Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

January–June 2016

Volume II

September 2016

Fairness ◆ Integrity ◆ Respect ◆
Service ◆ Transparency

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September 2016

Foreword

This 23rd Semi-Annual Report covers the time period of January through June 2016. In addition to its oversight of the employee discipline process within the California Department of Corrections and Rehabilitation (CDCR or the department), the OIG also uses a real-time monitoring model to provide oversight and transparency in several other areas within the State prison system. The OIG publishes the Semi-Annual Report in a two-volume format to allow readers to more easily distinguish the various categories of oversight activity.

Volume II is a summary of the OIG's monitoring and assessment of the department's handling of critical incidents, including those involving deadly force. It also reports on the department's use-of-force reviews, CDCR's adherence to its contraband surveillance watch policy, and the department's response to the OIG's field inquiries. Since each of these activities is monitored on an ongoing basis, they are combined into one report that is published every six months in this two-volume Semi-Annual Report.

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

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

VOLUME II

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Summary of Other Monitoring Activities

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

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. These cases are reported in Appendix D of the Semi-Annual Report.

The OIG maintains response capability 24 hours per day, seven days per week, for any critical incident (as described on the following page) 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.

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

Finally, the OIG provides a process by which inmates, CDCR staff, and the public can report misconduct or lodge complaints. The OIG examines complaints and assigns staff to conduct field inquiries regarding the complaints. Field inquiry cases are reported in Appendix G.

The OIG also monitors and reports on use-of-force incidents and CDCR's subsequent review process. The OIG's reports in this area can also be found in Volume II.

Critical Incidents

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

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

The OIG maintains a 24-hour contact number in each region to receive notifications. After notification, the OIG monitors the department's management of the incident, either by responding to the site of the incident or by obtaining the incident reports and following up at the scene at a later time. More specifically, the OIG evaluates what caused the incident and the department's immediate response to it. The OIG may make recommendations as a result of its review regarding training, policy, or referral for further investigation of potential negligence or misconduct. If the OIG believes the hiring authority should refer the incident to the Office of Internal Affairs, the OIG monitors the hiring authority's decision. If the Office of Internal Affairs

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

opens an investigation, the OIG may monitor the ensuing investigation. Critical incidents are customarily reported in the Semi-Annual Report that follows the incident occurrence. However, if an investigation is initiated, a report may be held at the discretion of the Inspector General until completion of the investigation if reporting it would potentially negatively impact the integrity of that investigation.

During this reporting period, the OIG completed assessments of 136 critical incidents (Appendices D and E), 16 of which were full investigations of deadly force incidents. Those 16 incidents are not included in the critical incident statistics, but the OIG's assessments can be found in Appendix D2. It is important to note that the number of critical incidents within any period is dependent upon the events taking place within the department. This report does not directly correlate to incidents that occurred within this time frame, but rather reflects the number of incidents the OIG has assessed and closed for the time period. The OIG rated 61 of the 120 cases in Appendices D1 and E insufficient. The OIG's rating system considers the department's actions prior to the incident, during the incident, and after the incident. Each incident is rated on all three phases and may be sufficient or insufficient in more than one phase. The OIG found the department's actions insufficient in only one phase in 39 cases. Sixteen cases had insufficient ratings in two phases, and six cases were insufficient in all three phases. In this reporting period, 22 cases (18 percent) were insufficient solely or partially due to late notification of the OIG. The case was only marked insufficient if the late notification interfered with the OIG's ability to respond to the scene and monitor the case. In order to monitor an incident on scene, the OIG relies on the department to provide timely notification that a critical incident has occurred. However, even when notification is untimely, the OIG still remotely monitors the event by collecting reports and conducting follow-up reviews.

For cases reported during this period in Appendices D1 and E, the department failed to provide timely notification of 24 critical incidents (20 percent). Two of those cases were not marked insufficient on that basis because they were cases where late notification did not interfere with the OIG's ability to respond to the scene and monitor the case. The timely notification of 80 percent of critical incidents is a vast improvement over the last reporting period, when only 61 percent of notifications were timely. California Department of Corrections and Rehabilitation administration previously agreed to emphasize timely notification, and the improvement is a positive trend, which we look forward to continuing.

PRISON RAPE ELIMINATION ACT (PREA) INCIDENTS

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

Before July 1, 2015, if an inmate alleged he or she was sexually involved with or assaulted by staff, the department's PREA policy required institutional staff to refer the case to the Office of Internal Affairs for an investigation or, if there were criminal allegations, to refer the case to a district attorney's office. There was no mechanism for the institution to perform a preliminary inquiry into the allegation. Institutional staff referred cases to the Office of Internal Affairs, which then routinely denied requests for investigations because there was no corroborating

evidence and no reasonable belief that staff misconduct occurred. As a result of the policy, there were cases in which neither the institution nor the Office of Internal Affairs investigated an inmate's allegations of PREA violations by staff.

In 2012, the United States Department of Justice issued a final rule in accordance with PREA that set national standards for protecting inmates. In order to conform to the national standards, the department amended Department Operations Manual Sections 31060, et. seq., 51030.3, 52050.16.4 through 52050.16.6, and 54040, et. seq., effective July 1, 2015. In addition, changes to Title 15 of the California Code of Regulations, Sections 3084.8, 3084.9, 3323, 3335, and 3401.5 are proposed but have not yet been implemented.

The new policies, enacted by the department in July 2015, restrict the hiring and promotion of staff who have engaged in sexual violence or sexual misconduct with an inmate and require employees to report sexual violence allegations made against them. The department also added additional restrictions to clothed and unclothed body searches. The policies require all staff to be trained in the prevention, detection, response, and investigation of offender sexual violence, staff sexual misconduct, and sexual harassment, with additional training for staff who perform specialized roles in the process. Institutions are required to take specified preventative measures to minimize staff incidentally viewing inmates' breasts, buttocks, or genitalia. The policy further requires documentation of any cross-gender unclothed body searches. Institutions must more rigorously review inmate housing assignments and the policy provides methods for inmates, staff, and third parties to report sexual abuse and harassment by other inmates or staff.

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

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

The policy provides additional guidance for handling parolee reports of sexual misconduct by other parolees or staff, and for processing the alleged suspect. The policy contains additional protections to guard against retaliation against inmates who report sexual violence or staff sexual misconduct. Each institution must have a PREA Compliance Manager who coordinates efforts to comply with the CDCR Prison Rape Elimination Policy. Hiring authorities must also review allegations that have been substantiated. There are also additional requirements for internal and external audits of the process. Currently the OIG has not been tasked with this responsibility.

An additional proposed change as a result of the public comment period would provide that there is no time limitation on allegations of sexual violence or staff sexual misconduct.

FEMALE SUICIDE AND ATTEMPTED SUICIDES

When the department notifies the OIG that a female inmate attempted suicide, the OIG opens a case for monitoring. The OIG reviews documents prepared by the institution in connection with the incident and evaluates the department's response to the emergency. The OIG then consults with the chief of mental health at the institution to determine whether, after mental health evaluation of the inmate, the department continued to classify the inmate's actions as a suicide attempt, or whether the inmate's actions were reclassified. The OIG will also discuss with the chief of mental health whether the department identified any mental health care deficiencies prior to or after the incident. The OIG does not independently evaluate the determinations made by the department's mental health staff, but will ask for clarification or raise potential issues with departmental staff.

2015

Prior to 2015, all suicides and any attempts resulting in serious bodily injury were monitored as critical incidents by the OIG. In response to an increase in the number of female inmates attempting suicide, in 2015 the OIG expanded monitoring to all attempted suicides by female inmates. Institutions are required to provide the OIG immediate notification of such incidents. There were 49 attempted suicides by female inmates in 2015—38 at the California Institution for Women (CIW) and 11 at the Central California Women's Facility (CCWF). There were no attempted suicides at the Folsom Women's Facility (FWF) in 2015.

January–June 2016

Between January and June 2016, there were 17 attempted suicides by female inmates: 13 at CIW and 4 at CCWF, and 2 of 4 four attempts at CCWF were made by the same inmate on the same day. For the purpose of statistical data below, such as age, race, housing, and sentencing, the inmate who attempted suicide twice was only counted once and the reader will note references to 16 inmates. However, for the purpose of the data regarding details of the attempts, each of the 17 attempts were counted independently. There were no attempted suicides at FWF between January and June 2016. The OIG monitored all of the reported female attempted suicides during the January through June 2016 reporting period. In that period, one female inmate committed suicide by hanging at CIW. She was a 35-year-old Hispanic inmate who was a participant in the Mental Health Services Delivery System (MHSDS) at the Enhanced Outpatient Services level of care at the time of the suicide. She had served 18 years, 10 months of a 19-years-to-life sentence for attempted second-degree murder. She was scheduled for a hearing with the Board of Parole Hearings the day after her death, where the victim of the inmate's crime was scheduled to make a statement.

The youngest female inmate to attempt suicide in the first half of 2016 was 23 years old and the oldest was 50 years old. The average age at the time of attempt was 34. Five of the 16 inmates

who attempted suicide were Hispanic, while four were white, four were black, and the other three identified as American Indian, Filipino, or Vietnamese.

Of the 17 attempted suicides in 2016, only 6 of the 16 inmates were housed alone at the time of the suicide attempt and the most common method used to attempt suicide was cutting (7 of the 17 attempts), followed by hanging or strangulation (4 attempts), overdosing on medication (3 attempts), and swallowing foreign objects (3 attempts).

The majority of inmates (14 of 16) were serving determinate sentences averaging seven years, five months, while two inmates were serving life terms with the possibility of parole.[2] Of the inmates with determinate sentences, the shortest incarceration before the suicide attempt was four and one half months (5 percent of the total term) and the longest was nearly 16 years (84 percent of the total term). On average, inmates with determinate sentences attempted suicide after serving 43 percent of their total terms.

Fourteen of the 16 female inmates who attempted suicide in this reporting period were participants in the MHSDS at the Correctional Clinical Case Management System (CCCMS) level of care or above at the time of the attempted suicide.[3]

Psychiatrists ultimately reclassified three of the 17 suicide attempts between January and June 2016 as not suicide attempts, reducing the actions classified as attempts from 17 to 14. One inmate's behavior of cutting her arm and finger with a razor, requiring 16 sutures, was reclassified as "non-suicidal self-injurious behavior" after a mental health assessment. Another inmate claimed she swallowed half of a sharpened toothbrush, but an x-ray revealed no foreign objects. The inmate's report was reclassified as a "suicide threat." A third inmate who tried to hang herself from a belt attached to the ceiling ultimately admitted her actions were part of a plan to distract custody staff so that other inmates could steal coffee from the officers' station. That inmate's behavior was reclassified as "misuse of staff and services."

Three of the inmates who attempted suicide in the first half of 2016 had previously attempted suicide in 2015. One inmate at CIW, whose 2016 suicide attempt was reclassified as "misuse of staff and services," had attempted suicide by hanging twice on consecutive days in 2015. A second inmate who attempted suicide by cutting in 2016 had also attempted suicide by cutting three times in 2015: twice while housed at CCWF and once while housed at CIW. A third inmate at CIW who attempted suicide by hanging in 2016 also attempted suicide by the same manner in 2015. All of these inmates were participants in the MHSDS at the CCCMS level of care or above at the time of the previous attempted suicides.

