Amarik K. Singh, *Inspector General*

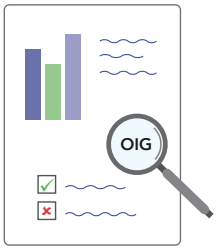
OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

February 2022

2021 Annual Report

A Summary of Reports



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STATE *of* CALIFORNIA
OIG | OFFICE *of the* INSPECTOR GENERAL

***Amarik K. Singh**, Inspector General*

Independent Prison Oversight

Regional Offices

Sacramento
Bakersfield
Rancho Cucamonga

February 22, 2022

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California

Dear Governor and Legislative Leaders:

Enclosed please find our annual report summarizing the work the Office of the Inspector General completed in 2021. In 2021, we issued 18 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: nine reports on medical inspection results; two reports and two sentinel cases concerning our monitoring of the department's internal investigations and employee disciplinary process; one report on our monitoring of the department's use of force; one special review comprising the third and final part of our three-part series concerning the spread of the novel coronavirus disease (COVID-19) throughout the State's prison system; one special review of the department's staff misconduct process; one report on the status of the *Blueprint*; and our 2020 annual report.

Respectfully submitted,

Amarik K. Singh
Inspector General

***Gavin Newsom**, Governor*

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Vision

The California prison system, by its very nature, operates almost entirely behind walls, both literal and figurative. The Office of the Inspector General (the OIG) exists to provide a window through which the citizens of the State can witness that system and be assured of its soundness. By statutory mandate, our agency oversees and reports on several operations of the California Department of Corrections and Rehabilitation (the department). We act as the eyes and ears of the public, measuring the department's adherence to its own policies and, when appropriate, recommending changes to improve its operations.

The OIG serves as an oversight agency known to provide outstanding service to our stakeholders, our government, and the people of the State of California. We do this through diligent monitoring, honest assessment, and dedication to improving the correctional system of our State. Our overriding concern is providing transparency to the correctional system so that lessons learned may be adopted as best practices.

Mission

Although the OIG's singular vision is to provide transparency, our mission encompasses multiple areas, and our staff serve in numerous roles providing oversight and transparency concerning distinct aspects of the department's operations, which include discipline monitoring, complaint intake, warden vetting, medical inspections, the California Rehabilitation Oversight Board (C-ROB), and a variety of special assignments.

Therefore, to safeguard the integrity of the State's correctional system, we work to provide oversight and transparency through monitoring, reporting, and recommending improvements on the policies and practices of the department.

— Amarik K. Singh
Inspector General

here is hereby created the independent **Office of the Inspector General** which shall not be a subdivision of any other governmental entity.

— State of California
Penal Code section 6125

Organizational Overview and Functions

The Office of the Inspector General (the OIG) is an independent agency of the State of California. First established by State statute in 1994 to conduct investigations, review policy, and conduct management review audits within California's correctional system, California Penal Code sections 2641 and 6125–6141 provide our agency's statutory authority in detail, outlining our establishment and operations.

The Governor appoints the Inspector General to a six-year term, subject to California State Senate confirmation. The Governor appointed our current Inspector General, Amarik K. Singh, on December 22, 2021; her term will expire at the end of 2027.

The OIG is organized into a headquarters operation, which encompasses executive and administrative functions and is located in Sacramento, and three regional offices: north, central, and south. The northern regional office is located in Sacramento, co-located with our headquarters; the central regional office is in Bakersfield; and the southern regional office is in Rancho Cucamonga.

Our staff consist of a skilled team of professionals, including attorneys with expertise in investigations, criminal law, and employment law, as well as inspectors knowledgeable in correctional policy, operations, and auditing.

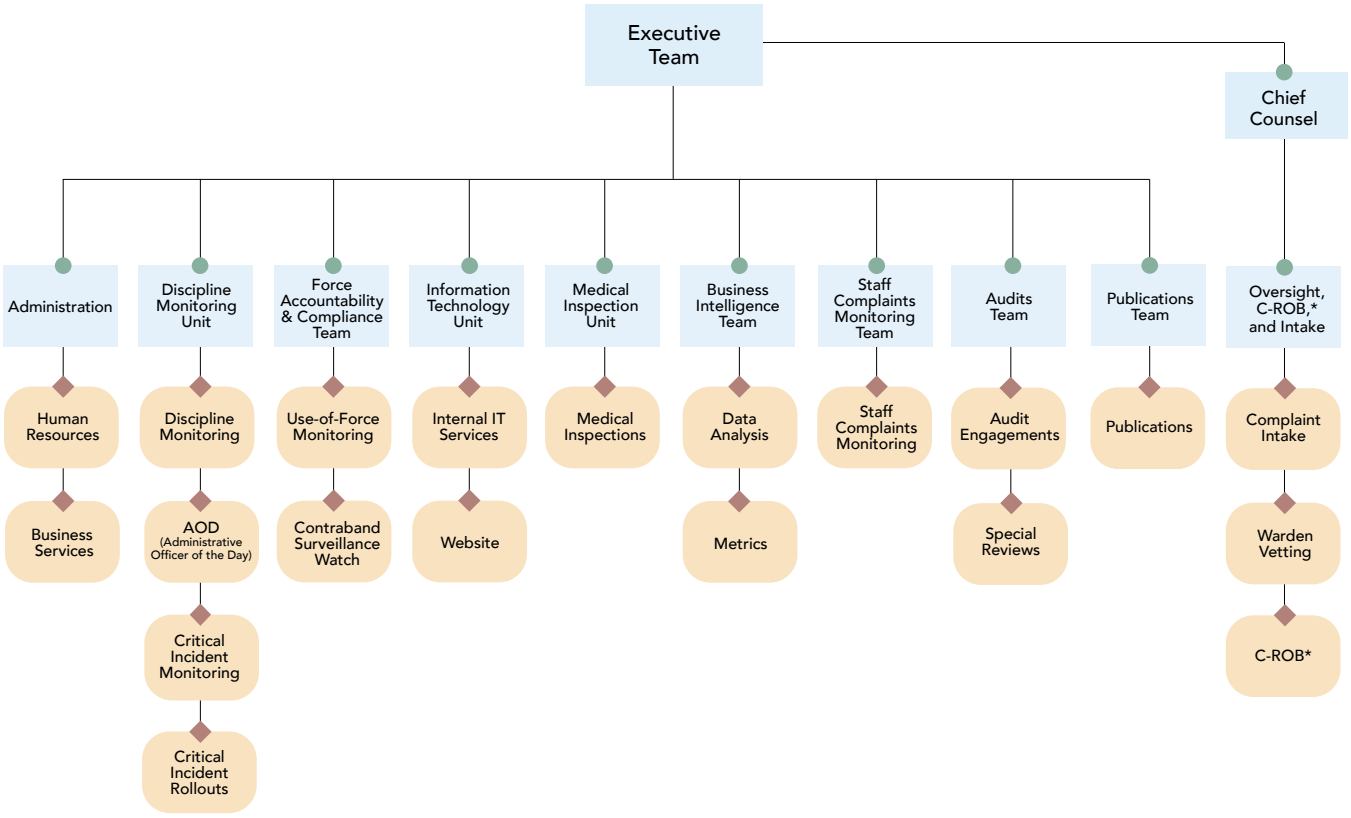
The OIG also employs a cadre of medical professionals, including physicians and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities, all of which are integral in achieving our mission.

Staff in our office perform a variety of oversight functions relative to the department, including those listed below:

- Conduct medical inspections
- Carry out audits and authorized special reviews
- Staff the complaint hotline and intake unit
- Review, and when appropriate, investigate whistleblower retaliation complaints

- Handle complaints filed directly with the OIG by incarcerated persons, employees, and other stakeholders regarding the department
- Conduct special reviews authorized by the Legislature or the Governor's Office
- As ombudsperson, monitor Sexual Abuse in Detention Elimination Act (SADEA)/Prison Rape Elimination Act (PREA) cases
- Coordinate and chair the California Rehabilitation Oversight Board (C-ROB)
- Conduct warden and superintendent vettings
- Monitor the following:
    - Internal investigations and litigation of employee disciplinary actions
    - Critical incidents, including deaths of incarcerated persons, large-scale riots, hunger strikes, and so forth
    - Staff complaint grievances filed by incarcerated persons
    - Adherence to the *Blueprint* plan for the future of the department
    - Uses of force
    - Contraband surveillance watches

Figure 1. The Office of the Inspector General Organizational Chart, 2021



* C-ROB is the abbreviation for the California Rehabilitation Oversight Board.

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Reports Published in 2021

In 2021, we issued 18 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: nine reports on medical inspection results; two reports and two sentinel cases concerning our monitoring of the department's internal investigations and employee disciplinary process; one report on our monitoring of the department's use of force; one special review comprising the third and final part of our three-part series concerning the spread of the novel coronavirus disease (COVID-19) throughout the State's prison system; one special review of the department's staff misconduct process; one report on the status of the *Blueprint*; and our 2020 annual report. Visit our website, **www.oig.ca.gov**, to view our public reports.

Internal Investigations and Employee Discipline Monitoring

Our attorneys within the Discipline Monitoring Unit are responsible for the contemporaneous oversight of the department's internal investigations and employee disciplinary process. We publish our findings and recommendations regarding investigative and disciplinary processes twice a year. We monitor and assess the performance of special agents who work for the department's Office of Internal Affairs. The special agents process referrals and investigate allegations. We also assess the performance of hiring authorities who make disciplinary decisions and the performance of department attorneys throughout the entire process.

