

NORTH REGION

Disposition

Potential staff misconduct was identified based on an officer's alleged use of unreasonable force during the incident and failure to accurately report the force used. Another officer allegedly failed to accurately report the force he observed. Therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because of alleged staff misconduct during and after the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  Two officers allegedly failed to document the force they used or observed.

- Was the hiring authority's response to the critical incident appropriate?

  An officer allegedly used unreasonable force and failed to document the force he used. A responding officer allegedly failed to document his observations of the force used.

Incident Date	OIG Case Number	Case Type
2014-11-10	**14-2634-RO**	**Other Significant Incident**

Incident Summary

On November 10, 2014, officers discovered an inmate on the roof of a building next to an exercise yard. The inmate was apprehended and admitted that he tried to escape.

Disposition

Potential staff misconduct was identified based on two officers' alleged failure to observe the inmate enter and move around in an out-of-bounds area; therefore, the hiring authority referred the case to the Office of Internal Affairs. OIA Central Intake returned the case to the hiring authority to take action, which the OIG did not accept for monitoring.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-11-11	**14-2633-RO**	**In-Custody Inmate Death**

Incident Summary

On November 11, 2014, officers responded to a request for assistance and observed an inmate having a seizure in his cell. Three nurses arrived and began performing life-saving measures. The inmate was transported by ambulance to an outside hospital where a physician pronounced the inmate dead.

Disposition

An autopsy determined that the inmate died from cardiac arrest. The department's Death Review Committee determined the death was not preventable. Potential staff misconduct was identified based on the failure of three nurses to bring proper equipment to the scene, failure to properly assess the inmate, and failure to identify signs of cardiac arrest. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG did not accept for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to appropriately respond to and document a medical emergency. The department also failed to make a timely decision regarding whether to refer the case to the Office of Internal Affairs. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

NORTH REGION

Assessment Questions

- 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 January 12, 2015, but the hiring authority did not refer the matter to the Office of Internal Affairs until March 12, 2015, 59 days after the date of discovery.

- Was the critical incident adequately documented?

  The responding nurses did not adequately document their actions on what medical procedures were performed during the incident.

- Was the hiring authority's response to the critical incident appropriate?

  Responding nurses failed to bring an automated external defibrillator to the cell where the inmate was having a cardiac arrest.

Incident Date	OIG Case Number	Case Type
2014-11-16	**14-2644-RO**	**In-Custody Inmate Death**

Incident Summary

On November 16, 2014, officers found an unresponsive inmate on the upper bunk of his cell, immediately started life-saving measures, and transported the inmate to the triage and treatment area. The life-saving measures were unsuccessful and the inmate was pronounced dead shortly thereafter.

Disposition

An autopsy determined that the cause of death was mild cardiomegaly with fibrosis. The department's Death Review Committee determined the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-12-07	**14-2828-RO**	**In-Custody Inmate Death**

Incident Summary

On December 7, 2014, an inmate yelled for assistance from his cell and reported that his cellmate was unresponsive. Two officers responded to the cell, ordered the cellmate to exit the cell, activated an alarm, entered the cell, and initiated life-saving measures on the unresponsive inmate. A nurse also responded and continued the life-saving measures. Outside emergency medical services responded and the inmate was declared dead. The investigative services unit searched the inmate's cell and discovered drug paraphernalia.

Disposition

An autopsy revealed the cause of death was acute methamphetamine and heroin intoxication. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-12-21	**14-2880-RO**	**Inmate Riot**

Incident Summary

On December 21, 2014, several wards participated in a riot in a housing unit at a juvenile facility. Officers used chemical agents including grenades and a pepper ball launcher to stop the riot. After the incident was under control, one of the wards reported being hit under his eye by a pepper ball. A nurse examined the ward and noted redness and minor bleeding to the area. The ward refused medical treatment and was returned to his housing unit.

NORTH REGION

Disposition

The facility's force review committee determined the use of force was in compliance with departmental policy; however, training was provided to officers in proper report writing. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-12-22	**14-2892-RO**	**PREA**

Incident Summary

On December 22, 2014, a non-departmental officer at a private contract facility allegedly told an inmate to take a shower so he could go into the control center and watch him. Later, the officer allegedly told the inmate to turn around so he could see his "pretty little face."

Disposition

The private contract facility conducted an inquiry into the allegations. The hiring authority at the private contract facility determined the allegations were unsubstantiated. Based on the failure to follow the appropriate departmental policies and procedures, the private contract facility trained its staff regarding the correct classification of Prison Rape Elimination Act cases.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to notify the OIG of the incident in a timely and sufficient manner. The department failed to correctly identify the matter as a Prison Rape Elimination Act case and follow appropriate protocols.

Assessment Questions

- 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 department incorrectly defined the incident as sexual harassment, not sexual misconduct. The OIG advised the department that this interpretation conflicts with the department's policies and procedures which define any sexual behavior between staff and inmates as sexual misconduct.

- Was the hiring authority's response to the critical incident appropriate?

  The department failed to correctly identify the matter as a Prison Rape Elimination Act case and follow appropriate protocols. The department also failed to timely notify the OIG regarding the incident.

- Was the OIG promptly informed of the critical incident?

  The department did not timely notify the OIG regarding the incident. Rather, the OIG learned of the incident from the department's daily briefing report.

Incident Date	OIG Case Number	Case Type
2014-12-25	**14-2891-RO**	**In-Custody Inmate Death**

Incident Summary

On December 25, 2014, officers observed an inmate in his cell bleeding from his mouth and nose. The inmate was transported to an outside hospital for a higher level of care. The inmate reported that the bleeding was caused by an ongoing medical condition and excluded his cellmate as the cause of any injury. The inmate remained at the outside hospital but died approximately eight hours later.

Disposition

The department's Death Review Committee concluded the inmate's death was unexpected and not preventable. The cause of death was determined to be hemorrhagic shock due to liver cirrhosis secondary to hepatitis. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

NORTH REGION

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-12-29	**14-2920-RO**	**In-Custody Inmate Death**

Incident Summary

On December 29, 2014, an inmate at an out-of-state institution fell backwards off the chair he was standing on to hang Christmas decorations in the dayroom, fell to the floor, and struck his head. Officers and nurses immediately arrived to assist the inmate. The inmate was unresponsive and was transported via ambulance to a local trauma center. The inmate died from his injuries on December 30, 2014.

Disposition

No department employee misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to timely notify the OIG of the incident. Department employees were not involved in the incident. Therefore, the OIG concurred with the decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The department did not timely notify the OIG regarding the incident.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified of the incident until over 21 hours after the inmate was pronounced dead.

Incident Date	OIG Case Number	Case Type
2015-01-06	**15-0122-RO**	**In-Custody Inmate Death**

Incident Summary

On January 6, 2015, a nurse observed an inmate fall to the ground as the inmate approached his cell door. Officers responded to the cell, conducted an emergency entry, and a nurse provided life-saving measures. The inmate was transported to the correctional treatment center and was subsequently pronounced dead after life-saving measures failed. On the previous day, the inmate had been involved in an altercation and sustained a puncture wound.

