Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

January–June 2014

Volume II

October 2014

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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FOREWORD

This 19th Semi-Annual Report covers the time period of January through June 2014. Pursuant to California Penal Code, Section 6133 et seq., the Office of the Inspector General (OIG) is required to report semi-annually on its oversight of the Office of Internal Affairs investigations and the employee discipline process of the California Department of Corrections and Rehabilitation (CDCR or the department). The OIG's Semi-Annual Reports have primarily served this purpose.

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 Reports in a two-volume format to allow readers to more easily distinguish the various categories of oversight activity.

Volume II reports the OIG's monitoring and assessment of the department's handling of critical incidents, including those involving deadly force. It also reports the monitoring of use-of-force reviews within the department and CDCR's adherence to its contraband surveillance watch policy. Since each of these activities is monitored on an ongoing basis, they are now combined into one report to be 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

TABLE OF CONTENTS

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, and contraband surveillance watch within CDCR. The OIG reports these monitoring activities here to reduce the overall need for separate reports, and also to give the reader a wider view of OIG-monitored activities in one place.

Historically, the OIG has maintained response capability 24 hours per day, seven days per week, for any critical incident occurring within the prison system. OIG staff respond on 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 D.

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

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

MONITORING CRITICAL INCIDENTS

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

1. Any use of deadly force, including warning shots;
2. Any death or any serious injury that creates a substantial risk of death to an individual in the custody or control of the department,[1] excluding lawful executions;
3. Any on-duty death of a department staff member;
4. Any off-duty death of a department staff member when the death has a nexus to the employee's duties at the department;
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;[2]
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 incident of notoriety or significant interest to the public; and
10. 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 on scene at a later time. More specifically, the OIG evaluates what caused the incident and the department's immediate response to the incident. 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 incident should be referred to the Office of Internal Affairs, the decision regarding any referral is also monitored. If the matter is opened for an investigation, the OIG monitors the ensuing investigation. Critical incidents are customarily reported in the next Semi-Annual Report following the incident occurrence. However, if an investigation is initiated, a report may be held at the discretion of the Inspector General until the completion of the investigation if reporting it would potentially negatively impact the integrity of that internal investigation.

During this reporting period, the OIG completed assessments of 159 critical incidents (Appendices D and E). It is important to note that the number of critical incidents within any period is dependent upon the events taking place within the department. This report does not

[1] As used herein, an individual within the custody and control of the department does not include a parolee.
[2] Contraband surveillance watch cases are summarized on page 24 and detailed in Appendix F.

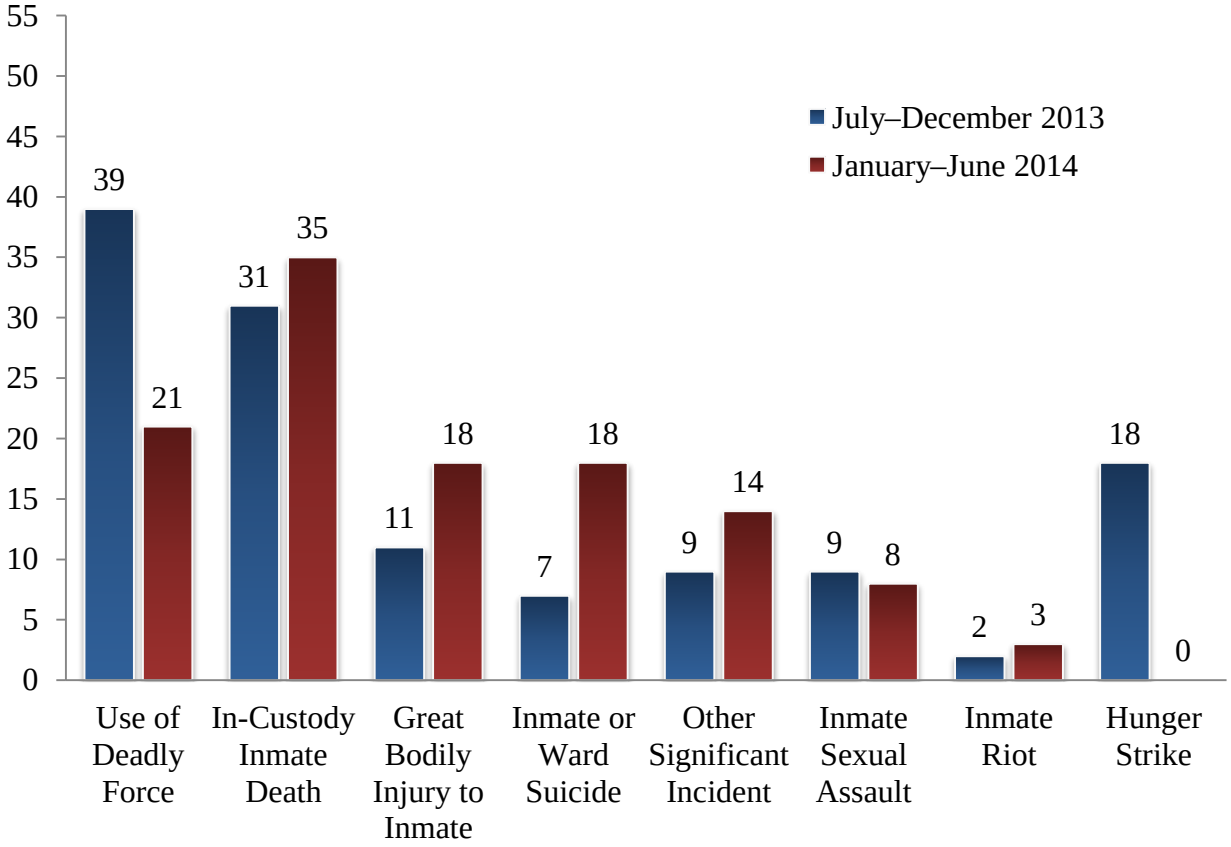
directly correlate to incidents that occurred within this time frame, but rather reflects the number of incidents the OIG has assessed and closed for the time period. In addition, in order to monitor an incident on scene, the OIG relies on the department to provide timely notification that a critical incident has occurred. However, even when notification is untimely, the OIG still remotely monitors the event by collection of reports and follow-up review.

The total number of monitored critical incidents closed and reported each reporting period by the OIG is displayed in Chart 1. It does not directly reflect the exact number of incidents occurring during each period because the OIG does not report incidents until a final assessment is completed. Some incidents may take longer than others to be resolved.

For cases reported during this period, the department provided timely notification for 93 percent of the critical incidents. This is a significant improvement from the two prior reporting periods, indicating an increased emphasis by the department on timely notification. The department has made a concerted effort to improve and is committed to timely notification. Delays in notification impact the OIG's ability to provide real-time, on-site monitoring and transparency for critical incidents.

The OIG also monitors critical incidents as they occur in the juvenile system.

Chart 1: Types of Critical Incidents Closed and Reported This Period



IN-CUSTODY INMATE HOMICIDES

Included in the 35 critical incidents involving in-custody inmate deaths in this report are 11 inmate-on-inmate homicides. As previously noted, the OIG examines cases to determine what led to the incident and if there are policy or training recommendations that can be made or trends observed. Of the 11 inmate-on-inmate homicides, 10 occurred on Level IV Sensitive Needs Yards (SNY), 8 of which were in-cell homicides. In addition to the 11 listed homicides in the table below, another case (14-1156-RO) was an in-cell great bodily injury case that also occurred on an SNY facility but did not result in death.

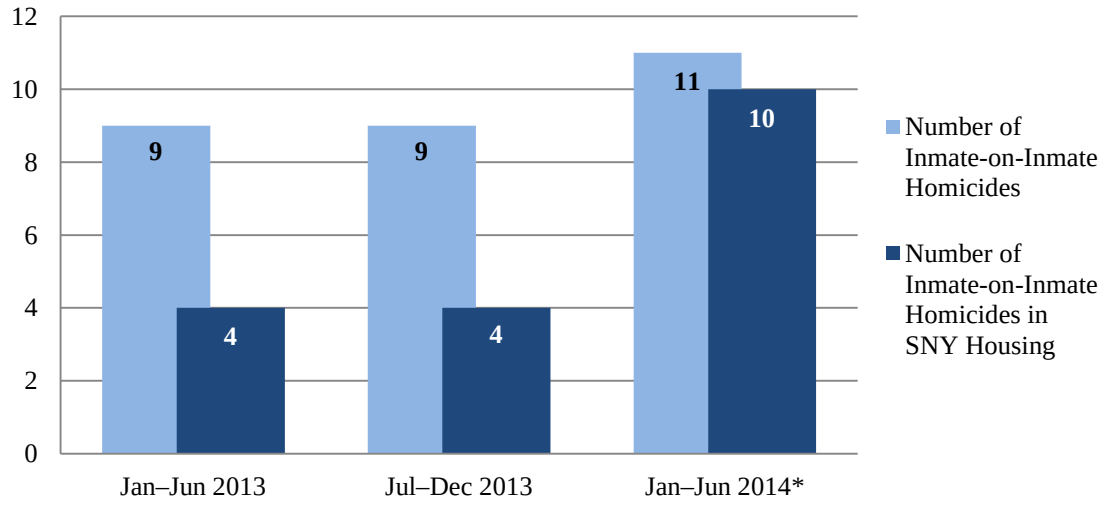
See Appendix D for details of the 11 inmate-on-inmate homicides.

Table 1: List of OIG Case Numbers Involving Inmate-on-Inmate Homicides

Inmate-on-Inmate Homicides	
OIG Case Number	OIG Case Number
13-0513-RO	13-2228-RO
13-0663-RO	13-2631-RO
13-2019-RO	13-1365-RO
13-2365-RO	13-2238-RO
13-0242-RO	14-0427-RO
13-0824-RO	

In the OIG's assessments of these events, it became clear that there are steps that the department can take to lessen such risks. Given the current nature of the SNY population, which comprises sex offenders as well as gang dropouts and other general population inmates, some additional preventative steps should be considered, notwithstanding the department's belief that placement on such yards includes an implied agreement by SNY inmates to co-exist peacefully. That assumption is no longer valid.

Chart 2: Inmate-on-Inmate Homicides and SNY Homicides



*During this period, in addition to the SNY homicides above, there was one in-cell SNY inmate great bodily injury that did not result in death.

The above chart shows the alarming upward trend in homicides that take place on the sensitive needs yard. The number of inmate-on-inmate homicides in SNY housing has more than doubled from the two prior reporting periods. This figure is disturbing in that 91 percent of the in-custody homicides occurred on a sensitive needs yard even though these yards house only 27 percent of the inmate population[3] and were originally created to prevent violence to those inmates requiring protection from the rest of the population for various reasons. It is problematic that these yards are increasingly violent.

In 2000, citing its policy that all inmates double cell unless specifically prohibited by a "single cell" designation, CDCR discontinued the requirement that institutions, other than reception centers, complete a *CDCR Form 1882-A, General Population Double Cell Review*. However, the department does still require completion of the *CDCR Form 1882-B, Administrative Segregation Unit/Security Housing Unit Double Cell Review* for all inmates requiring segregated housing. The department should re-examine its double cell policy for sensitive needs yards, and require completion of these forms for SNY housing. This compatibility form is meant to help ensure that inmates are properly placed with compatible cellmates, and potential cellmates are given the opportunity to document their agreement to house together. Inmates with prior violence toward cellmates should not be double celled, even in SNY, until an inmate's propensity for violence is considered.

The department should also review the process for transitioning inmates from single cell designation to double cell status pursuant to prior OIG recommendations. While these measures will add to the workload of staff, the increasing incidence of homicides calls for consideration.

[3] Second Report on CDCR's Progress Implementing its *Future of California Corrections Blueprint*, Page 74.

MONITORING DEADLY FORCE INCIDENTS

Deadly force incidents are a sub-type of both critical incidents and use-of-force reviews monitored by the OIG. They automatically result in both an administrative and a criminal investigation if the Office of Internal Affairs chooses to conduct a deadly force investigation, with the only exception being when the force occurs outside the prison and an outside law enforcement agency conducts the criminal investigation. Appendix E contains each use of deadly force case closed in this reporting period, divided in two categories: Appendix E1, where the Office of Internal Affairs opened a case and the OIG monitored the case; and Appendix E2, where the OIG monitored a case, but the Office of Internal Affairs did not open a corresponding case because these incidents did not meet the Office of Internal Affairs criteria for deadly force. Of the cases in Appendix E1, the Office of Internal Affairs determines if the case meets the criteria for a full deadly force investigation. Thus, some cases are closed after an initial review and do not receive a complete investigation.

Any time CDCR staff use deadly force, the department is required to promptly notify the OIG. When timely notice of a deadly force incident is received, OIG staff immediately respond to the incident scene to evaluate the department's management of the incident and the department's subsequent deadly force investigations, if initiated.

CDCR policy mandates that deadly force investigations be conducted by the Office of Internal Affairs' Deadly Force Investigation Team. The OIG also monitors any use of force involving a head strike by custody staff with any instrument on an inmate, and all warning shots.
The Office of Internal Affairs' Deadly Force Investigation Team is described and regulated by California Code of Regulations, Title 15, Article 1.5, Section 3268(a)(20).

> *Deadly Force Investigation Teams (DFIT): DFIT is a team of trained department investigators that shall conduct criminal and administrative investigations into every use of deadly force and every death or great bodily injury that could have been caused by a staff use of force, except the lawful discharge of a firearm during weapons qualifications or firearms training, or other legal recreational uses of a firearm. Although defined as deadly force DFIT need not investigate the discharge of a warning shot inside an institution/facility if an Investigative Services Unit Sergeant or above, or an uninvolved Correctional Lieutenant or above confirms that the discharge of deadly force was a warning shot and that no injuries were caused by the shot. All warning shots shall be reported to the Office of Internal Affairs/DFIT and the Bureau of Independent Review (BIR).*[4]

The OIG believes on-scene response is an essential element of its oversight role and will continue responding to any critical incident involving potentially deadly use of force whenever feasible. The very nature of the incident warrants additional scrutiny and review, regardless of whether any misconduct is suspected or whether the ultimate result of the force is an actual death.

4 In July 2011 the BIR was redesignated as the Office of the Inspector General (OIG).

Deadly Force Investigation Team incidents usually require review by the Deadly Force Review Board. An OIG representative participates as a non-voting member of this body. The Deadly Force Review Board reviews those cases to which the Office of Internal Affairs sends the Deadly Force Investigation Team. The Deadly Force Review Board is an independent body consisting of outside law enforcement experts and one 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.

Because the use of deadly force has such serious implications, the department's use of deadly force has always received the highest level of scrutiny. During this reporting period, the review process for 42 deadly force incidents monitored by the OIG concluded. The incidents included unintentional head strikes, warning shots, intentional uses of lethal weapons, and other uses of force that could have or did result in great bodily injury or death.

The Office of Internal Affairs responded with the Deadly Force Investigation Team in 16 of the 42 cases the OIG monitored, and in one case outside law enforcement responded to the scene instead of the Deadly Force Investigation Team. These numbers do not correlate with the actual number of times the Office of Internal Affairs responded on-scene during this reporting period. The OIG does not report on the cases until all activity is completed on the case. These numbers represent a mix of cases before and after the Office of Internal Affairs changed its policy, described below, for on-scene response. During the 42 incidents monitored by the OIG, various types of force were used, and in many cases, a variety of force options were utilized. Two cases involving lethal force resulted in death, including the case where outside law enforcement responded. In 20 incidents, less-lethal weapons were fired, unintentionally striking inmates in the head, and none of these resulted in death.

In seven of the incidents to which the Deadly Force Investigation Team did not respond, inmates were transported to outside hospitals for medical treatment of injuries, including lacerations and sutures to the head, fractures of the skull, pain and swelling, inmate-inflicted injuries, and a concussion.

There were ten additional incidents that did not receive the Deadly Force Investigation Team response where unintentional head strikes occurred but did not require outside hospitalization. Although no inmates were killed in the incidents in which department staff inflicted unintentional head strikes, any one of those incidents certainly could have resulted in serious injury and subjected the department to major liability. The department is currently addressing the need for responses to more of these incidents. In response to previous concerns raised by the OIG, on January 16, 2014, the Deputy Director for the Office of Internal Affairs distributed a memorandum to all CDCR extended executive staff, informing all staff that, pursuant to California Code of Regulations, Title 15, the and the Department Operations Manual, the Office of Internal Affairs would respond with the Deadly Force Investigation Team to any strike to the head of a person with a baton or impact munitions. This has significantly expanded the scope and

number of cases that the Office of Internal Affairs will now investigate, and is a significant positive development in the investigation of deadly force incidents.

MONITORING USE OF FORCE

The OIG monitors the department's evaluation of the force used by staff and reports its findings semi-annually. The monitoring process includes attending Institutional Executive Review Committee (IERC) meetings where every use of force incident is reviewed and evaluated for compliance with policy.[5] 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."[6]

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

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

a) Chemical agents such as pepper spray and tear gas;

b) Hand-held batons;

c) Physical force such as control holds and controlled take downs;

d) Less-lethal weapons (weapons used in a prescribed manner not intended to cause death), including the following: 37 mm or 40 mm launchers used to fire rubber, foam, or wooden projectiles, and electronic control devices; and

e) Lethal (deadly) force.[7] This includes any use of force that is likely to result in death, and any discharge of a firearm (other than during weapons training).

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. The OIG also

[5] See "*Pilot Program for Institutional Use-of-Force Reviews*" later in this section for the exception to this policy.
[6] Department Operations Manual, Chapter 5, Article 2.
[7] The department also investigates as lethal force strikes with a baton or impact munitions to the head of any person.

provides oversight and makes recommendations to the department in the development of new use-of-force policies and procedures.

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

The time period covered in this report is January 1, 2014, through June 30, 2014. The OIG attends as many use-of-force committee meetings that resources allow, but no fewer than one meeting each month at each prison, juvenile facility, and parole region.

Use-of-Force Meetings Attended, Incidents Reviewed, and Recommendations Made

Department of Corrections and Rehabilitation Data

During this reporting period, the department reported a total of 3,251 incidents involving the use of force and 4,448 applications of force. The department reports there were 2,370 applications of chemical agents (53 percent of the total applications of force), including Oleoresin Capsicum (OC), Chloroacetophenone (CN), and Orthochlorobenzalmalononitrile (CS). Batons were used 337 times, physical force 1,220 times, and shots from Mini-14 rifles or other lethal force 11 times. Less-lethal force, which includes 37mm and 40mm rounds, was used 489 times during this reporting period, accounting for 11 percent of the total applications of force.

Table 2: CDCR Data—Applications of Force

Force Type	Percentage
Chemical Agents	53%
Physical Force	27%
Less-Lethal Force	11%
Baton	8%
Lethal Force	<.05%
Other	<.05%
Total	100%

Office of the Inspector General Data

The OIG attended 427 use-of-force meetings where a total of 2,491 incidents were evaluated. The OIG also monitored an additional 530 incidents involving force, apart from the use-of-force

meetings. Of these 3,021[8] incidents that the OIG evaluated, 2,621 were reviewed for the first time, meaning 400 reviews were incidents that were referred to the IERC more than once, due to the cases not being fully prepared upon first review.

In preparation for a use-of-force meeting, the OIG evaluates all departmental reviews completed prior to the meeting. 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 3: Number of Separate Use-of-Force Incidents Reviewed, by Division

Division	Number of Incidents Reviewed
Division of Adult Institutions	2,410
Division of Juvenile Justice	170
Division of Parole Operations	32
Office of Correction Safety	9
Total	**2,621**

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 270 individual cases.

In the cases reviewed, CDCR found the actual force used was within policy 97 percent of the time at adult institutions, 94 percent of the time within the juvenile facilities, 100 percent of the time in the parole regions, and 100 percent of the time by the Office of Correctional Safety (OCS).

In 99 percent of adult institution monitored cases, the OIG ultimately concurred with the department's use-of-force committee decisions. In 99 percent of the juvenile facility and all of the parole region and OCS monitored cases, the OIG ultimately concurred with the use-of-force committee decisions. These numbers are consistent with prior reporting periods and show that of the cases fully prepared for review, the department is able to take meaningful and appropriate action. As noted in previous reports, the department has struggled with timeliness, thorough evaluations, and fact gathering by first- and second-level reviewers. In this reporting period, 566

[8] This data was received from CDCR on September 4, 2014, for incidents *occurring* from January 1 to June 30, 2014. This data is entered into CDCR's Daily Information Reporting System by the institutions. If there are multiple options used during one incident, each option is only counted once. If two different people use OC pepper spray during the same incident, OC pepper spray is counted once because only one force *option* was used. The number of incidents and breakdown by type of force numbers will not necessarily match as more than one option can be used per incident. This data differs from the OIG's data, because the OIG's data reflects incidents *reviewed* by the OIG from January 1 to June 30, 2014. Additionally, OIG data reflects the type of force used on each inmate during an incident. For example, if two inmates are fighting and OC pepper spray is used on each inmate, OC pepper spray will be counted twice for the one incident.

cases had to be deferred because they were not ready for complete review when they were brought to the use-of-force committee. From these reviews and prior reports, it is apparent that the department continues to have several institutions failing to make timely reviews.

While the department has been receptive to OIG input in each individual case, there was one incident this reporting period that the OIG referred to the department's executive review committee (DERC).[9] The incident, which occurred in the Reception Center mission, involved a non-conventional use of force where an inmate was struck in the head with a pepper spray canister. Ultimately, the DERC did not agree with the OIG's assessment that there was not an imminent threat requiring the use of lethal force. There were two other incidents, also in the Reception Center mission, involving the non-conventional use of a pepper spray canister to strike an inmate in the head. Those two cases adequately articulated the imminent threat requiring the use of lethal force and adequately described the force used.

Types of Force

A single incident requiring the use of force may involve more than one application of force and may require use of different types of force. For example, during a riot, officers may use lethal force, chemical agents, expandable batons, and less-lethal force to address varying threat scenarios as the riot progresses. The OIG reviewed 2,621 separate incidents during this reporting period. There were 5,807 individual applications of force used in the incidents.

Table 4: Types of Force and Frequency of Use

Type of Force	Applications	Percentage of Total Applications
Chemical Agent	3,674	63%
Physical Force	1,182	20%
Less-Lethal	550	9%
Baton	340	6%
Other/Non-Conventional[10]	35	<1%
Taser[11]	13	<.05%
Deadly Force*	13	<.05%
Total	**5,807**	**100%**

*Not all deadly force incidents are reviewed by the IERC. If an incident is heard by the Deadly Force Review Board, it will bypass the IERC Review. See Appendix E for a summary of the deadly force cases monitored by the OIG that closed in this reporting period.

[9] The DERC is a committee of staff selected by, and including, the Associate Director who oversees the respective mission-based group. The DERC has oversight responsibility and final review authority over the IERC. The DERC reviews every use of deadly force and every serious injury, great bodily injury, or death that could have been caused by a staff use of force. The DERC also reviews those incidents referred to the DERC by the IERC Chairperson or otherwise requested by the DERC.

[10] Non-conventional force is defined in departmental policy as force that utilizes techniques or instruments that are not specifically authorized in policy, procedures, or training. Depending on the circumstances, non-conventional force can be necessary and reasonable; it can also be unnecessary or excessive.

[11] Tasers are authorized for use by specially trained Parole Agents and Special Agents assigned to the Office of Correctional Safety. They are not currently used in the institutions.

Of these applications of force, 5,638 were immediate uses of force and 169 were controlled uses 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 of an Administrative Officer of the Day (AOD) during non-business hours. Staff must make every effort to identify disabilities, to include mental health concerns, and to note any accommodations that may need to be considered when preparing for a controlled use of force.

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

During this reporting period, the OIG found that staff contributed to the need for force in 80 of the 2,621 incidents reviewed, approximately 3 percent of the incidents. While there were varying reasons staff contributed to the need for the use of force, three major reasons were 1) staff's failure to sound an alarm during an incident, which may have negated the need for force; 2) entering the cell of an agitated or noncompliant inmate instead of leaving the cell door closed and waiting for additional staff, and 3) using force when no imminent threat was present.

Table 5: Staff Contribution to the Need for Force, by Mission

Mission	Incidents
High Security (Males)	23
Reception Centers	20
General Population (Males)	14
Female Offender/Special Housing	11
Juvenile Justice	11
Adult Parole	1
Total	**80**

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).[12] As of June 30, 2014, the department was responsible for housing 122,545 in-state inmates.[13] The following table displays a breakdown of how the inmate population is distributed throughout the missions.

Table 6: In-State Inmate Population, by Mission

Mission	Inmate Population	Percentage of Population
High Security	35,323	29%
Reception Centers	40,796	33%
General Population	34,062	28%
Female Offenders/Special Housing	12,364	10%
Total	**122,545**	**100%**

The OIG reviewed 2,410 use-of-force incidents occurring throughout the 36 institutions. Within the total number of incidents reviewed, there were 5,317 applications of force. Of those 2,410 incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in 2,344 incidents, 97 percent. The remaining 3 percent of incidents reviewed had inadequate justification for the use of force.

Table 7: Number of Incidents Reviewed by OIG, by Mission

Mission	Incidents	Percentage
High Security (Males)	904	37%
Reception Centers	747	31%
General Population (Males)	453	19%
Female Offenders/Special Housing	306	13%
Total	**2,410**	**100%**

[12] 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.

[13] The department contracts to house nearly 9,000 additional inmates in out-of-state facilities. The OIG does not monitor the use of force in out-of-state facilities. CDCR data derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1406.pdf

Table 8: Applications of Force Reviewed by OIG, by Mission

Mission	Applications	Percentage
High Security (Males)	2,323	44%
Reception Centers	1,432	27%
General Population (Males)	1,040	20%
Female Offenders/Special Housing	522	9%
Total	**5,317**	**100%**

Table 9: Types of Force/Number and Percentage of Individual Applications, by Mission

Force Used		Mission				
		High Security	Reception Center	General Population	Female Offenders/ Special Housing	Total
Chemical Agents	Applications	1,518	844	705	275	**3,342**
	Percent	45%	25%	21%	8%	**99%***
Physical Force	Applications	378	292	147	225	**1,042**
	Percent	36%	28%	14%	22%	**100%**
Less-Lethal Force	Applications	286	148	115	1	**550**
	Percent	52%	27%	21%	0%	**100%**
Baton	Applications	125	130	63	20	**338**
	Percent	37%	38%	19%	6%	**100%**
Other/Non-Conventional	Applications	9	16	6	1	**32**
	Percent	28%	50%	19%	3%	**100%**
Lethal Force	Applications	7	2	4	0	**13**
	Percent	54%	15%	31%	0%	**100%**

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

For the most part, the number of incidents and applications of force is proportionate to the size of the missions.

Table 10: Applications of Force in Reviews Completed, Grouped by Mission

Applications of Force in the Reviews Completed by the OIG								
Adult Institutions								
Institution Initialism	**Institution Name**	**Mission**	**Applications of Force**	**Physical Force**	**Chemical Agents**	**Expandable Baton**	**Less-Lethal Force**	**Deadly Force**
CCWF	Central California Women's Facility	Female/Special Housing	121	47%	49%	4%	0%	0%
CHCF	California Health Care Facility	Female/Special Housing	95	72%	27%	1%	0%	0%
CIW	California Institution for Women	Female/Special Housing	145	39%	52%	8%	0%	0%
CMF	California Medical Facility	Female/Special Housing	94	35%	64%	1%	0%	0%
FSP	Folsom State Prison	Female/Special Housing	67	15%	82%	1%	1%	0%
FWF	Folsom Women's Facility	Female/Special Housing	0	0%	0%	0%	0%	0%
ASP	Avenal State Prison	General Population	87	5%	93%	2%	0%	0%
CTF	Correctional Training Facility	General Population	42	21%	71%	7%	0%	0%
CVSP	Chuckawalla Valley State Prison	General Population	20	10%	80%	10%	0%	0%
ISP	Ironwood State Prison	General Population	67	15%	61%	9%	12%	0%
MCSP	Mule Creek State Prison	General Population	263	19%	54%	12%	15%	0%
PVSP	Pleasant Valley State Prison	General Population	43	33%	56%	2%	9%	0%
SOL	California State Prison, Solano	General Population	77	13%	70%	3%	14%	0%
VSP	Valley State Prison	General Population	14	43%	57%	0%	0%	0%
CAL	Calipatria State Prison	General Population	298	8%	72%	2%	15%	1%
CEN	Centinela State Prison	General Population	129	15%	71%	9%	5%	0%
CAC	California City Correctional Facility	High Security	45	18%	78%	0%	0%	0%
CCI	California Correctional Institution	High Security	66	14%	70%	6%	11%	0%
COR	California State Prison, Corcoran	High Security	125	17%	73%	7%	3%	0%
HDSP	High Desert State Prison	High Security	170	11%	66%	9%	11%	3%
KVSP	Kern Valley State Prison	High Security	242	12%	71%	2%	14%	0%
PBSP	Pelican Bay State Prison	High Security	232	17%	71%	3%	8%	0%
SAC	California State Prison, Sacramento	High Security	258	31%	54%	7%	8%	0%
SATF	Substance Abuse Treatment Facility & State Prison at Corcoran	High Security	116	11%	59%	10%	17%	2%
SVSP	Salinas Valley State Prison	High Security	298	11%	74%	5%	10%	0%
LAC	California State Prison, Los Angeles County	High Security	718	15%	6%	60%	19%	0%
CCC	California Correctional Center	Reception Center	121	17%	72%	9%	2%	0%
CMC	California Men's Colony	Reception Center	53	36%	60%	0%	0%	0%
CRC	California Rehabilitation Center	Reception Center	108	20%	72%	7%	0%	0%
SCC	Sierra Conservation Center	Reception Center	91	30%	70%	0%	0%	0%
CIM	California Institution for Men	Reception Center	111	23%	68%	2%	8%	0%
DVI	Deuel Vocational Institution	Reception Center	111	22%	48%	31%	0%	0%
NKSP	North Kern State Prison	Reception Center	295	13%	55%	9%	22%	0%
RJD	Richard J. Donovan Correctional Facility	Reception Center	223	35%	44%	7%	8%	0%
SQ	California State Prison, San Quentin	Reception Center	144	20%	61%	11%	8%	0%
WSP	Wasco State Prison	Reception Center	228	13%	60%	7%	18%	1%
TOTAL			**5317 Applications**	**22% Overall Average**	**61% Overall Average**	**7% Overall Average**	**7% Overall Average**	**<1% Overall Average**

Unreasonable Use of Force

During this six-month reporting period, CDCR's Office of Internal Affairs received requests for investigation into allegations of misconduct related to the use of force against 154 staff. The types of investigations involving misconduct in the use of force remained relatively consistent between this and the prior reporting period with one exception; there was a notable decrease in the number of allegations that officers failed to report force that they witnessed.