As part of our monitoring duties, we attend weekly central intake meetings in which the Office of Internal Affairs makes decisions regarding referrals of misconduct received from hiring authorities across the state. In 2021, the Office of Internal Affairs addressed and made decisions concerning 2,347 referrals for investigation or for authorization to take disciplinary action without an investigation. Of those 2,347 referrals, the Office of Internal Affairs approved 2,199 for investigation or direct disciplinary action. The OIG identified 300 of these cases to monitor. These cases typically involved dishonesty, sexual misconduct, code of silence, deadly force, abuse of authority, and criminal conduct.

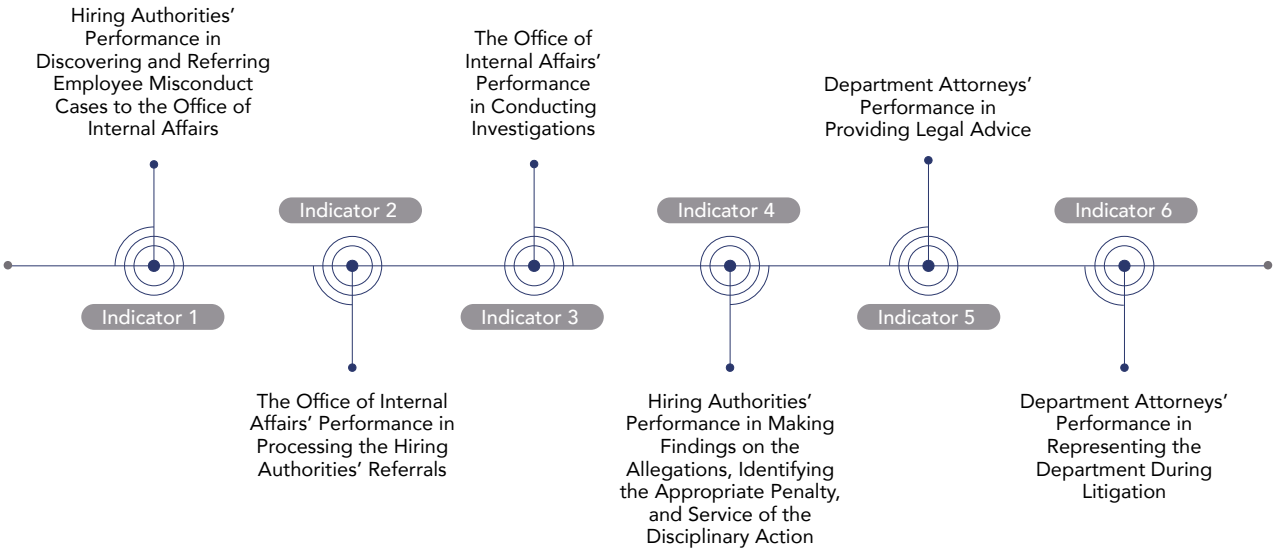
In 2021, we monitored and closed 210 cases. Of those cases, 173 involved administrative allegations, and 37 involved criminal

allegations by departmental staff. Of those cases, 12 administrative investigations and seven criminal investigations involved the use of deadly force.

The OIG categorized our assessments into six separate phases or indicators, listed as follows:

1. The performance of hiring authorities in discovering alleged employee misconduct and referring the allegations to the Office of Internal Affairs;
2. The performance of the Office of Internal Affairs in processing and analyzing the referrals;
3. The performance of the Office of Internal Affairs in investigating the allegations;
4. The performance of hiring authorities in making findings concerning the investigations and allegations;
5. The performance of department attorneys in providing legal advice to the Office of Internal Affairs; and
6. The performance of department advocates in representing the department in litigation regarding employee discipline.

Figure 2. The Six Indicators We Used to Assess the Department's Internal Investigations and Employee Disciplinary Process in Determining Our Overall Ratings of Departmental Performance



Source: The Office of the Inspector General.

When assessing cases, OIG attorneys answered a series of compliance- and performance-related questions and, depending on the answers, assigned a rating of *superior*, *satisfactory*, or *poor* to each of the six indicators; we also assigned an overall rating to each case. To monitor and track this data, we assigned a numerical point value to each of the individual indicator ratings and to the overall rating for each case. The OIG assigned four points for a superior rating, three points for a satisfactory rating, and two points for a poor rating. We then added the assigned points for each indicator and divided the total by the number of points possible to arrive at a weighted average score. We assigned a rating of *superior* to weighted averages that fell between 100 percent and 80 percent, *satisfactory* to weighted averages that fell between 79 percent and 70 percent, and *poor* to weighted averages that fell between 69 percent and 50 percent.

We applied this methodology in two discipline monitoring reports in 2021. We found that during both the July through December 2020, and January through June 2021 reporting periods, the department's overall performance was *satisfactory* in conducting internal investigations and handling the employee disciplinary process. However, hiring authorities' overall performance was *poor* in processing the employee discipline cases, and department attorneys' performance was *poor* in providing legal representation during litigation.

The OIG also identified and made recommendations regarding the disciplinary process. In our discipline monitoring report released in May 2021 regarding the July to December 2020 reporting period, we made the following recommendations:

1. The OIG recommended the department develop and implement a policy requiring that special agents in the Office of Internal Affairs conduct the first interview within 45 days of a case assignment, except in cases in which specific facts warrant delaying the interview and the warranted delay is approved by a manager in the Office of Internal Affairs.

2. The OIG recommended the department implement and enforce a bright-line rule requiring that hiring authorities hold investigative and disciplinary findings conferences within 14 days of receiving an investigative report, a report regarding an interview of the employee suspected of misconduct, or a notice of approval to take direct disciplinary action.

In our discipline monitoring report released in December 2021 regarding the January to June 2021 reporting period, we made the following recommendations:

1. The OIG recommended the Office of Internal Affairs open full administrative investigations in all cases involving alleged domestic violence when initially deciding a course of action during the central intake process.
2. The OIG recommended the Office of Internal Affairs classify all allegations of domestic violence as domestic violence, regardless of the extent of the injuries or presence of corroborating evidence.
3. The OIG recommended the department comply with its own departmental rules and require the inclusion of a no-rehire clause in any settlement that allows a dismissed employee to resign in lieu of dismissal. If the State Personnel Board rejects the settlement, the OIG recommended the department seek judicial review of the decision and obtain clarity from the courts regarding the applicability of *California Code of Civil Procedure*, section 1002.5, to settlements involving appeals from dismissals.
4. The OIG recommended hiring authorities refer all unintentional discharge cases to the Office of Internal Affairs for analysis and review. In addition, the OIG recommended the department assess all locations where weapons are stored and handled to ensure proper safety measures are taken to safeguard life and prevent unnecessary injury.
5. The OIG recommended the department categorize all cases involving the unintended discharge of a firearm consistently and in a manner the department can accurately track.

In addition to publishing the two discipline monitoring reports, the OIG issued two sentinel cases. We issue sentinel cases when we determine the department's handling of a case or issue was particularly poor and involved serious errors, even after the department had a chance to repair the damage. One sentinel case involved allegations received from an incarcerated person that officers and other staff at a prison had continuously failed to wear face coverings in a housing unit, which was a violation of departmental policy. The OIG determined that local investigators at the prison conducted a substandard inquiry and that the department failed to adequately address the incarcerated person's allegations. The other sentinel case involved a disciplinary

case against a sergeant who allegedly attempted to solicit sex from a minor. The OIG found that department attorneys failed to appropriately analyze the facts of the case when applying a statute they believed precluded them from including a no-rehire clause in the settlement and that the department violated its own policy when it entered into the settlement without including the required clause.

Use-of-Force Monitoring

Another means by which we fulfilled our oversight mandate was by monitoring the department's process for reviewing use-of-force incidents at committee meetings at both institutional and departmental levels. We used a monitoring methodology to assess whether departmental staff complied with the department's use-of-force policies and procedures prior to, during, and following each incident we monitored. Our methodology consisted of 11 units of measurement we call *performance indicators*. We developed a series of compliance questions for each indicator and, based on the collective answers, assigned a rating of *superior*, *satisfactory*, or *poor*, to each indicator, as well as to the overall incident. This tool aggregates information, allowing for in-depth analysis of incidents and identification of problematic trends.

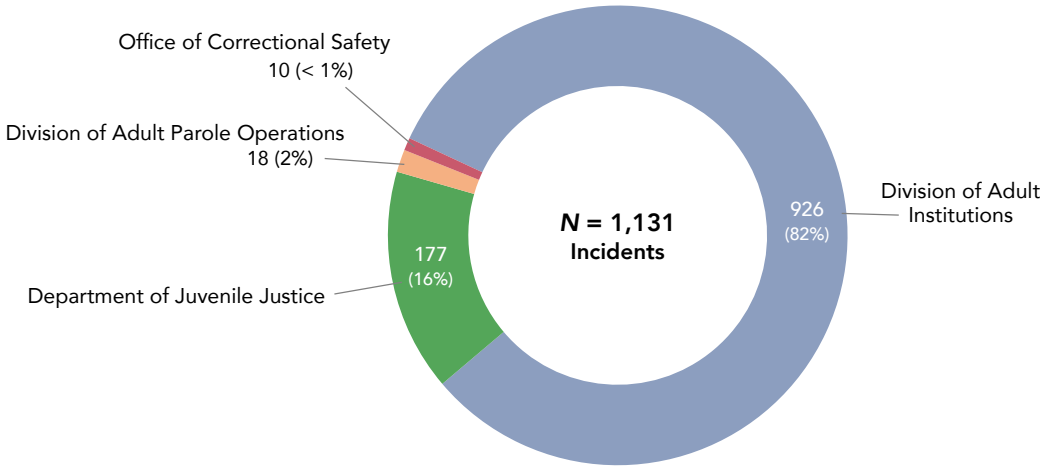
In November 2021, we published *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation*. This report covered our monitoring of use-of-force incidents that occurred during the period from January 1, 2020, through December 31, 2020.