Disposition

An autopsy revealed the manner of death to be homicide. Potential physician misconduct was identified for failing to adequately and legibly document the medical examination and treatment after the inmate sustained a puncture wound. The physician was referred to peer review rather than the Office of Internal Affairs.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate. The department failed to notify the OIG of the inmate altercation and the injuries sustained the previous day. Medical records were sparse and illegible, calling into question the thoroughness of the examination and treatment. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

NORTH REGION

Assessment Questions

- Was the critical incident adequately documented?

  Physician's notes of the examination and treatment following the altercation were illegible and unclear and did not directly address the injuries the inmate sustained. Further, the physician failed to document consideration of whether alternative housing or a higher level of medical care were necessary.

- Was the OIG promptly informed of the critical incident?

  Although the department timely notified the OIG of the inmate's death, the department failed to notify the OIG of the inmate altercation and the injuries sustained the previous day.

Incident Date	OIG Case Number	Case Type
2015-03-11	**15-0528-RO**	**Suicide**

Incident Summary

On March 11, 2015, an officer discovered an inmate hanging by a noose made from a bed sheet tied to a fire suppression sprinkler in the ceiling. Officers entered the inmate's cell and cut the noose from around the inmate's neck. Officers began life-saving measures which were continued by officers and a nurse while the inmate was transported to the institution's triage and treatment area until outside emergency services arrived. The inmate was transported to an outside hospital via an ambulance and pronounced dead by a physician.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-03-26	**15-0744-RO**	**PREA**

Incident Summary

On March 26, 2015, an officer allegedly inappropriately stared at an inmate's genitals during an unclothed body search.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-02-08	**14-0363-RO**	**In-Custody Inmate Death**

Incident Summary

On February 8, 2014, a psychiatric technician discovered an unresponsive inmate in her cell. The psychiatric technician summoned an officer, a licensed vocational nurse, and a registered nurse, all of whom entered the cell and initiated life-saving measures. The inmate was taken to an outside hospital via ambulance where she was pronounced dead.

Disposition

The coroner determined that the manner of death was natural, caused by cardiovascular disease. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response was not adequate because the hiring authority failed to notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The hiring authority did not notify the OIG until more than three hours after the incident.

Incident Date	OIG Case Number	Case Type
2014-02-24	**14-0461-RO**	**Suicide**

Incident Summary

On February 24, 2014, inmates reported to officers that an inmate was hanging in her cell. The inmates entered the cell and when the first officer arrived, she saw the inmates holding up the other inmate as they were lowering her from the hanging position and instructed the inmates to place her on the floor. Officers and nurses initiated life-saving measures until outside emergency personnel arrived. The inmate was transported to an outside hospital and was later pronounced dead.

Disposition

The autopsy report determined the cause of death was hanging but the manner of death was undetermined primarily due to the lack of investigation. The department's Death Review Committee also determined the cause of death was asphyxia by hanging. Although potential staff misconduct was identified related to the poor investigation, the hiring authority did not refer the matter to the Office of Internal Affairs. The hiring authority implemented training and improved procedures to identify and secure potential crime scenes.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to timely notify the OIG of the incident and the investigative services unit failed to conduct an adequate and thorough investigation. The hiring authority failed to refer any potential misconduct to the Office of Internal Affairs prior to the deadline to take disciplinary action. The OIG did not concur with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

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

  Although potential staff misconduct was identified, the hiring authority failed to refer any conduct to the Office of Internal Affairs.

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

  Although potential staff misconduct was identified, the hiring authority failed to refer the matter to the Office of Internal Affairs prior to the deadline for taking disciplinary action.

- 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 failures of custody staff and the investigative services unit to properly preserve a potential crime scene and evidence.

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

  The department failed to adequately provide all requested witness interview reports and videotapes and failed to adequately respond to requests for information in a timely manner.

- Was the critical incident adequately documented?

  The incident report failed to identify all inmate witnesses and failed to identify how and when the cell door was opened. Although the initial investigative report stated that witness interviews occurred, the report failed to identify the witnesses and what they said. The incident scene photographs were also inadequate.

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

  The investigative services unit failed to identify or interview all of the involved inmates. One inmate who reportedly removed the hanging inmate from her noose was not interviewed. After the OIG pointed this out, the investigative services unit made a failed attempt to interview the involved inmate. The investigative services unit failed to determine who actually opened the cell door and when it was opened. When the OIG pointed out this issue, the investigative services unit stated the officer who was responsible for opening the cell door was unavailable. Further, the investigative services unit failed to take clear, adequate photos of the scene. Photos of the noose had to be retaken using an evidence placard since no evidence placards were used in the initial photos. In addition, no photos of the sink area below where the inmate was found hanging nor photos of the covering of the door window were taken. Finally, prior to the investigative services unit arriving on scene, custody staff failed to preserve the scene as many inmates had been in and out of the cell at the time of the incident.

- Was the hiring authority's response to the critical incident appropriate?

  Custody staff failed to obtain or report the names of the witnesses at the time of the incident. The first two officers to respond on scene stated they saw unknown inmates lifting the inmate out of the noose and other unidentified inmates standing in the area. However, the hiring authority failed to request clarifications regarding the witnesses or how the cell door was opened.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified of the incident until almost two hours after the inmate was pronounced dead.

Incident Date	OIG Case Number	Case Type
2014-07-08	**14-1593-RO**	**In-Custody Inmate Death**

Incident Summary

On July 8, 2014, officers responded to a cell after an inmate reported his cellmate was having a medical emergency. The officers discovered a second inmate unresponsive, lying on his bunk. After additional officers and nursing staff arrived, the second inmate was removed from the cell and custody and medical staff initiated life-saving measures. The second inmate was transported to the triage and treatment area where life-saving measures continued without success. There were no signs of trauma to either inmate but the first inmate was placed in administrative segregation in accordance with departmental policy.

SOUTH REGION

Disposition

The autopsy determined that the cause of death was acute heroin intoxication. The department's Death Review Committee determined the inmate's death was not preventable. Potential staff misconduct was identified based on the officers' alleged failure to timely provide medical aid to the inmate; therefore, the case was referred to the Office of Internal Affairs for investigation. The Office of Internal Affairs rejected the request for investigation based upon information received after the referral which indicated the officers adequately responded. The OIG concurred.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was not adequate because the institution failed to adequately document a review of the incident. Based on the information available at the time the matter was referred to the Office of Internal Affairs, the OIG concurred with the referral.

Assessment Questions

- Was the critical incident adequately documented?

  The institution was unable to provide documentation to show the incident was reviewed by the Emergency Medical Response Review Committee as required by departmental policy.