[2] One inmate was in the custody of the Department of State Hospitals and thus sentencing data was not available.
[3] 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 State Hospitals (DSH). 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/DHCS/index.html

None of the inmates gave specific reasons for their suicide attempts, but some inferences can be drawn from the circumstances surrounding some of the attempts. Two inmates who attempted suicide appeared to have relationship problems. One of those inmates yelled out "suicidal" before the attempt and then reported she had done so because she wanted to get back at another inmate. Shortly after the inmate was rehoused, she attempted suicide. Another inmate cut her arms and broke a window with her fist after an argument in which she punched her cellmate. Some circumstances imply that inmates may have attempted suicide due to pending housing changes. For example, one inmate had been disruptive prior to the suicide attempt and officers were preparing to rehouse her in administrative segregation when she cut her arm and said she needed to go on suicide watch. Another inmate swallowed six blood pressure pills the day before she was scheduled to be transferred to another institution.

Eight of the seventeen female attempted suicide cases the OIG monitored can be found in Appendix E. The remaining nine cases are not yet complete and will be reported in a future Semi-Annual Report.

REVIEW OF VIDEO RECORDINGS DURING INSTITUTIONAL EXECUTIVE REVIEW COMMITTEE MEETINGS

Some institutions within the Division of Adult Institutions have installed cameras capable of capturing and preserving video of use-of-force incidents.

Table 1: *Video Cameras within the Division of Adult Institutions*

Institution Initialism	Institution Name	Video Recorded?	Locations	IERC review?
CCC	California Correctional Center	Yes	All yards	All incidents captured on video
CIM	California Institution for Men	No	N/A	N/A
CMC	California Men's Colony	No	N/A	N/A
CRC	California Rehabilitation Center	Yes	Main yard, Facility A stairwell	All incidents captured on video
DVI	Deuel Vocational Institution	Yes	All yards	10% of incidents captured on video
NKSP	North Kern State Prison	No	N/A	N/A
RJD	Richard J. Donovan Correctional Facility	Yes	Administrative Segregation	None
SCC	Sierra Conservation Center	Yes	All yards	All incidents captured on video
SQ	California State Prison, San Quentin	No	N/A	N/A
WSP	Wasco State Prison	No	N/A	N/A
CAC	California City Correctional Facility	Yes	All facilities, yards, and housing units	All incidents captured on video
CCI	California Correctional Institution	Yes	Facility A	All incidents captured on video
COR	California State Prison, Corcoran	No	N/A	N/A
HDSP	High Desert State Prison	No	N/A	N/A
KVSP	Kern Valley State Prison	No	N/A	N/A
LAC	California State Prison, Los Angeles County	Yes	All yards	None
PBSP	Pelican Bay State Prison	Yes	All yards	None
SAC	California State Prison, Sacramento	Yes	All yards	All incidents captured on video
SATF	Substance Abuse Treatment Facility & State Prison at Corcoran	Yes	Facility C	Certain incidents
SVSP	Salinas Valley State Prison	Yes	All yards	None
ASP	Avenal State Prison	No	N/A	N/A
CAL	Calipatria State Prison	Yes	Facility B yard, Facility A dining hall	All incidents captured on video
CEN	Centinela State Prison	Yes	All yards	All incidents captured on video
CTF	Correctional Training Facility	Yes	All yards	None
CVSP	Chuckawalla Valley State Prison	No	N/A	N/A
ISP	Ironwood State Prison	No	N/A	N/A
MCSP	Mule Creek State Prison	Yes	All yards	Hiring authority has pledged to start reviewing
PVSP	Pleasant Valley State Prison	Yes	All yards	All incidents captured on video
SOL	California State Prison, Solano	Yes	All yards	Cameras are not working
VSP	Valley State Prison	No	N/A	N/A
CCWF	Central California Women's Facility	No	N/A	N/A
CHCF	California Health Care Facility	Yes	All facilities, yards, and housing units	10–20% of incidents
CIW	California Institution for Women	No	N/A	N/A
CMF	California Medical Facility	No	N/A	N/A
FSP	Folsom State Prison	Yes	All yards	All incidents captured on video

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

Two institutions, the California Health Care Facility (CHCF) and California City Correctional Facility (CAC), have cameras on all facilities, yards, and housing units. Thirteen institutions have cameras on exercise yards only, while five institutions have cameras on selected facilities and in specific locations, such as administrative segregation. Fifteen institutions reported having no video cameras.

Many institutions follow best practices by preserving video recordings of incidents and reviewing them at institutional executive review committee (IERC) meetings, where managers review use-of-force incidents. In the reception center mission, California Correctional Center (CCC), California Rehabilitation Center (CRC), and Sierra Conservation Center (SCC) routinely review video recordings of all incidents captured on video at IERC meetings. In the high security mission, California City Correctional Facility (CAC), California Correctional Institution (CCI), and California State Prison, Sacramento (SAC) also review all captured video recordings. In the general population mission, Calipatria State Prison (CAL), Centinela State Prison (CEN), and Pleasant Valley State Prison (PVSP) likewise review available video recordings of incidents at IERC meetings. In the female offender programs and services, special housing mission, only Folsom State Prison's IERC reviews all incidents that were captured on video.

The practice of reviewing video recordings at IERC meetings is sporadic. For example, at the Substance Abuse Treatment Facility and State Prison at Corcoran (SATF), the IERC only reviews video if an inmate makes an allegation of unreasonable use of force or other staff misconduct or the incident is otherwise questionable. At Deuel Vocational Institution (DVI) and the California Health Care Facility (CHCF), the IERC only reviews a small fraction of the video available. The IERCs at Correctional Treatment Facility (CTF), Pelican Bay State Prison (PBSP), and Salinas Valley State Prison (SVSP) in the northern region and California State Prison, Los Angeles County (LAC) and Richard J. Donovan Correctional Facility (RJD) in the southern region do not preserve and review video recordings of incidents, although cameras are installed to capture such activity. Although California State Prison, Solano (SOL) has video cameras installed in exercise yards, they are not working. Mule Creek State Prison (MCSP) has not previously preserved and reviewed video from yard cameras at IERC meetings, but the hiring authority has pledged to do so in the future.

Video recordings are valuable objective evidence of the events surrounding uses of force. When recordings are available, they enhance the department's ability to critically evaluate whether the uses of force complied with policies, procedures, training, and applicable laws. At times, the images captured in video recordings refute claims by inmates of unreasonable use of force and, therefore, protect staff and the department from litigation. Video recordings of incidents may also prevent unnecessary investigations by the Office of Internal Affairs, thus preserving resources. Requiring institutions to preserve, and IERCs to review, recordings captured by cameras that are already installed should not appreciably increase the department's costs and would follow best practices being undertaken at other institutions.

In order to make sure any video captured is available for review, the OIG recommends the department create a consistent policy requiring institutions to preserve any video captured of an incident and specifying a process for including the video with the use-of-force incident package. In addition, the OIG recommends the department amend Department Operations Manual

Section 51020.19.5 to create a consistent policy requiring Institutional Executive Review Committees at all institutions to review any available video recordings of use-of-force incidents as part of the review process.

EVIDENCE COLLECTION AND CRIME SCENE PRESERVATION

In the Semi-Annual Report covering the January through June 2015 period, the OIG made the following formal recommendation:

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

After the publication of the Semi-Annual Report covering the time period of July through December, 2015, the department responded that the recommendation had been partially implemented as follows:

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

The department provided no explanation regarding why on-the-job training in this area would not begin until more than a year after the OIG made the recommendation. Despite the fact that the department claims to be committed to providing additional training, 23 of the 32 institutions that responded to the OIG's inquiry regarding such training have reported the training is not provided. Of the remaining nine institutions that reported providing such training, one institution reported the training was last given several years ago and a second institution reported the most recent training was given two years ago. A third institution reported training staff only every two years. California State Prison, Sacramento (SAC), and Sierra Conservation Center (SCC) reported that some training is given annually, while Centinela State Prison (CEN) provides training on crime scene preservation and evidence collection twice per year. These institutions should be commended for their commitment to properly train staff to preserve crime scenes and collect evidence properly. Given the regular addition of new staff and the department's persistent problems with crime scene preservation and evidence collection, it would benefit the department to require the remaining institutions to consistently provide training in this area.

Several cases in this reporting period illustrate why the department should follow the OIG recommendation.

In three cases, investigative services unit officers failed to secure potential crime scenes after inmates were found dead in their cells. In one of those three cases, officers also did not initiate a crime scene log and moved the inmate's body before the coroner arrived. In a fourth case involving an inmate death, officers processed the scene instead of the investigative services unit, which is specially trained in evidence collection and crime scene preservation. In that case, the officers who processed the scene failed to log items seized or inspected.

The investigative services unit in a fifth case failed to collect and properly examine a firearm after a negligent discharge. Similarly, in a sixth case, investigative services unit officers did not properly process crime scene evidence after an officer fired a warning shot on an exercise yard during an inmate fight.

IMPROPER INMATE COUNTS

The Department Operations Manual (DOM) Section 52020.4.2, "Method of Count," specifies that "[t]he count shall be performed by the physical observation of each inmate at his/her assigned housing unit or out counting inmates at his/her specified work/activity location." Section 52020.5 states, "[a] positive count is the actual number of inmates that each respective staff member has counted and reported to Central Control. (***Note*:** A positive/physical count means to count a living, breathing person and physically see that person.)"

In this reporting period, the OIG closed 36 cases where inmates were found in their cells dead or in medical distress. Of those, the OIG identified seven cases (19 percent of the cases being reported) in which officers allegedly improperly performed inmate counts. In one case where an inmate died of a drug overdose, an officer counted the inmate as alive less than two hours before the inmate was found dead with rigor mortis. In a second case, the inmate died of natural causes and an officer counted him as living six hours before he was found dead with rigor mortis. In both of those cases, despite the OIG's recommendation to refer the matters to the Office of Internal Affairs for investigation, the hiring authorities declined to do so. In a third case, an inmate committed suicide by placing a plastic bag over his head and tying a sheet around his neck. An officer counted the inmate as alive one hour before he was found dead, covered by a blanket, with rigor mortis. The hiring authority referred the case to the Office of Internal Affairs for investigation, but the Office of Internal Affairs refused to approve an investigation. In a fourth case, an inmate died of natural causes and an officer counted him as alive 33 minutes before he was found dead with rigor mortis. The inmate's body was in a partially prone position on the cell floor. The hiring authority did not identify the potential staff misconduct until the OIG recommended referring the case to the Office of Internal Affairs for investigation. The hiring authority referred the case and the Office of Internal Affairs approved the case for direct disciplinary or corrective action, which the OIG accepted for monitoring.

