Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

July–December 2014

Volume II

March 2015

Fairness ◆ Integrity ◆ Respect ◆ Service ◆ Transparency

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March 2015

FOREWORD

This 20th Semi-Annual Report covers the time period July through December 2014. 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

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SUMMARY OF OTHER MONITORING ACTIVITIES

In addition to the Office of the Inspector General's monitoring of the employee discipline process within the California Department of Corrections and Rehabilitation (CDCR or the department), reported in Volume I, the Office of the Inspector General (OIG) also monitors critical incidents, use of force, and contraband surveillance watch incidents within CDCR. The OIG reports these monitoring activities here to reduce the overall need for separate reports, and also to give the reader a wider view of OIG-monitored activities in one place.

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

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

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

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

MONITORING CRITICAL INCIDENTS

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

1. Any use of deadly force, including warning shots;
2. Any death or any serious injury that creates a substantial risk of death to an individual in the custody or control of the department, excluding lawful executions [1];
3. Any 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 it. The OIG may make recommendations as a result of its review regarding training, policy, or referral for further investigation of potential negligence or misconduct. If the OIG believes the 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 may monitor the ensuing investigation. Critical incidents are customarily reported in the Semi-Annual Report that follows the incident occurrence. However, if an investigation is initiated, a report may be held at the discretion of the Inspector General until the completion of the investigation if reporting it would potentially negatively impact the integrity of that internal investigation.

During this reporting period, the OIG completed assessments of 131 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 directly correlate to incidents that occurred within this time frame, but rather reflects the number

[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 28 and detailed in Appendix F.

of incidents the OIG has assessed and closed for the time period. There were 53 insufficient ratings overall, 15 of which were insufficient due to late notification. In order to monitor an incident on scene, the OIG relies on the department to provide timely notification that a critical incident has occurred. However, even when notification is untimely, the OIG still remotely monitors the event by collection of reports and follow-up review.

The department provided timely notification for 72 percent of the critical incidents being reported. This is a 20 percent decline in timely notification compared to the previous reporting period. Delays in notification impact the OIG's ability to provide real-time, on-site monitoring and transparency for critical incidents.

IN-CUSTODY INMATE HOMICIDES

In the last Semi-Annual Report, the OIG raised the issue of increasing violence on sensitive needs yards. It is important to note, as previously stated, that the dates of these homicides preceded the case closure and reporting of the events. The actual dates of occurrence were September 24, 2011, through December 7, 2013. More than half of the in-custody homicides involved sensitive needs yard (SNY) inmates even though these yards house only 27 percent of the inmate population and were originally created to prevent violence to those inmates requiring protection from the rest of the population for various reasons.[3] In addition to the listed homicides, there were three in-cell great bodily injury incidents that were against inmates classified as SNY, but that did not result in death. These incidents occurred on February 27, 2014; May 15, 2014; and June 5, 2014.

As previously reported in the OIG's assessments of these events, there are steps the department can take to lessen such risks. Given the current nature of the population on sensitive needs yards, which comprises sex offenders as well as gang dropouts and other general population inmates, the OIG recommended the department consider some additional preventative steps. These included re-examining its double-cell policy for sensitive needs yards, requiring completion of compatibility forms to help ensure that inmates are properly placed with compatible cellmates, and giving potential cellmates the opportunity to document their agreement to house together. Inmates with prior violence toward cellmates should not be double celled, even on an SNY, until each inmate's propensity for violence is considered. Additionally, the OIG recommended the department review the process for transitioning inmates from single-cell designation to double-cell status pursuant to prior OIG recommendations.

In response to the above recommendations, the department agreed to take into consideration the information provided by the OIG, but felt that the OIG's data for two reporting periods, one year, did not provide enough historical data to develop a hypothesis for the number of inmate homicides involving SNY inmates. The department cited the overall number of homicides, which has decreased from 20 in both 2012 and 2013 to nine in 2014. The OIG is not disputing the decrease in the overall homicide rate and hopes it will continue in 2015; however, the overall decrease only highlights the need to examine the disproportionate number of SNY inmate victims. The OIG will continue to monitor and report on the department's response to this issue.

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[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 type of both critical incidents and use-of-force events the OIG monitors. These incidents automatically result in both an administrative and a criminal investigation if the Office of Internal Affairs chooses to conduct a deadly force investigation, the only exception being when the force occurs outside the prison and an outside law enforcement agency conducts the criminal investigation. Appendix D contains each case involving use of deadly force closed in this reporting period, regardless of whether the Office of Internal Affairs was involved.

Any time CDCR staff use deadly force, the department is required to promptly notify the OIG. When the OIG receives timely notice of a deadly force incident, a Special Assistant Inspector General immediately responds to the incident scene to evaluate the department's management of the incident and the department's subsequent deadly force investigation, if initiated.

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

The Office of Internal Affairs' Deadly Force Investigation Team is described and regulated by Title 15, California Code of Regulations, Section 3268(a)(20) which specifically states the Deadly Force Investigation Team need not respond to warning shots that cause no injury.

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

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 a 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 was in compliance 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 OIG closed 46 potentially deadly force incidents. The incidents included the intentional use of lethal weapons, unintentional blows to the head, warning shots, and other uses of force that could have or did result in great bodily injury or death. Each incident is summarized in Appendix D, which

is broken into two categories: Appendix D1 contains cases where the OIG monitored an incident involving warning shots that the Office of Internal Affairs did not respond. Appendix D2 reports cases where the Office of Internal Affairs opened a case that the OIG monitored. There are 39 such cases being reported during this period. The number of cases being reported does not correlate with the actual number of times the Office of Internal Affairs responded on scene during this reporting period, as the OIG only reports a case once all activity is completed.

Of the 39 cases being reported in Appendix D2, the Office of Internal Affairs responded on scene in 35 cases, including six cases where a full Deadly Force Investigation Team responded. In two cases, outside law enforcement conducted the criminal investigation, while the Deadly Force Investigation Team conducted the administrative investigation. One of the cases involved an off-duty incident where a sergeant used his personal firearm to shoot and kill a pit bull dog that was attacking a child, and the other was a case involving a fugitive who engaged in a gun fight with multi-agency task force members.

In response to the OIG's recommendation, the Office of Internal Affairs instituted a pilot project on January 16, 2014, requiring an on-scene response for any incident involving any strike to the head with a baton or impact munition, regardless of injury. Of the 39 cases being reported during this period, July through December 2014, 31 cases involved incidents where a claim was made that the use of less-lethal force resulted in head injuries. In some of these cases, inmates claimed being struck on the head and then later recanted their claims, or the claims were unsubstantiated. Other cases involved custody staff reporting that the baton or impact munition may have inadvertently struck an inmate on the head.

Pursuant to the pilot project, the Office of Internal Affairs responded to all 31 cases involving potential head injuries due to the use of force. Of the 31 total cases, six resulted in inmate transport to an outside hospital for treatment of injuries consisting mainly of lacerations and concussions. None of the incidents resulted in death. The remaining incidents involved injuries such as bruising, redness, swelling, or abrasions that were treated at the institution. In many of the cases, it could not be determined whether the injuries were the result of the use of force as opposed to inmate assaults. In all 31 cases, the Office of Internal Affairs determined the incidents did not meet the requirements for a full deadly force investigation and the investigations were terminated. The OIG concurred with all of these determinations.

While none of these incidents resulted in serious injury or death or subjected the department to major liability, the potential for this type of outcome warranted the pilot program. The Office of Internal Affairs has terminated the pilot project, citing the major expenditure of resources. On February 12, 2015, the Office of Internal Affairs issued a memorandum noting a return to its prior policy. The OIG consulted with the Office of Internal Affairs regarding the pilot project and agreed that the pilot did not produce results justifying the increased use of Office of Internal Affairs resources involved in implementation of the pilot project. However, the OIG will continue responding and monitoring incidents involving the use of potentially deadly force as it has done in the past, and will recommend a Deadly Force Investigation Team be sent by the Office of Internal Affairs on a case-by-case basis if deemed necessary.

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.[4] 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."[5]

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

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

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

Any department employee who uses force, or who observes another employee use force, is required to report the incident to a supervisor and submit a written report prior to being released from duty. After the report is submitted, a multi-tiered review process begins. As part of its oversight process, the OIG reviews each of the reports, including the entire multi-tiered process. The OIG also provides oversight and makes recommendations to the department in the development of new use-of-force policies and procedures.

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

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

The OIG attends as many use-of-force committee meetings that resources allow, but no less than one meeting each month at each prison, juvenile facility, and parole region. During this reporting period the department reported that it held 518 use-of-force committee meetings. Of those, the OIG attended 390.

Use-of-Force Meetings Attended and Incidents Reviewed

During this reporting period, the OIG monitored and evaluated 2,148 use-of-force incidents. In addition, 188 incidents were reviewed more than once due to the cases not being fully prepared upon first review by the IERC. The use-of-force data being reported does not correspond to all of the incidents that occurred. This data is derived only from those incidents that were reviewed and monitored from July through December 2014.

In preparation for a use-of-force meeting, the OIG evaluates all departmental reviews completed prior to the meeting. At each level of review, the reviewer is tasked with evaluating reports, requesting necessary clarifications, identifying deviations from policy, and determining whether the use of force was within policies, regulations, and applicable laws. The levels of review are the initial review conducted by the incident commander; the first level management review conducted by a captain; the second level management review conducted by an associate warden; and the final level of review where the incident is reviewed by the use-of-force review committee, with the ultimate determination made by the institution head or designee. During the meeting, the OIG observes the review process and engages in contemporaneous oversight by raising concerns about the incidents when appropriate, asking for clarifications if reports are inconsistent or incomplete, and engaging in discussions with the committee about the incidents. Through this process the OIG draws an independent conclusion about whether the force used was in compliance with policies, procedures, and applicable laws and whether the review process was thorough and meaningful. Table 1 illustrates the OIG-monitored incidents by the division within CDCR.

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

Division	Number of Incidents Reviewed
Division of Adult Institutions	1,957
Division of Juvenile Justice	155
Division of Parole Operations	33
Office of Correctional Safety	3
Total	**2,148**

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 187 individual cases. The OIG commends the department on its willingness to consider OIG recommendations on the 187 cases to arrive at the appropriate outcome.

In the adult institution cases monitored by the OIG, CDCR found the force used was within policy 92 percent of the time, while the OIG found the force used was within policy 91 percent

of the time. In the juvenile facility cases, both CDCR and the OIG found the force used was within policy 90 percent of the time, and for both parole and the Office of Correctional Safety (OCS), CDCR and the OIG found the use of force to be in compliance in all of the cases reviewed. These numbers are consistent with prior reporting periods and show that of the cases fully prepared for review, the department is able to take meaningful and appropriate action. As noted in previous reports, the department has struggled with timeliness, thorough evaluations, and fact gathering by first and second-level reviewers. In this reporting period, 487 of the cases monitored by the OIG had to be deferred because they were not ready for complete review when they were brought to the use-of-force committee. From these reviews and prior reports, it is apparent that the department should continue efforts to achieve timely reviews.

Department Executive Review Committee (DERC)

Pursuant to Department Operations Manual, Sections 51020.4 and 51020.19.6, and Title 15, California Code of Regulations, Section 3268(18), the DERC is a committee of staff selected by and including the Associate Director of the respective mission-based group of institutions. The DERC has oversight responsibility and final review authority over the Institution Executive Review Committees. The DERC is required to convene and review the following use-of-force incidents:

- Any use of deadly force;
- Every serious injury or great bodily injury;
- Any death.

The DERC also reviews those incidents referred to the DERC by the IERC Chairperson or otherwise requested by the DERC. In the past, the DERC has also reviewed incidents referred by the OIG. The OIG also assigns a Deputy Inspector General to monitor DERC reviews.

Types of Force

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

The department also distinguishes between immediate and controlled use of force. Immediate use of force is defined in departmental policy as the force used to respond without delay to inmate behavior that constitutes an imminent threat to institution/facility security or the safety of persons. Employees may use immediate force without prior authorization from a higher official. Controlled use of force is the force used in an institution/facility setting when an inmate's presence or conduct poses a threat to safety or security and the inmate is located in an area that can be controlled or isolated. These situations do not normally involve the immediate threat of loss of life or immediate threat to institution security. All controlled use-of-force situations require the authorization and the presence of a first- or second-level manager or an Administrative Officer of the Day (AOD) during non-business hours. Staff must make every effort to identify disabilities, to include mental health concerns, and to note any accommodations that may need to be considered when preparing for a controlled use of force.

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

During this reporting period, staff contributed to the need for force in 92 of the 2,148 incidents reviewed, approximately 4 percent of the incidents. While there were varying reasons staff contributed to the need for the use of force, four major reasons were the following:

1) Using force when no imminent threat was present (23 incidents);

2) Opening a cell door or otherwise allowing inmates access to unauthorized areas (21 incidents);

3) Restraint equipment (such as handcuffs) being inappropriately applied or not applied when required (11 incidents); and

4) Failing to sound an alarm during an incident, which may have negated the need for force (10 incidents).

Other examples of how staff contributed to the need for force included entering the cell of an agitated or noncompliant inmate instead of leaving the cell door closed and waiting for additional staff; issuing unauthorized property to inmates while on property restriction (such as suicide watch); making inappropriate or violence-inciting statements; and ignoring safety concerns of inmates. The department made the same finding and took appropriate action in the vast majority of these cases.

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

Mission	Incidents
High Security (Males)	34
Reception Centers	25
General Population (Males)	8
Female Offender/Special Housing	10
Juvenile Justice	14
Adult Parole	1
Office of Correctional Safety	0
Total	**92**

Division of Adult Institutions

CDCR's Division of Adult Institutions (DAI) comprises four mission-based disciplines: reception centers (RC), high security (HS), general population (GP), and female offender/special housing (FOPS/SH).[6] As of December 31, 2014, the department housed 121,198 in-state inmates.[7] The following table displays a breakdown of how the inmate population is distributed throughout the missions.

Table 3: In-State Inmate Population, by Mission

Mission	Inmate Population	Percentage of Population
High Security	35,369	29%
Reception Centers	38,986	32%
General Population	34,357	28%
Female Offenders/Special Housing	12,486	10%
Total	**121,198**	**100%**

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

Of the 2,148 total use-of-force incidents the OIG reviewed, 1,957 (91 percent) occurred within the DAI. The OIG found the reports adequately articulated the justification for using force and adequately described the force used in 97 percent of the incidents. The remaining 3 percent of incidents reviewed had inadequate justification for the use of force. For the most part, the number of incidents of force is proportionate to the size of the missions, with the high security mission having a slightly higher percentage of use-of-force incidents.

Table 4: Number of Incidents Reviewed by the OIG, by Mission Within DAI

Mission	Incidents	Percentage
High Security (Males)	762	39%
Reception Centers	604	31%
General Population (Males)	367	19%
Female Offenders/Special Housing	224	11%
Total	**1,957**	**100%**

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

[6] The full name of this mission is "female offender programs and services, special housing" (FOPS/SH). All of the female institutions are part of this mission, as well as the California Medical Facility, the California Health Care Facility, and Folsom Women's Facility.

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

Table 5: Frequency of Force by Type in Reviews Completed, Grouped by Mission

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 Programs	106	34%	57%	8%	0%	0%
CHCF	California Health Care Facility	Female/Special Programs	55	64%	31%	4%	0%	0%
CIW	California Institution for Women	Female/Special Programs	93	47%	42%	8%	3%	0%
CMF	California Medical Facility	Female/Special Programs	51	24%	75%	2%	0%	0%
FWF	Folsom Women's Facility	Female/Special Programs	15	7%	80%	13%	0%	0%
ASP	Avenal State Prison	General Population	51	6%	88%	4%	0%	0%
CAL	Calipatria State Prison	General Population	170	7%	67%	1%	24%	1%
CEN	Centinela State Prison	General Population	60	8%	67%	8%	17%	0%
CTF	Correctional Training Facility	General Population	40	30%	58%	13%	0%	0%
CVSP	Chuckawalla Valley State Prison	General Population	20	15%	70%	15%	0%	0%
FSP	Folsom State Prison	General Population	53	8%	79%	11%	2%	0%
ISP	Ironwood State Prison	General Population	96	2%	95%	2%	1%	0%
MCSP	Mule Creek State Prison	General Population	118	16%	51%	18%	15%	0%
PVSP	Pleasant Valley State Prison	General Population	69	13%	67%	6%	14%	0%
SOL	California State Prison, Solano	General Population	77	19%	71%	1%	8%	0%
VSP	Valley State Prison	General Population	19	47%	47%	5%	0%	0%
CAC	California City Correctional Facility	High Security	25	8%	88%	4%	0%	0%
CCI	California Correctional Institution	High Security	51	16%	63%	6%	10%	0%
COR	California State Prison, Corcoran	High Security	111	22%	68%	7%	3%	0%
HDSP	High Desert State Prison	High Security	96	15%	65%	5%	15%	1%
KVSP	Kern Valley State Prison	High Security	209	7%	70%	3%	20%	0%
LAC	California State Prison, Los Angeles County	High Security	331	17%	58%	8%	16%	0%
PBSP	Pelican Bay State Prison	High Security	214	7%	69%	7%	16%	0%
SAC	California State Prison, Sacramento	High Security	283	41%	52%	4%	3%	0%
SATF	Substance Abuse Treatment Facility & State Prison at Corcoran	High Security	89	16%	53%	9%	17%	3%
SVSP	Salinas Valley State Prison	High Security	157	10%	78%	0%	12%	0%
CCC	California Correctional Center	Reception Center	48	13%	73%	6%	8%	0%
CIM	California Institution for Men	Reception Center	81	32%	64%	1%	2%	0%
CMC	California Men's Colony	Reception Center	60	42%	45%	5%	0%	0%
CRC	California Rehabilitation Center	Reception Center	103	21%	77%	2%	0%	0%
DVI	Deuel Vocational Institution	Reception Center	110	31%	45%	24%	0%	0%
NKSP	North Kern State Prison	Reception Center	209	10%	59%	4%	27%	0%
RJD	Richard J. Donovan Correctional Facility	Reception Center	170	34%	51%	7%	7%	0%
SCC	Sierra Conservation Center	Reception Center	75	20%	75%	5%	0%	0%
SQ	California State Prison, San Quentin	Reception Center	67	19%	54%	12%	15%	0%
WSP	Wasco State Prison	Reception Center	245	13%	62%	9%	17%	0%
TOTAL			**3,827 Applications**	**21% Overall Average**	**64% Overall Average**	**7% Overall Average**	**8% Overall Average**	**<1% Overall Average**

Use of Force on Mental Health Inmates

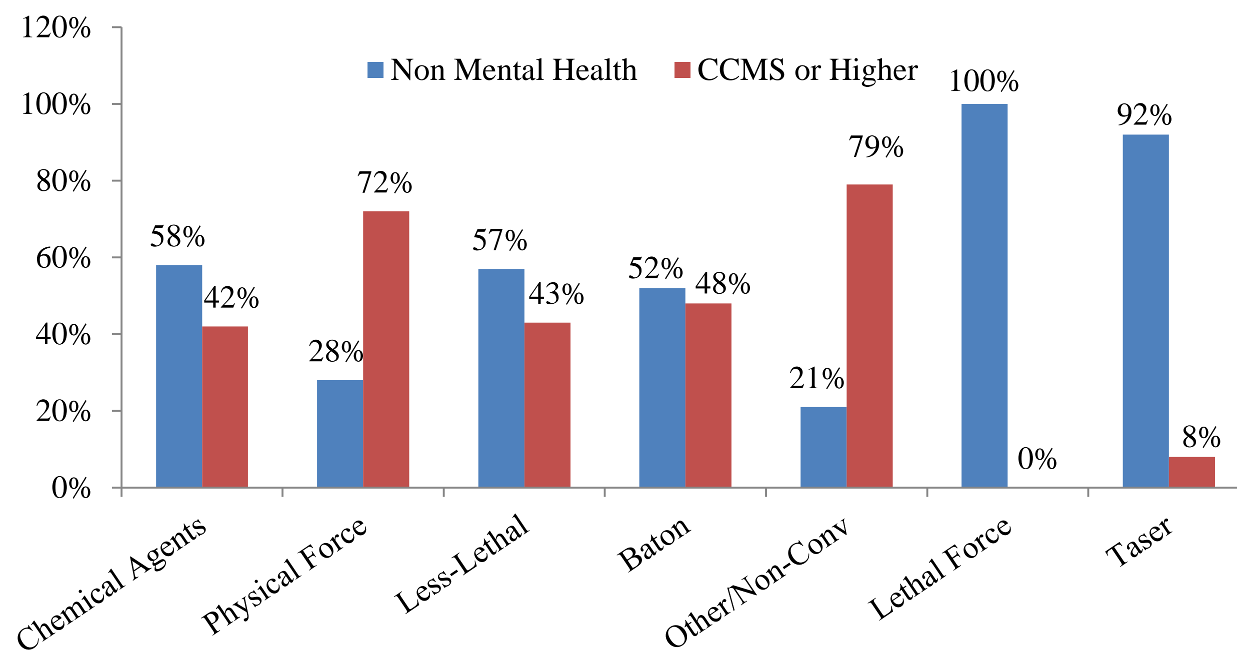
Nearly half of the total uses of force (48 percent) reviewed this reporting period were on inmates participating in the department's mental health services delivery system (MHSDS) at the Correctional Clinical Case Management System (CCCMS) level or above.[8,9] The department reports that about 29.5 percent of its in-state inmate population was at the CCCMS level or above during this reporting period.

Table 6: Use of Force, by Mental Health Status

<table>
<tr><th colspan="2">MH Code</th><th>Percentage</th></tr>
<tr><td colspan="2">Non-Mental Health</td><td>52%</td></tr>
<tr><td>CCCMS</td><td>31%</td><td rowspan="4">48%</td></tr>
<tr><td>EOP</td><td>14%</td></tr>
<tr><td>MHCB</td><td>2%</td></tr>
<tr><td>DMH</td><td>1%</td></tr>
</table>

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

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



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

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

Table 7: Frequency of Force by Type, Grouped by Mental Health Status

	Chemical Agents			Physical Force			Less-Lethal Force			Baton		
	Number	%		Number	%		Number	%		Number	%	
Non-MH	1,390	58%		215	28%		230	57%		128	52%	
CCMS	707	30%	42%	254	33%	72%	131	33	43%	75	30%	48%
EOP	246	10%		217	28%		37	9		39	16%	
MHCB	22	1%		53	7%		0	0		2	1%	
DMH	22	1%		30	4%		2	1		2	1%	
Total	2,387	100%		769	100%		400	100%		246	100%	

	Other/Non-Conventional			Lethal Force		Taser			Total #	Total %	
	Number	%		Number	%	Number	%		Number	%	
Non-MH	5	21%		6	100%	11	92%		1,985	52%	
CCMS	6	25%	79%	0	0%	1	8%	8%	1174	31%	48%
EOP	10	42%		0		0	0%		549	14%	
MHCB	2	8%		0		0	0%		79	2%	
DMH	1	4%		0		0	0%		57	1%	
Total	24	100%		6	100%	12	100%		3,844	100%	

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

The department recently modified its use-of-force policy with regard to mental health inmates, and the changes were implemented during this reporting period, July through December 2014. 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 has commenced and will continue over the next few months. Staff is responsible for complying with the new policies immediately upon receipt of training. It appears there is an effort to use physical restraint on the mentally ill as opposed to more severe methods. The data shows that while the use of force and chemical agents is proportionately greater (48 percent compared to 29.5 percent of the population), there is a lower proportionate percentage of use of batons, 40mm direct-impact rounds, and lethal force on the mentally ill. At this point, no conclusions are being drawn from this data, but it will be a focus of future monitoring.

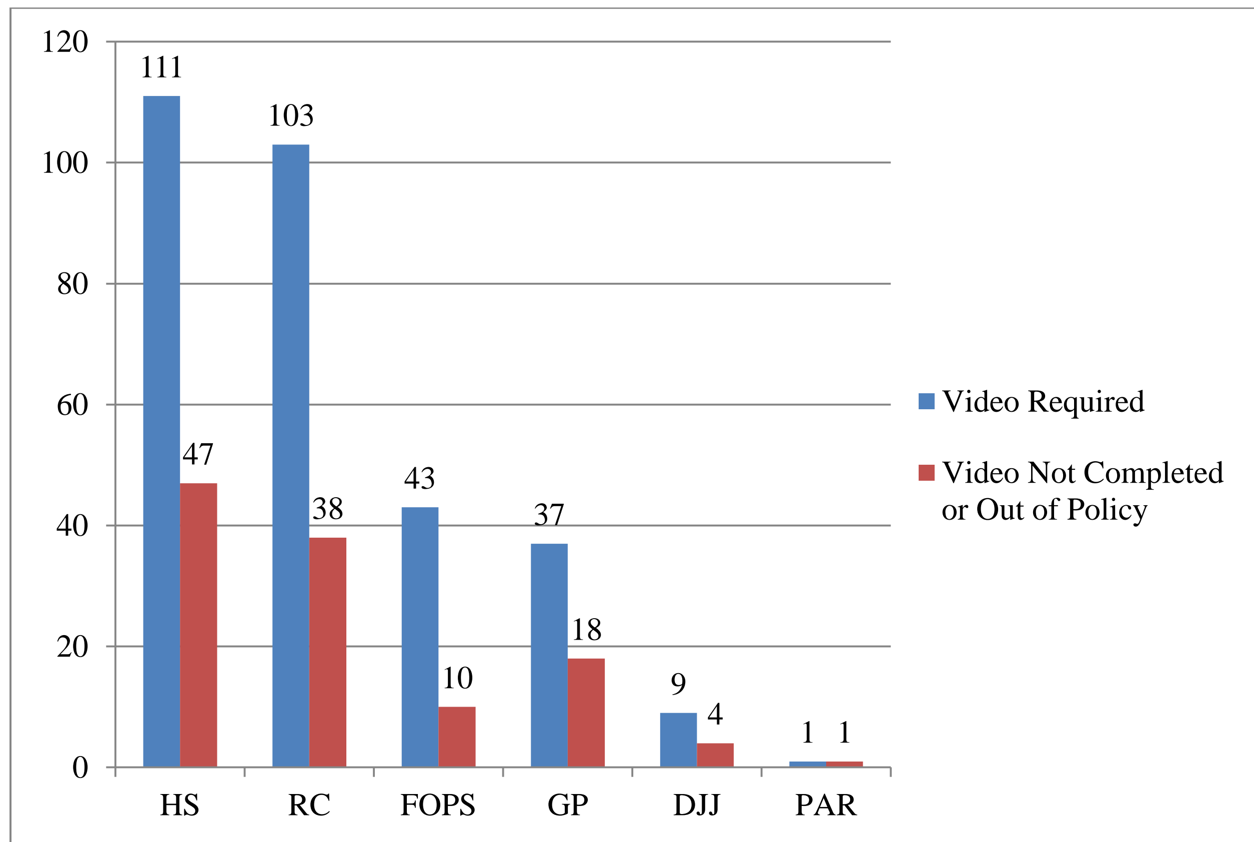
Video-Recorded Interviews

The department's use-of-force policy requires video-recorded interviews if an inmate alleges unreasonable force or has sustained serious or great bodily injury that could have been caused by the use of force. The video recording should be conducted within 48 hours of discovery of the injury or allegation. If the inmate refuses to be video recorded, CDCR policy requires staff to record the inmate confirming his or her refusal to be interviewed. However, the actual process for conducting video-recorded interviews of inmates involved in a use-of-force incident is

inconsistent among the adult institutions, as some institutions are not following the policy, with the most common deviations listed below.