Incident Date	OIG Case Number	Case Type
2014-08-19	**14-2579-RO**	**PREA**

Incident Summary

On August 19, 2014, while officers executed a controlled use of force to administer court-ordered medication, the inmate screamed "rape" several times.

Disposition

Potential staff misconduct was identified based on the inmate's allegations of staff sexual assault. Therefore, the hiring authority referred the matter to the Office of Internal Affairs. After review, OIA Central Intake determined there was not a reasonable belief that misconduct occurred.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the hiring authority failed to identify the incident as a matter that should be referred to the Office of Internal Affairs. Therefore, the hiring authority failed to notify the Office of Internal Affairs and the OIG of the incident. The investigative services unit failed to adequately respond to the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

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

  The hiring authority did not initially refer the matter to the Office of Internal Affairs. It was only upon urging by the OIG that the hiring authority agreed to refer the matter.

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

  The incident occurred on August 19, 2014, but the hiring authority did not refer the matter to the Office of Internal Affairs until December 14, 2014, 117 days after 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 potential staff misconduct.

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

  The hiring authority failed to immediately identify this matter as a potential violation of the Prison Rape Elimination Act and, therefore, the investigative services unit did not respond at the time of the incident.

- Was the hiring authority's response to the critical incident appropriate?

  The hiring authority failed to recognize the potential violation of the Prison Rape Elimination Act requiring immediate attention and, therefore, did not appropriately respond. Once the OIG informed the hiring authority of the allegations, the hiring authority took appropriate measures to comply with departmental policy.

- Was the OIG promptly informed of the critical incident?

  The OIG was not informed of the incident. The OIG learned of the incident while reviewing a videotape of the use of force at the institution's executive review committee meeting on October 21, 2014, 63 days after the incident.

- Did the hiring authority timely notify the Office of Internal Affairs of the incident?

  The hiring authority did not identify the matter as a potential violation of the Prison Rape Elimination Act and, therefore, did not notify the Office of Internal Affairs.

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

  The hiring authority did not identify the case as requiring a referral to the Office of Internal Affairs under the Prison Rape Elimination Act. It was not until the OIG noted the sexual assault allegations that the hiring authority agreed to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-08-22	**14-2082-RO**	**Contraband Watch**

Incident Summary

On August 22, 2014, the department placed an inmate on contraband surveillance watch and transported him to an outside hospital after he informed officers he was suicidal and swallowed razor blades. On August 26, 2014, the inmate returned to the institution and, because of a lack of communication, the inmate was placed on mental health crisis bed status where mental health staff, but not custody staff, continuously observed the inmate. On August 27, 2014, the department removed the inmate from contraband surveillance watch after an x-ray did not show a foreign body. Between August 28, 2014 and September 15, 2014, the department twice placed and removed the inmate from contraband surveillance watch and transported him to an outside hospital due to complications from swallowing the razor blades. The department recovered nothing from the inmate.

Disposition

No staff misconduct was identified; therefore, the hiring authority did not refer the matter to the Office of Internal Affairs. However, the hiring authority provided training to all involved custody staff, including supervisors, and provided documented counseling to the two most culpable officers. In addition, to prevent communication failures in the future, the hiring authority amended the institution's local operating procedure to require notification to the watch commander whenever an inmate on contraband surveillance watch is relocated.

SOUTH REGION

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was inadequate because it failed to timely notify the OIG of the inmate's placement on contraband surveillance watch and transport to an outside hospital. The department failed to follow contraband surveillance watch procedures when the inmate returned from the hospital. Officers failed to continually observe the inmate for approximately 18 hours and the inmate's restraints were removed during some of that time. Finally, the department failed to issue letters of instruction to the involved officers because it misplaced the documentation. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 noted that contraband surveillance watch procedures were not followed upon the inmate's return from an outside hospital. The hiring authority implemented new policies and procedures and provided training and counseling to two of the officers involved.

- Was the critical incident adequately documented?

  The department failed to adequately document the inmate and restraint hygiene and supervisory checks while the inmate was on contraband surveillance watch.

- Was the hiring authority's response to the critical incident appropriate?

  The officers in the correctional treatment center were allegedly not aware of the inmate's contraband surveillance watch status; therefore, the inmate was not under constant observation by officers for approximately 18 hours. In addition, because the officers in the correctional treatment center were allegedly not aware of the inmate's contraband surveillance watch status, the inmate's restraints were removed for a period while he was in his cell. The investigative services unit conducted an administrative review of the incident but the memorandum submitted to the hiring authority did not sufficiently identify the staff members interviewed or statements obtained. Letters of instruction intended for three officers involved in the incident were not served because documentation was misplaced.

- Was the OIG promptly informed of the critical incident?

  The department did not notify the OIG until more than three hours after the inmate was transported to an outside hospital and placed on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2014-08-26	**14-2483-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On August 26, 2014, an inmate was housed in a cell with a second inmate known to the institution as using violence and fear to control and intimidate other inmates. The first inmate was in disfavor with the second inmate for not following the second inmate's order to attack a third inmate. In less than an hour of being housed together, the second inmate assaulted the first inmate. Officers heard screaming and discovered the second inmate holding the first inmate down against the floor. The officers saw an extensive amount of blood on both inmates and the floor, and ordered both inmates to stop fighting. The inmate being attacked complied with orders but an officer deployed pepper spray to force the second inmate to comply. The inmate being attacked sustained approximately 20 stab wounds and punctured lungs during the attack. The inmate was air-lifted to an outside hospital for treatment and returned to the institution approximately ten days later.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation. The department concluded in the in-cell assault review, that the inmates were appropriately housed but there were deficiencies in the documentation. The hiring authority provided training to involved custody staff.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to notify the OIG of the attack in a timely and sufficient manner thereby preventing the OIG from real-time monitoring. In addition, the department incorrectly determined the inmates were properly housed together as there was significant information available indicating the inmates should not have been double celled. The hiring authority failed to consult with the OIG prior to deciding to provide training for involved custody staff instead of referring the matter to the Office of Internal Affairs for investigation. The OIG did not concur with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

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

  The institution had significant information that the inmate aggressor was a threat to inmates on the yard and should not have been double celled. An investigation into how the error occurred would have been appropriate to identify potential misconduct.

- 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 potential staff misconduct.

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

  The department did not notify the OIG of the critical incident. Further, the department did not consult with the OIG before deciding to provide corrective action.

- Was the OIG promptly informed of the critical incident?

  The OIG did not receive notification of the incident.

Incident Date	OIG Case Number	Case Type
2014-09-19	**14-2253-RO**	**In-Custody Inmate Death**

Incident Summary

On September 19, 2014, an officer discovered an unresponsive inmate in his cell. Officers removed the inmate from the cell and initiated life-saving measures. Two registered nurses and a licensed vocational nurse arrived on scene and continued life-saving efforts as the inmate was transported to the triage and treatment area. Paramedics arrived on scene and pronounced the inmate dead.