In a fifth case, an inmate who had been placed on suicide precautions with mandatory 15-minute welfare checks attempted to hang himself with an electrical cord. Although officers removed the cord while the inmate was still alive, he died shortly thereafter. A nurse had delayed starting the 15-minute welfare checks, potentially allowing the inmate additional time to commit suicide. The hiring authority provided training to the nurse. Similarly, in another case, an inmate committed suicide by wrapping a sheet around his neck. The inmate was housed in an area

requiring security checks at least every 30 minutes. Officers allowed more than 35 minutes to pass between security checks and did not document the checks. The hiring authority amended the institution's policy to correct a deficiency that contributed to the lapse, but declined to take corrective action against the officer until the OIG recommended it.

In the final case during this reporting period, an inmate committed suicide by hanging in his cell and an officer documented conducting security checks she had not performed. A video recording confirmed the officer had not performed the security checks and the institution dismissed her.

Clearly, some officers have not sufficiently physically observed each inmate during the institutional counts and have positively counted inmates who are not "living, breathing" persons. If officers in these cases had properly observed the inmates, they would have noted the inmates had died. When officers fail to properly view inmates during counts, inmates in medical or psychological distress may not receive the medical attention they require. The department's goal in performing counts should not only be to account for inmates' presence, but also to assess the welfare of the inmate. In the three cases cited above, the department did not hold officers accountable when they negligently performed physical observations of inmates. While it is likely the majority of counts are done properly, there are some that likely are not. These improper ones came to the OIG's attention only because the inmate death was reviewed as a critical incident.

DEADLY FORCE INCIDENTS

CDCR policy mandates that the Office of Internal Affairs' Deadly Force Investigation Team conduct deadly force investigations. Deadly force is, "[a]ny use of force that is likely to result in death. Any discharge of a firearm other than the lawful discharge during weapons qualification, firearms training, or legal recreational use of a firearm, is deadly force."[4] Use of less-lethal force methods, such as impact munitions or expandable batons in ways likely to result in death, may constitute deadly force. Examples include intentional strikes to the head or unintentional strikes that cause great bodily injury. The Office of Internal Affairs' Deadly Force Investigation Team is described and regulated by Title 15, California Code of Regulations, Section 3268(a)(20), which specifically states the Deadly Force Investigation Team need not respond to warning shots that cause no injury. Therefore, the Office of Internal Affairs conducts both administrative and criminal investigations for deadly force incidents except for warning shots. The Office of Internal Affairs will not conduct criminal investigations if an outside law enforcement agency conducts the criminal investigation.

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

[4] Title 15, California Code of Regulations, Section 3268(a)(9).

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

The Deadly Force Review Board reviews Deadly Force Investigation Team incidents. An OIG manager participates as a non-voting member of this body. The Deadly Force Review Board is an independent body consisting of outside law enforcement experts and a CDCR executive officer. Generally, after the administrative investigation is complete, the investigative report is presented to the Deadly Force Review Board. The Deadly Force Review Board examines the incident to determine the extent to which the use of force complied with departmental policies and procedures, and to determine the need for modifications to CDCR policy, training, or equipment. The Deadly Force Review Board's findings are presented to the CDCR Undersecretary of Operations, who determines whether further action is needed.

The OIG has always given the highest level of scrutiny to the department's use of deadly force due to the serious implications involved. During this reporting period, the OIG closed 26 potentially deadly force incidents. The incidents included the intentional use of lethal weapons, unintentional strikes to the head, warning shots, and other uses of force that could have or did result in great bodily injury or death. Each incident is summarized in Appendix D, which is broken into two categories. Cases that the OIG monitored but the Office of Internal Affairs did not respond to are reported in Appendix D1. There are ten such cases for this period. Cases that were investigated by the Office of Internal Affairs and monitored by the OIG are reported in Appendix D2. There are 16 such cases for this reporting period. The number of cases being reported does not correlate with the actual number of times the Office of Internal Affairs responded to the scene during this reporting period, as the OIG only reports a case once all activity is completed.

Of the 16 cases being reported in Appendix D2, the Office of Internal Affairs responded to the scene in 12 cases. In 9 of the 12 cases, as well as in 4 cases where the Office of Internal Affairs did not respond to the scene, the Deadly Force Investigation Team conducted both criminal and administrative investigations.

The department timely and adequately notified the OIG in 15 of the 16 Deadly Force Investigation Team cases (94 percent) reported in Appendix D2.

Use of Force

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

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

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

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

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

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

[5] Department Operations Manual, Chapter 5, Article 2.

When appropriate, the OIG recommends an incident be referred to CDCR's Office of Internal Affairs for investigation, or approval to take direct 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, superintendent, or the regional parole administrator, the OIG may confer with higher level department managers. If the OIG recommends investigation of a case, the department's response is monitored and reported.

Beginning January 1, 2016, the OIG implemented a new use-of-force monitoring tool. Consistent with past practice, a Deputy Inspector General or Special Assistant Inspector General reviews reports and other evidence gathered in connection with a use-of-force incident and attends the Institutional Executive Review Committee (IERC) meeting. Previously, the OIG collected basic information about each incident it monitored. With the new tool, the OIG is able to collect detailed information regarding the incident, the force used, any injuries resulting from the use of force, any allegations of unreasonable force made by the inmate, and the IERC meeting itself. The OIG tracks whether the department complied with policies and procedures during the use of force itself, as well as subsequent activities, including the review process. The OIG developed and designed the new tool to give the OIG the ability to more accurately track and report on types and frequency of force and injuries, as well as to identify pertinent or troubling trends and to provide more valuable feedback to the department and its public safety stakeholders. The use-of-force data in this Semi-Annual Report was gathered with the new tool.

The OIG attends as many use-of-force committee meetings as resources allow, but no less than one meeting each month at each prison, juvenile facility, and parole region. During this reporting period the department reported that it held 786 use-of-force committee meetings. Of those, the OIG attended 638 (81 percent).

USE-OF-FORCE MEETINGS ATTENDED AND INCIDENTS REVIEWED

During this reporting period, the OIG monitored and evaluated 2,873 unique use-of-force incidents and allegation reviews.[6] This data is derived from incidents that were reviewed from January 1, 2016, through June 30, 2016.

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 department reviewer is tasked with evaluating reports, requesting necessary clarifications, identifying deviations from policy, and determining whether the use of force was within policies, procedures, and applicable laws. The levels of review are the initial review conducted by the incident commander, the first level management review conducted by a captain, the second level management review conducted by an associate warden, and the final level of review where the incident is reviewed by the use-of-force review committee, with the ultimate determination made by the institution head (warden, superintendent, chief, or regional parole administrator) or designee. During the meeting, the OIG observes the review process and engages in contemporaneous oversight by raising concerns

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

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 complied with policies, and procedures, and whether the review process was thorough and meaningful. Table 2 illustrates the OIG-monitored incidents by division within CDCR.

Table 2: *Number of Separate Use-of-Force Incidents Reviewed, by Division*

Division	Number of Incidents Reviewed
Division of Adult Institutions	2,715
Division of Juvenile Justice	133
Division of Parole Operations	22
Office of Correctional Safety	3
Total	**2,873**

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 197 individual cases (7 percent).

CALIFORNIA CORRECTIONAL INSTITUTION

Pursuant to the department's use-of-force policy, "The IERC shall meet to review its cases on at least a monthly basis, or on a schedule to ensure all cases are reviewed within 30 days."[7] The use-of-force coordinator "shall normally schedule all logged use of force cases for review within 30 days of their logged occurrence."[8] During this reporting period the California Correctional Institution had ten use-of-force incident reviews that were seriously delayed or not adequately processed.

Below is a breakdown of the identified review times by the Institutional Executive Review Committee. The time of review was calculated from the date of the last action through the date of the IERC review:

- Three incidents were reviewed in two months or less.
- Two incidents were reviewed within 15–18 months.
- Three incidents were reviewed within 22–24 months**.
- One incident was reviewed within 27 months.
- One incident was reviewed within 33 months***.

Request for Investigation:

**Two of the three incidents which were reviewed within 22–24 months were requested to be investigated during the incident review process. An associate warden and captain made this request to the warden via a memorandum requesting for the case to be referred for further review

[7] Title 15, California Code of Regulations, Section 3268.1(e)(2)(E)(7)
[8] Title 15, California Code of Regulations, Section 3268.1(e)(2)(D)

into unnecessary force allegations. The incidents were never referred for investigation and were subsequently brought to IERC more than 22 months after the incident.

***The incident which was reviewed within 33 months was not requested for investigation or referred for an administrative inquiry. There is no indication why this serious delay occurred. The incident occurred on August 4, 2013, and was reviewed by IERC on May 13, 2016, with no explanation.

DEPARTMENT EXECUTIVE REVIEW COMMITTEE (DERC)

Pursuant to California Code of Regulations, Title 15, Section 3268(a)(19) and the Department Operations Manual, Sections 51020.4 and 51020.19.6, the DERC is a committee of staff selected by and including the Associate Director of the respective mission-based group of institutions. The DERC has oversight responsibility and final review authority over the Institution Executive Review Committees. The DERC is required to convene and review the following use-of-force incidents:

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

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

During this reporting period, three of the four missions held a total of eight DERC reviews during which they reviewed ten incidents: the Reception Center mission reviewed two incidents, the General Population mission reviewed four incidents, and the High Security mission reviewed four incidents. In addition, the Division of Juvenile Justice conducted two DERC reviews during which they reviewed six incidents.

The OIG determined that an additional 26 DERC reviews should have occurred: 7 in the Reception Center mission, 1 in the General Population mission, 15 in the High Security mission, and 3 in the Female Offender Programs and Services, Special Housing mission. The latter has not reported conducting any DERC reviews in the past four reporting periods. The DERC did not review 20 cases where inmates suffered serious injury or great bodily injury and did not review 6 cases where deadly force was used. Some cases may be reviewed by DERC in the future. The OIG monitored all of the DERC reviews the department conducted during this reporting period. The OIG raised the issue with CDCR senior management that DERC reviews were not occurring for all cases required by policy. Senior management advised that recent guidance has been given to the Associate Director for each mission to complete DERC review for each case where review is required within 60 days of the Institutional Executive Review Committee date.

TYPES OF FORCE

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

The department also distinguishes between immediate and controlled use of force. Immediate use of force is defined in departmental policy as the force used to respond without delay to inmate behavior that constitutes an imminent threat to institution/facility security or the safety of persons. Employees may use immediate force without prior authorization from a higher official. Controlled use of force is the force used in an institution/facility setting when an inmate's presence or conduct poses a threat to safety or security and the inmate is located in an area that can be controlled or isolated. These situations do not normally involve the immediate threat of loss of life or immediate threat to institution security. In addition, the department revised its policy in January 2016 to require the use of controlled force if the sole purpose for using force is to gain compliance with a lawful order. All controlled use-of-force situations require the authorization and the presence of a first- or second-level manager or an Administrative Officer of the Day (AOD) during non-business hours. Staff must make every effort to identify disabilities, to include mental health concerns, and to note any accommodations that may need to be considered when preparing for a controlled use of force.