Three hundred four incidents that OIG monitored required video recorded interviews. In 33 cases, a video recording was not completed. Video-recorded interviews were completed in 271 incidents; however, in 186 incidents, the video recorded interview, while done, was not completed according to policy. Combining the 33 cases where no video recording was completed with the 186 incidents where the video recording was not completed according to policy, results in a policy compliance rate of only 61 percent. The errors that were found included not conducting an interview when one was required, interviewers not adequately identifying themselves or interviewers not adequately identifying the inmate's injuries. The OIG has reported these concerns in prior reports. The Department has advised the OIG that it is directing staff to follow the instructions found in *CDCR Form 3013, (REV. 02/10), Inmate Interview Guidelines.* The OIG will continue to monitor this issue and report whether the Department's corrective action is effective.

Chart 2: Video Recordings, by Mission/Division



Pilot Program for Institutional Use-of-Force Reviews

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

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

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

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

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

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

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

During this reporting period, the department reviewed 108 incidents as a part of the pilot program. Of these, the OIG agreed with the conclusion of 106 of the incidents and the determinations made on them by the department.

Table 8: Number of Pilot Incidents Reviewed

Institution	Cases CDCR Referred for Consent	Cases OIG Concurred with Consent	Difference
Calipatria State Prison	54	53	1
High Desert State Prison	18	17	1
Kern Valley State Prison	14	14	0
California State Prison, Los Angeles County	22	22	0
Total	**108**	**106**	**2**

While it is still too early in the pilot program to make a determination on its efficiency, the table above illustrates that Calipatria State Prison, an institution with few inmates receiving mental health care, referred twice as many cases to consent as any other prison in the pilot. If rolled out statewide, this streamlined process might still prove beneficial, especially since the OIG monitors 100 percent of those decisions.

Division of Juvenile Justice

During this reporting period the Division of Juvenile Justice (DJJ) consisted of three facilities and one conservation camp and was responsible for supervising 653 juvenile offenders.[11] The OIG reviewed 155 use-of-force incidents occurring throughout the three juvenile facilities. There were no incidents in the juvenile conservation camp this reporting period.

Among the 155 incidents reviewed, there were 457 uses of force. The OIG found the reports adequately articulated the justification for using force and adequately described the force used in all but 14 of the incidents. In those 14 incidents where the OIG found that the reports did not adequately articulate the justification for the use-of-force and did not adequately describe the force, eight resulted in staff training, three resulted in corrective action, and three were referred for possible disciplinary action. The OIG commends the department on its willingness to identify and appropriately resolve use-of-force issues in the DJJ.

[11] Data derived from:
http://www.cdcr.ca.gov/Reports_Research/docs/research/Population_Overview/POPOVER2014.pdf.

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

Table 9: Number of Incidents Reviewed—Division of Juvenile Justice

Facility	Incidents
N.A. Chaderjian	59
O.H. Close	41
Ventura	55
Total	**155**

Table 10: Types of Force—Division of Juvenile Justice

Facility	Types of Force	Uses
N.A. Chaderjian	Baton	2
	Chemical Agent	169
	Less-Lethal Force[12]	1
	Physical Force	31
N.A. Chaderjian Total		**203**
O.H. Close	Chemical Agent	101
	Less-Lethal Force	3
	Physical Force	12
O.H. Close Total		**116**
Ventura	Chemical Agent	107
	Less-Lethal Force	1
	Physical Force	30
Ventura Total		**138**
Grand Total		**457**

[12] Less-lethal force used in DJJ consists of foam projectiles fired from a 37mm launcher.

Division of Adult Parole Operations

During this reporting period the Division of Adult Parole Operations (DAPO) consisted of two parole regions and was responsible for supervising over 42,000 parolees.[13] The OIG reviewed 33 use-of-force incidents: 17 in the north parole region and 16 in the south parole region. Among the 33 incidents reviewed, there were 39 individual uses of force. Of those incidents where a determination was made, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all cases. The following tables provide summaries of the types and frequency of force reviewed in the parole regions from July through December 2014.

Table 11: Types of Force—Parole Regions

Parole Region	Types of Force	Uses
PAR-North	Baton	1
	Chemical Agent	2
	Physical Force	12
	Taser	6
PAR-North Total		**21**
PAR-South	Physical Force	13
	Taser	5
PAR-South Total		**18**
Grand Total		**39**

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, gang-related investigations of inmates and parolees suspected of criminal gang activity, and oversight of special departmental operations such as special transports, hostage rescue, riot suppression, critical incident response, and joint task force operations with local law enforcement.

During the reporting period, the OIG conducted reviews of three use-of-force incidents involving three uses of force by OCS employees; there were two uses of physical force, and one use of a Taser. Of those three incidents, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in all cases. In addition, there were two incidents involving use of deadly force by OCS that the OIG monitored at the Deadly Force Review Board.

[13] Data derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1412.pdf

MONITORING CONTRABAND SURVEILLANCE WATCH

In 2012, citing concerns by the Legislature that CDCR's contraband surveillance watch process was not being applied consistently, the OIG developed a contraband surveillance watch monitoring program. Contraband surveillance watch is a significant budget driver for CDCR because it requires additional staffing for one-on-one observations. Additionally, contraband surveillance watch can subject the State to significant liability if abuses occur or if it is imposed punitively. On July 1, 2012, the OIG began its formal monitoring of this process. The department's policy for placing an inmate on contraband surveillance watch is found in the Department Operations Manual, Section 52050.23:

> *When it becomes apparent through medical examination, direct observation, or there is reasonable suspicion that an inmate has concealed contraband in their body, either physically or ingested, and the inmate cannot or will not voluntarily remove and surrender the contraband, or when a physician has determined that the physical removal 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 in 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 policy. This on-scene response is repeated every 72 hours until the inmate is removed from contraband surveillance watch. Any serious breaches of policy are immediately discussed with institution managers while on scene. For the first time since beginning contraband surveillance watch monitoring, the OIG now formally assesses the sufficiency of how the department conducts each contraband surveillance watch extending beyond 72 hours.

During this reporting period, the OIG was notified of 206 contraband surveillance watch cases. This report does not include contraband surveillance watch cases reported from the out-of-state facilities. Of these 206 cases, inmates were kept on contraband surveillance watch longer than 72 hours but less than 144 hours in 46 cases; nine cases involved inmates placed on watch for 144 to 216 hours; and four cases extended beyond 216 hours. This report assesses the 59 cases that extended beyond 72 hours, with a detailed description of the four 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 147 cases that did not extend beyond 72 hours, and in 44 percent of these cases (64 cases), contraband was recovered.

Contraband was found in 47 percent of the contraband surveillance watch cases that extended beyond 72 hours.

Chart 3: Duration of Contraband Surveillance Watch Cases

Total Contraband Surveillance Watch Cases = 206

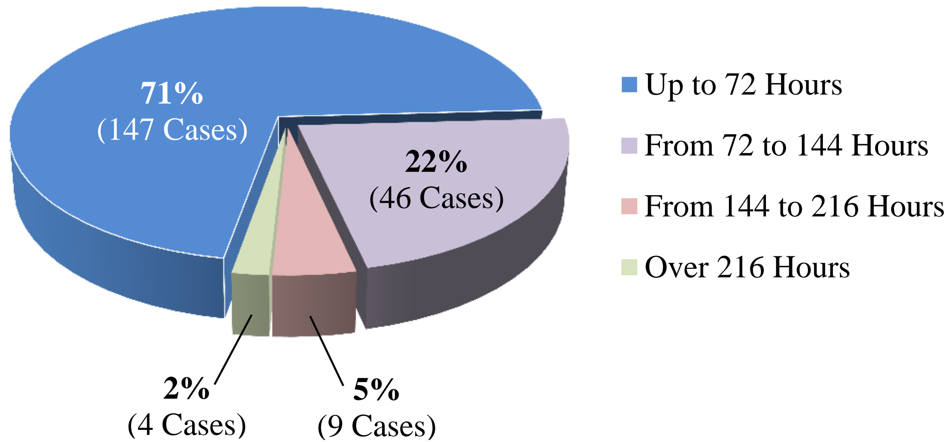
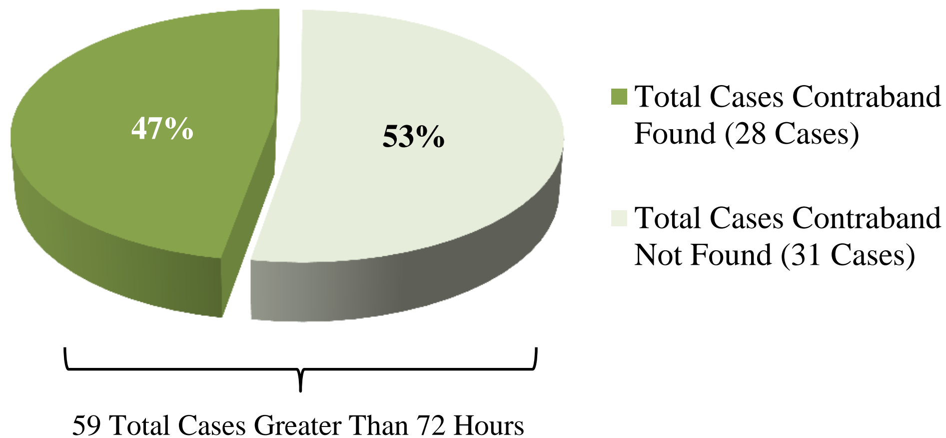


Chart 4: Contraband Found in Cases Extending Beyond 72 Hours



59 Total Cases Greater Than 72 Hours

Chart 5: Contraband Found in Cases Lasting Less Than 72 Hours

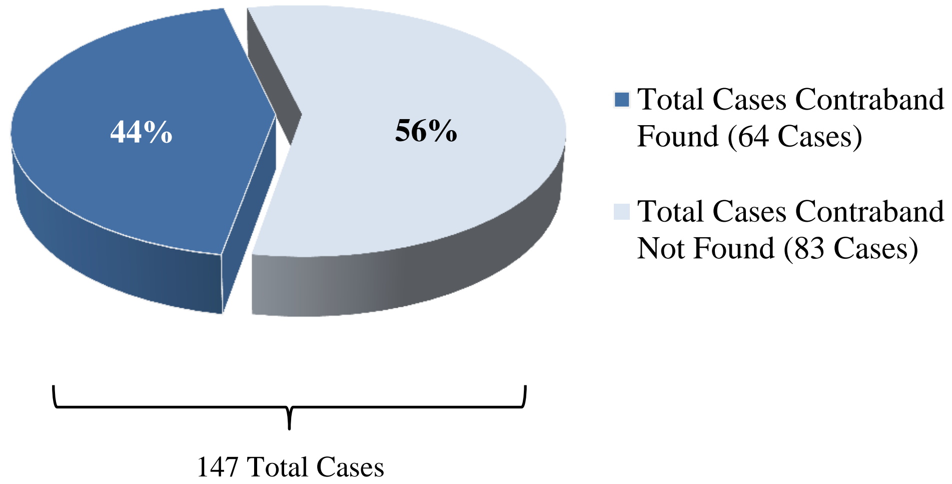
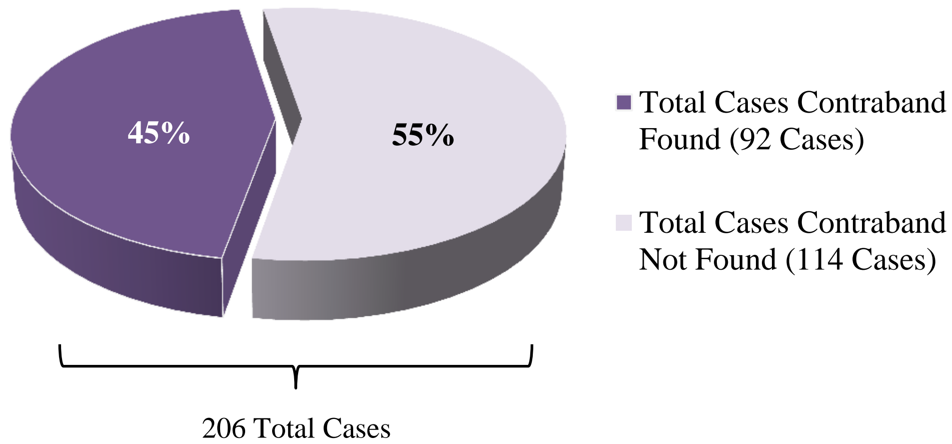
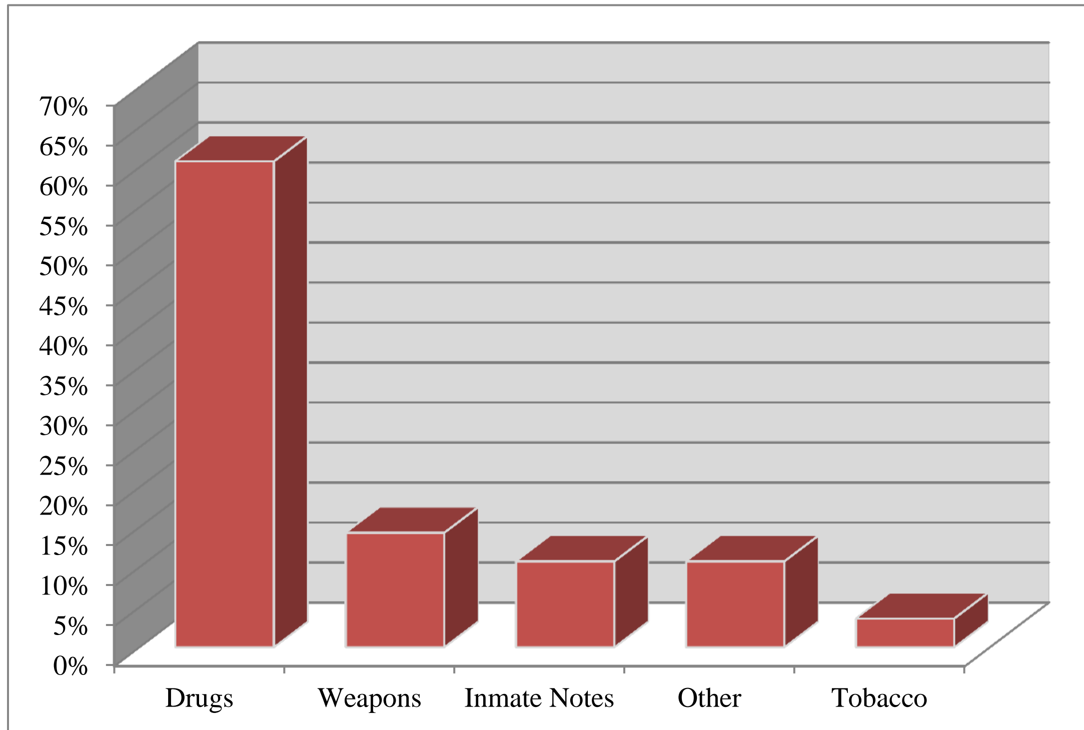


Chart 6: Contraband Found in All Contraband Surveillance Watch Cases



As previously noted, this report only covers in detail those 59 contraband surveillance watch cases that extended beyond 72 hours. Contraband was found in 28 cases that extended beyond 72 hours. Drugs were recovered in 61 percent of the cases where contraband was found, while the remaining recovered contraband primarily consisted of weapons, inmate notes, and other contraband.

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



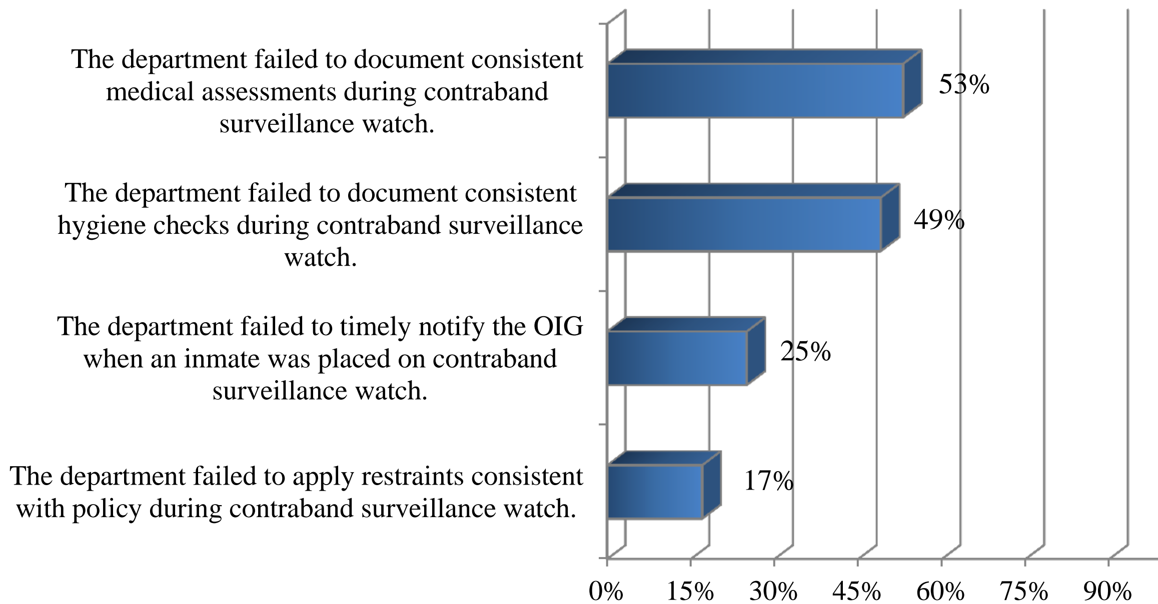
During this reporting period, the OIG rated the department on the adequacy of its management of contraband surveillance watch cases monitored by the OIG. Of the 59 cases that exceeded 72 hours, the OIG found that the department sufficiently managed the contraband surveillance watch process in 31 cases (53 percent) and was insufficient in its management of 28 contraband surveillance watch cases (47 percent). In those cases where deficiencies were noted, the department took corrective action mainly via staff training. While the OIG concurs that the majority of deficiencies could be appropriately addressed through additional staff training, the same issues are being seen again and again. The OIG recommends the department review its current contraband surveillance watch training policies and determine where improvements can be made. The OIG suggests the department develop an on-the-job training component for custody staff newly assigned to a contraband surveillance watch case. For staff who consistently fail to follow contraband surveillance watch policy, the OIG recommends the department take corrective action beyond training, up to and including disciplinary action.

In this reporting period, the department's contraband surveillance watch placements increased slightly over the prior reporting period (206 in this period compared to 192, 246, and 293 for the three prior reporting periods). Also, the number of inmates on contraband surveillance watch beyond 72 hours trended upward (59 in this period, compared to 48, 75, and 92 in the three prior

reporting periods). Finally, there were four contraband surveillance watch cases exceeding 216 hours in this reporting period, compared to 2, 11, and 8 in the three prior periods.

While the department's decision for placing an inmate on contraband surveillance watch in all but seven of the 59 cases exceeding 72 hours was within policy, 34 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 8: Policy Violations in Contraband Surveillance Watch Cases



In the 59 contraband surveillance watch cases that extended beyond 72 hours, the majority of process violations involved failures to complete appropriate documentation, failures to provide timely notification to the OIG, and failures to document consistent hygiene checks.

It should be noted that in 31 of the 59 contraband surveillance watch cases that extended beyond 72 hours (nearly 53 percent), medical staff failed to note required medical checks in the inmate's medical record, as required by policy. The OIG recommends that the department work with California Correctional Health Care Services (CCHCS) to ensure medical staff is trained on and familiar with CCHCS Policy 4.33, Contraband Surveillance Watch.

In 49 percent of contraband surveillance watch cases exceeding 72 hours that incurred policy violations, the department failed to complete appropriate documentation concerning inmate hygiene (up from 46 percent from the last reporting period). In 25 percent of cases, the department failed to timely notify the OIG when an inmate was placed on contraband surveillance watch (up from 23 percent from the last reporting period).

California Correctional Center had six cases with at least one policy violation; Centinela State Prison had five cases with at least one policy violation; and High Desert State Prison and the Richard J. Donovan Correctional Facility each had four cases with at least one policy violation. Six institutions had cases extending beyond 72 hours with no policy violations: Pelican Bay State Prison, Kern Valley State Prison, Pleasant Valley State Prison, Folsom State Prison, Avenal State Prison, and the N.A. Chaderjian Youth Correctional Facility.

When failures to comply with policies and procedures are identified, those responsible should be held accountable through the department's disciplinary process if neglect or misconduct is reasonably believed to have occurred. Without accountability, remediation is unlikely. The OIG is committed to monitoring this process to avoid abuses and accomplish the legitimate goals of contraband surveillance watch. With the department's returned focus on drug interdiction, it seems likely more contraband surveillance will occur. This makes it even more vital that the department make better efforts at notifying the OIG in a timely manner to ensure transparency and eliminate the repeated policy violations to achieve successful outcomes.

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

Table 12: Contraband Surveillance Watch Cases, by Institution, July–December 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	Number of Cases Over 72 Hours Rated Sufficient	Number of Cases Over 72 Hours Rated Insufficient
ASP	2	1	1	0	0	1	0
CAC	3	2	1	0	0	0	1
CAL	4	3	0	1	0	1	0
CCC	23	17	4	2	0	5	1
CCI	1	1	0	0	0	N/A	N/A
CCWF	2	1	1	0	0	0	1
CEN	9	4	5	0	0	2	3
CIW	8	6	1	1	0	0	2
CMC	3	3	0	0	0	N/A	N/A
CMF	2	1	1	0	0	0	1
COR	10	9	1	0	0	1	0
CRC	13	10	3	0	0	1	2
CVSP	2	2	0	0	0	N/A	N/A
DVI	6	3	3	0	0	3	0
FSP	8	6	1	1	0	2	0
HDSP	5	1	4	0	0	1	3
ISP	5	4	0	0	1	0	1
KVSP	8	7	1	0	0	1	0
LAC	8	7	1	0	0	0	1
MCSP	4	4	0	0	0	N/A	N/A
NACYCF	12	10	2	0	0	2	0
NKSP	3	2	1	0	0	0	1
OHCYCF	2	2	0	0	0	N/A	N/A
PBSP	13	10	3	0	0	3	0
PVSP	4	3	1	0	0	1	0
RJD	9	5	1	2	1	0	4
SAC	5	3	1	0	1	1	1
SATF	3	3	0	0	0	N/A	N/A
SCC	2	1	1	0	0	0	1
SOL	6	3	3	0	0	2	1
SQ	4	2	2	0	0	0	2
SVSP	15	10	2	2	1	3	2
WSP	2	1	1	0	0	1	0
Total CSW Cases	206	147	46	9	4	31	28
		Contraband Recovered: 64 Cases = 44%	**Contraband Recovered: 21 Cases = 46%**	**Contraband Recovered: 4 Cases = 44%**	**Contraband Recovered: 3 Cases = 75%**	**Sufficient = 52%**	**Insufficient = 48%**

Contraband surveillance watch is not meant to be a long-term event. As time passes, risks increase and it becomes a very costly practice. For this reason, the OIG pays close attention and will continue to report these cases separately. Nevertheless, there are some instances that may warrant it. A summary of the four cases of contraband surveillance watch lasting over 216 hours (nine days) is below.

The longest duration for contraband surveillance watch this reporting period lasted 410 hours (17 days). In that case, the department placed an inmate on contraband surveillance watch after officers observed what appeared to be a transfer of contraband during a kiss with an authorized visitor. The inmate was removed from contraband surveillance watch 17 days later. During that time, the department recovered drugs from the inmate. Deficiencies were noted in the department's management of this contraband surveillance watch. The OIG did not receive timely notification of the inmate's placement on contraband surveillance watch. Required medical assessments were not consistently conducted. The department addressed these deficiencies by implementing procedures to ensure that required medical assessments for inmates on contraband surveillance watch are conducted timely.

The second case involved a 354-hour (14-day) contraband surveillance watch that began after an inmate told staff that he swallowed razor blades and an x-ray confirmed the presence of a foreign object. The inmate was removed from contraband surveillance watch 14 days later. During that time, the department recovered nothing from the inmate. Deficiencies were noted in the department's management of this contraband surveillance watch. The department failed to notify the OIG when the inmate was transported to an outside hospital while on contraband surveillance watch. The department further failed to adequately document inmate hygiene and restraint cleaning. The department failed to document proper securing of clothing, initial cell searches, meals, and blanket issuance and removal in accordance with departmental policy. The department provided training to all involved custody staff to address these deficiencies.

The third case also involved a contraband surveillance watch that lasted 14 days (348 hours). In this case, the department placed an inmate on contraband surveillance watch after the inmate failed to pass a metal detector during a cell search. Specifically, the cell search was conducted after the department received information that the inmate was in possession of a weapon. Although a weapon was not recovered, the contraband surveillance watch did yield drugs and inmate notes. The OIG found no deficiencies in the department's management of this case.

The fourth and final case of contraband surveillance watch lasting over 216 hours was a case lasting 288 hours (12 days). An inmate was placed on contraband surveillance watch after an officer observed an inmate appear to insert something into his rectum while in the visiting room. The inmate was removed from contraband surveillance watch 12 days later. During that time, the department recovered approximately 42 grams of heroin from the inmate. Deficiencies were noted in the department's management of this contraband surveillance watch. Specifically, the department failed to timely obtain approval for the third 72-hour extension and failed to timely notify the OIG of the extension. The department also failed to consistently document supervisory checks and range of motion releases and failed to document any cleaning of the restraint equipment. Training was provided to address these deficiencies.

