Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

July – December 2015

Volume II

March 2016

Fairness ◆ Integrity ◆ Respect ◆ Service ◆ Transparency

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Foreword

This 22nd Semi-Annual Report covers the time period July through December 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, CDCR's adherence to its contraband surveillance watch policy, and the department's response to the OIG's field inquiries. Since each of these activities is monitored on an ongoing basis, they are combined into one report that is published every six months in this two-volume Semi-Annual Report.

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

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

VOLUME II

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Summary of Other Monitoring Activities

In addition to the Office of the Inspector General's monitoring of the employee discipline process within the California Department of Corrections and Rehabilitation (CDCR or the department), reported in Volume I, the Office of the Inspector General (OIG) also monitors critical incidents, use-of-force incidents, and contraband surveillance watch cases, and conducts field inquiries. The OIG 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.

The OIG also monitors and reports 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.

When CDCR suspects that an inmate has secreted contraband within the inmate's body, the department may place the inmate on contraband surveillance watch. Throughout the reporting period, the OIG collects data about the department's use of contraband surveillance watch, with special focus on cases exceeding 72 hours. The reader will find a report of the department's use of contraband surveillance watch in Appendix F.

Finally, the OIG provides a process by which inmates, CDCR staff, and the public can report misconduct or lodge complaints. The OIG examines complaints and assigns staff to conduct field inquiries regarding the complaints at the institutions. On July 1, 2015, the OIG began to collect data regarding CDCR's response to OIG's inquiries. Field inquiry cases are reported in Appendix G.

Critical Incidents

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

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,

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

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 investigation.

During this reporting period, the OIG completed assessments of 98 critical incidents (Appendices D and E), ten of which are full investigations of deadly force incidents. Those ten incidents are not included in the critical incident statistics, but the OIG's assessments can be found in Appendix D2. 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 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. The OIG rated 59 critical incident cases insufficient. The OIG's rating system considers the department's actions prior to the incident, during the incident, and after the incident. Each incident is rated on all three phases and may be sufficient or insufficient in more than one phase. The OIG found the department's actions insufficient in only one phase in 34 cases. Eighteen cases had insufficient ratings in two phases, and seven cases were insufficient in all three phases. In this reporting period, 17 cases (19 percent) were insufficient solely or partially due to late notification of the OIG. 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 of 39 percent of the critical incidents. However, the case was only marked insufficient if the late notification interfered with the OIG's ability to respond to the scene and monitor the case. The late notification of critical incidents is a continuing negative trend, representing an 8 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. Discussions with CDCR administration on this issue have resulted in additional commitment to emphasize timely notification.

Prison Rape Elimination Act (PREA) Incidents

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

Before July 1, 2015, the department's Prison Rape Elimination Policy contained many policies that were the same or similar to current policy, with some differences. Most notably, any time an inmate alleged he or she was involved with or assaulted by staff, the institution was immediately required to notify the Office of Internal Affairs and to refer the case to the Office of Internal Affairs for investigation or to the district attorney's office if the allegation was criminal. Policy provided no mechanism for the institution to perform a preliminary inquiry into the allegation. Many cases were referred to the Office of Internal Affairs and then investigations were denied because there was no corroborating evidence and no reasonable belief that staff misconduct occurred. As a result of the policy, there were cases in which neither the institution nor the Office of Internal Affairs investigated the inmates' allegations of PREA violations by staff.

In 2012, the United States Department of Justice issued a final rule in accordance with PREA that set national standards for protecting inmates. In order to conform to the national standards, the department amended Department Operations Manual sections 31060, et. seq., 51030.3,

52050.16.4 through 52050.16.6, and 54040, et. seq., effective July 1, 2015. In addition, changes to Title 15 of the California Code of Regulations, sections 3084.9, 3323, 3335, 3401.5 and 3401.6 are proposed but are still within the timeframe for public comment prior to implementation.

The new policies restrict the hiring and promotion of staff who have engaged in sexual violence or sexual misconduct with an inmate and require employees to report sexual violence allegations made against them. Additional restrictions to clothed and unclothed body searches were added. The policies require all staff to be trained in the prevention, detection, response, and investigation of offender sexual violence, staff sexual misconduct, and sexual harassment, with additional training for staff who perform specialized roles in the process. Institutions are required to take specified preventative measures to minimize staff incidentally viewing inmates' breasts, buttocks, or genitalia. The policy further requires documentation of any cross-gender unclothed body searches. Institutions must more rigorously review inmate housing assignments and the policy provides methods for inmates, staff, and third parties to report sexual abuse and harassment by other inmates or staff.

When an inmate reports a sexual violation, employees are required to respond with sensitivity while still taking steps to preserve evidence. The hiring authority will assign a Locally Designated Investigator (LDI) to conduct an inquiry. LDIs undergo additional special training for the role. Currently, all institutions have trained LDIs. If the information gathered indicates a reasonable belief that staff misconduct occurred, the matter is referred to the Office of Internal Affairs for an investigation.

Alleged victims are entitled to a victim advocate and a victim support person. A victim advocate is a trained person typically employed by a rape crisis center whose primary purpose is to give advice and assistance to victims of sexual assault. A victim support person is any person of the alleged victim's choosing. The victim advocate and victim support person may be present during any medical examinations related to the alleged assault as well as investigatory interviews, with some restrictions. The department also performs a suicide risk assessment and offers the alleged victim mental health treatment in accordance with detailed policies.

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

During this reporting period, the OIG monitored seven cases where violations of PREA were alleged. They are included in Appendix E, Critical Incidents. Because some of the incidents occurred before the policies described above went into effect, those cases were assessed based on the institutions' handling of the incidents under the previous policies and procedures.

Due Process in Inmate Rules Violation Reports

During this reporting period, in the course of its monitoring activities, the OIG identified that in some cases, the department failed to comply with policies that ensure inmates receive due process of law in the adjudication of rules violation reports. Current policy requires the

department to establish effective communication with the inmate when it serves the inmate with an initial or final rules violation report. Staff must document effective communication was established on a form. Unfortunately, policy does not specifically require the person who completes and signs the form to personally ensure that the inmate was served with the rules violation report or that effective communication was established. As a result, in order to expedite the process of serving and documenting the rules violation reports, some institutions have allowed staff to complete and sign the forms well in advance of actual service. The forms indicated effective communication was established and documented dates and times of service that were often inaccurate. Staff then copied the forms and filed them in departmental log books, and then delivered the rules violation reports to housing unit staff for service to the inmate. However, the department did not document that the inmate actually received the rules violation report, the time and date the inmate received the rules violation report, or that effective communication was established at the time of service. On some occasions, inmates were not served until days after the date documented on the effective communication forms. Inmates have five days from the date and time of the final service to appeal a final rules violation report. The department relied on the time and date of service indicated on the forms, which was often inaccurate, and denied inmate appeals as untimely if they were not filed within five days of the exact time indicated on the effective communication form. As a result, some timely claims were denied. In addition, effective communication was not necessarily established pursuant to policy. The OIG therefore recommends that the department amend its policy to ensure inmates receive due process in the adjudication of rules violation reports (See Recommendation 2.1, page 29).

Deadly Force Incidents

CDCR policy mandates that the Office of Internal Affairs' Deadly Force Investigation Team conduct deadly force investigations. Deadly force is, "[a]ny use of force that is likely to result in death. Any discharge of a firearm other than the lawful discharge during weapons qualification, firearms training, or legal recreational use of a firearm, is deadly force."[2] Use of less-lethal force methods, such as impact munitions or expandable batons in ways likely to result in death may constitute deadly force. Examples include intentional strikes to the head or unintentional strikes that cause great bodily injury. The Office of Internal Affairs' Deadly Force Investigation Team is described and regulated by Title 15, California Code of Regulations, Section 3268(a)(20), which specifically states the Deadly Force Investigation Team need not respond to warning shots that cause no injury. Therefore, the Office of Internal Affairs conducts both administrative and criminal investigations for deadly force incidents except for warning shots. The Office of Internal Affairs will not conduct criminal investigations if the force occurs outside the institution and an outside law enforcement agency conducts the criminal investigation.

The OIG, however, monitors all deadly force incidents, including warning shots. The OIG notes that even for warning shots, the justification for use of deadly force must be present. The OIG also monitors any use of force involving a head strike by custody staff with any instrument on an inmate, regardless of whether the strike was intentional or whether the inmate suffered injury. Any time CDCR staff use deadly force, the department is required to promptly notify the OIG. When the OIG receives timely notice of a deadly force incident, a Special Assistant Inspector General immediately responds to the incident scene to evaluate the department's management of the incident and the department's subsequent deadly force investigation, if initiated. The OIG believes on-scene response is an essential element of its oversight role and will continue

[2] Title 15, California Code of Regulations, Section 3268(a)(8).

responding to critical incidents involving all potentially deadly uses of force whenever feasible. The very nature of such an incident warrants additional scrutiny and review, regardless of whether any misconduct is suspected or whether the ultimate result of the force is great bodily injury or death.

The Deadly Force Review Board reviews Deadly Force Investigation Team incidents. An OIG representative participates as a non-voting member of this body. The Deadly Force Review 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 21 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 11 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 ten 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 ten cases being reported in Appendix D2, the Office of Internal Affairs responded to the scene in eight cases, including seven cases where the Deadly Force Investigation Team conducted both criminal and administrative investigations.

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.[3] 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."[4]

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

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).

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.

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

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 the regional 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 as resources allow, but no less than one meeting each month at each prison, juvenile facility, and parole region. During this reporting period the department reported that it held 812 use-of-force committee meetings. Of those, the OIG attended 470.

Future Use-of-Force Monitoring Efforts

Beginning January 1, 2016, 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. The OIG will begin reporting information gathered with the new tool in the next published Semi-Annual Report.

Use-of-Force Meetings Attended and Incidents Reviewed

During this reporting period, the OIG monitored and evaluated 1,746 unique use-of-force incidents and allegation reviews.[5] This data is derived from those incidents that were reviewed from July 1 through December 31, 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, procedures, 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 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 division within CDCR.

[5] 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.

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

Division	Number of Incidents Reviewed
Division of Adult Institutions	1,618
Division of Juvenile Justice	98
Division of Parole Operations	23
Office of Correctional Safety	7
Total	**1,746**

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 138 individual cases.

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 assigns a Deputy Inspector General to monitor DERC reviews.

During this reporting period, three of the four missions held DERC reviews: the General Population mission reviewed seven incidents, the Reception Center mission reviewed four incidents, and the High Security mission reviewed three incidents. This is a 40 percent increase in DERC reviews, which totaled ten in the last reporting period. The OIG monitored all of the DERC reviews.

The remaining mission, Female Offender Programs and Services, Special Housing, did not report conducting any DERC reviews in the past three reporting periods.

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 threats 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 for 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.

In the next published Semi-Annual Report, the OIG review will be able to detail the number of incidents where staff contributed to the need for force, if any. Some examples may be using force in the absence of an imminent threat or improper securing of cells or restraints.

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).[6] As of December 31, 2015, the department housed 124,490[7] in-state inmates.[8]

Of the 1,746 total use-of-force incidents the OIG reviewed this period, 1,618 (93 percent) occurred within the DAI.

The following table reflects the number of incidents reviewed by the OIG within the adult institutions during this reporting period. This constitutes a representative sample based on data collected at approximately 58 percent of the use-of-force meetings statewide. In addition, the table breaks down the applications of force. Note that "applications of force," as used in this report, considers each force used against each inmate. 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. In addition, the new use of force tool now allows the OIG to report multiple applications of force on one inmate. In past reports, if two applications of OC pepper spray were used on one inmate, it was only counted as one application of force. Going forward, each

[6] 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.
[7] This number includes the 1,920 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 5,000 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.
[8] CDCR data is derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1512.pdf.

separate application of force (OC pepper spray, baton strike, etc.) on a single inmate will be counted as a separate use of force.

Table 2: *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[9]**	**Lethal Force, Including Warning Shots**
CCC	California Correctional Center	20	69	72%	13%	3%	11%	0%	0%
CIM	California Institution for Men	38	127	63%	31%	2%	3%	0%	0%
CMC	California Men's Colony	31	96	35%	59%	0%	5%	0%	0%
CRC	California Rehabilitation Center	24	54	65%	28%	0%	7%	0%	0%
DVI	Deuel Vocational Institution	24	68	50%	28%	0%	16%	3%	3%
NKSP	North Kern State Prison	59	160	46%	21%	28%	4%	0%	2%
RJD	Richard J. Donovan Correctional Facility	64	187	44%	46%	5%	5%	0%	0%
SCC	Sierra Conservation Center	18	68	65%	31%	1%	1%	1%	0%
SQ	California State Prison, San Quentin	37	134	57%	24%	10%	7%	0%	2%
WSP	Wasco State Prison	61	177	62%	27%	6%	3%	2%	0%
CAC	California City Correctional Facility	7	26	85%	8%	0%	8%	0%	0%
CCI	California Correctional Institution	16	44	82%	11%	2%	5%	0%	0%
COR	California State Prison, Corcoran	58	185	52%	40%	4%	3%	0%	0%
HDSP	High Desert State Prison	122	369	57%	20%	17%	4%	1%	1%
KVSP	Kern Valley State Prison	166	936	71%	12%	14%	2%	<1%	0%
LAC	California State Prison, Los Angeles County	161	746	60%	25%	8%	6%	1%	0%
PBSP	Pelican Bay State Prison	22	80	60%	34%	6%	3%	1%	0%
SAC	California State Prison, Sacramento	85	429	37%	19%	42%	2%	<1%	1%
SATF	Substance Abuse Treatment Facility & State Prison at Corcoran	24	62	48%	21%	26%	5%	0%	0%
SVSP	Salinas Valley State Prison	75	265	72%	18%	9%	2%	0%	0%
ASP	Avenal State Prison	7	14	71%	29%	0%	0%	0%	0%
CAL	Calipatria State Prison	130	558	74%	8%	16%	1%	0%	1%
CEN	Centinela State Prison	39	116	66%	16%	13%	5%	0%	0%
CTF	Correctional Training Facility	18	70	24%	70%	0%	6%	0%	0%
CVSP	Chuckawalla Valley State Prison	5	40	100%	0%	0%	0%	0%	0%
ISP	Ironwood State Prison	36	240	70%	10%	4%	16%	<1%	0%
MCSP	Mule Creek State Prison	48	135	50%	22%	8%	13%	6%	0%
PVSP	Pleasant Valley State Prison	14	54	69%	20%	4%	7%	0%	0%
SOL	California State Prison, Solano	26	142	75%	15%	6%	3%	0%	0%
VSP	Valley State Prison	9	29	31%	69%	0%	0%	0%	0%
CCWF	Central California Women's Facility	26	58	40%	55%	0%	2%	3%	0%
CHCF	California Health Care Facility	34	119	14%	82%	0%	2%	3%	0%
CIW	California Institution for Women	73	190	29%	62%	2%	3%	4%	0%
CMF	California Medical Facility	25	41	39%	49%	0%	7%	5%	0%
FSP	Folsom State Prison	16	37	59%	30%	0%	8%	0%	3%
TOTAL		**1,618 Incidents**	**6,125 Applications**	**59% Overall Average**	**24% Overall Average**	**12% Overall Average**	**4% Overall Average**	**1% Overall Average**	**<1% Overall Average**

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

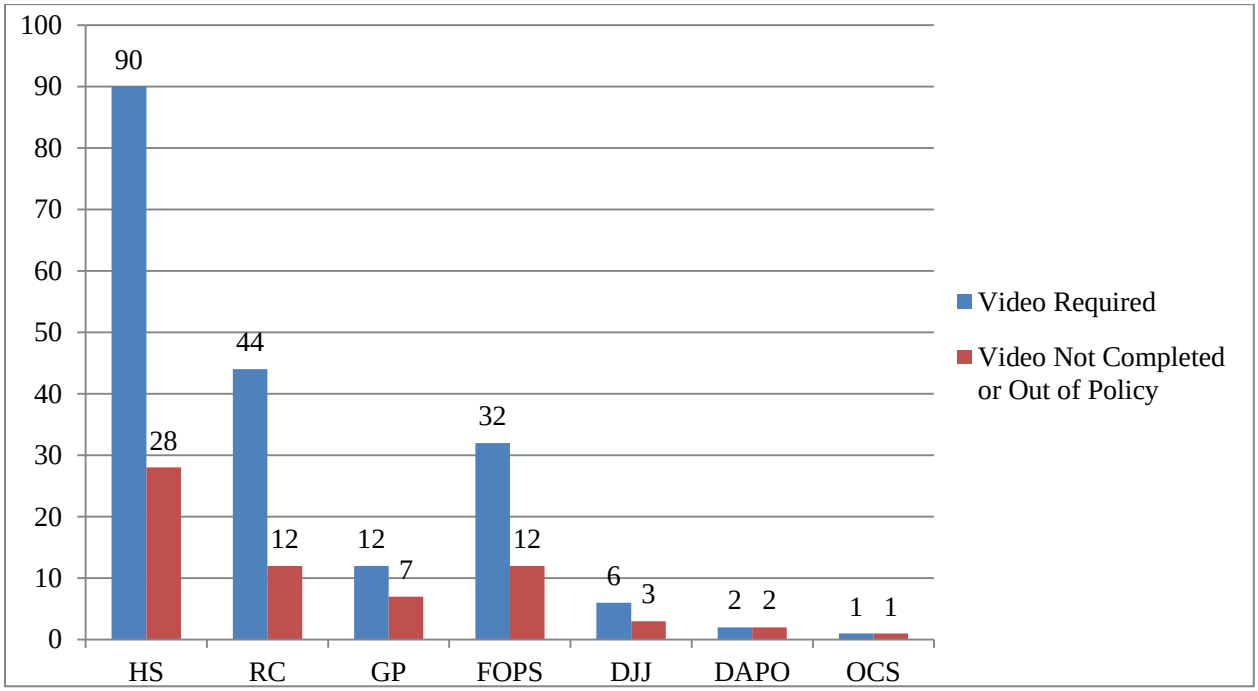
[9] Other/Non-conventional Force includes hand-to-hand combat, use of a shield to apply force, use of an available force tool in an unconventional manner (for example, striking with a chemical agent canister), or other force that utilizes techniques or instruments that are not specifically authorized in policy, procedures, or training.

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.

Of the incidents the OIG reviewed, 187 required video-recorded interviews. Of those, 122 incidents had the video-recorded interview or interviews conducted within policy, while in 65 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 65 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. Although the OIG has reported these concerns in prior reports, the policy compliance rate remains below 70 percent.

Chart 1: *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 cases, 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 therefore did not go into effect until February 11, 2014. The department implemented the new use-of-force review process at three institutions (High Desert State Prison; Kern Valley State Prison; and California State Prison, Los Angeles County) on a 24-month pilot basis.[10] The institutions were chosen based on the initial criteria, which did not exclude inmates participating in the Mental Health Services Delivery System. The criteria excluding MHSDS inmates was added immediately prior to implementation, but the department did not change the institutions selected. Because of the high number of mental health inmates at these pilot institutions, very few incidents met the requirements for consent review. To better determine if the process would 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 194 incidents as a part of the pilot program.

[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)).

Table 3: *Number of Pilot Incidents Reviewed*

Institution	Cases CDCR Referred for Consent
Calipatria State Prison	108
High Desert State Prison	5
Kern Valley State Prison	51
California State Prison, Los Angeles County	30
Total	**194**

As the table above illustrates, Calipatria State Prison, an institution with few inmates receiving mental health care, referred twice as many cases to consent as any other prison in the pilot. Based on the data, the consent review process will prove beneficial at institutions with populations similar to Calipatria State Prison. The consent process allows institutions to review use-of-force cases that meet the criteria in a more efficient manner because each of the stakeholders can analyze the cases independently rather than in lengthy meetings. This will also allow the institution's use-of-force committee to focus discussion on cases where the use of force caused serious injury, involved the mentally ill, was a controlled use of force, or may not have complied with policies and procedures.

Division of Juvenile Justice

During this reporting period the Division of Juvenile Justice (DJJ) consisted of three facilities[11] and one conservation camp and was responsible for supervising 666 juvenile wards.[12] The OIG reviewed 98 use-of-force incidents occurring throughout the three juvenile facilities. This constitutes a representative sample based on data collected at approximately 37 percent of the DJJ use-of-force meetings statewide. There were no incidents in the juvenile conservation camp this reporting period.

Among the 98 incidents reviewed, 28 were at N.A. Chaderjian Youth Correctional Facility (NAC), 10 were at O.H. Close Youth Correctional Facility (OHC), and 60 were at Ventura Youth Correctional Facility (VYCF). 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, one at NAC and one at VYCF. Both 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 resulted in staff training. The OIG did not concur that training was an adequate remedial measure in one of the cases but concurred in the other case.

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 43,500 parolees.[13] The OIG reviewed 23

[11] OHC and NAC are co-located in Stockton.
[12] Data derived from: http://www.cdcr.ca.gov/Reports_Research/docs/research/Population_Overview/POPOVER2015.pdf

[13] Data derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1512.pdf

use-of-force incidents: 6 in the north parole region and 17 in the south parole region. This constitutes a representative sample based on data collected at approximately 63 percent of the DAPO use-of-force meetings statewide. Of the incidents reviewed, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all cases. However, the department found one incident that occurred in the south region out of compliance with policy apart from the use of force and provided training to two parole agents. The OIG concurred.