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

During this reporting period, staff contributed to the need for force in 67 of the 2,873 incidents reviewed. This occurred in only about 2 percent of the cases. While there were varying reasons staff contributed to the need for the use of force, six major reasons were the following[9]:

1. Restraint equipment (such as handcuffs) being inappropriately applied or not applied when required (18 incidents);
2. Opening the wrong cell door or otherwise allowing inmates access to unauthorized areas (13 incidents);
3. Improperly opening a door or food port (11 incidents)
4. Using force when no imminent threat was present (11 incidents);
5. Failing to sound an alarm or seek back up during an incident, which may have negated the need for force (8 incidents);
6. Touching an inmate unnecessarily or improperly taking an inmate's property (6 incidents).

[9] Staff may have contributed to the need for the use of force for more than one reason in the same incident.

The department took appropriate action (counseling, training, or adverse action) to address the deficiencies in all cases. However, the OIG disagreed with the hiring authority's decisions not to appropriately address deficiencies in report writing in four cases and handcuffing procedures in one case.

Table 3: *Staff Contribution to the Need for Force, by Division*

Division	Total Use-of-Force Incidents	Incidents Where Staff Contributed to the Need for Force	Percentage
Division of Adult Institutions	2,715	58	2.1%
Division of Juvenile Justice	133	6	4.4%
Division of Adult Parole	22	3	13.6%
Office of Correctional Safety	3	0	0%
Total	**2,873**	**67**	**2.3%**

INMATE ALLEGATIONS AGAINST STAFF IN USE-OF-FORCE CASES REVIEWED BY THE OIG

Inmates alleged staff violated policies and procedures, or made statements that could be interpreted as allegations of staff misconduct, in 265 of the 2,873 cases (9 percent) the OIG reviewed during this reporting period. Of those, the overwhelming majority (94 percent) were allegations that staff unnecessarily used force or used excessive force. Other allegations included that staff improperly handled, broke, or confiscated inmates' property, or that staff falsified reports. In 17 cases (6 percent), inmates either recanted the allegations they made or clarified their statements were not intended as allegations of staff misconduct.

Table 4: *Allegations Against Staff, by Institution*

Institution or Division	Allegation*				Percentage of total, by institution
	Excessive or Unreasonable Use of Force	Property-Related	Staff Reports False	Other	
CCC	2	0	0	0	0.8%
CIM	1	0	1	0	0.8%
CMC	6	0	0	0	2.3%
CRC	5	0	0	0	1.9%
DVI	7	0	0	0	2.6%
NKSP	14	1	0	0	5.7%
RJD	9	1	0	0	3.8%
SCC	1	0	0	0	0.4%
SQ	0	0	0	0	0%
WSP	5	0	0	0	1.9%
CAC	0	0	0	0	0%
CCI	2	0	0	0	0.8%
COR	7	0	0	2	3.4%
HDSP	12	0	0	0	4.5%
KVSP	12	0	0	0	4.5%
LAC	26	1	2	0	10.9%
PBSP	6	0	0	0	2.3%
SAC	39	0	0	0	14.7%
SATF	10	0	0	1	4.2%
SVSP	16	0	0	3	7.2%
ASP	0	0	0	0	0%
CAL	2	0	0	0	0.8%
CEN	1	0	0	0	0.4%
CTF	2	0	0	0	0.8%
CVSP	2	0	0	1	1.1%
ISP	2	0	0	0	0.8%
MCSP	15	0	0	0	5.7%
PVSP	0	0	0	0	0%
SOL	0	0	0	0	0%
VSP	0	0	0	0	0%
CCWF	2	0	0	0	0.8%
CHCF	9	0	0	0	3.4%
CIW	22	1	1	0	9.1%
CMF	5	0	0	0	1.9%
FSP	1	0	0	0	0.4%
DJJ-CHAD	6	0	0	3	3.4%
DJJ-OHC	0	0	0	0	0%
DJJ-VYCF	1	0	0	0	0.4%
DAPO	2	0	0	0	0.8%
OCS	0	0	0	0	0%
Total	**250**	**4**	**4**	**10**	**100%**
Percentage	**94%**	**1.5%**	**1.5%**	**4%**	

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

*More than one type of allegation may have been made in the same incident.

Despite inmates claiming in 9 percent of the use-of-force cases reviewed by the OIG that staff used unnecessary force, the OIG found, during this reporting period, that staff used immediate force when no force was justified in only 25 of the 2,873 incidents (less than 1 percent) reviewed. In the majority of those 25 cases (80 percent), staff improperly used immediate force even though there was no immediate threat from the inmate or juvenile ward. In such cases, staff should have transitioned to a controlled use of force. In two cases (8 percent), staff inappropriately used force after accidental contact by an inmate.

Table 5: *Immediate Force Not Justified, by Division*

Division	Total Use-of-Force Incidents	Incidents Where Immediate Force Not Justified	Percentage
Division of Adult Institutions	2,715	22	0.8%
Division of Juvenile Justice	133	3	2.3%
Division of Adult Parole	22	0	0%
Office of Correctional Safety	3	0	0%
Total	**2,873**	**25**	**0.9%**

FREQUENCY OF USE OF FORCE AS AN EARLY-WARNING SYSTEM

During this reporting period, the OIG identified 25 staff members at ten different institutions who were involved in seven or more use-of-force incidents during this reporting period. Twenty-two officers were involved in between 7 and 10 incidents each, while the remaining three officers were involved in 16 or more incidents: One officer was involved in 16 incidents, one officer was involved in 17 incidents, and one officer was involved in 19 use-of-force incidents in this six-month reporting period. There could be many reasons for high numbers for staff involvement. A particularly difficult inmate population, an assignment that requires more frequent responses, and assignment to an armed post, among other reasons, could increase the likelihood a particular staff member uses force. The department determined the actual force used by the officers who were involved in seven or more use-of-force incidents reviewed by the OIG complied with policy in all cases, and the OIG concurred. The OIG uses this information, and shares it with the department, as an early-warning system to assist in determining whether a particular post or person is potentially at risk.

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 programs and services/special housing (FOPS/SH).[10] As of June 30, 2016, the department housed 123,786[11] in-state inmates.[12]

Of the 2,873 total use-of-force incidents the OIG reviewed this period, 2,715 (95 percent) occurred within the DAI.

The following table reflects the number of incidents reviewed by the OIG within the adult institutions during this reporting period. This constitutes a representative sample based on data collected at approximately 81 percent of the use-of-force meetings statewide. In addition, the table breaks down the applications of force. Note that "applications of force," as used in this report, considers each force used against each inmate. For example, if two inmates are fighting and OC pepper spray is used on each inmate, OC pepper spray is counted twice for the one incident. In addition, the new use of force tool allows the OIG to report multiple applications of force on one inmate. In past reports, if two applications of OC pepper spray were used on one inmate, it was only counted as one application of force. Now, each separate application of force (OC pepper spray, baton strike, etc.) on a single inmate is counted as a separate use of force.

[10] All of the female institutions are part of this mission, as well as the California Medical Facility, the California Health Care Facility, and Folsom State Prison.

[11] This number includes the 1,803 inmates housed at the California City Correctional Facility, which is a leased facility within the high security mission. The department additionally contracts to house nearly 5,000 inmates in out-of-state facilities and nearly 4,000 in in-state contract beds. The OIG does not monitor those facilities unless there is a deadly force incident.

[12] CDCR data is derived from: http://cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1606.pdf

Table 6: *Incidents Reviewed and Frequency of Force within the Division of Adult Institutions*[13]

Adult Institutions									
Institution Initialism	**Institution Name**	**Incidents Reviewed**	**Applications of Force**	**Chemical Agents**	**Physical Force**	**Less-Lethal Force**	**Expandable Baton**	**Other/Non-Conventional[14]**	**Lethal Force, Including Warning Shots**
CCC	California Correctional Center	40	94	41%	38%	9%	10%	0%	2%
CIM	California Institution for Men	34	76	39%	47%	11%	3%	0%	0%
CMC	California Men's Colony	43	121	35%	60%	2%	4%	0%	0%
CRC	California Rehabilitation Center	36	63	60%	40%	0%	0%	0%	0%
DVI	Deuel Vocational Institution	53	144	16%	72%	0%	12%	0%	0%
NKSP	North Kern State Prison	103	181	46%	30%	16%	6%	1%	1%
RJD	Richard J. Donovan Correctional Facility	118	286	30%	53%	7%	9%	0%	<1%
SCC	Sierra Conservation Center	35	103	47%	40%	3%	10%	1%	0%
SQ	California State Prison, San Quentin	38	80	40%	29%	8%	20%	4%	0%
WSP	Wasco State Prison	90	142	55%	23%	14%	8%	0%	0%
CAC	California City Correctional Facility	4	5	100%	0%	0%	0%	0%	0%
CCI	California Correctional Institution	71	124	72%	17%	6%	5%	0%	0%
COR	California State Prison, Corcoran	108	255	36%	45%	6%	11%	2%	0%
HDSP	High Desert State Prison	148	344	60%	19%	12%	8%	1%	1%
KVSP	Kern Valley State Prison	181	631	64%	19%	13%	3%	<1%	0%
LAC	California State Prison, Los Angeles County	219	515	49%	37%	8%	7%	<1%	0%
PBSP	Pelican Bay State Prison	40	140	42%	44%	9%	4%	1%	0%
SAC	California State Prison, Sacramento	227	550	43%	44%	7%	3%	1%	<1%
SATF	Substance Abuse Treatment Facility & State Prison at Corcoran	76	155	37%	47%	13%	3%	1%	0%
SVSP	Salinas Valley State Prison	237	848	64%	18%	17%	1%	<1%	<1%
ASP	Avenal State Prison	15	19	84%	16%	0%	0%	0%	0%
CAL	Calipatria State Prison	110	241	70%	5%	21%	3%	0%	1%
CEN	Centinela State Prison	37	84	58%	27%	12%	1%	1%	0%
CTF	Correctional Training Facility	19	44	45%	45%	0%	7%	2%	0%
CVSP	Chuckawalla Valley State Prison	8	21	33%	67%	0%	0%	0%	0%
ISP	Ironwood State Prison	38	106	50%	25%	8%	17%	0%	0%
MCSP	Mule Creek State Prison	131	293	41%	42%	9%	8%	<1%	0%
PVSP	Pleasant Valley State Prison	42	90	54%	26%	16%	4%	0%	0%
SOL	California State Prison, Solano	53	95	64%	19%	11%	3%	2%	1%
VSP	Valley State Prison	15	27	37%	59%	0%	4%	0%	0%
CCWF	Central California Women's Facility	55	152	16%	82%	0%	1%	1%	0%
CHCF	California Health Care Facility	117	391	12%	84%	0%	2%	3%	0%
CIW	California Institution for Women	104	261	18%	75%	1%	3%	3%	0%
CMF	California Medical Facility	50	83	39%	52%	0%	8%	1%	0%
FSP	Folsom State Prison	20	45	27%	69%	4%	0%	0%	0%
TOTAL		**2,715 Incidents**	**6,809 Applications**	**46% Average**	**39% Average**	**9% Average**	**5% Average**	**1% Average**	**<1% Average**

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

[13] This data is based upon a sample of 81 percent of the use-of-force incidents that the OIG reviewed during this reporting period.