VOLUME II CONCLUSION

The goal of publishing the OIG's Semi-Annual Report in two volumes is to allow the reader to easily focus on specific areas of monitoring conducted by the OIG. All areas of monitoring require transparent oversight in order to ensure public trust, proper adherence to policy, best practices, safety and security of staff and inmates, and accountability to the taxpayer. In all of the monitoring activities, the OIG alerts the department to potential risks or problem areas and makes recommendations for improvement. It is the goal of the OIG that this monitoring will help avoid potential abuse, costly litigation, and expensive federal oversight.

Critical incidents as described within this report have the potential for serious consequences for staff, inmates, and the taxpayers at large. As such, OIG oversight provides independent assessment on how the incidents occur, how they are handled, and their outcomes. A 20 percent decline in timely notification compared to the previous reporting period prevents the performance of this oversight role and requires attention by CDCR management.

This report repeats our recommendation that the department examine violence directed at SNY inmates. The OIG attended 390 use-of-force meetings throughout the State and evaluated a total of 2,148 unique incidents. In the overwhelming number of reviews, the committee took appropriate action. The department and the OIG noted improvement is needed in following the video policies. The OIG is also specifically monitoring the use of force on mentally ill inmates.

The OIG's monitoring of contraband surveillance watch continues to evolve. 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 OIG found the department to be insufficient in its management of contraband surveillance watch in almost half (47 percent) of the cases that exceeded 72 hours, with the majority of deficiencies being related to poor documentation. These cases will likely increase due to the new focus on drug interdiction, making OIG oversight even more important.

Another area of concern is that while the department does have a policy related to threat assessments for threats against parole agents and other government officials, the department lacks consistent statewide threat assessment procedures to follow when an inmate attacks a line staff member, such as an officer. Institutions have individual local operating procedures, but there is no statewide policy. In one case, inmates planned and executed an attack on an officer while on duty. The institution completed a threat assessment 30 days after the incident. However, despite numerous requests by the OIG, the department did not provide the threat assessment to the OIG until over six months after its completion. After reviewing the threat assessment, the OIG found it vague, not identifying why the officer was attacked. The OIG recommended the institution request a threat assessment by the department's experts, the Office of Correctional Safety, but the institution declined.

The OIG is concerned for the safety and security of all employees and recommends the department review and enact consistent policies to minimize future occurrences and determine the source of all threats against staff when possible.

The department is not acting consistently in instances where an inmate swallows a razor blade. An institution is authorized to place an inmate on contraband surveillance watch when there is reasonable suspicion that the inmate has concealed contraband in his or her body. A question has arisen whether a razor blade is considered contraband for purposes of the contraband surveillance watch policy. Inmates in a general population setting are entitled to possess razors for grooming, while inmates in segregated housing are not, making razors contraband in one setting and not the other. Most institutions have initiated contraband surveillance watch protocols for inmates who reported swallowing a razor blade, regardless of their assigned housing program. Institutions placing inmates on contraband surveillance watch generally articulate that when an inmate removes the blade from the shaving razor, it becomes contraband. However, in November 2014, the Director of Adult Institutions stated that a general population inmate should not be placed on contraband surveillance watch for swallowing a razor blade because it is an item he or she is entitled to have and is, therefore, not contraband. Even if not viewed as a security issue, the inmate still should be observed or monitored in a setting that will prevent any health risks. An inmate is certainly not authorized to possess a razor in an altered state within his or her body.

The practice at different institutions has remained inconsistent, with some placing the inmates on contraband surveillance watch, some placing them in a medical setting, and a few doing neither. Therefore, the OIG recommends that the department develop a clear policy for inmates who swallow, or reportedly swallow, foreign objects such as razor blades. The OIG further recommends that the department ensure its position is known to all institutions to prevent the inconsistent application of the contraband surveillance watch policy as it relates to razor blades and similar ingested items. Finally, the OIG recommends that the department address staffing needs if and when an inmate is placed simultaneously on contraband surveillance watch and suicide watch. Currently, mental health and custody staff are often assigned simultaneously to watch the same inmate, which may be a waste of resources.

Oversight is a critical element for the transparency of the California corrections system. As this Semi-Annual Report reflects, the OIG continues to provide recommendations to the department with the goal of the department's processes continuing to improve. The OIG is committed to monitoring the vital areas of critical incidents, use of force, and contraband surveillance watch and to providing transparency to the California correctional system.

VOLUME II RECOMMENDATIONS

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

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

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

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

VOLUME II RECOMMENDATIONS FROM PRIOR REPORTING PERIODS

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

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

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

CDCR Response: Substantially Implemented
The department has initiated a workgroup to amend its use-of-force policy, which is now in the third phase of implementation. The modifications will encompass clarification and direction on the interviewing process.

The department will make every effort to ensure that inmate interviews are free of outside noise or distractions. However, in a prison environment, background noise cannot always be avoided.

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

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

CDCR Response: Not Implemented
The department is reviewing the current practice of double celling inmates on sensitive needs yards.

The department will take into consideration the information provided by the OIG. The OIG's two reporting periods (one year) do not provide enough historical data to develop a hypothesis for the increase of inmate homicides in housing on sensitive needs yards. At this time, there will not be any modifications to the department's current policy. However, the department will continue to review the current practices and any developing trends that become apparent.

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

CDCR Response: 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 Investigative Services Unit 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.

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.

CDCR Response: 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.

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

CDCR Response: 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 has identified the need for contraband surveillance watch and has implemented observation or restraint measures, e.g., the inmate is isolated, staff begins direct and constant observation of the inmate, the inmate is placed in waist chains or taped clothing, etc.

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.

CDCR Response: 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.

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APPENDIX D1 7
MONITORED DEADLY FORCE INCIDENTS
Central Region

Incident Date: 2014-04-26	Deadly Force Incident

Incident Summary
OIG Case Number: **14-1055-RO**

On April 26, 2014, six inmates began fighting on an exercise yard. The observation officer gave repeated orders for all inmates on the exercise yard to get down; however, the inmates who were fighting ignored the orders. Responding custody staff deployed chemical agents without effect. The observation officer continued to order the inmates to get down. The fighting inmates continued ignoring the orders. Other uninvolved inmates refused to get in a seated position and began moving towards the fighting inmates. The observation officer discharged a warning shot from a Mini-14 rifle into a safe area. This caused some of the fighting inmates to stop; however, two inmates continued attacking a third inmate and other uninvolved inmates continued slowly moving towards the fighting inmates. The observation officer discharged another warning shot from the Mini-14 rifle into a safe area. This ultimately caused all inmates to comply with orders to get down. The third inmate who was being attacked sustained bleeding, swelling, and bruising to his face as a result of the attack. None of the inmates sustained serious injury. The department adequately notified the OIG and the OIG responded to the scene.

Disposition
There did not appear to be an immediate threat to justify the observation officer's two warning shots. Therefore, potential staff misconduct was identified and the case was referred to OIA Central Intake before going to the institution's executive review committee. An investigation was opened, which the OIG accepted for monitoring.

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: 2014-05-27	Deadly Force Incident

Incident Summary
OIG Case Number: **14-1229-RO**

On May 27, 2014, three inmates attacked a fourth inmate on an exercise yard, punching and kicking the fourth inmate in the head. The observation officer ordered the inmates to get down but the three inmates continued their attack. The observation officer then noticed one of the aggressors attempt to stab the fourth inmate with an inmate-manufactured weapon. The observation officer aimed a less-lethal round at that aggressor's thigh but missed and struck another aggressor in the shoulder. The three inmates ignored additional orders to get down and continued to punch, kick, and stab at the fourth inmate. The observation officer transitioned to the Mini-14 rifle and fired a warning shot at an open area on the ground, away from any inmates and staff. However, the three inmates continued their attack. Another officer deployed a pepper spray grenade, causing the main aggressor with the weapon to move away from the fourth inmate, but the other two aggressors continued to punch the fourth inmate. The observation officer then aimed a second less-lethal round at one of the remaining aggressors, but it missed and struck the ground. The inmates then complied with orders and got down. The fourth inmate was taken to the triage and treatment area for further treatment but was rehoused later the same day. The OIG was timely notified and responded to the scene.

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

North Region

Incident Date: 2013-06-21	Deadly Force Incident

Incident Summary

OIG Case Number: **13-0896-RO**

On June 21, 2013, a riot erupted involving 21 inmates. An officer in an observation tower observed approximately five inmates striking an inmate who was on the ground and unable to defend himself. The officer fired one warning shot from a Mini-14 rifle, which stopped the attack on the defenseless inmate; however, the riot continued. Three inmates later returned to the defenseless inmate and began striking him again. The observation officer again fired a warning shot from a Mini-14 rifle, which stopped the attack on the defenseless inmate, while the riot continued. Responding custody staff deployed chemical agents and less-lethal rounds to try to gain control of the incident; however, the involved inmates continued to riot. The observation officer saw an inmate knock another inmate to the ground and then continue to strike the defenseless inmate. The observation officer fired a third warning shot from a Mini-14 rifle. This warning shot caused the inmates to stop rioting. All injuries were minor in nature and consistent with fighting. The department adequately notified the OIG and the OIG responded on scene.

Disposition

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

Incident Assessment

Rating: **Insufficient**

The department's response was not adequate because the institution's executive review committee did not finalize the review of the incident until January 15, 2014, almost seven months after the date of the incident.

Assessment Questions

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

  The incident occurred on June 21, 2013, and was not brought to the executive review committee until January 15, 2014, almost seven months later, in violation of departmental policy.

Incident Date: 2014-06-25	Deadly Force Incident

Incident Summary

OIG Case Number: **14-1516-RO**

On June 25, 2014, two inmates attacked a third inmate on an exercise yard. An officer ordered all inmates to get down. All inmates complied except the three involved inmates. The tower officer gave an additional order to get down but the involved inmates still failed to comply. Through binoculars, the tower officer saw one inmate striking another inmate in the back of the head with a weapon and the inmate being struck was unable to defend himself. The officer fired one warning shot from a Mini-14 rifle and the inmates immediately got on the ground. The department adequately notified the OIG and the OIG responded on scene.

Disposition

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

Incident Assessment

Rating: **Insufficient**

The department’s response was not adequate because the institution's executive review committee did not finalize the review of the incident until December 15, 2014, almost six months after the date of the incident.

Assessment Questions

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

  The institution's executive review committee did not finalize the review of the incident until December 15, 2014, almost six months after the date of the incident.

North Region

Incident Date: 2014-07-03	Deadly Force Incident

Incident Summary

OIG Case Number: **14-1582-RO**

On July 3, 2014, two inmates were observed attacking another inmate on the exercise yard. The two inmates made stabbing motions and kicked the other inmate in the head. The inmates refused orders to stop fighting. An observation officer fired a warning shot from a Mini-14 rifle. Two officers simultaneously deployed pepper spray. The injured inmate sustained bleeding head wounds and was transported to an outside hospital for medical treatment. The inmate was later returned to the institution. 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: 2014-09-17	Deadly Force Incident

Incident Summary

OIG Case Number: **14-2266-RO**

On September 17, 2014, two inmates attacked a third inmate on an exercise yard, striking the inmate in the head and upper torso in a stabbing motion. The yard observation officer gave orders for all inmates to get down, to which all inmates complied except the involved inmates. The third inmate ran toward the observation tower while pursued by the first two inmates, as well as a fourth inmate who got up and ran towards the third inmate. The observation officer saw a weapon in the hands of one of the inmates and observed him striking the third inmate with stabbing motions. The observation officer fired a single warning shot from a Mini-14 rifle which stopped the attack. The third inmate was transported to an outside hospital for treatment of lacerations and puncture wounds. He returned to the institution two days later. 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. 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.

South Region

Incident Date: 2014-08-04	Deadly Force Incident

Incident Summary

OIG Case Number: **14-1861-RO**

On August 4, 2014, an officer observed an inmate on the ground being beaten by two other inmates. The inmate being beaten was unresponsive, in a fetal position, and unable to defend himself. One of the inmates was striking the victim in a manner consistent with a stabbing assault. The officer fired one warning shot from a Mini-14 rifle into a wall adjacent to where he saw the inmate on the ground. 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.

APPENDIX D2
INVESTIGATED AND MONITORED DEADLY FORCE CASES
Central Region

Incident Date: 2014-07-15	Deadly Force Incident

Incident Summary

On July 15, 2014, a suicidal inmate reported that he wanted to kill someone. The inmate then threw a milk carton and punched an officer in the eye, causing the officer to hit the wall and fall to the ground. A second officer ordered the inmate to get down but the inmate advanced towards the first officer. The second officer aimed his baton at the inmate's thigh but was not sure where the baton struck because the inmate slipped. The inmate then began lunging at the second officer. The second officer held the baton with both hands to block the inmate's advance and allegedly struck the inmate's face with the baton. Additional officers responded and ultimately subdued the inmate. The inmate sustained bruising, redness, and swelling to his face, head, knees, and hands. He was taken to the triage and treatment area for evaluation and returned to his cell the same day. The first two officers and a third officer were taken to an outside hospital for treatment. The first two officers remain off work due to their injuries, but the third officer returned to work. The Office of Internal Affairs and the OIG were timely notified and both responded to the scene.

Administrative Investigation	OIG Case Number: **14-1779-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department's predisciplinary process failed to sufficiently comply with policies and procedures. The Office of Internal Affairs failed to timely respond to the incident and failed to provide a draft report to the OIG. The institution failed to obtain adequate initial reports regarding the incident.

Assessment Questions

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs delayed more than six hours in responding to the scene.

- Was the critical incident adequately documented?

  The institution failed to properly document the incident. The institution initially obtained two different written versions of the incident, one from the involved officer and one from a supervisor who recorded a telephone interview with the officer.

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

  The special agent failed to provide a copy of the draft investigative report to 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 this determination. The institution's executive review committee determined that the use of force was within departmental policy; however, the hiring authority issued a letter of instruction to the incident commander for failure to submit a thorough and accurate incident report. The OIG concurred.

Incident Date: 2014-10-30	Deadly Force Incident

Central Region

Incident Summary

On October 30, 2014, six inmates began fighting in a housing unit. All inmates ignored orders to get down. A control booth officer fired six less-lethal rounds at the buttocks and legs of the fighting inmates but the officer did not see where the rounds struck. The inmates continued to fight. Several responding officers used pepper spray which caused most inmates to stop fighting; however, one inmate continued attacking an inmate who was no longer fighting back. One of the responding officers gave additional orders to get down but the inmate kept attacking the second inmate. The officer fired one less-lethal round at the first inmate's buttocks but did not know where the round struck. Another officer used pepper spray to finally stop the attack. Nine inmates were treated for minor injuries at the institution. One of the inmates claimed a less-lethal round struck the back of his head. The Office of Internal Affairs and the OIG were timely notified and both responded to the scene.

Administrative Investigation

OIG Case Number: **14-2583-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the predisciplinary process. OIA Central Intake delayed processing the case. In addition, the Office of Internal Affairs failed to conduct a proper investigation by not taking proper equipment to the scene and failed to provide the draft investigative report to the OIG.

Assessment Questions

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

  OIA Central Intake received the request for investigation on October 31, 2014, but did not take action until December 24, 2014, 54 days after the receipt of the request.

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

  The special agent did not take a camera to the scene. Therefore, he was unable to take adequately photograph the inmate's injuries.

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

  The Office of Internal Affairs did not provide the OIG with a draft copy of the investigative report.

- Was the predisciplinary/investigative phase conducted with due diligence?

  OIA Central Intake failed to process the case in a timely manner.

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 complied with departmental policy and the OIG concurred.

Incident Date: 2014-10-07	Deadly Force Incident

Incident Summary

On October 7, 2014, two inmates began fighting on an exercise yard. After the two inmates ignored orders to stop fighting, an officer fired one less-lethal round at the ground seven feet away from the inmates, causing the less-lethal round to skip. The two inmates continued to fight. The officer then fired a less-lethal round at one of the inmate's thighs but the inmates kept fighting. The officer fired another less-lethal round, again aiming at one of the inmate's thighs, causing both inmates to get down. At the same time, a second officer had observed the fighting inmates and gave orders for the inmates to get down, which the inmates had ignored. The second officer fired a less-lethal round aiming at an inmate's thigh but did not see where the round struck. The inmates began to comply with orders to get down. The inmates were taken to the triage and treatment area where one of the inmates reported he had been struck in the head by a less-lethal round. That inmate sustained abrasions to the back of his head. Both inmates were later rehoused the same day. Both the Office of Internal Affairs and the OIG were notified and responded to the scene.

Administrative Investigation

OIG Case Number: **14-2451-IR**

Central Region

1. Use of Deadly Force	Findings 1. N/A	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

Predisciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the predisciplinary process. The hiring authority failed to timely notify the OIG and the special agent failed to provide the draft investigative report to the OIG.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified by the hiring authority until the OIG was already at the institution. The OIG was notified by the Office of Internal Affairs and responded on scene.

- 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 report was not provided to 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 use of force was within departmental policy. The OIG concurred with the determination.

Incident Date: 2014-09-25	Deadly Force Incident

Incident Summary

On September 25, 2014, a control booth officer observed one inmate repeatedly strike a second inmate's head with his fists while they were on the upper tier of a housing unit. Both inmates ignored the control booth officer's orders to get down. The control booth officer discharged a less-lethal round, aiming at the first inmate's hip. The control booth officer did not see where the round struck; however, the first inmate sustained abrasions, bruising, pain, redness, and swelling on his neck which appeared consistent with being struck by a less-lethal round. The OIG and the Office of Internal Affairs were not timely notified but both responded on scene.

Administrative Investigation

OIG Case Number: **14-2450-IR**

1. Use of Deadly Force	Findings 1. N/A	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

Predisciplinary Assessment

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

The department's predisciplinary process failed to sufficiently comply with policies and procedures. The institution failed to timely notify the OIG and the Office of Internal Affairs. Additionally, the institution's executive review committee made a determination regarding the incident before OIA Central Intake completed its determination.

Assessment Questions

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

  The Office of Internal Affairs was not notified until more than three hours after the incident.

- Was the OIG promptly informed of the critical incident?

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

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

  The institution's executive review committee made a determination regarding the incident on October 17, 2014; however, OIA Central Intake did not complete its determination until October 22, 2014. Since the deadly force investigation team responded to the incident and the matter was referred to OIA Central Intake, the institution's executive review committee should have postponed its review.

Central Region

Disposition

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

Incident Date: 2014-09-08	Deadly Force Incident

Incident Summary

On September 8, 2014, an officer saw two inmates striking each other in the face with their fists. The officer activated his alarm and ordered both inmates to get down; however, both inmates continued fighting. The officer fired a less-lethal round, aiming at one of the inmate's thighs, but the officer did not know where the round struck. The inmates continued to fight and ignored the officer's repeated orders to get down. Eventually, one of the inmates began choking the other inmate. The officer fired a second less-lethal round, aiming at the lower leg of the inmate who was choking the other inmate, striking the intended target and causing both inmates to stop fighting. The inmate who began choking the other inmate claimed that a less-lethal round ricocheted and struck him in the head. That inmate had abrasions and redness to his head. Both inmates were medically examined and rehoused the same day as the incident. The Office of Internal Affairs and the OIG were notified and both responded to the scene.

Administrative Investigation

OIG Case Number: **14-2281-IR**

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department's predisciplinary process failed to comply with policies and procedures because the Office of Internal Affairs failed to provide the OIG with a draft copy of its memorandum which assessed the possible use of deadly force.

Assessment Questions

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

  The Office of Internal Affairs failed to provide the OIG with a draft copy of its memorandum wherein it was determined the incident did not meet the Office of Internal Affairs' criteria to open a deadly force investigation.

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

  The special agent failed to provide a draft copy of the investigative memorandum.

Disposition

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

Incident Date: 2014-09-04	Deadly Force Incident

Incident Summary

On September 4, 2014, an inmate porter asked for a cell door to be opened to hand an item to an inmate in the cell. As the control booth officer began to open the cell door, the inmate porter squeezed through the opening and began striking the inmate in the cell. The inmate's cellmate also began to attack the inmate. The control booth officer activated his alarm and gave orders for the inmates to get down. The inmates continued fighting, moving outside of the cell. The control booth officer fired two less-lethal rounds at the aggressor inmates. A responding officer utilized a pepper spray grenade which ultimately caused the inmates to stop fighting. All inmates were medically evaluated and rehoused. During the medical evaluation, it was determined that one inmate was struck in the forehead with a less-lethal round. The Office of Internal Affairs and the OIG were notified and both responded on scene.

Administrative Investigation

OIG Case Number: **14-2280-IR**

Central Region

1. Use of Deadly Force	Findings 1. N/A	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

Predisciplinary Assessment

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

The department's response was not adequate because the Office of Internal Affairs failed to provide the OIG with a draft copy of the investigative report to allow for feedback.

Assessment Questions

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

  A draft copy of the investigative report was not provided to 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 the use of force was in compliance with departmental policy. However, potential staff misconduct related to the control booth officer opening the cell door was identified. The OIG concurred. The hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Incident Date: 2013-11-05	Deadly Force Incident

Incident Summary

On November 5, 2013, a special agent and a parole agent from the Office of Correctional Safety participated in a joint task force operation with outside law enforcement agencies in order to apprehend a fugitive. After receiving information regarding the fugitive's whereabouts, members of the joint task force entered a residence and encountered gunfire from the fugitive. During the entry, the fugitive shot and injured a parole agent and, in response, the special agent and other outside law enforcement officers discharged multiple rounds from their firearms. The fugitive fled the residence while continuing gunfire. As the fugitive exited the residence, another parole agent and an outside law enforcement officer shot at the suspect. The fugitive died as a result of multiple gunshot wounds. The Office of Internal Affairs and the OIG were notified and both responded to the scene.

Administrative Investigation

OIG Case Number: **13-2482-IR**

1. Use of Deadly Force	Findings 1. Exonerated	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

Predisciplinary Assessment

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

The department's predisciplinary process failed to comply with the department's policies and procedures. The department attorney failed to accurately confirm the deadline for taking disciplinary action, failed to provide the OIG with a written summary regarding his review of the draft investigative report, and failed to identify the appropriate allegations at the findings conference. The Office of Internal Affairs failed to provide adequate notice regarding an interview conducted by outside law enforcement. The hiring authority failed to timely conduct the findings conference.

Assessment Questions

- Within 21 calendar days, did the department attorney make an entry into CMS accurately confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time?

  Although the department attorney made a timely CMS entry confirming key dates, he incorrectly noted the deadline for taking disciplinary action as November 7, 2014, instead of November 5, 2014.

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

  The department attorney sent an e-mail message to the special agent regarding his review of the draft investigative report. However, the department attorney failed to share the written confirmation with the OIG.

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

  The special agent sent e-mail notification for an interview being conducted that same day by outside law enforcement regarding the related criminal investigation. Rather than calling the OIG to immediately notify of the interview, the special agent sent e-mail notification three hours before the interview was scheduled to commence. The interview location was two hours away and the OIG was unable to attend.

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

  On September 25, 2014, the Deadly Force Review Board forwarded its findings to the hiring authority that the uses of deadly force complied with departmental policy; however, the hiring authority did not meet with the department attorney and the OIG regarding investigative findings until October 27, 2014, 32 days after the Deadly Force Review Board's results memorandum.

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

  The department attorney failed to identify the appropriate allegation as a use of deadly force. Instead, the department attorney recommended the appropriate allegation to be a use-of-force policy violation.

- Was the predisciplinary/investigative phase conducted with due diligence?

  The hiring authority failed to timely consult with the OIG and the department attorney regarding the investigative findings.

Disposition

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

Disciplinary Assessment

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

The department's disciplinary process sufficiently complied with policies and procedures.

Incident Date: 2014-08-20	Deadly Force Incident

Incident Summary

On August 20, 2014, an officer observed a two-on-one inmate altercation. The officer gave numerous orders for the inmates to stop with no effect. The officer discharged a less-lethal round which struck an inmate on the head as the inmate engaged in a fight on an exercise yard. The Office of Internal affairs and the OIG were both timely notified and both responded to the scene.

Administrative Investigation

OIG Case Number: **14-2117-IR**

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 within policy. The OIG concurred with the determination.

Incident Date: 2014-07-08	Deadly Force Incident

Central Region

Incident Summary

On July 8, 2014, a control booth officer observed two inmates fighting in the dayroom. The inmates ignored the control booth officer's orders to get down and continued fighting. The control booth officer fired one less-lethal round, aiming at one of the inmate's right thigh. The control booth officer was unable to see where the less-lethal round struck and the round did not stop the inmates. However, the inmates complied with orders to stop fighting once the door opened allowing more officers to respond. Both inmates had injuries from the fight. Additionally, one of the inmates reported being struck by the less-lethal round in the same place on his face where the second inmate had punched him. The inmate explained that he was struck by the less-lethal round while the second inmate had him in a choke-hold. The first inmate was taken to an outside hospital for further examination and returned to the institution three days later. The second inmate had an injury to his left arm that could have been consistent with being struck by the less-lethal round. Neither the Office of Internal Affairs nor the OIG were timely notified; however, both responded to the scene.

Administrative Investigation

OIG Case Number: **14-1656-IR**

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department's predisciplinary process failed to sufficiently comply with policies and procedures. The institution failed to timely notify the OIG and the Office of Internal Affairs.

Assessment Questions

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

  The Office of Internal Affairs was not notified until almost three hours after the incident occurred.

- Was the OIG promptly informed of the critical incident?

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

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 control booth officer's use of force was within policy; however, the video-taped interview of the inmate following the incident was determined to be out of policy because the purpose of the video-taped interview was not adequately explained to the inmate. Training was provided. The OIG concurred.

Incident Date: 2014-07-08	Deadly Force Incident

Incident Summary

On July 8, 2014, three inmates began attacking a fourth inmate, punching and kicking him while he was on the ground. Pepper spray grenades were deployed, but the inmates continued their attack. Two officers each fired one less-lethal round, aiming at the hip area of two different attackers. Neither officer could confirm where his respective round struck. However, a less-lethal round may have struck the inmate who was being attacked. That inmate sustained a possible concussion and lacerations to the left side of his head and the bridge of his nose. He was taken to an outside hospital for further treatment and returned to the institution on July 11, 2014. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation

OIG Case Number: **14-1649-IR**

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 found no violation of departmental policy. The OIG concurred.