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 seven use-of-force incidents involving 12 uses of force by OCS employees; there were six uses of physical force, five uses of a taser, and one use of non-conventional force. Of the seven incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all cases. However, in one incident where a parolee alleged unreasonable use of force, the department conducted an audio-recorded interview when policy required a video-recorded interview. In another case, officers failed to submit reports before the end of their shifts.

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 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 how long the inmate has been on watch, and in all cases where the watch extends beyond 72 hours. While at the scene, the OIG inspects the 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 at the scene. The OIG formally assesses the sufficiency of how the department conducts each contraband surveillance watch that exceeds 72 hours and in select cases that do not exceed 72 hours, but which involve special circumstances warranting closer examination.

During this reporting period, the OIG was notified of 135 contraband surveillance watch cases. Of these 135 cases, inmates were kept on contraband surveillance watch longer than 72 hours but less than 144 hours in 32 cases and five cases involved inmates placed on watch for 144 to 216 hours. Two cases extended beyond 216 hours (nine days) during this reporting period. This report assesses the 39 cases that extended beyond 72 hour as well as five cases involving inmates who required medical attention at an outside hospital but where the contraband surveillance watch did not extend beyond 72 hours. There were 96 cases that did not extend beyond 72 hours, and in 49 percent of those cases (47 cases), contraband was recovered. Contraband was found in 69 percent of the contraband surveillance watch cases that extended beyond 72 hours. This is down from 90 percent during the last reporting period. However, contraband recovery data for the last three years does not show a definitive trend.

Table 4: *Contraband Found in Cases Extending Beyond 72 Hours, 2013 to 2015*

Reporting Period	Cases Over 72 Hours	Contraband Found	Percentage
January-June 2013	92	58	63%
July-December 2013	75	43	57%
January-June 2104	48	17	35%
July-December 2014	59	28	53%
January-June 2015	42	38	90%
July-December 2015	39	27	69%

Chart 2: *Duration of Contraband Surveillance Watch Cases*

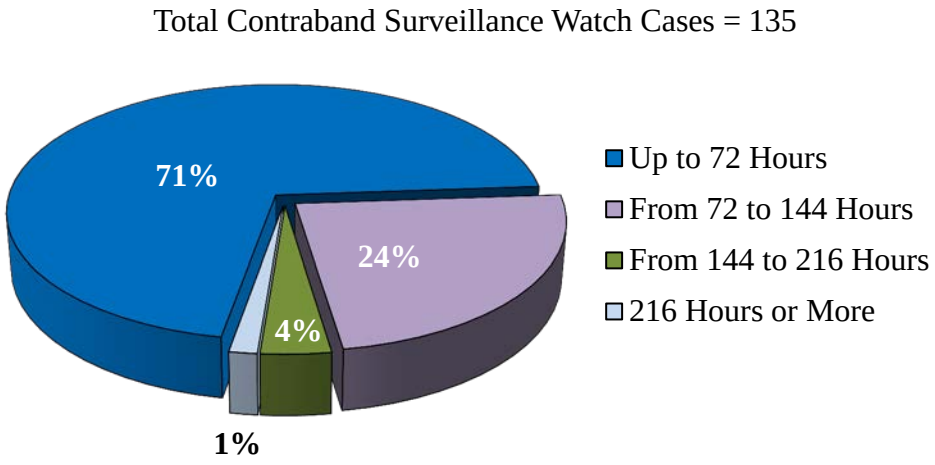


Chart 3: *Contraband Found in Cases Extending Beyond 72 Hours*

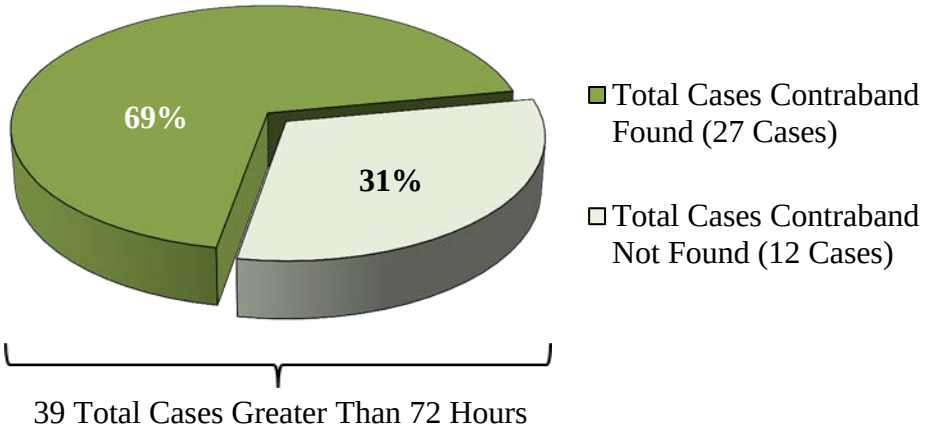
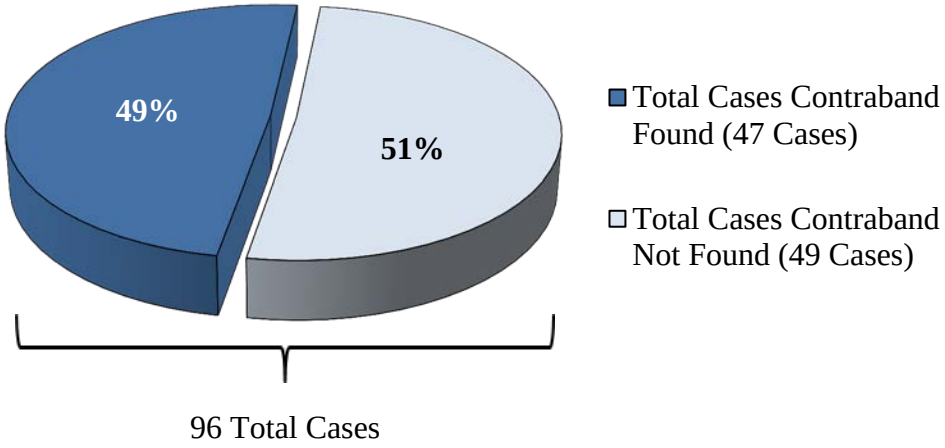


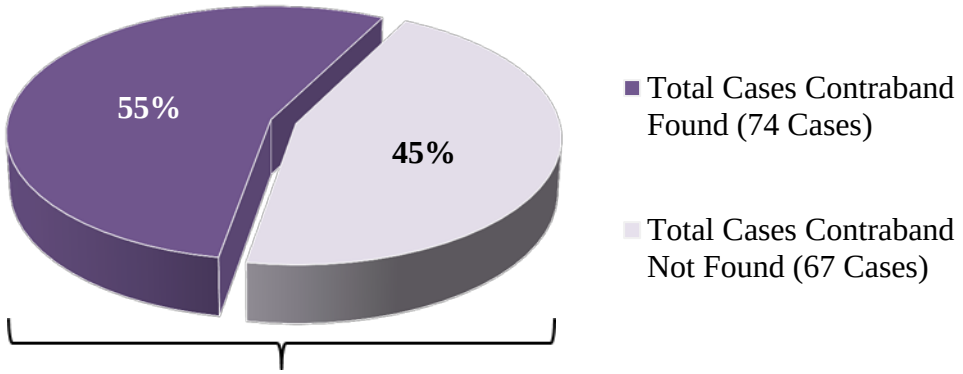
Chart 4: *Contraband Found in Cases Lasting Less Than 72 Hours*



As previously noted, this report covers in detail those 39 contraband surveillance watch cases that extended beyond 72 hours. Contraband was found in 27 cases that extended beyond 72 hours. Drugs were recovered in 52 percent of the cases where contraband was found, while the remaining recovered contraband consisted of weapons, inmate notes, phones, and other contraband.

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 39 cases that exceeded 72 hours, the OIG found that the department sufficiently managed the contraband surveillance watch process in 25 cases (64 percent) and was insufficient in its management of 14 contraband surveillance watch cases (36 percent). In addition, the department sufficiently managed the contraband surveillance watch process in four of the five cases (80 percent) being reported that did not exceed 72 hours. Of the 29 cases rated sufficient overall, 20 still involved minor policy violations, and almost all of those policy violations related to documentation. In nine cases, the OIG identified no policy violations. Four of the cases with no policy violations were from Kern Valley State Prison, which has six cases being reported herein. All of the cases were rated sufficient and Kern Valley State Prison should be commended.

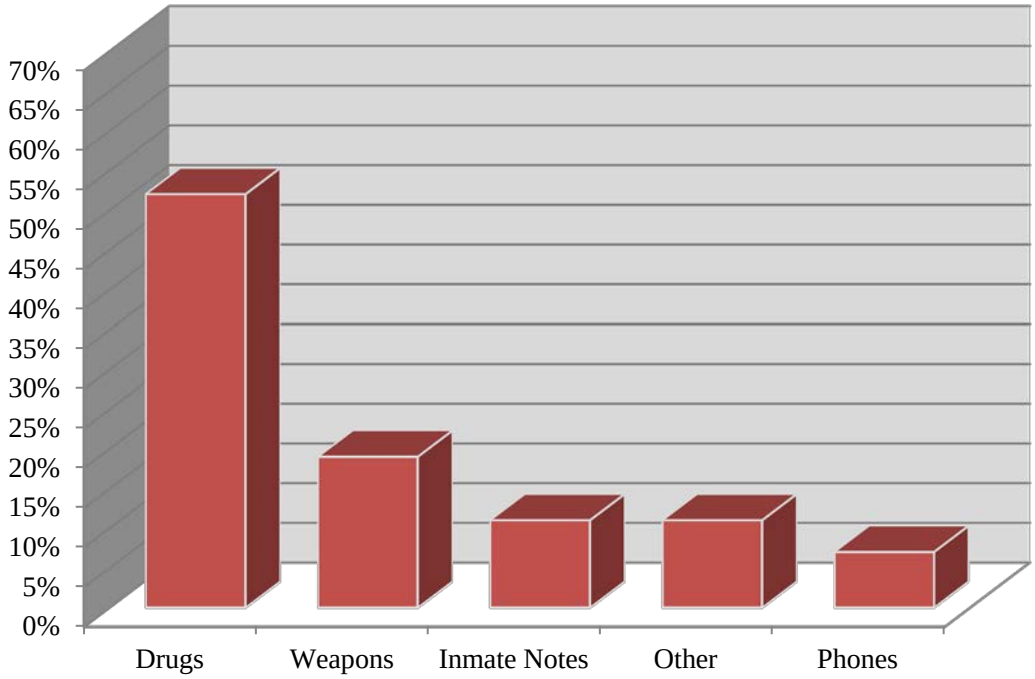
Chart 5: *Contraband Found in All Contraband Surveillance Watch Cases*



135 Total Cases

In all cases where deficiencies were noted, the department took corrective action mainly via staff training. While the OIG concurs that most deficiencies can be appropriately addressed through additional staff training, the same issues are continuing to occur. The OIG previously recommended that the department review its contraband surveillance watch training policies and determine where improvements can be made. The OIG also suggested the department develop an on-the-job training component for custody staff newly assigned to a contraband surveillance watch case. For trained staff who consistently fail to follow contraband surveillance watch policy, the OIG continues to recommend the department take corrective action beyond training, up to and including disciplinary action.

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



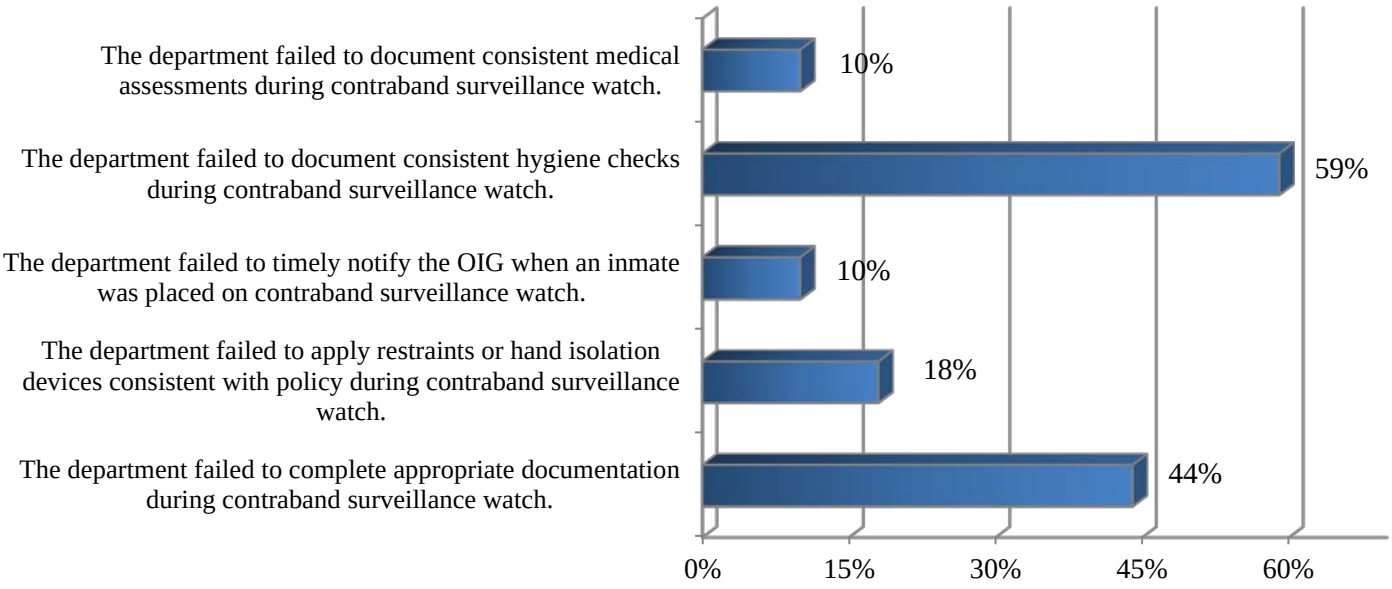
In this reporting period, the department placed fewer inmates on contraband surveillance watch compared to the four previous reporting periods (135 in this period compared to 155, 206, 192, and 246 in the four prior reporting periods). The number of inmates kept on contraband surveillance watch beyond 72 hours was consistent (39 in this period, compared to 42 in the prior reporting period).

The department kept two inmates on contraband surveillance watch longer than 216 hours in this reporting period, compared with none in the previous reporting period. In one of the cases, the inmate was placed on contraband surveillance watch after a nurse witnessed multiple bindles in his mouth. The department recovered four bindles of drugs at that time but was unable to recover all the suspected contraband. After six days and before the inmate produced three bowel movements free of contraband, the inmate passed another bindle of drugs. The following day, the department recovered a weapon and inmate notes. Two days later, after three bowel movements free of contraband, the department removed the inmate from contraband surveillance watch. The department failed to appropriately document inmate hygiene and complete other documentation in a timely manner, and staff received training.

In the second case exceeding 216 hours, officers observed the inmate placing items in his mouth during a visit and were able to recover two bindles of drugs but not the remaining suspected contraband. The inmate did not produce any bowel movements the next four days and the department obtained a search warrant. A CT scan of the inmate revealed the inmate still possessed suspected contraband. On the eighth day of contraband surveillance watch and before the inmate produced three bowel movements free of contraband, the department recovered two more bindles of drugs. After 11 days, when the inmate had produced three bowel movements free of contraband, the department removed him from contraband surveillance watch. A captain delayed removing the inmate from contraband surveillance watch after the third contraband-free bowel movement and the department issued him a letter of instruction.

The department's decision to place inmates on contraband surveillance watch was within policy in all 39 cases exceeding 72 hours.

Chart 7: *Policy Violations in Contraband Surveillance Watch Cases*



In the 39 contraband surveillance watch cases that extended beyond 72 hours, the majority of policy violations involved failures to complete appropriate documentation and failures to document consistent hygiene checks. The lack of documentation of hygiene checks may mean that the checks are not being done at all or may simply mean that, although they are done, they are not documented.

In 23 cases of contraband surveillance watch cases exceeding 72 hours (59 percent), the department failed to complete appropriate documentation concerning inmate hygiene (down from 67 percent in the last reporting period). Despite improvement, policy violations pertaining to inmate hygiene remain high and the OIG recommends the department continue to provide training to both custody and medical staff on Department Operations Manual section 52050.23.5 to further improve staff compliance with this policy.

The department failed to timely notify the OIG when an inmate was placed on contraband surveillance watch in only one (2 percent) of the 39 cases exceeding 72 hours. The department's improvement in this area is commendable, as its reporting of contraband surveillance watch placement was untimely in 12 percent of the cases in the last reporting period and 25 percent of cases in the reporting period before that.

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. The statistics for contraband recovered and sufficiency ratings include the five cases being reported that lasted fewer than 72 hours.

Table 5: ***Contraband Surveillance Watch Cases, by Institution, July–December 2015***

Institution	Number of CSW Cases	Less Than 72 Hours	72 to Less Than 144 Hours	144 to Less Than 216 Hours	216 Hours or More	Number of Cases Rated Sufficient	Number of Cases Rated Insufficient
ASP	1	0	1	0	0	0	1
CAC	2	1	1	0	0	0	1
CAL	9	8	1	0	0	1	1
CCC	18	9	7	2	0	8	1
CCI	4	1	3	0	0	1	2
CCWF	0	0	0	0	0	N/A	N/A
CEN	8	7	0	0	1	1	1
CHCF	1	1	0	0	0	N/A	N/A
CIM	1	1	0	0	0	N/A	N/A
CIW	1	1	0	0	0	N/A	N/A
CMC	1	1	0	0	0	N/A	N/A
CMF	0	0	0	0	0	N/A	N/A
COCF	0	0	0	0	0	N/A	N/A
COCF-LPCC	1	1	0	0	0	N/A	N/A
COCF-NFCF	0	0	0	0	0	N/A	N/A
COCF-TCCF	2	2	0	0	0	N/A	N/A
COR	4	2	1	1	0	1	1
CRC	2	1	1	0	0	2	0
CTF	0	0	0	0	0	N/A	N/A
CVSP	0	0	0	0	0	N/A	N/A
DVI	2	2	0	0	0	N/A	N/A
FSP	1	1	0	0	0	N/A	N/A
HDSP	3	0	2	0	1	2	1
ISP	2	2	0	0	0	N/A	N/A
KVSP	8	2	6	0	0	6	0
LAC	4	4	0	0	0	N/A	N/A
MCSP	2	1	1	0	0	0	1
NACYCF	3	2	1	0	0	1	0
NCYCC	0	0	0	0	0	N/A	N/A
NKSP	1	1	0	0	0	N/A	N/A
NYCRC	1	1	0	0	0	N/A	N/A
OHC	1	1	0	0	0	N/A	N/A
PBSP	7	6	1	0	0	1	0
PVSP	4	4	0	0	0	N/A	N/A
RJD	9	9	0	0	0	0	1
SAC	5	4	1	0	0	1	0
SATF	5	5	0	0	0	1	0
SCC	3	3	0	0	0	N/A	N/A
SOL	2	1	1	0	0	1	0

SQ	**4**	**2**	**1**	**1**	**0**	**0**	**2**
SVSP	**6**	**4**	**2**	**0**	**0**	**1**	**1**
VSP	**2**	**0**	**1**	**1**	**0**	**1**	**1**
VYCF	**2**	**2**	**0**	**0**	**0**	**N/A**	**N/A**
WSP	**3**	**3**	**0**	**0**	**0**	**N/A**	**N/A**
Total CSW Cases	**135**	**96**	**32**	**5**	**2**	**29**	**15**
		Contraband Recovered: 47 Cases = 49%	**Contraband Recovered: 20 Cases = 63%**	**Contraband Recovered: 4 Cases = 80%**	**Contraband Recovered: 2 Cases = 100%**	**Sufficient = 66%**	**Insufficient = 34%**

Field Inquiries

Since its inception, the OIG has provided a process by which inmates, CDCR staff, and the public can report misconduct or lodge complaints. The OIG examines complaints and assigns staff to conduct field inquiries regarding selected complaints at the institutions. On July 1, 2015, the OIG began to collect data regarding CDCR's response to OIG's inquiries to be included in our semi-annual report. In this reporting period, the OIG completed the collection of data concerning 24 field inquiries that were referred to the OIG's regional operations teams to bring the matters to the attention of the specific institutions and to monitor departmental response at the local level.

The OIG's assessment of the department's response to the inquiries does not consider whether the underlying complaint or allegation is substantiated. Rather, the OIG assesses whether the department takes appropriate action to investigate or address the issue. The OIG assesses whether the department developed and maintained sufficient documentation, whether the department adequately consulted with the OIG, whether the hiring authority appropriately referred allegations of misconduct to the Office of Internal Affairs, and whether the Office of Internal Affairs made appropriate determinations regarding the cases it received.