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

The OIG monitored 81 percent of the use-of-force meetings held during this reporting period and collected data about each incident reviewed at the meetings attended. Not surprisingly, the greatest amount of force was used within the High Security mission, with 1,311 incidents reviewed involving 3,567 uses of force at 10 institutions. Therefore, the average for high security institutions was 131 incidents in the six-month reporting period. On average, each incident involved 2.72 applications of force. The majority of the force within the mission (71 percent) was used at Salinas Valley State Prison (SVSP), Kern Valley State Prison (KVSP), California State Prison, Sacramento (SAC), and California State Prison, Los Angeles County (LAC). SVSP staff used 3.58 applications of force per incident, followed by KVSP with 3.49, SAC with 2.42 LAC with 2.35. SAC and LAC both had more incidents than KVSP, but used fewer applications of force. SVSP had only ten more incidents than SAC, but used 298 more applications of force. In the High Security mission, the majority of force used was chemical agents (54 percent), followed by physical force (29 percent). Again, any particular conclusions should be made carefully, since many variables are involved in use-of-force incidents. Some variables include the number of participants, number of responders, accuracy and efficacy of certain force choices, and even weather conditions, since wind may make chemical agents ineffective. This information can, however, be used to better inform training at particular prisons.

Unexpectedly, the institution with the fifth highest number of applications of force was the California Institution for Women (CIW), with 391 uses of force during 117 incidents for an average of 3.34 applications of force per incident. The majority of the force used at CIW was physical force (75 percent), followed by chemical agents (18 percent). By contrast, the Central California Women's Facility (CCWF) had less than half the number of incidents (55) in the same time period, and used less than 40 percent of the amount of force, averaging 2.76 applications of force per incident. Of the force used at CCWF, 82 percent was physical, followed by 16 percent chemical agents.

The fewest use-of-force incidents occurred at California City Correctional Facility (CAC), with only four incidents and five applications of force (1.25 applications of force per incident). Within the General Population mission, Avenal State Prison (ASP) had only 15 incidents with 19 applications of force (1.27 applications of force per incident), and Valley State Prison (VSP) also had 15 incidents, but with 27 applications of force (1.8 per incident). Chuckawalla Valley State Prison had only 8 incidents but had 21 applications of force, with a higher average of 2.63 per incident.

The following prisons had fewer than two applications of force per incident: CAC with 1.25 per incident, ASP with 1.27, Wasco State Prison (WSP) with 1.58, California Medical Facility (CMF) with 1.66, California Rehabilitation Center (CRC) with 1.75, California Correctional Institution (CCI) with 1.75, North Kern State Prison (NKSP) with 1.76, and California State Prison, Solano (SOL) with 1.79.

In addition, the OIG identified common locations where use-of-force incidents occurred at each institution. Ten locations statewide had between 20 and 33 use-of-force incidents; no location had more than 33 use-of-force incidents occur. Eight of the ten "hotspot" locations were yards and two were housing units. The housing units both housed inmates at the Enhanced Outpatient Program (EOP) level of care. One of the yards was exclusively EOP, one was a Sensitive Needs

Yard (SNY)[15] for EOP inmates, and one was a combination EOP and general population Correctional Clinical Case Management System (CCCMS) yard. Three of the yards with the most use-of-force incidents were general population yards, and the remaining two were Sensitive Needs Yards. As previously stated, there may be many reasons for the frequency at these locations. The OIG has provided CDCR with the information so the department can examine it.

The OIG also tracks when inmates suffer serious bodily injury or great bodily injury[16] as a result of staff use of force. Inmates sustained great bodily injury during two incidents being reported herein. In one case, an officer fired one round from a Mini-14 rifle and struck an inmate in the abdomen. The inmate had been attacking another inmate with an inmate-manufactured weapon. The department determined the use of deadly force complied with policy, and the OIG concurred. In the second case, an officer shot an inmate in the shoulder as he attacked another inmate with an inmate-manufactured weapon. Again, the department determined the use of deadly force complied with policy, and the OIG concurred.

Serious bodily injury resulted from 24 uses of force during this reporting period. The department found the actual force used within policy in all 24 cases, and the OIG concurred. In ten cases (42 percent), physical force caused the serious injury. Six uses of physical force resulted in cuts requiring stitches, three uses of physical force resulted in broken bones (nose, shin, and rib), and one use of physical force resulted in an inmate's jaw being dislocated. In nine cases (38 percent), less lethal rounds caused the serious injury. Injuries included five broken facial bones, one broken shin, three lacerations to the head requiring stitches, and one concussion. In all but one case, the less lethal rounds inadvertently struck inmates in the head. Of the remaining five cases of serious injury, four were caused by unconventional use of force. In two cases, officers struck inmates with pepper spray canisters, resulting in lacerations to the head requiring stitches. In another two cases, officers punched inmates. Of those, one resulted in a cut requiring stitches and the other resulted in a broken nose. In the final case of serious bodily injury, an inmate's hand was broken by a baton. There was no serious bodily injury caused by conventional use of pepper spray or other chemical agents.

Overall, inmates suffered great bodily injury or serious bodily injury in 26 (0.009 percent) of the 2,873 use-of-force incidents reviewed this period.

COMPLIANCE WITH THE USE OF FORCE POLICY

The use-of-force monitoring tool allows the OIG to collect information about whether uses of force complied with policies and procedures as well as the specific areas where the department did not comply with policies and procedures. The OIG collects data about whether the department complied with policies and procedures "Apart from Actual Force," "Actual Force

[15] Sensitive Needs Yards house inmates with protective custody needs, such as inmates who have been victims of attack, sex offenders, inmates with drug debts, or inmates seeking safety during their incarceration. More information can be found at http://www.cdcr.ca.gov/Blueprint-Update-2016/An-Update-to-the-Future-of-California-Corrections-January-2016.pdf

[16] As used herein, serious bodily injury refers to injury that results in loss of consciousness, concussion, protracted loss or impairment of function of any bodily member or organ, or disfigurement to an individual in the custody or control of the department. Great bodily injury refers to injury that creates a substantial risk of death.

Used," and "Non Use of Force." These categories are defined only by the OIG, the department has not adopted them.

- **Apart from Actual Force** refers to the department's policies and procedures encompassed within the use-of-force policy,[17] excluding the use of force itself. Examples include whether a medical assessment of the inmate was completed after a use of force, whether reports were thorough and submitted timely, and whether protocols were violated that may have led up to the use of force.
- **Actual Force Used** refers to the force itself.
- **Non Use of Force** refers to activities related to the use of force but not directly within the policy, such as holding cell procedures, escorts, and improperly completed medical assessments.

When a deputy inspector general or special assistant inspector general returns from an institutional executive review committee meeting, the OIG staff inputs data and makes an assessment regarding whether the department complied with policies in the various categories set forth above. Between January and June, 2016, the OIG reviewed 2,625 use-of-force incidents that occurred at institutions within the Division of Adult Institutions.

Apart from Actual Force

At the IERC meetings, the department assessed 2,114 (81 percent) of the incidents within policy for conduct the OIG deems "Apart from Actual Force." The department found 23 incidents involved a reasonable deviation from "Apart from Actual Force" policies. Eighty-nine incidents were deferred. The department took action on three inmate allegations against staff and determined to take no action on another four inmate allegations. The department conducted internal inquiries in two cases and the remaining 390 incidents (15 percent) were found out of policy. Of those, the hiring authority trained staff in 343 cases, counseled staff in 26 cases, and referred 13 cases to the Office of Internal Affairs. In addition, the department took disciplinary action in an additional eight cases previously referred to the Office of Internal Affairs and subsequently returned to the institution for action. The OIG concurred with the department's determinations in most cases. However, the OIG disagreed in 63 cases (2 percent). The OIG disagreed with the department's determination that 19 cases involving late use-of-force reports by staff were within policy or reasonable deviations from policy. In addition, the OIG disagreed with the department's determination that the IERC complied with policy when it reviewed incidents outside of mandated time frames in 22 cases. The OIG also identified that spit masks were used in four cases without justification as to why they were needed, outdated forms were used in nine cases, and video recordings were outside of policy in four cases. The department did not appropriately address the deficiencies in these 63 cases (2 percent).

Actual Force Used

The department assessed 2,589 (99 percent) of the incidents within policy for conduct the OIG deems "Actual Force Used." The OIG concurred with this assessment in all but six cases. In two

[17] Department Operations Manual, Chapter 5, Article 2.

cases, officers used improper techniques when deploying pepper spray but the IERCs found the applications within policy. In a third case, an officer twice deployed pepper spray at an inmate during a controlled use of force even though a psychologist had determined the inmate was not capable of understanding the orders he was given. The officer had not received the appropriate authorization from the administrative officer of the day to do so pursuant to policy, but the IERC found the use of force within policy. The OIG did not concur with the hiring authority's statement that since a captain gave approval it was the equivalent of approval from the administrative officer of the day. In a fourth case, the use of force was unnecessary because the inmate was contained in his cell. In a fifth case, the inmate's injuries depicted on a video recording were not consistent with the reported use of punches to the head and were more consistent with strikes by a baton. However, the IERC declined to refer the matter to the Office of Internal Affairs for further investigation of possible unreported baton strikes to the head. In a sixth case, an officer fired a warning shot without legal justification but the IERC found the use of force within policy. After OIG intervention, the hiring authority referred the warning shot matter to the Office of Internal Affairs and disciplinary action was imposed.

The department found 40 incidents involved a reasonable deviation from "Actual Force Used" policies. The department determined to take no action on eight inmate allegations of staff misconduct and the OIG concurred in all but one case. In that case, the inmate at a reception center alleged staff had used unreasonable force during a housing transfer, but he could not identify the involved staff. The department did not attempt to identify the staff involved or interview any potential witnesses and thus failed to adequately investigate the inmate's allegation. The department conducted internal inquiries in two cases and the remaining 58 incidents (2 percent) were found out of policy. Of those 58, the hiring authority trained staff in 27 cases, counseled staff in nine cases, referred 13 cases to the Office of Internal Affairs, and took disciplinary action in nine cases previously processed by the Office of Internal Affairs. Ninety incidents were deferred.

Non Use of Force

The department assessed 2,170 (94 percent) of the incidents within policy for conduct the OIG deems "Non Use of Force." The OIG concurred with this assessment in all but three cases. In one case, a medical assessment did not reflect the inmate had been exposed to pepper spray. In the second case, the IERC closed the matter without awaiting the results of the inmate's appeal on the same issue. In the third case, it appeared holding cell logs had been falsified. The hiring authority did not appropriately address the issues in these cases. The department found one incident involved a reasonable deviation from "Non Use of Force" policies. Eighty-nine incidents were deferred. The department determined to take no action on eight inmate allegations of staff misconduct and the OIG concurred in all but one case, which was described in the previous paragraph. The department conducted internal inquiries in the two cases and the remaining 516 incidents (20 percent) were found out of policy. Of those, the hiring authority trained staff in 470 cases, counseled staff in 21 cases, referred 13 cases to the Office of Internal Affairs, and took disciplinary action in 12 cases previously processed by the Office of Internal Affairs. The OIG concurred with all of these actions.