Incident Date: 2014-06-20	Deadly Force Incident

Incident Summary

On June 20, 2014, an inmate became irate with an officer because the officer refused to return a magazine picture the inmate had been using to block his cell window. The inmate used profanity and yelled that he would fight the officer and punched the officer on the forehead. A second officer saw the altercation, activated his alarm, and ordered inmates to get down; however, the inmate involved in the altercation refused to get down. The first officer attempted to control the inmate by grabbing the inmate's arms but the inmate kept punching the first officer in the face. The first officer attempted to defend himself by punching at the inmate's face. The second officer attempted to use his baton, aiming at the inmate's bicep; however, the inmate then punched the second officer, causing the second officer to lose control of the baton. The second officer was unsure if the baton struck the inmate. The inmate was taken to the correctional treatment center for medical evaluation and rehoused later the same day. The two officers were taken to outside hospitals for treatment of injuries, both sustaining minor injuries to the head and knees. Both officers later returned to work. On June 22, 2014, the institution discovered the second officer may have struck the inmate in the head with his baton. The Office of Internal Affairs and the OIG were notified later that same day and both responded to the scene.

Administrative Investigation	OIG Case Number: **14-1546-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department failed to comply with the policies and procedures governing the predisciplinary process. The department failed to timely notify the Office of Internal Affairs and the OIG of the incident and the Office of Internal Affairs failed to provide the OIG with the draft and final investigative report.

Assessment Questions

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

  The hiring authority failed to notify the Office of Internal Affairs until two and one-half hours after discovering that an officer may have struck an inmate on the head with a baton.

- Was the OIG promptly informed of the critical incident?

  The hiring authority failed to notify the OIG until two and one-half hours after discovering that an officer may have struck an inmate on the head with a baton.

- 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.

- Was the final investigative report thorough and appropriately drafted?

  A final report was not provided to the OIG.

- Was the predisciplinary/investigative phase conducted with due diligence?

  The department failed to timely notify the Office of Internal Affairs and 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 the use of force complied with departmental policy. The OIG concurred with the determination.

Incident Date: 2014-06-15	Deadly Force Incident

Central Region

Incident Summary

On June 15, 2014, an officer observed two inmates in a cell injecting themselves with suspected controlled substances. The officer notified a second officer. Both officers went to the cell, had the control booth officer open the cell, and ordered the inmates to leave the cell for a cell search. The inmates ignored the orders and squatted, making furtive motions towards their respective groin areas. When the inmates ignored the orders, the control booth officer activated an alarm and additional officers responded. A third officer gave additional orders for the inmates to get down, which were ignored and she discharged pepper spray at the inmates. One of the inmates ran out of the cell and hit the first officer several times on the face and head with his fists. The first officer struggled with the inmate and struck the inmate in the chest with the pepper spray canister, causing it to burst. A fourth responding officer attempted to use his body weight to force the inmate down but was unsuccessful. The inmate then started hitting the first and fourth officers. At the same time, the second inmate rushed out of the cell and began repeatedly hitting a fifth officer in the head. The fifth officer attempted to punch the second inmate but was uncertain if she was able to hit him. The second officer ordered the second inmate to get down, but the second inmate ignored the orders. The second officer aimed and struck his baton at the second inmate's right arm but the second inmate moved and instead the baton struck the second inmate's head. The second inmate continued to attack staff and ran at a lieutenant. A sixth officer aimed his baton at the second inmate's shoulders but missed as the inmate continued to move, striking the inmate's head. The second inmate got down, then got back up and resumed fighting with staff. A seventh officer then aimed his baton at the second inmate's shoulder but the inmate ducked down as the seventh officer swung the baton, striking the inmate's head. Both inmates were medically evaluated and rehoused in the administrative segregation unit the same day. Neither of the inmates sustained serious injuries. The officers received minor injuries and were taken to an outside hospital. The Office of Internal Affairs and the OIG were not timely notified, but both still responded on scene.

Administrative Investigation	OIG Case Number: **14-1465-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the predisciplinary process. The department failed to timely notify the Office of Internal Affairs and the OIG of the incident. Additionally, the Office of Internal Affairs failed to provide a copy of the investigative report assessing the possible use of deadly force.

Assessment Questions

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

  The incident occurred on June 15, 2014; however, the Office of Internal Affairs was not notified until the following day.

- Was the OIG promptly informed of the critical incident?

  The incident occurred on June 15, 2014; however, the OIG was not notified until the following day by the Office of Internal Affairs soon after they were notified.

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

  A draft copy of the investigative report was not forwarded to the OIG for feedback.

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

  The special agent did not provide the OIG with a draft copy of the investigative report which would have allowed OIG to provide feedback.

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 force used was in compliance with departmental policy. The OIG concurred.

Incident Date: 2014-06-14	Deadly Force Incident

Central Region

Incident Summary

On June 14, 2014, two inmates began fighting on an exercise yard. The inmates ignored repeated orders to stop fighting and were unaffected by pepper spray grenades that custody staff deployed. One of the fighting inmates restrained the second inmate in a headlock. A sergeant used his baton, aiming at the first inmate's arm; however, the baton struck both the first inmate's arm and the second inmate's face. The sergeant then aimed at and struck the first inmate's shoulder blade with the baton, but the first inmate still held the second inmate in a headlock. The sergeant then aimed at and struck the first inmate's wrist with the baton. This final strike caused the inmates to stop fighting and comply with orders. The first inmate sustained a broken wrist. The Office of Internal Affairs did not receive timely notification, but still responded on scene.

Administrative Investigation	OIG Case Number: **14-1464-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department failed to comply with the department's policies and procedures governing the predisciplinary process. The department failed to timely notify the Office of Internal Affairs and the OIG of the incident. In addition, the initial notification to the OIG failed to inform the OIG of a possible baton strike to an inmate's head.

Assessment Questions

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

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

- Was the OIG promptly informed of the critical incident?

  The institution notified the OIG over two hours after the incident and did not provide any information that there was a possible baton strike to an inmate's head. As a result, the OIG did not respond to the incident.

- Was the predisciplinary/investigative phase conducted with due diligence?

  The institution failed to provide timely notice to both the OIG and the Office of Internal Affairs and failed to advise the OIG of a possible baton strike to an inmate's head.

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.

Incident Date: 2014-05-13	Deadly Force Incident

Incident Summary

On May 13, 2014, as a counselor was escorting an inmate on the exercise yard, the inmate became distracted by other inmates and drifted several steps behind the counselor. Four inmates then attacked the first inmate. The counselor turned around when she heard a commotion and saw the four inmates attacking the first inmate. The control booth officer saw the four-on-one inmate attack and gave orders to stop fighting. The control booth officer utilized three less-lethal rounds, aiming at the thighs of the attacking inmates. One less-lethal round struck the knee of one of the attacking inmates. Additionally, one of the attacking inmates reported a less-lethal round ricocheted off the ground and struck him on the shoulder and cheek which resulted in redness and swelling to those areas. After being medically evaluated, all involved inmates were rehoused later that same day. Although not timely notified, upon notification, both the Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation	OIG Case Number: **14-1187-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Central Region

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

The department's predisciplinary process failed to comply with the department's policies and procedures. The institution failed to timely notify the Office of Internal Affairs and failed to notify the OIG. The Office of Internal Affairs failed to provide the OIG a copy of the draft and final memorandum assessing the possible use of deadly force during this incident.

Assessment Questions

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

  The institution failed to notify the Office of Internal Affairs until nearly two hours after the incident.

- Was the OIG promptly informed of the critical incident?

  The institution failed to notify the OIG. The OIG was notified by the Office of Internal Affairs nearly two hours after the incident.

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

  The Office of Internal Affairs failed to forward a draft copy of the investigative report to the OIG to allow for feedback.

Disposition

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

Incident Date: 2014-04-07	Deadly Force Incident

Incident Summary

On April 7, 2014, two inmates began attacking a third inmate on an exercise yard, hitting the third inmate with their fists. Officers gave orders for the inmates to get down, but the inmates refused to comply. An observation officer discharged four less-lethal rounds, aiming for the legs and buttocks of the two attackers. The observation officer could not confirm where each round struck. However, the observation officer believed a less-lethal round struck the back of one of the attacker's heads because the less-lethal round bounced in the air after an attacker's head suddenly moved forward. Another officer discharged five less-lethal rounds, aiming at and striking the attacking inmates' legs. After a total of nine less-lethal rounds and three pepper spray grenades were discharged by custody staff, the inmates ultimately stopped fighting and got on the ground. The inmate who may have been struck in the head sustained a large contusion to the back of his head, consistent with being struck by a less-lethal round. That inmate was sent to an outside hospital for observation and testing. He returned to the institution two days later. The inmate who was attacked sustained a possible broken nose and was also taken to an outside hospital for treatment and later returned to the institution. The Office of Internal Affairs and the OIG were notified and both responded to the scene.

Administrative Investigation	OIG Case Number: **14-0826-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 policy. The OIG concurred.

Incident Date: 2014-08-31	Deadly Force Incident

Central Region

Incident Summary

On August 31, 2014, five inmates attacked a sixth inmate in a dining hall. The inmates ignored orders to stop fighting. The observation officer fired one less-lethal round, aiming at the thigh of one of the five attacking inmates. However, the less-lethal round struck a seventh inmate who was not involved in the altercation. The seventh inmate sustained a wound on his scalp and was taken to an outside hospital where he received six staples to close the head wound. The OIG and the Office of Internal Affairs were both timely notified and responded to the scene.

Administrative Investigation

OIG Case Number: **14-2119-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 policy, but identified a policy violation following the incident. Specifically, an officer failed to offer water to decontaminate an inmate exposed to pepper spray. The officer was ordered to complete training. The OIG concurred with the hiring authority's determinations.

North Region

Incident Date: 2013-12-26	Deadly Force Incident

Incident Summary

On December 26, 2013, two inmates attacked a third inmate on an exercise yard. Custody staff gave numerous orders to stop and get down but the attackers failed to comply and continued attacking the third inmate, who had fallen to the ground. Custody staff deployed two less-lethal rounds and chemical agents and continued giving orders to stop and get down. The inmates continued their attack. The control booth officer fired one round from the Mini-14 rifle for effect, but the round missed its intended target. After the Mini-14 rifle was fired, the attacking inmates separated from the inmate who had been attacked and all inmates assumed prone positions. The inmate who was attacked was transported via life flight to an outside hospital for treatment and later returned to the institution. Both attacking inmates were remanded to administrative segregation. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation

OIG Case Number: **14-0009-IR**

Investigation Assessment

Rating: **Sufficient**

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

Administrative Investigation

OIG Case Number: **14-0010-IR**

Allegations	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

Overall, the department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

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

Disciplinary Assessment

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

The department's disciplinary process sufficiently complied with its policies and procedures.

Incident Date: 2013-08-13	Deadly Force Incident

Incident Summary

On August 13, 2013, an off-duty officer allegedly negligently discharged his personal weapon, with which he failed to qualify, during an altercation with a private citizen. The Office of Internal Affairs was notified and responded on scene.

Administrative Investigation

OIG Case Number: **13-1675-IR**

Allegations	Findings	Initial Penalty	Final Penalty
1. **Weapons - Carrying Unauthorized Weapon Off Duty** 2. **Negligent Discharge of a Firearm**	1. **Sustained** 2. **Sustained**	**Salary Reduction**	**Modified Salary Reduction**

Predisciplinary Assessment

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

The department’s predisciplinary process sufficiently complied with policies and procedures.

North Region

Disposition

The Deadly Force Review Board found that the discharge of the round was not in compliance with the department's use-of-force policy. The case was referred to the hiring authority for further action. The OIG concurred. The hiring authority sustained the allegations that the officer failed to qualify with and negligently discharged the weapon and imposed a 10 percent salary reduction for six months. The OIG concurred. At the *Skelly* hearing, the officer acknowledged that his actions violated policy and he should have exercised better care and control over his weapon. Based on these factors, the department entered into a settlement agreement with the officer wherein the penalty was reduced to a 10 percent salary reduction for three months and the officer agreed not to file an appeal with the State Personnel Board. The OIG concurred based on the factors learned at the *Skelly* hearing.

Disciplinary Assessment

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

The department sufficiently complied with policies and procedures.

Incident Date: 2014-08-22	Deadly Force Incident

Incident Summary

On August 22, 2014, two inmates engaged in a fight and failed to comply with orders to stop fighting. Officers fired seven less-lethal rounds to stop the fight. One of the inmates subsequently claimed he may have been struck in the head with one of the less-lethal rounds. All rounds left visible marks on the inmate's body. Pictures taken of the inmate following the incident depicted the impact points on his body, none of which were on his head.

Administrative Investigation

OIG Case Number: **14-2142-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 to be in compliance with the department's policy. The OIG concurred with the determination.

Incident Date: 2014-11-04	Deadly Force Incident

Incident Summary

On November 4, 2014, two inmates began to fight on an exercise yard. Officers gave multiple orders for the inmates to get down and stop fighting, but the inmates continued to fight. In order to stop the fight, the control booth officer fired one less-lethal round at the back thigh of one of the inmates. The round struck the inmate on the side of his chest. The second inmate alleged that the round struck him on his head behind his ear. The Office of Internal Affairs and the OIG were timely notified and both responded on scene.

Administrative Investigation

OIG Case Number: **14-2617-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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. The OIG concurred with the determination.

Incident Date: 2013-11-18	Deadly Force Incident

Incident Summary

On November 18, 2013, an inmate attempted to murder an officer by repeatedly slashing him in the head and neck with an inmate-manufactured weapon. Officers used chemical agents, physical force, and batons to stop the attack, without effect. A second inmate tried to attack the responding officers; however, he was sprayed with pepper spray and assumed a prone position. One responding officer allegedly intentionally struck the first inmate twice on the head with a baton to stop the attack. The officer who was attacked also allegedly intentionally struck the first inmate on the side of his head with a baton to stop the attack. The first inmate was physically forced to the ground and restrained. The officer who was attacked sustained several puncture wounds and lacerations to his head and neck, and was taken to an outside hospital by ambulance for medical treatment. The officer survived the attack but missed several months from work as a result. 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 and administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **13-2497-IR**

Investigation Assessment

Rating: **Sufficient**

The department's investigative process sufficiently complied with policies and procedures.

Administrative Investigation	OIG Case Number: **13-2498-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

The Deadly Force Review Board determined that the officers' actions were in full compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officers and the OIG concurred.

Disciplinary Assessment

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

The department's disciplinary process sufficiently complied with policies and procedures.

Incident Date: 2014-09-14	Deadly Force Incident

Incident Summary

On September 14, 2014, during an inmate fight, an officer used his expandable baton to strike at an inmate's right shoulder. The strike glanced off the inmate's shoulder and inadvertently struck the inmate on the back of the head. The officer delivered a second baton strike to the inmate's lower back. The inmate sustained a non-life-threatening cut on the back of his head which required two staples to close. The inmate was treated on site by medical staff and rehoused in administrative segregation. The Office of Internal Affairs and the OIG were timely notified and both responded on scene.

Administrative Investigation	OIG Case Number: **14-2348-IR**

North Region

1. Use of Deadly Force	Findings 1. N/A	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

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 complied with departmental policy. The OIG concurred with the determination.

Incident Date: 2013-10-29	Deadly Force Incident

Incident Summary

On October 29, 2013, an off-duty sergeant allegedly used his personal firearm to shoot and kill a pitbull dog that was attacking an 11-year-old boy. The boy was hospitalized with serious injuries and sustained multiple puncture wounds to his chest and abdominal area as a result of the pitbull dog attack.

Administrative Investigation

OIG Case Number: **13-2506-IR**

1. Use of Deadly Force	Findings 1. Exonerated	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

Predisciplinary Assessment

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

Overall, the department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

The Deadly Force Review Board determined the use of force complied with departmental policy. The hiring authority subsequently exonerated the sergeant. The OIG concurred with the hiring authority's determination.

Disciplinary Assessment

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

The department's disciplinary process sufficiently complied with policies and procedures.

Incident Date: 2014-08-11	Deadly Force Incident

Incident Summary

On August 11, 2014, a control booth officer observed two inmates fighting in the dayroom. The inmates continued fighting after officers ordered the inmates to stop. The control booth officer fired one less-lethal round at the buttocks of one of the inmates. The inmate moved and the round did not strike the intended target; however, the inmates stopped fighting. One inmate had blood on the side of his head, was sent to an outside hospital for treatment, and returned to the institution that night. The control booth officer believed he may have struck the inmate in the head with the less-lethal round. The OIG and the Office of Internal Affairs were timely notified and both responded on scene.

Administrative Investigation

OIG Case Number: **14-1975-IR**

1. Use of Deadly Force	Findings 1. N/A	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

North Region

Disposition

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

Incident Date: 2014-08-06	Deadly Force Incident

Incident Summary

On August 6, 2014, after officers removed paper from an inmate's window, the inmate blocked officers from closing his cell door and refused orders to remove his foot from the door. The inmate clenched his fists and made a sudden movement toward the officers. One of the officers pushed the inmate back into the cell, but the inmate began punching the officer and grabbed his baton. A second officer struck the inmate on the back and shoulders with a baton. A third officer and the first officer used physical force to gain control of the inmate and the baton that the inmate had taken. The inmate eventually complied with orders to get down and was placed in handcuffs. The inmate had a wound on his forehead requiring four staples that could have been caused by being struck in the head with the baton. The OIG and the Office of Internal Affairs were timely notified and both responded on scene.

Administrative Investigation

OIG Case Number: **14-1915-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 all uses of force complied with departmental policy. The OIG concurred with the determinations.

Incident Date: 2014-05-24	Deadly Force Incident

Incident Summary

On May 24, 2014, two inmates were involved in a fight. Officers responded and ordered the inmates to get down but the inmates continued fighting. One officer drew his baton and struck one of the inmates in the left shoulder. The inmates were again ordered to get down but continued fighting. The officer attempted to strike the second inmate in the shoulder with his baton. However, due to the erratic movements of the two inmates, and the first inmate pulling the second inmate toward him, the baton struck the second inmate on the top of his head causing a two-inch laceration on the inmate's scalp. The inmates stopped fighting and got down. The injured inmate was taken to the infirmary and received staples to close the laceration. The Office of Internal Affairs and the OIG were timely notified and both responded on scene.

Administrative Investigation

OIG Case Number: **14-1255-IR**

	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 institution's executive review committee determined that the use of force complied with departmental policy. The OIG concurred with these determinations.

North Region

Incident Date: 2014-04-29	Deadly Force Incident

Incident Summary

On April 29, 2014, approximately 25 inmates engaged in a riot on an exercise yard. Officers fired one warning shot from a Mini-14 rifle and six less-lethal rounds to stop the incident. One inmate was struck in the lip by a less-lethal round. The injured inmate was treated at the institution where he received three stitches and returned to his housing unit. The Office of Internal Affairs and the OIG were timely notified and responded on scene.

Administrative Investigation	OIG Case Number: **14-1075-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 complied with departmental policy. The OIG concurred with the determination.

Incident Date: 2014-03-15	Deadly Force Incident

Incident Summary

On March 15, 2014, two inmates began fighting in the day room. The control booth officer ordered the inmates to get down and, when they did not comply, the officer fired one less-lethal round at an inmate’s leg, but missed. The inmates continued fighting and the officer ordered them down again and aimed a second less-lethal round at an inmate’s leg. The round missed the inmate's leg, hit the inmate in the back, and ricocheted, hitting the inmate in the back of the head. The inmates separated and got down, but then resumed fighting. A third less-lethal round was fired at an inmate’s leg, but again missed. The inmates stopped fighting and got down. The Office of Internal Affairs and the OIG were timely notified and responded on scene.

Administrative Investigation	OIG Case Number: **14-0617-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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 within departmental policy and the OIG concurred.

Incident Date: 2014-02-14	Deadly Force Incident

Incident Summary

On February 14, 2014, custody staff observed two inmates fighting. The inmates refused orders to stop and an officer deployed pepper spray, to no avail. Another officer fired one less-lethal round that potentially struck one of the inmates on the head. The inmate sustained a laceration to his head, was transported to an outside hospital for treatment, and returned to the institution the following day. The Office of Internal Affairs and the OIG were timely notified and both responded on scene.

Administrative Investigation	OIG Case Number: **14-0476-IR**

North Region

1. Use of Deadly Force	Findings 1. N/A	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

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 found the inmate cut his head when he fell during the fight and that staff's use of force prior to, during, and following the incident complied with departmental policies and procedures. The OIG concurred.

Incident Date: 2014-10-24	Deadly Force Incident

Incident Summary

On October 24, 2014, two inmates began fighting on an exercise yard. Officers gave multiple orders for the inmates to get down and stop fighting but the inmates continued to fight. An observation officer fired one less-lethal round, aiming for the back thigh of one of the inmates. The round had no effect. The officer fired a second less-lethal round. Both inmates complied with orders to stop fighting and got down. Both inmates were removed from the exercise yard and were medically evaluated. One inmate suffered abrasions on the back of his right arm and the back of his upper left thigh. These abrasions were consistent with being struck by the less-lethal rounds. The second inmate had no injuries consistent with being struck by a less-lethal round; however, he claimed that he had been hit in the head and cheek by one of the rounds. The Office of Internal Affairs and the OIG were timely notified and responded on scene.

Administrative Investigation

OIG Case Number: **14-2533-IR**

1. Use of Deadly Force	Findings 1. N/A	Initial Penalty No Penalty Imposed	Final Penalty No Penalty Imposed

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. The OIG concurred with the determination.

South Region

Incident Date: 2014-09-17	Deadly Force Incident

Incident Summary

On September 17, 2014, two inmates attacked a third inmate. A control booth officer fired multiple less-lethal rounds in an attempt to stop the fight. One inmate initially claimed he was hit on the head by one of the rounds. The inmate had no serious injuries and was treated for wounds related to the fight. Later, the inmate said he did not know what caused his head injuries. The inmate did not require further medical care and was returned to his cell. The Office of Internal Affairs and the OIG were timely notified and responded to the scene.

Administrative Investigation

OIG Case Number: **14-2237-IR**

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

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

Disposition

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

Incident Date: 2013-12-23	Deadly Force Incident

Incident Summary

On December 23, 2013, an officer allegedly fired four rounds from his off-duty weapon and wounded a private citizen who had attempted to rob him. The private citizen sustained gunshot wounds to the left side of his lower abdomen, left lower back, and left upper arm. He was transported to a local hospital where he received life-saving treatment. The Office of Internal Affairs and the OIG were timely notified and both responded to the scene.

Administrative Investigation

OIG Case Number: **13-2724-IR**

	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

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

Disciplinary Assessment

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

The department's disciplinary process sufficiently complied with policies and procedures.

Incident Date: 2013-12-30	Deadly Force Incident

South Region

Incident Summary

On December 30, 2013, two parole agents and outside law enforcement officers located a parolee-at-large who was a suspect in a recent homicide. As the parolee attempted to flee in his vehicle, the parole agents and outside law enforcement officers fired at the vehicle, striking the parolee twice in the shoulder. The parolee did not sustain life-threatening injures and was taken to a local hospital where he obtained medical treatment before being placed into custody. The Office of Internal Affairs and the OIG were timely notified and responded on scene.

Administrative Investigation	OIG Case Number: **14-0002-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department's predisciplinary process sufficiently complied with policies and procedures.

Disposition

The Deadly Force Review Board and the institution's executive review committee found that the discharge of the lethal rounds complied with the department's use-of-force policy. The hiring authority subsequently exonerated the parole agents and the OIG concurred.

Disciplinary Assessment

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

The department's disciplinary process sufficiently complied with policies and procedures.

Incident Date: 2014-01-26	Deadly Force Incident

Incident Summary

On January 26, 2014, two inmates began fighting. Officers gave multiple orders for the inmates to get down but the inmates continued to fight. Two officers used their batons, striking the inmates on the thigh and buttocks, which stopped the fight. One of the inmates initially alleged that an officer struck him on the head with a baton. The inmate later denied being hit on the head with a baton, stating his injuries were the result of the fight. Both inmates were treated at the institution for non-life threatening injuries. Although the Office of Internal Affairs was not timely notified, they responded on scene.

Administrative Investigation	OIG Case Number: **14-0406-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

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. The OIG concurred with the determination.

Incident Date: 2014-04-08	Deadly Force Incident

Incident Summary

On April 8, 2014, two inmates began fighting. Orders to stop fighting were ineffective. One officer inadvertently struck one of the fighting inmates on the head with a baton while attempting to stop the fight. The inmate who was struck with the baton was treated at an outside hospital and returned to the institution later that day. The Office of Internal Affairs and the OIG were not timely notified but both responded to the scene.

Administrative Investigation	OIG Case Number: **14-0910-IR**

South Region

Administrative Investigation	OIG Case Number: **14-0910-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the predisciplinary process. The institution failed to timely notify the Office of Internal Affairs and the OIG.

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 four hours after the incident occurred.

- Was the OIG promptly informed of the critical incident?

  The institution did not notify the OIG until four hours after the incident occurred.

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 complied with departmental policy and the OIG concurred.

Incident Date: 2014-05-29	Deadly Force Incident

Incident Summary

On May 29, 2014, an officer allegedly struck an inmate on the head with a pepper spray canister after the inmate approached the officer with clenched fists and failed to stop his advance even though the officer deployed pepper spray in the direction of the inmate. The inmate suffered minor injuries. The OIG and the Office of Internal Affairs were not timely notified, but responded to the scene the following day.

Administrative Investigation	OIG Case Number: **14-1257-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The institution failed to timely notify the Office of Internal Affairs and the OIG. As a result, neither the Office of Internal Affairs nor the OIG were able to timely respond to the scene.

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 one and one-half hours after the incident.

- Was the OIG promptly informed of the critical incident?

  The institution did not notify the OIG until one and one-half hours after the incident.

Disposition

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

Incident Date: 2014-08-09	Deadly Force Incident

South Region

Incident Summary

On August 9, 2014, an inmate became disruptive and failed to comply with orders to get down. After the use of pepper spray, the inmate hit an officer in the chest. The officer inadvertently struck the inmate on the head with his baton while attempting to strike the inmate on the shoulder. The inmate received a laceration to the back of his head and was transported to a community hospital for treatment, which included staples. The inmate returned to the institution later the same day. The Office of Internal Affairs and the OIG were not timely notified; however, both responded to the scene.

Administrative Investigation	OIG Case Number: **14-2005-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. N/A**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department failed to sufficiently comply with policies and procedures governing the predisciplinary process. The institution failed to timely notify the Office of Internal Affairs and the OIG.

Assessment Questions

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

  The institution failed to notify the Office of Internal Affairs until three and one-half hours after the incident.

- Was the OIG promptly informed of the critical incident?

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

- Was the predisciplinary/investigative phase conducted with due diligence?

  The institution failed to notify the Office of Internal Affairs and the OIG of the incident in a timely manner.