Disposition

The coroner determined the manner of death was a heroin overdose. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response was inadequate because the investigative services unit failed to conduct an investigation into the origin of the heroin that caused the inmate's death. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The investigative services unit failed to conduct an investigation related to the source of the heroin that caused the inmate's death.

- Was the hiring authority's response to the critical incident appropriate?

  The institution failed to conduct an investigation related to the source of the heroin that caused the inmate's death.

Incident Date	OIG Case Number	Case Type
2014-11-20	**14-2671-RO**	**Contraband Watch**

Incident Summary

On November 20, 2014, the department placed an inmate on contraband surveillance watch after an officer suspected the inmate received drugs during visiting. Officers monitored telephone calls between the inmate and his spouse wherein it appeared that the two were using code words to suggest the introduction of drugs when the spouse was to visit the inmate. The monitored calls also revealed a connection to another inmate also suspected of attempting to bring drugs during visiting on the same day. The inmate was removed from contraband surveillance watch on November 22, 2015, two days later. The department recovered nothing from the inmate.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

SOUTH REGION

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-11-20	**14-2672-RO**	**Contraband Watch**

Incident Summary

On November 20, 2014, the department placed an inmate on contraband surveillance watch after an officer suspected the inmate had received drugs during visiting. Officers monitored telephone calls between the inmate and his spouse wherein it appeared the two were using code words to suggest the introduction of drugs when the spouse was to visit the inmate. The monitored calls also revealed a connection to another inmate also suspected of attempting to bring drugs during visiting on the same day. The inmate was removed from contraband surveillance watch on November 21, 2014, one day later. The department recovered nothing from the inmate.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-11-27	**14-2736-RO**	**In-Custody Inmate Death**

Incident Summary

On November 27, 2014, officers discovered an unresponsive inmate in his cell. Officers and nurses performed life-saving measures until outside medical personnel arrived at the institution and pronounced him dead.

Disposition

The autopsy determined that the manner of death was natural due to a kidney infection. The department's Death Review Committee determined the inmate's death was not preventable. Potential staff misconduct was identified based on the alleged failure of a physician and registered nurse to properly assess the inmate's condition and to properly document the treatment of the inmate and the alleged failure of two psychiatric technicians to timely provide treatment to the inmate when he reported abdominal pain. Therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened as to the physician and registered nurse, which the OIG did not accept for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was not adequate because medical staff allegedly failed to properly assess the inmate's condition, failed to timely provide treatment to the inmate after he reported abdominal pain, and failed to properly document their treatment. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 potential misconduct by a physician and registered nurse.

- Was the critical incident adequately documented?

  A physician and registered nurse allegedly failed to properly document their treatment.

- Was the hiring authority's response to the critical incident appropriate?

  The institution's response was not adequate because a physician and registered nurse allegedly failed to properly assess the inmate's condition and document their treatment. Two psychiatric technicians allegedly failed to timely respond to the inmate's report of abdominal pain.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-12-31	15-0049-RO	Contraband Watch

Incident Summary

On December 31, 2014, the department placed an inmate on contraband surveillance watch after officers observed him pull a bindle from his sock and swallow it. The department later transported him to an outside hospital due to a possible overdose. An x-ray revealed two possible foreign objects in the inmate's digestive tract. On January 2, 2015, the inmate returned to the institution in stable condition and was removed from contraband surveillance watch. No contraband was recovered.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the hiring authority provided training for the officers assigned to the incident regarding proper hygiene for inmates on contraband surveillance watch.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the inmate's placement on contraband surveillance watch. The department also failed to accurately document the contraband surveillance watch. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  The department's forms contained conflicting information related to the inmate's bowel movements and the chronology of events was not clearly articulated during the time the inmate was on contraband surveillance watch.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until nearly four hours after the inmate was placed on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2015-02-04	15-0321-RO	Contraband Watch

Incident Summary

On February 4, 2015, the department placed an inmate on contraband surveillance watch after he failed to clear a metal detector. On February 7, 2015, a supervising nurse determined the inmate needed to be transported to an outside hospital for a higher level of care. While the inmate was at the hospital, he produced a bowel movement containing an inmate-manufactured weapon. The inmate was removed from contraband surveillance watch the following day and returned to the institution on February 9, 2015.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the hiring authority identified documentation deficiencies during a self-audit and provided training to involved officers and supervisors.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to document that a medical assessment was conducted prior to placing the inmate on contraband surveillance watch. The department also failed to adequately document required information on the contraband surveillance watch forms. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

- Was the critical incident adequately documented?

  The department failed to document that a medical assessment was conducted prior to placing the inmate on contraband surveillance watch. In addition, documentation specific to hand and restraint hygiene, trash removal, range of motion exercises, cell hygiene, and issuance of a blanket was inadequate.

- Was the hiring authority's response to the critical incident appropriate?

  The department failed to document that a medical assessment of the inmate was conducted when he was placed on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2015-02-25	**15-0437-RO**	**In-Custody Inmate Death**

Incident Summary

On February 25, 2015, an officer discovered an unresponsive inmate on the floor of his cell. An officer and a registered nurse initiated life-saving measures. The inmate was transported to an outside hospital where a physician pronounced him dead.

Disposition

The coroner noted during the autopsy that the inmate's death was caused by heart disease. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-02-28	**15-0590-RO**	**Contraband Watch**

Incident Summary

On February 28, 2015, the department placed an inmate on contraband surveillance watch after officers observed him swallow suspected contraband from a bag of potato chips and located a bindle of heroin in the bag. The inmate informed nurses that he swallowed three bindles of heroin. A physician determined the inmate needed a higher level of care. The inmate was transported to an outside hospital where the department recovered three bindles of heroin from the inmate. On March 1, 2015, the inmate was released from contraband surveillance watch and returned to the institution.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, training was provided to an associate warden, lieutenants, and a sergeant to address the documentation deficiencies that occurred while the inmate was at the hospital on contraband surveillance watch.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was not adequate because it failed to timely notify the OIG when the inmate was placed on contraband surveillance watch and failed to notify the OIG when the inmate was transported to an outside hospital. In addition, the department failed to adequately document the inmate's activities while he was on contraband surveillance watch at the hospital. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

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

  The department failed to notify the OIG that the inmate was sent to an outside hospital.

- Was the critical incident adequately documented?

  The department failed to adequately document the inmate's activities while the inmate was on contraband surveillance watch.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until nearly three hours after the inmate was placed on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2015-03-01	**15-0553-RO**	**Contraband Watch**

Incident Summary

On March 1, 2015, the department placed an inmate on contraband surveillance watch after officers observed him swallowing suspected narcotics. The inmate was transported and admitted to an outside hospital after he exhibited symptoms of a drug overdose. The inmate tested positive for amphetamines and opiates, but no contraband was recovered. On March 3, 2014, the inmate was removed from contraband surveillance watch and returned to the institution.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, training was provided to an associate warden, lieutenants, and a sergeant regarding the contraband surveillance watch protocols while an inmate is at an outside hospital.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was not adequate. The department failed to notify the OIG that the inmate was sent to an outside hospital and failed to timely notify the OIG when the inmate was removed from contraband surveillance watch. In addition, the department failed to maintain adequate documentation of the contraband watch incident while the inmate was at the outside hospital. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 several deficiencies in the documentation of the contraband surveillance watch incident that were not discovered by the department in its self-audit. The OIG addressed the issues with an associate warden who reviewed the incident documentation and agreed with the OIG. Training was provided to another associate warden, a captain, lieutenants, and sergeants who were responsible for reviewing the documentation and ensuring that officers followed the policy.