Use-of-Force Statistics, From January 1, 2020, Through December 31, 2020

- The OIG monitored 1,131 of the 6,823 use-of-force incidents that occurred during this period (17 percent).
- The OIG attended 514 of the 657 review committee meetings (78 percent).
- More than 81 percent of the use-of-force incidents we monitored (926 of 1,131) occurred at adult institutions and contract facilities housing adult incarcerated persons, and the remainder occurred at juvenile facilities (177), involved parole staff (18), or involved Office of Correctional Safety staff (10).

- Approximately 38 percent of the incidents we reviewed occurred at only five prisons: California State Prison, Sacramento (103); Kern Valley State Prison (64); California State Prison, Los Angeles County (62); Salinas Valley State Prison (61); and California Correctional Institution (60).

Figure 3. Distribution of the 1,131 Use-of-Force Incidents the OIG Monitored, by Division and Other Entities



Note: Percentages may not sum to 100 percent due to rounding.
Source: The Office of the Inspector General Tracking and Reporting System.

- The 1,131 incidents we monitored involved 4,161 applications of force. An incident may have involved more than one application of force. For example, two baton strikes count as two applications of force during a single incident. Chemical agents accounted for 1,678 of the total applications (40 percent), while physical strength and holds accounted for 1,612 (39 percent). The remaining 21 percent of force applications consisted of force options such as less-lethal projectiles, baton strikes, tasers, and firearms.

Highlights of Our Use-of-Force Monitoring

We monitored 1,131 of the 6,823 use-of-force incidents that occurred in 2020 and concluded that the department's performance was *satisfactory* overall. We assessed the department's performance as *superior* in eight incidents, *satisfactory* in

960 incidents, and *poor* in 163 incidents. In the eight incidents for which we assessed the department's performance as *superior*, staff performed exceptionally well in multiple areas, such as attempting to de-escalate situations before using force, decontaminating involved incarcerated persons and exposed areas following the use of chemical agents, and documenting the force used and observed in the required reports. In the 163 incidents in which we assessed the department's overall performance as *poor*, we identified multiple failures, such as custody staff not following decontamination protocols after using chemical agents, medical staff not evaluating incarcerated persons as soon as practical following an incident, and the levels of review failing to identify and address policy deviations. The incidents for which we assessed the department's performance as *poor* also included our identifying a single violation that was particularly egregious, such as officers using unnecessary force or staff failing to recognize and address an incarcerated person's allegation of unreasonable force.

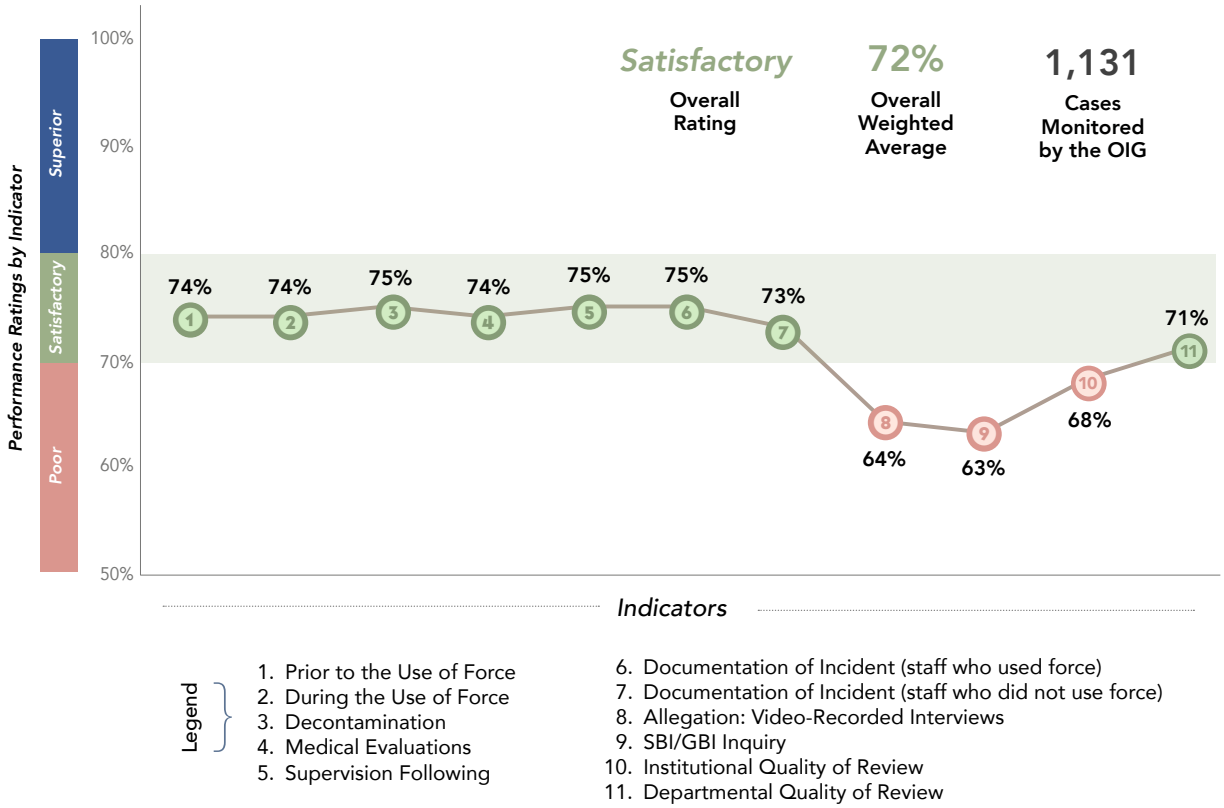
The department performed satisfactorily before using force. However, similar to our prior reports, we identified two areas of concern regarding officers' actions before the use of force. We identified 43 instances in which an officer's actions (or failure to act) unnecessarily contributed to the need to use force; we rated those incidents as *poor*. In addition, we identified 14 instances in which officers had the opportunity to de-escalate a potentially dangerous situation prior to using force, but failed to do so; we also rated those instances as *poor*.

We found that, overall, the department performed satisfactorily during the actual force. However, we identified one key area of concern regarding the force used that was similarly identified in our last report. The department's policy for the use of immediate force requires officers to provide justification for using force by articulating their reasoning in a written report. Despite this requirement, officers failed to describe an imminent threat to justify the force used in 37 of 1,131 incidents, which led us to conclude the force was unnecessary; we rated those 37 incidents as *poor*.

We assessed the department's performance in several areas following the use of force. While the department performed satisfactorily in most areas, we are concerned regarding the department's identification and assessment of a serious bodily injury that may have resulted from staff's use of force as well as its fact-finding in those cases. We found the department did not have a consistent process for determining whether a serious bodily

injury may have been caused by staff's use of force. Because of this, in 15 incidents requiring a video-recorded interview with an incarcerated person, the interview either was not conducted within 48 hours of discovering the injury as required by policy, or was not conducted at all. In addition, the quality of reviews conducted by supervisors and managers at departmental institutions continues to be an area of concern. The review process following a use-of-force incident involves a minimum of five levels of review, during which each reviewer is required to review and evaluate staff members' actions and identify policy violations. Of the 1,131 incidents we monitored, we identified 500 incidents in which one or more reviewers did not identify a deficiency. Figure 4 is reproduced from the report, and outlines the ratings and indicators in detail.

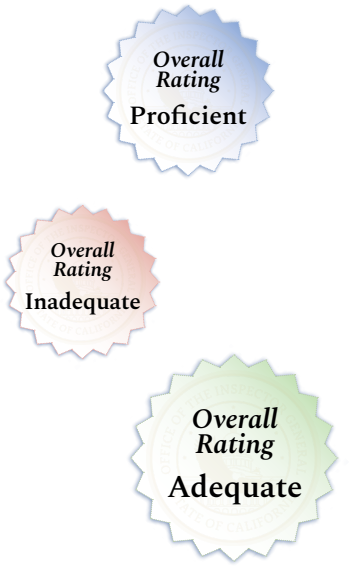
Figure 4. The OIG's Overall Rating of the Department's Reviewing of Its Use-of-Force Incidents



Source: The Office of the Inspector General Tracking and Reporting System.

Cycle 6 Medical Inspection Reports

In 2021, the OIG continued its sixth cycle of medical inspections and published nine reports, one for each of the following institutions: North Kern State Prison; California Medical Facility; Salinas Valley State Prison; Richard J. Donovan Correctional Facility; California Substance Abuse Treatment Facility and State Prison, Corcoran; California Correctional Institution; Folsom State Prison; and Avenal State Prison. Below, Table 1 lists the institutions for which we completed our Cycle 6 inspections and issued final reports in 2021, the month each report was published, and our overall rating for each institution. Through those reports, the OIG made several recommendations to the department to further improve the delivery of medical care to its patients; these recommendations can be viewed on the OIG's dashboard at www.oig.ca.gov. In 2021, the OIG also completed inspections of the following 12 institutions: California Correctional Institution; Avenal State Prison; Kern Valley State Prison; Central California Women's Facility; Centinela State Prison; Pelican Bay State Prison; California Institution for Women; High Desert State Prison; California Men's Colony; Correctional Training Facility; Calipatria State Prison; and California State Prison, Sacramento. We anticipate publishing inspection reports for several of these institutions in 2022.



Styling for the rating seals used in MIU reports as introduced for Cycle 6

Table 1. The Office of the Inspector General Cycle 6 Medical Inspections: Final Reports Published in 2021

Adequate
Inadequate

Institution Inspected	Publication Month	Overall Rating
California State Prison, Corcoran	April	Inadequate
California Medical Facility	May	Inadequate
North Kern State Prison	May	Adequate
Salinas Valley State Prison	June	Inadequate
Richard J. Donovan State Prison	July	Adequate
Substance Abuse Treatment Facility	September	Inadequate
California Correctional Institution	November	Inadequate
Folsom State Prison	November	Adequate
Avenal State Prison	November	Adequate

Source: The Office of the Inspector General medical inspection results.