Disposition

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

CRITICAL INCIDENT CASE SUMMARIES

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-02-02	**14-0486-RO**	**Other Significant Incident**

Incident Summary

On February 2, 2014, as inmates were preparing to be released for the evening meal, an officer noticed that the inmates were moving down the stairs without authorization. The officer asked the inmates why they were moving without permission. One of the inmates struck the officer in the face with his fist. A second inmate told the officer "we have to do this." Seven inmates began striking the officer in the head and upper torso. The officer was struck on the side of his right knee, causing him to collapse. As the inmates continued punching and kicking the officer while he was down, the control booth officer fired two less-lethal rounds to stop the attack. The injured officer stood to his feet, called for assistance on the radio, drew his baton, and ensured that the inmates remained down until responding officers arrived.

Disposition

The institution's executive review committee found that although the use of force was within departmental policy, officers failed to announce the alarm over the radio. Training was provided to the officers. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was inadequate. Although the department timely notified the OIG, it failed to attempt to identify why the officer was assaulted and it unnecessarily delayed providing the OIG with the threat assessment. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  Although the threat assessment was completed on March 4, 2014, the institution did not provide it to the OIG until September 22, 2014, despite numerous requests.

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

  The threat assessment the institution completed was vague and did not attempt to identify why the officer was assaulted.

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

  The OIG recommended that the institution request a threat assessment by the Office of Correctional Safety. The institution conducted its own threat assessment.

Incident Date	OIG Case Number	Case Type
2014-02-12	**14-0487-RO**	**In-Custody Inmate Death**

Incident Summary

On February 12, 2014, an officer heard someone yell "man down" on a basketball court. The officer ran to the location of the incident and found an inmate on the ground, unresponsive but breathing. An emergency medical response was requested. Within two minutes, medical staff arrived and provided life-saving measures. The inmate became responsive and was transferred to the institution's medical clinic. The inmate appeared to have a head injury caused by blunt force trauma. The inmate was transported to an outside hospital via ambulance where he stopped breathing and was pronounced dead after life-saving measures failed.

Disposition

The autopsy established the cause of death to be respiratory arrest due to a brain injury caused by blunt force trauma from a fall. The department's Death Review Committee determined that although there were inconsistencies in the timeline between first responder notes, the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

CENTRAL REGION

Overall Assessment

Rating: 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 three hours after the inmate was transported to an outside hospital and two hours after he died.

Incident Date	OIG Case Number	Case Type
2014-02-27	**14-0503-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On February 27, 2014, a housing unit officer heard slapping noises coming from a cell. The officer responded to the cell and saw an inmate striking his cellmate in the head and upper torso with his fist. The cellmate was lying on the lower bunk covering his head with his arms. The inmate attacker complied with orders to stop and laid prone on the floor. The officer activated the alarm. Responding staff arrived and removed the attacker from the cell without incident. Due to a serious head injury, the injured inmate was transported to an outside hospital via ambulance. The injured inmate returned to the institution from the hospital on March 3, 2014. Two days later, the inmate's condition deteriorated. Therefore, he was transferred back to the outside hospital for an additional five days before returning to the institution.

Disposition

The department completed an in-cell assault review and determined that the inmates were compatible at the time they were housed together. 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 response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-04-25	**14-1331-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On April 25, 2014, an officer ordered an inmate to return to his cell after the inmate became boisterous and quarrelsome with medical staff. The officer reported that the inmate suddenly hit him in the head with his fist. The officer attempted to force the inmate to the ground with his body weight. Additional officers arrived, forced the inmate to the ground, and placed him in restraints. The inmate alleged that the officers used unreasonable force. The inmate was transported to an outside hospital for treatment of a fractured orbit and returned after four days.

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: Insufficient

The department's response was not adequate because the department failed to notify the OIG that the inmate sustained a fractured orbit due to use of force, thereby 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 for investigation.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

  Although the OIG received timely notification of the incident, the OIG was not informed about the inmate's fractured orbit resulting from the use of force. The OIG was told only that the inmate assaulted custody staff and that the inmate received a slight cut during the incident.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-05-05	14-1053-RO	In-Custody Inmate Death

Incident Summary

On May 5, 2014, two officers responded to a cell and discovered an unresponsive inmate after the cellmate had yelled "man down." The cellmate was secured and removed from the cell. Responding custody and medical staff began life-saving measures on the unresponsive inmate. The inmate was taken to an outside hospital where he was later pronounced dead. As the cellmate was being photographed and processed for evidence, he stated that he and the inmate were doing exercises in their cell when the inmate suddenly fell to the ground. The cellmate had no apparent signs of injury on his body.

Disposition

The autopsy determined the inmate died of natural causes due to atherosclerotic heart disease. 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
2014-05-07	14-1081-RO	In-Custody Inmate Death

Incident Summary

On May 7, 2014, an inmate suddenly lost consciousness and hit his head in a shower. Officers responded and found the inmate unresponsive but breathing. Officers requested an emergency medical response. As medical staff removed the inmate from the shower, he stopped breathing and emergency life-saving measures were initiated. The inmate was transported to an outside hospital via ambulance where he was pronounced dead after life-saving efforts failed.

Disposition

The autopsy report revealed the cause of death was cardiac arrest. The inmate had an abnormally slow heartbeat that required a pacemaker. The department’s Death Review Committee determined that the death was not preventable, and the inmate had refused a pacemaker. 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 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
2014-06-04	14-1300-RO	In-Custody Inmate Death

Incident Summary

On June 4, 2014, an inmate told an officer "he hit me" during a security check. The officer noticed the cellmate was on the floor, covered with a blanket and unresponsive. An alarm was announced over the radio. The inmate that alerted officers was removed from the cell and an emergency extraction team entered the cell. Officers removed the blanket and discovered the unresponsive inmate had a bag and towel covering his head with a cloth tied around his neck. Officers immediately removed the towel and bag and began life-saving measures, while another officer obtained a cut-down tool and cut the cloth tied around the inmate's neck. Medical staff arrived and continued life-saving measures; however, the inmate was later pronounced dead.

Disposition

The autopsy determined that the inmate died of strangulation following blunt force trauma to his head. The manner of death was homicide. The department completed an in-cell assault review and concluded that the inmates were compatible at the time they were placed together, and their cell assignment followed departmental policy. 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 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 critical incident adequately documented?

  The institution was unable to provide documentation to show this incident was reviewed by the institution's emergency medical response review committee as required by departmental policy.

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

  The hiring authority was informed about departmental policy requiring an emergency medical response review but did not address the matter.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified. The OIG discovered the death while reviewing the department's daily briefing report.

Incident Date	OIG Case Number	Case Type
2014-06-05	**14-1303-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On June 5, 2014, an inmate was moved to a new cell. The inmate occupying the cell was instructed to sit on the lower bunk. As the officer was removing the handcuffs from the inmate, the other inmate jumped up from the lower bunk and began attacking the inmate with an inmate-manufactured weapon. The officer used pepper spray to stop the attack. The injured inmate was transported to an outside hospital via ambulance where he spent four days due to his injuries. The other inmate was placed in administrative segregation pending an investigation. The injured inmate alleged he was forced to move in with the other inmate after he told the sergeant that he was not compatible and feared for his safety.

Disposition

The hiring authority completed an inquiry into the injured inmate's allegation that he told the sergeant he feared for his safety prior to being placed in the cell with the inmate. The inquiry concluded that the injured inmate told the sergeant he could not be housed with specific gang associates and that the assailant was not affiliated with that gang. The institution's executive review committee determined that the officer used pepper spray closer than the minimum distance allowed by policy. The deviation from policy was deemed acceptable based on the immediate threat and the OIG concurred. The hiring authority's in-cell assault review determined that both inmates had a history of single-cell status due to in-cell assaults, but both inmates were housed appropriately at the time of the incident. The review did not address the inadequacy of the department's policy for determining compatibility of inmates on a sensitive needs yard. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

The department's response to this incident was satisfactory. 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
2014-06-10	**14-1335-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On June 10, 2014, an officer responded to a cell after hearing a loud, banging sound coming from the cell. The officer observed an inmate on the floor and his cellmate striking him in the face with his left fist. The officer saw that the attacker was holding an inmate-manufactured stabbing weapon in his right hand. The officer activated the alarm and ordered the inmate to stop the attack. The inmate ignored the orders and continued the attack until additional officers arrived. The inmate then submitted to restraints without incident. The injured inmate was transported to an outside hospital via ambulance for injuries, including two punctured lungs and multiple stab wounds to the face and upper torso. The inmate returned to the institution the following day.

Disposition

The department's in-cell assault review concluded that custody staff did not immediately place the injured inmate on single-cell status until three days after the incident. This delay did not result in any further incident and the involved staff received training. The OIG concurred with this decision. 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 adequate in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-06-15	**14-1467-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On June 15, 2014, officers were conducting an unclothed body search of an inmate after a visit when the inmate suddenly reached for his rectum and attempted to remove an object. Officers ordered the inmate to stop and get down on the ground. The inmate began to comply, but suddenly jumped to his feet. Officers forced the inmate down, causing him to hit his head on the ground, and placed a spit hood over his head allegedly to prevent the spread of bloodborne pathogens. The inmate became unresponsive. Medical staff determined the inmate had an open wound and bruising on his head. The inmate was transported to an outside hospital via ambulance for a life-threatening head injury. The inmate returned to the institution after treatment the following day.

Disposition

The institution's executive review committee ordered training for custody staff because of the inappropriate use of the spit hood. Training was also provided to custody staff regarding videotaping interviews. In addition, the OIG consulted with the hiring authority regarding the poor communication regarding the suspected contraband and the failure to request reports from the officers at the hospital. Since the primary reason the inmate was transported to an outside hospital was due to a medical emergency, the suspected contraband was a secondary issue and the officers at the hospital did not appear to know the inmate was concealing contraband. The OIG recommended training for the incident commander to ensure better communication and more thorough report writing. The hiring authority concurred with the OIG. 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. The department failed to notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the incident. The OIG determined custody staff at the institution failed to advise the officers at the hospital of the need to observe the inmate for suspected contraband, and reports were not requested from officers at the hospital. The department failed to properly follow the use-of-force policy regarding use of the spit hood and timely completion of the videotaped interview. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs for investigation.

Assessment Questions

- Was the critical incident adequately documented?

  The incident commander failed to identify the officers on duty at the hospital or request reports from them; therefore, it is unknown why the officers did not observe the inmate remove the contraband.

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

  Due to miscommunication, officers at the hospital were unaware that the inmate had suspected contraband. Also, officers placed a spit hood on the inmate because he was bleeding from a laceration, which is not consistent with departmental policy. The spit hood will not prevent the transfer of blood from a head injury, because it is composed of loose netting around the head. Also, although the video-taped interview was initially conducted within 48 hours, there was a malfunction that went undetected for nine days; therefore, a second video-taped interview was necessary. Therefore, the video-taped interview was not completed within 48 hours.

- Was the OIG promptly informed of the critical incident?

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-06-29	**14-1552-RO**	**In-Custody Inmate Death**

Incident Summary

On June 29, 2014, a control booth officer asked a floor officer to check a cell after hearing a "man down" call. The floor officer found an inmate unresponsive in the cell with visible injuries to his face and a large amount of blood on the floor. The officer announced a medical emergency over the radio. Responding officers removed the cellmate. Medical staff called an ambulance and began life-saving measures on the injured inmate after determining he did not have a pulse. The inmate was transported to the medical clinic while life-saving measures continued. The ambulance arrived and transported the inmate to an outside hospital where he was later pronounced dead. The cellmate told officers that he hit the inmate after he was sexually assaulted by him.

Disposition

The autopsy determined that the inmate died of blunt force trauma to his head, neck, and chest. The manner of death was homicide. The department completed an in-cell assault review and concluded that the inmates were compatible at the time they were placed together and their cell assignment followed departmental policy. The 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. The department adequately notified and consulted with 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
2014-06-30	**14-1537-RO**	**Hunger Strike**

Incident Summary

On June 30, 2014, 34 inmates in administrative segregation began a hunger strike, protesting restrictions on appliances and property in the administrative segregation unit. The inmates ended their hunger strike on July 3, 2014, after the hiring authority addressed some of the inmate grievances which included electrical repairs and access to property and canteen.

Disposition

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

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-07-06	**14-1645-RO**	**Suicide**

Incident Summary

On July 6, 2014, while conducting welfare checks, an officer discovered an inmate hanging by a bed sheet in his cell. Responding custody staff cut down the inmate. Officers and medical staff began life-saving measures. The inmate was transported to an outside hospital via ambulance where he was pronounced dead after life-saving efforts failed. The inmate was the sole occupant of the cell.

Disposition

The autopsy determined the cause of death was ligature strangulation. The inmate returned from the Department of State Hospitals for suicidal behavior and then was placed in administrative segregation because he feared for his life. The department's Forensic Psychological Autopsy Report determined clinical staff did not make the appropriate determination that the inmate was at risk for suicide which would have required the implementation of a five-day follow up. The report recommended training for clinical staff. 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.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-07-08	14-1659-RO	In-Custody Inmate Death

Incident Summary

On July 8, 2014, an officer discovered an unresponsive single-celled inmate lying on his bunk with the television and light on. Officers announced a medical emergency, entered the cell, and secured the inmate as medical staff arrived. Medical and custody staff removed the inmate from his cell and carried him to the emergency response vehicle where they began performing life-saving measures. Despite these life-saving efforts, the inmate was later pronounced dead.

Disposition

The coroner determined the cause of death was heart failure. The department's Death Review Committee determined the death was not preventable. The department evaluated the medical response to the emergency and determined that proper medical practices were followed. The OIG did not concur because life-saving efforts were delayed. The OIG recommended that the institution address the physical barriers in the housing unit which led to the delay and develop a plan for improvement. 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 they failed to notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the incident. The department also failed to address the delay in providing life-saving efforts to an unresponsive inmate. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The OIG informed the hiring authority about the delay in life-saving efforts. The hiring authority referred the matter to their chief physician who stated that medical staff should have considered never starting life-saving measures. The OIG clinical expert disagreed, noting that even after a significant delay in life-saving efforts, the automated external defibrillator recommended shocking the inmate. The OIG recommended that the institution improve their emergency medical response plan so that life-saving efforts can be initiated sooner to avoid missing the brief window to successfully restore circulation.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until more than two hours after the inmate was pronounced dead.

- Did the HA timely respond to the critical incident?

  Life-saving measures were delayed. Life-saving efforts should have begun within ten seconds after determining the absence of a pulse. The inmate was moved from the cell, down the hall, down a complex set of stairs, out of the building, onto a stretcher, and into the back of the emergency vehicle before life-saving efforts were started.

Incident Date	OIG Case Number	Case Type
2014-07-09	14-1648-RO	Suicide

Incident Summary

On July 9, 2014, medical staff discovered an unresponsive inmate hanging in a cell. The noose was made from a bed sheet tied around the inmate's neck and attached to the upper bunk. Responding custody staff cut the noose from the inmate's neck and began life-saving measures with the help of medical staff. Additional medical staff arrived and transported the inmate to the medical clinic where he was pronounced dead. The inmate was the sole occupant of the cell.

Disposition

The coroner's autopsy determined the manner of death was suicide and the cause of death was hanging. The department's Forensic Psychological Autopsy review determined that there was no record of the required suicide risk evaluation or initial mental health screening. Based on case factors, the review determined the inmate was a high risk for suicide. The Emergency Medical Response Review Committee identified opportunities for improvement specific to calling an ambulance and initiating the emergency response vehicle sooner. Based on the review, mental health clinicians received training and clinical supervisors will actively monitor the completion of suicide risk evaluations. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

CENTRAL REGION

Overall Assessment	Rating: **Insufficient**

The department adequately notified and consulted with the OIG regarding the incident. However, the department's actions prior to the incident were inadequate because the institution failed to complete the required mental health evaluation and suicide risk assessment or failed to document those encounters upon the inmate's arrival to the institution due to an inadequate mental health screening process. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  There was no documentation to confirm the inmate received the required suicide risk screening or the initial mental health evaluation upon arrival at the institution.

Incident Date	OIG Case Number	Case Type
2014-07-16	**14-1702-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On July 16, 2014, an inmate became verbally disruptive while waiting in a holding cell with other inmates. Officers were unsuccessful at calming the inmate down, so they asked the inmate to move out of the cell away from the other inmates. The inmate refused to move, so officers removed all uninvolved inmates. An officer activated the alarm after the inmate began screaming obscenities. As officers responded to the alarm, the inmate stood up and lunged toward officers with clenched fists. Two officers used physical force to take the inmate to the ground, restrain him, and place him in a spit hood. The inmate was transported to the medical clinic via a gurney and treated for a head injury.

Disposition

The institution's executive review committee determined the lieutenant should have remained at the cell front instead of placing the incident under the control of the sergeant and stepping away to call the captain about the escalating situation. The committee determined that door to the cell was not locked because the lieutenant was new to the reception center and unaware that the door did not automatically lock when it closed. The lieutenant received training following the committee's determination. In addition, the hiring authority instructed custody supervisors to thoroughly address the inmate's allegation of unreasonable force after the OIG expressed concerns regarding the initial video-taped interview with the inmate. The OIG also disagreed with the hiring authority about the use of the spit hood. 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 hiring authority failed to address the misuse of the spit hood. In addition, custody supervisors inadequately assessed the inmate's allegation of unreasonable force and the failure to secure the holding cell door after the uninvolved inmates were removed. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs for investigation.

Assessment Questions

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

  A sergeant placed a spit hood on the inmate because he was bleeding from a laceration on his forehead, which is not consistent with departmental policy. The spit hood will not prevent the transfer of blood from a head injury because it is composed of loose netting around the head.

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

  The custody supervisor and manager failed to fully address the inmate's allegation of unreasonable use of force. The lieutenant failed to secure the cell door after removing the other inmates from the holding cell and left the scene of the incident before it was resolved.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2014-07-17	**14-1935-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On July 17, 2014, officers on an exercise yard observed two inmates striking a third inmate in the upper torso and face. An alarm was announced on the institutional radio. Officers then noticed that the third inmate was bleeding profusely from his upper torso as the attack continued. Two officers fired three less-lethal rounds at the attackers. Although none of the inmates were struck with the less-lethal rounds, the attack stopped. One of the assailants threw an inmate-manufactured weapon over a concrete wall. The weapon was recovered and placed into evidence. The injured inmate suffered multiple stab wounds, was air-lifted to an outside hospital, and returned to the institution five days 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 an investigation.

Overall Assessment

Rating: **Sufficient**

Except for failing to timely document the assailants as enemies of the injured inmate, the department's response to the incident was otherwise satisfactory. 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
2014-07-25	**14-1761-RO**	**In-Custody Inmate Death**

Incident Summary

On July 25, 2014, an officer was escorting an unrestrained inmate, when the inmate complained of chest pain. The officer called medical staff, and a nurse responded. The nurse assisted with placing the inmate into a wheelchair and transporting the inmate to the triage and treatment area for a medical evaluation. As a physician was examining the inmate, the inmate went into cardiac arrest. Medical staff began life-saving measures and called an ambulance, which transported the inmate to an outside hospital. The inmate was pronounced dead after life-saving efforts failed.

Disposition

The autopsy determined that the inmate died of coronary artery disease. The department's Death Review Committee concluded that the death was not preventable, but the inmate should have been transported in an emergency response vehicle instead of a wheelchair. 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. The department adequately notified and consulted with 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
2014-08-02	**14-1864-RO**	**Other Significant Incident**

Incident Summary

On August 2, 2014, a suicidal inmate escaped from an institution's vehicle while being transported to another institution. While en route, the officers heard a "thump" noise, pulled over, and discovered the inmate missing and his leg restraints left behind. Outside law enforcement agencies were alerted and an incident command post was activated. The next day, outside law enforcement apprehended the inmate who had a ten-inch screwdriver in his possession.

Disposition

Potential staff misconduct was identified. The vehicle's holding area had equipment issues allegedly not identified or addressed prior to the inmate's transport. Additionally, required forms were allegedly not completed and the transportation officers allegedly made unauthorized stops and failed to comply with departmental policy regarding who should be armed during the transport. 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 response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-08-19	**14-2043-RO**	**Contraband Watch**

Incident Summary

On August 19, 2014, officers learned that an inmate was planning to introduce drugs into the administrative segregation unit. During questioning, the inmate admitted to having drugs hidden in his rectum. The inmate was placed on contraband surveillance watch. On August 22, 2014, the inmate asked medical staff if they would remove the drugs from his body because they were not coming out during bowel movements. The inmate was transported to an outside hospital where he remained on contraband surveillance watch. While at the hospital, the inmate defecated a bindle of drugs which an officer recovered. A colonoscopy verified the absence of additional contraband. The inmate was removed from contraband surveillance watch and returned to the institution on August 23, 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 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
2014-09-09	**14-2221-RO**	**Other Significant Incident**

Incident Summary

On September 9, 2014, two officers observed three inmates attempting to conceal an unknown object. The officers ordered the inmates to submit to a search. During the search, the metal detector alerted one of the officers to a potential weapon. The first officer ordered the inmate to submit to handcuffs, but the inmate turned and hit the officer in the face with his fist. The inmate then punched the second officer twice in the face, retrieved an inmate-manufactured weapon from his person, and attempted to stab the second officer in the neck. The alarm was activated and additional officers arrived. Officers used pepper spray, physical force, a baton, and a head strike with a pepper spray canister to gain control of the inmate. The second officer fractured his thumb during the incident. Two other officers received minor injuries. The inmates did not receive serious injuries as a result of the force used.

Disposition

The institution's executive review committee determined that the use of force deviated from departmental policy because pepper spray was used closer than the allowable minimum distance and the pepper spray canister was used to strike the inmate in the head. However, the committee concluded that the use of force was reasonable based on the threat presented to the officers. The committee also determined that the camera operator should receive training because he failed to identify himself during the video-taped interview. 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 OIG determined that the department adequately responded to the incident in all critical aspects. The department informed and consulted with 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.

Incident Date	OIG Case Number	Case Type
2014-09-11	**14-2190-RO**	**PREA**

Incident Summary

On September 11, 2014, an inmate alleged that a painter fondled her buttocks through her pants. The inmate also alleged that she reciprocated in sexual contact and exposed her breasts.

Disposition

Potential staff misconduct was identified based on the inmate's allegation of a sexual assault; therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

CENTRAL REGION

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 to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-11-04	**14-2645-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On November 4, 2014, during the dayroom release, several inmates told officers there was a “man down” in one of the cells. Officers found an inmate lying on the floor of his cell in a pool of blood. Officers requested an emergency medical response after determining the inmate was unresponsive, but breathing. Medical staff called for an ambulance and placed the injured inmate in a cervical collar and backboard. The inmate was transported to an outside hospital via ambulance and returned to a different institution 15 days later. The cellmate was placed in administrative segregation pending investigation.

Disposition

The injured inmate did not implicate his cellmate as the cause of his injury. Training was provided to custody staff after the OIG expressed concern regarding the inadequate investigation and crime scene management. 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 custody staff failed to adequately process the crime scene and document the investigation. In addition, the investigative services unit failed to provide the cellmate with the *Miranda* warning prior to questioning him. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  The investigative services unit documented that they gathered information and determined there was no substantial facts to conclude the cellmate committed a battery. The investigators failed to document what information was gathered and analyzed or how they arrived at their conclusion.

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

  The investigative services unit did not read the cellmate his Miranda rights prior to questioning him. They did not conduct a cell search for weapons, and did not use evidence markers or collect items with potential evidentiary value while processing the crime scene.

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

  Officers failed to immediately take custody of the cellmate and collect his clothing for potential evidence prior to the unclothed body search. Facility staff did not notify the investigative services unit until one and a half hours later.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-09-24	**13-2091-RO**	**Suicide**

Incident Summary

On September 24, 2013, a single-celled inmate was found hanging in his cell by a sheet. After cutting down the sheet, 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.

Disposition

An autopsy confirmed the manner of death as asphyxia due to hanging. Potential staff misconduct was identified based on the alleged failure of custody staff to immediately perform life-saving measures upon the inmate who had committed suicide; therefore, the hiring authority referred the case to the Office Of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because custody staff allegedly failed to immediately perform life-saving measures upon the inmate. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  Custody staff allegedly failed to immediately perform life-saving measures upon the inmate who committed suicide.

Incident Date	OIG Case Number	Case Type
2013-10-04	**13-2183-RO**	**In-Custody Inmate Death**

Incident Summary

On October 4, 2013, custody staff responded to a "man down" call and observed an inmate standing by his cell door. Custody staff also observed the cellmate lying on the cell floor on his back, bloodied from unknown injuries. The inmate standing by the cell door was handcuffed and removed from the cell. Custody staff began life-saving measures on the injured inmate until medical staff arrived and continued life-saving measures. The inmate was subsequently pronounced dead at the scene.

Disposition

An autopsy determined the cause of death was homicide. 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
2013-12-11	**13-2632-RO**	**In-Custody Inmate Death**

Incident Summary

On December 11, 2013, an inmate was discovered in a housing unit with a head injury that included active bleeding from the ear, nose, and mouth. Another inmate told an officer that the inmate slipped and fell in the restroom area. The injured inmate was transported by helicopter to an outside hospital where he was pronounced dead the next day.

Disposition

An autopsy determined that the inmate died as a result of blunt force injury to the head as the result of a fall. It was determined that he had no injuries to the face and was intoxicated at the time of death. The department's Death Review Committee determined there were no medical care concerns or emergency response issues. Potential staff misconduct was identified based on the captain's alleged failure to promptly notify the hiring authority and the OIG of the critical incident. Also, a lieutenant allegedly did not assume control of the potential crime scene or promptly notify the investigative services unit. The hiring authority referred the case to the Office of Internal Affairs for investigation. The case was returned to the hiring authority with approval for disciplinary action. The OIG accepted the case for monitoring. Training regarding evidence and crime scene preservation was provided to custody staff.

NORTH REGION

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case. The department also failed to properly secure the crime scene and preserve evidence. The OIG concurred with the 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 hiring authority discovered potential misconduct on December 12, 2013, but did not refer the matter to the Office of Internal Affairs until April 15, 2014, 124 calendar days later.

- Was the critical incident adequately documented?

  Some of the responding officers failed to submit reports prior to the end of their shift.

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

  The investigative services unit did not take control over the potential crime scene and investigation until four hours after it had been notified of the incident.

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

  Custody staff failed to timely secure the cell as a crime scene. The cell was secured as a potential crime scene only after custody staff were notified that the inmate was going to die from his injuries, four hours after the incident.

- Was the OIG promptly informed of the critical incident?

  The hiring authority notified the OIG over four hours after the department was notified that the inmate was likely going to die from his injuries.

Incident Date	OIG Case Number	Case Type
2014-01-08	**14-0135-RO**	**In-Custody Inmate Death**

Incident Summary

On January 8, 2014, an inmate complained of swollen legs and was transported to an outside hospital for medical tests. The inmate suffered cardiac arrest and died at the hospital.