- Was the critical incident adequately documented?

  The department failed to adequately document inmate and restraint hygiene and supervisory checks. In addition, there were significant gaps in time on the required documentation while the inmate was at the outside hospital.

- Was the OIG promptly informed of the critical incident?

  The department failed to notify the OIG when the inmate was sent to an outside hospital and failed to notify the OIG that the inmate was removed from contraband surveillance watch until the following day.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-03-01	15-0554-RO	Contraband Watch

Incident Summary

On March 1, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate place an unknown object in his mouth. Due to medical complications, the inmate was transported to an outside hospital where he produced a bowel movement containing heroin bindles. The inmate returned to the institution on March 4, 2015, and was removed from contraband surveillance watch two days later after he produced four bowel movements which did not contain contraband.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to notify the OIG that the inmate was sent to an outside hospital while on contraband surveillance watch. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The department failed to notify the OIG that the inmate was transported to an outside hospital while on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2015-03-11	15-0555-RO	Contraband Watch

Incident Summary

On March 11, 2015, the department placed an inmate on contraband surveillance watch after officers observed him swallow suspected drugs. Prior to being placed in an isolated setting, the inmate complained of abdominal pain and admitted that he swallowed heroin. The inmate was transported and admitted to an outside hospital where he produced a bowel movement containing a bindle of heroin. The inmate returned to the institution the following day and was removed from contraband surveillance watch.

Disposition

After the OIG inquired about the lack of discipline imposed on the inmate for possessing narcotics, the department discovered that the recovered evidence had not been submitted for testing, a prerequisite to the disciplinary process. Based on the OIG's inquiry, the department submitted the evidence and the hiring authority is modifying its local operating procedure to include weekly evidence audits by the investigative services unit. Additionally, the department's headquarters unit reviewed the contraband surveillance watch incident and recommended to the institution that specific documentation be initiated, even in circumstances where an inmate is transferred to an outside hospital. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the inmate's placement on contraband surveillance watch and failed to initiate contraband surveillance watch protocols after the decision was made to transport the inmate to an outside hospital. In addition, the department failed to follow evidence protocols with the suspected narcotics recovered from the inmate. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

- 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 inquired about the lack of discipline imposed on the inmate for possession of the suspected heroin and discovered that the department had not submitted the recovered evidence for testing. To avoid future errors, the department is modifying a local operating procedure to include more frequent evidence audits by a supervisor.

- Was the critical incident adequately documented?

  The department transported the inmate to an outside hospital prior to placing the inmate in an isolated setting; therefore, the required contraband surveillance watch documents were not initiated. During an audit, the department's headquarters unit recommended that the required documents be completed in future incidents.

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

  The department failed to timely submit the recovered narcotics to the Department of Justice for testing, thereby delaying the inmate disciplinary process. Nearly three months after the incident, the OIG inquired about the lack of discipline imposed on the inmate and the investigative services unit discovered that the evidence had inadvertently not been submitted for testing.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until nearly 90 minutes after the inmate was placed on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2015-03-17	**15-0573-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On March 17, 2015, officers found an unresponsive inmate in his cell. The inmate was foaming at the mouth but still breathing. The inmate was taken to an outside hospital and placed on a ventilator. It was determined the inmate had heroin and methamphetamine in his system. The inmate regained consciousness several weeks later.

Disposition

No staff misconduct was identified; therefore the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner thereby preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until three hours after the inmate was found unconscious in his cell.

Incident Date	OIG Case Number	Case Type
2015-04-30	**15-0952-RO**	**Hunger Strike**

Incident Summary

On April 30, 2015, in order to protest his conviction, an inmate began refusing meals. On May 11, 2015, the inmate was transported to an outside hospital due to dehydration concerns and consumed a meal, thereby ending his hunger strike. The inmate returned to the institution the same day in stable condition.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

SOUTH REGION

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-05-05	**15-0894-RO**	**Other Significant Incident**

Incident Summary

On May 5, 2015, inmates alerted an officer that an inmate had cut herself. The officer responded and discovered the inmate bleeding from a cut to her forearm. Nurses responded and provided first aid. The inmate was transported to an outside hospital where she received five sutures to her arm. She later returned to the institution and was placed on mental health crisis status.

Disposition

Although initially reported to the OIG as an attempted suicide, mental health providers evaluated the inmate and determined the inmate's actions did not constitute an attempted suicide. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Sufficient**

Other than the department's failure to timely notify the OIG that the inmate sustained the serious injury, the department's response to the incident was otherwise adequate. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-05-10	**15-0926-RO**	**Contraband Watch**

Incident Summary

On May 10, 2015, the department placed an inmate on contraband surveillance watch after officers observed a latex object protruding from the inmate's anal cavity during an unclothed body search. After exhibiting signs of an overdose, the inmate was transported to an outside hospital where he was admitted to the intensive care unit. On May 11, 2015, the department recovered marijuana and heroin from the inmate and removed him from contraband surveillance watch. The inmate returned to the institution on May 20, 2015.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Other than the department's failure to timely notify the OIG that the inmate was placed on contraband surveillance watch, the department's response to the incident was otherwise adequate. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2015-05-10	**15-0994-RO**	**Contraband Watch**

Incident Summary

On May 10, 2015, the department placed an inmate on contraband surveillance watch after an officer saw the inmate place an unknown object in his mouth. On May 13, 2015, the inmate produced a bowel movement containing four bindles of heroin and methamphetamine. The inmate complained of nausea and dizziness and was transported to an outside hospital. The inmate returned to the institution the same day and was removed from contraband surveillance watch.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-05-17	**15-1013-RO**	**Contraband Watch**

Incident Summary

On May 17, 2015, an inmate told an officer that he swallowed a razor blade. The inmate was evaluated at the triage and treatment area, then transported to an outside hospital where the department placed the inmate on contraband surveillance watch after an x-ray confirmed the presence of a razor blade. On May 18, 2015, the inmate produced a bowel movement containing a razor blade, was removed from contraband surveillance watch, and returned to the institution.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

APPENDIX F 46
CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-12-24	**2014-12-25**	**Suspicious Activity**	**Other**

Incident Summary 14-14331-CW

On December 24, 2014, the department placed an inmate on contraband surveillance watch after the inmate told an officer that he swallowed a razor blade. After an x-ray confirmed a razor blade was embedded in the inmate's colon, he was transported to an outside hospital. The department removed the inmate from contraband surveillance watch on December 25, 2014 after a surgeon successfully recovered the razor blade.The inmate was returned to the institution two days later.