In this reporting period, the OIG concluded 24 inquiries at 12 institutions. Of the 24 cases, the department sufficiently addressed the OIG's inquiry in 21 cases (88 percent). In one of the three cases where the department's response was not appropriate, an inmate submitted a complaint to the OIG more than six months after the alleged excessive force. The hiring authority completed an inquiry and concluded there was no evidence to support the allegations. The OIG disagreed because injuries to the inmate were documented at the time of the alleged excessive force that should have been investigated. Because the department failed to timely investigate, the deadline for taking disciplinary action expired. In another case, an inmate alleged violation of the Prison Rape Elimination Act but the hiring authority failed to refer the matter to the Office of Internal Affairs pursuant to policy. In the third case, the hiring authority identified potential staff misconduct based upon unnecessary use of force and referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs failed to open an investigation. Overall, the department should be commended for responding appropriately to a large majority (88 percent) of the OIG's field inquiries.

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. An 8 percent decline in timely notification compared to the previous reporting period, after declines of 3 percent and 20 percent in prior reporting periods, prevents the performance of this oversight role. CDCR management has pledged to improve notifications.

The OIG attended 470 use-of-force meetings throughout the State and evaluated a total of 1,746 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's monitoring of contraband surveillance watch continues to evolve. If departmental staff do not follow documentation and observation policies, serious medical issues may occur. In this reporting period, the department significantly improved its compliance with policy on contraband surveillance watch with 64 percent of the cases that exceeded 72 hours rated sufficient as compared to only 53 percent in the last reporting period. This percentage could be improved even further with focus on improving documentation. Overall, the department has improved significantly since OIG monitoring began.

This report now details the department's response to the OIG complaint intake process. While many complaints are returned for the complainant to exhaust his or her administrative remedies and many more are resolved informally by OIG headquarters intake staff, some require contact by regional OIG staff with the institution. In the majority (88 percent) of cases where an inquiry was made in the field, the department has been receptive and taken appropriate action.

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, July-December 2015.

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

Volume II Recommendations from Prior Reporting Periods

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

CDCR Response: **Partially Implemented**

The department will issue a memorandum to custody and health care staff reminding them of their responsibilities to immediately assess, provide, and initiate life-saving care without delay. The department expects to complete the memorandum by October 2016.

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.

CDCR Response: Partially Implemented

The department has partnered with the Office of Training and Professional Development to provide an additional four hours of instructional curriculum at the basic correctional officer academy in crime scene and evidence preservation. In addition, the department will provide on-the-job training in crime scene preservation and evidence collection to supervisors and managers. The department anticipates the training will begin by October 2016.

The OIG recommended the department implement the following recommendations from Volume II of the 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. [14]

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.

[14] 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.

Appendices

Appendix D1 contains the assessments for 11 deadly force incidents monitored by the OIG during the reporting period but not investigated by the Office of Internal Affairs, listed by geographical region.

Appendix D2 contains the assessments for 10 deadly force cases investigated by the Office of Internal Affairs and monitored by the OIG during the reporting period, listed by geographical region.

Appendix E contains the assessments for 89 critical incidents monitored during this reporting period, listed by geographical region.

Appendix F contains the results and outcomes of 44 OIG-monitored contraband surveillance watch cases during the reporting period, listed by the date the inmate was placed on contraband surveillance watch.

Appendix G contains the 23 field inquiries concluded by the OIG during the reporting period, listed by geographical region.

APPENDIX D1 11
MONITORED DEADLY FORCE INCIDENT CASE SUMMARIES
Central Region

Incident Date: 2015-08-05	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1553-RO**

On August 5, 2015, approximately 95 inmates participated in a riot on the exercise yard. An observation officer fired six less-lethal rounds. A second observation officer saw an unresponsive inmate being kicked in the head by three inmates and fired two warning shots from a Mini-14 rifle, which stopped the attack and the riot. Several inmates were treated at the institution for injuries sustained during the riot. The unresponsive inmate was taken to an outside hospital and he returned to the institution the same day. The OIG and the Office of Internal Affairs responded to the scene.

Disposition

The institution's executive review committee determined that the use of force complied with departmental policy. The OIG concurred. The hiring authority determined reports documenting the incident were inadequate and provided training to custody and medical staff.

Incident Assessment

The department's response was not adequate because an investigative services unit officer failed to document the recovery of drugs at the scene and nurses inaccurately documented inmate injuries.

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

North Region

Incident Date: 2015-04-24	Deadly Force Incident

Incident Summary

OIG Case Number: **15-0826-RO**

On April 24, 2015, two inmates attacked a third inmate on the exercise yard. An officer observed one of the inmates make stabbing motions with an inmate-manufactured weapon toward the third inmate's abdomen while the other inmate struck the third inmate in the head. The inmates ignored orders to stop fighting. The officer fired one warning shot from a Mini-14 rifle. The inmates stopped fighting, but the first inmate continued to pace the area. A second officer deployed a chemical grenade, following which the first inmate dropped the inmate-manufactured weapon. The third inmate was treated at the correctional treatment center for injuries to the head, chest, and abdomen sustained during the attack.

Disposition

The institution's executive review committee determined the use of force complied with departmental policies. However, the committee determined that actions following the use of force were not in compliance because medical reports of injuries were incomplete and inaccurate and an officer submitted an untimely report. The OIG concurred with the determination. The hiring authority provided training to the officer and nurses.

Incident Assessment

The department's response was not adequate because medical reports were inaccurate and incomplete and an officer failed to timely submit a report.

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

Incident Date: 2015-05-19	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1028-RO**

On May 19, 2015, over 150 inmates engaged in a riot on an exercise yard. Officers deployed chemical agents and less-lethal rounds. One officer fired a round from a Mini-14 rifle as a warning shot. Two inmates sustained life-threatening injuries and were flown to outside hospitals. Four other inmates with serious injuries were also transported to outside hospitals. The inmates' injuries were consistent with fighting. The inmates were released from the hospitals over several days and returned to the institution or sent to another institution.

Disposition

The institution's executive review committee found the matter was in compliance with the department's use-of-force policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

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

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

North Region

Incident Date: 2015-08-12	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1605-RO**

On August 12, 2015, two inmates stabbed a third inmate on the exercise yard, igniting a riot involving approximately 75 inmates. Two officers fired three warning shots from observation booths. Other officers fired 161 less-lethal rounds and deployed chemical agents. Officers recovered multiple inmate-manufactured weapons. The inmate who was originally stabbed was pronounced dead at the institution. Ten inmates were transported to outside hospitals and multiple others were treated at the institution for injuries sustained during the riot. Of the ten hospitalized inmates, seven returned to the institution by the following day. One inmate sustained head trauma requiring placement in a medically-induced coma. The department contacted the district attorney's office which conducted an investigation.

Disposition

An autopsy determined that the cause of death was homicide and the department's Death Review Committee determined the death was not preventable. The institution's executive review committee determined the use of force complied with departmental policy. The committee found the use-of-force reports were not submitted within the time required by department policy, but found the reports were submitted within a reasonable time given the magnitude of the incident, number of custody staff and inmates involved, seriousness of injuries sustained, and limited number of computers relative to the number of required reports. The OIG concurred. The hiring authority did not identify any staff misconduct.

Incident Assessment

The department's response was not adequate because the department lost medical reports, failed to document critical information, failed to timely collect use-of-force reports, and the institution's executive review committee failed to conduct a timely review of the incident.

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

Incident Date: 2015-08-22	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1703-RO**

On August 22, 2015, six inmates attacked a seventh inmate on an exercise yard, causing the inmate to fall to the ground. An observation officer observed the inmates kick the inmate in the face while he was on the ground, not defending himself. The officer fired one warning shot from a Mini-14 rifle, stopping the attack. The department transported the injured inmate to an outside hospital and the inmate returned to the institution the same day.

Disposition

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

Incident Assessment

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

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

North Region

Incident Date: 2015-09-09	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1816-RO**

On September 9, 2015, an observation officer observed two inmates punching each other. The officer fired two less-lethal rounds at the legs of the inmates but did not see where the rounds struck. Two officers deployed pepper spray grenades that stopped the fight. The department later determined that both inmates were struck in the head by the less-lethal rounds and transported one of the inmates to an outside hospital after he lost consciousness. The inmate returned to the institution at a later date.

Disposition

The institution's executive review committee determined that the use of force was within departmental policy. The OIG concurred. The hiring authority provided training to an officer who failed to properly complete a holding cell log.

Incident Assessment

The department's response was not adequate because the Office of Internal Affairs inappropriately determined that the incident did not meet the criteria for an investigation by the deadly force investigation team. An officer failed to properly complete a holding cell log and the institution's executive review committee failed to initially identify the error in the holding cell log.

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

Incident Date: 2015-09-24	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1960-RO**

On September 24, 2015, two inmates stabbed a third inmate on an exercise yard and an officer deployed a pepper spray grenade, which stopped the attack. Uninvolved inmates got on the ground but a responding officer pushed down an inmate who was still standing. As that officer and three others were returning to handcuff the inmate who had not gotten down, that inmate and ten others got up and began punching the officers. Fighting continued as additional officers arrived and used batons, pepper spray, and physical force to attempt to stop the attack. An observation tower officer fired one warning shot from a Mini-14 rifle into the ground and the inmates got down on the ground. The department transported the inmate who was attacked to an outside hospital and the inmate returned two days later.

Disposition

The institution's executive review committee determined the use of force did not comply with departmental policy. The OIG concurred. The hiring authority identified potential staff misconduct based on the officer pushing the inmate to the ground; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Incident Assessment

The department's actions during and after the incident were not adequate because an officer used unnecessary force when responding to the scene and the officer failed to accurately document the use of force.

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

North Region

Incident Date: 2015-10-06	Deadly Force Incident

Incident Summary

OIG Case Number: **15-2029-RO**

On October 6, 2015, 66 inmates participated in a riot on the exercise yard. An observation officer fired a warning shot from a Mini-14 rifle, which stopped the riot. The department transferred two inmates to an outside hospital for treatment of injuries incurred during the riot. The inmates returned to the institution the same day.

Disposition

The institution's executive review committee determined the use of force complied with department policy. The OIG concurred. The hiring authority identified potential staff misconduct because officers failed to submit timely reports, properly complete the holding cell logs, and document the chain of custody of the visual recording of the incident. The institution provided training to the officers.

Incident Assessment

The department's response was not adequate because the hiring authority failed to timely notify the Office of Internal Affairs and the OIG and officers failed to timely and accurately complete documentation.

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

South Region

Incident Date: 2015-06-12	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1193-RO**

On June 12, 2015, approximately 200 inmates participated in a riot on the exercise yard. Officers deployed pepper spray and discharged twenty less-lethal rounds. An officer fired one warning shot from a Mini-14 rifle, which stopped the riot. One of the inmates was allegedly struck in the head with a less-lethal round. Several inmates were treated for injuries at the institution, including the inmate allegedly struck in the head. Eleven inmates were transported to an outside hospital for serious injuries and later returned to the institution.

Disposition

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

Incident Assessment

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

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

Incident Date: 2015-07-29	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1498-RO**

On July 29, 2015, sergeants and officers conducted a cell extraction. One officer, while attempting to strike the inmate in the upper body or head, allegedly used his baton to repeatedly strike the top of a shield another officer held. The shield prevented any of the strikes from striking the inmate, but the force of the strikes cracked and broke the shield. The officer allegedly continued to use his baton to strike at the inmate. The inmate received nine sutures for wounds to his head.

Disposition

The hiring authority identified potential staff misconduct based on a lieutenant's alleged failure to have proper staffing during the cool-down period, failure to ensure extraction team members were aware of their duties and expectations, and failure to conduct a video-recorded inmate interview upon learning that he suffered serious injury. In addition, an officer allegedly used unreasonable force when he struck at the inmate 17 times with a baton during the extraction. Therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Incident Assessment

The department's actions were not adequate because custody staff did not properly prepare for or conduct the controlled cell extraction and the Office of Internal Affairs failed to respond to the scene.

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

South Region

Incident Date: 2015-08-28	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1756-RO**

On August 28, 2015, two inmates punched and kicked a third inmate on the exercise yard. The third inmate was on the ground in a fetal position with his arms and hands covering his head area. An observation officer fired a warning shot from a Mini-14 rifle, which did not stop the attack. Other officers deployed pepper spray and the attack stopped. A nurse treated the injured inmate at the institution for swelling and bruising. The Office of Internal Affairs and the OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force was in compliance with departmental policy. The OIG did not concur with the determination. The hiring authority identified potential staff misconduct based on the placement of the warning shot. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs rejected the case.

Incident Assessment

The department's response was not adequate because the officer fired a warning shot without sufficient justification for the use of deadly force. The department improperly determined that the use of deadly force was in compliance with departmental policy and the Office of Internal Affairs failed to open an investigation.

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

APPENDIX D2 10
INVESTIGATED AND MONITORED DEADLY FORCE INCIDENT CASE SUMMARIES

Central Region

Incident Date: 2014-07-15	Deadly Force Incident

Incident Summary

On July 15, 2014, officers deployed pepper spray on a disruptive inmate who refused orders to get down on the ground. The inmate punched one of the officers and two officers struck the inmate with batons. One of the officers allegedly struck the inmate in the head with a baton. Officers were then able to gain control of the inmate, who did not sustain any serious injuries. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **14-1780-IR**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The department failed to adequately document the incident. The Office of Internal Affairs failed to protect compelled statements obtained in the administrative case from being improperly used in a criminal case. The special agent failed to appropriately document case activity, failed to appropriately conduct the investigation, and failed to provide the OIG with a draft copy of the investigative report. The institution's executive review committee failed to timely review the use of force.

Assessment Questions

- Was the critical incident adequately documented?

  An officer failed to include in his report that he believed he struck the inmate in the head with a baton.

- Did the Office of Internal Affairs appropriately protect compelled statements obtained in the administrative case from being improperly used in a criminal case?

  The Office of Internal Affairs failed to appropriately separate the criminal and administrative investigations by assigning separate case numbers and supervisors. As a result, the criminal investigators had access to, and made entries in, the case management system for the administrative investigation even after one of the officers made a compelled statement.

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

  The special agent for the criminal investigation inappropriately accessed and entered case activity in the administrative investigation in the case management system subsequent to an officer's compelled statement.

- 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 copy of the investigative report.

- Was the investigation thorough and appropriately conducted?

  The Office of Internal Affairs failed to appropriately separate the criminal and administrative investigations by assigning separate case numbers and supervisors. As a result, the criminal investigators had access to, and made entries in, the case management system for the administrative investigation even after one of the officers made a compelled statement.

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

  The institution's executive review committee failed to review the use of force in a timely manner.

Central Region

Disposition

After an initial review, including collection of evidence and interviews of the inmate and the officer who struck the inmate with the baton, 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 custody staff failed to interview the inmate in a timely manner, failed to submit complete use-of-force reports, and failed to timely respond to requests for clarification of the reports. The committee ordered training for a sergeant and an officer. The OIG concurred. In addition, the hiring authority identified potential staff misconduct based on officers' inaccurately reporting how the inmate was injured; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Incident Date: 2015-02-02	Deadly Force Incident

Incident Summary

On February 2, 2015, an inmate resisted officer's efforts to remove him from his cell and attempted to kick escorting officers. Officers used physical force and batons to subdue the inmate. Nurses subsequently discovered a large bump on the back of the inmate's head. An officer later reported he inadvertently struck the inmate's head with his baton. The department transported the inmate to an outside hospital because he may have swallowed foreign objects. The inmate returned to the institution five days later. The Office of Internal Affairs did not respond to the scene.

Administrative Investigation	OIG Case Number: **15-0318-IR**

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the pre-disciplinary process. The institution failed to adequately notify the investigative services unit and the institution's executive review committee failed to timely review the incident.

Assessment Questions

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

  A lieutenant failed to notify the investigative services unit that an inmate allegedly battered staff.

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

  Since the lieutenant failed to notify the investigative services unit, the investigative services unit did not respond to collect evidence and photograph possible injuries to the inmate and officers.

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

  The Office of Internal Affairs returned the case to the hiring authority on March 4, 2015. However, the institution's executive review committee did not review the use of force until September 25, 2015, more than six months thereafter.

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. However, a lieutenant failed to adequately notify the investigative services unit following the use of force. The hiring authority ordered training. 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 toward him. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify any criminal conduct, it referred the matter to the district attorney's office for review pursuant to departmental policy. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **14-2629-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

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

Disposition

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

Incident Date: 2014-11-15	Deadly Force Incident

Incident Summary

On November 15, 2014, two inmates were fighting in a shower area. Officers deployed pepper spray and a pepper spray grenade. The inmates continued fighting and an officer struck one inmate in the shoulder with a baton. The officer then struck the second inmate in the shoulder with the baton and aimed a second strike at the inmate's arm, missing and potentially striking the inmate in the head. The inmates suffered injuries consistent with fighting and the inmate who was allegedly struck in the head had minor injuries consistent with the use of force. The OIG and the Office of Internal Affairs responded to the scene.

Administrative Investigation	OIG Case Number: **14-2681-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 and the Office of Internal Affairs of the incident and failed to adequately consult with the OIG thereafter. The department failed to timely request clarifying reports and timely review the incident. The special agent failed to adequately consult with the OIG, failed to identify conflicts in the evidence, and failed to complete a thorough investigation.

Assessment Questions

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

  The hiring authority did not notify the Office of Internal Affairs until more than two hours after the incident.

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

  The hiring authority did not notify the OIG until more than one hour after control of the incident.

- Was the critical incident adequately documented?

  The institution failed to timely request clarifying reports. As a result, the officers could not remember details of the incident and the clarifying reports were inadequate.

- Did the special agent adequately prepare for all aspects of the investigation?

  The special agent failed to adequately identify discrepancies in the officers' reports, request clarification, or interview the officers.

- 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 special agent failed to forward a draft copy of the report to the OIG until after submitting it to the special agent in-charge.

North Region

- Was the final investigative report thorough and appropriately drafted?

  The report failed to include that the institution initially informed the OIG and the Office of Internal Affairs that the officer had intentionally used deadly force, failed to identify discrepancies in the officers' reports, and failed to identify inconsistencies between the medical reports and the officers' reports. The special agent also failed to obtain the final documents before completing the report and the report inaccurately stated that the OIG concurred with terminating the investigation.

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

  The special agent failed to adequately consult with the OIG regarding terminating the investigation and inaccurately represented to the OIG that the Office of Internal Affairs rejected the case when the Office of Internal Affairs had not yet made a final determination.

- Was the investigation thorough and appropriately conducted?

  The special agent failed to follow up regarding discrepancies in the officers' reports and inconsistencies between the medical reports and the officers' reports. The special agent also failed to obtain the final documents before completing the investigation and report.

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

  The institution repeatedly failed to timely respond to the OIG's inquiries regarding the status of the institution's executive review committee meeting.

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

  The hiring authority failed to request clarifying reports from the officers until nearly nine months after the incident and the institution's executive review committee failed to review the case until nine months after the incident.

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 with the determination because the department failed to conduct an adequate initial review. After a significant delay, the department requested additional information from the involved officers, who were unable to recall the events. Therefore, the institution's executive review committee determined the use of force was within policy. Based upon the available information, the OIG concurred.

Incident Date: 2014-11-30	Deadly Force Incident

Incident Summary

On November 30, 2014, officers deployed pepper spray and less-lethal rounds at two inmates who were fighting on an exercise yard. One of the less-lethal rounds struck an inmate in the head. A physician at an outside hospital diagnosed the inmate with a fractured skull. The inmate returned to the institution the same day. The OIG and the Office of Internal Affairs responded to the scene.

Administrative Investigation	OIG Case Number: **14-2830-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 a draft investigative memorandum to the OIG for review. The institution's executive review committee failed to make a timely determination.

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 investigative memorandum.

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

  The Office of Internal Affairs determined that a deadly force investigation was not warranted on January 21, 2015, and informed the hiring authority that the use-of-force review could resume. However, the institution's executive review committee did not make its determination until June 23, 2015, five months later.

North Region

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 no violation of departmental policy. The OIG concurred with the determination.

Incident Date: 2015-04-22	Deadly Force Incident

Incident Summary

On April 22, 2015, two inmates attacked a third inmate on the exercise yard, punching and kicking the inmate's head while the inmate was motionless. Officers deployed chemical agents and the observation officer fired one warning shot from a Mini-14 rifle. The third inmate got up and the two attacking inmates resumed their attack, causing the third inmate to fall to the ground where the two inmates continued their attack. The observation officer fired a round from his Mini-14 rifle for effect, striking one of the assailants in the chest. Paramedics arrived and transported the inmate who was shot to an outside hospital where a physician pronounced him dead. The attacked inmate was treated at the institution for abrasions and bruising. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-0880-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department failed to comply with policies and procedures governing the investigative process. The special agent failed to timely and appropriately conduct interviews, prepare appropriate draft and final investigative reports, keep the criminal and administrative investigations separated, and timely complete the investigation.

Assessment Questions

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

  The Office of Internal Affairs interviewed the last witness on May 13, 2015, 21 days after the incident.

- Were all of the interviews thorough and appropriately conducted?

  The special agent asked numerous leading questions regarding the need to use deadly force.

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

  The investigative draft report contained numerous statements that were biased, leading, and opinion, and failed to thoroughly identify persons being described.

- Was the final investigative report thorough and appropriately drafted?

  The final investigative report still contained statements that were biased and leading.

- Was the investigation thorough and appropriately conducted?