The following table provides a comparison summary of the types of allegations the Office of Internal Affairs received for investigation during the current and previous reporting periods.

Table 11: Investigation Requests by Use-of-Force Allegation Type

Allegation	Current Reporting Period Jan–June 2014	Previous Reporting Period July–Dec 2013	Increase/Decrease
Unreasonable use of force	66	75	-9
Undetermined/Other*	25	10	+15
Failure to report unreasonable use of force witnessed	21	38	-17
Failure to report his/her own use of force	12	8	+4
Failure to report his/her own unreasonable use of force	12	23	-11
Failure to report use of force witnessed	9	5	+4
Significant unreasonable use of force likely to cause injury	9	2	+7

*The majority of these allegations are inadvertent head strikes from a baton or 40mm less-lethal round.

Use of Force on Mental Health Inmates

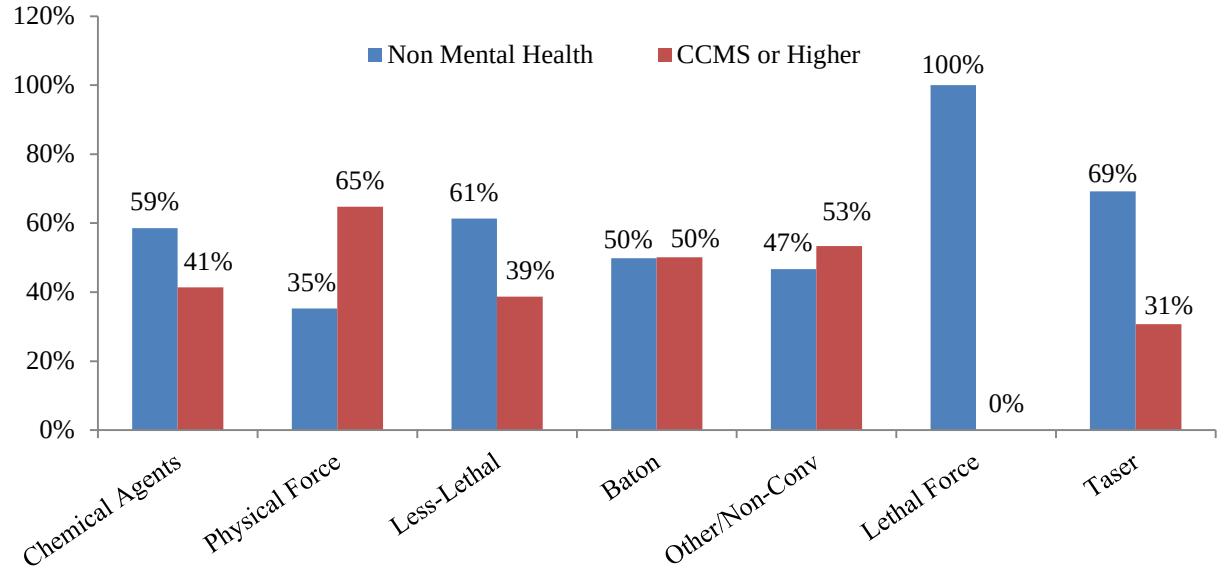
Nearly half of the total applications of force (46 percent) reviewed this reporting period were on inmates[14] participating in the department's mental health services delivery system (MHSDS)[15] at the Correctional Clinical Case Management System (CCCMS) level or above. This seems relatively high, as the department reports that about 29.2 percent of its in-state inmate population is at the CCCMS level or above.

Table 12: Applications of Force by Inmate Mental Health Code

MH Code		Percentage
Non-Mental Health		54%
CCCMS	30%	46%*
EOP	12%	
MHCB	3%	
DMH	2%	

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

Chart 3: Frequency of Force by Inmate Mental Health Code



[14] Note that multiple applications of force can be used on a single inmate and an inmate could have been involved in more than one incident during this reporting period.

[15] The department's MHSDS provides mental health services to inmates with a serious mental disorder or who meet medical necessity criteria. The MHSDS is designed to provide an appropriate level of treatment and to promote individual functioning within the clinically least restrictive environment. Mental Health care is provided by clinical social workers, psychologists, and psychiatrists. CDCR provides four different levels of care, these are: CCCMS, Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), and Department of Mental Health (DMH). A detailed description of the mental health services levels of care can be found on the department's website at http://www.cdcr.ca.gov/DCHCS/index.html.

Table 13: Frequency of Force by Inmate Mental Health Code

	Chemical Agents			Physical Force			Less-Lethal Force			Baton		
	Number	%		Number	%		Number	%		Number	%	
Non-MH	1954	59%		376	35%		336	61%		168	50%	
CCMS	981	29%	41%	331	31%	65%	172	31%	39%	115	34%	50%
EOP	308	9%		225	21%		40	7%		49	15%	
MHCB	66	2%		67	6%		0	0%		3	1%	
DMH	27	1%		68	6%		0	0%		2	1%	
Total	3336	100%		1067	100%		548	100%		337	100%	

	Other/Non-Conventional			Lethal Force			Taser			Total #	Total %	
	Number	%		Number	%		Number	%		Number	%	
Non-MH	14	47%		13	100%		9	69%		2870	54%	
CCMS	7	23%	53%	0	0%		4	31%	31%	1610	30%	46%
EOP	5	17%		0			0	0%		627	12%	
MHCB	4	13%		0			0	0%		140	3%	
DMH	0	0%		0			0	0%		97	2%	
Total	30	100%		13	100%		13	100%		5344	100%	

The department recently modified its use-of-force policy with regard to mental health inmates; however, these changes were made after this reporting period. On July 31, 2014, CDCR filed a plan with the court overseeing the *Coleman* lawsuit pertaining to how the department uses force on mental health inmates. Major changes to CDCR's use-of-force policy include limitations on the amount of chemical agents used, increased responsibilities for mental health clinicians to evaluate an inmate's mental status to determine whether the inmate is able to understand directions, and requirements that custody supervisors oversee the use of force. If a clinician decides force should not be used, the incident must be referred to senior custody and mental health management to resolve. The department has drafted new procedures to address this deficiency, and statewide training will be provided over the next few months.

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 varies greatly among the adult institutions.

Of the 2,621 incidents reviewed, 266 incidents were identified as requiring video-recorded interviews. The department complied with policy by recording interviews in 250 of these

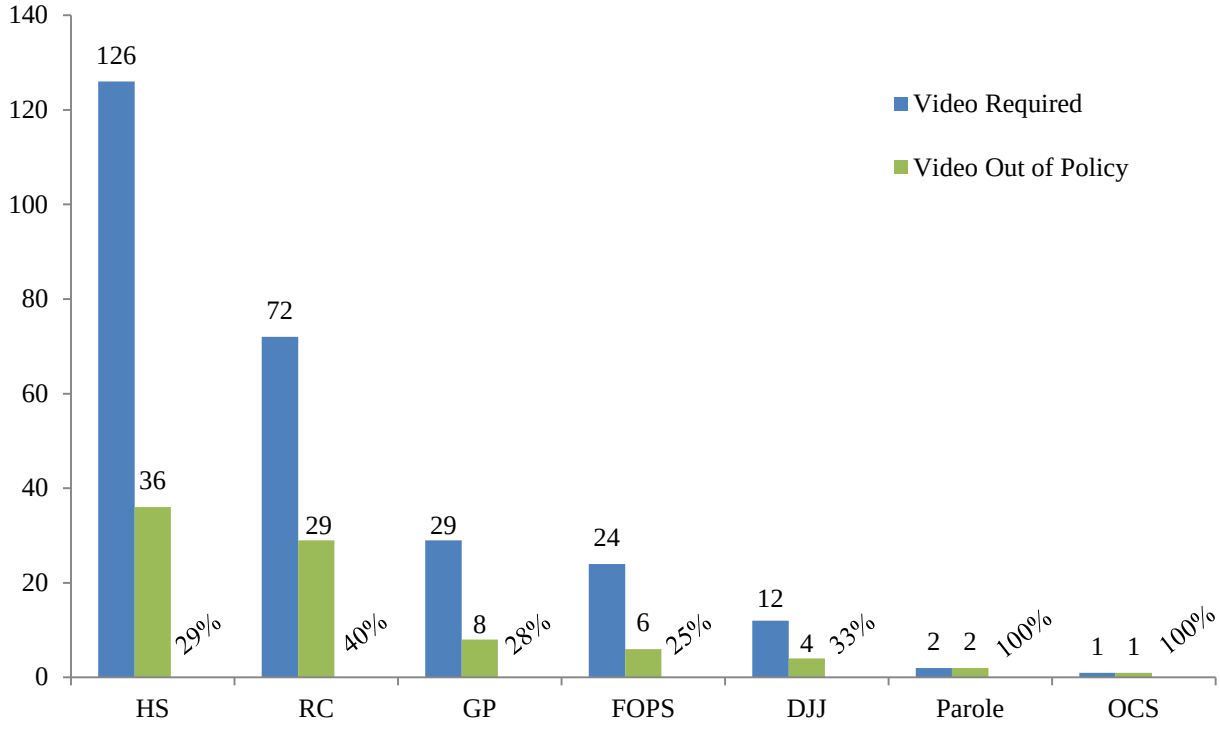
incidents (94 percent). The OIG reviewed the video-recorded interviews[16] and found that 168 were conducted according to policy guidelines, a compliance rate of 63 percent. Of the 86 incidents found out of compliance with policy, the most common deviations from departmental policy involved staff not conducting an interview when one was required, interviewers not adequately identifying themselves, or interviewers not adequately identifying the inmate's injuries.

The department is addressing the inconsistencies related to video-recorded interviews of inmates by revising procedures to direct staff to follow the instructions found in *CDCR Form 3013, (REV. 02/10), Inmate Interview Guidelines*.

It is recommended that the department revise this form to clearly include the following instructions:

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

Chart 4: Video Recordings by Mission/Division



[16] There were 12 videos that were not reviewed by the OIG, so it is unknown if they were within policy.

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 with 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. The new process provides the means by which certain use-of-force incident reports can be placed on a "consent calendar" based on the decisions reached in the first three levels of review. The OIG recommended a process whereby each stakeholder would review the incident reports, and if no issues were found, the incident could be forwarded to the warden for final disposition without having to be formally heard at the Institutional Executive Review Committee. The recommendation included a provision that if any of the stakeholders, including the OIG, had questions about any of the incidents, that incident 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 pilot test may indicate this type of review is more appropriate at institutions with lower security and non-mental-health designations.

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

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

This change to policy required approval by the Office of Administrative Law and late in this reporting period the department implemented the new use-of-force review process at three institutions (High Desert State Prison in Susanville; Kern Valley State Prison in Delano; and California State Prison, Los Angeles County, in Lancaster) on a 24-month pilot basis.[17]

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

[17] 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)).

met the requirements for consent review. As a result, as noted above, uses of force against an inmate who was a participant in the MHSDS would receive full review through the IERC. It was discovered that the institutions identified early in the process that had large numbers of uses of force and that might benefit from this program also had a large population of inmates participating in the MHSDS. The department has recently added to the pilot program Calipatria State Prison, which has a low population of inmates receiving mental health care, in order to better determine if this process will provide efficiencies worth implementing.

During this reporting period, the department reviewed 16 incidents as a part of the pilot program. Of these, the OIG agreed with the inclusion of 15 of the incidents and the determinations made on them by the department. One incident was returned, with the recommendation that the incident package be reviewed by the formal IERC, as the officer did not describe the threat well and this was not clarified at any level of review.

Division of Juvenile Justice

During this reporting period the Division of Juvenile Justice consisted of three facilities and one conservation camp and was responsible for supervising 668 juvenile offenders. The OIG reviewed 170 use-of-force incidents occurring throughout the three juvenile facilities (there were no incidents in the juvenile conservation camp this reporting period).

Among the 170 incidents reviewed, there were 442 applications of force. Of those 170 incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in 160 cases. In the other 10 cases, 5 resulted in staff training and 5 resulted in corrective action.

The following tables provide summaries of the types and frequency of force used in the juvenile facilities from January through June 2014.

Table 14: Number of Incidents Reviewed—Division of Juvenile Justice

Facility	Incidents
NA Chaderjian	43
OH Close	56
Ventura	71
Total	**170**

Table 15: Type and Application of Force—Division of Juvenile Justice

Facility	Type of Force	Applications
NA Chaderjian	Baton	1
NA Chaderjian	Chemical Agent	119
NA Chaderjian	Physical Force	21
NA Chaderjian Total		**141**
OH Close	Chemical Agent	148
OH Close	Other	2
OH Close	Physical Force	13
OH Close Total		**163**
Ventura	Chemical Agent	61
Ventura	Other	1
Ventura	Physical Force	76
Ventura Total		**138**
Grand Total		**442**

Division of Adult Parole Operations

During this reporting period the Division of Adult Parole Operations (DAPO) consisted of three parole regions[18] and was responsible for supervising over 40,000 parolees. The OIG reviewed 32 use-of-force incidents occurring throughout the parole regions. Among the 32 incidents reviewed, there were 37 applications of force. Of those 32 incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all 32 cases. The following tables provide summaries of the types and frequency of force used in the parole regions from January through June 2014.

Table 16: Number of Incidents Reviewed—Parole Regions

Parole Region	Incidents
PAR-I	11
PAR-II	2
PAR-South	19
Total	**32**

[18] On June 7, 2014, Parole Regions I and II were combined into Parole North.

Table 17: Type and Application of Force—Parole Regions

Parole Region	Types of Force	Applications
PAR-I	Chemical Agent	2
PAR-I	Physical Force	9
PAR-I	Taser	5
PAR-I Total		**16**
PAR-II	Chemical Agent	1
PAR-II	Physical Force	1
PAR-II Total		**2**
PAR-South	Baton	1
PAR-South	Chemical Agent	1
PAR-South	Physical Force	16
PAR-South	Taser	1
PAR South Total		**19**
Grand Total		**37**

Office of Correctional Safety

In addition to monitoring use-of-force incidents involving personnel at correctional institutions and in the parole system, the OIG also monitors such incidents involving employees of the department's Office of Correctional Safety.

The Office of Correctional Safety (OCS) 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, conducting gang related investigations of inmates and parolees suspected of criminal gang activity, and overseeing 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 9 use-of-force incidents involving 11 applications of force by OCS employees. Of those nine incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all nine cases. The following table summarizes the force used in these incidents by type.

Table 18: Number of Incidents Reviewed and Type and Application of Force—Office of Correctional Safety

Incidents Reviewed	Type of Force	Applications
9	Physical Force	4
	Taser	7
	Total	**11**

MONITORING CONTRABAND SURVEILLANCE WATCH

In 2012, citing concerns by the Legislature that CDCR's contraband surveillance watch process was not being applied consistently, the OIG developed a contraband surveillance watch monitoring program. Contraband surveillance watch is a significant budget driver for CDCR because it requires additional staffing for one-on-one observations. Additionally, contraband surveillance watch can subject the State to significant liability if abuses occur or contraband surveillance watch 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 notifies 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 was actually found, if any, and the dates and times the inmate was placed on and taken off watch. The OIG responds on scene to formally monitor any contraband surveillance watch where a significant medical problem occurs, regardless of the time the inmate has been on watch, and all cases where contraband surveillance watch extends beyond 72 hours. The monitoring includes inspection of the condition of the inmate and all logs and records, ensuring the department follows its policies. This on-scene response is repeated every 72 hours until the inmate is removed from contraband surveillance watch. Any serious breaches of policy are immediately discussed with institution managers while on scene.

During this reporting period, the OIG was notified of 192 contraband surveillance watch cases. Of these cases, inmates were kept on contraband surveillance watch longer than 72 hours but less than 144 hours in 43 cases; three cases involved inmates placed on watch for 144 to 216 hours; two cases extended beyond 216 hours. This report assesses the 48 cases that extended beyond 72 hours, with a detailed description of the two cases that extended beyond 216 hours. There were no cases during this reporting period where the OIG went on scene as a result of medical concerns. There were 144 cases that did not extend beyond 72 hours, and in 33 percent of these cases (47 cases) contraband was recovered.

Contraband was found in 35 percent of the contraband surveillance watch cases that extended beyond 72 hours.

Chart 5: Duration of Contraband Surveillance Watch Cases

192 Total Contraband Surveillance Watch Cases

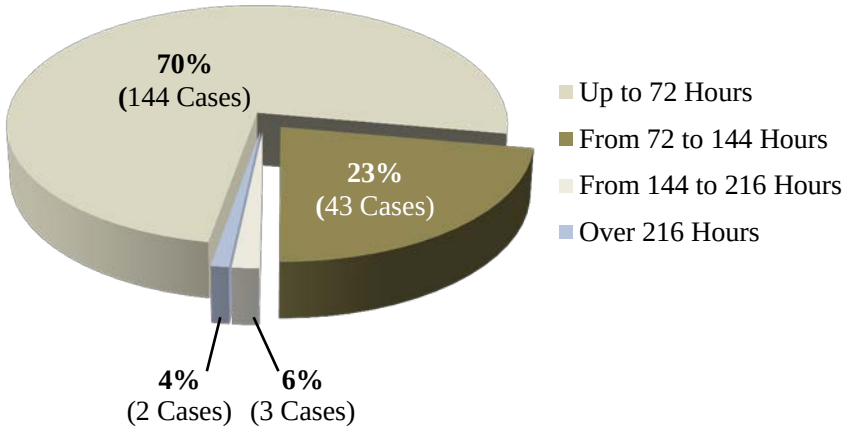
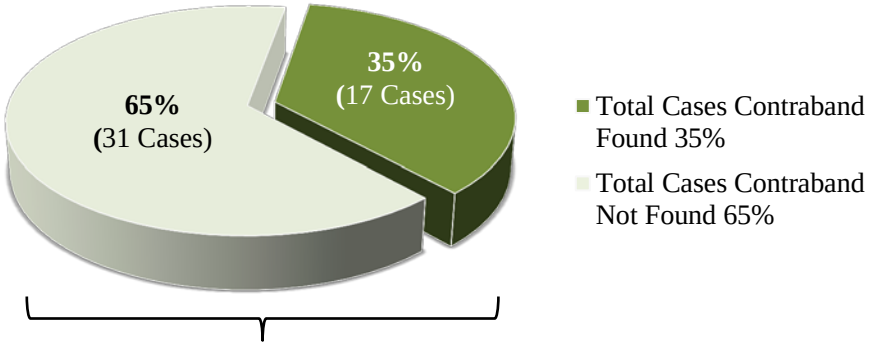


Chart 6: Contraband Found in Contraband Surveillance Watch Cases Extending Beyond 72 Hours



48 Total Cases Greater Than 72 Hours

Chart 7: Contraband Found in Contraband Surveillance Watch Cases Lasting Less Than 72 Hours

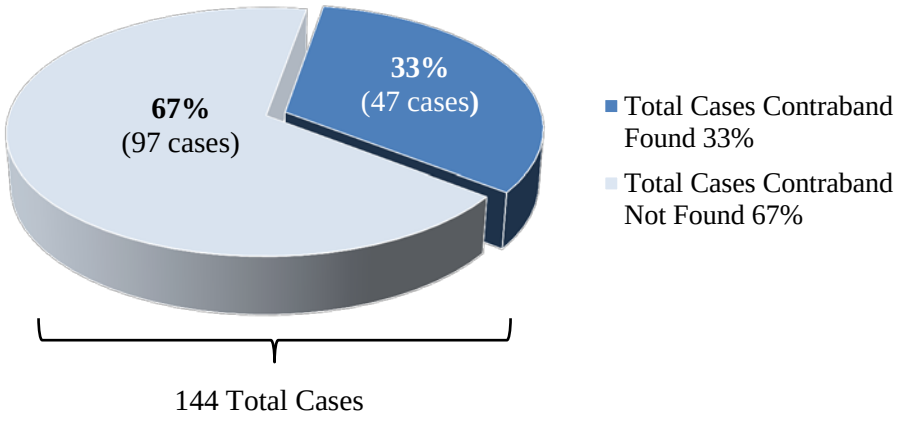
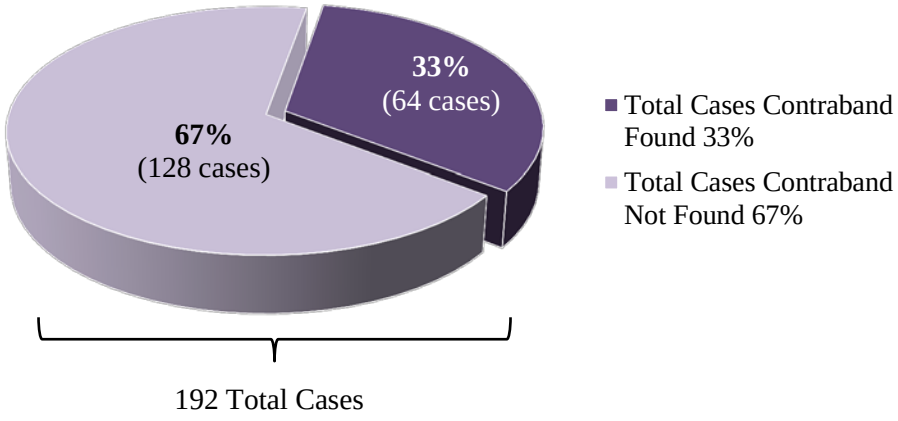
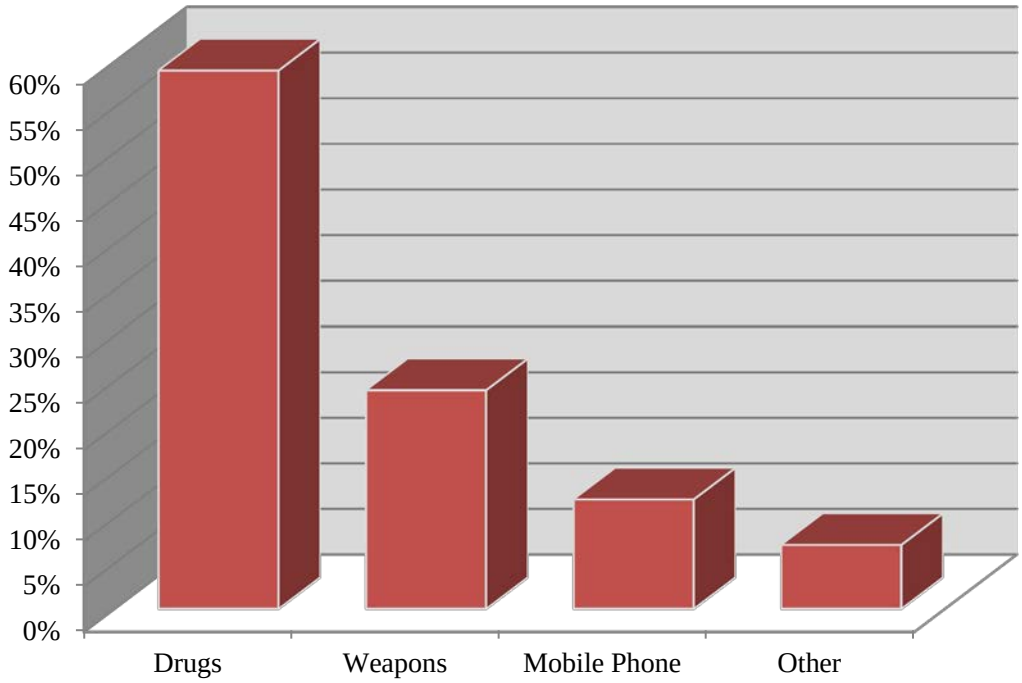


Chart 8: Contraband Found in All Contraband Surveillance Watch Cases



As previously noted, this report only covers in detail those contraband surveillance watch cases that extended beyond 72 hours. Contraband was found in 35 percent of cases that extended beyond 72 hours. Drugs were recovered in 59 percent of the cases where contraband was found, while the remaining recovered contraband was comprised primarily of weapons and mobile phones.

Chart 9: Contraband Type and Frequency in Cases Extending Beyond 72 Hours

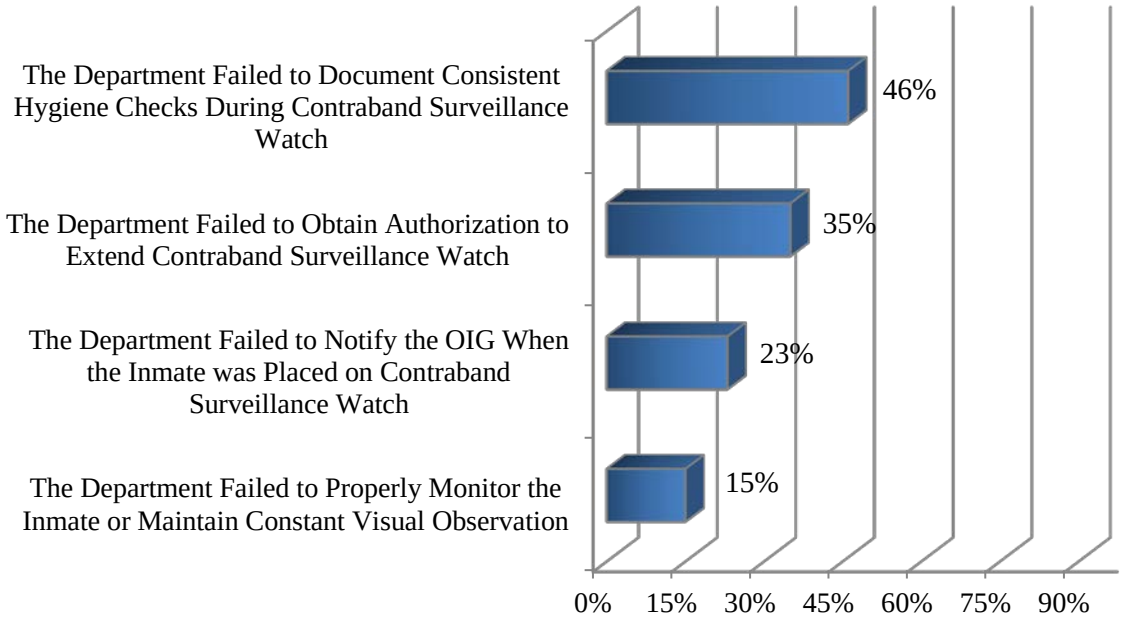


The OIG shares the department's concern that the introduction of contraband such as drugs or weapons into an institution jeopardizes safety and security. The OIG also shares the concern of the Legislature that the contraband surveillance watch process should not be administered inhumanely or punitively.

In this reporting period, the department's contraband surveillance watch placements continued to decrease for a second consecutive time (192 in this period, compared to 246 and 293 for the two prior reporting periods). Also, the number of inmates on contraband surveillance watch beyond 72 hours continued a downward trend (48 in this period, compared to 75 and 92 in the two prior reporting periods). Finally, the number of contraband surveillance watch cases exceeding 216 hours experienced a significant decrease in this reporting period (only 2 in this period, compared to 11 and 8 in the two prior periods).

While the department's decision for placing an inmate on contraband surveillance watch in all of the 48 cases exceeding 72 hours was within policy, 26 of those cases had subsequent policy violations, with many cases having multiple policy violations during the time the inmate was on contraband surveillance watch.

Chart 10: Policy Violations in Contraband Type and Frequency in Cases



In the 48 contraband surveillance watch cases that extended beyond 72 hours, the majority of process violations involved failures to complete appropriate documentation, failures to provide timely notification to the OIG, and failures to obtain proper authorization to extend contraband surveillance watch status.

In 46 percent of contraband surveillance watch cases exceeding 72 hours that incurred policy violations, the department failed to complete appropriate documentation concerning inmate hygiene. In 35 percent of the cases, the department failed to obtain authorization from headquarters to extend contraband surveillance watch, and, in 23 percent, failed to timely notify the OIG when an inmate was placed on contraband surveillance watch. In those cases, the OIG concurs with the department that the majority could be appropriately addressed through additional staff training.