Whistleblower Retaliation Claims

In addition to receiving complaints as described in the preceding paragraphs, our statutory authority directs us to receive and review complaints of whistleblower retaliation that departmental employees levy against members of departmental management. The OIG analyzes each complaint to determine whether it presents the legally required elements of a claim of whistleblower retaliation—that the complainant blew the whistle (reported improper governmental activity or refused to obey an illegal order)—and that the complainant was thereafter subjected to an adverse employment action because he or she blew the whistle. If the complaint meets this initial legal threshold, our staff investigate the allegations to determine whether whistleblower retaliation occurred. If the OIG determines the department's management subjected a departmental employee to unlawful retaliation, our office reports its findings to the department along with a recommendation for appropriate action.

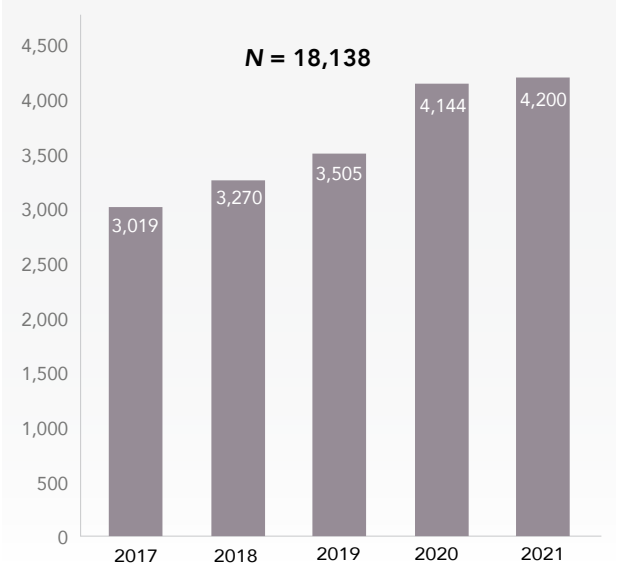
Due to public misperception regarding what constitutes whistleblower retaliation, few complaints present the legally required elements to state an actionable claim of whistleblower retaliation. To counteract this misunderstanding, we engage with complainants to educate them regarding the elements of a whistleblower retaliation claim, invite complainants to supplement their complaints with any necessary information, and correspond with complainants to clarify any questions we have regarding the information they submitted.

In 2021, the OIG received 23 retaliation complaints. The OIG completed analyses of 21 of those complaints and determined that 20 did not state the legally required elements of a whistleblower retaliation claim. The one complaint that stated a *prima facie* case of whistleblower retaliation is being investigated by another State agency. The OIG completed analyses of one complaint pending from 2018, four pending from 2019, and two pending from 2020. None stated the legally required elements of a whistleblower retaliation claim. Two complaints received in 2021 remain pending.

Complaint Intake

The OIG maintains a statewide complaint intake process that provides a point of contact for expressing allegations of improper activity within the department. We receive complaints from incarcerated persons, parolees, family members of incarcerated persons and parolees, departmental employees, advocacy groups, and other complainants. Complaints are submitted via letter, toll-free phone call, or email through our website. We screen all complaints within one business day of receipt to identify safety concerns, medical or mental health concerns, or reports of sexual abuse.

Figure 5. Total Complaints the Office of the Inspector General Received Over the Past Five Years, From 2017 Through 2021



Source: The Office of the Inspector General.

In 2021, the OIG received over 4,200 complaints. For nearly every complaint, OIG intake staff created a numbered record in our tracking and reporting system and detailed the OIG's response. Our office was not authorized to conduct investigations; however, our staff conducted inquiries by accessing information from various departmental databases, reviewing the department's policies and procedures, or requesting relevant documentation from institutions. In most cases, we provided a written response to the complainant after conducting our review or inquiry.

Data

Over 85 percent of all complaints came from incarcerated persons across the state. Citizen complainants made up roughly 13 percent of cases. The OIG received the remaining complaints from departmental employees, anonymous persons, parolees, Department of Juvenile Justice wards, or other individuals.

We received over 70 percent of the complaints by mail. The remainder was received as either web complaints (approximately 400) or voicemail messages (approximately 900). The number of voicemail messages did not include voicemails in which the caller hung up before speaking or made unintelligible sounds during the entire recording.

We categorized most complaints into one of eight categories, as shown in Figure 6 on the following page. Staff misconduct and the grievance process were the most common categories.

For more than 3,500 cases, our staff analyzed the alleged activity, reviewed departmental policies and procedures, reviewed the incarcerated person's case file, or requested additional documentation from the department. Our inquiry usually resulted in our advising complainants how to address their concerns with the department. Common examples of such advice included instruction on navigating the department's grievance, disciplinary, and visiting processes. Our advice occasionally included instruction on how to contact specific departmental divisions and offices to obtain services or additional help.

Complaint Examples

The following paragraphs summarize a sample of preliminary inquiries we completed in 2021. These samples exemplify the most common types of allegations our office received. They also demonstrate the types of assistance we provided to complainants or the steps we took to address the concern with the department.

Vague or Undetermined Complaints

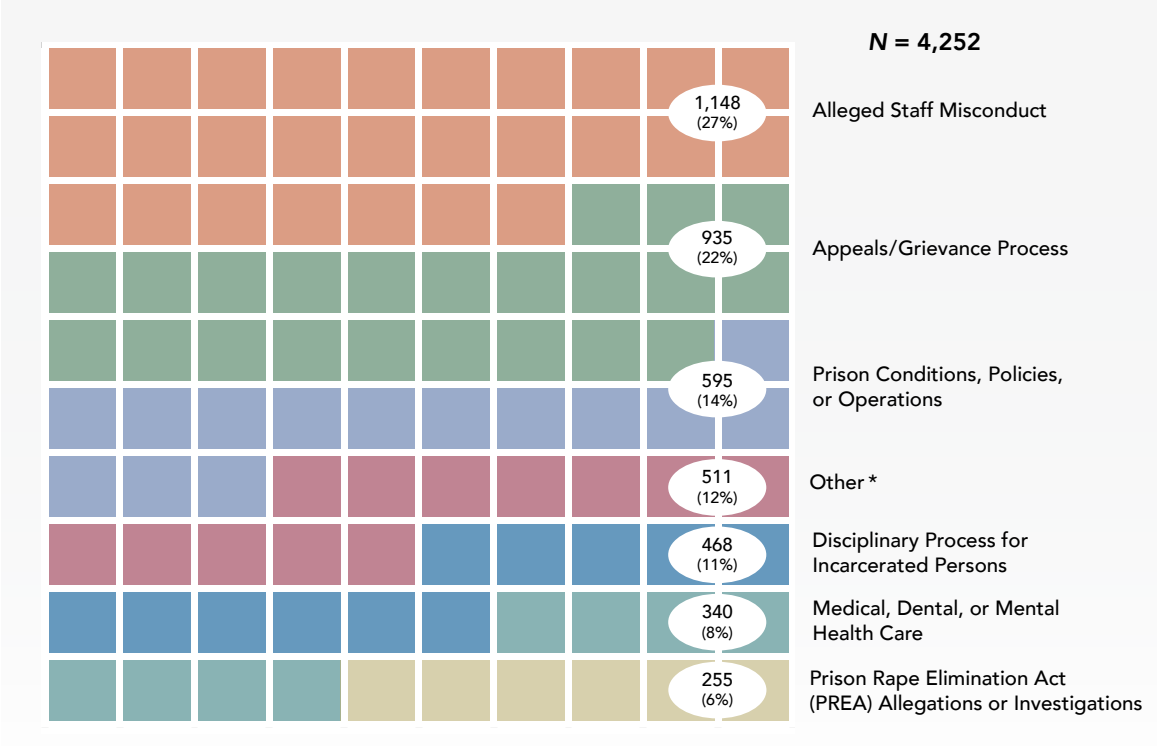
The OIG continued receiving complaints that were too vague for our staff to determine the complainant's allegation or which did not provide enough information for us to review the allegation. These complaints often did not include names, dates, or descriptions of the alleged misconduct. In many cases, the OIG informed complainants their complaints lacked sufficient

information and encouraged them to resubmit the complaints with additional description and documentation.

In one such example, we received a call from an incarcerated person claiming he had been a victim of retaliation and that staff at his institution were violating his due process rights. The incarcerated person further alleged that staff issued fictitious disciplinary reports against him after he reported officers' use of unnecessary force. The complainant did not provide names, dates, or further details.

Some callers simply left their name and number and stated general misconduct had been occurring within their institutions. Some incarcerated persons left voicemails on our complaint line about issues that had already been resolved. Some complainants did not provide accurate information. These types of complaints overwhelmed the OIG intake process. They not only interfered with our office, but negatively affected incarcerated persons who had legitimate complaints.

Figure 6. Distribution of Amounts and Types of Complaint Allegations the Office of the Inspector General Received in 2021



* Includes the following categories: 468 No Jurisdiction/Undetermined (11%) and 43 Employee Issues (1%).

Note: The amounts shown above are approximations.

Source: The Office of the Inspector General.

Medical, Dental, or Mental Health Care

Complaints in this category often involved allegations of poor care or lack of access to care. Complainants also expressed disagreement with decisions made by medical professionals. Several patients indicated they had chronic illnesses and lacked access to medical care. However, after reviewing institutional records, we verified those patients were, in fact, receiving medical care, and we informed them of this. Further, we advised them to file a request for service (Form 7362 or Health Care Appeal) if they continued to lack access to care.