  The special agent asked numerous leading questions during the interviews. After the officer invoked his Miranda rights and the Office of Internal Affairs compelled the officer's statement in the administrative investigation, the special agents for the criminal and administrative investigations both attended the weapon testing and communicated with each other regarding the status of obtaining evidence.

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

  The Office of Internal Affairs assigned a special agent on April 23, 2015, but he did not complete the investigation until December 7, 2015, more than seven months after assignment.

Incident Date: 2015-06-19	Deadly Force Incident

North Region

Incident Summary

On June 19, 2015, two inmates stabbed another inmate with inmate-manufactured weapons. An officer fired a shot from a Mini-14 rifle at one of the attacking inmates and struck him in the shoulder. The inmates stopped fighting. Officers transported the inmate who was shot and the inmate who was stabbed to an outside hospital for treatment. Both inmates returned to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-1233-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

Incident Date: 2015-08-16	Deadly Force Incident

Incident Summary

On August 16, 2015, approximately 50 inmates engaged in a riot in a dining hall. Officers fired several less-lethal rounds and deployed chemical agents. An observation officer fired four warning shots from a Mini-14 rifle and one shot at an inmate holding a broomstick over another inmate's head, striking the first inmate in the chest. The riot stopped shortly after the officer shot the inmate. Life-saving measures were not successful and a physician pronounced the inmate dead. The department transported another inmate to an outside hospital for a head injury reportedly caused by a less-lethal round. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs also opened administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-1636-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 complete a timely and thorough investigation.

Assessment Questions

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

  The criminal deadly force investigation team did not conduct the last interview until August 21, 2015, five days after the incident.

- Were all of the interviews thorough and appropriately conducted?

  The Office of Internal Affairs did not have all witnesses review and authenticate their reports and did not thoroughly question all witnesses regarding the extent of the fighting or injuries witnessed.

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

  Because the Office of Internal Affairs did not thoroughly question all witnesses, the investigative draft report was likewise not thorough.

- Was the final investigative report thorough and appropriately drafted?

  Because the Office of Internal Affairs did not thoroughly question all witnesses, the final investigative report was likewise not thorough.

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

  The Office of Internal Affairs assigned a special agent on August 17, 2015, but the special agent did not complete interviews timely and did not complete the investigation until December 14, 2015.

Incident Date: 2015-08-18	Deadly Force Incident

North Region

Incident Summary

On August 18, 2015, an officer allegedly negligently discharged a firearm while inside the complex control area of the institution. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. Although departmental policy requires the Office of Internal Affairs to refer deadly force investigation cases to the district attorney's office for review, the Office of Internal Affairs did not refer the case. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-1719-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department failed to comply with policies and procedures governing the investigative process. The department delayed notifying the Office of Internal Affairs and the OIG for several hours following the incident. A sergeant inappropriately handled evidence. The Office of Internal Affairs did not timely conduct interviews, initially refused to investigate the matter as a deadly force case, and failed to refer the matter to the district attorney's office.

Assessment Questions

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

  The institution did not notify the Office of Internal Affairs until almost six hours after the incident.

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

  The department did not notify the OIG until almost six hours after the incident.

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

  A sergeant responding to the scene secured the weapon and reloaded it with the remaining rounds, which the involved officer had removed, and then placed the weapon in a holster.

- Did the Office of Internal Affairs adequately respond to the incident?

  The Office of Internal Affairs did not timely respond to the institution due to late notification. Also, the Office of Internal Affairs initially refused to classify the matter as a deadly force case even though an officer negligently discharged a firearm. Only after the OIG intervened did the Office of Internal Affairs agree to investigate the matter as a case involving deadly force.

- Did the Office of Internal Affairs properly determine whether the case should be opened as a Deadly Force Investigation Team investigation?

  The Office of Internal Affairs initially refused to classify the matter as a deadly force case even though an officer allegedly negligently discharged a firearm. Only after the OIG intervened did the Office of Internal Affairs agree to investigate the matter as a deadly force case.

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

  The incident occurred on August 19, 2015, but the deadly force investigation team did not conduct interviews until September 22, 2015, 34 days after the incident.

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

  Departmental policy requires the Office of Internal Affairs to refer all deadly force investigation cases to the district attorney's office for review. The Office of Internal Affairs failed to refer the case.

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

  The hiring authority failed to notify the Office of Internal Affairs and the OIG regarding the incident in a timely manner and the Office of Internal Affairs failed to timely conduct the interviews.

South Region

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 the Office of Internal Affairs did not identify any criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **13-1656-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Sustained**	**Salary Reduction**	**Letter of Reprimand**

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 adequately consult with the department attorney. The department attorney failed to adequately consult with the Office of Internal Affairs and the OIG, failed to enter required information into the case management system, and failed to provide the hiring authority with appropriate legal advice. The department failed to conduct the investigative findings conference in a timely manner.

Assessment Questions

- Did the special agent adequately confer with the department attorney upon case initiation and prior to finalizing the investigative plan?

  The special agent did not confer with the department attorney regarding the investigative plan.

- Within 21 calendar days, did the department attorney or employee relations officer correctly assess the deadline for taking disciplinary action and make an entry into the case management system confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time?

  The department attorney was assigned on September 10, 2013, but did not make an entry into the case management system regarding the deadline for taking disciplinary action.

- 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?

  A department attorney was assigned to the case on September 10, 2013, but did not contact either the special agent or the OIG.

- 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 did not provide the department attorney with a draft copy of the investigative report.

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

  The Office of Internal Affairs completed its investigation and referred the matter to the hiring authority on April 22, 2014. However, the hiring authority did not consult with the OIG and the department attorney regarding the sufficiency of the investigation and the investigative findings until May 30, 2014, 38 days thereafter.

- Did the department attorney provide appropriate legal consultation to the HA regarding the sufficiency of the investigation and investigative findings?

  The department attorney did not appropriately analyze the applicable departmental policy, resulting in erroneous legal advice to the hiring authority.

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

  The special agent did not consult with the department attorney regarding the status of the investigation, scheduling witness interviews, and the sufficiency of the investigative report.

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

  The department failed to conduct the investigative findings conference in a timely manner.

South Region

Disposition

The Deadly Force Review Board found that the parole agent's use of deadly force was not in compliance with the department's use-of-force policy. The hiring authority imposed a 10 percent salary reduction for 13 months. The OIG concurred with the hiring authority's determinations. The parole agent filed an appeal with the State Personnel Board. Following a hearing, the State Personal Board determined the original penalty was too severe and reduced the penalty to a letter of reprimand.

Disciplinary Assessment

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

The department failed to comply with policies and procedures governing the disciplinary process. The department failed to conduct the disciplinary findings conference in a timely manner. The department attorney failed to adequately prepare for and conduct the State Personnel Board hearing.

Assessment Questions

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

  The Office of Internal Affairs completed its investigation and returned the case to the hiring authority on April 22, 2014. However, the hiring authority did not consult with the OIG and the department attorney regarding the disciplinary determinations until May 30, 2014, 38 days thereafter.

- Did the department's advocate adequately subpoena and prepare available witnesses for the hearing?

  The department attorney subpoenaed many witnesses that were not relevant to the issues and did not consult with the OIG concerning witness preparation. However, based on some of the testimony, it was clear that she did not appropriately prepare the witnesses.

- Did the department's advocate adequately and appropriately address legal issues prior to and during the SPB hearing?

  The department attorney did not appropriately articulate legal arguments, did not make appropriate objections, did not make cogent arguments to preserve the record for appeal, and stipulated to the introduction of evidence on behalf of the parole agent that was without foundation and otherwise inadmissible. Additionally, the department attorney's supervisor had to instruct the department attorney to stipulate to the parole agent's admission that he violated the use of force policy.

- Did the department's advocate present the necessary available evidence regarding the allegations at the hearing?

  The department attorney did not present all necessary evidence concerning the appropriateness of the penalty even though the penalty was the only contested issue at hearing.

- Did the department's advocate appropriately object to evidence presented by appellant(s) at the hearing?

  The department attorney did not appropriately object to much of the evidence the parole agent introduced at hearing. The department attorney also did not fully articulate objections and stipulated to the admissibility of letters of commendation the parole agent offered that would have been inadmissible.

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

  The department failed to conduct the disciplinary findings conference in a timely manner.

APPENDIX E
NON-DEADLY FORCE
CRITICAL INCIDENT CASE SUMMARIES

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CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-01-14	**14-2204-RO**	**PREA**

Incident Summary

On January 14, 2014, a physician assistant performed a rectal examination on an inmate. The inmate later alleged that the physician assistant committed a violent sexual assault on him during the examination.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was not adequate because the hiring authority conducted an internal inquiry to determine whether misconduct occurred rather than referring the matter to the Office of Internal Affairs.

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

Incident Date	OIG Case Number	Case Type
2014-04-23	**14-1987-RO**	**In-Custody Inmate Death**

Incident Summary

On April 23, 2014, two officers responded to an inmate yelling for assistance and found an inmate face-down and breathing, but unresponsive. Two nurses responded and provided emergency medical care. The inmate was air-lifted to an outside hospital where he died 11 days later. The institution placed three inmates in administrative segregation pending a homicide investigation.

Disposition

The coroner determined the manner of death was homicide and the cause of death was blunt-force head trauma. The department evaluated the emergency medical response and concluded life-saving efforts were appropriate. The OIG concurred. The hiring authority identified potential staff misconduct based on an officer's alleged disclosure of confidential information; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's response was not adequate because it failed to notify the OIG of the incident in a timely manner and an officer allegedly disclosed confidential information about the inmate who was killed to other inmates.

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

CENTRAL REGION

Assessment Questions

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

  The department did not notify the OIG until the following day.

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

  Prior to the homicide, an officer allegedly disclosed confidential information about the deceased inmate to other inmates.

Incident Date	OIG Case Number	Case Type
2014-09-04	**14-2219-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 4, 2014, two officers forced a handcuffed inmate to the ground after he resisted during an escort. Officers placed leg restraints on the inmate and escorted him to a holding cell, where they instructed him to kneel so the leg restraints could be removed. After one of the officers removed one leg restraint, the inmate suddenly moved and the officer allegedly pushed the inmate, causing his face to hit the back of the holding cell and fracturing the inmate's nose.

Disposition

The institution's executive review committee failed to review the matter. The hiring authority identified potential staff misconduct based on allegations of unreasonable use of force, dishonesty, and failing to comply with supplemental reporting requirements; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs did not open an investigation.

Overall Assessment

The department's response was not adequate because custody staff submitted inconsistent reports and the institution's executive review committee failed to review the incident and failed to consult with the OIG. The hiring authority failed to adequately consult with the OIG and failed to timely request an investigation. The Office of Internal Affairs failed to open an investigation.

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

Incident Date	OIG Case Number	Case Type
2014-09-18	**14-2236-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 18, 2014, an officer observed three inmates stabbing a fourth inmate on the exercise yard. Responding officers deployed pepper spray grenades. The inmates stopped their attack as additional officers arrived. The fourth inmate was air-lifted to an outside hospital and returned to the institution five days later.

Disposition

The institution's executive review committee determined the department's response did not comply with departmental policy because officers allegedly ordered the injured inmate to walk to the medical clinic. The OIG concurred. The hiring authority provided training.

Overall Assessment

The department's response was not adequate because officers ordered the injured inmate to walk to the medical clinic and the emergency medical response review committee failed to identify this concern. The hiring authority failed to refer the matter to the Office of Internal Affairs and failed to address the lack of guidelines for appropriately housing inmates pending transfer.

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

CENTRAL REGION

Assessment Questions

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

  Prior to the incident, the institution released one of the attacking inmates to a facility for lower-risk inmates due to unavailable bed space. The emergency medical response review committee failed to identify that officers ordered the injured inmate to walk to the medical clinic.

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

  The OIG identified that officers ordered the injured inmate to walk to the medical clinic with life-threatening injuries and the institution's practice of releasing inmates from security housing units to facilities where classification factors restrict them from placement.

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

  The OIG recommended that the hiring authority refer the matter to the Office of Internal Affairs because the officers risked further injury to the inmate by ordering him to walk with life-threatening injuries. The hiring authority declined to do so.

Incident Date	OIG Case Number	Case Type
2014-12-31	**15-0136-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On December 31, 2014, officers responded to a request for assistance and discovered an inmate in his cell bleeding profusely from his face. The department transported the inmate to an outside hospital for repair of a broken jaw and nose. The inmate returned to the institution three days later. The institution placed the cellmate in administrative segregation pending an investigation.

Disposition

The department conducted an in-cell assault review and determined staff complied with departmental guidelines when housing the involved inmates. The hiring authority did not identify any staff misconduct.

Overall Assessment

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. A lieutenant failed to take appropriate action to ensure preservation and processing of evidence and the crime scene. The hiring authority failed to timely respond to and document the incident, failed to make a timely decision regarding referral to the Office of Internal Affairs, and improperly declined to refer alleged misconduct to the Office of Internal Affairs for investigation.

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

CENTRAL REGION

Assessment Questions

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

  The incident occurred on December 31, 2014. A captain raised concerns about potential staff misconduct on January 2, 2015. However, an inquiry to identify possible staff misconduct was not completed and approved by the hiring authority until April 17, 2015, more than three months thereafter.

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

  The department failed to notify the OIG regarding the incident in a timely manner. The OIG discovered the incident seven days after it occurred.

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

  The department failed to timely notify the OIG of the incident preventing real-time monitoring of the case. A lieutenant failed to take appropriate action to ensure preservation and processing of evidence and the crime scene. The hiring authority failed to timely respond to and document the incident, failed to make a timely decision regarding referral to the Office of Internal Affairs, and improperly declined to refer alleged misconduct to the Office of Internal Affairs for investigation.

- Was the critical incident adequately documented?

  The department delayed documenting the incident until it received confirmation that the inmate suffered a serious injury. The department should have immediately documented the incident because of the indicators of serious injury and the circumstances of the assault.

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

  The OIG identified that a lieutenant failed to appropriately follow up regarding the severity of the inmate's injuries. The lieutenant also allegedly failed to notify the investigative services unit, which prevented timely crime scene preservation and processing of possible evidence.

- 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 December 31, 2014, and even though the hiring authority identified potential staff misconduct on January 2, 2015, the hiring authority failed to refer the matter to the Office of Internal Affairs for investigation until April 17, 2015.

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

  The hiring authority inappropriately declined to refer the lieutenant's alleged misconduct to the Office of Internal Affairs for investigation.

Incident Date	OIG Case Number	Case Type
2015-02-18	**15-0404-RO**	**In-Custody Inmate Death**

Incident Summary

On February 18, 2015, an officer saw an inmate lying unresponsive on the floor. A sergeant, second officer, and a nurse responded. The nurse requested an ambulance and started life-saving measures. An ambulance transported the inmate to an outside hospital where the inmate was placed on life support. On February 19, 2015, a hospital physician removed the inmate from life support and pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the primary cause of death was an accidental closed head injury. The hiring authority provided training to custody staff regarding critical incident assessments and response, timely notifying the investigative services unit, and thorough report writing.

Overall Assessment

The department's response was not adequate because it failed to adequately notify the OIG, preventing an on-scene response and real-time monitoring. In addition, the department assumed the inmate's injuries were accidental and, therefore, failed to properly respond following the incident.

CENTRAL REGION

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

Assessment Questions

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

  The department acted on the assumption that the inmate's injuries were accidental and, therefore, failed to timely secure the cell, process evidence, and contact the investigative services unit.

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

  When the investigative services unit responded the following morning, the scene had already been cleaned and the inmates allowed to return to the cell.

- Was the critical incident adequately documented?

  The incident commander failed to ensure the incident was adequately documented and failed to ensure that medical evaluations were performed timely and properly documented.

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

  When notifying the OIG, the department omitted critical information regarding the inmate's medical condition and level of consciousness.

Incident Date	OIG Case Number	Case Type
2015-03-16	**15-0561-RO**	**PREA**

Incident Summary

On March 16, 2015, an inmate informed an officer that he was forced to orally copulate his cellmate. The institution immediately placed the inmate who made the allegation in administrative segregation. The cellmate remained in his assigned cell and was placed in administrative segregation the following day.

Disposition

The hiring authority identified potential staff misconduct based on the unauthorized disclosure of confidential information, but chose not to refer the case to the Office of Internal Affairs for investigation. The department provided training to the investigative services unit regarding evidence collection and to the captain regarding the laws and policy that govern the disclosure of confidential information.

Overall Assessment

The department's response to the incident was not adequate because the institution failed to collect and preserve evidence, to treat the sexual assault information as confidential, and to refer the matter to the Office of Internal Affairs.

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

Incident Date	OIG Case Number	Case Type
2015-03-18	**15-0593-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On March 18, 2015, a control booth officer observed two inmates fighting in the dayroom. The officer fired three less-lethal rounds, which stopped the fighting. One of the inmates received a head injury that he initially denied was caused by a less-lethal round. The inmate later claimed a round ricocheted, causing the injury. An ambulance transported the inmate to an outside hospital for further evaluation and he returned to the institution a few hours later.

CENTRAL REGION

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-03-19	**15-0734-RO**	**PREA**

Incident Summary

On March 19, 2015, an inmate alleged that an officer asked him to perform a sexual act and threatened retaliation against the inmate if the inmate told anyone.

Disposition

The hiring authority identified potential staff misconduct based on the allegations; therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs rejected the case. The OIG concurred.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-03-22	**15-1258-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On March 22, 2015, an inmate punched an officer in the face while officers were conducting searches. Four officers forced the inmate to the ground face-first. The inmate suffered multiple head injuries, including an orbital fracture, and was transported to an outside hospital. The inmate returned to the institution three days later.

Disposition

The hiring authority identified potential staff misconduct based on alleged unreasonable use of force; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's response was not adequate because the institution failed to notify the OIG of the incident and the officers' reports failed to adequately document the incident.

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-04-08	15-0704-RO	In-Custody Inmate Death

Incident Summary

On April 8, 2015, an officer discovered an unresponsive inmate in his cell and removed the cellmate. Three nurses and a psychiatric technician placed the inmate on a gurney and began life-saving measures, which continued while transporting the inmate to the triage and treatment area. Paramedics continued life-saving efforts until a physician at an outside hospital pronounced the inmate dead.

Disposition

The coroner determined the cause of death was accidental due to a chronically enlarged heart. The department's Death Review Committee determined the death was not preventable. The emergency medical response review committee concluded the response to the emergency was sufficient. The OIG did not concur. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions were not adequate because the institution failed to call an ambulance until five minutes after initiating life-saving measures. The emergency medical response review committee failed to identify the delay.

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

Incident Date	OIG Case Number	Case Type
2015-04-11	15-0727-RO	In-Custody Inmate Death

Incident Summary

On April 11, 2015, an officer discovered an unresponsive inmate on the cell floor. Two officers removed the cellmate and one of the officers and a sergeant began life-saving measures. A nurse arrived and assisted with life-saving efforts. The inmate was transported to an outside hospital where he died of his injuries the following day. The institution referred the case against the cellmate to the district attorney's office, which accepted the case.

Disposition

An autopsy revealed that the cause of death was asphyxia due to strangulation and the manner of death was homicide. The department conducted an in-cell assault review and found both inmates were housed in compliance with the department's double-cell housing policy. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions prior to the incident were not adequate because the department failed to address the cellmate's threats prior to changing his housing status. The department also delayed ten minutes in calling an ambulance after initiating life-saving efforts and failed to provide specific policy guidelines for transitioning an inmate's housing status despite the OIG's prior recommendations.

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

Incident Date	OIG Case Number	Case Type
2015-04-11	15-0728-RO	In-Custody Inmate Death

Incident Summary

On April 11, 2015, officers responded to a cell and discovered an unresponsive inmate on the cell floor. The officers removed the cellmate and began life-saving measures as two nurses arrived and assisted. The inmate was transported to an outside hospital via ambulance and pronounced dead after life-saving efforts failed. The institution placed the cellmate in administrative segregation and referred the case against the cellmate to the district attorney's office.

CENTRAL REGION

Disposition

The autopsy determined the cause of death was strangulation. The department completed an in-cell assault review and concluded that the inmates were housed appropriately in compliance with the double-cell housing policy. The emergency medical response review committee determined the response time was adequate and departmental policy was followed during the emergency. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-04-19	**15-0777-RO**	**Suicide**

Incident Summary

On April 19, 2015, an officer discovered an inmate unresponsive in his cell. Officers removed the inmate from his cell and initiated life-savings measures. Two nurses arrived and continued life-saving efforts. Paramedics arrived and transported the inmate to an outside hospital where a physician pronounced the inmate dead.

Disposition

The autopsy determined the manner of death was suicide and the cause of death was an overdose of prescribed medication. The emergency medical response review committee found that the emergency response was adequate. The Statewide Mental Health Program suicide report stated the death was foreseeable and preventable. The department previously identified the inmate as high risk for suicide. The report identified shortcomings in the required mental health evaluations and that the institution gave the inmate large amounts of medication to self-administer despite his suicide risk. The report required the institution to provide proof of training and to implement enhanced monitoring of inmates with high suicide risk and recommended considering a policy change by requiring high-risk inmates to receive medication in single doses by direct observation. Although there were systemic inefficiencies, the hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions prior to the incident were not adequate because the department failed to adequately monitor the inmate's mental health status prior to his death.