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
2015-01-04	**2015-01-07**	**Suspected Drugs**	**Nothing**

Incident Summary 15-14451-CW

On January 4, 2015, the department placed an inmate on contraband surveillance watch after officers observed a prophylactic protruding from the inmate's rectum following a visiting session. The inmate also later failed to clear a metal detector. The inmate was removed from contraband surveillance watch on January 7, 2015. During that time, the department recovered no contraband from the inmate.

Incident Assessment Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. An officer allegedly did not properly observe the inmate while the inmate was on contraband watch and, therefore, the inmate may have had an opportunity to dispose of contraband. The hiring authority referred the matter to the Office of Internal Affairs for investigation. The OIG concurred with the decision.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-02-28	**2015-03-02**	**Suspected Drugs**	**Nothing**

Incident Summary 15-14871-CW

On February 28, 2015, the department placed an inmate on contraband surveillance watch after the inmate told an officer that he swallowed a methamphetamine bindle and that it may have burst. The inmate was taken to an outside hospital for a suspected drug overdose. A CT scan revealed a dense area in the stomach that appeared to represent drugs, but did not reveal any other foreign object. After three days, the inmate was removed from contraband surveillance watch and returned to the institution. The department recovered no contraband 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
2015-03-22	**2015-03-26**	**Suspected Drugs**	**Drugs**

Incident Summary 15-14979-CWRM

On March 22, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallowing several bindles of suspected drugs concealed in a burrito wrapper during a visit. The inmate was removed from contraband surveillance watch on March 26, 2015, four days later. 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
2015-03-24	**2015-03-31**	**Suspected Drugs**	**Nothing**

Incident Summary 15-14980-CWRM

On March 24, 2015, the department placed an inmate suspected of trafficking drugs on contraband surveillance watch after an officer observed the inmate place an unknown object wrapped in cellophane into his mouth and swallow it. The inmate was removed from contraband surveillance watch on March 31, 2015, seven days later. During that time, the department recovered nothing 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
2015-04-15	**2015-04-19**	**Suspected Tobacco**	**Drugs**

Incident Summary 15-15001-CWRM

On April 15, 2015, the department placed an inmate on contraband surveillance watch because officers suspected the inmate was concealing tobacco. The inmate was removed from contraband surveillance watch on April 19, 2015, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Sufficient

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-05-17	**2015-05-20**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15036-CWRM

On May 17, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate retrieve an unknown object, put his hand down the front of his pants, and appear to manipulate the object as if trying to insert the object into his anal cavity. The inmate was removed from contraband surveillance watch on May 20, 2015, three days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. The department extended contraband surveillance watch beyond 72 hours without the required approval, failed to regularly document hygiene, and could not locate an initial medical assessment report the institution advised had been completed.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-05-27	**2015-05-28**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15042-CW

On May 27, 2015, the department placed an inmate on contraband surveillance watch after he failed to clear the metal detector. Prior to beginning contraband surveillance watch, the inmate was placed in a holding cell for over ten hours with 15 minute checks by an officer. After ten hours in the holding cell, as officers were escorting the inmate to be placed on contraband surveillance watch, the inmate told officers he did not have any contraband. The inmate cleared the metal detector, but was placed on contraband surveillance watch as a precaution. The inmate was removed from contraband surveillance watch on May 28, 2015, one day later. During that time, the department recovered nothing.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to obtain the appropriate signatures required when hand isolation devices are used and failed to tape the inmate's clothing as required. The OIG identified the above deviations from policy and presented them to the department. The department provided training as a result of these deficiencies.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-12-18	**2014-12-21**	**Suspicious Activity**	**Nothing**

Incident Summary 14-14261-CWRM

On December 18, 2014, the department placed an inmate on contraband surveillance watch after an officer observed a clear lubricant around the inmate's anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on December 21, 2014, three days later. During that time, the department recovered nothing 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
2015-01-13	**2015-01-17**	**Suspected Drugs**	**1. Drugs** **2. Inmate Note**

Incident Summary 15-14481-CWRM

On January 13, 2015, the department placed an inmate on contraband surveillance watch because during a clothed body search, officers observed the inmate swallow an object. The inmate was removed from contraband surveillance watch on January 17, 2015, four days later. During that time, the department recovered three inmate notes and 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
2015-01-18	**2015-01-23**	**Suspicious Activity**	**Nothing**

Incident Summary 15-14511-CWRM

On January 18, 2015, the department placed an inmate on contraband surveillance watch after a sergeant observed a clear lubricant on the inmate's rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on January 23, 2015, five days later. During that time, the department recovered nothing 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
2015-02-26	**2015-03-06**	**Suspicious Activity**	**Inmate Note**

Incident Summary 15-14831-CWRM

On February 26, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an unknown object. The inmate was removed from contraband surveillance watch on March 6, 2015, eight days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. During an on-scene review, the inmate reported to the OIG that two days prior, he informed an officer that he needed to urinate but after waiting over 40 minutes, urinated on himself. An inquiry determined the officer requested assistance to remove the inmate's restraints but there was a delay in the response. As a result of the inquiry, training was provided to advise the officer that if he does not receive timely assistance, he could remove the hand isolation device without removing the inmate's restraints to allow the inmate to urinate.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-02-26	**2015-03-03**	**Suspected Drugs**	**Drugs**

Incident Summary 15-14841-CWRM

On February 26, 2015, the department placed an inmate on contraband surveillance watch after receiving information the inmate was in possession of drugs. The inmate was removed from contraband surveillance watch on March 3, 2015, five days later. 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
2015-02-26	**2015-03-03**	**Suspected Drugs**	**Nothing**

Incident Summary 15-14851-CWRM

On February 26, 2015, the department placed an inmate on contraband surveillance watch after receiving information that the inmate was in possession of drugs. The inmate was removed from contraband surveillance watch on March 3, 2015, five days later. During that time, the department recovered nothing 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
2015-03-11	**2015-03-16**	**Suspicious Activity**	**Inmate Note**

Incident Summary 15-14964-CWRM

On March 11, 2015, the department placed an inmate on contraband surveillance watch after an officer observed lubricant around the inmate's anal cavity and a cylinder-shaped object in his mouth during an unclothed body search. The inmate was suspected of swallowing the object. The inmate was removed from contraband surveillance watch on March 16, 2015, five 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
2015-03-15	**2015-03-24**	**Suspicious Activity**	**Drugs**

Incident Summary 15-14972-CWRM

On March 15, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate take a drink from another inmate's cup and walk away. After drinking from the cup, the inmate appeared to be having difficulty swallowing as though he wasn't simply swallowing liquid. The inmate was removed from contraband surveillance watch on March 24, 2015, nine days later. 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.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-03-16	**2015-03-21**	**Suspicious Activity**	**Nothing**