Disposition

The autopsy report identified the cause of death as an anaphylactic reaction to dye used during a CT scan at the hospital. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2014-01-21	**14-0240-RO**	**Suicide**

Incident Summary

On January 21, 2014, an officer observed an inmate straddling the guard rail on the fourth tier of a housing unit. The officer ordered the inmate to get off the rail. The officer, while turning to get the attention of other custody staff, observed the inmate fall to the ground level floor. Responding officers found the inmate lying face down and bleeding with obvious severe head trauma. Medical staff and a fire captain responded to the scene and provided emergency care. The inmate was transported to the triage and treatment area and then to an outside hospital. On January 22, 2014, the inmate was pronounced dead at the hospital.

Disposition

The coroner did not perform an autopsy, but the coroner's report indicated the inmate died of multiple blunt force injuries by suicide. The department's Death Review Committee concluded the death was not preventable, and the standard of care during the emergency was met. The department's executive summary of suicide report identified concerns with the inmate's mental health treatment and recommended training to the primary clinician in suicide risk evaluation. In addition, the institution asked for an architectural and engineering assessment to determine if additional fencing on the upper tiers is within design standards. 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 OIG was not timely notified of the incident preventing the OIG from real-time monitoring. 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 promptly informed of the critical incident. The OIG was notified almost 30 hours after the critical incident when the inmate was pronounced dead by a hospital physician.

Incident Date	OIG Case Number	Case Type
2014-02-21	14-0445-RO	Other Significant Incident

Incident Summary

On February 21, 2014, an inmate failed to fully comply with orders to get down and officers deployed pepper spray. The inmate then attacked an officer. Two other inmates moved toward the incident and officers responded by deploying pepper spray and using physical force. Four officers were injured in the process of stopping the assaults. One officer received lacerations to his face and another officer struck his head on a wall and sustained injury to his hand. The third officer sustained a hand injury and an abrasion on the face, and the fourth officer sustained a knee injury.

Disposition

The institution's executive review committee determined that the use of force was 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: **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 not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-02-27	14-0485-RO	Suicide

Incident Summary

On February 27, 2014, a single-celled inmate was observed standing in his cell leaning forward with a ligature around his neck. Life-saving measures were unsuccessful.

Disposition

An autopsy revealed that the cause of death was strangulation consistent with suicide. The institution's suicide report and administrative review determined there was potential staff misconduct by a lieutenant, a sergeant, five officers, and a registered nurse who were all allegedly negligent in their duties prior to the incident, or in response to the incident. 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 adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-03-04	**14-0518-RO**	**In-Custody Inmate Death**

Incident Summary

On March 4, 2014, a single-celled inmate was found unresponsive in his cell. Officers removed the inmate from his cell and immediately began life-saving measures. The inmate was transported to the triage and treatment area for medical treatment. Medical staff continued life-saving measures; however, these attempts failed and the inmate was pronounced dead by a responding paramedic.

Disposition

The autopsy determined that the cause of death was cardiac dysrhythmia. 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
2014-03-06	**14-0949-RO**	**In-Custody Inmate Death**

Incident Summary

On March 6, 2014, officers found an unresponsive inmate on the floor of his cell with his cellmate cradling his head. Officers removed the cellmate from the cell, determined the inmate not to be breathing, and began life-saving measures. Life-saving measures continued as the inmate was transported via ambulance to an outside hospital where he was later pronounced dead.

Disposition

An autopsy revealed that the cause of death was asphyxia due to strangulation and the manner of death was homicide. The department's Death Review Committee determined that the death was not preventable. 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 discovered that some classification forms were not appropriately completed and provided training. No other 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 Officer of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-03-10	**14-0576-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On March 10, 2014, a yard officer observed three inmates attack a fourth inmate with inmate-manufactured weapons on the exercise yard. One of the three inmates was holding the fourth inmate while the other two were striking the fourth inmate in the upper torso and head area in stabbing motions. The yard officer activated his alarm and ordered the inmates to get down. After the inmates failed to comply with orders to get down, the control booth officer fired a less-lethal round aiming for the thigh of one of the involved inmates. The round missed the intended target and the inmates continued their attack. The officer fired a second less-lethal round at the thigh of an involved inmate. The officer was unable to identify where the round struck; however, all inmates stopped fighting and assumed prone positions. All four inmates suffered injuries consistent with fighting and one inmate sustained a laceration to his knee which may have been a result of the less-lethal round. The inmate who was attacked was taken to the triage and treatment area for multiple stab wounds. He was subsequently air-lifted to an outside hospital for treatment of injuries consisting of numerous stab wounds and lacerations to his head, torso, and arms, and a puncture wound to his chest. It was determined the injuries were not life threatening. The inmate returned to the institution later the same day.

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.

NORTH REGION

Overall Assessment	Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-03-15	**14-0619-RO**	**In-Custody Inmate Death**

Incident Summary

On March 15, 2014, an officer was conducting a count when he came to a cell occupied by two inmates. When the officer asked one inmate to wake his cellmate, who was lying on his bunk, the inmate stated that he had killed his cellmate during the previous evening because he kept waking him up at night. The officer attempted to get the cellmate's attention by knocking on the door and calling his name. When the inmate did not respond, the officer initiated a medical emergency alarm. Custody and medical staff responded to the cell. The responsive inmate was restrained and removed from the cell. The unresponsive inmate was subsequently transported to the triage and treatment area where he was pronounced dead.

Disposition

The autopsy report indicated the inmate's death was due to asphyxia. Rigor mortis and lividity were present when the inmate's body was discovered. An officer responsible for conducting counts during the previous shift allegedly failed to notice the inmate was lying unresponsive on his assigned bed. As potential staff misconduct was identified, 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: **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 concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-03-20	**14-0690-RO**	**PREA**

Incident Summary

On March 20, 2014, a single-celled inmate housed in a mental health facility alleged that he was raped by an unidentified staff member while in his cell. The inmate was interviewed and the institution's investigative services unit reviewed the housing unit video. During the time of the alleged incident the inmate was under one-on-one observation, and the video did not show anyone entering the inmate's cell. The inmate was not taken for a medical evaluation based on the results of the video review. In the four days prior, the inmate had made similar allegations of sexual assaults being committed by unknown persons. In each instance, the housing unit video was reviewed, and did not show anyone entering the inmate's cell. The inmate was interviewed and transported to a local hospital for a medical evaluation.

Disposition

Potential staff misconduct was identified based on the inmate's allegation of a sexual assault; therefore, the case was referred to the Office of Internal Affairs for investigation. 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 overall response was inadequate because the hiring authority failed to timely refer the matter to the Office of Internal Affairs and only referred the matter after recommendation by the OIG. The department also failed to timely notify the OIG.

NORTH REGION

Assessment Questions

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

  The inmate alleged incidents occurred from March 16, 2014, through March 20, 2014. The hiring authority discovered the alleged misconduct on March 20, 2014, but did not refer the matter to the Office of Internal Affairs until August 28, 2014, 161 days after the date of discovery and only after the OIG recommended the referral.

- 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.

- Was the OIG promptly informed of the critical incident?

  Of the five allegations over a five day period, the department only notified the OIG on two occasions.

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

  The matter was not referred to the Office of Internal Affairs until 161 days after the inmate made the allegations.

Incident Date	OIG Case Number	Case Type
2014-03-22	**14-0698-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On March 22, 2014, as officers released culinary workers back to their housing units, officers observed an inmate stumble from the inmate restroom with visible injuries to his head and neck. The inmate was transported to the triage and treatment area, and then transported to an outside hospital. The inmate was treated for multiple stab wounds and was returned to the institution on March 25, 2014. Several inmates were placed under investigation for this assault.

Disposition

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

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG in a timely 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 of the incident until the following morning.

Incident Date	OIG Case Number	Case Type
2014-04-08	**14-0840-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On April 8, 2014, seven inmates attacked another inmate on an exercise yard. Officers ordered the inmates to get down but they did not comply. The yard observation officer fired one less-lethal round aiming at the right thigh of one of the seven inmates. The round hit the inmate's lower back and he stopped fighting while the other inmates continued fighting. Officers deployed chemical agents to stop the fighting. Two inmates, including the inmate being attacked, used inmate-manufactured weapons. One inmate suffered a laceration to the back of the head and neck. He was transported to an outside hospital and returned to the institution the next day. Another inmate suffered a puncture wound to his back. He also was transported to an outside hospital and returned to the institution on May 2, 2014. A third inmate received medical treatment at the institution for a cut and puncture wound to his left shoulder and a puncture wound to his back.

Disposition

The institution's executive review committee found the use of force in compliance with departmental policy; however, training was provided to responding officers regarding proper report writing procedures because an officer involved with the search and escort of one inmate was not identified in reports. 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 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 hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-04-09	**14-1172-RO**	**Hunger Strike**

Incident Summary

On April 9, 2014, an inmate initiated a hunger strike due to issues related to his diet, programming, and property. The inmate was subsequently transferred to the institution's correctional treatment center where medical staff could closely monitor his condition. On July 9, 2014, an administrative law judge authorized the department to administer involuntary psychiatric medication to the inmate. On July 14, 2014, the inmate ended his hunger strike by eating while monitored by medical staff.

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
2014-04-20	**14-0940-RO**	**In-Custody Inmate Death**

Incident Summary

On April 20, 2014, inmates in a dormitory unit alerted custody staff of a "man down." Officers who responded to the scene found an inmate lying on his bunk with his head directly facing into the pillow and vomit at the head of the bed. The inmate was not breathing and did not have a pulse. Custody and medical staff initiated life-saving measures which were continued as the inmate was transported to the triage and treatment area. The inmate was subsequently pronounced dead.

Disposition

The department's Death Review Committee concluded that the inmate's death was unexpected and unpreventable. The autopsy attributed the death to opiate intoxication. 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
2014-05-13	**14-1158-RO**	**Hunger Strike**

Incident Summary

On May 13, 2014, an inmate missed his ninth consecutive meal. The inmate told custody staff that he was on a hunger strike because he wanted to starve himself to death. Although the inmate was being monitored by mental health and medical staff, officers failed to timely notify management of the hunger strike. The inmate ended his hunger strike on May 19, 2014.

Disposition

The hiring authority determined that custody staff failed to follow hunger strike protocols by not making appropriate timely notification to management staff. As a result, the hiring authority issued a memorandum to all staff regarding hunger strike protocols and training was provided to the custody staff involved in this incident. The OIG concurred. No staff misconduct was identified. Therefore, the hiring authority did not refer the matter to the Office of Internal Affairs.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to timely notify the OIG and failed to timely make other required notifications. The department also failed to timely complete required documentation. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  Hunger strike protocols require that custody staff generate a report and immediately notify medical staff and the facility lieutenant. The lieutenant is then required to immediately notify the captain and associate warden. In this case, the report was not generated until five days later.

- Was the OIG promptly informed of the critical incident?

  On May 13, 2014, an inmate missed his ninth consecutive meal. The OIG was not notified of the hunger strike until May 16, 2014, three days later, and was told that administrators were just made aware of the hunger strike.

Incident Date	OIG Case Number	Case Type
2014-05-17	**14-1169-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On May 17, 2014, an inmate informed a nurse that he was feeling suicidal and the inmate agreed to see a physician. Therefore, the nurse left the cell to call a physician while a medical technical assistant remained at the cell to observe the inmate. The medical technical assistant also left the cell front. A second medical technical assistant asked the control booth officer to open the inmate’s cell door so the inmate could go to see the physician. The inmate ran out of the cell and began climbing the second tier railing. Medical and custody staff ordered the inmate to get down but the inmate jumped off the second tier, landing on his head on the floor below. The inmate was flown by helicopter to an outside hospital for treatment and returned to the institution the same day. The nurse and the medical technical assistants are employed by the Department of State Hospitals.

Disposition

No departmental staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The Department of State Hospitals is conducting its own investigation to determine whether any of its employees engaged in misconduct.

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
2014-05-19	**14-1173-RO**	**Suicide**

Incident Summary

On May 19, 2014, an inmate summoned an officer and reported that his cellmate had hung himself. The cellmate was lying on his bed with torn bed sheets wrapped around his neck. The first inmate was placed in hand restraints and taken to a holding cell. Officers entered the cell, cut the sheets, and placed the second inmate on a gurney. Officers and medical staff performed life-saving measures. The inmate was taken to an outside hospital where he died the next day. The first inmate later admitted to a sergeant that he had assisted in the suicide of his cellmate by holding him down.

NORTH REGION

Disposition

Potential staff misconduct was identified in that custody staff allegedly failed to timely submit reports and properly gather and preserve evidence. The hiring authority did not refer the matter to the Office of Internal Affairs for an investigation. However, the hiring authority provided training regarding timely submission of reports and asked the local district attorney's office to provide training to the entire institution regarding evidence preservation. The hiring authority also changed the local procedure so that the investigative services unit would be primarily in charge of all evidence collection and preservation in inmate deaths. The hiring authority also purchased new equipment for the investigative services unit. The OIG concurred with the hiring authority's determinations.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the institution failed to properly process the deceased inmate's cellmate for evidence and allowed officers to leave the institution without writing reports before their shift ended.

Assessment Questions

- Was the critical incident adequately documented?

  The department failed to require every employee involved in the incident to write a report before they left work at the end of their shifts.

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

  The investigative services unit failed to properly process the dead inmate's cellmate for evidence. The inmate was secured in another cell but was not evaluated for injuries and not properly checked for evidence of a crime. One of the investigative services unit officers failed to timely write an incident report.

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

  The institution failed to properly process the deceased inmate's cellmate for evidence. The cellmate was secured in another cell but was not evaluated for injuries and not properly checked for evidence of a crime. Officers were also allowed to leave the institution without writing reports documenting their involvement in the incident before their shift ended.

Incident Date	OIG Case Number	Case Type
2014-05-21	**14-1197-RO**	**Suicide**

Incident Summary

On May 21, 2014, while conducting welfare checks, an officer discovered a single-celled inmate hanging from a bed sheet tied to the top of the cell door. An alarm was activated and officers entered the cell, cut the material, and initiated life-saving measures. Medical staff responded, assumed life-saving measures, and called for an ambulance. Paramedics continued life-saving measures; however, the inmate was pronounced dead at the institution.

Disposition

The coroner 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 the 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
2014-05-31	**14-1284-RO**	**Contraband Watch**

Incident Summary

On May 31, 2014, an inmate was placed on contraband surveillance watch after drugs were found in his possession during an unclothed body search. On June 1, 2014, medical staff transferred the inmate to an outside hospital for a higher level of care when the inmate became unresponsive. The inmate produced four bindles of suspected drugs at the outside hospital and was returned to the institution later that day.

Disposition

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

NORTH REGION

Overall Assessment

Rating: **Insufficient**

The department failed to provide timely notification to the OIG when the inmate was sent to the outside hospital. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Assessment Questions

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

  The department did not consult with the OIG regarding this critical incident. The OIG became aware of the critical incident when reviewing the contraband surveillance watch documentation that identified the inmate's transfer to an outside hospital.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified when the inmate was transferred to an outside hospital.

Incident Date	OIG Case Number	Case Type
2014-06-03	**14-1574-RO**	**PREA**

Incident Summary

On June 3, 2014, an inmate alleged he was the victim of a sexual assault and that an officer pushed his closed baton into the inmate's buttocks area while making lewd remarks. The inmate claimed that he had his boxer shorts on and that there was no penetration.

Disposition

Potential staff misconduct was identified based on the allegations of staff sexual assault; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-06-09	**14-1325-RO**	**PREA**

Incident Summary

On June 9, 2014, a nurse informed custody staff that a single-celled inmate alleged an unidentified officer entered his cell and raped him while he was asleep sometime during the previous week. The inmate was interviewed and taken to an outside hospital but refused an examination.

Disposition

Potential staff misconduct was identified based on the allegation of staff sexual assault; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. After review, OIA Central Intake determined there was not a reasonable belief misconduct occurred. The OIG concurred.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the OIG was not timely notified and the hiring authority did not timely refer the case to the Office of Internal Affairs.

NORTH REGION

Assessment Questions

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

  The hiring authority failed to timely notify the Office of Internal Affairs.

- Was the OIG promptly informed of the critical incident?

  The OIG was notified almost two hours after the inmate reported the allegation.

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

  The inmate reported the allegation on June 9, 2014. The institution notified the Office of Internal Affairs on June 19, 2014.

Incident Date	OIG Case Number	Case Type
2014-06-13	**14-1531-RO**	**Hunger Strike**

Incident Summary

On June 13, 2014, an inmate began a hunger strike due to custody, family, and legal issues. The inmate was subsequently transferred to the correctional treatment center so he could be closely monitored by medical staff. On July 7, 2014, the inmate ended his hunger strike and started eating as monitored by medical staff.

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
2014-06-27	**14-1573-RO**	**PREA**

Incident Summary

On July 4, 2014, an inmate alleged that on June 27, 2014, he was the victim of a sexual assault by two officers. He claimed that he was forced to orally copulate the two officers.

Disposition

Potential staff misconduct was identified based upon allegations of staff sexual assault; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-06-28	**14-1830-RO**	**Hunger Strike**

Incident Summary

On June 28, 2014, an inmate initiated a hunger strike because he wanted to be released from prison. The inmate was subsequently transferred to the correctional treatment center where he could be monitored by medical staff. On August 12, 2014, the inmate ended his hunger strike by eating as monitored by medical staff. On August 19, 2014, the inmate was discharged from the correctional treatment center and transferred to a housing unit.

Disposition

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

NORTH REGION

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 not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-07-07	14-1581-RO	Suicide

Incident Summary

On July 7, 2014, an officer discovered a cell window covered. The officer knocked on the door and attempted to get the single-celled inmate to respond. After no response, the officer placed a shield in front of the food port and opened the food port. The officer pushed his alarm after observing the inmate's motionless body in the middle of the room. Responding officers found the inmate hanging from torn bed sheets tied to the light fixture in his cell. Officers entered the cell, cut the noose, and with the assistance of a nurse who was also present, lowered the inmate to the floor. Medical staff initiated life-saving measures. The inmate was later pronounced dead.

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.

Incident Date	OIG Case Number	Case Type
2014-07-07	14-1627-RO	Suicide

Incident Summary

On July 7, 2014, an inmate was found hanging in a bathroom with a bed sheet tied to the vent and around his neck. Medical staff observed him, activated an alarm, and responded. The inmate was taken down and emergency life-saving measures were started. The inmate's pulse was restored and he was taken to an outside hospital where he was placed on life support. Subsequent tests determined that the inmate had no brain activity. On July 9, 2014, the inmate was removed from life support and subsequently pronounced dead.

Disposition

The autopsy report concluded that the cause of death was hypoxic ischemic encephalopathy due to asphyxia by hanging. Potential staff misconduct was identified based on the officer’s alleged failure to conduct the required inmate count; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-07-08	14-1654-RO	Contraband Watch

Incident Summary

On July 8, 2014, an inmate was placed on contraband surveillance watch after reporting that two weeks prior he had placed a weapon in his rectum. The following day, the inmate complained of abdominal pain and was transported to an outside hospital. The inmate returned to the institution later the same day after receiving treatment for pain. The inmate was removed from contraband surveillance watch when test results indicated there was no foreign object in his body.

Disposition

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

NORTH REGION

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-07-17	**14-1723-RO**	**In-Custody Inmate Death**

Incident Summary

On July 17, 2014, officers observed six inmates attacking two inmates on an exercise yard. The tower officer fired two less-lethal rounds, which missed their intended target, and two yard officers deployed pepper spray to stop the altercation. One inmate sustained multiple puncture wounds and was pronounced dead by medical staff at the institution. The other inmate sustained multiple stab wounds and was sent to an outside hospital for further treatment. He later returned to the institution. Two inmate-manufactured weapons made of metal stock and two made of melted plastic were found at the scene.

Disposition

The institution's executive review committee determined that the use of force was 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: **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
2014-07-19	**14-1712-RO**	**Contraband Watch**

Incident Summary

On July 19, 2014, an inmate was placed on contraband surveillance watch after custody staff observed the inmate place an unknown object in his mouth during visiting. The following day, the inmate was transported to an outside hospital because he appeared very anxious and had an elevated pulse and blood pressure. While at the outside hospital, the inmate became very agitated as a result of a ruptured bindle and was placed in four-point restraints. On July 22, 2014, the inmate was removed from contraband surveillance watch after producing a total of eight bindles of suspected narcotics. On July 25, 2014, the inmate returned to the institution after receiving treatment for a drug overdose.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation. However, the department addressed the lack of documentation by providing on-the-job training to involved custody and medical staff.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the medical assessment and other required documentation were not properly completed. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the critical incident adequately documented?

  The documentation related to the contraband surveillance watch did not contain an initial medical assessment form, a comprehensive medical assessment, and did not identify that a supervisory review was conducted during two shifts. Other required documentation was also incomplete.

Incident Date	OIG Case Number	Case Type
2014-08-12	**14-2058-RO**	**Hunger Strike**

Incident Summary

On August 12, 2014, 12 inmates initiated a hunger strike to protest that they are not permitted to have televisions in the administrative segregation unit. After 24 days, all 12 inmates ended their hunger strike on September 5, 2014, by eating.

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 concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2014-08-13	**14-2241-RO**	**Hunger Strike**

Incident Summary

On August 13, 2014, an inmate began a hunger strike in protest of a rules violation report he received for battery on staff. On September 19, 2014, the inmate was transferred to the outpatient housing unit to be monitored more closely by medical staff. The inmate ended his hunger strike on September 22, 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 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
2014-08-14	**14-2166-RO**	**PREA**

Incident Summary

On August 14, 2014, a nurse allegedly rubbed an inmate's buttocks while giving him a medication by injection into his buttocks. The nurse also allegedly licked his lips while giving the injection and made a sexually suggestive comment.

Disposition

Potential staff misconduct was identified based on the allegations of staff sexual assault; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. After review, OIA Central Intake determined there was not a reasonable belief misconduct occurred. The OIG concurred with this 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 concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2012-10-27	**14-1379-RO**	**Suicide**

Incident Summary

On October 27, 2012, an officer discovered an unresponsive single-celled inmate in his cell and called for a medical response. Medical staff responded to the scene but life-saving measures were not initiated because the inmate was pulseless and in full rigor mortis. The department's Death Review Committee opined that the inmate died of an accidental overdose; however, the coroner later determined that the inmate death was a suicide, caused by an intentional overdose of amitriptyline, a medication prescribed to the inmate.

Disposition

The coroner determined the manner of death was suicide, caused by an overdose of amitriptyline. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs. However, subsequent to this incident, the department implemented new statewide protocols for administering amitriptyline to prevent inmates from keeping a supply of the drug on their person or in their cell.

Overall Assessment

Rating: **Sufficient**

Overall the department's response to the incident was adequate; however, the department failed to timely notify the OIG that the coroner determined that the inmate's death was a suicide. 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
2013-11-14	**13-2473-RO**	**Suicide**

Incident Summary

On November 14, 2013, an inmate notified an officer that another inmate was attempting to hang herself in the housing unit shower. The officer responded to the location and discovered an unresponsive inmate hanging from a shower pipe by a sheet tied around her neck. The officer activated his alarm and used scissors to cut down the inmate. Another officer immediately responded, and they began life-saving measures. Medical staff responded to the scene and took over life-saving measures until paramedics arrived. The inmate was transported to an outside hospital, where she was placed on a ventilator. The inmate died two days later.

Disposition

The coroner determined that the manner of death was suicide 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: **Insufficient**

The department's response was not adequate because the hiring authority failed to address concerns expressed by the OIG related to the security of the shower programs. 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?

  The OIG expressed concerns to the hiring authority regarding the lack of supervision and the inability of officers to ensure the safety of inmates in the shower areas. The hiring authority agreed with the concerns and stated that she would implement a more structured shower program and explore the procurement of curtains or doors that would ensure inmate privacy but improve the safety and security. Several months later, the hiring authority has yet to take any action.

Incident Date	OIG Case Number	Case Type
2013-11-26	**13-2591-RO**	**Suicide**

Incident Summary

On November 26, 2013, custody staff discovered a single-celled inmate unresponsive on the floor of his cell with a sheet tied around his neck. Custody staff activated an alarm, removed the inmate from his cell, and initiated life-saving measures. Medical staff responded and the inmate was transported to the triage and treatment area where life-saving measures continued but the inmate was pronounced dead. There was an allegation that before his death the inmate called out for help but was ignored by custody staff.

Disposition

An autopsy determined the cause of death to be suicide by hanging. The OIG met with the hiring authority and discussed the deficiencies with the manner in which the inquiry into the inmates' allegations was conducted. 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. In addition, the inquiry conducted by the investigative services unit was not thorough because the control booth officer neither submitted a memorandum nor was he interviewed. Likewise, the inquiry failed to identify all inmates who were interviewed about the incident and it was not clear whether all inmates who were housed near the deceased inmate were interviewed. Based on the hiring authority's unwillingness to conduct further inquiry, the OIG concurred with the decision not to refer the matter to the Office of Internal Affairs because there was not sufficient evidence to determine whether potential staff misconduct occurred.

Assessment Questions

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

  The department failed to notify the OIG of the inmate's suicide. The OIG became aware of the incident through a daily report nine days after the inmate's death.

- Was the critical incident adequately documented?

  The control booth officer neither submitted a memorandum nor was he interviewed. Likewise, the inquiry by the investigative services unit did not identify all inmates who were interviewed and it was not clear whether all inmates who were housed near the deceased inmate were interviewed.

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

  Immediately following the suicide, other inmates reported that two days prior to the suicide, the dead inmate told housing unit officers that he was suicidal; however, the officers did not take steps to ensure the inmate received appropriate mental health treatment. Furthermore, the inmates reported that the deceased inmate called out for help hours before the suicide, but no officers responded. The institution's investigative services unit did not conduct an inquiry into these allegations until January 9, 2013, over a month after the suicide. Additionally, the inquiry report was neither complete nor clear. The report did not fully indicate which inmates were interviewed, whether the inmates housed closest to the deceased were actually interviewed, and exactly what each inmate said.

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

  Immediately following the suicide, other inmates reported that two days prior to the suicide, the deceased inmate told housing unit officers that he was suicidal; however, the officers did not take steps to ensure the inmate received appropriate mental health treatment. Furthermore, the inmates reported that the deceased inmate called out for help hours before the suicide, but no officers responded. The institution did not conduct an inquiry into these allegations until January 9, 2013, over a month after the suicide. Additionally, the inquiry report was neither complete nor clear. The report failed to fully indicate which inmates were interviewed, whether the inmates housed closest to the deceased were actually interviewed, and exactly what each inmate said.