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

Incident Date	OIG Case Number	Case Type
2015-04-20	**15-0792-RO**	**Other Significant Incident**

Incident Summary

On April 20, 2015, shots were fired from outside an institution's secure perimeter into an exercise yard. An officer was grazed by a bullet, transported to an outside hospital, and released. The department requested assistance from outside law enforcement. The department and outside law enforcement thoroughly searched the area with the aid of a helicopter, but the suspect was not found.

Disposition

Multiple law enforcement agencies assisted with searching for the suspect and clearing the outer perimeter of the institution, but did not locate any suspects. Multiple shell casings and empty beer cans were found approximately 1,000 yards west of the institution. From that location, there was no direct line of sight to the area where the officer was struck by the bullet. The department determined this was an isolated incident and the OIG concurred. The hiring authority did not identify any staff misconduct.

CENTRAL REGION

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-04-24	**15-1894-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On April 24, 2015, two inmates repeatedly punched a third inmate in the head, face, and upper torso. Two sergeants and five officers deployed seven chemical grenades. The observation officer fired three less-lethal rounds at the legs of the two inmates, stopping the attack. The inmate who was attacked received treatment for minor injuries at the institution. A less-lethal round struck one of the other inmates in the leg. The department transported the inmate to an outside hospital where he underwent multiple surgeries to save his leg. The inmate returned to the institution after four weeks. The institution referred the case to the district attorney.

Disposition

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

Overall Assessment

The department's response was not adequate because it failed to timely notify the OIG, failed to document the severity of the inmate's injury, and failed to complete a video-recorded interview as required.

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

Incident Date	OIG Case Number	Case Type
2015-04-27	**15-0862-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On April 27, 2015, several inmates began fighting in a dining hall. The observation officer fired one less-lethal round at the leg of an aggressor after the inmates disregarded orders to stop fighting. The officer fired a second round at an aggressor's hip, which stopped the fight. One of the inmates received five staples for a head injury he claimed was due to a less-lethal round.

Disposition

The institution's executive review committee determined the use of force was within policy; however, the institution provided training to the observation officer to ensure the Mini-14 rifle is carried pursuant to policy. The OIG concurred.

Overall Assessment

The department's actions prior to the incident were not adequate because the observation officer failed to carry the Mini-14 rifle pursuant to policy.

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-05-02	**15-0885-RO**	**In-Custody Inmate Death**

Incident Summary

On May 2, 2015, two officers found an inmate in respiratory distress. The inmate stopped breathing and one of the officers initiated life-saving measures while the second officer retrieved resuscitation equipment. The inmate started breathing again, but began to vomit and again stopped breathing. The first officer and another inmate resumed life-saving measures while two nurses arrived and assisted. The nurses and officers placed the inmate on a gurney and transported him to the triage and treatment area. A physician pronounced the inmate dead during transport to an outside hospital.

Disposition

The autopsy determined the inmate died of a heart attack due to heart disease. The department's Death Review Committee concluded the institution delayed ten minutes in calling an ambulance once life-saving measures were initiated. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department failed to timely call an ambulance once life-saving efforts began and the emergency medical response committee failed to identify and address the delay.

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

Incident Date	OIG Case Number	Case Type
2015-05-16	**15-1005-RO**	**In-Custody Inmate Death**

Incident Summary

On May 16, 2015, an inmate notified officers that another inmate was unresponsive. Officers initiated life-saving measures until two nurses arrived and continued life-saving efforts. Paramedics relieved the nurses and a paramedic pronounced the inmate dead after life-saving efforts failed.

Disposition

The coroner concluded that the inmate died from heart failure. The department's Death Review Committee determined the death was not preventable. The emergency medical response review committee provided training to a nurse because she failed to administer emergency medication, test the blood sugar level, and properly document care.

Overall Assessment

The department's response was not adequate because a nurse failed to follow emergency care protocols.

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

Incident Date	OIG Case Number	Case Type
2015-05-19	**15-1026-RO**	**Inmate Riot**

Incident Summary

On May 19, 2015, approximately 70 inmates attacked 15 inmates on an exercise yard. Officers used pepper spray and 16 less-lethal rounds to stop the attack. After the incident, an inmate alleged an officer restrained him and ordered him to stand. The inmate told the officer he could not walk because he was shot in the knee with a less-lethal round. The inmate alleged the officer picked him up, forced him to walk, and pushed him from behind, causing him to fall face-first while restrained. The department transported the inmate to an outside hospital due to a potential head injury and the inmate's claim that he may have lost consciousness during the riot. The inmate returned to the institution the following day.

CENTRAL REGION

Disposition

The institution's executive review committee determined the use of force was in compliance with departmental policy but that custody staff deviated from policy when conducting the video-recorded interviews. The institution provided training. The investigative services unit also completed an inquiry regarding the inmate's allegation of unreasonable physical force and concluded the evidence did not support the inmate's allegation. The OIG concurred with the committee's decision.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-05-22	**15-1115-RO**	**PREA**

Incident Summary

On May 22, 2015, an instructor at a private contract facility allegedly wrote an acronym containing a direct reference to prison rape on a dry erase board in a classroom. The instructor also allegedly made sexual comments to the inmates during previous classes.

Disposition

The hiring authority identified potential staff misconduct and conducted an internal inquiry. The hiring authority did not refer the case to the Office of Internal Affairs because the instructor is not a departmental employee. The hiring authority sustained an allegation that the instructor wrote an inappropriate comment on a board during class but not that the instructor violated the provisions of the Prison Rape Elimination Act or that he made inappropriate comments to inmates during prior classes. The hiring authority served the instructor with a written reprimand for unprofessional conduct. The private contract facility changed local operating procedures to adequately address non-physical sexual harassment incidents. After the incident, the department and the private contract facility provided training to their employees regarding the Prison Rape Elimination Act provisions regarding non-physical sexual harassment.

Overall Assessment

The private contract facility's and department's responses were not adequate. The private contract facility and the department failed to notify the OIG, preventing the OIG from real-time monitoring of the case. The private contract facility's local operating procedures failed to address non-physical sexual harassment.

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

Incident Date	OIG Case Number	Case Type
2015-05-27	**15-1097-RO**	**Contraband Watch**

Incident Summary

On May 27, 2015, the department placed an inmate on contraband surveillance watch after he failed to clear a metal detector. Prior to starting the contraband surveillance watch, the institution placed the inmate in a holding cell with 15-minute checks. After ten hours in the holding cell, as officers were escorting the inmate for contraband surveillance watch, the inmate told officers he did not have any contraband. The inmate cleared the metal detector but the department placed him on contraband surveillance watch as a precaution. The inmate refused to wear the required jumpsuit and officers used force to clothe the inmate in the jumpsuit. The inmate alleged that officers used unreasonable force, injuring his arm. The department removed the inmate from contraband surveillance watch on May 28, 2015, one day later, after he cleared the metal detector.

CENTRAL REGION

Disposition

The department recovered no contraband from the inmate. The institution's executive review committee determined the use-of-force did not comply with departmental policy after the OIG explained that immediate force was not authorized because there was no imminent threat. The department provided training to the managers, supervisors, and officers involved in the incident.

Overall Assessment

The department's actions were not adequate because the department failed to timely place the inmate on contraband surveillance watch and to constantly observe him after he did not clear a metal detector. Officers also inappropriately used immediate force to clothe the inmate in a jumpsuit and did not properly tape the jumpsuit. A lieutenant failed to properly document the video-recorded interview. A captain failed to obtain the required signatures for use of hand isolation devices.

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

Incident Date	OIG Case Number	Case Type
2015-06-10	**15-1194-RO**	**Other Significant Incident**

Incident Summary

On June 10, 2015, an inmate reported to mental health staff that the inmate was suicidal. Officers transported the inmate to the triage and treatment area where nursing staff observed the inmate open an arm wound, which caused extensive bleeding. The department transferred the inmate to an outside hospital and the inmate returned to the institution the next day.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-06-15	**15-1211-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On June 15, 2015, an officer discovered two inmates fighting in a cell. The officer deployed pepper spray after the inmates ignored orders to stop fighting. One of the inmates suffered numerous puncture wounds to his back and had difficulty breathing. The injured inmate was taken to an outside hospital and returned later that day. The institution placed both inmates in long-term restricted housing pending an investigation. The department referred the case to the district attorney's office.

Disposition

The department completed an in-cell assault review and concluded the inmates were appropriately housed together prior to the incident. The emergency medical response review committee found that the clinic was scheduled to be without nursing staff for one hour during the time the incident occurred. The hiring authority ordered training for 23 nurses to ensure vacant positions are filled and nurses do not leave the clinic until they are relieved.

Overall Assessment

The department's actions prior to the incident were not adequate because the facility clinic was left vacant, resulting in a delayed medical response.

CENTRAL REGION

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

Incident Date	OIG Case Number	Case Type
2015-06-18	**15-1220-RO**	**Other Significant Incident**

Incident Summary

On June 18, 2015, a psychiatric technician saw a substantial amount of blood on the floor of an inmate's cell in the mental health crisis unit. The inmate reported that she intentionally cut her arm with a staple. The department transported the inmate to an outside hospital and the inmate returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-06-18	**15-1255-RO**	**Other Significant Incident**

Incident Summary

On June 18, 2015, an officer discovered an unresponsive inmate having a seizure in her cell. During transport to the triage and treatment area, the inmate stopped breathing and a nurse initiated life-saving measures. The inmate subsequently became responsive and began breathing on her own. An ambulance arrived and transported the inmate to an outside hospital. The inmate returned to the institution the next day.

Disposition

After review of a note found in the inmate's property, a physician deemed the inmate suicidal and placed her on suicide watch. The emergency medical response review committee determined that nurses failed to follow seizure protocol and provided training.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-07-06	**15-1376-RO**	**Inmate Serious/Great Bodily Injury**

CENTRAL REGION

Incident Summary

On July 6, 2015, an officer deployed pepper spray at an inmate who charged at him. The inmate pushed the officer down, punched him in the head and face, and struck him with a hard plastic cup. A responding officer pushed the inmate off of the first officer, who stood up and deployed pepper spray, striking both the inmate and the responding officer. The department transported the inmate to an outside hospital for treatment of a fractured nose and lacerated cheek. The inmate returned to the institution the next day.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy but that a lieutenant failed to follow procedures for video-recording the inmate interview and collecting reports. The institution provided training to the lieutenant. The OIG concurred with the committee's determinations.

Overall Assessment

The department's actions following the incident were not adequate because a lieutenant failed to collect reports from all involved officers before they left the institution and failed to complete a timely video-recorded interview of the inmate.

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

Incident Date	OIG Case Number	Case Type
2015-07-06	**15-1454-RO**	**In-Custody Inmate Death**

Incident Summary

On July 6, 2015, custody staff conducted a cell extraction of an unresponsive inmate, placed him in a wheelchair, and rinsed him in a shower before he was medically assessed. A nurse determined he was not breathing and had no pulse. A second nurse initiated life-saving measures and additional nurses arrived and continued life-saving efforts. Paramedics arrived at the scene and pronounced the inmate dead.

Disposition

An autopsy determined the cause of death was a pulmonary embolism. The department's death review committee concluded the death was natural, unexpected, and not preventable. The hiring authority identified potential staff misconduct based on the alleged failure of custody and medical staff to immediately initiate life-saving measures; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions during and after the incident were not adequate because custody and medical staff delayed initiating life-saving measures and the hiring authority permitted custody staff involved in the cell extraction to review the video recording of the incident before writing their reports.

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

Incident Date	OIG Case Number	Case Type
2015-07-20	**15-1453-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On July 20, 2015, an officer responded to a cell and saw one inmate standing at the cell door and the cellmate lying on his bunk covered in blood. The officer removed the first inmate from the cell and a nurse evaluated the injured inmate in the dayroom. The cellmate was later air-lifted to an outside hospital due to a suspected skull fracture and returned three days later. The department placed the first inmate in administrative segregation on single-cell status pending an investigation.

CENTRAL REGION

Disposition

The hiring authority did not identify any staff misconduct. The department conducted an in-cell assault review and found both inmates were housed in compliance with the department's double-cell housing policy. However, the OIG had previously addressed the single-cell policy shortcomings with the Director of Adult Institutions after a hiring authority disregarded the prior violent history of an inmate, resulting in an attempted murder. The department has yet to provide specific guidelines in its policy for transitioning an inmate on single-cell status to double-cell status.

Overall Assessment

The department's actions prior to the incident were not adequate because the department inappropriately changed the first inmate's status from single-cell to double-cell. The inmate was involved in three prior incidents of violence with cellmates. One of the incidents involved a weapon and two of the incidents resulted in serious injury to his cellmates. Institution classification committees kept the inmate on single-cell status for 54 months, noting his violent history. However, the department later changed the inmate's status to double-cell status without fully addressing his history of in-cell violence.

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

Incident Date	OIG Case Number	Case Type
2015-08-06	**15-1616-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On August 6, 2015, an officer deployed pepper spray on two inmates who were fighting in their cell. One of the inmates suffered an orbital fracture and six broken ribs. The department transported the injured inmate to an outside hospital and the inmate returned to the institution the following day. The institution placed the cellmate in administrative segregation pending an investigation. The department referred the case to the district attorney's office.

Disposition

The department completed an in-cell assault review and concluded the inmates were appropriately housed together prior to the incident. The institution's executive review committee determined that the officer's use of force was in compliance with departmental policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-08-07	**15-1591-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On August 7, 2015, two officers discovered an inmate lying on a bed with head trauma. Officers removed the cellmate. A nurse and the officers removed the injured inmate from the cell and transported him to the triage and treatment area. An ambulance transported the inmate to an outside hospital and he returned the following day. The cellmate was medically evaluated and placed in administrative segregation. The institution did not refer this case to district attorney's office pursuant to a memorandum of understanding with the district attorney's office.

CENTRAL REGION

Disposition

The institution completed an in-cell assault review and concluded the two inmates were appropriately housed together. The OIG did not concur because the cellmate had a history of violence toward sex offenders and he was housed with a sex offender. The emergency medical response review committee modified its process to ensure the committee reviews all unscheduled transfers to outside hospitals. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department failed to identify that the two inmates were incompatible before housing them together. The institution failed to conduct an emergency medical response review.

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

Incident Date	OIG Case Number	Case Type
2015-08-08	**15-1565-RO**	**Suicide**

Incident Summary

On August 8, 2015, a psychiatric technician discovered an inmate alone and unresponsive in his cell with a noose tied around his neck. Three officers entered the cell, removed the noose, and began life-saving measures. A nurse and a psychiatric technician arrived and assisted with life-saving efforts. The inmate was taken to the triage and treatment area where additional nurses assisted with life-saving measures. A paramedic arrived and, after consulting with a physician, pronounced the inmate dead.

Disposition

The autopsy and the department's Death Review Committee concluded that the cause of death was asphyxiation and manner of death was suicide. The Statewide Mental Health Program suicide report stated there was "a moderate risk that suicide was foreseeable" and the suicide was preventable. The hiring authority identified potential staff misconduct based on an officer's alleged failure to conduct an appropriate inmate count, an alleged inadequate emergency medical response, and alleged inconsistencies in various reports. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions were not adequate because an officer allegedly failed to discover the unresponsive inmate during an inmate count, a nurse allegedly failed to carry a required equipment, reports contained conflicting information, and the hiring authority failed to timely refer the matter to the Office of Internal Affairs.

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

Incident Date	OIG Case Number	Case Type
2015-08-12	**15-1604-RO**	**Other Significant Incident**

Incident Summary

On August 12, 2015, an instructor found an inmate lying on the floor in a large pool of blood. Two nurses administered first aid. The department transported the inmate to an outside hospital for self-inflicted wounds. The inmate returned to the institution the same day and was placed on suicide watch.

Disposition

The emergency medical response review committee determined the medical response time was adequate and care was appropriate. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was not adequate because the department failed to timely notify the OIG regarding the incident.

CENTRAL REGION

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

Incident Date	OIG Case Number	Case Type
2015-08-12	**15-1615-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On August 12, 2015, an officer observed two inmates fighting in a cell, ordered them to stop, and they complied. One inmate had multiple stab wounds, was transported to an outside hospital, and returned to the institution the following day. The department referred the case to the district attorney's office.

Disposition

The department completed an in-cell assault review and concluded the inmates were appropriately housed together prior to the incident. The department agreed that the existing policy required the emergency medical response review committee to review this incident and agreed to review similar incidents in the future. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response following the incident was not adequate because the emergency medical response review committee failed to properly review the incident.

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

Incident Date	OIG Case Number	Case Type
2015-08-25	**15-1735-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On August 25, 2015, an officer saw two inmates fighting and fired one less-lethal round at the hip of one of the inmates. The round struck the inmate in the neck and the inmates stopped fighting. The injured inmate developed respiratory distress and the department transported him to an outside hospital. The inmate returned to the institution the following day.

Disposition

The institution's executive review committee determined the use of force complied with departmental policy and the OIG concurred. The OIG identified that an officer failed to respond and submit a report regarding the incident. The hiring authority asked the officer for a report and the officer admitted he did not respond to the incident. The hiring authority issued a letter of instruction to the officer for the failure to respond and provided training to a lieutenant for using an inappropriate camera operator.

Overall Assessment

The department's response was not adequate because the department failed to notify the OIG and the Office of Internal Affairs in a timely and sufficient manner. An officer required to respond to the incident failed to do so. The department did not identify that the officer did not respond and that he failed to submit a report. The department also assigned a non-supervisor as the camera operator during the video-recorded inmate interview.

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

Incident Date	OIG Case Number	Case Type
2015-09-01	**15-1787-RO**	**Inmate Serious/Great Bodily Injury**

CENTRAL REGION

Incident Summary

On September 1, 2015, an officer heard loud noises coming from a cell and saw blood throughout the cell. Officers removed the two inmates from the cell. One inmate was uninjured and the other inmate had multiple stab wounds. The department transported the injured inmate to an outside hospital. The inmate returned to the institution the following day. The hiring authority referred the matter to the district attorney's office.

Disposition

The department completed an in-cell assault review and concluded the inmates were appropriately housed together prior to the incident. The emergency medical response review committee found that the emergency response was adequate. However, the institution provided training to nurses to ensure emergency medical response documentation is completed correctly.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-09-06	**15-1803-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 6, 2015, an officer observed two inmates attacking a third inmate on a basketball court. One officer attempted to stop the assault with his baton and a sergeant deployed pepper spray. One of the inmates attempted to hit the sergeant in the head with his elbow. The sergeant struck the inmate on the head with the pepper spray canister, stopping the attack. The struck inmate received sutures in the triage and treatment area for a head injury.

Disposition

The institution’s executive review committee determined that the sergeant's use of unconventional force was a reasonable response to the threat the inmate presented. The committee found that a lieutenant did not follow protocols related to the video-recorded interview and the institution provided training to the lieutenant. The OIG concurred with the committee's determinations.

Overall Assessment

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 and a lieutenant failed to follow protocols for the video-recorded interview.

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

Incident Date	OIG Case Number	Case Type
2015-09-08	**15-1820-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 8, 2015, an inmate repeatedly punched an officer in the face after the officer ordered him to return to his cell. A second officer struck the inmate's shins with a baton. A third officer forced the inmate to the ground and restrained him. The inmate sustained multiple wounds to his legs and a laceration to his nose requiring sutures but refused treatment. The department referred the case to the district attorney's office.

CENTRAL REGION

Disposition

The institution's executive review committee determined that the incident commander failed to identify that an officer who should have responded to the incident failed to submit a report and failed to timely conduct a video-recorded interview. The committee ordered training for the responding sergeant and the captain regarding thorough review of the incident reports prior to forwarding the reports to the next level of review. The OIG concurred with the committee's decision.

Overall Assessment

The department's response was not adequate because the incident commander failed to ensure all reports were submitted and did not conduct a timely video-recorded interview. The department also failed to notify the OIG of the severity of the inmate's injury in a timely manner, preventing the OIG from real-time monitoring of the case.

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

Incident Date	OIG Case Number	Case Type
2015-09-11	**15-1946-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 11, 2015, an inmate began arguing with and yelling at a sergeant. The sergeant instructed an officer to restrain and escort the inmate to a holding cell. During the escort, the inmate broke free of the officer's grasp and turned and faced the officer. The officer used physical force to force the inmate to the floor face-first. The inmate sustained an orbital fracture and laceration near his right eye. The inmate was transported to an outside hospital and returned to the institution four days later.

Disposition

The institution's executive review committee determined that the officer's use of force was in compliance with departmental policy and the OIG concurred. The committee agreed with the OIG that a video-recorded interview should have been completed because the inmate received a serious injury from the use of force. The committee ordered a video-recorded interview and training to the incident commander to ensure follow-up on potential serious injuries that require video-recorded interviews.

Overall Assessment

The department's response was not adequate because the incident commander failed to follow-up regarding the seriousness of the inmate's injury and complete a video-recorded interview within 48 hours as required.