Incident Summary

15-14973-CWRM

On March 16, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an unknown object during a clothed body search. The inmate was removed from contraband surveillance watch on March 21, 2015, five days later. During that time, the department recovered nothing 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
2015-03-17	**2015-03-24**	**Suspicious Activity**	**Inmate Note**

Incident Summary

15-14974-CWRM

On March 17, 2015, an inmate was placed on contraband surveillance watch after an officer observed him swallowing a white round object wrapped in plastic. The inmate was removed from contraband surveillance watch on March 24, 2015, seven days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. Medical assessments were not conducted and the inmate was not timely released from contraband surveillance watch. The department also failed to timely complete self-audit documentation. The institution revised its post orders for first, second, and third watch and provided training to the medical staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-03-27	**2015-03-30**	**Suspicious Activity**	**Inmate Note**

Incident Summary

15-14981-CWRM

On March 27, 2015, the department placed an inmate on contraband surveillance watch after a counselor observed the inmate swallow two bindles of suspected contraband during a routine search. The inmate was removed from contraband surveillance watch on March 30, 2015, three days later. During that time, the department recovered three inmate notes from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to timely notify the OIG of the inmate's placement on contraband surveillance watch. Additionally, the department failed to properly document hygiene, cell searches, blanket issuance and removal, and range of motion. The department provided training to address these deficiencies.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-03-29	**2015-04-02**	**Suspicious Activity**	**Nothing**

Incident Summary

15-14985-CWRM

On March 29, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate placing an item wrapped in clear plastic into his mouth. The inmate was removed from contraband surveillance watch on April 2, 2015, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The inmate was not timely removed from contraband surveillance watch and the policy for documenting the use of leg restraints was not followed. The department provided training as a result of these deficiencies and medical staff have revised the current practice to ensure that medical assessments are conducted.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-04-06	**2015-04-10**	**Suspected Weapons**	**Weapons**

Incident Summary

15-14994-CWRM

On April 6, 2015, the department placed an inmate on contraband surveillance watch after the inmate informed medical staff that he ingested a razor blade. An x-ray confirmed a foreign metal object. The inmate was removed from contraband surveillance watch on April 10, 2015, four days later. During that time, the department recovered the razor blade 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
2015-04-06	**2015-04-11**	**Suspected Drugs**	**Weapons**

Incident Summary

15-14995-CWRM

On April 6, 2015, the department placed an inmate on contraband surveillance watch after an x-ray, conducted during treatment of injuries sustained in a fight with another inmate, confirmed the presence of a foreign object in the inmate's lower intestine. The inmate was removed from contraband surveillance watch on April 11, 2015, five days later. During that time, the department recovered a weapon 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
2015-04-06	**2015-04-10**	**Suspicious Activity**	**1. Drugs** **2. Inmate Note** **3. Tobacco** **4. Weapons**

Incident Summary 15-14996-CWRM

On April 6, 2015, the department placed an inmate on contraband surveillance watch after he resisted during a random clothed body search and swallowed an object that had been concealed in his fist. The inmate was removed from contraband surveillance watch on April 10, 2015, four days later. During that time, the department recovered a weapon, an inmate note, tobacco, and 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
2015-04-13	**2015-04-17**	**Suspicious Activity**	**1. Drugs** **2. Inmate Note**

Incident Summary 15-14999-CWRM

On April 13, 2015, the department placed an inmate on contraband surveillance watch after an officer observed lubricant around the inmate's anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on April 17, 2015, four days later. During that time, the department recovered inmate notes, suspected heroin, and marijuana from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-04-18	**2015-04-21**	**Suspicious Activity**	**Drugs**

Incident Summary 15-15006-CWRM

On April 18, 2015, the department placed an inmate on contraband surveillance watch after officers saw an unidentified object protruding from the inmate's anal cavity during an unclothed body search. The object fell to the ground during the search. The inmate was removed from contraband surveillance watch on April 21, 2015, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment Sufficient

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-04-19	**2015-04-23**	**Suspicious Activity**	**Drugs**

Incident Summary 15-15007-CWRM

On April 19, 2015, the department placed an inmate on contraband surveillance watch after he was observed swallowing an unknown object during visiting. The inmate was removed from contraband surveillance watch on April 23, 2015, four days later. 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.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-05-03	**2015-05-08**	**Suspicious Activity**	**Nothing**

Incident Summary 15-15024-CWRM

On May 3, 2015, the department placed an inmate on contraband surveillance watch after an officer observed lubricant around the inmate's anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on May 8, 2015, five days later. During that time, the department recovered nothing 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
2015-05-10	**2015-05-15**	**Suspicious Activity**	**Nothing**

Incident Summary 15-15030-CWRM

On May 10, 2015, an inmate was placed on contraband surveillance watch after officers, during an unclothed body search following visiting, observed the inmate swallow a balloon. The inmate was removed from contraband surveillance watch on May 15, 2015, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment Sufficient

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-05-14	**2015-05-19**	**Suspicious Activity**	**Inmate Note**

Incident Summary 15-15034-CWRM

On May 14, 2015, the department placed an inmate on contraband surveillance watch after an officer observed him swallow three bindles. The inmate was removed from contraband surveillance watch on May 19, 2015, five 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
2015-05-18	**2015-05-23**	**Suspicious Activity**	**1. Inmate Note** **2. Weapons**

Incident Summary 15-15037-CWRM

On May 18, 2015, the department placed an inmate on contraband surveillance watch after he failed to pass a metal detector during a search. The inmate was removed from contraband surveillance watch on May 23, 2015, five days later. During that time, the department recovered inmate notes and a weapon 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
2015-05-29	**2015-06-02**	**Suspected Weapons**	**Nothing**

Incident Summary 15-15044-CWRM

On May 29, 2015, the department placed an inmate on contraband surveillance watch after the inmate reported that he had swallowed a razor blade. The inmate was removed from contraband surveillance watch on June 2, 2015, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment Insufficient

The department's response was not adequate because it did not provide sufficient justification or obtain appropriate approvals prior to placing the inmate in leg restraints and hand isolation devices. The institution agreed to change its local policy to require that appropriate authorization is obtained for use of leg restraints and hand isolation devices for every inmate placed on contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-05-29	**2015-06-03**	**Suspected Mobile Phone**	**1. Drugs** **2. Inmate Note** **3. Weapons**

Incident Summary 15-15045-CWRM

On May 29, 2015, the department placed an inmate on contraband surveillance watch based on confidential information received from outside law enforcement indicating the inmate may be concealing contraband. The inmate was removed from contraband surveillance watch on June 3, 2015, five days later. During that time, the department recovered drugs, inmate notes, and a weapon 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
2015-06-11	**2015-06-17**	**Suspicious Activity**	**Drugs**

Incident Summary 15-15060-CWRM

On June 11, 2015, the department placed an inmate on contraband surveillance watch after officers observed lubricant around the inmate's anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on June 17, 2015, six days later. During that time, the department recovered suspected 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
2015-06-12	**2015-06-15**	**Suspicious Activity**	**Nothing**