USE OF FORCE ON MENTAL HEALTH INMATES

The department reports during this reporting period about 30.5 percent of its in-custody inmate population were mentally ill inmates participating in the department's Mental Health Services Delivery System at the Correctional Clinical Case Management System (CCCMS) level of care or above. Over half (55 percent) of the total uses of force within the Division of Adult Institutions reviewed this reporting period were on inmates at the CCCMS level or above.[18, 19]

The OIG's new use-of-force monitoring tool allows OIG staff to track more detailed statistics and identify trends regarding use of force on all inmates, including mentally ill inmates. Some of the data collected includes frequency of specific inmates being involved in uses of force, the classification level of inmates involved in use-of-force incidents, and the locations of use-of-force incidents. The table below outlines the use of force at each institution, broken down by mental health code of the inmate on whom the force was used.

[18] 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.
[19] See footnote 4, page 6, regarding the department's MHSDS and levels of care provided by CDCR.

Table 7: *Use of Force, by Mental Health Status, by Institution*

			Mental Health Code				
		Institution	Non-Mental Health	CCCMS	EOP	MHCB	DSH
CDCR Missions	Reception Center	CCC	100%	0%	0%	0%	0%
		CIM	49%	29%	9%	13%	0%
		CMC	32%	10%	57%	0%	0%
		CRC	69%	26%	0%	0%	5%
		DVI	48%	36%	15%	1%	0%
		NKSP	64%	24%	8%	4%	0%
		RJD	9%	31%	56%	4%	0%
		SCC	60%	35%	0%	6%	0%
		SQ	60%	27%	12%	0%	1%
		WSP	53%	36%	11%	0%	0%
	High Security	CAC	100%	0%	0%	0%	0%
		CCI	54%	45%	1%	1%	0%
		COR	33%	31%	29%	7%	0%
		HDSP	57%	41%	1%	1%	0%
		KVSP	53%	43%	3%	0%	0%
		LAC	35%	34%	30%	0%	0%
		PBSP	48%	27%	10%	14%	0%
		SAC	16%	26%	55%	4%	0%
		SATF	48%	42%	11%	0%	0%
		SVSP	38%	27%	32%	2%	2%
	General Population	ASP	42%	58%	0%	0%	0%
		CAL	100%	0%	0%	0%	0%
		CEN	99%	1%	0%	0%	0%
		CTF	39%	54%	7%	0%	0%
		CVSP	96%	4%	0%	0%	0%
		ISP	92%	0%	0%	8%	0%
		MCSP	11%	29%	60%	1%	0%
		PVSP	79%	19%	0%	2%	0%
		SOL	52%	42%	0%	7%	0%
		VSP	31%	28%	42%	0%	0%
	Female Offender/ Special Housng	CCWF	24%	51%	17%	8%	0%
		CHCF	6%	3%	44%	15%	32%
		CIW	10%	47%	20%	11%	11%
		CMF	21%	21%	35%	20%	4%
		FSP	49%	43%	0%	8%	0%
		Percentage	**45%**	**30%**	**20%**	**3%**	**2%**
				55%			

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

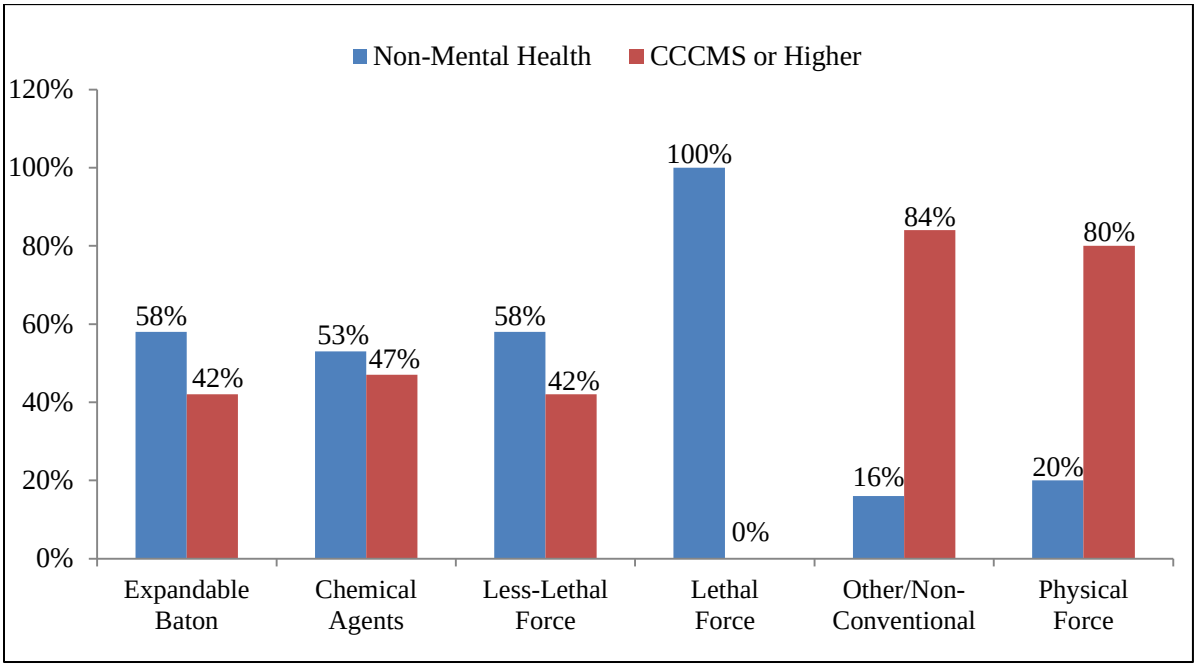
In addition to these general statistics, the OIG identified 22 inmates and wards who were involved in four or five use-of-force incidents during this reporting period.[20] No inmates or wards were involved in more than five uses of force during this reporting period. Eight of the twenty-two were wards, and of those, five were participants in the Wards with Disabilities

[20] The ward or inmate may have been involved in additional uses of force in addition to those reported here, since this report only provides data regarding incidents reviewed by the OIG at IERC meetings or during the consent process. The OIG attended 81 percent of the IERC meetings statewide.

Program (WDP),[21] which includes wards with mental illness as well as other disabilities, and three had no such designation at the time of the incidents.

Of the 14 inmates involved in 4 or 5 use-of-force incidents, 12 were participants in the Mental Health Services Delivery System (MHSDS) at the Correctional Clinical Case Management System (CCCMS) level of care or above at the time of the incident. Seven inmates were at the CCCMS level of care, three were at the Enhanced Outpatient Program (EOP) level of care, one was a Department of State Hospitals (DSH) inmate, and one was at the Mental Health Crisis Bed (MHCB) level of care. The remaining two inmates had no mental health designation. Based on these statistics, mental health inmates and wards are more likely to be involved in repeated use-of-force incidents.

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



Even though more than half of the total uses of force within the Division of Adult Institutions were on inmates at the CCCMS level or above, it appears there is an effort to use physical restraint on mentally ill inmates, as opposed to more severe use-of-force methods. There is also a greater proportional use of shields and non-conventional force methods on mentally ill inmates. The data shows while the use of physical force and chemical agents is proportionately greater, there is a lower proportionate percentage of use of batons and 40mm direct-impact rounds on the mentally ill inmate population. The department did not use any lethal force on a mentally ill inmate during this reporting period. In an immediate force situation, such as an attack on staff, a mentally ill inmate or ward is just as dangerous and possibly more so than other inmates.

[21] A more detailed description of the criteria for designating wards WDP can be found in the Wards with Disabilities Remedial Plan at http://www.cdcr.ca.gov/juvenile_justice/docs/adaplan.pdf

Table 8: *Frequency of Force by Type, Grouped by Mental Health Status*

	Mental Health Status											
	Non-MH		**CCCMS**		**EOP**		**MHCB**		**DSH**		**Total**	
Force Type	Number	%	Number	%	Number	%	Number	%	Number	%	**Number**	**%**
Chemical Agents	3,507	53%	2,086	32%	928	14%	28	<1%	25	<1%	**6,574**	**100%**
			3,067 uses of chemical agents on mental health inmates (47%)									
Physical Force	514	20%	691	26%	958	37%	275	11%	170	7%	**2,608**	**100%**
			2,094 uses of physical force on mental health inmates (80%)									
Less-Lethal Force	474	58%	239	29%	104	13%	0	0%	1	<1%	**818**	**100%**
			344 uses of less-lethal force on mental health inmates (42%)									
Expandable Baton	158	42%	117	31%	93	25%	4	1%	3	1%	**375**	**100%**
			217 uses of expandable batons on mental health inmates (58%)									
Other/Non-Conventional	9	16%	9	16%	17	31%	17	31%	3	5%	**55**	**100%**
			46 uses of other/non-conventional force on mental health inmates (84%)									
Lethal Force	7[22]	100%	0	0%	0	0%	0	0%	0	0%	**7**	**100%**
			0 uses of lethal force on mental health inmates (0%)									
Total	**4,669**	**45% of all force**	**3,142**	**30% of all force**	**2,100**	**20% of all force**	**324**	**3% of all force**	**202**	**2% of all force**	**10,437**	**100% of all force**
	4,669 Uses of Force on Non-Mental Health Inmates (45%)		**5,768 Uses of Force on Mental Health Inmates (55%)**									

Of the 4,669 uses of force on inmates with no mental health classification during 994 incidents, the OIG found only 19 individual uses of immediate force (0.4 percent) were not justified. The actual force[23] used on general population inmates was out of policy in 23 incidents. Of those, the hiring authority trained staff in 15 cases, issued counseling or corrective action in two cases, and imposed disciplinary action in four cases. The hiring authority also referred one case to the Office of Internal Affairs for investigation or approval to take direct disciplinary action and conducted an internal inquiry in another case.

Of the 3,142 uses of force on CCCMS inmates during 784 incidents, the OIG found 19 individual uses of immediate force (0.6 percent) were not justified. The actual force used on CCCMS inmates was out of policy in 12 incidents. Of those, the department trained staff in five cases, issued counseling or corrective action in three cases, and imposed disciplinary action in the remaining four cases.

Of the 2,100 uses of force on EOP inmates during 684 incidents, the OIG found 13 individual uses of immediate force (less than 1 percent) were not justified. The actual force used on EOP inmates was out of policy in 12 incidents. Of those, the hiring authority trained staff in four cases, issued counseling or corrective action in two cases, imposed disciplinary action in one case, and referred the remaining five cases to the Office of Internal Affairs.