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

Incident Date	OIG Case Number	Case Type
2015-09-15	**15-1917-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 15, 2015, two inmates attacked a third inmate in a dayroom. The control booth officer fired one less-lethal round at an attacking inmate and the inmates stopped the attack. Simultaneously, on the exercise yard, two inmates attacked the cellmate of the inmate attacked in the dayroom. An observation officer fired two less-lethal rounds at the attacking inmates and a second observation officer fired one less-lethal round at an attacking inmate, stopping the attack. An ambulance transported the inmate who was attacked in the dayroom to an outside hospital for treatment of stab wounds to the head and torso. The inmate returned to the institution the same day. The cellmate was air-lifted to an outside hospital for treatment of stab wounds to the chest and collapsed lungs and returned to the institution five days later. The department referred the case to the district attorney's office.

Disposition

The institution's executive review committee agreed with the OIG that the second observation officer failed to adequately document his threat assessment prior to his use of force. The hiring authority provided training to the officer. The OIG concurred. However, the hiring authority failed to provide training to the officer who failed to collect the attacking inmate's clothing as evidence. The OIG did not concur.

CENTRAL REGION

Overall Assessment

The department's response was not adequate because the second observation officer failed to adequately document his threat assessment prior to his use of force and the investigating officer failed to collect critical evidence.

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

Incident Date	OIG Case Number	Case Type
2015-09-28	**15-1981-RO**	**Other Significant Incident**

Incident Summary

On September 28, 2015, an inmate slid an inmate-manufactured weapon under the cell door toward an officer and said his cellmate needed medical attention. Officers removed both inmates from the cell and placed them in restraints. A nurse evaluated the cellmate and found a puncture wound on his back. An ambulance transported the cellmate to an outside hospital and he returned to the institution the same day. The department referred the case to the district attorney's office.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-07-11	**14-1652-RO**	**Other Significant Incident**

Incident Summary

On July 11, 2014, two officers escorted a suicidal inmate to a holding cell without searching him. While two other officers escorted the inmate back to his cell, the inmate slipped out of handcuffs and stabbed one of the officers multiple times with an inmate-manufactured weapon. One of the officers subdued the inmate with pepper spray and physical force. The attacked officer was transported to an outside hospital for treatment of his injuries and released the same day.

Disposition

The institution's executive review committee determined that the use of force did not comply with departmental policy because officers failed to properly secure and search the inmate and failed to timely submit reports. The committee further determined that training was appropriate. The OIG concurred with the committee's determination that the use of force did not comply with departmental policy but not that training was appropriate. The OIG recommended referral to the Office of Internal Affairs for investigation. The hiring authority identified potential staff misconduct based on an officers' failure to search the inmate when he was removed from the cell; 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 and the OIG accepted the case for monitoring. The hiring authority also provided training to the officer who used the incorrect chemical agent.

Overall Assessment

The department's response to the incident was not adequate because the department failed to notify the OIG of the incident, an officer allegedly inappropriately used a fogger and not a streamer to dispense the pepper spray, officers failed to properly secure and search an inmate and timely submit reports, and the hiring authority failed to timely refer the matter to the Office of Internal Affairs.

NORTH REGION

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

Assessment Questions

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

  The department failed to notify the OIG of the incident. The OIG learned of the incident through a news report three days after the incident.

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

  The department failed to notify the OIG of the incident, an officer allegedly inappropriately used a fogger and not a streamer to dispense pepper spray, and the hiring authority failed to timely refer the matter to the Office of Internal Affairs. Officers also allegedly failed to properly secure and search the inmate and failed to timely submit reports.

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

  The department failed to notify the OIG of the incident. The OIG learned of the incident through a news report three days after the incident.

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

  The hiring authority learned of the alleged misconduct on July 11, 2014, but the hiring authority did not refer the matter to the Office of Internal Affairs until June 4, 2015, nearly 11 months after the date of discovery.

Incident Date	OIG Case Number	Case Type
2014-10-14	**14-2441-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On October 14, 2014, an officer saw an inmate in his cell stomping while looking down, but did not see the cellmate. The inmate complied with an order to lie on the floor. Officers opened the cell door and discovered the cellmate unresponsive, bleeding on the floor. The department air-lifted the unresponsive inmate to an outside hospital where he underwent surgery for injuries to his head and face. After seven days at the outside hospital, the department transferred the inmate to different institution. The department referred the matter to the district attorney's office.

Disposition

The department completed an in-cell assault review and concluded the inmates were appropriately housed together prior to the incident. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2014-12-29	**14-2908-RO**	**In-Custody Inmate Death**

NORTH REGION

Incident Summary

On December 29, 2014, four inmates attacked two other inmates with inmate-manufactured weapons on the exercise yard. Officers deployed one less-lethal round and pepper spray grenades, following which the inmates stopped fighting. One of the attacked inmates died from his injuries. The second attacked inmate was taken to an outside hospital for treatment and returned to the institution three days later. The institution referred the matter to the district attorney's office for investigation of possible homicide.

Disposition

The coroner determined that the cause of death was multiple sharp-force injuries. The department's Death Review Committee determined the death was not preventable. The institution's executive review committee determined that the use of force was in compliance with departmental policy. The OIG concurred with the committee's findings. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-01-25	**15-0246-RO**	**Other Significant Incident**

Incident Summary

On January 25, 2015, officers placed a suicidal inmate in a shower pending transportation to the correctional treatment center. The inmate grabbed a plastic bag located in the shower and attempted to place it over his head. One officer ordered the inmate to stop, and deployed pepper spray which struck the inmate's back. The inmate continued to place the bag over his head. Another officer responded and the officers removed the plastic bag from the inmate's head.

Disposition

The institution's executive review committee determined that the use of force was within policy. The OIG concurred. The hiring authority provided training to a lieutenant, sergeant, and officer regarding search procedures and the use of alternatives to holding cells. The hiring authority also provided training to sergeants regarding making consistent entries into the sergeant's log book.

Overall Assessment

The department's actions were not adequate because the department placed a suicidal inmate in a shower as a temporary holding cell without searching and removing items such as the plastic bag from the shower. During a review of the incident, the department also discovered that sergeants periodically failed to make entries into the sergeant's log book.

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

Incident Date	OIG Case Number	Case Type
2015-01-27	**15-0323-RO**	**Hunger Strike**

Incident Summary

On January 27, 2015, an inmate began a hunger strike because medical staff had taken his cane and disability vest. The inmate ended his hunger strike the following day but resumed the hunger strike on January 29, 2015. As of February 8, 2015, the inmate had lost 13 percent of his body weight. On February 10, 2015, the inmate consumed a meal and ended the hunger strike.

Disposition

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

NORTH REGION

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-02-03	**15-0290-RO**	**In-Custody Inmate Death**

Incident Summary

On February 3, 2015, two officers discovered an inmate lying in blood on the floor of his cell. The inmate was alive but unconscious with multiple stab wounds to his torso and neck. Two nurses initiated life-saving measures. The inmate was transported to the triage and treatment area where four nurses and two officers continued life-saving measures without success. A physician pronounced the inmate dead. A sergeant discovered an inmate-manufactured weapon in the cellmate's pants. The department referred the case against the cellmate to the district attorney's office, which accepted the case.

Disposition

The department's Death Review Committee identified the primary cause of death as hemorrhagic, hypovolemic shock and the secondary cause of death as multiple stab wounds to the throat, face, upper torso, and abdomen. The hiring authority identified potential staff misconduct based on the social worker and officer's failure to take appropriate action after the inmate expressed safety concerns; therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to and after the incident were not adequate because a social worker and an officer failed to take appropriate action in response to the inmate's safety concerns.

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

Incident Date	OIG Case Number	Case Type
2015-03-07	**15-0499-RO**	**Suicide**

Incident Summary

On March 7, 2015, an officer discovered an inmate alone in his cell, hanging from a sheet tied to an air vent. Officers entered the cell, removed the inmate, and began life-saving measures, which continued while transporting the inmate to the triage and treatment area, where medical staff took over life-saving measures until a physician pronounced the inmate dead.

Disposition

The autopsy determined the cause of death to be suicide due to asphyxiation by hanging. The department's death review committee concluded the death was not preventable. The hiring authority identified potential staff misconduct because one officer allegedly failed to maintain visual observation of the inmate and timely sound his alarm , another officer allegedly failed to document security checks, and a third officer allegedly failed to sign his post orders. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to and during the incident were not adequate because an officer allegedly failed to maintain visual observation of the inmate and timely sound his alarm, another officer allegedly failed to document security checks, and a third officer allegedly failed to sign his post orders.

NORTH REGION

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

Incident Date	OIG Case Number	Case Type
2015-03-13	**15-0551-RO**	**Suicide**

Incident Summary

On March 13, 2015, an officer found an inmate unresponsive, alone in his cell. A sergeant, two officers, and two nurses responded and began life-saving measures until a physician pronounced the inmate dead at the scene.

Disposition

An autopsy determined the cause of death was acute prescription drug intoxication. The Statewide Mental Health Program suicide report recommended the department provide training to mental health staff regarding review and access to mental health records and conduct a statewide policy review regarding the amount of medication inmates may possess in their cells in administrative segregation units. The hiring authority provided training to mental health and medical staff addressing the documentation and review of health records. The institution formed a work group to address inmate possession of medication in their cells. The hiring authority identified potential staff misconduct based on a captain's failure to inform mental health staff of the inmate's previous suicide plan and the officer's delay in responding to the unresponsive inmate; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to and during the incident were not adequate. A captain allegedly failed to inform mental health staff of the inmate's past suicide plan and an officer allegedly failed to timely respond when he found the unresponsive inmate in his cell.

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

Incident Date	OIG Case Number	Case Type
2015-04-02	**15-0673-RO**	**PREA**

Incident Summary

On April 1, 2015, two officers allegedly sexually assaulted an inmate in his cell and a nurse allegedly sexually assaulted the inmate in the shower. On April 2, 2015, the department transported the inmate to an outside hospital where the inmate pushed an officer, breaking free of an escort. Officers used physical force to restrain the inmate. The inmate subsequently punched a nurse, and officers again used physical force to restrain the inmate. The inmate refused a medical examination and returned to the institution.

Disposition

The hiring authority provided training to supervisors and managers and verbally counseled the lieutenant because the lieutenant and an associate warden failed to timely initiate Prison Rape Elimination Act protocols. The institution's executive review committee determined that the use of force was within departmental policy. The OIG concurred. The hiring authority identified potential staff misconduct based on the alleged sexual assault and referred the case to the Office of Internal Affairs for investigation. After review, the Office of Internal Affairs determined there was not a reasonable belief misconduct occurred. The OIG concurred.

Overall Assessment

The department's response was not adequate. The department failed to timely notify the OIG and failed to timely initiate Prison Rape Elimination Act protocols.

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

NORTH REGION

Assessment Questions

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

  The inmate reported the alleged sexual assaults on April 1, 2015. However, a lieutenant failed to initiate Prison Rape Elimination Act protocols until April 2, 2015. An associate warden failed to ensure the protocols were initiated.

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

  The department learned of the incident on April 1, 2015, but did not notify the OIG until April 2, 2015, one day later.

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

  A lieutenant failed to timely initiate Prison Rape Elimination Act protocols and an associate warden failed to ensure the protocols were initiated.

Incident Date	OIG Case Number	Case Type
2015-04-11	**15-0724-RO**	**In-Custody Inmate Death**

Incident Summary

On April 11, 2015, an inmate vomited and collapsed in his cell and his cellmate called for assistance. After other inmates removed the inmate from the cell, the inmate stopped breathing and nurses and officers initiated life-saving measures. After life-saving efforts failed, a physician pronounced the inmate dead.

Disposition

An autopsy determined that the cause of death was methamphetamine intoxication. The department's Death Review Committee concluded that the death was not preventable. The district attorney's office identified the inmate's wife as the source of the drugs and filed charges against her. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-04-22	**15-0819-RO**	**In-Custody Inmate Death**

Incident Summary

On April 22, 2015, an officer found an unresponsive inmate in his cell. A sergeant, six officers, and six nurses responded and began life-saving measures. Outside emergency medical responders arrived and pronounced the inmate dead at the scene.

Disposition

The coroner concluded that the cause of death was cirrhosis of the liver. The department 's Death Review Committee initially identified two potential systemic vulnerabilities regarding provider communication and documentation and patient documentation. A supplemental inquiry determined that the initial death review did not contain complete information and there were no systemic issues. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

NORTH REGION

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

Incident Date	OIG Case Number	Case Type
2015-04-30	**15-0873-RO**	**In-Custody Inmate Death**

Incident Summary

On April 30, 2015, an officer discovered an inmate alone in his cell, lying on the floor. Responding officers initiated life-saving measures until nurses arrived and continued life-saving measures. A physician later pronounced the inmate dead.

Disposition

An autopsy reported the inmate's death was due to acute morphine and methadone intoxication. The department's Death Review Committee determined that the death was not preventable. The investigative services unit conducted an investigation to determine the source of the morphine and methadone, but located no evidence. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-05-04	**15-0887-RO**	**In-Custody Inmate Death**

Incident Summary

On May 4, 2015, an officer discovered an inmate's body in a trash can on the second tier of his housing unit. The inmate's body had been severed at the abdomen and internal organs were missing. The crime scene location could not be determined. Due to the severity of the injuries, life-saving measures were not attempted. The institution conducted an investigation and referred the case to the district attorney's office.

Disposition

An autopsy determined that the cause of death was homicide by blunt force trauma to the head and the organs were removed post-mortem. The department's Death Review Committee determined that the death was not preventable. The department's in-cell homicide review concluded that the inmates were appropriately housed but an initial housing review form was not completed accurately. The hiring authority identified potential staff misconduct based on officers' alleged failure to conduct required inmate counts; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to the incident were not adequate because the initial housing review for one inmate was not accurately completed and officers may have failed to conduct institution counts.

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

Incident Date	OIG Case Number	Case Type
2015-05-23	**15-1049-RO**	**Suicide**

NORTH REGION

Incident Summary

On May 23, 2015, officers attempted to conduct an emergency cell extraction after observing that an inmate covered his cell window. However, the inmate had jammed the door, preventing immediate entry. When officers were able to open the door, they discovered the inmate hanging from a noose. The officers immediately lowered the inmate and began life-saving measures. Nurses continued life-saving measures while the inmate was transported to the triage and treatment area where a physician pronounced the inmate dead.

Disposition

An autopsy determined the cause of death was asphyxiation due to hanging. The department's Death Review Committee identified deficiencies in the inmate's mental health assessments. The department implemented quality improvement plans to improve inmate mental health assessments at three institutions. The Committee also identified two nursing issues arising from poor documentation that were the subject of a Nursing Professional Practice Committee referral. As part of the quality improvement plans, the department provided training to 36 physicians, 22 psychologists, 24 social workers, and 11 nurses. The department also provided training to the three officers who failed to support the inmate before lowering him. The hiring authority identified potential staff misconduct because security and welfare checks were not being timely performed. The hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to the incident were not adequate because physicians, psychologists, social workers, and nurses failed to properly assess the inmate's condition and officers failed to properly conduct inmate welfare and security checks. The department's response was not adequate because three responding officers failed to support the inmate before removing him to relieve pressure on the airway.

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

Incident Date	OIG Case Number	Case Type
2015-05-23	**15-1050-RO**	**Suicide**

Incident Summary

On May 23, 2015, a sergeant and several officers conducted an emergency cell extraction after observing that an inmate covered his cell window. They entered the cell and discovered the inmate hanging from a noose. Officers and nurses immediately began life-saving measures. Paramedics arrived and continued life-saving measures without success and a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee determined that the standards of care were met and the death was not preventable. The hiring authority identified potential staff misconduct based on one officer's alleged failure to act when she could not see whether the inmate was in his cell during a security check and the sergeant and officers' alleged failure to timely enter the cell. The hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring. Additionally, the department provided training to security housing unit officers regarding security checks, inmate accountability, and emergency response procedures.

Overall Assessment

The department's response was not adequate because officers and a sergeant failed to act timely and one officer grabbed and pulled the noose on the inmate's neck. The hiring authority failed to timely refer the matter to the Office of Internal Affairs.

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

Incident Date	OIG Case Number	Case Type
2015-09-03	**15-1797-RO**	**In-Custody Inmate Death**

NORTH REGION

Incident Summary

On September 3, 2015, an officer and a nurse found an inmate in his cell unresponsive and without a pulse after he had returned from an outside hospital earlier that day. The officer and the nurse initiated life-saving measures and a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee concluded that the inmate's death was natural but of unknown cause. The hiring authority identified potential staff misconduct based on nurses' failure to follow physician's orders; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation.

Overall Assessment

The department's actions prior to the incident were not adequate because registered nurses failed to follow physician's orders to constantly observe the inmate.

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

Incident Date	OIG Case Number	Case Type
2015-09-13	**15-1896-RO**	**Suicide**

Incident Summary

On September 13, 2015, an officer discovered an inmate hanging from a noose in his cell. Other officers arrived, cut the noose, and lowered the inmate. Officers and a nurse performed life-saving measures and paramedics subsequently pronounced the inmate dead.

Disposition

The institution's suicide case review committee concluded the suicide was not foreseeable or preventable. The hiring authority did not identify staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-09-21	**15-2220-RO**	**Hunger Strike**

Incident Summary

On September 21, 2015, an inmate initiated a hunger strike because he did not receive a religious book in a timely manner. Although the institution provided the book to the inmate, he refused it and continued his hunger strike. On October 9, 2015, the institution transferred the inmate to a mental health crisis bed at the correctional treatment center. On November 13, 2015, the inmate ended his hunger strike by consuming a meal.

Disposition

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

Overall Assessment

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner, preventing the OIG from real-time monitoring of the case.

NORTH REGION

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

Incident Date	OIG Case Number	Case Type
2015-09-28	**15-1973-RO**	**In-Custody Inmate Death**

Incident Summary

On September 28, 2015, an officer discovered an unresponsive inmate in his cell and removed the inmate and his cellmate from the cell. Nurses and a psychiatric technician performed life-saving measures, which were not successful. A paramedic pronounced the inmate dead. The cellmate admitted to killing the inmate the previous evening. The department referred the case to the district attorney's office.

Disposition

The hiring authority identified potential staff misconduct based on an officer's alleged failure to conduct appropriate security checks; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's response was not adequate because an officer failed to conduct appropriate security checks, thus delaying discovery of the homicide.

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-09-28	**14-2428-RO**	**Contraband Watch**

Incident Summary

On September 28, 2014, the department placed an inmate on contraband surveillance watch after officers observed the inmate place an unknown object in his rectum. Later that day, the inmate retrieved a bindle from his rectum, broke it open, and ate the contents. The department transported the inmate to an outside hospital after he complained of abdominal pain and reported swallowing methamphetamine. The inmate returned to the institution the following day and the department removed him from contraband surveillance watch.

Disposition

The department recovered no contraband from the inmate. The hiring authority identified potential staff misconduct based on one officer failing to properly document the inmate's activities while on contraband surveillance watch and a second officer failing to provide proper hygiene materials. The hiring authority elected to issue letters of instruction. However, since the associate warden failed to timely issue the letters of instruction, the department provided training to the officers. The hiring authority also decided to issue a letter of instruction to the associate warden for failing to follow the hiring authority's instructions. However, the associate warden retired before the letter of instruction was issued.

Overall Assessment

The department's response was not adequate because the department failed to properly notify the OIG and failed to maintain constant visual observation of the inmate, properly preserve evidence, appropriately document the inmate's activities, and provide hygiene materials to the inmate. The associate warden failed to follow the hiring authority's instructions.

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

SOUTH REGION

Assessment Questions

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

  The department failed to notify the OIG that the inmate was sent to an outside hospital.

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

  The department failed to follow policies and procedures for contraband surveillance watch documentation, notification, observation, and administrative review. While on contraband surveillance watch for only 24 hours, the inmate was able to retrieve contraband from his rectum. The department failed to properly document the incident and properly notify the OIG. The associate warden failed to follow the hiring authority's instructions to issue letters of instruction to two officers.

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

  A sergeant failed to direct an officer to photograph evidence before removing it from the cell. The sergeant also directed the officer to provide clean clothes to the inmate, but failed to keep the original clothing as evidence even after the officer reported that the closure on the clothing was ripped open.

- Was the critical incident adequately documented?

  There was a four-hour and 45 minute gap after the inmate was placed on contraband surveillance watch until the second entry. During that time, the inmate accessed contraband from his rectum but officers failed to document the inmate's access to the contraband.

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

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

- 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?

  Sergeants failed to properly document and ensure proper documentation of all required information. Sergeants also failed to notify the departmental administrative officer of the day when the inmate was sent to an outside hospital, resulting in the department failing to notify the OIG. Officers assigned to watch the inmate failed to properly document required information and failed to ensure that the inmate's hands were visible at all times, thereby allowing the inmate to retrieve contraband while being watched.

Incident Date	OIG Case Number	Case Type
2014-12-31	**15-0048-RO**	**In-Custody Inmate Death**

Incident Summary

On December 31, 2014, an officer discovered an unresponsive inmate on her bed with blood and mucous coming from her nose. The officer removed the cellmate from the cell and a nurse initiated life-saving measures, which continued while the inmate was transported to the triage and treatment area. The department transferred the inmate to an outside hospital, where a physician pronounced the inmate dead.