Half (13 of 26) of the cases extending beyond 72 hours with policy violations came from just three prisons: Salinas Valley State Prison had six cases with at least one policy violation; California State Prison, Corcoran, had four cases with at least one policy violation; and Centinela State Prison had three cases with at least one policy violation. Five institutions had cases extending beyond 72 hours with no policy violations. North Kern State Prison had four cases extending beyond 72 hours with no policy violations. In addition, California State Prison, Sacramento; Folsom State Prison; California State Prison, Solano; and Pleasant Valley State Prison each had one case extending beyond 72 hours, and none contained policy violations.

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.

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

Table 19: Contraband Surveillance Watch Cases by Institution January–June 2014

Institution	Number of CSW Cases by Institution	Less Than 72 Hours	72 to Less Than 144 Hours	144 to Less Than 216 Hours	216 Hours or More
ASP	1	1			
CAL	3	2	1		
CCC	21	15	5	1	
CCI	15	14	1		
CCWF	1	1			
CEN	14	8	6		
CHCF	1		1		
CIM	2	2			
CIW	2	2			
CMC	1		1		
COCF	3	3			
COR	18	11	6	1	
CRC	4	4			
CTF	1	1			
CVSP	4	1	3		
DVI	5	5			
FSP	4	3	1		
HDSP	6	4	2		
ISP	1		1		
KVSP	13	13			
LAC	2	2			
MCSP	2	1	1		
NACYCF	8	8			
NKSP	9	5	4		
PBSP	2	1	1		
PVSP	3	2	1		
RJD	1		1		
SAC	5	4		1	
SATF	4	4			
SCC	9	8	1		
SOL	3	2	1		
SVSP	19	13	4		2
VYCF	3	3			
WSP	2	1	1		
Total CSW Cases	192	144	43	3	2
		Contraband Recovered: 47 Cases = 33%	**Contraband Recovered: 17 Cases = 40%**	**Contraband Recovered: 0 Cases**	**Contraband Recovered: 0 Cases**

Contraband surveillance watch is not meant to be a long-term event. As time passes, risks increase and it becomes a very costly practice. Nevertheless, there are some instances that may warrant it. A summary of the cases of contraband surveillance watch lasting over 216 hours (nine days) is below.

The longest duration for contraband surveillance watch this reporting period lasted 238 hours (10 days). In that case, correctional officers monitoring surveillance cameras in the inmate visiting area observed an inmate ingesting bindles of suspected contraband while in the company of his visitor. A subsequent search of the inmate and his visitor found both to be in possession of a suspected controlled substance. The visitor was arrested and remanded to the custody of local law enforcement, and the inmate was placed on contraband surveillance watch. The inmate was released from contraband surveillance watch after 10 days with no contraband being recovered. The department notified the OIG when each 72-hour period was completed, and the OIG conducted on-site inspections of the inmate's living conditions. The OIG noted that the department failed to follow specific documentation policies throughout the contraband surveillance watch, resulting in a rating of insufficient.

The second case involved a 217-hour contraband surveillance watch that the OIG assessed as insufficient due to the department's failure to properly monitor the inmate during the contraband surveillance watch. The inmate was released from contraband surveillance watch after just over nine days, and the department recovered no contraband. The department referred this case to the Office of Internal Affairs for investigation of potential employee misconduct, and the OIG is monitoring the related investigation.

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. The OIG makes recommendations to avoid or mitigate similar incidents in the future. The OIG assessed the department on 159 critical incidents during this reporting period. There were 63 insufficient ratings overall. The department has improved timely notification to 93 percent of critical incident cases. Failure to timely notify the OIG prevents the performance of this oversight role.

The OIG has also increased its response to inmate Prison Rape Elimination Act complaints against staff and has discovered that while policy requires such complaints to be sent automatically to the Office of Internal Affairs, not all institutions follow this requirement. Any Prison Rape Elimination Act cases referred for investigation against staff are monitored by the OIG. Page 13 of Volume I of the Semi-Annual Report discusses issues the OIG has observed and recommendations the OIG has made to the department to correct them.

Among the 42 deadly force incidents identified by the OIG, 16 did receive an immediate Deadly Force Investigation Team response from the Office of Internal Affairs (and in one case outside law enforcement responded to the scene instead of the Deadly Force Investigation Team) and five others were warning shot cases. It is not the policy of the department, however, to respond to warning shots, so there remains a discrepancy between the number of cases the OIG responds to as deadly force and the number of cases the department responds to as deadly force.

Twenty-four cases did not receive a Deadly Force Investigation Team response, and two cases received a Deadly Force Team Response the day after the incident. Seventeen of these cases received insufficient ratings by the OIG either procedurally, substantively, or both. In response to this, the department issued a memorandum on January 16, 2014, distributed by the Office of Internal Affairs, significantly expanding the scope and number of cases that the Office of Internal Affairs will now investigate. This is a positive development in the willingness of the Office of Internal Affairs to investigate deadly force incidents.

Among the 109 non-deadly-force critical incidents, 42 critical incidents received insufficient ratings. The details for those ratings can be found in Appendix D. Of particular note in this appendix are the previously discussed homicide cases occurring on Sensitive Needs Yards that give rise to the recommendations being made to the department.

The OIG attended 427 use-of-force meetings where a total of 2,491 incidents were evaluated. Apart from the use-of-force meetings, the OIG also monitored an additional 530 incidents involving force. Of these 3,021[19] incidents that the OIG evaluated, 2,621 were reviewed for the first time, meaning 400 reviews were incidents that were referred to the IERC more than once because the cases were not fully prepared upon first review. 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 270 individual cases.

The OIG monitoring of contraband surveillance watch continues to evolve. It is clear that since monitoring began, the department is following its policy in determining whom to put on watch; however, these reports have identified areas still needing improvement. If documentation and observation policies are not followed, serious medical issues could occur. If the process does not maintain policy integrity, there may also be a waste of departmental resources. Overall, the instances and lengths of duration of contraband surveillance watch cases continue to decline.

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.

[19] OIG data is reported on incidents *reviewed* between January 1 and June 30, 2014, either at IERC meetings or after the fact. Therefore, OIG data will differ from CDCR's data, which consists of incidents that *occurred* between January 1 and June 30, 2014.

VOLUME II RECOMMENDATIONS

The OIG commends the department for implementing prior recommendations and continues to encourage CDCR to implement those that remain. The OIG recommends the department implement the following recommendations from Volume II of this Semi-Annual Report, January–June 2014.

Recommendation 2.1 is made because the OIG has consistently found a high percentage of the video-recorded interviews required when an inmate alleges unreasonable force or has sustained serious or great bodily injury that could have been caused by the use of force are out of compliance with policy.

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

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

Recommendation 2.2 is made due to the increasing rate of in-cell homicides occurring on Sensitive Needs Yards (SNY) during this reporting period and the need for a review and revision in procedures to prevent further deadly incidents.

2.2 The OIG recommends the department review and revise its current policies regarding cellmate placement and double celling on Sensitive Needs Yards. Implementation steps should include the following:

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

VOLUME II RECOMMENDATIONS FROM PRIOR REPORTING PERIODS

The OIG recommended the department implement the following recommendation from Volume II of the prior Semi-Annual Report, July–December 2013.

July–December, 2013
Recommendation 2.1 The OIG recommends the department, including the Department of Juvenile Justice, implement a statewide policy directing the investigative services unit at each institution to investigate the origin of narcotics whenever they are discovered during contraband surveillance watch, cell searches, or overdose. This would include, but not be limited to, obtaining visitor logs and surveillance video as it pertains to the inmate or ward in question. If such a policy is in existence, additional training is necessary to ensure it is followed statewide.

Fully Implemented
It is the expectation all criminal activity is thoroughly investigated in a timely manner and in accordance with the law. DAI will direct wardens to ensure ISU post orders encompass due diligence requirements for investigations, including, but not limited to, narcotics discoveries. Wardens will be informed of the requirement at the next Wardens' meeting and will be required to provide proof of practice.

The OIG recommended the department implement the following recommendations from Volume II of the Semi-Annual Report, January–June 2013.

January–June, 2013
Recommendation 2.1 The OIG recommends refresher training for all wardens and institution administrative officers of the day on the requirement and process for prompt notification to the OIG on all critical incidents.

Fully Implemented
On February 3, 2014, wardens and all staff members responsible for overseeing or performing the duties of an Administrative Officer of the Day (AOD) were provided an instructional memorandum amending the AOD Notification Matrix. The amended AOD Notification Matrix provided additional persons and offices that shall be notified of certain incidents and provided clarity as to what shall be reported. This amended AOD Notification Matrix has been in effect since February 3, 2014.

January–June, 2013
Recommendation 2.2 The OIG recommends that for any intentional or unintentional use of force that results in serious injury, the Office of Internal Affairs send a Deadly Force Investigation Team.

Fully Implemented
On January 16th, 2014 the Office of Internal Affairs issued a memo to CDCR Executive Staff that announced that Office of Internal Affairs would respond for a Deadly Force Investigation to any strike to the head of a person with a Baton and/or Impact munitions.

January–June, 2013
Recommendation 2.3 The OIG recommends the department provide sufficient funding to send a Deadly Force Investigation Team to each of these types of cases.

Fully Implemented
The Office of Internal Affairs is sending a DFIT team to each reported incident. An evaluation of the process is scheduled for June 2014.

January–June, 2013
Recommendation 2.4 The OIG recommends the department develop a policy that defines when the clock officially starts for contraband surveillance watch.

Substantially Implemented
On March 28, 2014, a contraband surveillance watch workgroup met to discuss and clarify CDCR's policy as to when an inmate is officially on contraband surveillance watch. The group concluded that the most prudent time measurement for an inmate on contraband surveillance watch would be the day/date calculation. This time measurement is consistent with most other departmental policy time frames and should simplify and enhance the contraband surveillance watch tracking, extension, and notification process.

Contraband Surveillance Watch Start Clock Defined: The contraband surveillance watch time measurement clock shall start on the day/date the inmate is initially placed on contraband surveillance watch. An inmate is initially placed on contraband surveillance watch when staff have identified the need for contraband surveillance watch and have implemented observation or restraint measures, e.g., the inmate is isolated, staff begin direct and constant observation of the inmate, the inmate is placed in waist chains or taped clothing, etc.

January–June, 2013

Recommendation 2.5 The OIG recommends the department ensure that each institution conduct thorough training for all custody staff on all policies and procedures of contraband surveillance watch. This should include supervisor training so those tasked with ensuring compliance are also fully familiar with and enforcing those policies and procedures.

Fully Implemented

All available institution custody managers and supervisors were provided refresher contraband surveillance watch training. This training was completed on January 1, 2014. Any institution custody managers and supervisors who did not receive the training due to a long term absence, e.g., extended sick leave, military duty, etc., will be required to take the refresher training upon their return to duty. Additionally, as new institution custody managers and supervisors are hired, they will be provided refresher contraband surveillance watch training accordingly.

TABLE OF CHARTS

APPENDICES

Appendix D contains the assessments for 109 critical incidents monitored during this reporting period, listed by geographical region.

Appendix E contains the assessments for 42 deadly force incidents monitored during the reporting period, listed by geographical region.

E1 contains the assessments for 21 deadly force incidents monitored by the OIG during the reporting period but not investigated by the Office of Internal Affairs, listed by geographical region.

E2 contains the assessments for 21 deadly force cases investigated by the Office of Internal Affairs and monitored by the OIG during the reporting period, listed by geographical region.

Appendix F contains the results and outcomes of 48 OIG-monitored contraband surveillance watch cases during the reporting period, listed by the date the inmate was placed on contraband surveillance watch.

APPENDIX D 109
CRITICAL INCIDENT CASE SUMMARIES
CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-01-24	**13-0242-RO**	**In-Custody Inmate Death**

Incident Summary

On January 24, 2013, custody staff received a note stating there was a dead inmate in one of the cells. Custody staff responded to the cell and discovered the dead inmate on a bunk, partially covered with a blanket. The inmate had cuts to both wrists, but very little blood from those cuts. There was also minor trauma to his face and blood from his ear. The body was noticeably stiff. The cellmate was removed from the cell. No life-saving measures were attempted because of obvious signs of death.

Disposition

The coroner determined the manner of death was homicide and the cause of death was manual strangulation. The department conducted a review of the in-cell homicide, which revealed that the inmates were appropriately housed in compliance with policy; however, issues regarding substantial difference in height, weight, and age were noted. The department's Death Review Committee determined the death was not preventable. The department evaluated the medical response to the emergency and determined that the response was adequate. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs. The OIG concurred with this decision.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-01-25	**13-0229-RO**	**In-Custody Inmate Death**

Incident Summary

On January 25, 2013, an officer observed a single-celled inmate lying on the floor, unresponsive, and apparently not breathing. The officer immediately alerted custody and medical staff and they arrived at the cell together. The inmate was removed from the cell and medical staff began life-saving measures. The inmate was subsequently transported to the hospital located on institutional grounds via the emergency response vehicle. The inmate was pronounced dead after life-saving measures failed.

Disposition

The coroner determined that the cause of death was an overdose of antidepressant medication and noted the inmate had a history of hoarding his medications. The department's Death Review Committee identified issues related to documentation and a possible failure to initially apply oxygen. The conclusion was that the death could not have been prevented by responding staff. Two nurses received training because they failed to document the application of oxygen after they administered it. No staff misconduct was discovered; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

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

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The department failed to provide timely notification, preventing the OIG from responding on scene.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-02-21	13-0347-RO	In-Custody Inmate Death

Incident Summary

On February 21, 2013, an inmate began vomiting at a routine medical appointment. The inmate received medication for his vomiting and was returned to his cell after one hour of observation. Later in the afternoon, the inmate was found unresponsive in his cell as the evening meal was being served. The alarm was activated and the cellmate was removed from the cell. The unresponsive inmate was placed on a stretcher and removed from the cell. Medical staff determined the inmate was not breathing, although he had a weak pulse. Life-saving efforts were initiated. The inmate was transported to an outside hospital via ambulance for a higher level of care. The inmate was pronounced dead after life-saving efforts failed.

Disposition

The coroner determined the cause of death was due to an infection in the heart and acute alcohol intoxication. The department's Death Review Committee determined the death may have been prevented if the physician had considered a differential diagnosis of intoxication and if officers were notified to search the cell for inmate-manufactured alcohol. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-02-28	13-0369-RO	In-Custody Inmate Death

Incident Summary

On February 28, 2013, an inmate was discovered unresponsive in her cell by officers. The officers began life-saving measures and requested medical assistance. The inmate was transported to the medical clinic, where she died after life-saving efforts failed. The investigative services unit determined that there was no indication of foul play.

Disposition

The coroner determined the cause of death was due to an accidental overdose of methamphetamine. The department's Death Review Committee determined the death was not preventable; however, it noted one departure from the standard of care that did not contribute to the death, which resulted in training for medical staff. Potential staff misconduct was identified because a physician allegedly failed to assist with life-saving measures; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG did not accept for monitoring.

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department adequately responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-03-02	13-0413-RO	Other Significant Incident

Incident Summary

On March 2, 2013, a confidential informant advised custody staff that an inmate may have escaped from the minimum support facility. An emergency count and search were conducted, confirming the inmate's escape. Emergency escape procedures and the incident command post were activated. Custody staff determined that the inmate climbed a fence. On March 5, 2013, the inmate was apprehended without incident while hiding in a closet at his girlfriend's house.

Disposition

Potential staff misconduct was identified because two officers allegedly failed to account for the inmate; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The case was approved and referred back to the hiring authority to take disciplinary action after interviews of the officers. The OIG accepted the case for monitoring.

Overall Assessment

Rating: **Sufficient**

The department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the department's decision to refer the matter to the Office of Internal Affairs.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-03-04	13-0382-RO	In-Custody Inmate Death

Incident Summary

On March 4, 2013, an inmate requested medical assistance because she was coughing and having difficulty breathing. Custody staff announced a medical emergency and notified medical staff. The inmate collapsed as medical staff responded. The inmate was unresponsive and without a pulse, so medical staff called an ambulance and initiated life-saving measures. The inmate was pronounced dead after life-saving efforts failed.

Disposition

The coroner chose not to conduct an autopsy. After a review of the inmate's medical file, the coroner concluded that the cause of death was due to natural causes related to chronic heart disease. The department's Death Review Committee determined the death was not preventable. No staff misconduct was discovered; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not timely notified because the department called the wrong phone number.

Incident Date	OIG Case Number	Case Type
2013-03-12	13-0440-RO	In-Custody Inmate Death

Incident Summary

On March 12, 2013, an inmate notified an officer in a housing unit that there was a "man down." Two officers responded to the location and discovered an inmate lying unconscious on the floor but appearing to be gasping for air. One of the officers attempted to locate a pulse but was unable to do so. An alarm was sounded and the officer immediately started life-saving measures. The inmate was transported to a local hospital while life-saving measures continued. The inmate was later pronounced dead at the hospital.

Disposition

The coroner's autopsy determined the cause of death was a toxic blood level of methamphetamine with other contributing ailments, including congestive heart failure and end-stage renal disease. The department's Death Review Committee concluded the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-03-18	13-0523-RO	Inmate Riot

Incident Summary

On March 18, 2013, an inmate riot involving 46 inmates began in a dormitory after two inmates began fighting. An officer activated an alarm and ordered the inmates to get down. Officers used pepper spray to stop the incident after verbal orders were ignored by the inmates. Approximately 45 inmates sustained minor injuries, but one inmate was transported to an outside hospital via ambulance for facial fractures.

Disposition

The institution's executive review committee found the use of force in compliance with departmental policy; however, training was provided to managers related to documentation and to an officer regarding alarm response because he did not respond to the alarm with the required equipment. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.

CENTRAL REGION

Overall Assessment

Rating: **Sufficient**

With the exception of not initially identifying all inmates exposed to pepper spray, the department's overall response to the incident was sufficient. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-03-21	**13-0513-RO**	**In-Custody Inmate Death**

Incident Summary

On March 21, 2013, while conducting a building security check, an officer noticed an inmate lying unresponsive on the floor of his cell. Officers activated an alarm and responded to the cell. The inmate's cellmate was removed from the cell as medical staff arrived and initiated life-saving measures on the inmate. The unresponsive inmate was transported to an outside hospital for further treatment and pronounced dead later that evening. The cellmate was placed in administrative segregation pending an investigation. The OIG attended the autopsy.

Disposition

The coroner determined the manner of death was homicide and the cause of death was asphyxia due to strangulation. The department's Death Review Committee evaluated the medical response to the emergency and determined there were no deviations from standards of care. Staff misconduct was not identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2013-03-24	**13-0515-RO**	**Other Significant Incident**

Incident Summary

On March 24, 2013, an inmate refused to report to the sergeant's office. Officers responded to the dorm and found the inmate lying on his bunk. The inmate refused to roll onto his stomach and submit to handcuffs, so an officer sprayed the inmate in the face with pepper spray. The inmate still refused, so a second officer pulled the inmate off of the bunk and onto the floor. The inmate again refused to submit to handcuffs, so a third officer forced the inmate onto his stomach. The inmate continued to refuse to comply, so the second officer struck the inmate twice in the calf with his expandable baton. The third officer pulled the inmate's hands from underneath his body and applied handcuffs. During the escort from the dorm to the medical clinic, the inmate attempted to pull away from the first officer, so the officer struck the inmate once in the thigh with his expandable baton. The inmate then complied. The inmate sustained minor injuries in addition to a cut above his right eye that required four sutures.

Disposition

This incident was not reviewed by the institution's executive review committee because the hiring authority referred the case to the Office of Internal Affairs for investigation due to potential staff misconduct. Two officers allegedly used unreasonable force when one officer used pepper spray and the other officer delivered two baton strikes to an inmate who refused to submit to handcuffs. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The OIG was not notified of this incident because the injuries to the inmate did not meet the OIG's notification criteria. However, the OIG discovered this incident through routine monitoring and opened a case for evaluation because the force used was questionable. Overall, the department's response to the incident was sufficient. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-04-18	**13-0568-RO**	**Suicide**

Incident Summary

On April 18, 2013, an officer was conducting cell security checks when he discovered a single-celled inmate hanging by the neck from a bed sheet. An alarm was activated and responding officers cut the noose and began life-saving measures. The inmate was transported to the triage treatment area, where he was pronounced dead by paramedics. The inmate had a prior history of serious mental illness that was not identified by mental health clinicians when he arrived at the institution.

CENTRAL REGION

Disposition

The coroner determined that the cause of death was asphyxia secondary to hanging. The inmate arrived at the institution as a parole violator with a new term. He had an extensive, serious mental health history related to a prior offender number. Upon arrival at the institution, the inmate was evaluated by a mental health clinician. Based on the inmate's untruthful answers and lack of historical information available to the clinician, he was not referred for further evaluation or placed in the Mental Health Services Delivery System. As a result of issues identified during the suicide review, the department developed a new process using computer systems to ensure clinicians have access to inmate histories that are linked to retired offender numbers. Computers were also added to screening areas, and training was provided to clinicians. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2013-04-29	**13-0600-RO**	**Suicide**

Incident Summary

On April 29, 2013, while conducting 30-minute welfare checks, two officers noticed a cell with its interior lights off. Upon closer inspection with a flashlight, the officers discovered an inmate with a ligature around his neck and tied to an air vent. An alarm was activated and as officers prepared for an emergency cell entry, the ligature broke and the inmate fell to the floor. An emergency cell entry was made and responding medical staff initiated life-saving measures. A physician pronounced the inmate dead after life-saving measures failed. The inmate was the sole occupant at the time of the incident.

Disposition

The coroner chose not to perform an autopsy. The department's Executive Summary of Suicide Report noted that the inmate's mental health information had not been transferred from the county when the inmate transferred to State prison. As a result of this incident, a committee was assembled to identify ways to improve transmitting health care information from county jails to state prisons. Additionally, the report noted that the nurse who first responded on scene did not indicate whether he brought the emergency response bag and did not explain why he failed to apply the automated external defibrillator. The report directed the institution to conduct an inquiry and take corrective action as necessary. The institution interviewed the nurse, who stated he did bring the emergency response bag but did not apply the automated external defibrillator because the emergency response vehicle arrived shortly after he began life-saving measures. The institution provided training to the nurse to emphasize that if circumstances allow, as they did in this case, the automated external defibrillator should be applied, even before beginning life-saving measures. The department's Death Review Committee determined the cause of death was suicide by hanging and was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-05-16	**13-0663-RO**	**In-Custody Inmate Death**

Incident Summary

On May 16, 2013, officers responded to a cell after hearing a "man down" call. Officers activated the alarm and requested emergency medical response after observing an inmate with visible head trauma lying face down in a pool of blood. After the cellmate was removed, custody and medical staff administered life-saving measures to the injured inmate. The inmate was transported by ambulance to an outside hospital and pronounced dead after life-saving efforts failed. The cellmate had a history requiring single-celled status because of his acts of violence against inmates. Most recently, he was on single-celled status for nearly two years after threatening to harm any cellmate he considered to be "lame." Past institutional classification committees considered him a viable threat because of a prior in-cell assault, and a recent attempted murder of an inmate. In those incidents, each inmate was found face down in a pool of blood with serious head trauma. Despite his history of violence, an institutional classification committee chairperson elected to change the inmate's status from single- to double-celled at the inmate's own request, which resulted in a homicide about nine months later.

CENTRAL REGION

Disposition

The autopsy results showed the cause of death to be extensive blunt force trauma to the head and concluded that the death was a homicide. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The department conducted an in-cell homicide review and found both inmates were housed in compliance with the department's double-celled housing policy. However, the OIG had previously addressed the single-celled policy shortcomings with the Director of Adult Institutions after a hiring authority's decision to disregard the prior violent history of an inmate, which resulted in an attempted murder. The department has yet to provide specific guidelines in its policy for transitioning a single-celled inmate to double-celled status.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-05-23	**13-0824-RO**	**In-Custody Inmate Death**

Incident Summary

On May 23, 2013, an officer discovered an inmate lying unresponsive on the floor of his cell with a sheet pulled over him and a classification document resting on top of the sheet. Custody staff secured and removed the cellmate. Responding officers placed a shield over the inmate while they removed the sheet covering the unresponsive inmate. There was a ligature around the inmate's neck, wound tight by a connected State-issued cup, and blood near his head. Officers cut the ligature and noticed fabric in the first inmate's mouth so they removed it. Medical staff initiated life-saving measures. The inmate was transported to an outside hospital where he was later pronounced dead after life-saving efforts failed. The classification document found on the deceased inmate noted that his commitment offense was for lewd and lascivious acts with a child under 14 years of age.

Disposition

The coroner determined the manner of death was homicide and the cause of death was strangulation. The department evaluated the medical response to the emergency and determined that staff members responded appropriately during the emergency. The OIG concurred. The department also conducted an in-cell assault review and analysis following the homicide and concluded that the two inmates were not housed according to policy. There was no documentation to support why the classification committee changed the assailant's status from single-celled to double-celled. In addition, the required compatibility forms could not be found for either inmate. The department concluded that both inmates were appropriately housed at the time of the homicide. The OIG did not concur with that assessment. Prior to placing two inmates together in a security housing unit, custody staff are required to consider case factors for each inmate that includes racial or in-cell violence history, height, weight, age, commitment offense, time to serve, classification score, custody level, and disciplinary history, among other things. Once the case factors of both inmates are reviewed and the inmates are interviewed and agree to be cellmates, a correctional supervisor at the rank of lieutenant or above must approve and sign the form.

CASE FACTORS OF BOTH INMATES

Assailant: Serving a 259 years to life sentence, classification score of 422, and a serious history of violence against inmates.

Deceased: Serving a seven year sentence, classification score of 32, no history of violence against inmates, mobility impaired.

The assailant's file noted that he considered a child molester his enemy because "this is the lowest crime possible." The deceased was found in his cell with a classification document placed on his body noting the decedent's commitment offense was for lewd and lascivious acts with a child under 14 years of age.

The OIG concluded that the department's requirement for completing the compatibility form lacks clear guidelines for comparing case factors prior to housing inmates together. In addition, the department does not provide guidelines to classification committees specific to changing the status of an inmate from single-celled to double-celled for inmates totally isolated from other inmates due to violent behavior. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs, but the OIG will provide the department with recommendations.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department's in-cell assault review and analysis report concluded that the inmates were appropriately housed together when, in fact, there were numerous case factors that indicated they were not compatible cellmates. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

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

  Although the department conducted an analysis of the incident and concluded that the compatibility forms were missing and recommended training for staff, the analysis failed to fully evaluate the compatibility of the involved inmates.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-06-16	**14-1045-RO**	**In-Custody Inmate Death**

Incident Summary

On June 16, 2013, officers discovered an inmate lying under a sheet unresponsive in his cell. The cellmate was removed from the cell and officers entered the cell, removed the sheet, and found a string wrapped loosely around the inmate's neck. The string did not have a knot and was not tied to any fixture. Officers began life-saving measures and requested an emergency medical response after they determined the inmate was not breathing. Medical staff arrived and assumed responsibility for the medical emergency. The inmate was pronounced dead after life-saving measures failed. The cellmate was placed in administrative segregation pending a homicide investigation. A suicide letter believed to be authored by the inmate was discovered in the cell. The OIG received timely notification.

Disposition

The autopsy report revealed the cause of death was cardiac arrhythmia and methamphetamine toxicity along with multi-organ congestion, which could be consistent with drug overdose, cardiac arrhythmia, or ligature strangulation. There was insufficient evidence to prove that the death was a homicide. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-08-03	**13-1525-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On August 3, 2013, an inmate was under escort to an exercise module when an officer reported the inmate quickly turned and forced his shoulder into the chest of the escorting officer. The escorting officers used physical force and pepper spray to gain control of the inmate. The inmate was transported to an outside area hospital where he received five staples and two sutures to close a head wound, and he also received treatment for an orbital fracture. Upon completion of medical treatment, the inmate was returned to the institution the same day and rehoused without incident.

Disposition

Potential staff misconduct was identified based on the officers alleged use of unreasonable force and failure to report use of force. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring. The institution's executive review committee will review the use of force pending completion of the investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. The hiring authority chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until nearly six hours later.

Incident Date	OIG Case Number	Case Type
2013-08-12	**13-1623-RO**	**In-Custody Inmate Death**

Incident Summary

On August 12, 2013, an inmate was found unresponsive in her cell and was later pronounced dead. The inmate was housed with a cellmate, but there were no signs of a struggle.

Disposition

The autopsy determined that the cause of death was methamphetamine and heroin overdose. Potential staff misconduct was identified based on the psychiatric technician's refusal to render aid to the unresponsive inmate; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

CENTRAL REGION

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department adequately responded to the incident in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-09-16	**13-2019-RO**	**In-Custody Inmate Death**

Incident Summary

On September 16, 2013, an inmate alerted an officer as he was passing by his cell that he felt suicidal. As the officer was removing the inmate from his cell, he noticed that the cellmate was on the lower bunk entirely covered by a bed sheet. The officer called out to the cellmate, but he was unresponsive. The officer activated an alarm, secured the suicidal inmate, and then re-entered the cell and tugged at the foot of the unresponsive inmate. The officer left the cell, claiming he felt uneasy. Medical staff arrived and started life-saving efforts after determining the inmate did not have a pulse. Life-saving efforts continued as the inmate was transported to the triage treatment area. Paramedics transported the inmate to an outside hospital where he was pronounced dead after life-saving efforts failed.