We received a complaint from an incarcerated person stating "they" were trying to kill him by poisoning his food. We sought information within the department's databases verifying mental health or custody staff were aware of these allegations concerning this individual's safety, but were unsuccessful. We, therefore, sent a routine mental health evaluation request to the chief of mental health. Mental health professionals assessed the patient and found he was not a participant in the mental health treatment program. Based on the mental health staff's assessment, the patient was referred to mental health services.

Grievance Process

Concerns with the grievance process generally involved disagreements with how the department handled a grievance or appeal. They also involved grievances that were still in progress.

The grievance process is designed to provide the incarcerated population an opportunity to rectify issues arising within their institutions. In general, incarcerated persons must attempt to address their concerns either informally or formally at their institutions via the grievance process. However, many incarcerated persons attempted to bypass this process by contacting the OIG about issues for which they had not filed a grievance or by informing us of an issue while a grievance was pending. In these cases, we advised complainants they needed to exhaust their administrative remedies before we could address their concerns. However, when incarcerated persons contacted the OIG regarding access to administrative remedies, we could assist. For example, one incarcerated person contacted the OIG and provided a grievance log number, indicating she had filed a complaint, but had not received a response in more than six months. The incarcerated person further alleged staff did not know where her grievance form was located. The OIG conducted research, communicated with the department, and

found a miscommunication had occurred during the "redirect" process between the department's office of grievances and California Correctional Health Care Services' (CCHCS) health care correspondence and appeals branch. The institution had no record indicating the grievance was received by the health care grievance officer. Because we contacted CCHCS and explored the matter further, CCHCS opened a case at the headquarters level and resolved to respond to the patient immediately. We responded to the incarcerated person, informing her she would receive a response to her grievance within the next couple of weeks and to contact our office again if she did not.

Another incarcerated person complainant expressed issues with the administrative remedies process. He had filed a grievance alleging a Prison Industry Authority (PIA) supervisor directed a racist remark toward him; however, the Office of Grievances informed him that PIA employees were outside the jurisdiction of the institution's grievance process. The OIG contacted PIA and discovered the grievance was not forwarded to its office as policy required. PIA staff processed the grievance and met with staff involved in the incident. The involved staff member received counseling, and PIA reported communicating this information to the incarcerated person. We then sent a response to the incarcerated person informing him of the results of our review and of our communication with PIA staff.

Prison Conditions, Policies, or Operations

We received a significant number of complaints regarding living conditions, records information, mail and property, classification and transfers, and access to rehabilitative programs.

One complaint received from an incarcerated person indicated that because the kitchens at his institution were not properly cleaned and inspected, they were infested with cockroaches and mice. Ordinarily, for such a complaint, we would advise the complainant to try to resolve the issue via the administrative process. However, the complainant indicated the grievance process had not resolved the issue and provided tangible evidence (photocopy and details) to support his claims. Consequently, we went on-site, inspected the prison's kitchens, and photographed the unsanitary practices. We then sent recommendations to the correctional business manager (CBM) to use more rodent traps in food storage areas and to spray those areas for cockroaches. In addition, we recommended "food slop" be stored in more secure containers than those currently used. Lastly, we recommended

the vector abatement program include a more formal reporting process by which the CBM would be more routinely notified of monthly vector abatement efforts and pertinent results, especially those concerning food preparation and storage areas. After providing these recommendations, we were informed by the facility that the contracted vendor had begun laying more traps; that the prison had ordered 69 bins including lids for the "food slop" area; and that the contracted vendor intended to provide monthly updates to the CBM.

One of the complaints we received was submitted by an incarcerated person who credibly claimed to be experiencing poor living conditions due to extreme heat and a nonfunctioning air conditioning system in one of the facilities. Due to the serious health and safety concerns, our team expeditiously contacted the institution and learned work orders were in place to fix the air conditioning system. Further, plant operations staff confirmed the air conditioning units were restored and parts were replaced promptly.

Staff Misconduct

Staff misconduct allegations included discourteous treatment, harassment, intimidation, threats, excessive force, or other violations of departmental policy by correctional officers and staff.

One third-party complainant alleged multiple officers used excessive force on her son, who was incarcerated. She claimed officers threw her son down onto his face and broke his hand while he was in handcuffs. We verified an incident occurred on the date and time the third party alleged and, according to departmental medical records, the incarcerated person fractured one of his fingers. Our OCI staff forwarded the complaint to our Force Accountability and Compliance Team (FACT). One of our FACT inspectors attended the institutional executive review committee meeting and watched the original incident videos. We did not identify misconduct in staff's use of force in this incident.

Disciplinary Process

When filing complaints about the disciplinary process, complainants often disagreed with the outcome of a disciplinary action or with the lack of due process during the disciplinary process.

The OIG received many complaints from incarcerated persons alleging they received false rules violation reports (RVRs). In most

of the cases we researched and reviewed, we found incarcerated persons either did not wait until their RVR had been heard to file a grievance or filed a grievance after the 30-day time period in which the grievance was to have been filed.

Because we were not authorized to conduct investigations, in most cases, we encouraged incarcerated persons who disagreed with the disciplinary process to utilize and exhaust their administrative remedies within the prison.

Prison Rape Elimination Act

In 2021, the department notified us of reports regarding serious incidents, including those involving alleged sexual misconduct, commonly referred to as Prison Rape Elimination Act (PREA) allegations. The reports included allegations of nonconsensual sexual acts, abusive sexual acts, sexual harassment, and sexual misconduct. As shown in Table 2 (below), we received 1,380 sexual incident reports, a substantial increase from the 999 we received in 2020. The department also notified us of 277 critical incidents related to sexual misconduct or sexual harassment allegations made against a departmental staff member, a slight increase from the 256 received in 2020.

Table 2. Sexual Misconduct Allegations

Type	Incident	Sexual Incident Report	Critical Incident Notification
Incarcerated Person-on-Incarcerated Person	Nonconsensual Sexual Acts	266	12*
	Abusive Sexual Acts	166	0
	Sexual Harassment	179	0
	Subtotal	**611**	**12**
Staff-on-Incarcerated Person	Sexual Misconduct	406	153
	Sexual Harassment	338	111
	Subtotal	**744**	**264**
Unknown	**Unknown**	**25**	**1**
Total Sexual Misconduct Allegations		**1,380**	**277**

* The department is not required to notify the OIG concerning allegations made by incarcerated persons against other incarcerated persons as they are reported separately via sexual incident reports.

Source: The Office of the Inspector General Tracking and Reporting System.

According to departmental policy, an incarcerated person may report an allegation of sexual violence, sexual misconduct, or sexual harassment to any staff member, verbally or in writing, via the department's grievance process, the sexual assault hotline, or a third party. In addition, an incarcerated person may report these allegations directly to the OIG's ombudsperson for sexual abuse in detention elimination. Any departmental employee who observes an incident or receives a report by a victim must complete the required reports, including a sexual incident report. A trained departmental investigator must investigate the claims and the institution's hiring authority must review the results.

In 2021, our staff reviewed over 230 complaints received directly from incarcerated persons, family members, and third parties alleging sexual misconduct or sexual harassment. For example, an anonymous incarcerated person reported that an officer removed PREA screens (privacy screens) from a facility. Subsequently, we sent a PREA notification to the PREA coordinator and compliance manager at the institution. Our inspectors promptly verified all PREA screens were set up at the specified facility.

Monitoring *The Blueprint*

California Penal Code section 6126 mandates that the OIG periodically review the delivery of the reforms the department identified in its 2012 report, *The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight, and Improve the Prison System* (the *Blueprint*). In January 2016, the department issued *An Update to the Future of California Corrections* (the *Update*), which provided a summary of the goals identified in the initial *Blueprint*, the progress made, and the department's vision for future rehabilitative programming.

In late 2021, we released our twelfth *Blueprint* Monitoring Report. Of the five key *Blueprint* components the OIG monitored, the department previously achieved a 100 percent adherence rate for maintaining custody staffing patterns that matched budgeted levels and for implementing its classification score system for incarcerated persons. Our 2020 and 2021 reports evaluated the remaining *Blueprint* components: adhering to the standardized staffing model for educational programs and increasing the total number of incarcerated persons served in rehabilitative programs. This report also addressed the changes made in rehabilitative program expansion, specialized housing, gang management, and population management following the *Update*.

To collect data for our report, we visited each of the department's 35 adult institutions in March 2021 and reviewed and reconciled departmental documents, interviewed staff, and observed departmental programs in operation. Of note, these on-site visits occurred during the COVID-19 pandemic. Beginning in March 2020, the department suspended all Division of Rehabilitative Programs (DRP) treatment programming. By June 2021, most institutions had resumed limited in-person programming.

Findings

Of the 35 institutions, 16 had an academic instructor vacancy rate of 10 percent or below; 10 had rates between 11 percent and 20 percent; four had rates between 21 percent and 30 percent; two had rates between 31 and 40 percent; and three had rates between 41 and 50 percent. Notably, Deuel Vocational Institution had a vacancy rate of 50 percent at the time of our review, but it was in the process of being deactivated; its deactivation was completed September 30, 2021.

- Of the 35 institutions, 13 had a career technical education instructor vacancy rate of 10 percent or below; eight had rates between 11 and 20 percent; two had rates between 21 and 30 percent; six had rates between 31 and 40 percent; four had rates between 41 and 50 percent; and two had rates above 50 percent.
- The department reported that it sent 15,863 California Identification Card program applications to the Department of Motor Vehicles (DMV) for processing between July 1, 2020, and June 30, 2021. The DMV approved and issued 12,196 identification cards (77 percent of applications). The department released 8,726 individuals with an identification card (72 percent of approved applications), while the remaining 2,996 were released without an identification card.
- The department projected a reduction of approximately 10,600 incarcerated persons by 2021–22, as a result of the implementation of Proposition 57. The department reported that between July 2020 and June 2021, it released a total of 17,804 people due to their advanced release date authorized by Proposition 57. According to the department, those individuals earned an estimated average of 173.6 days of additional credit, excluding incarcerated persons released from fire camps.