Disposition

The autopsy report identified the cause of death as subarachnoid hemorrhage due to hypertensive cardiovascular disease. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-02-17	15-0382-RO	Suicide

Incident Summary

On February 17, 2015, an inmate discovered her cellmate hanging from a noose in their cell and called for assistance. A sergeant and an officer cut the noose and lowered the inmate to the floor. A second sergeant and a second officer initiated life-saving measures until nurses and the institution's fire department staff arrived and performed life-saving measures. Paramedics arrived and consulted with a physician at an outside hospital, who pronounced the inmate dead.

Disposition

The coroner determined the cause of death was suicide by hanging. The department's forensic psychological autopsy identified a need for statewide training regarding the identification and understanding of manifestations of emotional distress when dealing with inmates from diverse cultural backgrounds. As a result, the department implemented a statewide training program to assist mental health clinicians in the identification and understanding of cultural idioms related to suicidality.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-02-26	15-0461-RO	PREA

Incident Summary

On February 26, 2015, two officers allegedly touched an inmate's breasts and genitals during an escort.

Disposition

The inmate refused repeated efforts to provide an interview and refused to submit to a physical examination. Based on the inmate's lack of cooperation and the lack of corroborating information, the hiring authority did not refer the matter to the Office of Internal Affairs.

Overall Assessment

The department's response was not adequate because the department failed to properly notify the OIG and the hiring authority failed to refer the matter to the Office of Internal Affairs.

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

Assessment Questions

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

  The department failed to notify the appropriate OIG region, resulting in the OIG's inability to respond on scene.

- 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.

Incident Date	OIG Case Number	Case Type
2015-03-06	15-0490-RO	Suicide

SOUTH REGION

Incident Summary

On March 6, 2015, inmates alerted officers that an inmate was hanging from a noose in her cell. Two officers and a lieutenant found that other inmates had lowered the inmate to the floor and started life-saving measures. One of the officers and the lieutenant took over life-saving efforts until three nurses and a physician arrived. Paramedics arrived and transported the inmate to an outside hospital, where a physician pronounced her dead.

Disposition

The coroner determined the cause of death was suicide by hanging. The Statewide Mental Health Program suicide report stated that a psychologist failed to include critical risk factors on a suicide risk evaluation. The hiring authority for the psychologist issued a letter of expectation regarding proper documentation and completion of detailed assessments. The suicide report also identified concerns related to the inmate's mental health care, including the inmate's discharge from a mental health crisis bed two days after a serious suicide attempt in July 2014 and removal of the inmate from the high risk list without documented rationale. In response to the concerns, the hiring authority for mental health staff assigned a dedicated supervisor to improve oversight of mental health crisis bed admissions and level of care changes, and provided training to mental health clinicians.

Overall Assessment

The department's overall response was not adequate because a psychologist failed to properly document the inmate's suicide risk factors and the department downgraded the inmate's suicide risk level without properly documenting a rationale.

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

Incident Date	OIG Case Number	Case Type
2015-04-18	**15-0776-RO**	**Suicide**

Incident Summary

On April 18, 2015, an officer discovered an unresponsive inmate kneeling in his cell with a noose around his neck. Officers entered the cell, cut the noose, and removed the inmate from the cell. An officer and a nurse began life-saving efforts, which continued while the inmate was transported to the triage and treatment area. Paramedics arrived and continued life-saving efforts, which failed.

Disposition

The coroner determined the cause of death to be suicide by hanging. The department's forensic psychological autopsy concluded that the suicide was not preventable, but identified deficiencies in the timeliness of mental health referrals at the institution where the inmate was housed before his death. As a result, the institution established a system to reduce the backlog of referrals by assigning a psychiatrist to complete an immediate review of all inmates who arrive from county jails and are on psychiatric medications. In addition, the department provided training to all primary clinicians to improve the timeliness of inmate placement in the mental health delivery system.

Overall Assessment

The department's response was not adequate because the department failed to timely notify the OIG, failed to timely complete a mental health referral for the inmate, and failed to timely include the inmate in the mental health delivery system.

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

Incident Date	OIG Case Number	Case Type
2015-05-07	**15-0905-RO**	**Suicide**

SOUTH REGION

Incident Summary

On May 7, 2015, an officer discovered an inmate kneeling in his cell with one end of a sheet tied around his neck and the other end tied around his bunk. Officers entered the cell, removed the inmate, and initiated life-saving measures. Two nurses continued life-saving measures while the inmate was transported to the triage and treatment area. Paramedics responded to the institution and consulted with a physician, who pronounced the inmate dead.

Disposition

The autopsy report listed the cause of death as suicide by hanging. The department's forensic psychological autopsy identified the department's failure to conduct an annual review of the inmate's case factors and a psychologist's deficient clinical practice. The hiring authority provided training to four counselors, a captain, and an associate warden regarding the required reviews. The hiring authority authorized overtime for counselors to address the backlog and failure to conduct timely annual reviews and implemented an audit system in which senior management review the workload, delays, and status of annual reviews on a weekly basis. The hiring authority issued a letter of instruction to the psychologist.

Overall Assessment

The department's actions prior to the incident were not adequate because the department failed to conduct the required annual review of the inmate's case factors and a psychologist failed to properly assess the inmate's suicide risk.

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

Incident Date	OIG Case Number	Case Type
2015-05-09	**15-0925-RO**	**Suicide**

Incident Summary

On May 9, 2015, an officer discovered an inmate hanging by a noose in his cell. Officers lowered the inmate and an officer and a nurse initiated life-saving measures. Paramedics arrived and pronounced the inmate dead.

Disposition

The coroner determined the inmate's cause of death was suicide. The Statewide Mental Health Program suicide report found that officers failed to conduct timely wellness checks, initial responders failed to bring the tool used to cut the noose to the cell, the institution failed to remove the inmate's body from the tier for approximately three hours, and the institution failed to provide reviewers access to the deceased inmate's property. The hiring authority changed the policy to require wellness checks within 15 minutes of officers starting their shifts. The hiring authority also amended policy to require first responders to a suicide by hanging to bring to the scene the tool used to cut a noose and amended the policy concerning the collection of a deceased inmate's property to allow for timely investigative review. The hiring authority determined that laws and department policy required the department to keep the inmate's body on the tier until the coroner arrived. The hiring authority provided training to custody staff regarding the amended policies.

Overall Assessment

The department's response was not adequate because officers failed to conduct timely hourly wellness checks and delayed obtaining the tool used to cut the noose and delayed entering the cell. The department failed to make the inmate's property available for a forensic psychologist to inspect.

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

Incident Date	OIG Case Number	Case Type
2015-06-20	**15-1479-RO**	**PREA**

Incident Summary

On June 20, 2015, an officer allegedly reached into an inmate's pants and touched her genitals during a use-of-force incident.

SOUTH REGION

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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.

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

Incident Date	OIG Case Number	Case Type
2015-06-24	**15-1267-RO**	**Other Significant Incident**

Incident Summary

On June 24, 2015, a parole agent allegedly took a parolee from a psychiatric hospital without authorization and transported the parolee in a State vehicle. The parolee forcibly took the parole agent's handgun from the holster, jumped out of the car, and fired several rounds on a busy street. Outside law enforcement responded and arrested the parolee.

Disposition

The hiring authority identified potential staff misconduct based on the parole agent taking the parolee from the psychiatric hospital and alleged dishonest statements the parole agent made to his supervisor and outside law enforcement. The hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to the incident were not adequate because the parole agent removed the parolee from the psychiatric hospital without authorization, which resulted in the underlying incident.

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

Incident Date	OIG Case Number	Case Type
2015-07-10	**15-1403-RO**	**Other Significant Incident**

Incident Summary

On July 10, 2015, an inmate informed an officer that she wanted to kill herself and had swallowed a razor blade. The inmate's arm was actively bleeding. The department treated the inmate at the institution for the minor arm injury and an x-ray confirmed the presence of a possible foreign object in her abdomen. The department placed the inmate under direct observation by mental health staff.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-07-23	15-1478-RO	Other Significant Incident

Incident Summary

On July 23, 2015, officers placed an inmate in a cell after the inmate reported wanting to kill herself. An officer subsequently discovered the inmate sitting on the cell floor with one end of a torn shirt tied around her neck and the other end tied to a handrail. Officers entered the cell and removed the noose from the inmate. The department transported the inmate to an outside hospital. The inmate returned to the institution the same day.

Disposition

The hiring authority identified potential staff misconduct based on the officer's alleged failure to maintain constant visual observation of the inmate; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's response was not adequate because an officer failed to maintain continuous observation of an inmate awaiting a mental health evaluation after the inmate reported wanting to kill herself.

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

Incident Date	OIG Case Number	Case Type
2015-08-03	15-1547-RO	Contraband Watch

Incident Summary

On August 3, 2015, the department placed an inmate on contraband surveillance watch after officers observed him swallow suspected drugs. Later that day, the department transported the inmate to an outside hospital after the inmate complained of abdominal pain and vomiting. The inmate returned to the institution the same day. On August 5, 2015, the department removed the inmate from contraband surveillance watch.

Disposition

The department recovered no contraband from the inmate and the hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-08-03	15-1549-RO	Contraband Watch

Incident Summary

On August 3, 2015, the department placed an inmate on contraband surveillance watch after the inmate reported swallowing a bindle of heroin. A nurse evaluated the inmate and concluded the inmate needed a higher level of care. The department transported the inmate to an outside hospital where tests revealed no controlled substances or foreign objects in the inmate's body. The inmate returned to the institution the following day and the department removed the inmate from contraband surveillance watch.

Disposition

The department recovered no contraband from the inmate and the hiring authority did not identify any staff misconduct.

SOUTH REGION

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-08-06	**15-1569-RO**	**Contraband Watch**

Incident Summary

On August 6, 2015, an inmate reported swallowing a razor blade. The department transported the inmate to an outside hospital where an x-ray confirmed the presence of a foreign object. The inmate was admitted to the hospital and placed on contraband surveillance watch. On August 7, 2015, the department removed the inmate from contraband surveillance watch after two negative bowel movements and a negative x-ray and the inmate returned to the institution the same day.

Disposition

The department recovered no contraband. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-08-10	**15-1567-RO**	**In-Custody Inmate Death**

Incident Summary

On August 10, 2015, an officer discovered an unresponsive inmate sitting on the toilet in his cell. Officers removed the cellmate from the cell and initiated life-saving efforts on the unresponsive inmate with the assistance of a nurse. Officers transported the inmate to the triage and treatment area where paramedics continued life-saving efforts. Paramedics consulted with a physician at an outside hospital, who pronounced the inmate dead. Officers discovered a syringe and traces of heroin in the cell.

Disposition

The coroner discovered fresh needle marks on the inmate's arms during the autopsy and indicated in his preliminary findings that the inmate's death was likely caused by an accidental drug overdose. Pending the final autopsy report from the coroner, the department's Death Review Committee preliminarily determined the inmate's death was unexpected and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-09-07	**15-1798-RO**	**In-Custody Inmate Death**

Incident Summary

On September 7, 2015, an inmate alerted officers that his cellmate was unresponsive. Officers found the cellmate on his bed, not breathing, and an officer and a nurse began life-saving measures. The department transported the inmate to the correctional treatment center where a physician pronounced him dead.

Disposition

The coroner determined that the inmate died of a drug overdose based on bindles of narcotics and pieces of latex recovered during the autopsy. The department's Death Review Committee determined the death was not preventable. The institution conducted an investigation and could not locate the source of the narcotics. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

APPENDIX F 44
CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-01-17	**2015-01-20**	**Suspected Drugs**	**1. Drugs** **2. Nothing**

Incident Summary 15-14551-CWRM

On January 17, 2015, the department placed an inmate on contraband surveillance watch after officers recovered a bindle of suspected marijuana during an unclothed body search. The department removed the inmate from contraband surveillance watch on January 20, 2015, three days later. During that time, the department recovered no additional contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-02-07	**2015-02-12**	**Suspected Drugs**	**Other**

Incident Summary 15-14741-CWRM

On February 7, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate placing an unknown object into the inmate's mouth during a visit. On February 10, 2015, officers recovered a torn bindle from the inmate and transported the inmate via ambulance to an outside hospital after a nurse determined the inmate had an elevated blood pressure and pulse. The inmate returned to the institution the following day and remained on contraband surveillance watch until February 12, 2015. During that time, the department recovered no further contraband from the inmate.

Incident Assessment Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. The department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch and did not completely document hygiene or contacts with medical staff. The department provided training to address the deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-06-27	**2015-07-01**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15072-CWRM

On June 27, 2015, the department placed an inmate on contraband surveillance watch after officers saw him swallow unknown objects during a visit. The department removed the inmate from contraband surveillance watch on July 1, 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.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-07-07	**2015-07-09**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15078-CW

On July 7, 2015, the department transported an inmate to an outside hospital and placed him on contraband surveillance watch after he admitted to swallowing marijuana. The inmate was removed from contraband surveillance watch on July 9, 2015, and returned to the institution on the following day. During that time, the department recovered marijuana from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-07-19	**2015-07-23**	**Suspected Drugs**	**Nothing**

Incident Summary 15-15085-CWRM

On July 19, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an unknown object. The department removed the inmate from contraband surveillance watch on July 23, 2015, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-01	**2015-08-04**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15094-CWRM

On August 1, 2015, the department placed an inmate on contraband surveillance watch after an officer observed a visitor pass the inmate an unknown object. The department removed the inmate from contraband surveillance watch on August 4, 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.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-14	**2015-08-21**	**Suspected Weapons**	**Weapons**

Incident Summary 15-15103-CWRM

On August 14, 2015, the department placed an inmate on contraband surveillance watch after the inmate admitted to swallowing razor blades. An x-ray confirmed the presence of foreign objects and the department transported the inmate to an outside hospital. The inmate returned to the institution four days later and the department removed him from contraband surveillance watch on August 21, 2015. During that time, the department recovered razor blades from the inmate.

Incident Assessment Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. The department failed to complete daily activity documentation regarding officers signing in and out, supervisory checks, and access to proper hygiene. The institution provided training to involved custody staff.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-16	**2015-08-19**	**Suspicious Activity**	**Nothing**

Incident Summary

15-15104-CWRM

On August 16, 2015, the department placed an inmate on contraband surveillance watch after officers discovered broken pieces missing from a television set and suspected the inmate made a weapon and was hiding it. The department removed the inmate from contraband surveillance watch on August 19, 2015, three days later. 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. The department failed to consistently document officers on duty, medical or mental health assessments, searches, supervisory checks, hygiene, and range of motion. The department failed to obtain timely authorization to use hand isolation devices and to keep the inmate on contraband surveillance watch longer than 72 hours. The hiring authority ordered training for officers and sergeants and in the future, will require all officers and sergeants to review policies and procedures prior to contraband surveillance watch assignments.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-16	**2015-08-19**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15105-CWRM

On August 16, 2015, the department placed an inmate on contraband surveillance watch after officers discovered broken pieces missing from a television set and suspected the inmate made a weapon and was hiding it. The department removed the inmate from contraband surveillance watch on August 19, 2015, three days later. 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. The department failed to consistently document officers on duty, medical or mental health assessments, searches, supervisory checks, hygiene, and range of motion. The department failed to obtain timely authorization to use hand isolation devices and to keep the inmate on contraband surveillance watch longer than 72 hours. The hiring authority ordered training for officers and sergeants and in the future, will require all officers and sergeants to review policies and procedures prior to contraband surveillance watch assignments.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-17	**2015-08-21**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15106-CWRM

On August 17, 2015, the department placed an inmate on contraband surveillance watch after an x-ray confirmed the inmate's report to officers that the inmate had swallowed razor blades. The department removed the inmate from contraband surveillance watch on August 21, 2015, four days later, after an x-ray determined the razor blades were no longer present. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-25	**2015-08-29**	**Suspected Drugs**	**Nothing**

Incident Summary 15-15113-CWRM

On August 25, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate retrieve an object from his waistband and swallow it. The department removed the inmate from contraband surveillance watch on August 29, 2015, four days later. 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. The department failed to provide or failed to document the inmate's basic hygiene and failed to consistently document when officers started or ended contraband surveillance watch assignments. The hiring authority provided training to the officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-28	**2015-09-01**	**Suspected Weapons**	**Mobile Phone**

Incident Summary 15-15114-CWRM

On August 28, 2015, the department placed an inmate on contraband surveillance watch because he failed to pass a metal detector. The department removed the inmate from contraband surveillance watch on September 1, 2015, four days later. During that time, the department recovered a mobile phone 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
2015-09-20	**2015-09-28**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15137-CWRM

On September 20, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow two unknown objects during a visit. The department placed the inmate on suicide watch after he stated he didn't feel like living. The department removed the inmate from contraband surveillance watch and suicide watch on September 28, 2015, eight 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 failed to adequately conduct or document supervisory checks on the inmate and failed to adequately document or provide the inmate with opportunities for proper hygiene. The hiring authority provided training to the sergeants and officers involved in the contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-09-20	**2015-09-25**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15138-CWRM

On September 20, 2015, the department placed an inmate on contraband surveillance watch after he was observed swallowing unknown objects during a visit. The department removed the inmate from contraband surveillance watch on September 25, 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.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-09-23	**2015-09-26**	**Suspected Drugs**	**Nothing**

Incident Summary 15-15143-CWRM

On September 23, 2015, the department placed an inmate on contraband surveillance watch after an x-ray identified the presence of a foreign body. The department removed the inmate from contraband surveillance watch on September 26, 2015, three days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-09-27	**2015-10-01**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15147-CWRM

On September 27, 2015, the department placed an inmate on contraband surveillance watch after he was observed placing an unknown object in his mouth during a visit. The department removed the inmate from contraband surveillance watch on October 1, 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
2013-12-12	**2013-12-18**	**Suspicious Activity**	**Inmate Note**

Incident Summary 13-10111-CWRM

On December 12, 2013, the department placed an inmate on contraband surveillance watch because officers noticed string protruding from the inmate's rectum. The department removed the inmate from contraband surveillance watch on December 18, 2013, six days later. During that time, the department recovered two 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
2015-04-16	**2015-04-21**	**Suspected Drugs**	**1. Inmate Note** **2. Weapons**

Incident Summary 15-15003-CWRM

On April 16, 2015, the department placed an inmate on contraband surveillance watch after he was observed swallowing an unknown object. The department removed the inmate from contraband surveillance watch on April 21, 2015, five days later. During that time, the department recovered two bindles containing inmate notes and an inmate-manufactured weapon.

Incident Assessment Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. The department failed to properly complete medical assessment and other required documentation including range of motion, hygiene, and authorization for the use of leg restraints. The department addressed the lack of documentation by providing training to involved custody and medical staff. The institution also completed a revision of the contraband surveillance watch post orders for each watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-06-08	**2015-06-13**	**Suspicious Activity**	**Drugs**

Incident Summary 15-15053-CWRM

On June 8, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate place latex in his mouth and swallow it. The department removed the inmate from contraband surveillance watch on June 13, 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
2015-06-24	**2015-06-30**	**Suspicious Activity**	**Nothing**

Incident Summary 15-15068-CWRM

On June 24, 2015, the department placed an inmate on contraband surveillance watch after receiving confidential information that the inmate secreted contraband. The department removed the inmate from contraband surveillance watch on June 30, 2015, six days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-06-25	**2015-06-30**	**Suspected Drugs**	**1. Tobacco** **2. Weapons**

Incident Summary 15-15071-CWRM

On June 25, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate reach into his pants and remove and swallow a bindle. The inmate reached into his pants again, removing a second bindle and an inmate-manufactured weapon, which he placed on the floor. The department removed the inmate from contraband surveillance watch on June 30, 2015, five days later. During that time, the department recovered no additional contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-07-02	**2015-07-06**	**Suspicious Activity**	**Inmate Note**

Incident Summary 15-15074-CWRM

On July 2, 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 department removed the inmate from contraband surveillance watch on July 6, 2015, four 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.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-07-09	**2015-07-13**	**Suspicious Activity**	**Nothing**

Incident Summary 15-15081-CWRM

On July 9, 2015, the department placed an inmate on contraband surveillance watch after officers observed an oily substance around the inmate's rectum. The department removed the inmate from contraband surveillance watch on July 13, 2015, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-07-21	**2015-07-27**	**Suspected Inmate Note**	**Nothing**

Incident Summary 15-15086-CWRM

On July 21, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an unknown object. The department removed the inmate from contraband surveillance watch on July 27, 2015, six days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-03	**2015-08-12**	**Suspicious Activity**	**1. Drugs** **2. Inmate Note** **3. Weapons**

Incident Summary

15-15095-CWRM

On August 3, 2015, the department placed an inmate on contraband surveillance watch after a nurse observed bindles in the inmate's mouth, which he refused to spit out. During an escort, the inmate spit out four bindles that tested positive for heroin. The department removed the inmate from contraband surveillance watch on August 12, 2015, nine days later. During that time, the department recovered drugs, a weapon, and inmate notes from the inmate.