Disposition

The coroner determined the manner of death was homicide and the cause of death was from blunt force trauma. A review of the in-cell homicide conducted by the department revealed that the inmates were appropriately housed in compliance with departmental policy. The department's Death Review Committee determined that the death was not preventable. The department evaluated the medical response to the emergency and determined that officers may not have initiated life-saving efforts in a timely manner. The allegations against the responding custody staff were referred to the Office of Internal Affairs; however, the case was rejected due to lack of evidence. The OIG concurred with the determination.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The hiring authority chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-09-20	**13-2238-RO**	**In-Custody Inmate Death**

Incident Summary

On September 20, 2013, an inmate attacked another inmate with a six-inch inmate-manufactured weapon on an exercise yard. Both inmates complied with orders to stop and get down. Officers restrained the assailant and placed him in administrative segregation. The injured inmate sustained a total of ten lacerations and stab wounds to his chest and face. The injured inmate was air-lifted to an outside hospital because of life-threatening injuries. On October 3, 2013, the inmate died of his injuries while still at the hospital.

Disposition

The coroner determined the manner of death was homicide and the cause of death was prolonged low blood pressure caused by blood loss from stab wounds. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

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

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until more than three hours after the incident.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-09-21	**13-2239-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 21, 2013, custody staff observed two inmates with blood on them in a housing unit. One of the inmates entered the shower and began washing off the blood. Custody staff activated an alarm and placed the inmate who was showering in handcuffs. Medical staff arrived and determined the other inmate had life-threatening stab wounds to his neck, so the inmate was air-lifted to an outside hospital. The inmate suspected of foul play was placed in administrative segregation, and the injured inmate was returned to the institution after spending 18 days at the hospital.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with this decision.

Overall Assessment

Rating: **Insufficient**

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

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until nearly two hours after the incident.

Incident Date	OIG Case Number	Case Type
2013-09-24	**13-2081-RO**	**In-Custody Inmate Death**

Incident Summary

On September 24, 2013, an officer discovered an inmate unresponsive and straddling the toilet during an institutional count. Officers made an emergency entry into the cell to remove the inmate. Medical staff arrived and began life-saving measures after determining that the inmate was not breathing. The inmate was transported to an outside hospital via ambulance where he was later pronounced dead after life-saving measures failed. The inmate was the sole occupant of the cell.

Disposition

The coroner determined that the cause of death was a drug overdose with contributing factors of heart disease. A small bindle of black tar heroin was found in the cell. The department' Death Review Committee identified opportunities for improvement related to documentation and basic life-saving measures. The committee determined the death could not have been prevented by responding staff. Nurses and officers received training for emergency response. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with this decision.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department's notification and consultation with the OIG regarding the incident was sufficient. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-10-01	**13-2131-RO**	**Suicide**

Incident Summary

On October 1, 2013, an inmate was found dead, hanging from a shower faucet. The inmate had packed up his belongings and left notes for family, staff, and his cellmate. He had also erected a religious altar in the shower.

Disposition

An autopsy confirmed that the cause of death was asphyxia by hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

CENTRAL REGION

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-10-07	**13-2178-RO**	**In-Custody Inmate Death**

Incident Summary

On October 7, 2013, custody staff were alerted to a cell where they found an inmate lying on her bunk face down and unresponsive. There were no apparent injuries or trauma observed on the inmate. Custody staff entered the cell and commenced life-saving measures until medical staff arrived to assist. However, the inmate was pronounced dead at the scene.

Disposition

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

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-10-11	**13-2226-RO**	**Other Significant Incident**

Incident Summary

On October 11, 2013, outside law enforcement notified the hiring authority that an off-duty officer shot himself in the hand. Outside law enforcement placed a 72-hour mental health hold on the officer because they believed the officer may have attempted suicide. The hiring authority placed the officer on unpaid leave pending an inquiry.

Disposition

No staff misconduct was identified. The county mental health department cleared the officer for full duty as a peace officer. The Office of Legal Affairs determined the officer would be allowed to return to work upon recovery from his injury.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-10-11	**13-2228-RO**	**In-Custody Inmate Death**

Incident Summary

On October 11, 2013, during a security check, an officer found an inmate lying in his cell covered in blood. An alarm was activated and the cellmate was removed from the cell. A cell extraction team was assembled as medical staff arrived. Officers secured the area and removed the inmate from the cell. The emergency response vehicle arrived and life-saving measures were initiated. The inmate was transported to the institution's hospital where he was pronounced dead after life-saving measures failed.

Disposition

The coroner determined the manner of death was homicide and the cause of death was due to blood loss from sharp force trauma to the neck. The department's Death Review Committee determined that the medical standard of care was met. The institution's Emergency Medical Response Review Committee requested an investigation because first responders are required to start life-saving measures according to departmental policy, but in this incident appeared to have waited for the emergency response vehicle. Both medical and custody staff were on scene as first responders. Potential staff misconduct was identified; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

CENTRAL REGION

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was satisfactory except for inadequate documentation of first aid and life-saving measures by first responders. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-10-13	**13-2335-RO**	**Contraband Watch**

Incident Summary

On October 13, 2013, an inmate was observed swallowing an unknown object while in visiting. The inmate was subsequently placed on contraband surveillance watch for 17 days. The OIG received timely notification and periodically monitored the inmate on scene due to the length of time he was on contraband surveillance watch.

Disposition

The inmate ultimately cooperated with two search warrants that involved laxatives and enemas by medical staff. Five bindles of drugs were recovered from the inmate. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department sufficiently responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-10-15	**13-2229-RO**	**Suicide**

Incident Summary

On October 15, 2013, a psychiatric technician who was delivering medications discovered an inmate hanging from a bed sheet tied to a vent in his cell in the administrative segregation unit. The psychiatric technician alerted the control booth officer, who summoned an emergency medical response team. The psychiatric technician retrieved a cut-down tool and told the sergeant that they needed to start life-saving measures. The sergeant allegedly told the psychiatric technician, "No, at this point, it is a crime scene." Life-saving measures were not initiated because the sergeant secured the cell door to preserve evidence after he noted obvious signs of prolonged death. A nurse arrived and was permitted to enter the cell and he confirmed that the inmate had been dead for hours. The inmate was the sole occupant of the cell.

Disposition

The coroner determined the manner of death was suicide by hanging. The department's Death Review Committee determined the death was not preventable. The committee determined that the health care provider requested an ambulance and ordered life-saving measures be attempted after the nurse confirmed the inmate had been dead for hours. The committee determined that life-saving measures should not have been attempted after prolonged death was confirmed. The department's Suicide Case Review Subcommittee recommended training for medical staff regarding timely processing of referrals. The subcommittee also recommended an investigation be initiated to determine if security rounds were properly conducted and if custody staff acted appropriately by preventing medical staff from initiating life-saving measures. Potential staff misconduct was identified; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department adequately responded to the incident in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority decided to refer the matter to the Office of Internal Affairs, and the OIG agreed.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-10-22	**13-2276-RO**	**Other Significant Incident**

Incident Summary

On October 22, 2013, two cellmates from a maximum-security facility were under escort from a small management yard back to their cell in restraints. One of the inmates used an inmate-manufactured handcuff key to break free, retrieved a stabbing weapon that he had hidden, and began stabbing one of the escorting officers in the neck, head, and upper torso. A second officer attempted to stop the attack with his baton, but the cellmate began kicking the officer. Additional officers responded and used pepper spray and batons to stop the attack and secure the inmates. The injured officer was air-lifted to an outside hospital, where he was treated for 12 stab wounds. The officer was discharged from the hospital but remained off work.

Disposition

The Office of Correctional Safety completed a threat assessment at the OIG's urging. The assessment concluded that the incident was isolated and not part of a larger plan to assault additional officers. Potential staff misconduct was identified based on alleged security violations; therefore, the hiring authority referred the case to the Office of Internal Affairs. The case was rejected for investigation and referred back to the hiring authority for direct action. The OIG concurred with this determination. Several deviations from policy occurred during this incident that contributed to the inmate's ability to plan and carry out the assault on staff. The officers were not in compliance with policy because they did not conduct an unclothed body search prior to yard recall. The inmates were likely not checked with a metal detector because the inmates were found with an inmate-manufactured weapon and a handcuff key, both made with metal. The handcuffs were applied key holes down and not double locked, allowing the inmate to use the handcuff key to release one handcuff. Officers escorted the two inmates with one officer per inmate, whereas policy required two officers per inmate. The yard officer who was scheduled to provide less-lethal gun coverage was redirected to another position on the day of and the week prior to this incident. The institution's executive review committee has not yet reviewed the use of force because this incident is currently under investigation.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-10-26	**13-2367-RO**	**Contraband Watch**

Incident Summary

On October 26, 2013, an inmate was placed on contraband surveillance watch after he was observed in the visiting area swallowing an unknown object. In the early morning hours of October 27, 2013, the inmate informed custody staff it was a bindle of drugs that he had swallowed and that he believed the bindle ruptured because he was not feeling well. Medical staff were immediately notified, and the inmate was transported to the triage treatment area for medical care and ultimately to an outside hospital via ambulance. The OIG was not notified when the inmate was transported to the outside hospital.

Disposition

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

Overall Assessment

Rating: **Insufficient**

Overall, the department's response was not adequate because it failed to provide timely notification to the OIG of the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was notified two and one-half hours after the inmate was placed on contraband surveillance watch. However, the OIG was never notified that the inmate was transported by ambulance due to a possible drug overdose, and was not notified that the inmate was removed from contraband surveillance watch until two days later.

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

  The OIG initiated contact with the institution to obtain a status of the contraband surveillance watch case and discovered that an emergency transport to an outside hospital occurred days earlier due to a possible drug overdose.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-10-27	13-2348-RO	In-Custody Inmate Death

Incident Summary

On October 23, 2013, an inmate that was in the institution's hospital because of a compromised airway was transported to an outside hospital after the inmate requested and was given food to which he was allergic, from a nurse at the institution. The food triggered a serious allergic reaction. On October 27, 2013, the inmate was found unconscious and covered in blood, lying on the floor of the outside hospital's intensive care unit. The inmate had removed his tracheostomy tube and had a history of doing so. Hospital staff attempted life-saving measures; however, they were unsuccessful and the inmate was pronounced dead.

Disposition

The department's Death Review Committee determined the cause of death was asphyxiation due to swelling and bleeding of the airway. The committee identified problems with the nursing standard of care and documentation that occurred while the inmate was housed at the institution; however, it was determined the death of the inmate was unexpected and not preventable. The inmate had serious preexisting medical conditions that were complicated when he forcibly removed his tracheostomy tube. The case was referred to the department's Nursing Professional Practice Council to address the documentation issues identified by the death review. The OIG concurred.

Overall Assessment

Rating: **Insufficient**

Overall, the department's response was not adequate because it failed to provide timely notification to the OIG of the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

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

Incident Date	OIG Case Number	Case Type
2013-10-31	13-2365-RO	In-Custody Inmate Death

Incident Summary

On October 31, 2013, after an inmate was heard yelling from a cell, an officer responded and discovered the inmate's cellmate unresponsive and covered with a blanket. At that time, the inmate admitted to killing his cellmate. The officer alerted additional staff, then secured and removed the inmate. When staff removed the blanket they discovered the cellmate had cloth ligatures tied around his neck and his hands were bound together and tied to the upper bunk with cloth material. Medical and custody staff removed the cellmate from the cell and immediately began life-saving efforts. The unresponsive inmate was transported to an outside hospital where he was pronounced dead after life-saving efforts failed. The investigative services unit, district attorney's office, and coroner's office responded to process the scene.

Disposition

The coroner concluded the death was a homicide caused by ligature strangulation. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department adequately responded to the incident in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2013-11-18	13-2499-RO	PREA

Incident Summary

On November 18, 2013, the department received allegations that a custody staff was having an ongoing sexual relationship with an inmate and had sexually assaulted other inmates. Furthermore, the officer was allegedly introducing contraband into the institution for personal gain.

CENTRAL REGION

Disposition

Potential staff misconduct was identified by the department; therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The department chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-11-27	**13-2558-RO**	**Contraband Watch**

Incident Summary

On November 27, 2013, an inmate reported to medical staff that he had swallowed nine bindles containing drugs. At the time, the inmate appeared to be under the influence of drugs. As a result, the inmate was placed on contraband surveillance watch and transported to an outside hospital for continued observation and care. An x-ray later confirmed the presence of foreign objects in the inmate's lower intestine.

Disposition

After treatment for a drug overdose, the inmate was returned to the institution on December 3, 2013, where he remained on contraband surveillance watch. After nine bindles were recovered, the inmate was removed from contraband surveillance watch on December 5, 2013. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to provide timely notification to the OIG. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified of the incident until the following day, after the inmate was transported to the hospital.

Incident Date	OIG Case Number	Case Type
2013-12-05	**13-2592-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On December 5, 2013, two inmates attacked a third inmate in a dayroom with inmate-manufactured weapons. Officers used pepper spray and three less-lethal rounds to stop the attack. The injured inmate was air-lifted to an outside hospital for treatment of multiple stab wounds. The two inmates who carried out the attack were medically cleared and rehoused in administrative segregation pending an investigation. The injured inmate was returned to the institution the same day.

Disposition

The institution's executive review committee found that the use of force was within departmental policy and training. Although the OIG did not participate in the meeting due to inadequate notification, the OIG concurred with the decision based on a review of the incident report. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was inadequate because it failed to provide adequate notification, which prevented the OIG from attending the institution's executive review committee for the purpose of evaluating the use of force. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG concurred.

CENTRAL REGION

Assessment Questions

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

  Departmental policy states that the institution's executive review committee should normally complete the final review of the incident within 30 days. This incident did not receive a final review until six months after the incident occurred. The OIG did not identify a plausible reason for such a delay.

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

  Although the OIG specifically requested notification, the department did not provide adequate notice to the OIG when the incident was scheduled for review by the institution's executive review committee, so the OIG was not able to attend.

Incident Date	OIG Case Number	Case Type
2013-12-07	**13-2631-RO**	**In-Custody Inmate Death**

Incident Summary

On December 7, 2013, an inmate was punched in the face by another inmate, causing him to fall and hit his head on the concrete. The inmate was rendered unconscious and was taken to an outside hospital. The inmate was later removed from life support and pronounced dead after it was determined that he was brain dead.

Disposition

The coroner determined the cause of death was blunt force trauma to the head. The department's Death Review Committee evaluated the medical response to the emergency and determined there were no deviations from the standard of care. Staff misconduct was not identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG did not receive telephone notification as required. Email notification was sent but not received by the OIG until two days after the incident.

Incident Date	OIG Case Number	Case Type
2013-12-16	**13-2662-RO**	**Suicide**

Incident Summary

On December 16, 2013, an inmate was found unresponsive in his cell lying on his bunk with a bed sheet tightly wrapped around his neck. Officers put on protective gear, entered the cell, and performed life-saving efforts until relieved by medical staff. The inmate was later pronounced dead by paramedics after life-saving efforts failed. The inmate was the sole occupant of the cell.

Disposition

The coroner determined the cause of death was suicide by asphyxiation. The department's Death Review Committee determined the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-12-17	**13-2663-RO**	**Other Significant Incident**

Incident Summary

On December 17, 2013, a mental health inmate was walking down the hall with a psychologist when he suddenly turned and punched her in the face. The psychologist fell backward and hit her head on the floor with force. Two custody staff witnessed the battery and ordered the inmate to stop and get down; however, the inmate began walking to the exit of the building. One of the custody staff used pepper spray to stop the inmate. The inmate was restrained and placed in a holding cell while the psychologist was transported to an outside hospital via ambulance after medical staff determined she needed a higher level of care for head trauma. The inmate was later placed in a mental health crisis bed. The OIG was at the institution when the incident occurred and responded on scene.

Disposition

The injured psychologist returned to work four weeks after the incident. The institution's executive review committee determined the use of force was in compliance with departmental policy, and the OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2013-12-25	**13-2770-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On December 25, 2013, custody staff observed two inmates fighting, hitting each other in the head with their fists. The observation officer ordered the inmates to get down, but the two inmates continued fighting. The observation officer fired one less-lethal round, aiming for the lower left leg of one of the fighting inmates, but the round hit the inmate's left hand. The inmate was sent to an outside hospital, where it was confirmed that the inmate had sustained a broken hand.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because they failed to timely notify the OIG of the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The incident occurred on December 25, 2013, but the OIG was not notified until December 30, 2013, five days after the incident occurred.

Incident Date	OIG Case Number	Case Type
2013-12-27	**13-2761-RO**	**Suicide**

Incident Summary

On December 27, 2013, while conducting welfare checks in administrative segregation, an officer discovered an unresponsive inmate in a standing position. Upon further inspection, the officer noticed a noose fabricated from a bed sheet tied around the inmate's neck and attached to a pipe. An alarm was activated; officers cut the inmate down and removed him from the cell. A nurse was on scene and began life-saving efforts. The inmate was transported to an outside hospital by ambulance where he was pronounced dead.

CENTRAL REGION

Disposition

The coroner determined the cause of death was hanging and the manner of death was suicide. The department determined the death was not preventable. The department also found incomplete documentation and that the inmate had obvious signs of prolonged death at the time of the emergency response. Potential staff misconduct was identified because welfare checks may not have been conducted as required; therefore, the case was referred to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department adequately responded to the incident in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-12-31	**14-0013-RO**	**Contraband Watch**

Incident Summary

On December 31, 2013, an inmate told custody staff that he swallowed razor blades. Medical staff confirmed with an x-ray that the inmate had, in fact, swallowed razor blades. The inmate was transferred to an outside hospital and placed on contraband surveillance watch.

Disposition

Medical staff at the outside hospital medically removed the razor blades from the inmate. The inmate remained on contraband surveillance watch until he was returned to the institution five days later. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

Because of failure to provide timely notification to the OIG of the incident, the OIG found that the department's response to the incident was insufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until two days after the inmate was placed on contraband surveillance watch.

Incident Date	OIG Case Number	Case Type
2014-02-07	**14-0379-RO**	**Contraband Watch**

Incident Summary

On February 7, 2014, an inmate was placed on contraband surveillance watch after he told medical staff that he had attempted to stop rectal bleeding by placing an apple in his rectum. He further explained that the bleeding was a result of using a spoon to try to remove a blockage in order to alleviate his constipation. The inmate was transported to an outside hospital after medical staff were unable to retrieve the object. The inmate returned to the institution four days later, after the outside hospital retrieved the apple from his rectum.

Disposition

Staff misconduct was not identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department failed to provide timely notification to the OIG, but its overall response to the incident was adequate. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-02-24	14-1012-RO	Suicide

Incident Summary

On February 24, 2014, officers performing a routine count discovered an inmate hanging in his cell from a bed sheet attached to a vent. The alarm was activated, and an emergency extraction team removed the inmate from the cell and carried him on a stretcher downstairs, where medical staff started life-saving efforts. Paramedics arrived and relieved the department's medical staff of the medical emergency. The inmate was pronounced dead after life-saving efforts failed. The inmate was the sole occupant of the cell.

Disposition

The coroner determined the cause of death was suicide by hanging. A suicide note was found. The department's Death Review Committee concluded the death was not preventable; however, officers received training because life-saving efforts were delayed due to moving the inmate downstairs before beginning life-saving efforts. Staff misconduct was not identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

Because of failure to provide timely notification to the OIG of the incident, the OIG found that the department's response to the incident was insufficient. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG did not receive notification until the day after the incident.

Incident Date	OIG Case Number	Case Type
2014-02-27	14-0491-RO	Other Significant Incident

Incident Summary

On February 27, 2014, an officer saw an inmate hanging from the bathroom door with a sheet tied around her neck. An alarm was sounded, and custody staff entered the room, cut the sheet, and initiated life-saving measures. Medical staff responded to the scene and continued life-saving measures. An ambulance transported the inmate to an outside hospital where she later fully recovered and returned to the institution.

Disposition

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

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-03-03	14-0534-RO	In-Custody Inmate Death

Incident Summary

On March 3, 2014, while conducting a morning security check in a dormitory building, an officer discovered an inmate sitting slumped in a wheelchair that was not assigned to the inmate. The first officer and a second officer both tried to rouse the inmate, but the inmate was unresponsive. A medical emergency was declared, and the first officer went to retrieve emergency medical response equipment; however, the second officer could not remove the inmate from the wheelchair unassisted and waited for responding staff. Medical staff responded and initiated life-saving measures. The inmate was taken to an outside hospital, then air-lifted to another hospital for a higher level of care, where he was pronounced dead on March 4, 2014.

Disposition

The autopsy report indicated the inmate's cause of death was morphine overdose. Potential staff misconduct was identified based on the responding officers not initiating life-saving measures; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

CENTRAL REGION

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate. The institution contacted the OIG on the morning of March 4, 2014, to confirm contact information and notification process; however, the inquiring party insisted that he was not yet making any notifications as the inmate had not yet died. The OIG was not timely notified because notification should have been made on March 3, 2014, when the inmate was first discovered unresponsive and sent to an outside hospital. This failure prevented the OIG from real-time monitoring of the case.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG should have been notified on March 3, 2014, when the inmate was discovered unresponsive and sent to an outside hospital. The OIG was only contacted on March 4, 2014, by the institution to confirm contact information and notification requirements for inmate deaths; however, the inquiring party insisted that no notification was being made yet since the inmate had not yet died. The inmate died almost 12 hours later on March 4, 2014.

Incident Date	OIG Case Number	Case Type
2014-05-08	**14-1090-RO**	**Inmate Riot**

Incident Summary

On May 8, 2014, an inmate riot involving 20 inmates broke out on an exercise yard. Officers used pepper spray in an attempt to stop the incident. One inmate had a second inmate in a choke hold, and the second inmate was unable to defend himself. An officer ordered the first inmate to stop, but the first inmate continued to choke the second inmate. The officer struck the first inmate on the lower back with a baton; however, the first inmate refused to comply with repeated orders. The officer struck the first inmate on the back a second time with a baton and the first inmate then complied with orders. Two inmates received lacerations to their necks caused by other inmates.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because they failed to timely notify the OIG of the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until approximately two and one-half hours after the incident took place.

Incident Date	OIG Case Number	Case Type
2014-05-15	**14-1156-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On May 15, 2014, shortly after an officer told an inmate he would be transferred to another cell, the inmate attacked his cellmate, punching him with his fists and slicing at his cellmate's head, neck, and arm with an inmate-manufactured weapon. The officer returned to the cell as the attack was happening and ordered the attacking inmate to get down. The inmate complied with the order. The officer alerted other staff and the attacking inmate was secured and removed from the cell. The injured inmate was taken to an outside hospital where he received treatment for numerous lacerations to his head, neck, shoulder, forearm, and wrist. The injured inmate was returned to the institution later the same day.

Disposition

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

CENTRAL REGION

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because the investigative services unit failed to properly admonish the attacking inmate before talking to the inmate and also surreptitiously recorded that conversation without proper authorization. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs but recommended that appropriate training be provided to the investigative services unit.

Assessment Questions

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

  An investigative services unit sergeant spoke to the attacking inmate but failed to issue a Miranda warning even though his questioning would likely elicit an incriminating response. The investigative services sergeant also advised that during his conversation with the attacking inmate, the attacking inmate was unaware that the sergeant was recording the conversation. This surreptitious recording was not properly authorized. Despite these issues, a criminal case against the attacking inmate would still be viable since the attacking inmate already made unsolicited spontaneous admissions and other independent evidence was also available.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2012-07-23	12-1758-RO	In-Custody Inmate Death

Incident Summary

On July 23, 2012, staff observed an unresponsive inmate in his cell. Medical personnel and officers responded and initiated life-saving measures. The inmate was later pronounced dead by the institution's physician. The inmate was housed with another inmate, but there were no signs of trauma or foul play. The institution's investigative services unit secured the area as a potential crime scene and questioned the cellmate.

Disposition

An autopsy was performed and it was determined that the inmate died from an overdose of morphine. Potential custody staff misconduct was identified based on an officer's failure to properly conduct security checks. Therefore, the custody hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring. Furthermore, potential medical staff misconduct was identified based upon a psychiatric technician documenting that the inmate had taken medications after the time of death, but later altering the documentation. The medical hiring authority has not yet referred the case to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

This incident involved both custody staff and medical staff, and therefore, involved two hiring authorities. The department's response was not adequate because the medical hiring authority did not make a timely decision regarding whether to refer any conduct to the Office of Internal Affairs. Furthermore, the medical hiring authority did not adequately consult with the OIG regarding the critical incident. The custody hiring authority's response was satisfactory in all critical aspects. The custody hiring authority adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the custody hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The medical hiring authority did not make a timely decision regarding whether to refer any conduct to the Office of Internal Affairs. Despite multiple contacts from the OIG concerning potential medical staff misconduct, the hiring authority did not timely take action or explain the lack of action. The custody hiring authority made a timely determination regarding whether to refer conduct to the Office of Internal Affairs.

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

  The medical hiring authority and staff failed to timely respond to OIG inquiries regarding potential misconduct of medical staff by failing to respond to the OIG's inquiries for more than seven months. The custody hiring authority and staff adequately consulted with the OIG regarding the critical incident.

Incident Date	OIG Case Number	Case Type
2013-02-12	13-0291-RO	In-Custody Inmate Death

Incident Summary

On February 12, 2013, an inmate was found unresponsive in his cell. Officers immediately began life-saving measures and the inmate was taken to the triage treatment area. The inmate was later declared dead by an institution physician.

Disposition

An autopsy was performed and it was determined that the inmate died from congestive heart failure. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.

Overall Assessment

Rating: **Sufficient**

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-02-16	**13-0326-RO**	**Suicide**

Incident Summary

On February 16, 2013, an inmate told custody staff that he was feeling suicidal. As custody staff escorted the inmate to the triage treatment area, the inmate became unsteady and lethargic. At the triage treatment area, the inmate told medical staff that he had ingested multiple pills; he then lost consciousness. Medical staff performed life-saving measures until a physician pronounced the inmate dead.

Disposition

An autopsy was performed and the cause of death was determined to be suicide by ingesting an excessive amount of prescription medication. The suicide report produced by the department's Statewide Mental Health Program commended the institution's mental health, custody, and medical staff for their actions related to the case. The department referred to its clinical peer review committee the issue of how the inmate was able to amass a large amount of prescription medication. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with that decision.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-02-24	**13-2240-RO**	**In-Custody Inmate Death**

Incident Summary

On February 24, 2013, an officer discovered an inmate culinary worker lying motionless and unresponsive on the floor of an inmate restroom. The officer announced a medical emergency on his radio and activated his personal alarm. Responding officers noticed blood around the inmate's mouth. Medical staff responded to the scene and transported the inmate to the triage treatment area. The inmate was transported by ambulance to an outside hospital for treatment, where he remained until he was pronounced dead on October 11, 2013.

Disposition

The inmate was initially diagnosed with a fracture to the left temporal lobe of his skull. There is a continuing investigation to determine whether the inmate was the victim of a homicide. An autopsy indicated the inmate died of septic shock, recurrent aspiration pneumonia, difficulty swallowing, and complications of traumatic brain injury. The department's Death Review Committee determined the inmate's death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to provide timely notification to the OIG of the incident in which the inmate was injured. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified of the incident when the inmate was injured until February 26, 2013, two days later.

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

  Because of the late notification by the department, the OIG was unable to respond to this incident.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-03-01	**13-0414-RO**	**In-Custody Inmate Death**

Incident Summary

On March 1, 2013, while conducting a standing count, officers observed an unresponsive inmate hanging from a sheet around his neck while sitting on a bed in his assigned cell. Officers immediately alerted additional staff. Responding staff obtained a cut-down tool and removed the inmate from his cell. Medical staff initiated life-saving measures while simultaneously transporting the inmate to the institution's triage treatment area. The inmate was subsequently pronounced dead.

Disposition

The coroner determined the inmate's death was accidental from an autoerotic asphyxiation event while under the influence of methamphetamine and cannabis. The department's Death Review Committee determined the death was the result of a probable miscalculation when the inmate deliberately brought himself to the brink of unconsciousness. The noose allowed the inmate to control the pressure around his neck, but when the inmate mistakenly lost consciousness, he succumbed to asphyxiation. At the time of death, the institution interviewed the inmates in the surrounding cells but obtained no information regarding the inmate's death or drug use. The institution conducted a thorough search of the cell and its contents but found no narcotics or other related material in the inmate's property to indicate drug use. The warden said that no information was received or developed identifying how the inmate received the narcotics identified in the toxicology report. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The OIG agreed with the hiring authority's decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-03-08	**13-0431-RO**	**Suicide**

Incident Summary

On March 8, 2013, an officer observed a single-celled inmate hanging from a sheet attached to a shelf in his cell. Custody staff removed the inmate from the cell but did not initiate life-saving measures until the inmate was being transported to the triage treatment area. The inmate was transported to an outside hospital, where he was pronounced dead.