Incident Summary 15-15061-CWRM

On June 12, 2015, an inmate was placed on contraband surveillance watch after custody staff observed the inmate placing an unknown object into his mouth as they approached his cell to conduct a cell search. The inmate was removed from contraband surveillance watch on June 15, 2015, three days later. During that time, the department recovered nothing 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
2014-08-22	**2014-08-27**	**Suspected Weapons**	**Nothing**

Incident Summary

14-12851-CWRM

On August 22, 2014, the department placed an inmate on contraband surveillance watch after the inmate stated he was suicidal and swallowed two razor blades. The institution transferred the inmate to an outside hospital and continued contraband surveillance watch. While at the hospital, an x-ray confirmed the presence of two objects resembling razor blades. The hospital discharged the inmate on August 26, 2014, following which the institution placed the inmate on suicide watch. The inmate was removed from contraband surveillance watch on August 27, 2014, five days later after a negative x-ray. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to timely notify the OIG of the inmate's placement on contraband surveillance watch and transport to an outside hospital. The department failed to follow contraband surveillance watch procedures when the inmate returned from the hospital. Officers failed to continually observe the inmate for approximately 18 hours and the inmate's restraints were removed during some of that time. Finally, the department failed to issue letters of instruction to the involved officers because it misplaced the documentation. However, the hiring authority provided training to all involved custody staff, including supervisors, and provided documented counseling to the two most culpable officers. The hiring authority also amended the institution's local operating procedure to require notification to the watch commander whenever an inmate on contraband surveillance watch is relocated.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-11-24	**2014-11-30**	**Suspected Weapons**	**Nothing**

Incident Summary

14-14091-CWRM

On November 24, 2014, the department placed an inmate on contraband surveillance watch after an officer observed lubricant around the inmate's anal cavity and found a weapon in his cell. The inmate was removed from contraband surveillance watch on November 30, 2014, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. Nursing staff failed to conduct required medical assessments. In addition, the department misplaced the inmate's contraband watch file containing required documentation of the inmate's daily activities; therefore, the OIG could not complete an accurate assessment of the department's response to the incident. The department conducted an institution-wide search but was not able to locate the file. The hiring authority counseled the lieutenant responsible for the lost file.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-01-13	**2015-01-17**	**Suspected Drugs**	**Nothing**

Incident Summary

15-14491-CWRM

On January 13, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow a bindle of suspected drugs. The inmate was removed from contraband surveillance watch on January 17, 2015, four days later. During that time, the department recovered nothing 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
2015-03-01	**2015-03-06**	**Suspected Drugs**	**Drugs**

Incident Summary 15-14881-CWRM

On March 1, 2015, the department placed an inmate on contraband surveillance watch after officers observed him placing a bindle of suspected drugs into his mouth and swallowing it. The inmate was removed from contraband surveillance watch on March 6, 2015, five days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch because it failed to notify the OIG that the inmate was transported to an outside hospital. In its self-audit, the department identified the failure to consistently document that the inmate was afforded hand hygiene prior to meals and after using the restroom. The department provided training to the involved officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-03-15	**2015-03-20**	**Suspected Drugs**	**Drugs**

Incident Summary 15-14971-CWRM

On March 15, 2015, the department placed an inmate on contraband surveillance watch after he was observed removing an unknown object from his anal cavity and swallowing it. The inmate was removed from contraband surveillance watch on March 20, 2015, five days later. 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
2015-04-16	**2015-04-20**	**Suspected Weapons**	**Nothing**

Incident Summary 15-15005-CWRM

On April 16, 2015, the department placed an inmate on contraband surveillance watch after he swallowed a razor blade. The inmate was removed from contraband surveillance watch on April 20, 2015, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment Insufficient

The department did not sufficiently comply with contraband surveillance watch policies and procedures. Specifically, the department failed to adequately document inmate bowel movements, supervisory checks, and inmate hygiene. The department provided an officer with a written record of counseling for failing to document a bowel movement and other required information. Three sergeants and two officers were provided training to address other documentation inadequacies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-04-18	**2015-04-23**	**Suspected Weapons**	**Inmate Note**

Incident Summary 15-15009-CWRM

On April 18, 2015, the department placed an inmate on contraband surveillance watch after receiving information that the inmate was in possession of a weapon. The inmate was removed from contraband surveillance watch on April 23, 2015, five days later. During that time, the department recovered an inmate note 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
2015-04-24	**2015-04-28**	**Suspicious Activity**	**Nothing**

Incident Summary

15-15016-CWRM

On April 24, 2015, the department placed an inmate on contraband surveillance watch after officers observed lubricant around the inmate's anal cavity during an unclothed search. The inmate was removed from contraband surveillance watch on April 28, 2015, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to sufficiently comply with contraband surveillance watch policies and procedures. The department failed to document required medical assessments. Training was provided to nursing and custody staff. The department identified the failure to timely remove the inmate's blanket and inadequate documentation of the inmate's activities in its self-audit and provided training to the officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-04-24	**2015-04-28**	**Suspicious Activity**	**Nothing**

Incident Summary

15-15017-CWRM

On April 24, 2015, the department placed an inmate on contraband surveillance watch after officers observed lubricant around the inmate's anal cavity during an unclothed search. The inmate was removed from contraband surveillance watch on April 28, 2015, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to sufficiently comply with contraband surveillance watch policies and procedures. The department failed to document required medical assessments of the inmate. The department provided training to officers and nurses regarding the requirement. During a self-audit, the department identified deficiencies in the documentation related to hand hygiene and the removal of the inmate's blanket. The department provided training to the officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-04-29	**2015-05-04**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15020-CWRM

On April 29, 2015, the department placed an inmate on contraband surveillance watch after the inmate claimed he swallowed a razor blade. The inmate was removed from contraband surveillance watch on May 4, 2015, five days later. During that time, the department recovered nothing 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
2015-05-10	**2015-05-13**	**Suspected Drugs**	**Drugs**

Incident Summary

15-15031-CWRM

On May 10, 2015, the department placed an inmate on contraband surveillance watch after he was observed during visiting placing an unknown object into his mouth. The inmate was removed from contraband surveillance watch on May 13, 2015, three days later. 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.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-05-11	**2015-05-17**	**Suspicious Activity**	**Other**

Incident Summary

15-15032-CWRM

On May 11, 2015, an inmate was placed on contraband surveillance watch after he was observed swallowing pieces of his intravenous tubing and an x-ray confirmed the presence of several foreign objects in the inmate's body. The inmate was removed from contraband surveillance watch on May 17, 2015, six days later. During that time, the department recovered three pencils, two pieces of metal, and pieces of plastic and wire wrapped in plastic from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

SEMI-ANNUAL REPORT

January–June 2015

Volume II

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STATE OF CALIFORNIA
September 2015