Special Reviews

The Office of the Inspector General completed two special reviews in 2021, the first of which was the third in a series of reports we began issuing in 2020. In it, we examined the department's response to the novel coronavirus (COVID-19) and the public health disaster that ensued when the department transferred incarcerated persons among its prisons. We also issued five reports to the court that followed up on these three previous reports. The second special review investigated the department's staff complaints monitoring process.

Staff Complaints Monitoring

A small team of OIG staff provided contemporaneous oversight of the department's process for reviewing and investigating incarcerated persons' allegations of staff misconduct, which are referred to as *staff misconduct grievances*. On February 16, 2021, we issued a report titled *The California Department of Corrections and Rehabilitation: Its Recent Steps Meant to Improve the Handling of Incarcerated Persons' Allegations of Staff Misconduct Failed to Achieve Two Fundamental Objectives: Independence and Fairness; Despite Revising Its Regulatory Framework and Being Awarded Approximately $10 Million of Annual Funding, Its Process Remains Broken.* This publication reviewed the department's new unit dedicated to performing inquiries (or investigations) into such allegations: the Allegation Inquiry Management Section (AIMS); it also served as a progress report on the department's implementation of its new process for handling such allegations.

Two years earlier, on January 24, 2019, we had issued a report titled *Special Review of Salinas Valley State Prison's Processing of Inmate Allegations of Staff Misconduct*, in which we concluded that Salinas Valley State Prison's handling of incarcerated persons' allegations of staff misconduct was inadequate. More than half the inquiries into the allegations we reviewed were performed inadequately because prison staff who investigated the allegations did not follow sound practices in conducting interviews, collecting evidence, and writing reports. We also concluded that reviewers' bias in favor of coworkers contributed significantly to the inadequacy of their investigative efforts.

We recommended the department consider a complete overhaul of its process statewide. Specifically, we urged the department to reassign the responsibility of conducting staff misconduct inquiries to employees who work outside the prison's command

structure. We also urged the department to adopt a regionalized staffing model, so staff members performing inquiries at prisons would not be located at those prisons and would not work in facilities with staff whose actions they investigate.

In response, the department submitted a budget proposal to the California State Legislature requesting $9.8 million in ongoing additional funding to perform inquiries into incarcerated persons' allegations of staff misconduct through a new unit, AIMS as noted above. In June 2019, the Governor and the legislature approved the department's proposal as part of the State's 2019–20 Budget Act. The department subsequently developed new regulations and procedures for handling grievances involving staff misconduct.

Highlights of our 2021 review include the following:

We remain concerned about the independence of the department's process, as most staff misconduct grievances were handled internally, at the prisons; the department's newly created Allegation Inquiry Management Section handled few staff misconduct grievances even though it should have handled many more. The department formed AIMS as an independent entity outside the prisons' chain of command; its purpose is to investigate possible misconduct committed by prison staff. However, prisons largely avoided using AIMS and instead investigated most complaints internally. Because we also established a new unit to monitor the handling of staff complaints by predominantly monitoring AIMS, the prisons' lack of referrals to AIMS has, essentially, circumvented our oversight process.

- Between April 1, 2020, and August 31, 2020, incarcerated persons filed 50,412 grievances; wardens determined that 2,339 of those grievances alleged staff misconduct (4.6 percent) and referred 541 of the 2,339 to AIMS (23 percent).
- By failing to refer the remaining 1,798 staff misconduct grievances (77 percent) to AIMS, wardens undermined the purpose of this newly established unit.
- The department's budget proposal, which had requested $9.8 million in additional funding, provided AIMS with 47 new positions, 36 of which were investigator (lieutenant) positions. The persons in those positions were each expected to perform about 13 inquiries per month. The department projected that AIMS would perform 474 inquiries per month and 5,690 inquiries per year.

- In the first five months that AIMS was fully operational, AIMS accepted for inquiry only 86 inquiries per month (18 percent of the projected volume); however, prisons received 468 staff misconduct grievances per month, nearly equal to the volume the department projected AIMS could perform.
- AIMS unnecessarily returned to the prisons many of the staff misconduct grievances that wardens referred. Of the 541 staff misconduct grievances wardens referred to AIMS, the new unit returned 113 (21 percent) without conducting an inquiry.

The department's process for determining where to route staff misconduct grievances is overly complex and subjective, diverts staff misconduct grievances from the Allegation Inquiry Management Section, and lacks oversight. The department requires staff to make numerous subjective decisions to screen grievances before the grievances reach AIMS; at each screening juncture, more grievances are diverted away from AIMS' independent investigative process. All those decisions occur without oversight.

The department defines the term *staff misconduct* as an allegation that staff violated a law, regulation, policy, or procedure, or acted contrary to an ethical or a professional standard that would, more likely than not, lead to adverse disciplinary action if it were found to be true. Prison staff must apply subjective interpretations of the term *staff misconduct* to determine where to route a grievance. To further determine where to route each grievance, wardens must subjectively determine whether an allegation is likely to be true before any investigation occurs.

AIMS returned various types of staff misconduct grievances without conducting investigations. Despite regulations requiring AIMS to conduct an allegation inquiry into every staff misconduct grievance it receives, AIMS returned without investigation many grievances that fit certain categories it used to screen referrals. The following list presents the types of staff misconduct that AIMS returned uninvestigated, despite having no reasonable justification for doing so:

- Allegations of excessive use of force that staff self-reported which did not result in serious bodily injury; sexual misconduct or harassment; due process violations during the disciplinary process; disagreement with staff's decisions during the disciplinary process; false rules violation reports;

and staff misconduct related to the Americans With Disabilities Act's (ADA) reasonable accommodation process

- Allegations filed more than 30 days after the misconduct allegedly occurred
- Allegations for which AIMS overruled the warden's determination that the accused staff would likely incur adverse disciplinary action were the allegations proven true

Rather than perform a complete inquiry into a staff misconduct grievance, investigators abruptly stop their work as soon as they form a reasonable belief that staff misconduct had occurred. AIMS investigators conduct interviews and gather evidence to help wardens determine whether an allegation is likely true; however, when an investigator forms a reasonable belief misconduct occurred, the department requires the investigation be terminated—even though it is incomplete—and a report be sent immediately to the warden for review. Terminating an inquiry before gathering all evidence and interviewing all witnesses precludes investigators from discovering relevant evidence and may cause allegations to pass uninvestigated.

Fewer than two percent of staff misconduct allegations were found to have merit, resulting in a policy violation; the low rate at which wardens determined their staff had violated policy and the department's use of ambiguous language to track the results of its reviews raises serious concerns about the fairness and transparency of the process. The department could not produce a report showing the number of inquiries that resulted in policy violations. We reviewed, as an alternative, a departmental report that showed the number of staff misconduct allegations that wardens had resolved, including those labeled as approved (as those would be the only ones capable of including a violation of policy).

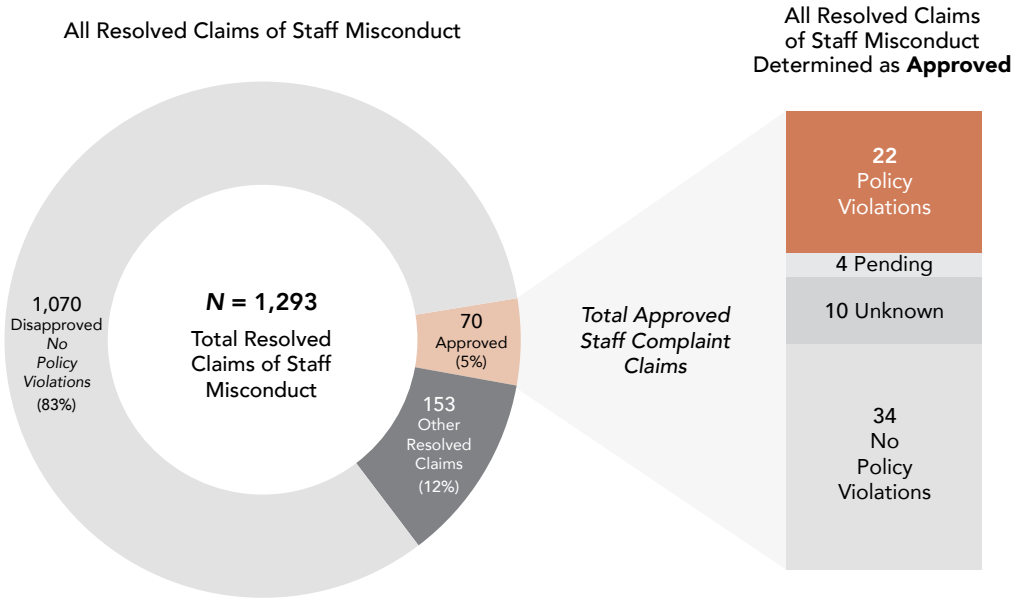
Of the 1,293 allegations the department resolved between June 1, 2020, and August 31, 2020, only 70 (5.4 percent) were labeled approved. Our closer inspection of those 70 approved allegations, however, revealed that only 22 were found to actually contain policy violations, or 1.7 percent of the total 1,293 (see Figure 7, next page, bottom).