Disposition

The coroner determined the cause of death was suicide by hanging. Potential staff misconduct was identified based on custody staff's failure to immediately start life-saving measures; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The OIG found the department's overall response to the incident was insufficient because custody staff failed to immediately initiate life-saving measures. The department adequately notified and consulted with the OIG on the incident. The hiring authority chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Assessment Questions

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

  The hiring authority's response to the critical incident was inappropriate because custody staff failed to initiate life-saving measures immediately after the ligature was removed from the inmate's neck, and once life-saving measures were taken, custody staff failed to perform rescue breathing in addition to chest compressions in violation of departmental policies and procedures.

- Was the critical incident adequately documented?

  The institution did not adequately document the critical incident because it failed to procure the autopsy report.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-05-17	13-0670-RO	PREA

Incident Summary

On May 17, 2013, an inmate alleged that four unidentified officers entered his cell and sexually assaulted him with a broom handle. The inmate was medically examined at the institution, but no physical injuries were found. The inmate was transported to an outside hospital for a medical examination but the inmate refused to cooperate with medical staff upon arrival. Although the inmate initially cooperated with custody staff regarding the incident, he subsequently refused to provide specific information during a video-taped interview with the investigative services unit.

Disposition

Pursuant to departmental policy, the hiring authority referred the case to the Office of Internal Affairs. After review, OIA Central Intake determined there was not a reasonable belief that misconduct occurred. The OIG concurred with the decision.

Overall Assessment

Rating: **Insufficient**

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

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The hiring authority became aware of the incident on May 17, 2013; however, the OIG was not notified until May 18, 2013.

Incident Date	OIG Case Number	Case Type
2013-05-27	13-0701-RO	Suicide

Incident Summary

On May 27, 2013, during an early morning count, custody staff discovered an inmate unconscious, unresponsive, and hanging in his cell with a sheet around his neck and his back to the cell door. Custody staff called a medical emergency on the institutional radio and requested additional staff to bring the cut-down tool. Responding staff opened the door and entered the cell. After removing the sheet from the inmate's neck, custody staff lowered the inmate to the ground and immediately began life-saving measures. Custody and medical staff continued life-saving measures and transported the inmate to the institution's triage treatment area. The inmate was transported to an outside hospital, where he was pronounced dead.

Disposition

The coroner determined the cause of death was suicide by hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The department's Death Review Committee found that the standard of care during the emergency was met and concluded the death was not preventable. However, the Committee identified an area for improvement. The inmate was seen two days after the referral instead of within the required 24 hours. Training was provided to staff who failed to appropriately process an urgent mental health referral for the inmate.

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department adequately responded to the incident in all critical aspects, and agreed with the hiring authority's decision not to refer the matter to the Office of Internal Affairs. The department adequately notified and consulted with the OIG on the incident.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-06-16	13-0833-RO	Suicide

Incident Summary

On June 16, 2013, an officer discovered an inmate hanging from a noose made of cloth tied to the ceiling vent directly above the toilet in his assigned cell. The officer yelled that there was an inmate hanging and that he needed assistance. A sergeant and two other officers responded to the location. One of the officers retrieved the cut-down tool before responding. The cell door was opened and three officers entered the cell. Two of the officers lifted the inmate's body to remove the weight from the knot while the other officer cut the cloth above the knot using the cut-down tool. After the cloth was cut, the officers lowered the inmate's body to the ground and cut the knot from around the inmate's neck. The inmate was immediately placed on a stretcher and taken to the infirmary. Upon arrival to the infirmary, medical staff initiated life-saving measures which continued until a paramedic arrived, assessed the inmate, and pronounced him dead.

Disposition

The coroner determined that the death was a result of suicide by hanging. The hiring authority determined that officers and medical staff may have violated departmental policy by not immediately starting life-saving measures prior to taking the inmate to the infirmary. The case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-06-17	13-0834-RO	In-Custody Inmate Death

Incident Summary

On June 17, 2013, an officer responded to an inmate yelling for assistance. The officer observed two inmates in a cell, one of whom was on his bunk and appeared to be having a seizure. The officer activated his alarm and placed the other inmate in handcuffs. Other officers responded and removed the restrained inmate from the cell. After the restrained inmate was secured, officers performed an emergency cell extraction and removed the second inmate from the cell. The inmate continued to demonstrate seizure-like symptoms. Medical staff arrived and provided medical assistance. The inmate stopped breathing and medical staff provided life-saving measures. Paramedics arrived on scene and pronounced the inmate dead. The investigative services unit secured the cell as a crime scene.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-07-04	13-1261-RO	In-Custody Inmate Death

Incident Summary

On July 4, 2013, an inmate was found dead in his cell with a wound to his throat. The inmate was housed alone and a weapon was recovered. The inmate left a suicide note and a poem.

Disposition

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

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-07-26	13-1365-RO	In-Custody Inmate Death

Incident Summary

On July 26, 2013, officers heard loud noises coming from a cell and responded to the scene. An officer observed one inmate sitting at the toilet with a small amount of blood around his ear. The other inmate was standing with his fists clenched. Both inmates were removed from the cell. Medical staff were called to the scene because the first inmate appeared incoherent and was unable to walk. The injured inmate was transported to an outside hospital where he underwent emergency surgery. He was subsequently pronounced dead. The cell was secured as a crime scene. The second inmate was interviewed and said that he thought his cellmate had sexually assaulted him the previous night. The institution initiated Prison Rape Elimination Act protocols based on the inmate's statements.

Disposition

The coroner determined the inmate died of hemorrhagic shock caused by severe laceration of the spleen as a result of blunt force trauma. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

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

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until nearly seven hours later.

Incident Date	OIG Case Number	Case Type
2013-07-31	13-1438-RO	Suicide

Incident Summary

On July 31, 2013, an inmate approached custody staff in the dayroom and advised them to check on his cellmate who was in his cell. When the officers went to the cell they saw the cellmate standing with a noose in his hands. The officers ordered that inmate to drop the noose and lie on the floor. Instead of obeying, he dropped the noose, brought his hand up to his neck, and slashed both sides of his throat with a razor blade. The officers activated an alarm and ordered the inmate to stop his actions. The inmate continued to refuse their orders and the officers deployed pepper spray in an attempt to gain compliance. The inmate responded by placing a mattress against his cell door. The officers initiated procedures to conduct an emergency cell extraction. The inmate, meanwhile, crawled under the lower bunk in his cell. The officers entered the cell and, after several attempts, were able to pull him out from under the bunk and place him into restraints. By that time, a large volume of blood covered the cell floor. Medical staff initiated life-saving measures; however, due to the amount of blood loss, the inmate was taken by ambulance to an outside hospital, where a physician pronounced him dead.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-08-14	13-1624-RO	Suicide

Incident Summary

On August 14, 2013, an inmate was found hanging in his cell, in which he was the sole occupant, by a yellow extension cord. After cutting down the inmate, custody and medical staff initiated life-saving measures, which continued while the inmate was transported to the medical clinic, where a physician pronounced the inmate dead.

NORTH REGION

Disposition

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

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-08-16	**13-1702-RO**	**In-Custody Inmate Death**

Incident Summary

On August 16, 2013, an inmate in respiratory distress was taken to the triage treatment area. After paramedics responded, the inmate stopped breathing and died. The institution's investigative services unit secured the inmate's cell as a crime scene and interviewed the cellmate. The cellmate had no markings that suggested an altercation between the two inmates, and there were no signs that a struggle occurred in the cell. The cellmate reported that the inmate had been in chronic pain and approximately three days prior to death had taken 15 to 20 blood pressure pills at one time. The inmate had also been seen by medical staff one to two times daily for several days before his death.

Disposition

An autopsy was performed and revealed that the inmate died of septic shock subsequent to a medical procedure performed one week prior to death. The department's Death Review Committee determined that the death was not preventable, but that there were many opportunities for improvement of medical treatment. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-08-19	**13-1720-RO**	**Suicide**

Incident Summary

On August 19, 2013, an inmate was discovered hanging in his cell by a sheet tied to the upper bunk. The inmate was housed alone. Staff initiated a medical emergency response, entered the cell, and began life-saving measures, but the inmate was eventually pronounced dead after life-saving measures failed.

Disposition

The autopsy confirmed that the inmate had died from hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-09-21	**13-2090-RO**	**Suicide**

Incident Summary

On September 21, 2013, a single-celled inmate was found hanging in his cell by a rope. After cutting the rope, custody and medical staff initiated life-saving measures, which continued while the inmate was transported to the medical clinic. Subsequently, a physician pronounced the inmate dead.

NORTH REGION

Disposition

The coroner's office confirmed that the inmate died from hanging. Potential staff misconduct was identified based on medical and custody staff's failure to properly respond to the inmate's allegations of sexual assault made prior to his death; therefore, both medical and custody hiring authorities referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs. The OIG concurred with the Office of Internal Affairs' response to the hiring authority's referral.

Incident Date	OIG Case Number	Case Type
2013-09-30	**13-2132-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 30, 2013, an officer fired one less-lethal round at three fighting inmates. The officer did not see where the round hit, but one of the inmates had a head injury and was taken to an outside hospital and later returned to the institution.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because the institution failed to timely notify the OIG, thereby preventing the OIG from real-time monitoring of the case.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until more than five hours after the incident.

Incident Date	OIG Case Number	Case Type
2013-10-05	**13-2181-RO**	**Suicide**

Incident Summary

On October 5, 2013, while performing a welfare check, an officer observed an inmate hanging from a noose fashioned from bed sheets attached to the upper part of his cell door. Custody staff also observed that the inmate tied another piece of the bed sheet from his bunk to the cell door making it difficult for staff to enter the cell. After cutting the lower sheet, custody staff entered the cell, cut the noose, and placed the inmate outside the cell, where they performed life-saving measures until medical staff arrived. The inmate was subsequently pronounced dead at the scene.

Disposition

A coroner's report determined the cause of death was asphyxia due to hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG concurred with the hiring authority's decision not to submit the matter to the Office of Internal Affairs.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-10-19	13-2262-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On October 19, 2013, two inmates began fighting on a housing unit and continued even after officers activated their personal alarms and ordered them to stop. Responding officers deployed pepper spray, which was ineffective. Numerous less-lethal rounds were used to stop the fighting. It is unknown where the rounds hit; however, the inmates continued to fight. An officer deployed a pepper spray blast grenade, which stopped the fighting. Following the incident, it was determined that one of the less-lethal rounds may have inadvertently hit one of the inmates in the head, resulting in an injury. The injured inmate was transported to an outside hospital and received treatment for a facial fracture and a laceration requiring sutures. The inmate returned to the institution the same day.

Disposition

The institution's executive review committee determined that the use of force complied with departmental policy. The OIG concurred. A video-taped interview of the injured inmate was not conducted within 48 hours of the incident as required by departmental policy. However, a video-taped interview was completed by the incident commander after it was determined that the inmate's injury constituted serious injury. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-10-28	13-2345-RO	In-Custody Inmate Death

Incident Summary

On October 28, 2013, officers responded to an inmate pounding on his cell door. The inmate reported his cellmate was not breathing and was unresponsive. Officers immediately announced a medical emergency and, after removing and securing the reporting inmate, initiated life-saving measures for the unresponsive cellmate. Medical staff arrived shortly thereafter and continued to provide life-saving measures. The inmate was subsequently transported by ambulance to an outside hospital for further medical assistance, but was eventually pronounced dead by a hospital physician.

Disposition

The coroner determined the cause of death was ingestion of a lethal combination of opiates and alcohol. Custody staff interviewed the reporting inmate regarding the source of the opiates, and the reporting inmate said the opiates were purchased on the yard from members of a rival prison gang. Custody staff considered the information from the cellmate's interview to be misleading. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2013-11-09	13-2438-RO	Critical Incident

Incident Summary

On November 9, 2013, a riot involving seven inmates occurred on an exercise yard. Custody staff assembled and responded by ordering the involved inmates to stop their actions, but the inmates continued fighting. In order to gain compliance, a control booth officer fired two less-lethal rounds at the inmates' lower extremities. The first round missed but the second round hit one of the inmates. Responding staff also deployed pepper spray to quell the riot. During the riot, one inmate was knocked unconscious by another inmate. The unconscious inmate was transported to an outside hospital for a medical evaluation and was returned to the institution on the same day. Medical evaluations for all involved inmates noted only minor injuries.

NORTH REGION

Disposition

The institution's executive review committee determined the use of force was in compliance with departmental policy and the OIG concurred. Potential staff misconduct was identified based on the failure of the incident commander to properly complete the use of force incident package. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs referred the matter back to the hiring authority for corrective or disciplinary action. The OIG did not accept the case for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to provide timely notification to the OIG of the incident, preventing the OIG from real-time monitoring of the case. The incident commander also failed to properly review the documentation of the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The hiring authority failed to report the incident to the OIG. The OIG learned of the incident by reviewing the department's daily report.

- Was the critical incident adequately documented?

  The incident commander failed to ensure the incident reports were thoroughly completed requiring multiple requests for clarifications by the institution's executive review committee.

Incident Date	OIG Case Number	Case Type
2013-11-14	**13-2649-RO**	**PREA**

Incident Summary

On November 14, 2013, an inmate alleged an officer sexually assaulted him when the officer pressed a security scanning wand between his legs. The institution conducted an investigation and determined the routine scan was not a sexual assault as alleged by the inmate. The institution did not immediately refer the alleged sexual assault to the Office of Internal Affairs as required by departmental policies and procedures.

Disposition

The hiring authority did not identify potential staff misconduct. The hiring authority did not believe the case met the Prison Rape Elimination Act reporting requirements; therefore, the hiring authority reported the case to the Office of Internal Affairs through an informal, casual, off-duty notification. The Office of Internal Affairs did not open an investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to provide timely notification to the OIG of the incident. The hiring authority failed to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The inmate reported the alleged misconduct on November 14, 2013. The institution notified the OIG on November 19, 2013, five days later.

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

  The department's policies and procedures require that all allegations of staff on inmate sexual assaults be immediately referred to the Office of Internal Affairs for investigation. The hiring authority failed to refer the matter to the Office of Internal Affairs.

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

  The institution was five days late in advising the OIG of the incident.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-11-23	**13-2515-RO**	**Other Significant Incident**

Incident Summary

On November 23, 2013, an inmate attacked an officer during a cell search. Responding officers deployed pepper spray, which failed to stop the attack. One responding officer struck the inmate in the back of the legs with an expandable baton, which stopped the attack. The officer who was attacked was taken to an outside hospital for treatment for serious bodily injuries. The officer recovered from his injuries and returned to duty. The inmate received a minor abrasion, which was treated at the institution.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-11-28	**13-2630-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On November 28, 2013, an inmate was attacked in his cell by his cellmate. An officer discovered the inmate lying on his bunk with his face covered in blood. Custody staff discovered blood on the soles of the cellmate's boots. Medical staff arrived on scene and assessed the attacked inmate. The attacked inmate was transported to an outside hospital for a higher level of care. The institution's investigative services unit processed the cell as a crime scene. The attacked inmate suffered multiple injuries, including brain injury and a broken jaw. After nearly six weeks in outside hospitals, the inmate was returned to another institution.

Disposition

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

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG agreed with the hiring authority's decision not to refer the case to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-12-06	**13-2602-RO**	**In-Custody Inmate Death**

Incident Summary

On December 6, 2013, an inmate was found unresponsive in his cell. The inmate was taken to an outside hospital where he was pronounced dead. An autopsy revealed that the inmate died from a drug overdose.

Disposition

The autopsy report indicated the cause of death was acute combined heroin and citalopram toxicity. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-12-20	13-2711-RO	Inmate Riot

Incident Summary

On December 20, 2013, a riot involving approximately 200 inmates erupted on an exercise yard. Custody staff deployed chemical agents and less-lethal rounds to gain control of the incident. As officers were securing the inmates in restraints, an inmate got up and walked toward the skirmish line. An officer deployed chemical agents toward the inmate, who returned to a prone position. A secondary altercation broke out involving approximately eight inmates. An officer deployed chemical agents; however, this was not effective as the inmates continued to fight. Another officer fired a less-lethal round, which missed the intended target, but had the intended effect: the inmates stopped fighting and assumed a prone position. Only minor injuries were noted among the rioting inmates. Subsequently, as officers performed security checks in nearby dormitories, an inmate made a threatening move toward an officer. The officer fired a less-lethal round hitting the inmate in the left thigh, which resulted in the inmate ceasing his actions and assuming a prone position. This inmate sustained a bruise on his thigh consistent with the force used.

Disposition

The institution's executive review committee determined the use of force was in compliance with departmental policy. The OIG concurred. The department provided training to the custody staff who improperly chambered a round into the Mini-14 rifle. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The OIG determined that the department's response to the incident was inadequate because the OIG was not timely notified of the incident. The OIG also determined that custody staff improperly chambered, but did not fire, a round in a Mini-14 rifle during the riot. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The department did not notify the OIG of the riot until three days later.

Incident Date	OIG Case Number	Case Type
2013-12-22	13-2708-RO	Other Significant Incident

Incident Summary

On December 22, 2013, an off-duty officer allegedly stabbed a citizen in the neck during an altercation outside of a bar. The citizen sustained a serious injury but survived. The officer was later arrested and charged with assault with a deadly weapon.

Disposition

The hiring authority determined that the officer engaged in off-duty misconduct and referred the matter to the Office of Internal Affairs. The Office of Internal Affairs returned the matter to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-01-05	14-0072-RO	PREA

Incident Summary

On January 5, 2014, an inmate alleged he had been sexually battered by a sergeant while at an outside hospital. The inmate reported the alleged battery on the same day.

Disposition

Pursuant to departmental policy, the hiring authority referred the case to the Office of Internal Affairs. After review, OIA Central Intake determined that there was not a reasonable belief that misconduct occurred. The OIG concurred with the decision.

NORTH REGION

Overall Assessment

Rating: **Insufficient**

In general, the department's response was not adequate because the hiring authority failed to timely refer the matter to the Office of Internal Affairs for investigation. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the hiring authority's later decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The incident was reported on January 5, 2014; however, the hiring authority did not refer the matter to the Office of Internal Affairs until January 28, 2014.

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

  According to departmental policy, the hiring authority should have immediately referred the matter to the Office of Internal Affairs for investigation. The incident was reported on January 5, 2014; however, the hiring authority did not submit a referral to the Office of Internal Affairs until January 28, 2014.

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

  According to departmental policy, the hiring authority should have referred the matter to the Office of Internal Affairs for investigation immediately. However, the hiring authority conducted their own investigation prior to sending a referral to the Office of Internal Affairs. The incident was reported on January 5, 2014; however, the referral was not sent to the Office of Internal Affairs until January 28, 2014.

Incident Date	OIG Case Number	Case Type
2014-01-11	**14-0154-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On January 11, 2014, an inmate reportedly slipped and fell in a puddle while walking across an exercise yard in the security housing unit. The inmate was on the yard by himself. The inmate was able to alert staff who responded to provide assistance. The inmate was taken to an outside hospital for treatment for a broken hip.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-01-15	**14-0189-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On January 15, 2014, one inmate attempted to murder a second inmate while they were in their assigned work area. The inmate attacker approached the second inmate from behind while he was seated at his work station, and began stabbing him with scissors in the chest area. The second inmate was stabbed seven times in the head, neck, shoulder, arm, and back areas. He sustained multiple puncture wounds, resulting in a collapsed lung. He was air-lifted to an outside hospital. He was released from the hospital on January 24, 2014, and returned to the institution.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-01-15	14-0241-RO	PREA

Incident Summary

On January 15, 2014, an officer allegedly slapped an inmate on the buttocks at the conclusion of a clothed body search. The inmate reported the allegation on January 22, 2014.

Disposition

The institution's investigative services unit interviewed the complainant inmate, as well as staff and inmates who were identified as potential witnesses. The institution concluded that the inmate's allegations were unsubstantiated. The case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate. Although the hiring authority notified the Office of Internal Affairs of the allegation, the institution's investigative services unit conducted its own inquiry by interviewing the inmate and witnesses instead of allowing the Office of Internal Affairs to investigate.

Assessment Questions

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

  The hiring authority conducted an inquiry of the inmate's allegations and concluded that no further investigation was warranted. The case was not referred to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-01-30	14-0305-RO	Other Significant Incident

Incident Summary

On January 30, 2014, an inmate assaulted an escorting officer by attempting to bite him. The officer used physical force to place the inmate on the ground, causing the inmate's head to hit the concrete floor. The inmate was treated on site but air-lifted to an outside hospital for further treatment. The inmate sustained a laceration to his head requiring stitches, and a fractured orbital socket. The inmate's injuries were not life threatening and he later returned to the institution.

Disposition

Potential staff misconduct was identified based on the inmate's allegation of unreasonable use of force; therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The OIG agreed with the hiring authority's decision. The Office of Internal Affairs rejected the case. The institution's executive review committee subsequently determined the use of force was within departmental policy and the OIG agreed.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the OIG was not timely notified of the incident thereby preventing real-time monitoring.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until more than three hours after the incident occurred.

Incident Date	OIG Case Number	Case Type
2014-02-03	14-0319-RO	Other Significant Incident

Incident Summary

On February 3, 2014, an inmate was discovered in his dormitory with facial injuries and an ankle deformity. He claimed he had attempted a back flip off of a bunk bed. There were no staff witnesses, and the nearby inmates in the dormitory claimed they had not witnessed the incident. Medical staff determined that air-lifting the inmate to a trauma center was warranted due to a risk of nerve damage or vascular damage and the probable need for surgery.

NORTH REGION

Disposition

The inmate underwent surgery and was returned to the institution. It was later determined that the injuries had occurred as a result of mutual combat with another inmate. Both involved inmates received rules violation reports and were rehoused in administrative segregation. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2014-02-05	**14-0332-RO**	**In-Custody Inmate Death**

Incident Summary

On February 5, 2014, a 77-year-old inmate was pronounced dead by a physician after institution staff discovered the unresponsive inmate was not breathing and had no vital signs. The inmate was in a general population setting; however, there was no evidence of a criminal homicide.

Disposition

The cause of death was not determined, and no autopsy was performed. The inmate had chronic health issues and had been receiving treatment and medications. There was no evidence of criminal homicide and no use of force prior to, or in response to, this incident. All indications were that this was a death by natural causes. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-02-06	**14-0359-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On February 6, 2014, an inmate worker was injured when a civilian's pickup truck lost control and pinned the inmate between the truck and a wood chipper. The inmate was being supervised by an employee from an outside agency at the time. The inmate was air-lifted to an outside hospital for medical care. The inmate underwent surgery for fractures to his arm and ribs. A chest tube was also inserted to prevent a collapsed lung. The inmate was later transferred to a departmental medical facility for additional surgeries and continued care.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because they failed to notify the OIG of the incident. The OIG learned of the incident after reading the department's daily report. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not informed of the inmate's injuries.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-02-08	14-0427-RO	In-Custody Inmate Death

Incident Summary

On February 8, 2014, officers responded to an inmate yelling "man down." Upon arrival to the cell, an officer observed an inmate standing at the cell door and saying that his cellmate had something tied around his throat, but he untied it and took it off. The officer looked through the cell window and observed the cellmate lying face up and unresponsive on the lower bunk. Custody staff made several unsuccessful attempts to elicit a response from the cellmate. Custody staff secured and removed the first inmate from the cell and then entered the cell and moved the unresponsive inmate onto a gurney. Medical and custody staff began life-saving measures, but their efforts failed and the inmate was pronounced dead. The first inmate admitted that he murdered his cellmate.

Disposition

The autopsy report confirmed the cause of death was strangulation with a ligature. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for Investigation.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-02-14	14-0429-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On February 14, 2014, officers observed two inmates attacking another inmate on an exercise yard. The officers responded to the scene without incident or use of force. The injured inmate was transported to a local hospital for treatment for multiple stab wounds in his back. The inmate was returned to the institution in stable condition.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-02-14	14-0433-RO	PREA

Incident Summary

On February 14, 2014, an inmate alleged that a librarian was conducting inappropriate inmate searches of the groin area. The inmate claimed the librarian searched all inmates in the same manner and the contact with the groin area was short. The inmate was under the misunderstanding that a librarian could not search an inmate under his supervision. Once the inmate was informed that a librarian was allowed to search inmates, he wanted to withdraw his complaint. The inmate was informed that his appeal would still be processed according to departmental policy.

Disposition

No staff misconduct was identified; therefore, the hiring authority did not to refer the matter to the Office of Internal Affairs. The OIG concurred.

Overall Assessment

Rating: **Insufficient**

The OIG determined that the department's response to the incident was inadequate because they did not provide timely notification to the OIG of the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

NORTH REGION

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The hiring authority learned of the allegations on February 18, 2014, but did not inform the OIG until February 19, 2014.

Incident Date	OIG Case Number	Case Type
2014-02-18	14-0430-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On February 18, 2014, officers responded to two inmates attacking another inmate on an exercise yard. The officers responded without incident or use of force. The injured inmate was flown to the nearest hospital for treatment for multiple stab wounds in the back. The inmate's wounds were superficial and he was returned to the institution the next day.

Disposition

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

Overall Assessment

Rating: **Sufficient**

The department's response was satisfactory in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-02-23	14-0473-RO	Contraband Watch

Incident Summary

During visiting hours on February 23, 2014, officers observed an inmate secrete an unknown object in his rectum while his visitor attempted to shield his actions from custody staff. Based on this observation, the inmate's visit was terminated and the inmate was placed on contraband surveillance watch. While on contraband surveillance watch the same day, the inmate produced a bowel movement containing a bindle of suspected methamphetamine. On February 24, 2014, medical staff checked the inmate's vital signs and determined that the inmate needed further evaluation. The inmate was transported by ambulance to an outside hospital for a higher level of care. The inmate was returned to the institution on February 25, 2014.

Disposition

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

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The OIG concurred with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-02-24	14-0483-RO	Suicide

Incident Summary

On February 24, 2014, officers approached a cell solely occupied by an inmate who appeared unresponsive. Medical staff was summoned to assess the inmate. When the inmate again failed to respond, a medical emergency was activated and the control officer immediately activated his alarm. An emergency medical response team entered the cell and found a small rope made out of a sheet was tied to the bunk from the end and side of the upper bunk and ran behind the inmate's head, where it was tied in a knot around the back of his neck. Custody staff removed the ligature that was tied tightly around his neck. Medical staff began life-saving measures and the inmate was transported to an outside hospital where the physicians pronounced him dead.

Disposition

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

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-03-11	**14-0578-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On March 11, 2014, an inmate reported to medical staff that he was stabbed by another inmate while exiting his housing unit. The inmate received medical care at the triage treatment area and was air-lifted to an outside hospital for additional treatment. The inmate was returned to the institution later the same day.

Disposition

An investigation of the incident was conducted and no evidence was found to support that the inmate was stabbed by another inmate. Based on the investigation, it was determined that the stab wound was self-inflicted. No staff misconduct was identified. Therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The OIG determined that the department adequately responded to the incident in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-03-20	**14-0777-RO**	**Contraband Watch**

Incident Summary

On March 20, 2014, an inmate was placed on contraband surveillance watch after an officer observed lubricant around the inmate's rectum during an unclothed body search. The inmate informed custody staff that he had secreted drugs inside his anal cavity. Additional drugs were found in the inmate's cell. On March 21, 2014, custody officers escorted the inmate to the triage treatment area after they observed him acting restlessly. Medical staff determined the inmate needed to be transported to an outside hospital for a possible drug overdose. Two bindles of suspected drugs were recovered from the inmate while in the hospital. The inmate was subsequently returned to the institution on March 22, 2014. He was released from contraband surveillance watch on March 23, 2014.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department did not provide timely notification to the OIG when the inmate was transported to an outside hospital and failed to follow departmental policy in supervision of inmates on contraband surveillance watch. Training was provided. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not timely notified of the transport of the inmate to an outside hospital.

- Was the critical incident adequately documented?

  The documentation related to the contraband surveillance watch did not indicate that personal hygiene was offered to the inmate during the contraband surveillance watch nor did the documentation identify that a supervisory review was conducted at each watch while the inmate was on contraband surveillance watch.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-03-22	14-0701-RO	Other Significant Incident

Incident Summary

On March 22, 2014, an officer observed an inmate with a mobile phone. The officer ordered the inmate to give him the phone but the inmate attempted to run away. The officer pursued the inmate and grabbed the back of his shirt. The inmate hit the officer in the chest with his elbow. The officer fell, hit his head, and briefly lost consciousness. The inmate continued running and when he came to a toilet, he flushed the mobile phone. Immediately thereafter, the inmate got in the prone position on the floor. The officer was taken via ambulance to an outside hospital and released the same day. The officer had a large bump on the back of his head, two broken ribs, and a laceration on his arm.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because they failed to timely notify the OIG of the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until two hours and 12 minutes after the incident occurred. However, the OIG responded on scene.