- Was the OIG promptly informed of the critical incident?

  The institution failed to notify the OIG.

Incident Date	OIG Case Number	Case Type
2013-12-08	**13-2651-RO**	**Contraband Watch**

Incident Summary

On December 8, 2013, an inmate was transported to an outside hospital after informing staff that he swallowed three razor blades. A medical evaluation performed at the hospital confirmed the inmate ingested foreign objects and he was immediately admitted to the hospital and placed on contraband surveillance watch. On December 15, 2013, the inmate returned to the institution. A medical assessment noted that the inmate had swelling and a laceration above his right eye. The inmate alleged that one of the transportation officers punched him in the eye during the transport from the hospital.

SOUTH REGION

Disposition

Potential staff misconduct could not be determined due to the department's failure to adequately document the incidents. Therefore, the matter was not referred to the Office of Internal Affairs for investigation. However, the hiring authority provided training to custody staff regarding documentation requirements and providing constant visual observation of an inmate on contraband surveillance watch during transport.

Overall Assessment

Rating: **Insufficient**

The department failed to comply with contraband surveillance watch policies and procedures. Specifically, there is no documentation verifying that the inmate was kept under constant visual observation during his transport to and from the hospital. Further, the department failed to follow use-of-force policy concerning the allegation that the inmate had been assaulted by an officer. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs because the hiring authority failed to conduct a sufficient inquiry to determine whether potential staff misconduct occurred.

Assessment Questions

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

  The department failed to adequately notify the OIG when the inmate was removed from contraband surveillance watch.

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

  The institution failed to timely conduct a video-taped interview of the inmate concerning his complaint of assault by an officer. As a result of the delay, a timely decision was not made about whether to refer any conduct to the Office of Internal Affairs.

- Was the critical incident adequately documented?

  Transportation officers failed to adequately document that the inmate was taken to an outside hospital, that the inmate sustained an injury during his return trip to the institution, or that officers maintained constant visual observation of the inmate during transport to and from the hospital.

Incident Date	OIG Case Number	Case Type
2014-01-08	14-0132-RO	In-Custody Inmate Death

Incident Summary

On January 8, 2014, an inmate was found unresponsive in his cell approximately two hours after being seen in the clinic complaining of difficulty breathing. Life-saving measures were initiated and the inmate was transported to an outside hospital. However, he was pronounced dead three days later.

Disposition

The autopsy determined the cause of death was cardiac dysfunction and that bronchial asthma contributed to the death. The department's Death Review Committee determined the inmate was not properly assessed when complaining of difficulty breathing. Potential staff misconduct was identified based on the alleged failure to properly perform a nursing assessment and alleged failure to provide appropriate medical care; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate. The department failed to timely notify the OIG and the hiring authority delayed six months before referring the matter to the Office of Internal Affairs. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- 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 the misconduct on April 1, 2014, but the hiring authority did not refer the matter to the Office of Internal Affairs until September 29, 2014, six months after the date of discovery.

- Was the OIG promptly informed of the critical incident?

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-01-14	**14-0209-RO**	**PREA**

Incident Summary

Between January 14, 2014, and January 22, 2014, an inmate made seven separate allegations that he was sexually assaulted by staff.

Disposition

Potential staff misconduct was identified based on the alleged failure to comply with the Prison Rape Elimination Act; therefore, after urging by the OIG, the hiring authority referred one of the sexual assault claims to the Office of Internal Affairs for investigation. An investigation was not opened.

Overall Assessment

Rating: **Insufficient**

The department's response to the incidents was not satisfactory. The hiring authority failed to sufficiently inform the OIG regarding the allegations. Additionally, the hiring authority failed to comply with the Prison Rape Elimination Act policy because it failed to timely refer the allegations to the Office of Internal Affairs for investigation, failed to adequately document each allegation, and cannot confirm that a sexual assault advocate was provided to the inmate for each of the claimed assaults. Further, there appeared to be a misunderstanding by custody staff regarding the scope and requirements of the Prison Rape Elimination Act policy. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  The department failed to consult with the OIG on three of the sexual assault claims.

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

  The hiring authority did not refer this case to the Office of Internal Affairs for investigation until the OIG made the recommendation.

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

  The hiring authority failed to notify the Office of Internal Affairs until two months after the date of discovery.

- Was the critical incident adequately documented?

  The institution only completed four incident packages out of the seven sexual assault allegations.

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

  The investigative services unit failed to follow the Prison Rape Elimination Act protocols because they did not generate a request for investigation of each sexual assault claim as required.

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

  The hiring authority failed to adequately document, notify, and request investigations on each sexual assault claim as required by the Prison Rape Elimination Act policy.

- Was the OIG promptly informed of the critical incident?

  The institution failed to notify the OIG of three of the sexual assault claims and failed to timely notify the OIG regarding a fourth claim.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-02-01	**14-0348-RO**	**Contraband Watch**

Incident Summary

On February 1, 2014, officers observed a bindle protruding from an inmate's anal cavity during an unclothed body search. The inmate ran, and an officer forced the inmate to the ground to effect custody. A bindle containing suspected heroin was recovered near the inmate. As a result of the force used by officers, the inmate sustained a bump on his head. The inmate claimed he lost consciousness. The inmate was placed on contraband surveillance watch and hours later complained of dizziness and vomiting. The inmate was transferred to an outside hospital for a higher level of care, where he was diagnosed with a concussion. He returned to the institution the next day in stable condition. On February 4, 2014, the inmate was removed from contraband surveillance watch. No additional contraband was recovered. The inmate alleged that officers used unreasonable force and that he was sexually assaulted by an officer during the incident.

Disposition

The institution's executive review committee determined the use of force was in compliance with policy and there was insufficient evidence to sustain the inmate's allegation of unreasonable force. The OIG concurred. The hiring authority ordered training for custody staff assigned to the contraband surveillance watch incident for proper hand hygiene and documentation of effective communication. The sexual assault allegation was referred to the Office of Internal Affairs for investigation; however, the case was rejected. The OIG concurred with these decisions.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because they failed to notify the OIG of the serious injury sustained by the inmate during the incident. Additionally, although the OIG concurred with the hiring authority's ultimate decision to refer the inmate's sexual assault allegation to the Office of Internal Affairs, the department failed to discover and address the allegation in a timely manner.

Assessment Questions

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

  On May 28, 2014, the OIG advised the hiring authority that the crossed out section of the inmate's written statement contained an allegation of sexual assault. On June 24, 2014, the OIG again met with the hiring authority and urged the hiring authority to take further action. The matter was ultimately referred to the Office of Internal Affairs on July 1, 2014, nearly five months after the allegation was made.

- Was the critical incident adequately documented?

  The hiring authority failed to adhere to policies related to documentation for contraband surveillance watch and failed to document the date and the identity of the staff member who accepted the inmate's written allegation of unreasonable force, which included an allegation of sexual assault.

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

  On February 3, 2014, the department interviewed the inmate based on his injury and allegation of excessive force. The inmate also provided a written allegation that included a crossed out statement alleging that he was sexually assaulted by an officer during the incident. The department failed to take any action on the sexual assault allegation until the OIG inquired on May 28, 2014.

- Was the OIG promptly informed of the critical incident?

  The hiring authority failed to notify the OIG of the inmate's injury and the allegation of sexual assault. The OIG discovered the inmate's injury while monitoring the contraband surveillance watch and the sexual assault allegation while reviewing the inmate's allegation of unreasonable force.

- Did the HA timely respond to the critical incident?

  On February 3, 2014, the department interviewed the inmate based on his injury and allegation of excessive force. The inmate also provided a written allegation that included a crossed out statement alleging that he was sexually assaulted by an officer during the incident. The department failed to take any action on the sexual assault allegation until the OIG inquired on May 28, 2014.

South Region

Incident Date	OIG Case Number	Case Type
2014-02-11	14-0444-RO	Hunger Strike

Incident Summary

On February 11, 2014, an inmate refused to eat or drink because she was depressed. After the inmate refused nine consecutive meals, the department initiated hunger strike protocols in accordance with departmental procedure. On February 17, 2014, the inmate was transported to an outside hospital for a higher level of care due to dehydration concerns. Three days later, the inmate returned to the institution in stable condition and consumed a meal. Subsequently, the inmate initiated three additional hunger strikes over a four month period which resulted in hospitalization, but ended with the inmate returning to the institution with no serious medical complications.

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 found the department's overall response to the incident was inadequate because they failed to notify the OIG that the inmate was taken to an outside hospital as a result of her hunger strike. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  Medical and custody staff recorded conflicting information specific to the dates of the inmate's hunger strikes and the number of missed meals.

- Was the OIG promptly informed of the critical incident?

  The institution failed to notify the OIG that the inmate had been taken to an outside hospital as a result of her hunger strike. The OIG learned of the incident by reviewing the department's daily report.

Incident Date	OIG Case Number	Case Type
2014-02-22	14-0462-RO	In-Custody Inmate Death

Incident Summary

On February 22, 2014, an inmate alerted custody staff that his cellmate was unconscious. Custody staff removed the inmate from the cell and responding medical staff initiated life-saving measures. The inmate was transported to the triage and treatment area where he was pronounced dead.

Disposition

The coroner determined the inmate died of a drug overdose. 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 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
2014-03-13	14-0629-RO	In-Custody Inmate Death

Incident Summary

On March 13, 2014, an inmate alerted officers that her cellmate was having a medical emergency. Custody staff responded to the cell and found an unresponsive inmate lying on the floor. Officers called for medical assistance and removed the inmate from the cell, and responding medical staff initiated life-saving measures. The inmate was transported via ambulance to an outside hospital, where she was pronounced dead.

Disposition

The coroner determined the inmate died from a pulmonary embolism. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

SOUTH REGION

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 more than three hours after the incident.

Incident Date	OIG Case Number	Case Type
2014-05-03	**14-1100-RO**	**In-Custody Inmate Death**

Incident Summary

On May 3, 2014, an officer conducting morning security checks discovered a double-celled inmate unresponsive inside his cell. The officer activated his alarm and responding custody staff initiated life-saving measures. Medical staff responded and continued life-saving measures while the inmate was transported to the triage and treatment area. Paramedics arrived and took over the medical emergency, but the inmate was pronounced dead. The cell was secured as a possible crime scene, and the cellmate of the dead inmate was placed in administrative segregation pending further investigation. The inmate was later cleared of any involvement.

Disposition

The autopsy determined the cause of death was an accidental overdose of fentanyl. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The hiring authority agreed with the OIG that the investigative services unit should have taken steps to determine the possible source of the fentanyl. The hiring authority has since modified its post orders to require an investigation into the origin of narcotics whenever there is an inmate overdose.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the investigative services unit failed to investigate the origin of the fentanyl used by the dead inmate. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

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

  After the coroner's report concluded that the inmate died from a lethal level of fentanyl, the OIG inquired about an investigation into its source. The investigative services unit assumed the inmate died from a heroin overdose and had not taken steps to investigate the overdose beyond questioning the dead inmate's cellmate.

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

  The toxicology report from the coroner found that the inmate died from a lethal level of fentanyl, an analgesic prescription drug that is also known to be used for illicit purposes. After the coroner's report was released, the institution failed to investigate how the inmate obtained the fentanyl.

Incident Date	OIG Case Number	Case Type
2014-05-05	**14-1135-RO**	**In-Custody Inmate Death**

Incident Summary

On May 5, 2014, an inmate returning from his work assignment alerted custody staff of a "man down" in his cell. Officers responded to the cell and found an unresponsive inmate lying on the floor. Officers removed the inmate from the cell and initiated life-saving measures until medical staff relieved them. Paramedics responded to the institution and took over the medical emergency but the inmate was pronounced dead.

Disposition

An autopsy determined the cause of death was heroin intoxication. 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.

South Region

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 90 minutes after the inmate died. By the time the OIG responded, the coroner's investigator had already responded to the scene, removed the inmate's body, and completed their inspection.

Incident Date	OIG Case Number	Case Type
2014-05-10	**14-1168-RO**	**PREA**

Incident Summary

On May 10, 2014, an inmate alleged that he had been sexually assaulted by two officers who had been involved in an earlier use-of-force incident involving the inmate.

Disposition

Potential staff misconduct was identified based on the inmate's allegation of sexual assault; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs determined there was insufficient evidence to open an 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 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 institution did not notify the OIG for over 24 hours after the allegation was made.

Incident Date	OIG Case Number	Case Type
2014-05-20	**14-1506-RO**	**Hunger Strike**

Incident Summary

On May 20, 2014, an inmate began a hunger strike and weighed 190 pounds. Over 30 days later, the inmate remained on a hunger strike and had lost 41 pounds. The inmate's stated reason for his hunger strike was a lack of programming available at the institution and he wanted to be included in the early release program for non-violent inmates. The OIG began monitoring the hunger strike, the inmate's medical condition, and legal proceedings the department initiated when notified of the inmate's weight loss. The inmate was transferred to an outside hospital on July 16, 2014, and returned to the institution after ending his hunger strike on July 30, 2014.

Disposition

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

Overall Assessment	Rating: **Insufficient**

The department's response was not adequate. The department failed to adequately document the inmate's ability to understand advice provided by medical staff when the inmate refused care, and the department's daily report failed to accurately document the inmate's weight. The department also failed to provide the OIG accurate information regarding the inmate's weight and failed to timely notify the OIG when the inmate was transferred to an outside hospital on July 15, 2014. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Assessment Questions

- Was the critical incident adequately documented?

  The department failed to document the inmate's ability to understand medical staff's advice when the inmate was refusing care. In addition, the department failed to document the inmate's weight in the daily report.

- Was the OIG promptly informed of the critical incident?

  The OIG was not informed that the inmate was transferred to an outside hospital until the day following his transfer.

Incident Date	OIG Case Number	Case Type
2014-06-23	**14-1493-RO**	**Other Significant Incident**

Incident Summary

On June 23, 2014, an officer was returning a loaded revolver and holster to the armory. Upon entering the armory, the officer removed the revolver from the holster at which time he noticed the hammer was pulled back in a ready-to-fire position. The officer attempted to reset the hammer and, while doing so, discharged the weapon, causing one round to enter a cinder block wall. There were no injuries.

Disposition

The institution's executive review committee determined the conduct was outside of departmental policy. The OIG concurred. Potential staff misconduct was identified due to the alleged careless handling of the firearm; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the case to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-07-01	**14-1533-RO**	**Other Significant Incident**

Incident Summary

On July 1, 2014, an inmate attempted suicide by wetting the top of his head and inserting an object into an electrical outlet in his cell. The inmate was housed in administrative segregation on single-cell status at the time of the incident and is the suspect in the murder of a correctional officer. After initial evaluation, the inmate was sent to an outside hospital for further evaluation and when returned to the institution, was placed on suicide watch for a week, following which he was returned to administrative segregation.

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
2014-07-30	**14-1820-RO**	**Suicide**

Incident Summary

On July 30, 2014, an officer discovered a single-celled inmate in her cell hanging by a bed sheet that was tied to a bookcase and tied around the inmate's neck. Custody staff entered the inmate’s cell, cut the noose from around the inmate's neck, and began life-saving measures. The inmate was transported to an outside hospital and shortly after her arrival, was pronounced dead by a hospital physician.

SOUTH REGION

Disposition

Autopsy results revealed that the death was caused by asphyxiation. The suicide review committee examined the case and provided recommendations to the institution concerning training for mental health staff in identifying inmates who meet the criteria for referral to the psychiatric in-patient unit, state-wide training concerning prevention of prescription drug abuse and the controlled circulation of syringes in institutions, as well as state-wide training to reduce the introduction and distribution of drugs in institutions. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for an investigation.

Overall Assessment

Rating: **Insufficient**

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

Assessment Questions

- Was the OIG promptly informed of the critical incident?

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

Incident Date	OIG Case Number	Case Type
2014-08-06	**14-1916-RO**	**Contraband Watch**

Incident Summary

On August 6, 2014, an inmate notified custody staff that he swallowed razor blades. The inmate was evaluated by medical staff and placed on mental health crisis status. Later that evening, the department transported the inmate to an outside hospital and initiated contraband surveillance watch protocols after an x-ray confirmed the presence of an object that appeared to be a toothbrush handle with a razor blade. The hospital recommended a medical procedure to remove the items, but the inmate refused. The department removed the inmate from contraband surveillance watch on August 13, 2014, after it was determined by medical staff that the objects would not pass without the recommended procedure. On August 15, 2014, the inmate returned to the institution in stable condition and was returned to mental health crisis status.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, training was provided to involved custody staff to address the documentation deficiencies that occurred during the contraband surveillance watch.

Overall Assessment

Rating: **Insufficient**

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. Also, the department failed to adequately document inmate and restraint hygiene and failed to consistently document supervisory checks. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  The department failed to adequately document inmate and restraint hygiene and supervisory checks.

- Was the OIG promptly informed of the critical incident?

  The OIG was not notified until more than four hours after the inmate was placed on contraband surveillance watch.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-08-07	**14-1914-RO**	**Contraband Watch**

Incident Summary

On August 7, 2014, two inmates attacked a third inmate on an exercise yard directly in front of officers, requiring the use of pepper spray to stop the attack. The three involved inmates were placed on contraband surveillance watch because it was believed the inmates staged the incident as part of a plan to introduce contraband into the administrative segregation unit. Additionally, drug paraphernalia was found during a subsequent search of one of the inmate's property. The department released the inmates from contraband surveillance watch on August 10, 2014, after one of the inmates produced a bowel movement containing four separate packages of suspected narcotics and inmate notes related to narcotic trafficking.

Disposition

The institution's executive review committee determined the use of force was within departmental policy and training. The hiring authority ordered training for all involved custody staff related to the contraband surveillance watch documentation policy. The OIG agreed with the hiring authority's decisions. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

Although the department did not clearly articulate the justification for placing the inmates on contraband surveillance watch, the OIG's review of the circumstances and discussion with the department revealed that the placement was justified. The department's response was satisfactory in all other critical aspects. The department adequately notified and consulted with 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
2014-08-11	**14-1933-RO**	**Suicide**

Incident Summary

On August 11, 2014, while conducting a security check on an inmate who did not report for his meal, an officer discovered a single-celled inmate in his cell hanging by a sheet tied around his neck. Officers cut the sheet and initiated life-saving measures until medical staff responded and took over. The inmate was transported to an outside hospital for a higher level of care but was pronounced dead by the emergency room physician.

Disposition

The examiner opined during the autopsy that the inmate's injuries were consistent with hanging. The department's preliminary Death Review Committee summary and the department's Statewide Mental Health Program suicide report noted the cause of death was asphyxiation due to hanging, and the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs. However, as a result of this incident and the department's quality improvement plan, the institution completed training for mental health care staff to achieve better coordination with county correctional institutions for mental health care screenings and services provided to inmates.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to notify the OIG in a timely 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 three hours after the inmate died.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-08-11	**14-2169-RO**	**Hunger Strike**

Incident Summary

On August 11, 2014, an inmate began a hunger strike to protest his placement in administrative segregation pending a transfer to a different institution. The inmate ended the hunger strike approximately 30 days later by consuming a nutritional drink. The inmate lost 20 pounds, 13 percent of his body weight, during the strike but suffered no medical complications and was transferred to a different institution.

Disposition

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.

Incident Date	OIG Case Number	Case Type
2014-08-19	**14-2021-RO**	**Suicide**

Incident Summary

On August 19, 2014, an officer conducting an inmate count discovered an inmate holding his cellmate from behind in the back of their cell. The inmate told the officer he woke up, found his cellmate hanging and had just cut him down. The officer activated his alarm and responding medical and custody staff initiated life-saving measures. The inmate was transported to the triage and treatment area where he was pronounced dead. The cellmate of the dead inmate was placed in administrative segregation pending further investigation, but was later cleared of any involvement.

Disposition

The medical examiner concluded the cause of death was suicide by hanging. The department's suicide review noted that the mental health documentation for the inmate did not provide a clear understanding of the inmate's symptoms or formulation of treatment interventions and recommended further inquiry of the mental health records to determine appropriate training for mental health staff. 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
2014-08-23	**14-2032-RO**	**In-Custody Inmate Death**

Incident Summary

On August 23, 2014, an inmate alerted custody staff that his cellmate was having a medical emergency. Responding custody staff lowered the inmate from his bunk and initiated life-saving measures. The inmate was transported to the triage and treatment area where he was pronounced dead by a physician.

Disposition

The coroner determined the cause of death was heart disease with methamphetamine intoxication as a contributing factor. The department's Death Review Committee determined the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: **Sufficient**

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-08-23	**14-2033-RO**	**In-Custody Inmate Death**

Incident Summary

On August 23, 2014, an officer discovered an unresponsive, single-celled inmate slumped over his in-cell toilet. An officer pressed his alarm and responding custody staff initiated life-saving measures until medical staff arrived. The inmate was transported to the triage and treatment area where he was pronounced dead by a physician.

Disposition

The coroner determined that the manner of death was natural, caused by cardiovascular disease. Potential staff misconduct was identified based on an officer's alleged failure to conduct the required inmate count; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-08-30	**14-2268-RO**	**PREA**

Incident Summary

On August 30, 2014, officers used physical force to gain control of an inmate after the inmate struck an officer in the face with his head. The inmate sustained a small cut on his cheek and alleged that officers used unreasonable force during the incident. The inmate also alleged that he was sexually assaulted by an officer during a subsequent search. Prison Rape Elimination Act protocols were initiated.

Disposition

The institution's executive review committee determined the use of force was in compliance with departmental policy but ordered training for custody staff regarding timely completion of incident reports. The OIG concurred. The sexual assault and unreasonable force allegations were referred to the Office of Internal Affairs for investigation; however, the case was rejected.

Overall Assessment

Rating: **Insufficient**

The department's response was not adequate because the department failed to timely notify the OIG. The OIG agreed 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 OIG was not notified until nearly three hours after the incident.

Incident Date	OIG Case Number	Case Type
2014-09-23	**14-2245-RO**	**In-Custody Inmate Death**

Incident Summary

On September 23, 2014, an officer conducting security checks discovered a single-celled inmate unresponsive in his cell. The officer summoned custody and medical staff who responded to the cell and found the inmate with an inmate-manufactured syringe protruding from his abdomen. No life-saving measures were taken because the on-scene nurse determined that lividity and rigor mortis had set in.

Disposition

The department's Death Review Committee concluded that the inmate's death was an accidental heroin overdose 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 to the incident was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2014-10-12	**14-2504-RO**	**Contraband Watch**

Incident Summary

On October 12, 2014, an inmate informed custody staff that he swallowed 25 razor blades. The inmate was escorted to the triage and treatment area where an x-ray confirmed the presence of a foreign object resembling a razor blade. The inmate was transported to an outside hospital for observation. Four days later, the inmate returned to the institution. The following morning, the inmate was evaluated by medical staff and again transported to an outside hospital due to medical complications from swallowing the razors. The inmate returned to the institution on October 21, 2014, and was placed on contraband surveillance watch. He was removed from contraband surveillance watch on October 23, 2014, after an x-ray showed negative results for foreign objects.

Disposition

Potential staff misconduct was identified based on the inmate being attired in a security smock, rather than the taped jumpsuit required by the contraband surveillance watch protocol. The hiring authority issued a letter of instruction to a captain and a lieutenant. The OIG agreed with the hiring authority's decision.

Overall Assessment

Rating: **Sufficient**

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

Incident Date	OIG Case Number	Case Type
2014-10-23	**14-2522-RO**	**Contraband Watch**

Incident Summary

On October 23, 2014, an inmate in administrative segregation informed custody staff that he swallowed razor blades. The inmate was placed on contraband surveillance watch after an x-ray confirmed the presence of metal objects. On October 26, 2014, the inmate complained of abdominal pain and was transported to a local hospital for evaluation and returned to the institution the same day. The inmate was removed from contraband surveillance watch on October 28, 2014, after an x-ray confirmed the lack of foreign objects. While the inmate was on contraband surveillance watch, the department recovered one piece of a metal object.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the hiring authority provided training to staff related to proper documentation of contraband surveillance watch incidents.

Overall Assessment

Rating: **Insufficient**

The department's response to the incident was not adequate because it failed to comply with contraband surveillance watch protocols after it was determined that the inmate had ingested contraband and failed to adequately complete documentation related to the contraband surveillance watch. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of the Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

  The department failed to adequately document the inmate's activities for the duration of the contraband surveillance watch, as required by departmental policy. Specifically, the department failed to consistently complete documentation regarding range of motion, supervisory checks, and access to proper hygiene.

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

  When the inmate was placed on contraband surveillance watch, the department failed to properly tape the waist of the inmate's paper shorts.

APPENDIX F
CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-08-18	**2014-08-21**	**Suspected Drugs**	**Nothing**

Incident Summary
14-12791-CWRM

On August 18, 2014, the department placed an inmate on contraband surveillance watch after an officer observed him swallow a small plastic bag as his door was opening for a cell search. The inmate was removed from contraband surveillance watch on August 21, 2014, three days later. During that time, the department did not recover anything from the inmate.

Incident Assessment
Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department did not timely notify the OIG of the inmate's placement on contraband surveillance watch; documentation was not provided after the inmate exceeded the initial 72 hours on contraband watch; hygiene checks were not consistently documented; medical staff did not evaluate the inmate on a regular basis. These problems were addressed by providing training to the officers after the OIG discussed the insufficiencies with the hiring authority.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-08-19	**2014-08-23**	**Suspected Drugs**	**Drugs**

Incident Summary
14-12801-CWRM

On August 19, 2014, officers learned that an inmate was planning to introduce drugs into the administrative segregation unit. During questioning, the inmate admitted to having drugs hidden in his rectum. The inmate was placed on contraband surveillance watch. On August 22, 2014, the inmate asked medical staff if they would remove the drugs from his body because they were not coming out during bowel movements. The inmate was transported to an outside hospital where he remained on contraband surveillance watch. The inmate defecated a bindle of drugs while at the hospital, which was recovered by an officer. A colonoscopy was completed and it verified the absence of additional contraband. The inmate was removed from contraband surveillance watch and returned to the institution on August 23, 2014.