Weaknesses in the department's data collection and tracking process limit the department's ability to effectively analyze trends and self-assess its process for handling staff misconduct grievances. The department maintains numerous information systems that capture data regarding the staff misconduct

grievance process, but none of these systems can produce basic management reports that enable managers to perform meaningful trend analyses or assessments of the process. The department cannot produce basic reports necessary to successfully manage the process from a statewide perspective, including any of the following:

- The number or names of staff who have been accused of misconduct by incarcerated persons
- The names of staff found to have violated a policy in connection with a staff misconduct grievance allegation
- Any actions taken against staff to rectify any related policy violations

Figure 7. Very Few of the Department's Resolved Claims of Staff Misconduct Resulted in Policy Violations During the Three-Month Period From June 1, 2020, Through August 31, 2020



Disapproved The reviewing authority found by a preponderance of the evidence available that all applicable policies were followed and that all relevant decisions, actions, conditions, or omissions by the department or departmental staff were proper.

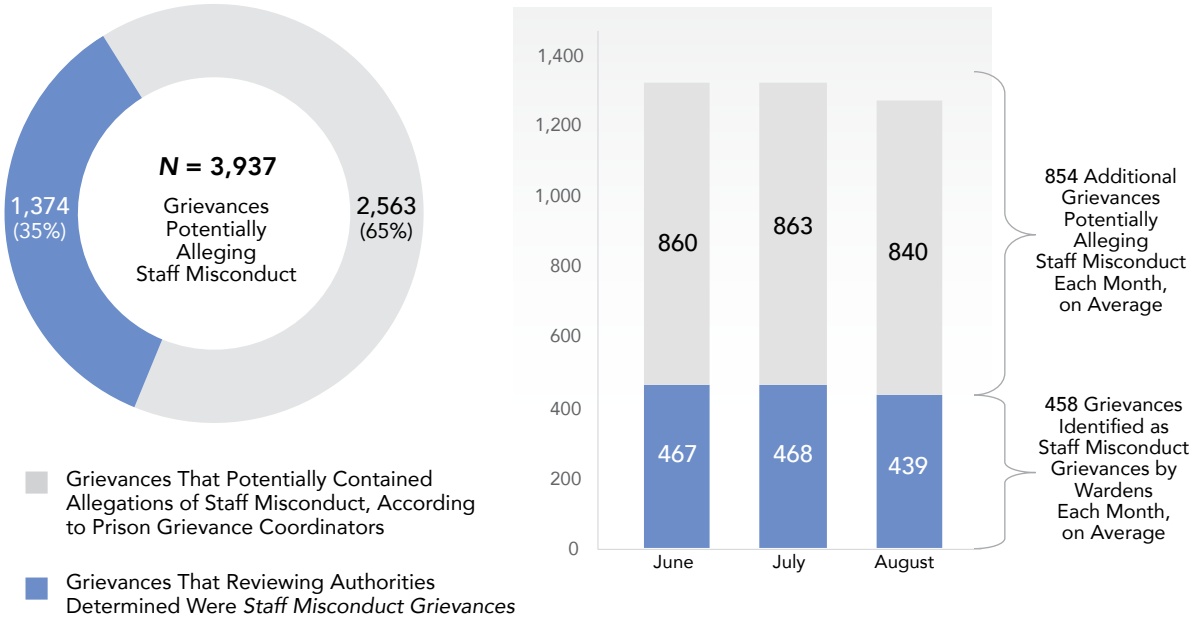
Approved The reviewing authority did not find by a preponderance of the evidence available that all applicable policies were followed or that all relevant decisions, actions, conditions, or omissions by the department or departmental staff were proper.

Other Resolved Claims We are using the term *resolved* to include grievance decisions of *approved*, *disapproved*, *rejected*, and *time expired*. We exclude unresolved claims categorized as *no jurisdiction*, *reassigned*, *redirected*, and *under investigation*. *California Code of Regulations*, Title 15, Section 3483(i), "Grievance Review."

Source: The Office of the Inspector General's analysis of the California Department of Corrections and Rehabilitation's grievance data associated with its 35 prisons.

Because of the department's subjective internal grievance review process, wardens may have misclassified as routine thousands of grievances potentially alleging staff misconduct in just a three-month period, bypassing the allegation inquiry process and raising concerns about underreporting and data collection. Wardens overruled grievance coordinators more than two-thirds of the time to reclassify nearly 2,600 staff misconduct grievance allegations in three months as merely routine (see Figure 8, below). At this rate, the annualized number of staff misconduct grievances may be as high as 10,000 more than reported by the department.

Figure 8. Wardens Frequently Overruled Grievance Coordinators When Determining Whether a Grievance Alleged Staff Misconduct, Leading Us to Believe the Actual Number of Staff Misconduct Grievances Was Much Higher Than Reported During the Three-Month Period From June 1, 2020, Through August 31, 2020



Note: Prior to June 2020, the department did not track the number of grievances categorized as *staff misconduct* by grievance coordinators.

Source: The Office of the Inspector General's analysis of the California Department of Corrections and Rehabilitation's Offender Grievance Tracking System data for June 1, 2020, through August 31, 2020.

The department should require incarcerated persons to submit staff misconduct grievances directly to AIMS to increase the independence and, ultimately, the fairness of the process. To provide greater independence and consistency, and increase the legitimacy of the staff misconduct grievance process, we recommend, among other things, that the department restructure

its grievance routing process so that incarcerated persons submit allegations of staff misconduct directly to AIMS, bypassing prison staff's subjective determinations. The department should also establish a new central intake function specifically for AIMS so that it can consistently process all allegations of staff misconduct arising from this process.

A Special Review Series Concerning COVID-19 in the California State Prisons

In April 2020, the Speaker of the California Assembly requested that the OIG assess the policies, guidance, and directives the department had implemented since February 1, 2020, in response to COVID-19. The Speaker asked us to focus on three concerns:

1. The department's screening process for individuals entering a prison or facility in which incarcerated persons are housed or are present,

2. Its distribution of personal protective equipment (PPE) to departmental staff and incarcerated persons, and

3. How it treats incarcerated persons who are suspected to have either contracted or been exposed to COVID-19.

Two of our reports were issued in 2020; part one focused on the process of screening individuals entering a prison or facility in which incarcerated persons were housed or present (issued August 2020), and part two focused on the department's distribution of PPE to staff and incarcerated persons (issued October 2020). In February 2021, we issued our third and final report in the series, which focused on the department's treatment of incarcerated persons who were suspected to have either contracted or been exposed to COVID-19. As part of our review, we focused our efforts on a particular decision by the department and California Correctional Health Care Services (CCHCS) to transfer 189 incarcerated persons from the California Institution for Men to California State Prison, Corcoran (Corcoran) and to San Quentin State Prison (San Quentin), and the subsequent disastrous effects.

Part Three: California Correctional Health Care Services and the California Department of Corrections and Rehabilitation Caused a Public Health Disaster at San Quentin State Prison When They Transferred Medically Vulnerable Incarcerated Persons From the California Institution for Men Without Taking Proper Safeguards

When the COVID-19 pandemic began in March 2020, the California Institution for Men was one of the first prisons to face a significant outbreak. At the time, the California Institution for Men had a significant population of medically vulnerable incarcerated persons. In an effort to protect those individuals, the department transferred 189 vulnerable incarcerated persons to Corcoran and San Quentin between May 28, and May 30, 2020.

We found the process of transferring incarcerated persons was flawed and risked the health and lives of thousands of incarcerated persons and staff. Pressure from both CCHCS and departmental management to complete the transfers resulted in poor planning and insufficient time for the receiving prisons to prepare. An example of the poor planning was the department's reliance on outdated COVID-19 test results, as some results were nearly one month old at the time of the transfer.

Nursing staff conducted temperature screenings the day of the transfers and, in some cases, several hours before the incarcerated persons boarded the transfer buses. As a result, some incarcerated persons may have exhibited symptoms of COVID-19 before their departures to the receiving institutions. The department also made a decision to exempt the sending prison from limiting the number of incarcerated persons on the buses. The transfer buses were overcrowded, which significantly reduced passengers' ability to practice physical distancing during the several-hours-long ride to their destinations.

Once incarcerated persons arrived at San Quentin, nursing staff identified that two of the transferees were exhibiting symptoms consistent with COVID-19. Most of the incarcerated persons who arrived at San Quentin were placed in a housing unit without solid doors, where air could freely flow from one cell to the next. Prison staff eventually tested the incarcerated persons who transferred from the California Institution for Men and determined that several tested positive for COVID-19 infection, as did other incarcerated persons already housed in the same housing unit on different tiers (see Figure 9, next page).

Figure 9. Test Results for Incarcerated Persons Housed in San Quentin's South Block Facility's Badger Housing Unit on May 31, 2020,
Who Tested Positive for COVID-19
Between May 31, 2020, and August 6, 2020

N = 321

	Transferred		Not Transferred	
P = Positive N = Not Positive	P	N	P	N
Tier 5	53	17	0	0
Tier 4	38	9	0	0
Tier 3	0	0	30	40
Tier 2	0	0	27	43
Tier 1	0	2	29	33

Photograph by the Office of the Inspector General.

Note: Of the incarcerated persons who transferred from the California Institution for Men to San Quentin, 119 were housed on tiers 1, 4, and 5 in the prison facility's Badger housing unit along with 202 incarcerated persons who were already housed in the unit.

Source: Unaudited data provided by the California Department of Corrections and Rehabilitation to support its COVID-19 population tracker and housing data from the Strategic Offender Management System.

The prison's inability to quarantine incarcerated persons who had tested positive led to several thousand individuals testing positive for the virus, including prison staff. In contrast, Corcoran had a much smaller outbreak, likely because the incarcerated persons who transferred from the California Institution for Men were housed in a unit with solid doors.

When both San Quentin and Corcoran began identifying incarcerated persons who had tested positive for COVID-19, neither prison conducted meaningful contact-tracing investigations. San Quentin stated that the emergence of a significant number of positive cases occurring over a short period of time had affected its ability to perform contact tracing.