Incident Date	OIG Case Number	Case Type
2014-04-23	14-0968-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On April 23, 2014, an inmate was bludgeoned in the head by another inmate with a rock wrapped in a laundry bag. The attacking inmate was identified and admitted to the assault. There was no staff use of force. The injured inmate was air-lifted to an outside hospital and treated for severe head trauma and a fractured jaw. The injuries were later determined not to be life-threatening.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-05-03	14-1097-RO	Contraband Watch

Incident Summary

On May 3, 2014, medical staff observed an inmate appear to place a razor blade in his mouth and make swallowing motions. The inmate was searched and placed on contraband surveillance watch. On May 4, 2014, the inmate was transported to an outside hospital due to complaints of abdominal pain and elevated blood pressure. An x-ray did not show the presence of a foreign object. The inmate was returned to the institution on the same day, removed from contraband watch, and placed in the correctional treatment center under one-on-one suicide observation.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to provide timely notification to the OIG when the inmate was transferred from the institution to an outside hospital and when the inmate was removed from contraband surveillance watch. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

NORTH REGION

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not informed when the inmate was transferred from the institution to an outside hospital or when the inmate was removed from contraband surveillance watch.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2012-10-04	**12-2276-RO**	**Other Significant Incident**

Incident Summary

On October 4, 2012, an institution released an inmate on parole 14 days after his scheduled release date due to an error in applying the inmate's credits after the inmate was received from another institution. The error occurred after the receiving institution calculated the inmate's credits based on a verbal notification from the sending institution of the inmate's work group status. When the receiving institution later received the inmate's file from the sending institution, the work group status was documented differently than initially reported. The inmate's credits were recalculated and the inmate was released the day the error was discovered.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the institution has instituted a practice of relying on source documentation, rather than verbal commitments from staff members at other institutions, to prevent future errors. The OIG agreed with the decisions.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-01-23	**13-0177-RO**	**In-Custody Inmate Death**

Incident Summary

On January 23, 2013, an inmate on his way to the exercise yard notified custody staff of a "man down" in a cell. Custody staff responded to the cell and discovered a single-celled inmate on the cell floor. The officers entered the cell to check the inmate's condition and, after getting no response, summoned medical staff who arrived and began life-saving measures. The inmate was transported to the triage treatment area where life-saving measures continued but the inmate was pronounced dead.

Disposition

The coroner determined the manner of death was natural, caused by cardiovascular disease. The department's Death Review Committee concluded that the inmate's death was not preventable. Although potential staff misconduct was identified based on the responding officers' failure to initiate basic life-saving measures to the inmate, the hiring authority chose not to refer the matter to the Office of Internal Affairs for investigation. The OIG did not concur with this decision.

Overall Assessment

Rating: **Insufficient**

The OIG determined that the department's response to the incident was inadequate because responding custody staff failed to timely provide basic life-saving measures to the inmate. The department neglected to consult with the OIG about the incident in a sufficient manner. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG did not concur with this decision.

SOUTH REGION

Assessment Questions

- Did the HA timely respond to the critical incident?

  Upon discovery of the unresponsive inmate, the responding officers failed to immediately provide basic life-saving measures as required by departmental policy and training.

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

  Upon discovery of the unresponsive inmate, the responding officers failed to immediately provide basic life-saving measures as required by departmental policy and training.

- Was the critical incident adequately documented?

  Reports by custody staff contain conflicting information as to the status of the inmate when he was discovered in his cell and it was not articulated why the officers did not initiate life-saving measures upon discovering the inmate.

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

  The inmate died in January 2013; however, it was not until September 2013, after prompting by the OIG, that the institution looked at the delay in initiating life-saving measures to the inmate. The OIG discussed the matter with the institution several times before the hiring authority concluded that no action was necessary. By the time the hiring authority reached this conclusion, the deadline for taking disciplinary action had passed.

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

  The involved officers potentially violated departmental policy and training requirements by failing to initiate life-saving measures on the unresponsive inmate. The OIG discussed the possible misconduct with the hiring authority who advised that he would look into the matter. Ultimately, the hiring authority declined to take any action.

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

  Despite the OIG recommendations to address the possible misconduct related to the officers' failure to initiate life-saving measures, the hiring authority decided not to refer the matter to the Office of Internal Affairs for investigation.

Incident Date	OIG Case Number	Case Type
2013-02-07	**13-0278-RO**	**In-Custody Inmate Death**

Incident Summary

On February 7, 2013, housing unit officers responded to a "man down" call from a cell. An inmate informed officers that his cellmate was having trouble breathing and the officers observed an inmate lying on his bunk unresponsive. Officers removed the inmate and initiated life-saving efforts until medical staff arrived. Medical staff took over life-saving efforts and transported the inmate to the triage treatment area, where he was pronounced dead by a physician. There were no visible injuries to either inmate.

Disposition

The coroner determined the manner of death was natural, caused by cardiovascular disease. The department's Death Review Committee determined the inmate's death was not preventable but identified a deficiency of care by a nurse and physician and referred the matter to the medical hiring authority at the institution to take corrective action. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2013-04-19	**13-0587-RO**	**Other Significant Incident**

Incident Summary

On April 19, 2013, an officer discovered a bag of rope while conducting a cell search of two inmates. A sergeant and the investigative services unit were called and it was discovered that the security screen and outer metal bars of the cell window had been cut. Additional items were found in the cell, including wire cutters, a map, extra sets of clothing, and wooden canes that were modified in a manner that, according to the institution's electrician, could have been used to ground the electrified fence. The institution placed the inmates in administrative segregation and issued both inmates rules violations for attempted escape. Both inmates were subsequently transferred to another institution.

Disposition

Possible staff misconduct was identified based on the failure of staff to complete thorough cell searches and security inspections. The hiring authority decided not to refer the matter to the Office of Internal Affairs for investigation because the failure to complete the searches and inspections likely occurred over several months and it was not possible to hold specific staff accountable. Instead, the hiring authority ordered institution-wide cell searches to remove excess property from inmates' cells and required daily building security inspections to be logged and reviewed by a captain daily. The OIG concurred with the hiring authority's decisions.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because the department failed to timely notify the OIG of the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until almost nine hours after the incident.

Incident Date	OIG Case Number	Case Type
2013-05-20	**13-0695-RO**	**In-Custody Inmate Death**

Incident Summary

On May 20, 2013, officers responded to a "man down" call from a cell. The officers discovered an unresponsive inmate lying on the cell floor. Custody staff pulled the unresponsive inmate out of the cell, at which time responding medical staff initiated life-saving measures. The inmate was transferred to an outside hospital, where he later died. There were no visible injuries to either inmate. However, the cellmate was rehoused in administrative segregation until it was determined the inmate died of natural causes.

Disposition

The autopsy results revealed the inmate died from gastrointestinal bleeding, secondary to long-term end-stage liver disease. The department's Death Review Committee concluded that the inmate's death was possibly preventable based on the medication prescribed by the medical provider. The Committee recommended further education for the medical provider. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with this decision.

Overall Assessment

Rating: **Sufficient**

Although the department failed to timely notify the OIG of the incident, the department's overall response was satisfactory. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2013-08-08	**13-1664-RO**	**Suicide**

Incident Summary

On August 8, 2013, a Prison Industry Authority supervisor discovered an inmate unresponsive, hanging by a noose made of shoelaces from a metal beam in a shoe factory. The supervisor notified another Prison Industry Authority supervisor, who responded and cut the shoelaces from the inmate's neck then called for an emergency medical response. Custody and medical staff arrived and administered life-saving measures, but failed to resuscitate the inmate. The inmate was taken to the triage treatment area and pronounced dead. Video surveillance of the shoe factory revealed that the inmate may have been unsupervised for approximately three hours before he was discovered hanging.

SOUTH REGION

Disposition

An autopsy was performed and the coroner determined the cause of death was asphyxia due to hanging. Potential staff misconduct was identified, based on an officer's failure to conduct required security checks and the failure of the two Prison Industries Authority supervisors to monitor the inmate and activate their personal alarms when they discovered the inmate hanging. 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, but returned the matter to the hiring authority for corrective or disciplinary action. The OIG concurred with this decision and accepted the case for monitoring.

Overall Assessment

Rating: **Insufficient**

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

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until three hours after the inmate was discovered hanging.

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

  The discovery of potential misconduct occurred on August 8, 2013; however, the case was not referred to the Office of Internal Affairs until November 6, 2013, almost three months later.

Incident Date	OIG Case Number	Case Type
2013-09-16	**13-2082-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On September 16, 2013, two inmates attacked another inmate with an inmate-manufactured weapon on an exercise yard. Officers gave multiple orders for the inmates to stop their attack and get down, but the inmates continued their attack. An officer fired one less-lethal round, missing his intended target; however, the inmates stopped their attack and got down. One inmate sustained a scratch to his right knee. The inmate who was attacked was transported to an outside hospital and underwent emergency surgery for multiple stab wounds to his torso. The inmate survived and returned to the institution a week later.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2013-11-26	**13-2575-RO**	**PREA**

Incident Summary

On November 26, 2013, an inmate housed in the mental health crisis unit told a nurse that on November 10, 2013, she was sexually assaulted by three unidentified officers. The inmate's gown was secured into evidence; however, due to the passage of time between the alleged attack and the date of reporting, a physical examination was not conducted. The inmate refused to be interviewed concerning the alleged sexual attack.

Disposition

The matter was not timely referred to the Office of Internal Affairs for investigation and was only referred after recommendations by the OIG. No staff misconduct was identified.

SOUTH REGION

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because the department failed to timely notify the OIG of the incident, conducted an internal inquiry regarding the facts of the case, and delayed referring the case for investigation. The OIG concurred with the hiring authority's decision that no staff misconduct was identified related to the critical incident.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG did not become aware of the critical incident until three hours after the inmate reported the incident to the institution's staff.

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

  The hiring authority's response to the critical incident was not appropriate because the hiring authority delayed reporting the incident to the Office of Internal Affairs while the institution conducted its own internal investigation.

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

  The investigative services unit did not adequately respond to the critical incident because it delayed reporting the incident to the Office of Internal Affairs while it conducted its own internal investigation.

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

  The hiring authority delayed reporting the incident to the Office of Internal Affairs while the institution conducted its own internal investigation.

Incident Date	OIG Case Number	Case Type
2014-01-09	**14-0152-RO**	**Contraband Watch**

Incident Summary

On the morning of January 9, 2014, an inmate was placed on contraband surveillance watch based on officers' observations during an unclothed body search. Later that evening, the inmate was transported to an outside hospital after almost losing consciousness in his cell. The subsequent medical evaluation revealed the urine toxicology analysis was positive for amphetamines and the x-rays were negative for any foreign objects. After six hours of hospital observation, the inmate was discharged and returned to the institution.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-01-10	**14-0211-RO**	**Other Significant Incident**

Incident Summary

On January 10, 2014, an inmate was at an outside hospital for a post-surgery exam. A nurse touched the inmate during the exam and the inmate reacted by pushing the nurse's hand away, stating it was painful. An officer was present during the exam but no force was necessary. The nurse did not sustain any injuries. The hiring authority initially issued a rules violation to the inmate for battery on a non-prisoner; however, it was later voided for lack of evidence.

Disposition

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

Overall Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-01-25	**14-0266-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On January 25, 2014, an officer discovered a single-celled inmate face down on the floor of his cell. The inmate was conscious but not responding to the officer. Medical staff were called to the cell to assess the inmate, and after determining that the inmate was intoxicated, they decided to leave the inmate in his cell. Approximately seven hours later, on January 26, 2014, an officer found the inmate vomiting in his toilet. Medical staff responded and the inmate was transported to the triage treatment area where the inmate was evaluated, and subsequently transported to an outside hospital, where he was diagnosed with swelling to the brain. The inmate was air-lifted to another outside hospital for treatment and returned to the institution three days later in stable condition. There were no signs of trauma and no alcohol or drugs were found in the inmate's system. The inmate's medical records indicate that the condition may have been caused by low sodium levels.

Disposition

Potential staff misconduct was identified based on a nurse's failure to perform a thorough medical evaluation when the inmate was seen in his cell, and a supervising nurse's failure to notify a physician regarding the inmate's condition; therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The OIG determined that the department's response to the incident was inadequate because the hiring authority failed to timely refer the matter to the Office of Internal Affairs. The department adequately notified and consulted with the OIG on the incident. The hiring authority ultimately chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Assessment Questions

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

  The possible misconduct was discovered on January 26, 2014; however, the hiring authority did not refer the matter to the Office of Internal Affairs until April 16, 2014, approximately 80 days after the date of discovery.

Incident Date	OIG Case Number	Case Type
2014-02-04	**14-0335-RO**	**Contraband Watch**

Incident Summary

On February 4, 2014, officers observed an inmate remove an item from his sock and place it in his mouth. Custody staff determined that the inmate should be placed on contraband surveillance watch and escorted the inmate to the triage treatment area for a medical evaluation, as required by departmental policy. During the evaluation, the inmate informed medical staff that he swallowed a bindle containing methamphetamine. Based on this information and an elevated heart rate, the inmate was taken to an outside hospital for observation. The department notified the OIG that the inmate had been placed on contraband surveillance watch, but later rescinded the placement because the inmate went directly to the hospital. The inmate returned to the institution two days later in stable condition. No contraband was recovered from the inmate, but laboratory results revealed a positive test for methamphetamine.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The OIG determined that the department's response to the incident was inadequate because it failed to follow contraband surveillance watch protocols after it was determined that the inmate had ingested contraband and failed to timely issue a rules violation to the inmate. The department informed the OIG about the incident in a timely and sufficient manner. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

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

  The department failed to initiate the contraband surveillance watch protocols after the decision was made to transport the inmate to an outside hospital. Additionally, the institution did not issue a rules violation to the inmate for the positive drug test until prompted by the OIG. The incident occurred on February 4, 2014, but the department did not issue the rules violation to the inmate until June 20, 2014.

- Was the critical incident adequately documented?

  Because the institution rescinded the inmate's placement on contraband surveillance watch after it was decided to transport the inmate to an outside hospital, none of the contraband surveillance watch documents were generated.

Incident Date	OIG Case Number	Case Type
2014-03-16	**14-0627-RO**	**Contraband Watch**

Incident Summary

On March 16, 2014, an inmate was placed on contraband surveillance watch after officers in the visiting area observed him swallowing suspected contraband. Later that evening, the inmate was transported and admitted to an outside hospital after complaining of stomach pains. On March 17, 2014, a CT scan confirmed the presence of approximately eight bindles of suspected contraband in the inmate's stomach. While the inmate was at the hospital, after being given a laxative, the inmate passed bindles containing substances believed to be methamphetamine and heroin. On March 19, 2014, the inmate was released from contraband surveillance watch, discharged from the hospital, and returned to the institution.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the hiring authority ordered corrective action for the officer initially assigned to the contraband surveillance watch for failing to properly document all of the inmate's activities on the required forms. Additionally, the institution modified its post orders for hospital coverage officers by adding the requirement that officers document the inmate's activities while on contraband surveillance watch. Staff assigned to the hospital received training on the new post orders.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate except for its failure to properly complete the required documentation related to the contraband surveillance watch. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-04-24	**14-1010-RO**	**PREA**

Incident Summary

On April 24, 2014, an inmate reported that he was awakened by an officer who was rubbing his genitals around the inmate's mouth.

Disposition

OIA Central Intake determined there was not a reasonable belief that staff misconduct occurred and declined to open an investigation. The OIG concurred.

Overall Assessment

Rating: **Insufficient**

Overall, the department's response was not adequate because it failed to provide timely notification to the OIG of the incident and the department delayed a medical evaluation of the inmate following the report of the sexual assault. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

- Did the HA timely respond to the critical incident?

  The medical examination did not begin until more than 12 hours after the alleged assault, which was almost four hours after the inmate first reported the assault.

- Was the OIG promptly informed of the critical incident?

  The OIG received notice more than one hour after the inmate reported the sexual assault.

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

  There was an excessive delay in having the inmate examined by medical personnel, and the hiring authority did not promptly notify the Office of Internal Affairs of the complaint on the day the complaint was made.

Incident Date	OIG Case Number	Case Type
2014-05-08	**14-1099-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On May 8, 2014, custody staff on an exercise yard observed an inmate knock another inmate to the ground and kick him several times in the head. The yard alarm was activated and the inmate stopped the attack. The inmate who was attacked was transported to the triage treatment area and subsequently air-lifted to an outside hospital where he was admitted and diagnosed with a fractured skull. The inmate returned to the institution three days later and was admitted to the institution's correctional treatment center for further observation and treatment.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until more than two hours after the incident occurred.

Incident Date	OIG Case Number	Case Type
2014-05-20	**14-1211-RO**	**Contraband Watch**

Incident Summary

On May 20, 2014, an inmate was placed on contraband surveillance watch after an officer observed the inmate swallow a bindle of suspected heroin during a search. Later that day, the inmate was transported to an outside hospital for a higher level of care due to a suspected drug overdose. The inmate returned to the institution the following day in stable condition and was removed from contraband surveillance watch after producing four negative bowel movements.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the hiring authority ordered training to custody staff assigned to the contraband surveillance watch incident for proper documentation of inmate hygiene, inmate searches, and the issuance of a blanket. The OIG concurred with the hiring authority's decisions.

Overall Assessment

Rating: **Sufficient**

The department's overall response to the incident was adequate except for the failure to document the inmate's activities for the duration of the contraband surveillance watch. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

APPENDIX E1 21
MONITORED DEADLY FORCE INCIDENTS
Central Region

Incident Date: 2013-01-10	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0240-RO**

On January 10, 2013, two inmates began to attack a third inmate on an exercise yard. The two inmates ignored orders to "get down" and continued to attack the third inmate. The third inmate fell to the ground in a fetal position and appeared unable to protect himself as the other two inmates continued to punch and kick him in the head. An officer deployed a chemical agent grenade, but it did not stop the attack. After inmates ignored additional orders to "get down," a second officer discharged one lethal round from the Mini-14 rifle, aiming toward an unoccupied dirt area. The inmates stopped their attack and assumed a prone position a few seconds after the shot was fired. No staff members or inmates were hit by the round. The inmate injured in the attack was later transported to an outside hospital for treatment and returned to the institution. The OIG was timely notified and responded on scene.

Disposition

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

Incident Assessment

Rating: **Sufficient**

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

Central Region

Incident Date: 2013-04-04	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0527-RO**

On March 27, 2013, two inmates attacked a third inmate in the dayroom. The inmates ignored verbal orders to get down. Pepper spray and an expandable baton were used to stop the attack. One of the aggressors was inadvertently struck in the head with the baton during the incident. The inmates stopped the attack and were placed in restraints. The injured inmate was transported to an outside hospital for suturing of the head wound and overnight observation. Although the Office of Internal Affairs was notified, it was the department's practice at the time not to respond on scene unless less-lethal force was intentionally used in a lethal manner. The OIG did not receive timely notification and therefore did not respond on scene.

Disposition

The institution's executive review committee found the use of force in compliance with departmental policy. The OIG concurred. However, other actions by staff members were found to be out of compliance because the injured inmate was not interviewed until twenty days after the incident. The medical assessment did not reflect whether the inmate was afforded the opportunity to decontaminate from the effects of the pepper spray, and a supervisor failed to sign a holding cell log. The hiring authority recommended training for these issues. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation and the OIG concurred.

Incident Assessment

Rating: **Insufficient**

The department's overall response to the incident was not adequate because the department failed to notify the OIG of the incident in a timely manner, preventing the OIG from real-time monitoring of the case. The hiring authority also failed to notify the OIG of the date the incident would be reviewed by the institution's executive review committee, and the OIG was thus precluded from participating in the review. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until approximately two hours after control of the incident was established.

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

  The department failed to notify the OIG of the date the incident would be reviewed by the institution's executive review committee.

Incident Date: 2013-05-29	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0823-RO**

On May 29, 2013, custody staff observed two inmates with weapons attacking a third inmate on the exercise yard. Several orders were given to "get down" and three less-lethal rounds were fired, but the two inmates continued their attack on the third inmate. An observation officer fired one lethal round from a Mini-14 rifle into a grassy area away from inmates and staff as a warning, but the two inmates continued their attack. A second warning shot was fired and the two inmates then stopped their attack and complied with orders. Two inmate-manufactured weapons were recovered by officers. The third inmate sustained puncture wounds to his head, back, and arm, but the injuries were not life-threatening. The injured inmate received medical treatment at the institution. The OIG was timely notified and responded on scene.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. The department's executive review committee also evaluated the incident and agreed with the institution's assessment. No staff misconduct was identified. The OIG concurred.

Incident Assessment

Rating: **Sufficient**

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

Central Region

Incident Date: 2013-10-02	Deadly Force Incident

Incident Summary

OIG Case Number: **13-2142-RO**

On October 2, 2013, an inmate became argumentative with a physician's assistant and refused to leave the medical clinic. Two responding officers ordered the inmate to submit to handcuffs, but the inmate refused. The officer placed his hand on the inmate's right elbow. The inmate jumped up from a seated position and pushed the officer in the chest knocking the officer back. Both officers forced the inmate's upper body onto an examination table to gain control. As the inmate continued to resist the officers' applying handcuffs, one of the officers drew his pepper spray canister, but realized he was going to expose himself and the other officer to pepper spray, so he struck the inmate twice on the top of his head with the one-pound metal canister. The inmate continued to resist. A third responding officer arrived, and the three officers physically forced the inmate to the ground and gained compliance. The inmate received a one-inch laceration on the back of his head requiring sutures. The OIG was not notified of the incident.

Disposition

The institution's executive review committee and the department's executive review committee determined that the use of force was in compliance with departmental policy. The OIG did not concur. The threat necessitating immediate force was present; however, after a thorough review of all facts, the OIG determined that the force used by the officer was excessive. Striking an inmate in the head with the metal canister could have been deadly. Had the officers been in imminent danger, the force used would have been justified; however, the inmate was under a level of control, but resisting being placed in restraints at the time he was struck in the head with the metal canister.

Incident Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because the department failed to notify the OIG of the incident and refused to satisfactorily address the unreasonable force used during this incident.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The department failed to notify the OIG of the incident.

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

  The OIG advised the hiring authority of its concern that the institution's executive review committee found the use of force in compliance with departmental policy. Striking the inmate in the head with a canister is likely to result in severe injury or death. The hiring authority insisted that the force used was within policy; however, he conceded that in a similar incident, he terminated a peace officer for striking an inmate in the head with a pepper spray canister where deadly force was not authorized. The OIG requested that the department's executive review committee evaluate the force used during the incident. The committee determined that the force used was reasonable. The OIG did not concur. There was no justification for using deadly force.

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

  During the institution's executive review committee, the OIG expressed concern that the force used on the inmate was unreasonable and excessive compared to the threat. The committee determined that the use of force was reasonable and within departmental policy. The OIG did not concur with the decision.

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

  The OIG recommended that the matter be referred to the Office of Internal Affairs, but the hiring authority inappropriately asserted that there was no violation of departmental policy.

Central Region

Incident Date: 2013-11-25	Deadly Force Incident

Incident Summary

OIG Case Number: **13-2516-RO**

On November 25, 2013, two officers attempted to handcuff an inmate before escorting the inmate for the evening shower program. However, a control booth officer opened the inmate's cell door before the handcuffs were placed on the inmate. As the officers tried to alert the control booth officer, the inmate squeezed through the opening cell door and punched the first officer in the face. The second officer utilized his baton, aiming for and striking the inmate's thigh area; however, the inmate continued to use his fists to hit the first officer on his head. The first officer went to the ground, but was able to regain his footing and used his baton, first aiming and striking the inmate's thigh area. The inmate continued his attack and the first officer then aimed a baton strike at the inmate's bicep, which accidentally struck the inmate's head. The inmate stopped his attack and lay prone on the floor. The inmate went to the triage treatment area for two lacerations on his head, which required seven staples. The first officer sustained a cut and bruising to his face. The second officer sustained a superficial cut to one of his fingers. As a precaution, both officers went to outside hospitals for follow-up care. The OIG was timely notified regarding the inmate's attack on the officers; however, the OIG and the Office of Internal Affairs were never notified regarding the first officer's baton strike to the inmate's head.

Disposition

Potential staff misconduct was identified. The control booth officer allegedly opened the cell door prior to the inmate being placed in handcuffs, which allowed the inmate an opportunity to attack two officers. The hiring authority referred the case to the Office of Internal Affairs for investigation; therefore, the institution's executive review committee deferred its review of the case. An investigation was opened, which the OIG did not accept for monitoring.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate. The institution notified the OIG that the inmate attacked the officers and provided a description of injuries sustained by the officers and the inmate, including lacerations to the inmate's head, which required staples. However, the institution failed to notify the OIG and the Office of Internal Affairs that one of the officers inadvertently struck the inmate's head with a baton.

Assessment Questions

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

  There is no record that the Office of Internal Affairs was notified of the incident once it was reported that one of the officers used his baton and inadvertently struck the inmate in the head.

- Was the OIG promptly informed of the critical incident?

  The OIG was never informed that one of the officers used his baton and inadvertently struck the inmate in the head.

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

  The OIG and the Office of Internal Affairs were not timely notified regarding the reported baton strike to the inmate's head.

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

  The department failed to provide updated information to the OIG once it was discovered that an officer inadvertently struck the inmate in the head with a baton.

Central Region

Incident Date: 2013-12-09	Deadly Force Incident

Incident Summary

OIG Case Number: **13-2650-RO**

On December 9, 2013, an inmate exited his cell and assumed a fighting stance with his fists to his chest as he approached an inmate exiting the cell next to his. The two inmates began fighting on the top tier, refusing orders by officers to stop and get down. The control booth officer activated an alarm and fired one less-lethal round at the lower leg of one of the inmates, but did not see where the round hit. The floor officer heard the round hit a metal door and saw a black object ricochet off the wall. One of the fighting inmates covered his face with both of his hands and then both inmates assumed prone positions. One inmate was transported to an outside hospital for treatment of a fractured eye socket with a laceration requiring eight sutures caused by the less-lethal round. The inmate was later returned to the institution. The OIG received timely notification.

Disposition

The institution's executive review committee found the use of force in compliance with departmental policy. The less-lethal round that struck the inmate was the result of a ricochet. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.

Incident Assessment

Rating: **Sufficient**

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

Incident Date: 2013-12-31	Deadly Force Incident

Incident Summary

OIG Case Number: **13-2772-RO**

On December 31, 2013, a control booth officer observed two inmates in the dayroom attacking a third inmate, striking the third inmate in the face and upper body with what appeared to be their fists. The third inmate went to his knees, holding his hands up and tucked his head down to avoid being hit. The control booth officer gave repeated orders to get down, but the two attacking inmates ignored the orders. The control booth officer fired three less-lethal rounds, aiming at the legs of the first attacking inmate who was the main aggressor. A responding officer discharged a burst of pepper spray at the same inmate, causing both attacking inmates to stop. The inmate who was attacked sustained a laceration to his ear and wrist and an apparent puncture wound to his chest. The first attacking inmate reported that a less-lethal round struck his head. The first attacking inmate and the inmate who was attacked went to the triage treatment area for care. Neither inmate sustained serious or life-threatening injuries. The OIG and the Office of Internal Affairs were both timely notified and responded on scene.

Disposition

The institution’s executive review committee found the matter was in compliance with the department's use-of-force policy, and the hiring authority subsequently exonerated the officer. The OIG concurred.

Incident Assessment

Rating: **Sufficient**

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

Central Region

Incident Date: 2013-11-09	Deadly Force Incident

Incident Summary

OIG Case Number: **14-0378-RO**

On November 9, 2013, two inmates attacked a third inmate on an exercise yard. The alarm was activated and the inmates were ordered to get down, but they ignored the command and continued to fight. The observation officer fired three less-lethal rounds to stop the fight. A sergeant observed one of the rounds ricochet off an unknown object and hit the third inmate in the face. The inmate was transported to an outside hospital where it was determined he had a concussion due to a fractured skull. The inmate was treated and returned to the institution after three days. The Office of Internal Affairs was not timely notified. The OIG was not notified of the incident.

Disposition

The institution's executive review committee determined the use of force was in compliance with department policy; however, deadly force protocols were not adequately followed, so training was provided. The OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Assessment

Rating: **Insufficient**

The department's response to the incident was insufficient because it failed to notify the OIG, thereby preventing the OIG from real-time monitoring of the incident. The institution also failed to timely notify the Office of Internal Affairs or convey the seriousness of the inmate's injury.

Assessment Questions

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

  Email notification to Office of Internal Affairs was nearly two hours after the incident ocurred.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified by the department of this incident. The OIG discovered this incident during a routine review of use-of-force incidents.

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

  The OIG did not receive notification of this incident and thus did not attend the institution's executive review committee. The OIG reviewed the incident and the committee's decision after becoming aware of the incident. The OIG noted that the committee did not accurately state the extent of the inmate's injuries resulting from the use of force. The OIG recommended that the hiring authority amend the use-of-force critique to accurately reflect the inmate's injuries and the hiring authority agreed. The critique was amended to include the skull fracture.

- Was the critical incident adequately documented?

  The photographs of the suspects did not include a lead card in each photograph to identify the inmate, nor indicate which inmate's hands were photographed. The medical assessment for serious bodily injury was not timely documented by the institution.

Central Region

Incident Date: 2014-01-10	Deadly Force Incident

Incident Summary

OIG Case Number: **14-0942-RO**

On January 10, 2014, two inmates attacked a third inmate with inmate-manufactured weapons in a dayroom. The incident started a riot in the dayroom. Officers deployed five pepper spray grenades and seven less-lethal rounds to stop the riot. Two inmates were transported to an outside hospital for treatment of non-life-threatening stab wounds. Another inmate was also transferred to an outside hospital and treated for a fractured cheek bone. The inmate later stated that he was intentionally hit in the face by a less-lethal round. A physician confirmed that the injury was likely caused by a less-lethal round. The OIG did not respond on scene due to late notification.