Incident Assessment

Insufficient

The department failed to sufficiently comply with the policies and procedures governing contraband surveillance watch. The department failed to regularly document hygiene and timely complete the self-audit documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-05	**2015-08-10**	**Suspicious Activity**	**Nothing**

Incident Summary

15-15097-CWRM

On August 5, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate remove an object from his rectum and swallow it. The department removed the inmate from contraband surveillance watch on August 10, 2015, five days later. 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. The department failed to perform a medical evaluation prior to placing the inmate on contraband surveillance watch and failed to remove the inmate from contraband surveillance watch or provide justification for continued monitoring after the inmate produced three contraband-free bowel movements. The department provided training to the involved custody staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-21	**2015-08-25**	**Suspicious Activity**	**Other**

Incident Summary

15-15107-CWRM

On August 21, 2015, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an unknown object during an unclothed body search. An X-ray confirmed that the inmate had ingested a foreign object. The department removed the inmate from contraband surveillance watch on August 25, 2015, four days later. During that time, the department recovered a metal object 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
2015-09-04	**2015-09-10**	**Suspected Drugs**	**Drugs**

Incident Summary

15-15124-CWRM

On September 4, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate place an unknown item in his mouth. The inmate spit out the item, which tested positive for methamphetamine. The department removed the inmate from contraband surveillance watch on September 10, 2015, six days later. During that time, the department recovered no additional contraband from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-09-06	**2015-09-11**	**Suspicious Activity**	**Drugs**

Incident Summary

15-15125-CWRM

On September 6, 2015, the department placed an inmate on contraband surveillance watch after a sergeant observed the inmate place his hands down his pants. During a subsequent unclothed body search, officers observed an oily substance around the inmate's rectum. The department removed the inmate from contraband surveillance watch on September 11, 2015, five 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 failed to regularly document the inmate's hygiene, range of motion, and the justification for using leg restraints. The department trained all involved custody staff to address these deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-09-27	**2015-10-01**	**Suspicious Activity**	**Weapons**

Incident Summary

15-15145-CWRM

On September 27, 2015, the department placed an inmate on contraband surveillance watch after the inmate failed to pass a metal detector. The department removed the inmate from contraband surveillance watch on October 1, 2015, four days later. During that time, the department recovered weapons 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
2015-10-04	**2015-10-10**	**Suspicious Activity**	**1. Mobile Phone** **2. Other**

Incident Summary

15-15154-CWRM

On October 4, 2015, the department placed an inmate on contraband surveillance watch after officers received information that the inmate was in possession of drugs. The department removed the inmate from contraband surveillance watch on October 10, 2015, six days later. During that time, the department recovered a mobile phone, a phone charger, and plastic packaging from the inmate.

Incident Assessment

Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not notify the OIG when placing the inmate on contraband surveillance watch and did not timely complete self-audit documentation. The department trained an associate warden to address the deficiency.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-10-15	**2015-10-19**	**Suspicious Activity**	**1. Drugs** **2. Inmate Note**

Incident Summary 15-15160-CWRM

On October 15, 2015, the department placed an inmate on contraband surveillance watch after officers saw a latex glove protruding from his rectum during an unclothed body search. The inmate relinquished the glove, which contained drugs. The department removed the inmate from contraband surveillance watch on October 19, 2015, four 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
2015-10-17	**2015-10-21**	**Suspicious Activity**	**Inmate Note**

Incident Summary 15-15161-CWRM

On October 17, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow an unknown item. The department removed the inmate from contraband surveillance watch on October 21, 2015, four 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
2015-10-19	**2015-10-23**	**Suspicious Activity**	**Nothing**

Incident Summary 15-15163-CWRM

On October 19, 2015, the department placed an inmate on contraband surveillance watch after an officer saw an unidentified object protruding from the inmate's rectum during an unclothed body search. The department removed the inmate from contraband surveillance watch on October 23, 2015, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-10-22	**2015-10-27**	**Suspicious Activity**	**Drugs**

Incident Summary 15-15167-CWRM

On October 22, 2015, the department placed an inmate on contraband surveillance watch after officers observed a clear lubricant around the inmate's rectum during an unclothed body search. The department removed the inmate from contraband surveillance watch on October 27, 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.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-10-22	**2015-10-30**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15168-CWRM

On October 22, 2015, the department placed an inmate on contraband surveillance watch after officers discovered 21 bindles of drugs hidden on the inmate's person during a search. When he vomited on October 27, 2015, the department transferred the inmate to an outside hospital and he returned to the institution the same day. The department removed the inmate from contraband surveillance watch on October 30, 2015, eight days later. During that time, the department recovered 20 additional bindles of drugs from the inmate.

Incident Assessment Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to notify the OIG when the inmate was transferred to an outside hospital for a higher level of care.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-10-22	**2015-10-28**	**Suspicious Activity**	**Nothing**

Incident Summary 15-15169-CWRM

On October 22, 2015, the department placed a ward on contraband surveillance watch after a metal detector alerted on his body and he told a youth counselor he had inserted a pen in his rectum. The ward was removed from contraband surveillance watch on October 28, 2015, six days later. During that time, the department recovered no contraband from the ward.

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
2015-02-04	**2015-02-08**	**Suspected Weapons**	**Weapons**

Incident Summary

15-14671-CWRM

On February 4, 2015, the department placed an inmate on contraband surveillance watch after the inmate failed to clear a metal detector. The department removed the inmate from contraband surveillance watch on February 8, 2015, four days later. During that time, the department recovered an inmate-manufactured weapon from the inmate.

Incident Assessment

Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. The department failed to document a medical assessment prior to placing the inmate on contraband surveillance watch and failed to adequately document hand and restraint hygiene, trash removal, range of motion exercises, cell hygiene, and issuance of a blanket. The department identified the deficiencies during a self-audit and provided training to involved officers and supervisors. Despite the OIG's recommendations, the hiring authority refused to refer the matter to the Office of Internal Affairs for investigation for possible staff misconduct.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-06-07	**2015-06-11**	**Suspicious Activity**	**Other**

Incident Summary

15-15052-CWRM

On June 07, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate place a bindle of suspected drugs into his mouth and swallow it. The department removed the inmate from contraband surveillance watch on June 11, 2015, four days later. During that time, the department recovered one empty bindle 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
2015-06-22	**2015-06-25**	**Suspicious Activity**	**Nothing**

Incident Summary

15-15065-CW

On June 22, 2015, the department placed an inmate on contraband surveillance watch after officers observed latex protruding from the inmate's rectum during an unclothed body search. The next day, the department transported the inmate to an outside hospital where he was admitted due to a suspected drug overdose. The inmate returned to the institution the same day. The department removed the inmate from contraband surveillance watch on June 25, 2015, five days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-09-26	**2015-10-08**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15146-CWRM

On September 26, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow suspected contraband during visiting. The department removed the inmate from contraband surveillance watch on October 8, 2015, 12 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. A captain failed to timely terminate the inmate's contraband surveillance watch and the hiring authority issued him a letter of instruction.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-10-11	**2015-10-11**	**Suspected Weapons**	**Weapons**

Incident Summary 15-15159-CW

On October 11, 2015, the department placed an inmate on contraband surveillance watch after the inmate reported to an officer he had swallowed a razor blade and pills. The department transported the inmate to an outside hospital where an x-ray confirmed the presence of foreign objects and the inmate underwent surgery. The department removed the inmate from contraband surveillance watch the same day. During that time, the department recovered a razor blade and plastic fork tines from the inmate and he returned to the institution the following day.

Incident Assessment Insufficient

The department failed to sufficiently comply with policies and procedures governing contraband surveillance watch. The department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch and transported to an outside hospital.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-10-30	**2015-10-30**	**Suspected Drugs**	**Drugs**

Incident Summary 15-15176-CW

On October 29, 2015, the department transported an inmate to an outside hospital after the inmate reported not feeling well and admitted to swallowing three bindles of heroin. On October 30, 2015, the department placed the inmate on contraband surveillance watch after a CT scan revealed two foreign objects in his colon. The department removed the inmate from contraband surveillance watch later that day. During that time, the department recovered two bindles containing 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
2015-12-06	**2015-12-07**	**Suspected Drugs**	**Nothing**

Incident Summary 15-15199-CW

On December 6, 2015, the department placed an inmate on contraband surveillance watch and transported him to an outside hospital after the inmate informed officers that he swallowed a bindle containing an unknown substance. The department removed the inmate from contraband surveillance watch on December 7, 2015, one day later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch.

APPENDIX G 24
FIELD INQUIRY CASE SUMMARIES
CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-09-05	**14-2135-FI**	**Field Inquiry**

Incident Summary
On September 5, 2014, an inmate submitted a complaint to the OIG alleging that two officers assaulted him in retaliation for the inmate having a relationship with a teacher.

Disposition
The hiring authority conducted an inquiry and was unable to substantiate the inmate's allegations.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-02-09	**15-0332-FI**	**Field Inquiry**

Incident Summary
On February 9, 2015, an inmate submitted a complaint to the OIG alleging a social worker offered gifts and money to him in exchange for sexual favors. The department failed to notify the OIG when the inmate first complained to the department.

Disposition
The OIG reminded the hiring authority that the inmate's complaint required OIG notification and confirmed the hiring authority would notify the OIG in the future. The hiring authority previously identified potential staff misconduct based on sexual misconduct allegations and referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs did not open an investigation.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-03-18	**15-0570-FI**	**Field Inquiry**

Incident Summary
On March 18, 2015, an inmate's mother submitted a complaint to the OIG alleging multiple officers assaulted her son three days earlier without cause, causing injuries to his face, neck, arms, and back. The inmate's mother further alleged the department failed to provide medical care for for the inmate's injuries.

Disposition
The department conducted an inquiry into the allegation of excessive force. The institution's executive review committee reviewed a video-recorded interview of the inmate and the inquiry results and determined the use of force complied with departmental policy. The OIG concurred.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-04-16	15-0761-FI	Field Inquiry

Incident Summary

On April 16, 2015, an inmate submitted a complaint to the OIG alleging seven officers used excessive and unreported force on September 24, 2013. The officers allegedly forced the inmate to the ground, kicked him, forced his legs open, and placed a flashlight between his buttocks. A sergeant allegedly denied the inmate's request for medical attention and when he was unable to move, officers allegedly tried to pick him up off the ground, causing him to scream. A nurse arrived and completed a medical evaluation. The inmate stated he filed an inmate appeal regarding the incident, but alleged the department lost it.

Disposition

The hiring authority completed an inquiry into the alleged unreported and excessive force and determined there was no evidence to support the inmate's allegations. The OIG did not agree because the inmate had documented injuries on September 24, 2013, as noted on a rules violation report issued to the inmate for delaying a peace officer.

Overall Assessment

Rating: **Insufficient**

The department failed to sufficiently address the matter because it failed to thoroughly investigate the complaint and the deadline to take disciplinary action expired. The institution's executive review committee did not review the complaint as required. A nurse completed a medical report that did not document the inmate's injuries and the department did not interview the nurse to clarify the conflicting information.

Incident Date	OIG Case Number	Case Type
2015-05-04	15-0907-FI	Field Inquiry

Incident Summary

On May 4, 2015, an inmate's parents submitted a complaint to the OIG alleging the department ignored their hardship request that their son be transferred to an institution closer to them.

Disposition

The OIG independently evaluated the documents in support of the inmate's transfer and found the department's actions were appropriate and within departmental policy. The institution identified the inmate's preferred choice in the transfer recommendation. However, classification employees, who have final approval authority, found that no bed space was available at the primary choice and approved a transfer to the second choice.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-05-22	15-1059-FI	Field Inquiry

Incident Summary

On May 22, 2015, an inmate submitted a complaint to the OIG alleging the department failed to appropriately process an appeal administrative segregation inmates filed regarding lack of outdoor exercise time and that several institutional officials allegedly asked the inmate to withdraw the appeal.

Disposition

The OIG brought issues involving potential staff misconduct and discrepancies in the documentation of outdoor exercise time to the hiring authority's attention and recommended an investigation. Although the hiring authority did not refer the matter to the Office of Internal Affairs for investigation, the hiring authority agreed to modify the operational procedure governing the use of outdoor exercise modules.

Overall Assessment

Rating: **Insufficient**

The department failed to sufficiently address the matter because it declined to refer the matter to the Office of Internal Affairs for investigation.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-07-07	15-1382-FI	Field Inquiry

Incident Summary

On July 7, 2015, an inmate submitted a complaint to the OIG alleging the department did nothing after he complained that an officer touched him in a sexual manner. The department failed to notify the OIG the inmate was complaining of a sexual assault.

Disposition

The OIG reminded the hiring authority of the obligation to promptly notify the OIG of all allegations involving the Prison Rape Elimination Act.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-07-07	15-1458-FI	Field Inquiry

Incident Summary

On July 7, 2015, a district attorney submitted an inmate's complaint to the OIG alleging the department did nothing when he reported his cellmate had raped him.

Disposition

The hiring authority initiated Prison Rape Elimination Act protocols in response to the inmate's initial complaint but failed to notify the OIG of the allegation in a timely manner. The OIG reminded the hiring authority to notify the OIG of all alleged violations of the Prison Rape Elimination Act in a timely manner and the department agreed to do so in the future.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-07-09	15-1387-FI	Field Inquiry

Incident Summary

On July 9, 2015, an inmate submitted a complaint to the OIG alleging officers were not completing 30-minute welfare checks in the security housing unit as required by departmental policy.

Disposition

The OIG independently evaluated the security logs, reviewed policy, and interviewed a sergeant and five officers in four housing units and confirmed that 30-minute welfare checks were conducted according to departmental policy. The officers also explained the steps they must follow when an inmate covers his cell window, preventing them from completing the welfare check. The hiring authority did not identify any staff misconduct.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG’s field inquiry.

Incident Date	OIG Case Number	Case Type
2015-07-13	15-1413-FI	Field Inquiry

Incident Summary

On July 13, 2015, an inmate submitted a complaint to the OIG alleging an officer grabbed his genitals and buttocks on two occasions and that when he reported the allegations to the hiring authority, the department refused to investigate.

Disposition

The hiring authority properly determined that a full investigation was not warranted under the Prison Rape Elimination Act and also determined that the institution failed to timely notify the OIG of the allegation. The OIG reminded the hiring authority of the obligation to timely notify the OIG of all alleged violations of the Prison Rape Elimination Act and the hiring authority agreed to do so in the future.

CENTRAL REGION

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-10-09	**15-2074-FI**	**Field Inquiry**

Incident Summary

On October 9, 2015, an inmate's anonymous family member submitted a complaint to the OIG alleging that the food preparation area and dining facility at an institution are unsanitary and the institution serves spoiled food to inmates.

Disposition

The OIG conducted an unannounced inspection of the kitchen and dining areas and interviewed 14 inmate workers, the plant manager, and the hiring authority. The inmate workers informed the OIG that they have not seen spoiled food or rodent droppings in the food. The OIG did not observe any spoiled or outdated food, but found rodent droppings on top of sealed food containers and in the corners of the kitchen. The institution placed mouse traps along the kitchen walls. The OIG identified damaged floor trimming where rodents are able to enter the kitchen. The hiring authority agreed with the OIG that repairs are needed and should be completed when funding is available.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG’s field inquiry.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-03-18	15-0617-FI	Field Inquiry

Incident Summary

On March 18, 2015, an inmate's friend submitted a complaint to the OIG alleging that she was inappropriately suspended from visiting the inmate for one year.

Disposition

The OIG conducted a review of case notes, photographs, and the visitor's approval for searching of her person, vehicle, and cell phone and concluded the visiting suspension was appropriate.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-05-11	15-0957-FI	Field Inquiry

Incident Summary

On May 11, 2015, an inmate submitted a complaint to the OIG alleging that officers failed to secure the dining hall doors during a riot on the exercise yard. The inmate alleged this caused the riot to move into the dining hall and officers failed to activate the building alarm.

Disposition

The department's executive review committee determined that officers failed to secure the dining hall doors during the incident. Therefore, the hiring authority provided training to the involved officers. The OIG concurred.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-06-25	15-1269-FI	Field Inquiry

Incident Summary

On June 25, 2015, an inmate's wife submitted a complaint to the OIG alleging that an officer chewed tobacco and used electronic cigarettes in the housing unit, removed tobacco from his mouth and then served an inmate dinner without changing gloves, and spit chewing tobacco on the inmate's toilet seat. The inmate's wife also alleged that the officer did not allow the inmate to use the phone or do his assigned work as a porter. On September 8, 2015, the inmate's wife submitted a second complaint alleging the department had retaliated against the inmate because he was removed from his position as a porter, subjected to a random cell search, and received a rules violation for possession of inmate-manufactured alcohol.

Disposition

The hiring authority identified potential staff misconduct and issued the officer a letter of instruction.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-09-15	15-1916-FI	Field Inquiry

Incident Summary

Between August 30, 2015, and September 15, 2015, multiple individuals submitted complaints to the OIG alleging that a warden hit a dog while driving a vehicle at the institution and he then drove away and allowed the animal to suffer for an entire night without care, eventually to die. An associate warden allegedly learned of the misconduct but failed to take appropriate action.

NORTH REGION

Disposition

The hiring authority conducted an inquiry and did not identify any potential staff misconduct. Therefore, the hiring authority did not refer the case to the Office of Internal Affairs.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-06-30	14-1607-FI	Field Inquiry

Incident Summary

On June 30, 2014, an inmate submitted a complaint to the OIG alleging that officers used excessive force and that two officers failed to report the incident.

Disposition

The institution's executive review committee determined the force used during the incident was in compliance with departmental policy. The OIG concurred with the department's determination. The department conducted an appeal inquiry regarding the inmate's allegations and determined there was insufficient evidence to support the allegations.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-02-06	15-0328-FI	Field Inquiry

Incident Summary

On February 6, 2015, an inmate submitted a complaint to the OIG alleging the department's appeal system is ineffective because the department inappropriately rejected inmate appeals and officers failed to conduct interviews inmates requested.

Disposition

In response to the complaint, the department met with inmate representatives to establish routine meetings and implemented inmate education on the informal and formal appeal processes.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-03-12	15-0542-FI	Field Inquiry

Incident Summary

On March 12, 2015, an officer's spouse submitted a complaint to the OIG alleging that inmates are allowed to conceal their bed areas by hanging bed sheets or other materials, causing safety concerns for officers.

Disposition

The hiring authority wrote a memorandum to officers and supervisors reminding them of the policy prohibiting inmates from concealing bed areas.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-03-19	15-0645-FI	Field Inquiry

Incident Summary

On December 4, 2014, an inmate's mother submitted a complaint to the OIG alleging the department moved the inmate to seven different institutions within a five-month period.

Disposition

In response to the OIG's field inquiry, the hiring authority reviewed the inmate's movement history and determined the moves were appropriate. The hiring authority did not identify potential staff misconduct. Therefore, the hiring authority did not refer the case to the Office of Internal Affairs

SOUTH REGION

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-04-09	**15-0721-FI**	**Field Inquiry**

Incident Summary

On April 9, 2015, an inmate submitted a complaint to the OIG alleging that the department improperly rejected his appeal because it relied on an inaccurate classification date.

Disposition

In response to the OIG's inquiry, the department determined that the inmate's appeal was rejected based on an inaccurate classification date. The department contacted the inmate and advised him to re-submit his appeal.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-04-27	**15-0836-FI**	**Field Inquiry**

Incident Summary

On April 27, 2015, an inmate submitted a complaint to the OIG alleging that an officer negligently opened the cell door of an inmate on orientation status, allowing the inmate to attack the complainant in the day room.

Disposition

The hiring authority identified potential staff misconduct based on the control booth officer opening the cell door of an inmate on orientation status while general population inmates were in the dayroom. Therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs approved the case for disciplinary action, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-06-03	**15-1118-FI**	**Field Inquiry**

Incident Summary

On June 3, 2015, an inmate's wife submitted a complaint to the OIG alleging an officer used unprovoked force on her husband.

Disposition

The hiring authority identified potential staff misconduct of unnecessary use of force. Therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs did not open an investigation.

Overall Assessment

Rating: **Insufficient**

The department failed to sufficiently address the matter because the Office of Internal Affairs failed to open an investigation into the alleged misconduct.

Incident Date	OIG Case Number	Case Type
2015-06-09	**15-1182-FI**	**Field Inquiry**

Incident Summary

On June 9, 2015, an inmate's mother submitted a complaint to the OIG alleging that after her son made allegations that an officer committed sexual misconduct, he was rehoused in administrative segregation. The institution failed to inform the OIG of the sexual misconduct allegation.

SOUTH REGION

Disposition

The hiring authority conducted an inquiry and did not identify any staff misconduct. The hiring authority acknowledged the requirement to timely notify the OIG of all allegations of staff sexual misconduct.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-11-02	**15-2405-FI**	**Field Inquiry**

Incident Summary

On November 2, 2015, an inmate informed the OIG of irregularities regarding his placement in administrative segregation. The institution placed the inmate in administrative segregation on July 22, 2014, after another inmate accused him of sexual assault. The institution failed to notify the OIG of this Prison Rape Elimination Act allegation.

Disposition

The OIG informed the hiring authority of the failure to timely notify the OIG of a Prison Rape Elimination Act incident and reminded the hiring authority of the need to do so.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SEMI-ANNUAL REPORT

July–December 2015

Volume II

OFFICE OF THE INSPECTOR GENERAL

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INSPECTOR GENERAL

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STATE OF CALIFORNIA
March 2016