[22] The number of rounds fired from Mini-14 rifles includes four shots for effect and three warning shots that were determined to be aimed at stopping the conduct of general population inmates. The numbers do not include eight warning shots where it could not be determined the classification of inmates at risk.
[23] The figures herein refer only to the "Actual Force Used" assessment, not "Apart from Actual Force" or "Non Use of Force."

Of the 324 uses of force on MHCB inmates during 93 incidents, the OIG found that only two individual uses of actual force (0.6 percent) during 2 incidents were not justified. The department trained staff in both cases.

Of the 202 uses of force on DSH patients during 60 incidents, the OIG found that two individual uses of force (1 percent) during the same incident were not justified. The hiring authority referred the matter to the Office of Internal Affairs. Referral to the Office of Internal Affairs may not have been appropriate.

The OIG has identified a gap in policy for use of force on Department of State Hospitals patients. The department provides services for DSH in several of the institutions. For example, at Patton State Hospital, CDCR officers provide security and transportation services for the hospital. In addition, at several other institutions, DSH patients are housed within the institution. Those patients are not inmates. The Department of State Hospitals has its own use-of-force policy, which differs significantly from CDCR's use-of-force policy. The Department of State Hospitals requires therapeutic strategies and interventions prior to the use of force. Failure to use these techniques is a violation of DSH policy. When CDCR officers use force in the DSH setting, the use of force is evaluated by the Institutional Executive Review Committee using CDCR standards rather than DSH standards. Because the targets of use of force are patients, not inmates, the CDCR policy is an inappropriate standard to determine whether the use of force is within policy.

In discussions with Office of Law Enforcement Support within DSH, the OIG has learned discussions are ongoing regarding who has jurisdiction to investigate inappropriate use of force on DSH patients. The OIG believes that these discussions should be expanded to also include an agreement that DSH policy should be followed when force is used.

The OIG concurred with the hiring authority's determination in all cases where actual force was found out of compliance with policy. It appears the department in the overwhelming majority of cases is addressing out-of-policy use of force appropriately.

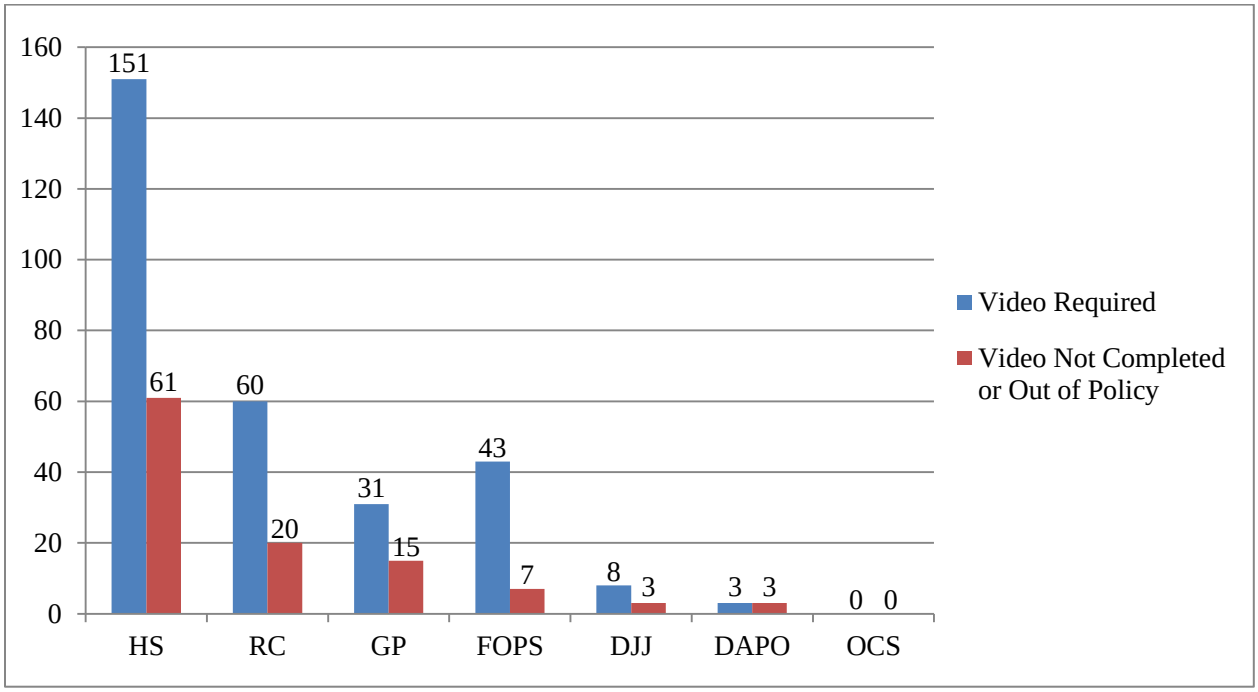
VIDEO-RECORDED INTERVIEWS

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.

The OIG reviewed 296 incidents that required video-recorded interviews. Of those, 187 incidents had the video-recorded interview or interviews conducted within policy, while in 109 incidents the video-recorded interview was either not completed or was not completed according to policy. This results in a policy compliance rate of only 63 percent. The errors identified included not

conducting interviews timely, interviewers not adequately identifying themselves or interviewers not adequately identifying the inmates' injuries, not conducting an interview when one was required, and not video recording inmates' refusals to be interviewed. Although the OIG has reported these concerns in prior reports, the policy compliance rate remains below 70 percent.

Chart 2: *Video Recordings, by Mission/Division*



PILOT PROGRAM FOR INSTITUTIONAL USE-OF-FORCE REVIEWS

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

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

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

This change to policy required approval by the Office of Administrative Law and therefore did not go into effect until February 11, 2014. The department implemented the new use-of-force review process at three institutions (High Desert State Prison in Susanville; Kern Valley State Prison in Delano; and California State Prison, Los Angeles County, in Lancaster) on a 24-month pilot basis.[24] The institutions were chosen based on the initial criteria, which did not exclude inmates participating in the Mental Health Services Delivery System. The criteria excluding MHSDS inmates was added immediately prior to implementation, but the department did not change the institutions selected. Because of the high number of mental health inmates at these pilot institutions, very few incidents met the requirements for consent review. To better determine if the process would provide efficiencies worth implementing, the department added Calipatria State Prison to the pilot program, as it has a low population of inmates receiving mental health care.

During this reporting period, the department reviewed 129 incidents as a part of the pilot program.

Table 9: *Number of Pilot Incidents Reviewed*

Institution	Cases CDCR Referred for Consent
Calipatria State Prison	82
High Desert State Prison	9
Kern Valley State Prison	23
California State Prison, Los Angeles County	15
Total	**129**

As the table above illustrates, Calipatria State Prison, an institution with few inmates receiving mental health care, referred four times as many cases to consent as any other prison in the pilot. Based on the data, the consent review process would prove beneficial at institutions with populations similar to Calipatria State Prison. The consent process allows institutions to review

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

use-of-force cases that meet the criteria in a more efficient manner because each of the stakeholders can analyze the cases independently rather than in lengthy meetings. This would also allow the institution's use-of-force committee to focus discussion on cases where the use of force caused serious injury, involved the mentally ill, was a controlled use of force, or may not have complied with policies and procedures.

However, the pilot project expired by operation of law in February 2016 and the department has not expressed an intention to revive the consent review process despite its success at Calipatria.

DIVISION OF JUVENILE JUSTICE

During this reporting period the Division of Juvenile Justice (DJJ) consisted of three facilities[25] and one conservation camp, and was responsible for supervising 705 juvenile wards.[26] The OIG reviewed 133 use-of-force incidents occurring throughout the three juvenile facilities. This constitutes a representative sample based on data collected at approximately 79 percent of the DJJ use-of-force meetings statewide. There were no incidents in the juvenile conservation camp this reporting period.

Among the 133 incidents reviewed, 59 were at N.A. Chaderjian Youth Correctional Facility (NAC), 33 were at O.H. Close Youth Correctional Facility (OHC), and 41 were at Ventura Youth Correctional Facility (VYCF). The OIG found the actual force used complied with policy in all but two incidents, both at NAC. In one case, an officer unnecessarily grabbed a ward's hand, escalating the situation. The department counseled the officer. In the other case, an officer intervened in a physical altercation between wards without appropriate back up and the department provided training. In addition, staff was counseled or trained in 74 cases, primarily because of inadequate or untimely use-of-force reporting. The OIG concurred with the department's actions in all cases. In addition, only NAC has a video recording capability. However, they refuse to review video of use-of-force incidents, claiming it is too difficult to review video. The OIG recommends the institution use all tools available to review each incident.

DIVISION OF ADULT PAROLE OPERATIONS

During this reporting period, the Division of Adult Parole Operations (DAPO) consisted of two parole regions and was responsible for supervising over 43,500 parolees.[27] The OIG reviewed 22 use-of-force incidents: 4 in the north parole region and 18 in the south parole region. This constitutes a representative sample based on data collected at approximately 83 percent of the DAPO use-of-force meetings statewide. Of the incidents reviewed, the OIG found the reports adequately articulated the justification for using force and adequately described the force used in

[25] OHC and NAC are co-located in Stockton.
[26] Data derived from: http://www.cdcr.ca.gov/Juvenile_Justice/Research_and_Statistics/FPR_Monthly_2016.html
[27] Data derived from: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1606.pdf

all cases. In five cases, the department trained parole agents regarding report writing. In two cases, the department trained parole agents regarding proper handcuffing procedures.

OFFICE OF CORRECTIONAL SAFETY

In addition to monitoring use-of-force incidents involving personnel at correctional institutions and in the parole system, the OIG also monitors such incidents involving employees of the department's Office of Correctional Safety (OCS). The Office of Correctional Safety is the primary departmental link with allied law enforcement agencies and the California Emergency Management Agency. Major responsibilities of OCS include criminal apprehension efforts of prison escapees and parolees wanted for serious and violent felonies, gang-related investigations of inmates and parolees suspected of criminal gang activity, and oversight of special departmental operations such as special transports, hostage rescue, riot suppression, critical incident response, and joint task force operations with local law enforcement.

During the reporting period, the OIG conducted reviews of three use-of-force incidents involving four uses of force by OCS employees; there were three uses of physical force and one use of a taser. The OIG found the reports adequately articulated the justification for using force and adequately described the force used in all cases. In addition, the OIG did not identify any policy violations during the uses of force.

Contraband Surveillance Watch

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

> When it becomes apparent through medical examination, direct observation, or there is reasonable suspicion that an inmate has concealed contraband in their body, either physically or ingested, and the inmate cannot or will not voluntarily remove and surrender the contraband, or when a physician has determined that the physical removal of contraband may be hazardous to the health and safety of the inmate, the inmate may be placed in a controlled isolated setting on [contraband surveillance watch] under constant visual observation until the contraband can be retrieved through natural means, or is voluntarily surrendered by the inmate.