Disposition

Two months after the incident, the inmate alleged that the officer intentionally hit him in the face with the less-lethal round as he was trying to move away from the riot. An internal inquiry was conducted and the facts were presented to the institution's executive review committee. The committee determined that the impact to the inmate's face by the less-lethal round was unintentional and the force used was in compliance with policy and training. The OIG concurred with the committee's conclusion. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG concurred.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate because it failed to provide timely notification to the OIG of the incident.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until over three hours after the incident.

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs did not respond to the incident because they were not notified until two months after the incident. The hiring authority notified the Office of Internal Affairs as soon as they received the inmate's complaint alleging that he was intentionally shot in the face with the less-lethal round.

Central Region

Incident Date: 2014-03-21	Deadly Force Incident

Incident Summary

OIG Case Number: **14-1077-RO**

On March 21, 2014, a sergeant and four officers began to search two cells after receiving information that the inmates in those cells might have had weapons. As one of the inmates turned around to submit to handcuffs, he instead turned toward the sergeant. The sergeant deployed pepper spray in the inmate's face while ordering the inmate to get down, but the inmate continued toward the sergeant and started hitting the sergeant with his fists. The sergeant then struck the inmate in the head two times with his pepper spray canister. The inmate ran past the sergeant toward two of the officers. The first officer discharged pepper spray in the inmate's face; however, that had no effect on the inmate, and the inmate began to punch the first officer in the head and body, which caused the first officer to almost fall backward while she was on the top level tier. A second officer then struck the inmate in the neck area with his pepper spray canister, but the canister exploded on impact, affecting the first and second officers' vision and breathing. The inmate slipped on the pepper spray residue on the floor, and a third responding officer was able to handcuff the inmate. The inmate's cellmate also ran toward the sergeant, following the first inmate. A fourth and fifth officer used physical force to gain control of the second inmate. Both inmates sustained cuts to their heads, which required staples to close. Both were rehoused in administration segregation later the same day. Several of the involved officers sustained injuries, including a concussion, fractured ribs, cuts, and bruises. The OIG was not timely notified.

Disposition

The institution's executive review committee determined that staff's actions following the use of force were in compliance. The OIG did not concur because the video-taped inmate interviews were not conducted within 72 hours as required. The institution's executive review committee also determined that staff's actions during the use of force were in compliance with policy, and the OIG concurred. No staff misconduct was identified. The OIG concurred.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate because the institution failed to conduct video-taped inmate interviews to document the inmates' injuries within 72 hours, instead delaying approximately seven weeks before the interviews were accomplished.

Assessment Questions

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

  The institution's executive review committee noted that staff were not in compliance with the holding cell check requirements of 15 minutes, and on-the-job training was to be provided. The OIG concurred. The OIG did not concur with the institution's executive review committee determination that staff were in compliance because they failed to conduct video-taped inmate interviews within 72 hours. The interviews were conducted approximately seven weeks after the incident.

Central Region

Incident Date: 2014-04-02	Deadly Force Incident

Incident Summary

OIG Case Number: **14-1137-RO**

On April 2, 2014, an officer ordered an inmate to remove cardboard that was covering the inmate's cell window. The inmate did not comply, yelled profanities, and became agitated. The officer ordered the cell door open, stepped into the cell, and turned on the light. As the officer attempted to remove the cardboard covering the window, the inmate hit the officer's nose with his fist. The inmate grabbed at the officer and the officer tried to push the inmate away, but the inmate kept hold of the officer and pulled the officer back into the cell when the officer tried to get out. The control booth officer and the officer both activated their alarms. A second officer responded, ordering the inmate to get down. When the inmate ignored the second officer's orders, the second officer used her baton, aiming for and striking the inmate's shoulder; however, the inmate maintained his hold on the first officer's hips. A third officer also ordered the inmate to get down, but the inmate refused. The third officer discharged one burst of pepper spray at the inmate's face and ordered the inmate to let go of the first officer, but the inmate ignored the orders. The first officer and the inmate then fell to the ground and continued to struggle with each other. The third officer ultimately struck the inmate on the head with his pepper spray canister, which caused the inmate to release the first officer. A fourth responding officer saw that the inmate was now trying to pull the third officer down. The fourth officer used his baton and aimed at and struck the inmate's knee. The inmate continued to be combative with the third officer, so the fourth officer aimed his baton at the inmate's buttock area, but inadvertently struck the right side of the inmate's back. The inmate was taken to the triage treatment area and treated for multiple bruises and cuts and a laceration to his head, which required staples. The first officer sustained a broken nose, multiple scratches, and bruises. The third officer sustained a broken hand.

Disposition

The institution's executive review committee determined staff's actions prior to the use of force were not in compliance with departmental policies. The OIG concurred with that assessment. However, the OIG did not concur with the institution's executive review committee's determination that staff's actions following the use of force were in compliance because a video-taped inmate interview was not completed as required. Potential staff misconduct was identified since the officer ordered the cell door opened and entered the cell with a potentially combative inmate. The same officer also failed to timely activate his alarm. The hiring authority issued a letter of instruction to the officer.

Incident Assessment

Rating: **Insufficient**

The department failed to comply with policies and procedures. The institution failed to conduct a required video-taped inmate interview within 72 hours after the incident. Despite this deficiency, the institution's executive review committee determined that staff's actions following the use of force were in compliance with policy. The hiring authority failed to refer potential staff misconduct to the Office of Internal Affairs and instead issued corrective action in violation of departmental policy and without consulting the OIG.

Assessment Questions

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

  The institution failed to conduct a video-taped inmate interview within 72 hours as required due to the laceration sustained by the inmate, which required staples to close.

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

  The institution's executive review committee failed to identify that staff's actions following the use of force violated departmental policy regarding video-taped interviews.

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

  The hiring authority failed to refer potential staff misconduct to the Office of Internal Affairs and instead issued corrective action in violation of departmental policy and without consulting the OIG.

North Region

Incident Date: 2013-02-07	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0284-RO**

On February 7, 2013, three inmates began fighting in the dining hall. Officers gave multiple orders for the inmates to get down and stop fighting, but the inmates continued to fight. Officers fired one less-lethal round and deployed pepper spray to stop the incident. One less-lethal round inadvertently hit an uninvolved inmate in the back of the head, causing pain, swelling, and a laceration. The inmate was transported to an outside hospital for treatment and returned to the institution later the same day. The institution did not timely notify the Office of Internal Affairs. The OIG was not timely notified, but responded when notified.

Disposition

Although the Office of Internal Affairs was notified, it was the department's practice at the time of the incident not to respond on scene unless less-lethal force is intentionally used in a lethal manner or inadvertently causes potentially lethal injury. The department did not adequately notify the OIG, but the OIG responded on scene when notified. The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate. Although the institution notified the Office of Internal Affairs, the Office of Internal Affairs failed to respond on scene despite the potentially lethal injury caused by the use of less-lethal force.

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 it was recommended by the OIG. The elapsed time was more than four hours.

- Was the OIG promptly informed of the critical incident?

  The institution did not notify the OIG until approximately four hours after the incident was brought under control. A representative from the OIG was at the institution at the time of the notification and responded immediately to the scene.

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs did not respond to the incident despite the potentially lethal injury caused by the use of less-lethal force.

Incident Date: 2013-04-02	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0516-RO**

On April 2, 2013, an officer fired a less-lethal round to stop two fights between inmates on the exercise yard. The round hit an inmate in the face, causing an orbital fracture and a laceration that required 13 sutures to close.

Disposition

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

Incident Assessment

Rating: **Sufficient**

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

North Region

Incident Date: 2013-04-22	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0583-RO**

On April 22, 2013, a riot erupted on an exercise yard involving approximately 43 inmates. An observation officer fired two warning rounds from a Mini-14 rifle, which stopped the riot. No other force was used by custody staff. There were no staff injuries reported, but several inmates were treated at the institution for injuries incurred during the riot. Although the Office of Internal Affairs was notified of the incident, its practice is not to respond on scene to warning shots. The department adequately notified the OIG, and the OIG responded on scene.

Disposition

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

Incident Assessment

Rating: **Sufficient**

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

North Region

Incident Date: 2013-05-18	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0669-RO**

On May 18, 2013, a riot occurred on an exercise yard involving approximately 300 inmates. After the riot, an inmate alleged that he was hit in the head by a less-lethal round. He sustained a bruise and abrasions to his face. The OIG was notified that there was a riot, but the department did not notify the OIG that an inmate alleged that he was hit in the head with a less-lethal round as soon as it was discovered.

Disposition

The hiring authority learned of the misconduct on May 18, 2013, but failed to refer the matter to the Office of Internal Affairs until October 3, 2013. On August 1, 2013, the institution's executive review committee determined that the matter should be referred to the Office of Internal Affairs for investigation. The OIG concurred. An investigation was opened, which the OIG accepted for monitoring.

Incident Assessment

Rating: **Insufficient**

The department's response was inadequate because the department failed to notify the OIG that an inmate alleged that he was hit in the head with a less-lethal round in a timely manner thereby preventing the OIG from real-time monitoring of the case. The hiring authority failed to refer the matter to the Office of Internal Affairs in a timely manner.

Assessment Questions

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

  The institution failed to timely notify the Office of Internal Affairs that an inmate claimed he was hit in the head with a less-lethal round during the incident.

- Was the OIG promptly informed of the critical incident?

  Although the institution promptly notified the OIG of the riot, it failed to timely notify the OIG that an inmate claimed he was hit in the head with a less-lethal round during the incident.

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

  The department learned of potential misconduct on May 18, 2013, but the hiring authority did not refer the matter to the Office of Internal Affairs until October 3, 2013, more than four months after the date of discovery.

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

  The hiring authority learned of the potential misconduct on May 18, 2013; however, the hiring authority initially determined that corrective action rather than disciplinary action was appropriate. Due to the OIG's intervention, the hiring authority ultimately referred the matter to OIA Central Intake on October 3, 2013.

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

  The department did not immediately notify the OIG that an inmate claimed he was hit in the head with a less-lethal round.

North Region

Incident Date: 2013-08-27	Deadly Force Incident

Incident Summary

OIG Case Number: **13-1842-RO**

On August 27, 2013, a fight erupted in an exercise yard involving three inmates. Custody staff ordered the inmates to stop, but they continued to fight. Custody staff discharged pepper spray with no effect. One of the inmates fell to the ground and was unable to defend himself as two other inmates repeatedly punched him around the head area. An officer fired one round from his Mini-14 rifle as a warning shot into a safe area. Officers deployed pepper spray grenades and the inmates eventually stopped the attack. The inmate who fell to the ground sustained numerous reddened areas, swelling on his head, and abrasions on his knees. All of the inmates were medically treated at the institution. Although the Office of Internal Affairs was notified of the incident, its practice is not to respond on scene to warning shots. The department adequately notified the OIG, and the OIG responded on scene.

Disposition

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

Incident Assessment

Rating: **Sufficient**

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

Incident Date: 2013-11-19	Deadly Force Incident

Incident Summary

OIG Case Number: **13-2484-RO**

On November 19, 2013, two inmates attacked another inmate on an exercise yard. A third inmate joined in on the attack, then a fourth inmate joined to defend the attacked inmate. An observation officer gave orders for the inmates to get down, but the inmates continued to fight. The observation officer fired one less-lethal round at the thigh of one of the assailants, which caused the inmates to stop fighting. The less-lethal round fired by the observation officer missed its intended target, bounced off the ground, and hit the attacked inmate in the face. All five inmates suffered injuries consistent with fighting; additionally, the attacked inmate suffered an injury on his right cheek consistent with being hit with a less-lethal round. The injured inmate was treated at the institution's correctional treatment center.

Disposition

The institution's executive review committee determined that the use of force complied with the department's policies and procedures. The OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG agreed with the hiring authority's decision.

Incident Assessment

Rating: **Sufficient**

Overall, the department's response to the incident was sufficient.

Incident Date: 2014-01-28	Deadly Force Incident

Incident Summary

OIG Case Number: **14-0265-RO**

On January 28, 2014, custody staff observed two inmates attacking another inmate on an exercise yard. Officers gave multiple orders for the inmates to stop their attack and get down, but the inmates continued. An officer fired one round from a Mini-14 rifle into a designated warning shot area, which caused the inmates to stop their attack and get down. The inmate being attacked sustained multiple stab wounds to his upper torso area. He was treated at the institution for his injuries. Although the Office of Internal Affairs was notified of the incident, its practice is not to respond to warning shots. The department adequately notified the OIG, and the OIG responded on scene.

Disposition

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

Incident Assessment

Rating: **Sufficient**

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

South Region

Incident Date: 2013-07-21	Deadly Force Incident

Incident Summary

OIG Case Number: **13-1841-RO**

On July 21, 2013, four inmates began fighting in the dining hall. Officers gave multiple orders for the inmates to get down and stop fighting, but the inmates continued to fight. Officers utilized eight less-lethal rounds and pepper spray to stop the fight. Officers discovered two inmate-manufactured weapons near the incident. Three of the involved inmates sustained minor injuries consistent with fighting and were treated at the institution. One inmate was inadvertently hit in the back of the head with a less-lethal round, resulting in a laceration that required eight sutures to close. The inmate was transported to an outside hospital for further evaluation and returned to the institution the same day. The institution failed to notify the Office of Internal Affairs and the OIG in a timely manner.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy, but provided training to a lieutenant regarding notification protocols following a critical incident. The OIG concurred with the committee's findings. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with the hiring authority's decision.

Incident Assessment

Rating: **Insufficient**

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

Assessment Questions

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

  The institution failed to timely notify the Office of Internal Affairs of the incident.

- Was the OIG promptly informed of the critical incident?

  The hiring authority notified the OIG more than five hours after the incident occurred and reported that pepper spray was the only type of force used. The OIG did not learn of the less-lethal force and resulting head injury until a later date.

South Region

Incident Date: 2013-12-02	Deadly Force Incident

Incident Summary

OIG Case Number: **13-2608-RO**

On December 2, 2013, two inmates attacked another inmate in the dining hall. Officers used pepper spray and one less-lethal round to stop the attack. The less-lethal round ricocheted off a wall and hit one of the inmates on the right side of his face. The inmate sustained a cut to the side of his face and was treated at the institution. The inmate who was attacked received four staples to the top of his head as a result of the attack and was also treated at the institution. The hiring authority failed to notify the Office of Internal Affairs and the OIG of the incident.

Disposition

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

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate because the institution failed to notify the Office of Internal Affairs and the OIG, thereby preventing the OIG from real-time monitoring of the case.

Assessment Questions

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

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

- Was the OIG promptly informed of the critical incident?

  The hiring authority failed to notify the OIG of the incident. The OIG learned of the incident by reviewing the department's daily report.

Incident Date: 2013-12-14	Deadly Force Incident

Incident Summary

OIG Case Number: **13-2652-RO**

On December 14, 2013, an inmate was attacked by four other inmates on an exercise yard. A control booth officer ordered the inmates to get down, but the inmates refused to comply. The control booth officer fired three less-lethal rounds, after which the inmates stopped fighting. The officer observed one round hit an inmate, who sustained a bruise to his left foot. The officer did not observe the point of impact for the other two rounds; however, one of the inmates sustained a laceration to his head and reported being hit in the head by one of the less-lethal rounds. All involved inmates were treated at the institution. Although the Office of Internal Affairs was notified, the department's practice at the time was not to respond on scene unless less-lethal force was intentionally used in a lethal manner or inadvertently caused potentially lethal injury. The OIG was timely notified and responded on scene.

Disposition

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

Incident Assessment

Rating: **Sufficient**

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

APPENDIX E2 21
INVESTIGATED AND MONITORED DEADLY FORCE CASES
Central Region

Incident Date: 2010-08-09	Deadly Force Incident

Incident Summary

On August 9, 2010, an inmate applied a choke hold to another inmate while on an exercise yard. Officers were unsuccessful in their attempt to stop the attack with a hydroforce cannon, an instrument that combines water and pepper spray into a large stream. An officer attempted to stop the attack with three less-lethal rounds, but was unsuccessful. The officer successfully stopped the attack by intentionally hitting the attacking inmate in the head with a less-lethal round after the inmate being choked appeared unconscious and was no longer struggling. Both inmates survived the incident but received serious injuries. The officer who intentionally hit the inmate in the head allegedly did so after the incident was over and there was no longer any threat or risk of further injury. He also allegedly failed to immediately notify a sergeant that he had intentionally hit an inmate in the head with a less-lethal round. The sergeant, once notified, allegedly failed to timely obtain medical treatment for the inmate, who was not seen by medical staff until approximately 20 minutes after he had been hit. A lieutenant allegedly failed to provide appropriate guidance to subordinate staff during the incident and failed to ensure that the inmate who was hit in the head received immediate medical attention. Although the Office of Internal Affairs was notified, it did not respond on scene. The department adequately notified the OIG, and the OIG responded on scene.

Administrative Investigation	OIG Case Number: **10-3196-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Unreasonable Use of Force** 2. **Neglect of Duty**	1. **Sustained** 2. **Sustained**	**Salary Reduction**	**Modified Salary Reduction**

Predisciplinary Assessment

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

The Office of Internal Affairs failed to comply with the department's policies and procedures governing the predisciplinary process by failing to initiate a deadly force investigation team on-scene response. The OIG recommended this incident be handled as a deadly force incident because the less-lethal round was intentionally fired at an inmate's head in a manner that may have been outside of policy and because it created the potential for death; however, the Office of Internal Affairs failed to open a deadly force investigation. Therefore, this case was never reviewed by the Deadly Force Review Board for compliance with departmental policies.

Assessment Questions

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs did not initiate a deadly force investigation team response, even though a less-lethal round was intentionally aimed at and hit an inmate's head. The use of force created a potential for death and may have been outside of departmental policy.

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

  The Office of Internal Affairs declined to initiate a deadly force investigation team investigation, despite the use of deadly force.

- Was the investigation thorough and appropriately conducted?

  The investigation should have been conducted as a deadly force investigation, because deadly force was used; however, the Office of Internal Affairs declined to open a deadly force investigation.

Disposition

The hiring authority determined there was sufficient evidence to sustain all allegations and imposed a 5 percent salary reduction for 24 months on the officer, a 5 percent salary reduction for 12 months on the sergeant, and a 5 percent salary reduction for 12 months on the lieutenant. The OIG concurred with the hiring authority's determinations. The officer, sergeant, and lieutenant filed appeals with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into settlement agreements with the officer, sergeant, and lieutenant due to concerns raised over the willingness of certain witnesses to testify. The officer's penalty was reduced to a 5 percent salary reduction for 20 months, the sergeant's penalty was reduced to a 5 percent salary reduction for six months, and the lieutenant's penalty was reduced to a 5 percent salary reduction for one month. The OIG concurred with the settlement agreements for the officer and the sergeant. The OIG did not concur with the terms of the settlement agreement for the lieutenant; however, the terms of the settlement did not merit a higher level of review.

Central Region

Disciplinary Assessment

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

The department failed to comply with policies and procedures governing the disciplinary phase. The hiring authority deviated from departmental policy with regard to the penalty without justification.

Incident Date: 2013-03-07 — Deadly Force Incident

Incident Summary

On March 7, 2013, an officer allegedly struck an inmate repeatedly in the head with a closed baton after the inmate physically assaulted the officer. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

OIG Case Number: **13-0483-IR**

Investigation Assessment

Rating: **Insufficient**

The department's investigative process did not sufficiently comply with policies and procedures. The hiring authority failed to timely notify either the Office of Internal Affairs or the OIG of the incident, preventing an immediate response. Additionally, the Office of Internal Affairs failed to timely conduct interviews and the investigation was not timely completed.

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 regarding the incident until more than four hours after the incident had taken place, preventing the Office of Internal Affairs from immediately responding. By the time of notification, involved officers were no longer at the institution and the scene had been processed.

- Was the OIG promptly informed of the critical incident?

  The hiring authority did not notify the OIG regarding the incident until more than four hours after the incident had taken place, preventing the OIG from immediately responding. By the time of notification, involved officers were no longer at the institution and the scene had been processed.

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

  The incident occurred on March 7, 2013. The first interviews were not conducted until May 29, 2013. The final interviews were conducted on June 19, 2013.

- Was the predisciplinary/investigative phase conducted with due diligence?

  The case was assigned to the special agent on March 28, 2013. The investigative report was not completed until August 5, 2013, more than four months after the special agent's assignment to the case.

Administrative Investigation

OIG Case Number: **13-0494-IR**

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

Predisciplinary Assessment

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

The hiring authority failed to comply with the department's policies and procedures governing the predisciplinary process as the Office of Internal Affairs and the OIG were not timely notified of the incident and, as such, the OIA and the OIG were prevented from an immediate response. In addition, the Office of Internal Affairs failed to exercise due diligence in completing the 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 regarding the incident until more than four hours after the incident had taken place, preventing the Office of Internal Affairs from immediately responding. By the time of notification, involved officers were no longer at the institution and the scene had been processed.

Central Region

- Was the OIG promptly informed of the critical incident?

  The hiring authority did not notify the OIG regarding the incident until more than four hours after the incident had taken place, preventing the OIG from immediately responding. By the time of notification, involved officers were no longer at the institution and the scene had been processed.

- Was the predisciplinary/investigative phase conducted with due diligence?

  The special agent was assigned to investigate the matter on March 28, 2013, but did not complete the investigation until August 19, 2013, 144 days later.

Disposition

The department's independent Deadly Force Review Board found no violation of departmental policy, and the hiring authority subsequently exonerated the officer. The OIG concurred.

Disciplinary Assessment

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

The department sufficiently complied with policies and procedures.

Incident Date: 2013-06-03 — Deadly Force Incident

Incident Summary

On June 3, 2013, approximately 30 to 40 inmates began rioting and fighting on an exercise yard. The observation officer saw several of those inmates hitting and kicking another inmate who was on the ground and appeared to be injured and unable to defend himself. The observation officer discharged a round from a Mini-14 rifle, striking and killing one of the attacking inmates. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

OIG Case Number: **13-0736-IR**

Investigation Assessment

Rating: **Insufficient**

The department failed to comply with policies and procedures governing the investigative process. The Office of Internal Affairs failed to conduct all interviews within the timeframe required by departmental policy.

Assessment Questions

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

  The special agent did not conduct all interviews within 72 hours as required by departmental policy. Interviews started on June 3, 2013, the day of the incident; however, interviews were conducted over the course of several weeks, and an interview of the officer was not attempted until July 1, 2013.

Administrative Investigation

OIG Case Number: **13-0737-IR**

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

Predisciplinary Assessment

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

The Office of Internal Affairs failed to comply with the department's policies and procedures governing the predisciplinary process. The investigation was not timely completed.

Assessment Questions

- Was the predisciplinary/investigative phase conducted with due diligence?

  The incident occurred on June 3, 2013. However, the special agent did not complete the final investigative report until October 17, 2013, 136 days later.

Central Region

Disposition

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

Disciplinary Assessment

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

The department sufficiently complied with policies and procedures.

Incident Date: 2014-03-06	Deadly Force Incident

Incident Summary

On March 6, 2014, two inmates on the exercise yard began attacking a third inmate in the head and upper torso with their fists. Officers utilized two cans of pepper spray and two less-lethal rounds to stop the incident. Two of the inmates received minor cuts and scratches to their hands. The third inmate sustained a laceration to his head that did not require sutures. The third inmate reported he was hit in the head with a less-lethal round; however, his injury was more consistent with being struck by a walking cane, which was used and subsequently broken during the attack. This inmate also denied being one of the attacking inmates, but video surveillance later showed him to be an aggressor during the attack. The OIG was timely notified and responded to the scene. The department's deadly force investigation team also responded to the scene.

Administrative Investigation	OIG Case Number: **14-0786-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Predisciplinary Assessment

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

The department's predisciplinary process did not comply with policies and procedures. The Office of Internal Affairs failed to notify the institution that the case was still pending determination by OIA Central Intake. As a result, the institution's executive review committee conducted a review of the case on April 2, 2014, the same day OIA Central Intake took action on the case.

Assessment Questions

- Did DFIT adequately respond to the incident if dispatched to the incident?

  The deadly force investigation team failed to notify the institution that the case was still pending determination by OIA Central Intake. As a result, the institution was unaware of OIA Central Intake's pending determination and the case was heard by the institution's executive review committee on the same day OIA Central Intake took action on the case.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Date: 2014-04-16	Deadly Force Incident

Incident Summary

On April 16, 2014, two inmates began fighting in a dayroom and one of the inmates placed the second inmate in a headlock. The control booth officer ordered the inmates to get down, but the inmates continued to fight. The control booth officer fired one less-lethal round, aiming for the first inmate's thigh. The first inmate sustained swelling to his eye area and knuckles, and also sustained a laceration to his eye area, upper lip, and one of his fingers and claimed that the less-lethal round struck his eye. The OIG was timely notified. Both the OIG and the Office of Internal Affairs responded on scene.

Administrative Investigation	OIG Case Number: **14-1006-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Central Region

Predisciplinary Assessment	Procedural Rating: **Sufficient** Substantive Rating: **Sufficient**

The department's predisciplinary process sufficiently complied with policies and procedures.

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 investigation concluded that the less-lethal round missed, ricocheted, and went over the two inmates. The OIG concurred with the determination. The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

North Region

Incident Date: 2014-03-20	Deadly Force Incident

Incident Summary

On March 20, 2014, two inmates attacked a third inmate on an exercise yard. The inmates did not comply with orders to get down, and an officer fired one less-lethal round at one inmate's thigh. The round struck the inmate in the head. The inmate sustained abrasions on his right hand and both knees and a cut to the right side of his head with active bleeding. The Office of Internal Affairs and the OIG were notified and both responded on scene.

Administrative Investigation	OIG Case Number: **14-0769-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1.**		

Predisciplinary Assessment	Procedural Rating: **Sufficient** Substantive Rating: **Sufficient**

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

Disposition

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

Incident Date: 2014-02-18	Deadly Force Incident

Incident Summary

On February 18, 2014, three inmates began fighting. An officer responded, activated his personal alarm, and ordered the inmates to get down. One inmate complied, but the other two kept fighting. The officer drew his baton and struck one of the fighting inmates in the right shoulder. The inmates continued to fight. The officer swung again, aiming for the inmate's shoulder, but the inmate was struck on the side of his head. The institution failed to notify the OIG and failed to timely notify the Office of Internal Affairs. The OIG received delayed notification of the incident from the Office of Internal Affairs but responded on scene the following day.

Administrative Investigation	OIG Case Number: **14-0465-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1.**		

Predisciplinary Assessment	Procedural Rating: **Insufficient** Substantive Rating: **Insufficient**

The hiring authority failed to comply with the department's policies and procedures governing the predisciplinary process. The hiring authority failed to timely notify the Office of Internal Affairs or the OIG regarding the incident.

North Region

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 the day after the incident.

- Was the OIG promptly informed of the critical incident?

  The institution did not notify the OIG of the critical incident. When the Office of Internal Affairs received notification of the incident on the day following the incident, the Office of Internal Affairs then notified the OIG.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that, while the use of force was within policy, staff failed to follow policy following the use of force because the OIG and the Office of Internal Affairs were not timely notified of the incident. Training was provided. The OIG concurred.

Incident Date: 2014-05-21	Deadly Force Incident

Incident Summary

On May 21, 2014, two inmates were fighting in a dining hall. Officers ordered the inmates to stop fighting, but they refused. An officer fired one less-lethal round, aiming for the leg of one of the inmates; however, the round hit the inmate's cheek as the inmates were falling to the floor. Officers then deployed pepper spray, which stopped the fighting. The inmate hit by the less-lethal round was sent to an outside hospital for medical care. The inmate did not sustain serious injury and returned to the institution later that day. The OIG and the Office of Internal Affairs responded on scene.

Administrative Investigation	OIG Case Number: **14-1254-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1.**		

Predisciplinary Assessment	Procedural Rating: **Sufficient** Substantive Rating: **Sufficient**

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

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

Incident Date: 2014-02-19	Deadly Force Incident

Incident Summary

On February 19, 2014, an inmate battered medical staff. Multiple officers and a sergeant responded. Officers discharged pepper spray with no effect. An officer struck the inmate in the ribs with his baton and another officer struck the inmate twice in the shoulder with his baton. The sergeant used physical force to take the inmate to the ground. The sergeant was struck in the face by a baton deflecting off of the inmate. The inmate sustained an injury to his forehead. The institution notified the Office of Internal Affairs and the OIG the following day, and both responded on scene.

Administrative Investigation	OIG Case Number: **14-0437-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1.**		

North Region

Predisciplinary Assessment

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

The hiring authority failed to comply with the department's policies and procedures governing the predisciplinary process. The hiring authority did not timely notify the Office of Internal Affairs or the OIG regarding the incident, and the hiring authority failed to provide continual real-time consultation with the OIG throughout the predisciplinary phase.

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 more than six hours after the incident.

- Was the OIG promptly informed of the critical incident?

  The institution did not notify the OIG until more than six hours after the incident.