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
2014-10-05	**2014-10-09**	**Suspected Drugs**	**Drugs**

Incident Summary
14-13421-CWRM

On October 05, 2014, the department placed an inmate on contraband surveillance watch after officers observed him placing a bindle of suspected drugs into his mouth and swallowing it. The inmate was removed from contraband surveillance watch on October 09, 2014, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment
Sufficient

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch. Although the hiring authority verbally approved the use of hand isolation devices, the signature to support the authorization was not obtained until the OIG brought this to the hiring authority's attention. Training was provided to all involved custody staff.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-08	**2014-10-12**	**Suspected Weapons**	**1. Other** **2. Weapons**

Incident Summary 14-13431-CWRM

On October 08, 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 October 12, 2014, four days later. During that time, the department recovered drug paraphernalia and metal sharpened to a point 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 obtain proper authorization to place the inmate on contraband surveillance watch. The department identified these discrepancies during a self-audit and provided training to the involved custody staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-12	**2014-10-17**	**Suspected Drugs**	**Drugs**

Incident Summary 14-13481-CWRM

On October 12, 2014, the department placed an inmate on contraband surveillance watch after he appeared to swallow contraband during a visit. The inmate was removed from contraband surveillance watch on October 17, 2014, five days later. During that time, the department recovered five bindles of drugs from the inmate.

Incident Assessment Sufficient

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch. Minor discrepancies were noted related to consistency of documentation specific to supervisory checks and cell searches. These minor discrepancies were identified by the department, and training was provided to all involved.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-11-27	**2014-12-01**	**Suspected Weapons**	**Nothing**

Incident Summary 14-14111-CWRM

On November 27, 2014, the department placed an inmate on contraband surveillance watch after the inmate informed staff he had swallowed a razor blade and it was confirmed by an x-ray. The inmate produced four bowel movements that were negative for contraband, and an x-ray determined the inmate was clear of any foreign body. The inmate was removed from contraband surveillance watch on December 01, 2014, four days later. During that time, and the department recovered nothing from the inmate.

Incident Assessment Sufficient

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch. Although the department had minor discrepancies documenting range of motion and hygiene, the hiring authority addressed these discrepancies with training.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-06-25	**2014-07-01**	**Suspicious Activity**	**Nothing**

Incident Summary

14-12191-CWRM

On June 25, 2014, the department placed an inmate on contraband surveillance watch. Specifically, during an unclothed body search subsequent to a cell search, staff observed suspected contraband protruding from the inmate's anal cavity. The inmate was removed from contraband surveillance watch on July 01, 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 because it failed to provide timely notification to the OIG when the inmate was placed on contraband surveillance watch and failed to complete a medical assessment prior to the inmate's placement on contraband surveillance watch. Documentation related to daily activity and other required forms were not provided to the OIG. The department acknowledged these problems and agreed to provide training to custody staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-06-25	**2014-07-01**	**Suspicious Activity**	**Nothing**

Incident Summary

14-12201-CWRM

On June 25, 2014, the department placed an inmate on contraband surveillance watch, after custody staff observed the inmate placing suspected contraband into his mouth as they approached his cell to conduct a cell search. The inmate was removed from contraband surveillance watch on July 01, 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 provide timely notification to the OIG when the inmate was placed on contraband surveillance watch and failed to timely remove the inmate from contraband surveillance watch status at the appropriate time. Documentation specific to medical assessments and inmate hygiene was inadequate. The department agreed to provide training to custody and nursing staff regarding documentation and other policy requirements after consulting with the OIG.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-06-27	**2014-07-11**	**Suspected Weapons**	**1. Drugs** **2. Inmate Note**

Incident Summary

14-12241-CWRM

On June 27, 2014, the department placed an inmate on contraband surveillance watch after the inmate failed to pass a metal detector during a cell search. Specifically, the cell search was conducted after the department received information that the inmate was in possession of a weapon. The inmate was removed from contraband surveillance watch on July 11, 2014, 15 days later. During that time, the department recovered drugs and inmate notes from the inmate.

Incident Assessment

Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-06-30	**2014-07-05**	**Suspected Drugs**	**Nothing**

Incident Summary 14-12321-CWRM

On June 30, 2014, the department placed an inmate on contraband surveillance watch after he assaulted an officer and was suspected of concealing drugs. During the course of placing the inmate on contraband surveillance watch, the inmate surrendered drugs. The inmate was removed from contraband surveillance watch on July 05, 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. Documentation specific to hand washing and range of motion was insufficient. The department agreed to provide training to custody staff regarding documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-07-05	**2014-07-09**	**Suspected Drugs**	**Drugs**

Incident Summary 14-12331-CWRM

On July 05, 2014, the department placed an inmate on contraband surveillance watch after custody staff observed a clear object protruding from his anal cavity during an unclothed body search. Custody staff also discovered a bindle in the inmate's work area which the inmate admitted was his. The inmate was removed from contraband watch on July 9, 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
2014-07-13	**2014-07-18**	**Suspicious Activity**	**Drugs**

Incident Summary 14-12391-CWRM

On July 13, 2014, the department placed an inmate on contraband surveillance watch after he was observed placing an unknown object into his rectum during visiting. The inmate was removed from contraband surveillance watch on July 18, 2014, five days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-07-18	**2014-07-22**	**Suspected Weapons**	**Nothing**

Incident Summary 14-12481-CWRM

On July 18, 2014, the department placed a ward on contraband surveillance watch. Specifically, the ward told custody staff that he was going to harm himself and he failed to clear a metal detector. The ward was removed from contraband surveillance watch on July 22, 2014, four days later. During that time, the department recovered nothing from the ward.

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
2014-07-19	**2014-07-22**	**Suspicious Activity**	**Drugs**

Incident Summary 14-12491-CWRM

On July 19, 2014, an inmate was placed on contraband surveillance watch after he was observed during visiting placing an unknown object into his mouth. The inmate was removed from contraband surveillance watch on July 22, 2014, three days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Insufficient

The department did not sufficiently comply with contraband surveillance watch policies and procedures. The department failed to conduct a medical assessment of the inmate prior to placement on contraband surveillance watch. Additionally, the department failed to document that consistent supervisory checks were conducted and did not complete self-audit documents. The department addressed the lack of documentation and health and safety requirements by providing training to custody and medical staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-07-26	**2014-08-01**	**Suspicious Activity**	**Drugs**

Incident Summary 14-12551-CWRM

On July 26, 2014, the department placed an inmate on contraband surveillance watch. Specifically, during an unclothed body search after visiting, an officer observed a clear plastic object drop to the ground and further observed clear plastic material protruding from the inmate's rectum. The inmate was removed from contraband surveillance watch on August 01, 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
2014-08-05	**2014-08-11**	**Suspected Weapons**	**Nothing**

Incident Summary 14-12621-CWRM

On August 05, 2014, the department placed an inmate on contraband surveillance watch after informing custody staff he ingested a razor blade. The inmate was removed from contraband surveillance watch on August 11, 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
2014-08-06	**2014-08-11**	**Suspected Drugs**	**Drugs**

Incident Summary 14-12631-CWRM

On August 06, 2014, the department placed an inmate on contraband surveillance watch after staff observed the inmate swallowing bindles. The inmate was removed from contraband surveillance watch on August 11, 2014, five days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Documentation specific to inmate hygiene, supervisory checks, and cell searches was inadequate. The department identified the deficiencies and agreed to provide 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
2014-08-06	**2014-08-09**	**Suspicious Activity**	**Other**

Incident Summary 14-12641-CWRM

On August 06, 2014, the department placed a ward on contraband surveillance watch. Specifically, officers observed cloth protruding from the ward's buttocks, and he refused to be searched. The inmate was removed from contraband surveillance watch on August 09, 2014, three days later. During that time, the department recovered money from the ward.

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
2014-08-07	**2014-08-10**	**Suspicious Activity**	**Nothing**

Incident Summary 14-12651-CWRM

On August 07, 2014, the department placed an inmate on contraband surveillance watch. Specifically, during an unclothed body search the inmate removed a small bindle from her bra and swallowed it. The inmate was removed from contraband surveillance watch on August 10, 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 document that supervisory checks were consistently conducted and failed to timely complete internal audit documentation. The department provided training to the involved custody staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-08-11	**2014-08-15**	**Suspicious Activity**	**Nothing**

Incident Summary 14-12751-CWRM

On August 11, 2014, the department placed an inmate on contraband surveillance watch. Officers observed the inmate acting suspiciously while on the exercise yard. After officers requested the inmate submit to a search, the inmate ran towards a fence and started to climb the fence while placing items in his mouth. The inmate was removed from contraband surveillance watch on August 15, 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
2014-08-14	**2014-08-18**	**Suspicious Activity**	**Nothing**

Incident Summary 14-12761-CWRM

On August 14, 2014, the department placed an inmate on contraband surveillance watch when he failed to clear a metal detector upon arrival at the institution. The inmate was removed from contraband surveillance watch on August 18, 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.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-08-29	**2014-09-03**	**Suspected Weapons**	**Nothing**

Incident Summary 14-12881-CWRM

On August 29, 2014, the department placed an inmate on contraband surveillance watch. Specifically, the inmate informed staff that he ingested one or more razor blades. The inmate was removed from contraband surveillance watch on September 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
2014-09-04	**2014-09-09**	**Suspicious Activity**	**Nothing**

Incident Summary 14-12991-CWRM

On September 04, 2014, the department placed an inmate on contraband surveillance watch after custody staff observed a clear lubricant in and around his anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on September 09, 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 did not consistently document the application, removal, and sanitizing of hand isolation devices, and the presence or absence of contraband in inmate-produced bowel movements. The department also retained the inmate on contraband surveillance watch a day longer than necessary and failed to document a medical assessment. The department agreed to provide corrective action and training to involved custody staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-09-09	**2014-09-12**	**Suspicious Activity**	**1. Inmate Note** **2. Weapons**

Incident Summary 14-13001-CWRM

On September 9, 2014, an inmate was placed on contraband surveillance watch after the inmate swallowed a large white bindle during a clothed body search. The inmate was removed from contraband surveillance watch on September 12, 2014, three days later. During that time, the department recovered a weapon and inmate notes.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-09-07	**2014-09-15**	**Suspicious Activity**	**Drugs**

Incident Summary 14-13031-CWRM

On September 07, 2014, the department placed an inmate on contraband surveillance watch. Specifically, while the inmate was being monitored in the visiting area, an authorized visitor passed him an open popcorn bag. Officers believed the bag contained contraband and retrieved the bag. Suspected drugs were found in the bag and the visitor was arrested for introducing drugs into the prison. The inmate was removed from contraband surveillance watch on September 15, 2014, eight days later. During that time, the department recovered drugs from the inmate.

Incident Assessment Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-09-21	2014-09-25	Suspected Weapons	Inmate Note

Incident Summary 14-13201-CWRM

On September 21, 2014, the department placed an inmate on contraband surveillance watch after receiving information the inmate was one of several inmates suspected of being in possession of weapons and inmate notes. The inmate was removed from contraband surveillance watch on September 25, 2014, four days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-09-21	2014-09-25	Suspected Weapons	Nothing

Incident Summary 14-13211-CWRM

On September 21, 2014, an inmate was placed on contraband surveillance watch. Specifically, the department received information that the inmate was one of several inmates in possession of weapons or inmate notes. On September 25, 2014, the inmate was removed from contraband surveillance watch, 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
2014-09-19	2014-09-25	Suspected Inmate Note	Inmate Note

Incident Summary 14-13241-CWRM

On September 19, 2014, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow an inmate note. The inmate was removed from contraband surveillance watch on September 25, 2014, six days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The department failed to document that the inmate received a medical assessment prior to being placed on contraband surveillance watch and did not document that hand isolation devices were consistently removed during meals or that proper hygiene opportunities were provided. The department agreed to provide training to custody and nursing employees regarding documentation and other policy requirements.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-12	2014-10-17	Suspected Drugs	Nothing

Incident Summary 14-13461-CWRM

On October 12, 2014, the department placed an inmate on contraband surveillance watch. Specifically, the inmate's visitor was observed acting nervously as she handed an opened candy bag to the inmate. An officer approached the inmate and discovered a bindle of suspected contraband in the candy bag. The inmate was removed from contraband surveillance watch on October 17, 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 document the approval to place the inmate on contraband surveillance watch and failed to complete the appropriate documentation for the application and removal of hand isolation devices. The documentation specific to inmate hygiene was also inadequate. The department provided training to custody staff regarding these documentation requirements.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-22	**2014-10-26**	**Suspected Weapons**	**Drugs**

Incident Summary 14-13611-CWRM

On October 22, 2014, the department placed an inmate on contraband surveillance watch when a metal detector indicated the presence of metal in his groin area. The inmate was removed from contraband surveillance watch on October 26, 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
2014-10-24	**2014-10-28**	**Suspected Drugs**	**Drugs**

Incident Summary 14-13651-CWRM

On October 24, 2014, the department placed an inmate on contraband surveillance watch after custody staff observed lubricant around the inmate's anus during an unclothed body search. The inmate was removed from contraband surveillance watch on October 28, 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
2014-10-24	**2014-10-27**	**Suspected Drugs**	1. **Drugs** 2. **Inmate Note**

Incident Summary 14-13681-CWRM

On October 24, 2014, the department placed an inmate on contraband surveillance watch after receiving information that the inmate was in possession of contraband and custody staff observed lubricant around the inmate's anal cavity. The inmate was removed from contraband surveillance watch on October 27, 2014, three days later. During that time, the department recovered drugs and inmate notes from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-25	**2014-10-28**	**Suspicious Activity**	**Weapons**

Incident Summary 14-13701-CWRM

On October 25, 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 October 28, 2014, three days later. During that time, the department recovered a razor blade 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
2014-11-02	**2014-11-05**	**Suspicious Activity**	**Nothing**

Incident Summary
14-13801-CWRM

On November 2, 2014, the department placed an inmate on contraband surveillance watch after custody staff observed the inmate secreting suspected contraband during visiting. The inmate was removed from contraband surveillance watch on November 5, 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 timely notify the OIG of the inmate's placement on contraband surveillance watch. Additionally, documentation specific to daily activity regarding range of motion, supervisory checks, access to proper hygiene, and cell searches was inconsistent. The department identified these problems and providing training. The department also agreed to train administrative custody staff regarding timely notification.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-26	**2014-11-12**	**Suspicious Activity**	**Drugs**

Incident Summary
14-13811-CWRM

On October 26, 2014, the department placed an inmate on contraband surveillance watch after officers observed what appeared to be a transfer of contraband during a kiss with an authorized visitor. The inmate was removed from contraband surveillance watch on November 12, 2014, 17 days later. During that time, the department recovered drugs from the inmate.

Incident Assessment
Insufficient

Overall, the department failed to comply with policies and procedures governing contraband surveillance watch. The OIG did not receive timely notification of the inmate's placement on contraband surveillance watch. Required medical assessments were not consistently conducted. The department addressed this problem by implementing procedures to ensure that required medical assessments for inmates on contraband surveillance watch are conducted timely.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-11-13	**2014-11-17**	**Suspicious Activity**	**Nothing**

Incident Summary
14-13961-CWRM

On November 13, 2014, the department placed an inmate on contraband surveillance watch when custody staff observed the inmate with a clear lubricant around his anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on November 17, 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
2014-11-16	**2014-11-21**	**Suspected Drugs**	**Nothing**

Incident Summary
14-14021-CWRM

On November 16, 2014, the department placed an inmate on contraband surveillance watch after officers observed him swallowing an unidentified object passed to him by a visitor. The inmate was removed from contraband surveillance watch on November 21, 2014, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment
Sufficient

Overall, the department sufficiently complied with policies and procedures governing contraband surveillance watch. The hiring authority identified inconsistencies in the documentation in regards to cell searches. Training was provided to all involved custody staff.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-11-15	**2014-11-18**	**Suspicious Activity**	**Nothing**

Incident Summary 14-14031-CWRM

On November 15, 2014, the department placed an inmate on contraband surveillance watch. Specifically, the inmate was observed holding steel wool and a battery in his right hand and an unidentified object in his left hand. The inmate swallowed the unidentified item after an officer ordered him to show what was in his left hand during a clothed body search. The inmate was removed from contraband surveillance watch on November 18, 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
2014-11-20	**2014-11-24**	**Suspected Weapons**	**Weapons**

Incident Summary 14-14081-CWRM

On November 20, 2014, the department placed an inmate on contraband surveillance watch after an X-ray confirmed that the inmate had swallowed a razor blade and the inmate was threatening self harm. The inmate was removed from contraband surveillance watch on November 24, 2014, four days later. During that time, the department recovered weapons from the inmate.

Incident Assessment Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch by not documenting whether hand isolation devices were removed during meals, and the presence or absence of contraband in bowel movements. Additionally, a medical evaluation prior to the inmate being placed on contraband surveillance watch was not documented. The department agreed to provide training to custody and medical staff regarding these deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-12-10	**2014-12-17**	**Suspicious Activity**	**Tobacco**

Incident Summary 14-14181-CWRM

On December 10, 2014, the department placed an inmate on contraband surveillance watch after custody staff received information that the inmate would attempt to transport controlled substances into the institution in his anal cavity. The inmate was removed from contraband surveillance watch on December 17, 2014, seven days later. During that time, the department recovered tobacco from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-12-14	**2014-12-22**	**Suspicious Activity**	**Inmate Note**

Incident Summary 14-14211-CWRM

On December 14, 2014, the department placed an inmate on contraband surveillance watch after custody staff observed the inmate place a plastic bag in his mouth. The inmate was removed from contraband surveillance watch on December 22, 2014, eight days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-12-22	**2014-12-26**	**Suspicious Activity**	**Nothing**

Incident Summary

14-14281-CWRM

On December 22, 2014, the department placed an inmate on contraband surveillance watch after he was observed swallowing razor blades. The inmate was removed from contraband surveillance watch on December 26, 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 timely notify the OIG of the inmate's placement on contraband surveillance watch and documentation specific to hand washing and nurse assessments were insufficient. The department agreed to provide training to custody and nursing staff regarding documentation requirements.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-08-07	**2014-08-13**	**Suspected Weapons**	**Nothing**

Incident Summary 14-12661-CWRM

On August 7, 2014, the department placed an inmate on contraband surveillance after a medical procedure confirmed the presence of an object consistent with a razor blade, which the inmate indicated he had swallowed. The inmate was removed from contraband surveillance watch on August 13, 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 and failed to consistently and accurately document inmate and restraint hygiene and supervisor checks. The department provided training to address the deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-08-10	**2014-08-18**	**Suspected Drugs**	**Drugs**

Incident Summary 14-12711-CWRM

On August 10, 2014, the department placed an inmate on contraband surveillance watch after he was observed swallowing a bindle in the visiting area. The inmate was removed from contraband surveillance watch on August 18, 2014, eight 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
2014-08-21	**2014-08-24**	**Suspicious Activity**	**Nothing**

Incident Summary 14-12831-CWRM

On August 21, 2014, the department placed an inmate on contraband surveillance watch after the inmate reached for an unknown item in his sock during a search, then moved his hand toward his mouth as if to swallow something. The inmate was removed from contraband surveillance watch on August 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
2014-08-26	**2014-08-29**	**Suspected Weapons**	**Nothing**

Incident Summary 14-12901-CWRM

On August 26, 2014, the department placed an inmate on contraband surveillance watch after he informed staff that he was suicidal and had swallowed a razor blade. The inmate was removed from contraband surveillance watch on August 29, 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 adequately document inmate and restraint hygiene. The department further failed to maintain proper restraints on the inmate when he returned from an outside hospital, thereby allowing the inmate to be unrestrained for an extended period of time in violation of departmental policy. The department provided training to involved custody staff.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-08-31	**2014-09-15**	**Suspected Weapons**	**Nothing**

Incident Summary
14-12921-CWRM

On August 31, 2014, the department placed an inmate on contraband surveillance watch after an inmate told staff that he swallowed razor blades and an x-ray confirmed the presence of a foreign object. The inmate was removed from contraband surveillance watch on September 15, 2014, 15 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 notify the OIG when the inmate was transported to an outside hospital while on contraband surveillance watch. The department further failed to adequately document inmate hygiene and restraint cleaning. The department did not document proper securing of clothing, initial cell searches, meals, and blanket issuance and removal in accordance with departmental policy. The department provided training to all involved custody staff.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-09-16	**2014-09-19**	**Suspicious Activity**	**Nothing**

Incident Summary
14-13091-CWRM

On September 16, 2014, the department placed an inmate on contraband surveillance watch after he was observed with lubricant around his anal cavity. The inmate was removed from contraband surveillance watch on September 19, 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 conduct the appropriate medical assessments. Additionally, the department failed to properly document the initial cell search and unclothed body search, as well as range of motion, hygiene, restraint hygiene, trash, and blanket issuance and removal. The department provided training to custody staff to address the deficiencies related to documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-09-23	**2014-09-26**	**Suspected Drugs**	**Nothing**

Incident Summary
14-13251-CWRM

On September 23, 2014, the department placed an inmate on contraband surveillance watch after custody staff observed him swallow a white bindle. The inmate was removed from contraband surveillance watch on September 26, 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 conduct the appropriate medical assessment of the inmate prior to placement on contraband surveillance watch. Additionally, the department failed to complete daily activity documentation regarding medical assessments, range of motion, supervisory checks, mattress and blanket issuance and removals, and access to proper hygiene. The department provided corrective action and training to custody and nursing staff regarding documentation requirements.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-04	**2014-10-08**	**Suspicious Activity**	**Nothing**

Incident Summary

14-13411-CWRM

On October 04, 2014, the department placed an inmate on contraband surveillance watch after the inmate appeared to remove a bindle from a bag of chips and place it in his mouth during visiting. The inmate was removed from contraband surveillance watch on October 08, 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 institution failed to notify the OIG of the inmate's placement on contraband surveillance watch in a timely and sufficient manner. In addition, the department failed to document the authorization of leg restraints and failed to document the initial cell search. Documentation related to supervisor checks, range of motion, and cell inspections was inadequate. The department provided training to address the deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-15	**2014-10-20**	**Suspicious Activity**	**Nothing**

Incident Summary

14-13541-CWRM

On October 15, 2014, the department placed an inmate on contraband surveillance watch after the inmate fought another inmate in plain view of officers. The fight appeared to be staged for the sole purpose of introducing contraband to the administrative segregation unit. The inmate was removed from contraband surveillance watch on October 20, 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 conduct a medical assessment of the inmate prior to placement on contraband surveillance watch. In addition, the department failed to consistently document that the inmate was afforded access to proper hygiene and failed to obtain proper authorization for the use of leg restraints. The department provided training for involved custody staff to ensure proper use of leg restraints.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-23	**2014-10-28**	**Suspected Weapons**	**Other**

Incident Summary

14-13631-CWRM

On October 23, 2014, the department placed an administrative segregation inmate on contraband surveillance watch after he admitted swallowing razor blades. The inmate was removed from contraband surveillance watch on October 28, 2014, five days later. During that time, the department recovered a metal foreign object.

Incident Assessment

Insufficient

The department failed to comply with policies and procedures governing contraband surveillance watch. The institution failed to adequately tape the waist of the inmate's clothing. In addition, not all inmate activities were documented as required. The department addressed these deficiencies by providing training to the officers.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-26	**2014-10-30**	**Suspected Drugs**	**Drugs**

Incident Summary
14-13661-CWRM

On October 26, 2014, the department placed an inmate on contraband surveillance watch after he was observed swallowing a bindle during a search. The inmate was removed from contraband surveillance watch on October 30, 2014, four days later. During that time, the department recovered four small bindles of suspected heroin from the inmate.

Incident Assessment
Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-27	**2014-11-05**	**Suspected Weapons**	**Nothing**

Incident Summary
14-13711-CWRM

On October 27, 2014, the department placed an inmate on contraband surveillance watch after an inmate reported to staff that she swallowed a bolt that had been removed from her bed. An x-ray confirmed the presence of a metal object in the shape of a bolt. The inmate was removed from contraband surveillance watch on November 05, 2014, nine days later, but remained on one-on-one observation by mental health staff. During the time on contraband surveillance watch, 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 adequately document supervisor checks, inmate and restraint hygiene, restraint checks, and range of motion releases. Furthermore, the department failed to provide constant visual observation by custody staff on at least two occasions. The department provided training to supervisory custody staff to address the deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-10-31	**2014-11-04**	**Suspected Drugs**	**Nothing**

Incident Summary
14-13751-CWRM

On October 31, 2014, the department placed an inmate on contraband surveillance watch after the inmate surrendered two razor blades and an inmate manufactured syringe from his anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on November 04, 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. There is no documentation that custody staff provided constant visual observation during first watch shifts. In addition, documentation specific to inmate hygiene, unclothed body searches, mattress searches, blanket issuance and removal, and request for additional custody staff coverage was inadequate. The department provided written counseling to the employees to address the deficiencies.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-11-01	**2014-11-05**	**Suspicious Activity**	**Nothing**

Incident Summary 14-13761-CWRM

On November 01, 2014, the department placed an inmate on contraband surveillance watch after she was observed cutting her arm with a razor and then telling an officer that she swallowed the blade. The inmate was removed from contraband surveillance watch on November 05, 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 adequately document supervisor checks, inmate and restraint hygiene, restraint checks, range of motion releases, and the results of an inmate bowel movement. The department provided training to custody staff to address the inadequate documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-11-07	**2014-11-13**	**Suspected Weapons**	**Nothing**

Incident Summary 14-13871-CWRM

On November 07, 2014, the department placed an administrative segregation inmate on contraband surveillance watch after the inmate informed staff he swallowed a razor blade. The inmate was removed from contraband surveillance watch on November 13, 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's self-audit identified that custody staff failed to document blanket issuance and removal, but provided no corrective action. The OIG's review found that documentation specific to range of motion, hygiene, supervisory checks, and blanket issuance and removal were inadequate. The department agreed to provide training to custody staff to address these deficiencies.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-12-07	**2014-12-19**	**Suspicious Activity**	**Drugs**

Incident Summary 14-14151-CWRM

On December 07, 2014, the department placed an inmate on contraband surveillance watch after an officer observed an inmate appear to insert something into his rectum while in the visiting room. The inmate was removed from contraband surveillance watch on December 19, 2014, 12 days later. During that time, the department recovered approximately 42 grams of heroin from the inmate.

Incident Assessment Insufficient

The department failed to substantially comply with policies and procedures governing contraband surveillance watch. Specifically, the department failed to timely obtain approval for the third 72-hour extension and failed to timely notify the OIG of the extension. The department also failed to consistently document supervisory checks and range of motion releases and failed to document any cleaning of the restraint equipment. Training was provided to address the deficiencies.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2014-12-17	**2014-12-22**	**Suspected Mobile Phone**	**Other**

Incident Summary
14-14241-CWRM

On December 17, 2014, the department placed an inmate on contraband surveillance watch after he failed to clear a metal detector upon admission to the administrative segregation unit. The inmate was removed from contraband surveillance watch on December 22, 2014, five days later. During that time, the department recovered string, paper, and pieces of a latex glove.

Incident Assessment
Sufficient

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

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STATE OF CALIFORNIA
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