Corcoran's contract-tracing efforts were also limited. Due to their inability to thoroughly conduct contact tracing, both prisons may have failed to alert some of the close contacts of infected individuals, thereby potentially increasing the spread of the virus.

To the credit of both CCHCS and the department, the lessons learned from transferring incarcerated persons to San Quentin and to Corcoran resulted in the department establishing policy changes designed to reduce the potential for future outbreaks.

U.S. Federal Court Follow-Up: Face-Covering Mandate

Our October 2020 report on the department's lack of compliance with face-covering and physical-distancing policies for both staff and incarcerated persons resulted in a request from the U.S. Federal court that the OIG conduct unannounced inspections at the department's 35 adult institutions and three juvenile facilities. We were specifically asked to observe compliance with the department's policies regarding face coverings and physical distancing. We also monitored disciplinary actions the prisons took as a result of staff's and incarcerated persons' failures to follow face-covering and physical-distancing policies. The OIG developed an inspection program and began conducting the inspections.

We issued five reports to the court that covered the department's compliance from December 2020 through April 2021. (The OIG completed the five reports at the request of the federal court. Although the reports were not published on our website, they are part of the public record in the case entitled *Plata, et al.* v. *Newsom, et al.*, USDC Case No. 4:01-cv-01351-JST.) These reports included OIG staff's observations regarding the extent to which incarcerated persons and staff complied with face-covering and physical-distancing policies, and any other significant observations we noted. We measured compliance using a scale of full compliance, substantial compliance, partial compliance, and significant noncompliance. In general, we found that most staff maintained full or substantial compliance, and staff compliance generally improved during each round of inspections. However, within the incarcerated person population, we found most prisons had partial or significant noncompliance, and we generally did not see significant improvement during our inspections within the incarcerated population.

Our inspectors also reported on observations of significance during their inspections, several of which are as follows:

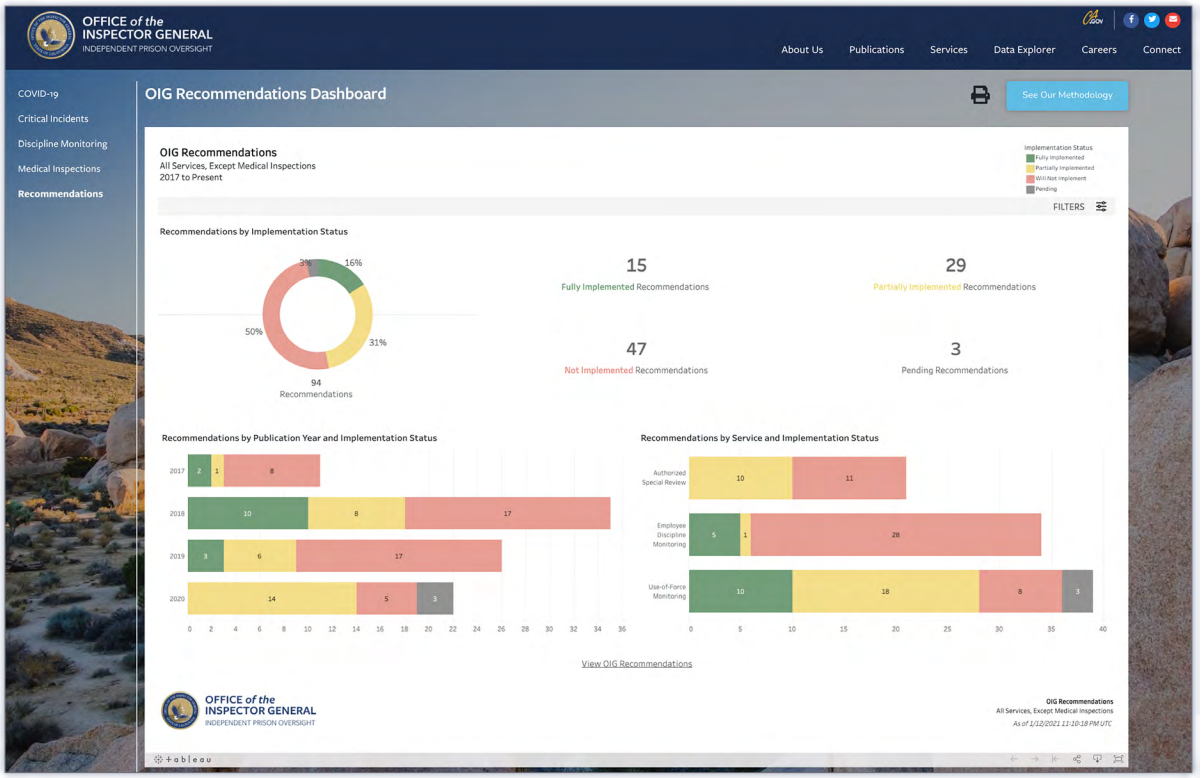
- Our staff observed incarcerated culinary workers not wearing their face coverings correctly at three prisons: California State Prison, Solano; California Substance Abuse Treatment Facility and State Prison, Corcoran; and High Desert State Prison. The workers wore their face coverings below their noses or on their chins while preparing food. On these occasions, we did not observe prison staff instructing the culinary workers to wear their face coverings properly.
- At multiple prisons, we identified that staff and incarcerated persons had modified how their N95 face coverings fit, which impacted the effectiveness of the face coverings.
- At multiple prisons, we identified large groups of incarcerated persons not wearing face coverings properly, or at all. In some cases, we observed groups of up to 50 incarcerated persons not in compliance.

As part of our inspection process, we requested the department provide the corrective and adverse actions taken against staff and incarcerated persons that related to failure to adhere to the department's COVID-19 protocols. For staff, the most common action was verbal counseling, which constituted nearly 70 percent of the actions we reported in our five reports to the court; the second most common action was written counseling, which constituted nearly 14 percent of the actions we reported in our five reports to the court. The next most common action was letters of instruction—a higher level of action—which constituted nearly 15 percent of the actions taken. Nine staff members received adverse actions, which included both letters of reprimand and termination of employment. Of the disciplinary actions taken against incarcerated persons, nearly 73 percent constituted corrective counseling, the lowest form of disciplinary action. Rules violation reports issued to incarcerated persons numbered nearly 27 percent. Rules violation reports are a higher level of disciplinary action, and these can lead to a loss of privileges for the incarcerated person.

Recommendations Made to the Department

In 2021, the OIG published 18 formal reports, some of which contained recommendations. These recommendations promote greater transparency, process improvements, increased accountability, and higher adherence to policies and constitutional standards. Details concerning the vast number of recommendations made to the department are available on our dashboards, which can be accessed at our website, www.oig.ca.gov. If viewing this report on our website, clicking on the image below will take the reader to the main interactive dashboard web page. Choose from among several filter options to select a specific group of recommendations: publication year, service (authorized/special review; employee discipline monitoring, and use-of-force monitoring), general topic, associated entity, report title, and report number. A separate dashboard is also available on our site that lists the medical inspection report recommendations we have made to both California Correctional Health Care Services and the department.

Exhibit 1. The Office of the Inspector General's Dashboard Recommendations' Module



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Appendix: Publications Released in 2021

Annual and Semiannual Reports

- *2020 Annual Report: A Summary of Reports* (April 2, 2021)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, July–December 2020* (May 19, 2021)
- *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation* (November 18, 2021)
- *Monitoring the Internal Investigations and Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, January–June 2021* (December 14, 2021)

Periodical Reports

Sentinel Cases

- Nº 21–01: *California Department of Corrections and Rehabilitation Prison Investigators Conducted an Inadequate Inquiry Into Allegations Staff Members Failed to Wear Face Coverings and, Despite a Reasonable Belief That Staff Misconduct Occurred, the Warden Failed to Refer the Case to the Office of Internal Affairs for an Investigation* (June 3, 2021)
- Nº 21–02: *The Department Violated Its Own Policy When It Failed to Include a No-Rehire Clause in a Settlement of a Strong Dismissal Case Against a Sergeant Accused of Soliciting a Minor for Sex* (December 2, 2021)

Medical Inspection Reports: Cycle 6 Results

- California State Prison, Corcoran (April 30, 2021)
- California Medical Facility (May 21, 2021)

- North Kern State Prison (May 28, 2021)
- Salinas Valley State Prison (June 25, 2021)
- Richard J. Donovan State Prison (July 23, 2021)
- Substance Abuse Treatment Facility (September 10, 2021)
- California Correctional Institution (November 9, 2021)
- Folsom State Prison (November 16, 2021)
- Avenal State Prison (November 23, 2021)

Special Reviews

- *The California Department of Corrections and Rehabilitation: Its Recent Steps Meant to Improve the Handling of Incarcerated Persons' Allegations of Staff Misconduct Failed to Achieve Two Fundamental Objectives: Independence and Fairness; Despite Revising Its Regulatory Framework and Being Awarded Approximately $10 Million of Annual Funding, Its Process Remains Broken* (February 16, 2021)

COVID-19 Review Series

- *Part Three: California Correctional Health Care Services and the California Department of Corrections and Rehabilitation Caused a Public Health Disaster at San Quentin State Prison When They Transferred Medically Vulnerable Incarcerated Persons From the California Institution for Men Without Taking Proper Safeguards* (February 1, 2021)

The Blueprint Monitoring Report

- *The Twelfth Report Concerning the OIG's Monitoring of the Delivery of the Reforms Identified by the California Department of Corrections and Rehabilitation in Its Report Titled* The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight, and Improve the Prison System *and Its Update* (December 29, 2021)

2021
Annual Report

A Summary of Reports

OFFICE *of the* INSPECTOR GENERAL

Amarik K. Singh
Inspector General

STATE *of* CALIFORNIA
February 2022

OIG