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

  The hiring authority failed to timely notify the OIG that the matter was going to be considered by the institutional executive review committee; therefore, the OIG monitor did not attend.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force, and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the use of force was within departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Date: 2014-02-25 — Deadly Force Incident

Incident Summary

On February 25, 2014, two inmates started fighting and refused to comply with orders to stop. An officer fired one less-lethal round, aiming at the upper torso area of one inmate. One of the inmates claimed the round struck him in the head. That inmate sustained active bleeding and a swollen area and abrasion on the right side of his head, an abrasion and active bleeding on the back of his neck, and an abrasion on his hand. The second inmate sustained abrasions, swollen areas, and bruised areas on his face. The Office of Internal Affairs and the OIG responded.

Administrative Investigation

OIG Case Number: **14-0477-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1.**		

Predisciplinary Assessment

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

Overall, the department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force, and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Date: 2014-04-03 — Deadly Force Incident

North Region

Incident Summary

On April 3, 2014, an inmate refused to leave the shower and submit to restraints. Officers deployed pepper spray in an attempt to gain compliance, but the inmate still refused. The officers believed the inmate may have had a razor blade and conducted a shower extraction. During the shower extraction, the inmate attacked the shield officer. Another officer struck the inmate with his baton six times. Two of the strikes inadvertently struck the inmate on the head. The strikes caused the inmate to stop his attack and submit to restraints. The inmate sustained three lacerations to the top of his head, but no other serious injuries. The OIG and the Office of Internal Affairs were notified and both responded on scene.

Administrative Investigation	OIG Case Number: **14-0861-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force, and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.

Incident Date: 2014-04-21	Deadly Force Incident

Incident Summary

On April 21, 2014, two inmates fought in a dining hall. Officers ordered the inmates to get down, but the inmates refused. Officers deployed pepper spray, but the inmates continued to fight. One officer fired one less-lethal round, which ricocheted and struck an inmate in the head. The OIG and the Office of Internal Affairs were timely notified and responded on scene.

Administrative Investigation	OIG Case Number: **14-1033-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

After an initial review, the Office of Internal Affairs determined that the circumstances did not meet its criteria for a full investigation of the use of deadly force, and the investigation was terminated. The OIG concurred with the determination. The institution's executive review committee determined that the use of force was within departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.

Incident Date: 2014-05-06	Deadly Force Incident

Incident Summary

On May 6, 2014, officers used pepper spray, batons, and physical force in an attempt to stop four inmates who were fighting. None of the inmates sustained serious injuries. However, one inmate, who exhibited a reddened area on his face and left shoulder blade, complained of pain and alleged he was struck in the head with a baton during the incident. He later recanted his statement. The OIG was not timely notified. The OIG and Office of Internal Affairs responded to the institution the following day.

Administrative Investigation	OIG Case Number: **14-1133-IR**

North Region

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Predisciplinary Assessment

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

The department's response was not adequate because the OIG was not timely notified. In addition, the Office of Internal Affairs failed to provide a draft copy of the investigative report to the OIG for review.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not informed of the incident until more than five hours after it occurred.

- 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 OIG was not provided with a draft copy to review.

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 OIG concurred with the Office of Internal Affairs' determination to return the case to the institution for evaluation through the use-of-force process. The institution's executive review committee determined that the use-of-force incident was in compliance with departmental policy. The OIG concurred with the committee's conclusions.

Incident Date: 2014-02-04	Deadly Force Incident

Incident Summary

On February 4, 2014, officers observed two inmates fighting on an exercise yard. The officers ordered the inmates down but they refused. One of the officers used pepper spray without effect. During the course of the incident, one inmate attempted to hit one of the officers in the head. The officer attempted to strike the inmate in the shoulder with his baton; however, due to the inmate's movement, the officer struck the inmate on the left side of his head with his baton. The Office of Internal Affairs was notified and dispatched its deadly force investigation team.

Administrative Investigation	OIG Case Number: **14-0394-IR**

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the predisciplinary process because the department failed to notify the OIG of the incident, thereby preventing the OIG from responding on scene. The Office of Internal Affairs failed to notify the OIG of the incident and failed to provide the OIG with a draft copy of the investigative report.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The department failed to notify the OIG of the incident thereby preventing the OIG from responding on scene. The OIG learned of the incident through the department's daily reports.

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

  A draft copy of the investigative report was not provided to the OIG.

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

  The special agent was timely notified of the incident but failed to contact the OIG.

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.

South Region

Incident Date: 2014-05-26	Deadly Force Incident

Incident Summary

On May 26, 2014, an officer fired three less-lethal rounds at two inmates who were fighting on an exercise yard. One round allegedly ricocheted and glanced off the left cheek area of one of the inmates, causing redness to the area. Neither inmate sustained serious injuries. The OIG and the Office of Internal Affairs were timely notified and responded to the scene.

Administrative Investigation	OIG Case Number: **14-1258-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1.**		

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

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

Incident Date: 2013-02-11	Deadly Force Incident

Incident Summary

On February 11, 2013, a law enforcement multi-agency task force, which included members of the department's fugitive apprehension team, initiated a felony vehicle stop to apprehend a violent parolee-at-large. The parolee was not compliant and attempted to flee in the vehicle. The parolee drove the vehicle head-on into a vehicle being driven by one of the fugitive apprehension team agents. The parolee then ran from the car while reaching into his waistband. A fugitive apprehension team agent fired his duty weapon at the parolee, resulting in the parolee's death. The department's deadly force investigation team responded to the scene and provided support for outside law enforcement. The OIG also responded. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **13-0295-IR**		
	Findings	Initial Penalty	Final Penalty
1. Discharge of Lethal Weapon	**1. Exonerated**	**No Penalty Imposed**	**No Change**

Predisciplinary Assessment

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

Overall, the department sufficiently complied with policies and procedures.

Disposition

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

Disciplinary Assessment

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

The department's disciplinary process sufficiently complied with policies and procedures.

South Region

Incident Date: 2014-03-03	Deadly Force Incident

Incident Summary

On March 3, 2014, two inmates were fighting on the yard and refused orders to stop. The observation officer fired two less-lethal rounds at the two inmates. The first round did not stop the inmates. The second round allegedly hit one of the fighting inmates in the head, causing minor injury. The Office of Internal Affairs and the OIG were timely notified and responded on scene.

Administrative Investigation	OIG Case Number: **14-0727-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

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

Incident Date: 2014-03-25	Deadly Force Incident

Incident Summary

On March 25, 2014, an inmate assaulted an officer inside a housing unit and refused to comply with orders to get down. Responding custody staff utilized pepper spray and a baton, but the inmate remained combative. An officer fired one less-lethal round, which allegedly struck the inmate in the face. The inmate was transported to an outside hospital for medical care. Medical staff determined the inmate's injuries were not life-threatening. The Office of Internal Affairs and the OIG were timely notified and responded on scene.

Administrative Investigation	OIG Case Number: **14-0922-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1.		

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

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

Incident Date: 2014-04-30	Deadly Force Incident

Incident Summary

On April 30, 2014, an observation booth officer fired three less-lethal rounds at two inmates who were fighting on the yard. One of the rounds allegedly hit one of the combatants in the head, causing minor injury. The Office of Internal Affairs and the OIG were timely notified and responded on scene.

Administrative Investigation	OIG Case Number: **14-1227-IR**

South Region

1. Use of Deadly Force	Findings 1.	Initial Penalty	Final Penalty

Predisciplinary Assessment

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

The department failed to comply with policies and procedures governing the predisciplinary process. The hiring authority failed to notify the OIG when the case was to be considered by the institution's executive review committee.

Assessment Questions

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

  The institution failed to apprise OIG that the incident had been reviewed by the institution's executive review committee.

Disposition

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

APPENDIX F 48
CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-12-31	**2014-01-04**	**Suspected Weapons**	**Weapons**

Incident Summary 13-10271-CWRM

On December 31, 2013, the department placed an inmate on contraband surveillance watch after an x-ray revealed metal in his rectum. The inmate was removed from contraband surveillance watch on January 04, 2014, four days later. During that time, the department recovered five razor blades 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
2014-01-02	**2014-01-05**	**Suspected Weapons**	**Nothing**

Incident Summary 14-10291-CWRM

On January 02, 2014, the department placed an inmate on contraband surveillance watch after a medical procedure revealed the presence of possible metal. The inmate was removed from contraband surveillance watch on January 05, 2014, 76 hours later, after a CT scan at an outside hospital was clear of contraband. During that time, the department recovered nothing from the inmate.

Incident Assessment Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to obtain authorization and appropriately document the extension of contraband surveillance watch beyond 72 hours. The department is aware of the authorization requirement to extend a contraband surveillance watch beyond 72 hours, but chose not to pursue it in this case, as they were in the process of simultaneously discharging the inmate from an outside hospital and contraband surveillance watch. The department agreed with the OIG that in the future, if a contraband surveillance watch may exceed 72 hours, regardless of circumstance, departmental policy requires appropriate authorization.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-10	**2014-01-15**	**Suspected Mobile Phone**	**Mobile Phone**

Incident Summary 14-10371-CWRM

On January 10, 2014, the department placed an inmate on contraband surveillance watch after failing to clear a metal detector. The inmate was removed from contraband surveillance watch on January 15, 2014, five 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.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-28	**2014-01-31**	**Suspected Weapons**	**Weapons**

Incident Summary

14-10661-CWRM

On January 28, 2014, the department placed an inmate on contraband surveillance watch after failing to clear a metal detector. The inmate was removed from contraband surveillance watch on January 31, 2014, three days later. During that time, the department recovered a piece of unsharpened metal stock approx. 4.5-5 inches long and .25 inch wide from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch because it failed to provide timely notification to the OIG and failed to document that the inmate received consistent supervisory or hygiene checks. The department agreed to provide training to employees regarding documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-02	**2014-02-05**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10721-CWRM

On February 02, 2014, the department placed an inmate on contraband surveillance watch. Specifically, as staff was approaching his cell to conduct a cell search the inmate was observed putting suspected contraband/evidence into his mouth. The inmate was removed from contraband surveillance watch on February 05, 2014, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to complete daily activity documentation regarding range of motion, supervisory checks, and access to proper hygiene. The authorization to extend contraband surveillance watch beyond 72 hours and the medical assessment of the inmate were not provided to the OIG. The department agreed to provide training to employees regarding documentation and other policy requirements.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-06	**2014-02-10**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10791-CWRM

On February 06, 2014, the department placed an inmate on contraband surveillance watch. An officer observed the inmate acting bizarrely, and ordered the inmate to open his mouth. The officer observed a light brown colored bindle on the roof of the inmate's mouth and ordered the inmate to relinquish the bindle; the inmate refused and swallowed the bindle. The inmate was removed from contraband surveillance watch on February 10, 2014, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to provide timely notification to the OIG. Documentation specific to supervisory checks and inmate hygiene was inadequate. The department provided training to officers regarding documentation.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-09	**2014-02-14**	**Suspected Drugs**	**Nothing**

Incident Summary

14-10911-CWRM

On February 09, 2014, the department placed an inmate on contraband surveillance watch after staff observed him swallow what appeared to be a small cellophane bindle. The inmate was removed from contraband surveillance watch on February 14, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to timely notify the OIG of the inmate's placement on contraband surveillance watch. Documentation specific to range of motion, hygiene, the use of unapproved clothing, and using hand isolation devices prior to appropriate authorization was inadequate. The department agreed to provide training to staff after consulting with the OIG.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-21	**2014-02-24**	**Suspected Drugs**	**Nothing**

Incident Summary

14-11001-CWRM

On February 21, 2014, the department placed an inmate on contraband surveillance watch after an officer observed him bend over, retrieve an object from his sock and place it in his mouth. When questioned, the inmate stated the object was "just a little weed." The inmate was removed from contraband surveillance watch on February 24, 2014, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-21	**2014-02-24**	**Suspected Inmate Note**	**Drugs**

Incident Summary

14-11021-CWRM

On February 21, 2014, the department placed an inmate on contraband surveillance watch after failing to clear a metal detector. The inmate was removed from contraband surveillance watch on February 24, 2014, three days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. Documentation specific to inmate supervisory checks and hygiene was inadequate and the department failed to provide timely notification to the OIG. The department addressed these problems by providing training to the officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-27	**2014-03-03**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11081-CWRM

On February 27, 2014, the department placed an inmate on contraband surveillance watch. Specifically, information was received from outside law enforcement that the inmate may be concealing contraband. The inmate was removed from contraband surveillance watch on March 03, 2014, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-09	**2014-03-13**	**Suspected Drugs**	**Drugs**

Incident Summary 14-11121-CWRM

On March 09, 2014, the department placed an inmate on contraband surveillance watch after he was observed in the visiting room swallowing suspected contraband. The inmate was removed from contraband surveillance watch on March 13, 2014, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department either failed to search the cell prior to placing the inmate on contraband watch, or failed to maintain constant visual observation of the inmate, or both. Although the OIG recommended that the matter be referred to the Office of Internal Affairs for investigation of possible neglect of duty, the department declined to do so.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-13	**2014-03-17**	**Suspected Drugs**	**Drugs**

Incident Summary 14-11161-CWRM

On March 13, 2014, the department placed an inmate on contraband surveillance watch after, during a cell search, he was observed swallowing a round white object. The inmate was removed from contraband surveillance watch on March 17, 2014, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-15	**2014-03-19**	**Suspected Drugs**	**Drugs**

Incident Summary 14-11181-CWRM

On March 15, 2014, the department placed an inmate on contraband surveillance watch. Specifically, during an unclothed body search, the inmate relinquished a bindle of drugs to officers and then agreed to an x-ray, but later refused to be x-rayed. The inmate was removed from contraband surveillance watch on March 19, 2014, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-04-11	**2014-04-14**	**Suspected Weapons**	**Nothing**

Incident Summary 14-11441-CWRM

On April 11, 2014, the department placed an inmate on contraband surveillance watch after informing staff he had swallowed a razor blade. The inmate was removed from contraband surveillance watch on April 14, 2014, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch. Although documentation specific to inmate hygiene and range of motion was inconsistent, the department addressed this problem by providing training to the officers.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-04-30	**2014-05-07**	**Suspected Inmate Note**	**Nothing**

Incident Summary

14-11641-CWRM

On April 30, 2014, the department placed an inmate on contraband surveillance watch. Specifically, while searched upon entering the education area, the inmate was evasive with his hands by keeping them clenched. When ordered to open his hands, the officer observed a bindle wrapped in clear tape, which the inmate quickly swallowed.The inmate was removed from contraband surveillance watch on May 07, 2014, seven days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

The department sufficiently complied with policies and procedures governing contraband surveillance watch. Although documentation specific to inmate hygiene was inadequate, the department identified the need for training to ensure that the required documentation is completed.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-11	**2014-01-14**	**Suspected Weapons**	**Other**

Incident Summary

14-10411-CWRM

On January 11, 2014, the department placed an inmate on contraband surveillance watch after informing staff he ingested razor blades. The inmate was removed from contraband surveillance watch on January 14, 2014, three days later. During that time, the department recovered two small metal objects from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to document or obtain the approval to extend the inmate on contraband surveillance watch and failed to document consistent supervisory checks. The department addressed these problems by providing training to employees after consulting with the OIG.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-11	**2014-01-14**	**Suspected Weapons**	**Other**

Incident Summary

14-10421-CWRM

On January 11, 2014, the department placed an inmate on contraband surveillance watch after informing staff he had swallowed pills and razor blades, in an attempt to kill himself. The inmate was removed from contraband surveillance watch on January 14, 2014, three days later. During that time, the department recovered two small pieces of metal from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to document or obtain the approval to extend the inmate on contraband surveillance watch beyond 72 hours. Documentation specific to consistent supervisory checks and inmate hygiene was also inadequate. The department addressed these problems by providing training to employees after consulting with the OIG.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-15	**2014-01-21**	**Suspected Weapons**	**Nothing**

Incident Summary

14-10431-CWRM

On January 15, 2014, the department placed an inmate on contraband surveillance watch. Specifically, the institution received a package addressed to the inmate containing two .380 magazines from Smith & Wesson, with a note saying, "Thank you for your purchase." The inmate subsequently failed to clear a metal detector and submitted to an x-ray which revealed a possible metallic object.The inmate was removed from contraband surveillance watch on January 21, 2014, six days later. During that time, it was determined that the possible metal object could have been an obstructed bowel, and the department recovered nothing 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
2014-01-23	**2014-01-28**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10571-CWRM

On January 23, 2014, the department placed an inmate on contraband surveillance watch after the inmate, who had just been involved in a fight, failed a metal detector and an officer observed lubricant around the inmate's rectum during an unclothed body search prior to placement in administrative segregation. The inmate was removed from contraband surveillance watch on January 28, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-23	**2014-01-29**	**Suspicious Activity**	**Drugs**

Incident Summary

14-10581-CWRM

On January 23, 2014, the department placed an inmate on contraband surveillance watch after an officer observed lubrication around the inmate's rectum. The inmate was removed from contraband surveillance watch on January 29, 2014, six 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
2014-01-30	**2014-02-04**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10681-CWRM

On January 30, 2014, the department placed an inmate on contraband surveillance watch after an officer observed lubricant around the inmate's rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on February 04, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to substantially comply with policies and procedures governing contraband surveillance watch because the the department failed to obtain the proper authorization for the application of hand isolation devices on the inmate. Additionally, on one occasion, the department did not indicate in its documentation the presence or absence of contraband in a bowel movement produced by the inmate. The department addressed these problems by providing training to employees.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-06	**2014-02-09**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10761-CWRM

On February 06, 2014, the department placed an inmate on contraband surveillance watch due to the inmate being observed placing unidentified contraband in his rectum. The inmate was removed from contraband surveillance watch on February 09, 2014, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The documentation related to extending the inmate on contraband surveillance watch beyond 72 hours was not completed. The department has provided additional training to key personnel and instituted enhanced procedures to the contraband surveillance watch program to assure that the status of active cases is reviewed daily.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-06	**2014-02-11**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10781-CWRM

On February 06, 2014, the department placed an inmate on contraband surveillance watch because officers observed the inmate place probable contraband in his mouth. The inmate was removed from contraband surveillance watch on February 11, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The supervisory checks for each shift were not documented by the supervisor, and the self-audit documentation was not completed timely and lacked the required signatures. The department acknowledged these deficiencies and agreed to take appropriate action.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-09	**2014-02-14**	**Suspicious Activity**	**1. Drugs** **2. Weapons**

Incident Summary

14-10851-CWRM

On February 09, 2014, the department placed an inmate on contraband surveillance watch. Specifically, the inmate was observed ingesting possible contraband during visiting. The inmate was removed from contraband surveillance watch on February 14, 2014, five days later. During that time, the department recovered weapons and drugs from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-15	**2014-02-24**	**Suspected Drugs**	**Nothing**

Incident Summary

14-10951-CWRM

On February 15, 2014, the department placed an inmate on contraband surveillance watch after he was observed during visiting receiving bindles of suspected marijuana. On February 20, 2014, an officer discovered the inmate had slipped out of the restraints, while still on contraband surveillance watch, and possibly re-ingested the contraband. The inmate was removed from contraband surveillance watch on February 24, 2014, nine days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to properly monitor the inmate during the contraband surveillance watch. The hiring authority referred the case for investigation of potential staff neglect of duty.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-08	**2014-03-14**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11131-CWRM

On March 08, 2014, the department placed an inmate on contraband surveillance watch after the inmate was observed possibly secreting contraband during visiting. The inmate was removed from contraband surveillance watch on March 14, 2014, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-16	**2014-03-22**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11211-CWRM

On March 16, 2014, the department placed an inmate on contraband surveillance watch after an officer noticed a clear liquid around the inmate's rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on March 22, 2014, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-20	**2014-03-23**	**Suspicious Activity**	**Drugs**

Incident Summary

14-11221-CWRM

On March 20, 2014, the department placed an inmate on contraband surveillance watch after officers observed lubricant around his rectum during an unclothed body search. The inmate informed custody staff that he had secreted drugs inside his anal cavity. The inmate was removed from contraband surveillance watch on March 23, 2014, three days later. During that time the department recovered drugs from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch because the documentation lacked appropriate notations, including supervisory checks and inmate hygiene. In addition, the department failed to obtain the proper approval to extend the contraband surveillance watch beyond 72 hours. The department identified the need for training to ensure the required documentation is completed.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-23	**2014-04-02**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11241-CWRM

On March 23, 2014, the department placed an inmate on contraband surveillance watch after observing the inmate ingest contraband received from a visitor. The inmate was removed from contraband surveillance watch on April 2, 2014, ten days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. While the department obtained the proper approval to extend the contraband surveillance watch beyond 72 hours, it failed to obtain the proper approval to extend the contraband surveillance watch beyond 144 hours. When the OIG brought this to the attention of the department, the inmate was removed from contraband surveillance watch. Additionally, the department failed to properly document the use of restraints and hand-isolation devices. Health and safety requirements, specifically related to hygiene, were not properly documented by the department. The department addressed the lack of documentation by providing training to the officers.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-04-08	**2014-04-11**	**Suspected Weapons**	**Nothing**

Incident Summary

14-11411-CWRM

On April 08, 2014, the department placed an inmate on contraband surveillance watch after failing to clear a metal detector. After an x-ray revealed a possible bullet fragment, the inmate was removed from contraband surveillance watch on April 11, 2014, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to properly document the use of restraints and hand-isolation devices and the presence or absence of contraband in inmate bowel movements. The department addressed this problem by providing training to employees.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-04-12	**2014-04-17**	**Suspected Drugs**	**Drugs**

Incident Summary

14-11451-CWRM

On April 12, 2014, the department placed an inmate on contraband surveillance watch after he was observed in visiting retrieving something from his visitor's pocket, placing it in his mouth, and then drinking something. The inmate was removed from contraband surveillance watch on April 17, 2014, five days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch because the inmate's placement was not authorized at the required level, and the documentation was not appropriately completed. The department provided training to address these issues.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-04-28	**2014-05-03**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11601-CWRM

On April 28, 2014, the department placed an inmate on contraband surveillance watch after staff observed the inmate place a cellophane bindle in his mouth and swallow it. The inmate was removed from contraband surveillance watch on May 03, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-06-10	**2014-06-13**	**Suspicious Activity**	**Nothing**

Incident Summary

14-12091-CWRM

On June 10, 2014, the department placed an inmate on contraband surveillance watch after conducting an unclothed body search. During the search, officers observed the inmate attempting to retrieve an object from his rectum. The inmate was removed from contraband surveillance watch on June 13, 2014, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to provide documentation for its use of leg restraints during contraband surveillance watch. The department addressed this issue by providing training to staff.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-06-16	**2014-06-21**	**Suspicious Activity**	**Nothing**

Incident Summary 14-12131-CWRM

On June 16, 2014, the department placed an inmate on contraband surveillance watch because a nurse observed the inmate with a bindle in his mouth. When asked to spit it out, the inmate swallowed the bindle. The inmate was removed from contraband surveillance watch on June 21, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-06-19	**2014-06-23**	**Suspicious Activity**	**Weapons**

Incident Summary 14-12151-CWRM

On June 19, 2014, the department placed an inmate on contraband surveillance watch because the inmate was observed with a string protruding from his rectum. The inmate admitted having a weapon and contraband in his rectum, but refused to remove it. The inmate was removed from contraband surveillance watch on June 23, 2014, 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.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-12-29	**2014-01-02**	**Suspicious Activity**	**Nothing**

Incident Summary

13-10241-CWRM

On December 29, 2013, the department placed an inmate on contraband surveillance watch for suspicious activity. The inmate placed his hand behind his back and made a motion consistent with pushing contraband up into his anal cavity, while his visitor attempted to block the view of staff. The inmate was removed from contraband surveillance watch on January 02, 2014, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-10	**2014-01-14**	**Suspicious Activity**	**Inmate Note**

Incident Summary

14-10391-CWRM

On January 10, 2014, the department placed an inmate on contraband surveillance watch after custody staff discovered he had lubricant around his anal cavity. The inmate was removed from contraband surveillance watch on January 14, 2014, four days later. During that time, the department recovered an inmate note from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The institution failed to notify the OIG of the inmate's placement on contraband surveillance watch until three days after the incident. Additionally, the department failed to complete appropriate documentation related to inmate hygiene and health and safety concerns. The department provided training to staff to address these issues.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-01-25	**2014-01-28**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10621-CWRM

On January 25, 2014, the department placed an inmate on contraband surveillance watch after he was observed placing an unknown object down the back of his pants. The inmate was removed from contraband surveillance watch on January 28, 2014, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to complete the appropriate documentation and failed to document the approval to extend the inmate beyond the initial 72 hours. The department provided training to staff regarding documentation requirements.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-06	**2014-02-10**	**Suspicious Activity**	**Nothing**

Incident Summary

14-10771-CWRM

On February 06, 2014, the department placed an inmate on contraband surveillance watch after he swallowed an unidentified item upon being confronted by custody staff. The inmate was removed from contraband surveillance watch on February 10, 2014, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to conduct the appropriate medical assessment of the inmate prior to placement on contraband surveillance watch. Additionally, the department failed to maintain complete and accurate logs and failed to properly document health and safety and hygiene related checks. The department provided training to staff to address the deficiencies related to documentation and health and safety and hygiene requirements and upon the recommendation of the OIG, the department will work with custody and medical staff to ensure the proper medical assessment is done prior to placement on contraband surveillance watch.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-10	**2014-02-13**	**Suspected Mobile Phone**	**1. Drugs** **2. Mobile Phone**

Incident Summary

14-10841-CWRM

On February 10, 2014, the department placed an inmate on contraband surveillance watch after confidential information was received that the inmate was in possession of a cell phone. Staff used a metal wand which alerted near the inmate's buttocks and an unclothed body search revealed lubrication around the inmate's anus. The inmate was removed from contraband surveillance watch on February 13, 2014, three days later. During that time, the department recovered a mobile phone and drugs from the inmate.

Incident Assessment

Insufficient

The department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch and failed to comply with policies and procedures in other critical aspects. The department failed to adequately document required hand-washing hygiene, failed to provide the inmate with dental hygiene items, and failed to adequately document officer shift changes. The department provided training to officers regarding documentation requirements.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-15	**2014-02-19**	**Suspected Drugs**	**Nothing**

Incident Summary

14-10941-CWRM

On February 15, 2014, the department placed an inmate on contraband surveillance watch. Specifically, the inmate was seen with an item in his hand. When ordered to submit to a search, the inmate refused and was seen swallowing an item. Four bindles of suspected methamphetamine were found in the direct area. The inmate was removed from contraband surveillance watch on February 19, 2014, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-02-25	**2014-03-03**	**Suspected Weapons**	**Nothing**

Incident Summary

14-11071-CWRM

On February 25, 2014, the department placed an inmate on contraband surveillance watch after informing staff he had swallowed razor blades. The inmate was removed from contraband surveillance watch on March 03, 2014, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch. The department further failed to address health and safety concerns regarding hygiene, and failed to complete the appropriate documentation. The department provided training to staff regarding proper documentation and other policy requirements.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-09	**2014-03-14**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11111-CWRM

On March 09, 2014, the department placed an inmate on contraband surveillance watch after staff observed the inmate remove an object from his underwear and place it in his mouth. The inmate was removed from contraband surveillance watch on March 14, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The institution failed to notify the OIG of the inmate's placement on contraband surveillance watch until the day after the incident. In addition, the department failed to consistently and accurately document the required health and safety checks. The department provided training to staff regarding documentation requirements.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-03-17	**2014-03-21**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11201-CWRM

On March 17, 2014, the department placed an inmate on contraband surveillance watch. Specifically, during a clothed body search, the inmate reached into his waistband and pulled out an unknown object, placed it in his mouth, and swallowed it. The inmate was removed from contraband surveillance watch on March 21, 2014, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-04-16	**2014-04-20**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11551-CWRM

On April 16, 2014, the department placed an inmate on contraband surveillance watch after he failed to clear a metal detector. The inmate was removed from contraband surveillance watch on April 20, 2014, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to complete the required documentation and left the inmate in leg restraints without documented justification. In addition, the department failed to obtain the proper approval to extend the contraband surveillance watch beyond 72 hours. The department provided training to staff regarding documentation requirements and the use of leg restraints.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-05-08	**2014-05-13**	**Suspicious Activity**	**Nothing**

Incident Summary

14-11741-CWRM

On May 08, 2014, the department placed an inmate on contraband surveillance watch after custody staff observed him remove an unknown object from his underwear and place it in his mouth. The inmate was removed from contraband surveillance watch on May 13, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-05-24	**2014-05-28**	**Suspected Drugs**	**Drugs**

Incident Summary

14-11871-CWRM

On May 24, 2014, the department placed an inmate on contraband surveillance watch. Specifically, the inmate's visitor was observed removing something from her waistband and placing it in a chip bag. The visitor then removed that item from the chip bag and placed it in the inmate's mouth. The inmate swallowed the item. The inmate was removed from contraband surveillance watch on May 28, 2014, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. There is no documentation that custody staff provided constant visual observation during significant periods of the contraband surveillance watch. The department provided training to address these issues and corrective action was taken against staff who failed to adhere to the contraband surveillance watch policies.

SEMI-ANNUAL REPORT

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Volume II

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STATE OF CALIFORNIA
October 2014