The department is required to notify the OIG every time an inmate is placed on contraband surveillance watch. The OIG collects all relevant data, including the name of the inmate, the reason the inmate was placed on contraband surveillance watch, what contraband, if any, was found, and the dates and times the department put the inmate on and off watch. The OIG responds to the scene to formally monitor any contraband surveillance watch where a significant medical problem occurs, regardless of how long the inmate has been on watch, and in all cases where the watch extends beyond 72 hours. While at the scene, the OIG inspects the condition of the inmate and all logs and records, ensuring the department is following its policy. This on-scene response is repeated every 72 hours until the inmate is removed from contraband surveillance watch. Any serious breaches of policy are immediately discussed with institution managers while at the scene. The OIG formally assesses the sufficiency of how the department conducts each contraband surveillance watch that exceeds 72 hours and in select cases that do not exceed 72 hours, but which involve special circumstances warranting closer examination.

During this reporting period, the OIG was notified of 128 contraband surveillance watch cases. Of these 128 cases, inmates were kept on contraband surveillance watch longer than 72 hours but less than 144 hours in 37 cases, and 3 cases involved inmates placed on watch for 144 to 216 hours. Three cases extended beyond 216 hours (nine days) during this reporting period. This report assesses the 43 cases that extended beyond 72 hour as well as 4 cases involving inmates who required medical attention at an outside hospital but where the contraband surveillance watch did not extend beyond 72 hours. There were 85 cases that did not extend beyond 72 hours, including the 4 mentioned above, and in 58 percent of those cases (49 cases), contraband was recovered. Contraband was found in 65 percent of the contraband surveillance watch cases that extended beyond 72 hours. This is down slightly from 69 percent during the last reporting period. However, contraband recovery data for the last three years does not show a consistent

increase or decrease. Rather, the data shows that, more often than not, the department recovers contraband from inmates placed on contraband surveillance watch.

Table 10: *Contraband Found in Cases Extending Beyond 72 Hours, 2013 to 2016*

Reporting Period	Cases Over 72 Hours	Contraband Found	Percentage
July–December 2013	75	43	57%
January–June 2104	48	17	35%
July–December 2014	59	28	53%
January–June 2015	42	38	90%
July–December 2015	39	27	69%
January–June 2016	43	28	65%

Chart 3: *Duration of Contraband Surveillance Watch Cases*

Total Contraband Surveillance Watch Cases = 128

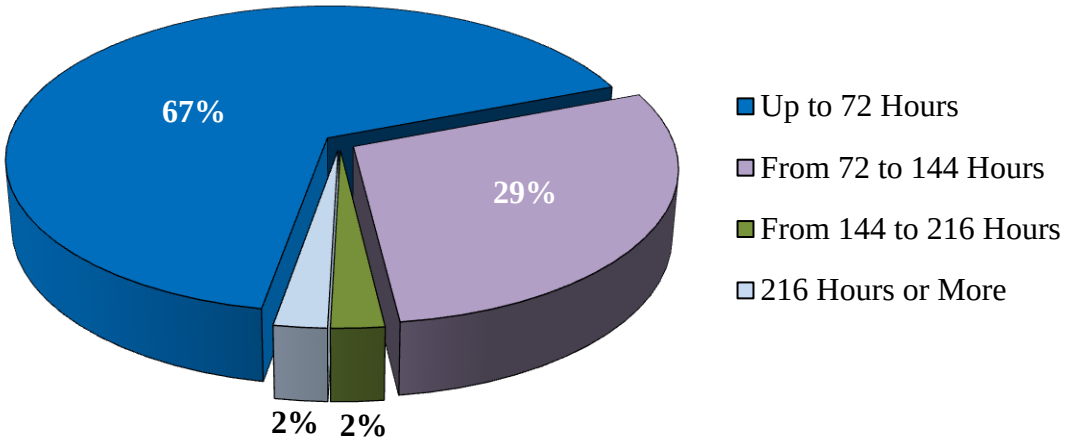


Chart 4: *Contraband Found in Cases Extending Beyond 72 Hours*

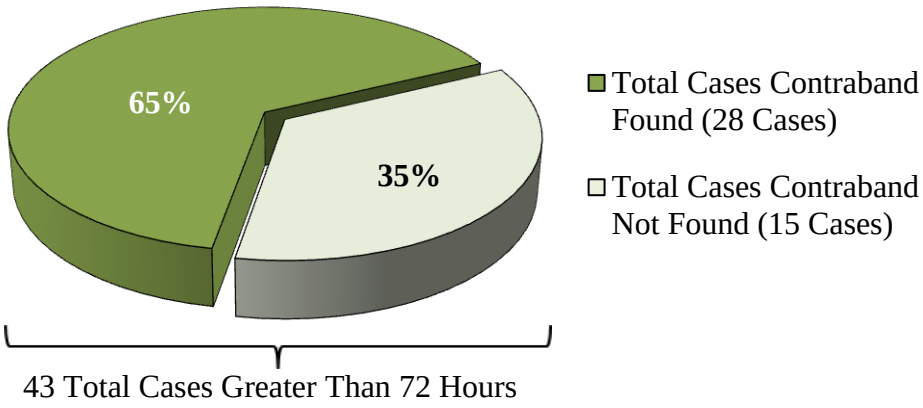


Chart 5: *Contraband Found in Cases Lasting Less Than 72 Hours*

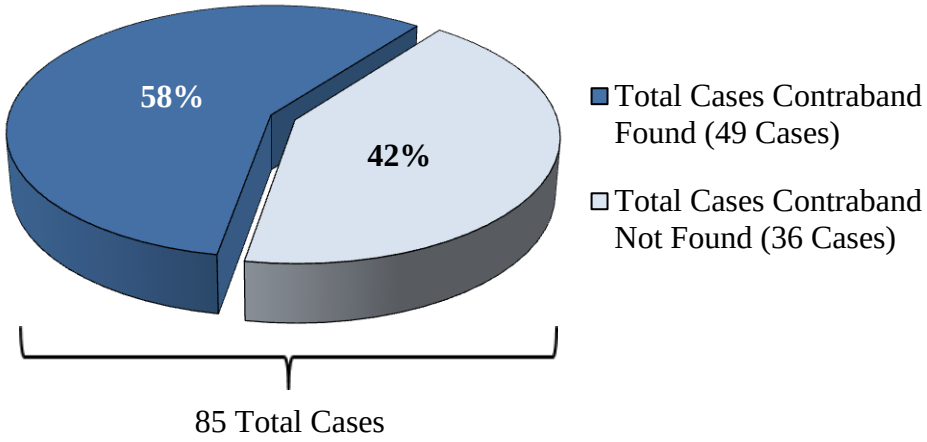
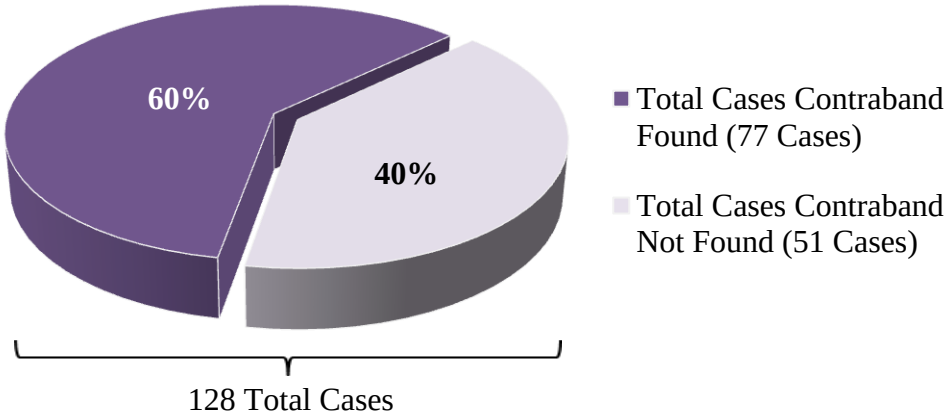
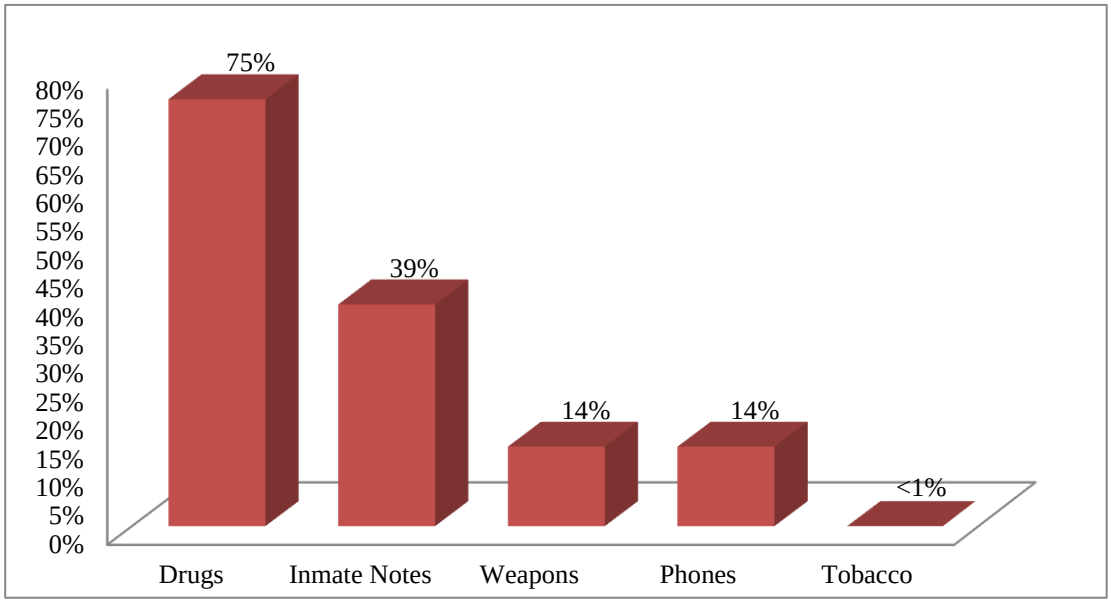


Chart 6: *Contraband Found in All Contraband Surveillance Watch Cases*



As previously noted, this report covers in detail those 43 contraband surveillance watch cases that extended beyond 72 hours. Contraband was found in 28 cases that extended beyond 72 hours. Drugs were recovered in 75 percent of those 28 cases, while the remaining 25 percent of recovered contraband consisted of inmate notes, weapons, phones, and tobacco.

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 43 cases that exceeded 72 hours, the OIG found that the department sufficiently managed the contraband surveillance watch process in 23 cases (53 percent) and was insufficient in its management of 20 contraband surveillance watch cases (47 percent). In addition, the department sufficiently managed the contraband surveillance watch process in all four cases (100 percent) being reported that did not exceed 72 hours. Of the 27 cases rated sufficient overall, 16 still involved minor policy violations related to documentation. In 11 cases, the OIG identified no policy violations. Centinela State Prison, Pelican Bay State Prison, and California State Prison, Solano had more than three cases being reported and all cases were rated overall sufficient.

In 16 of the 20 cases rated insufficient overall, the insufficient rating was based solely or partly on the department's failure to keep adequate documentation. The department's continuing failure to document contraband surveillance watch is inexplicable given that the officers assigned to perform contraband surveillance watch duty are given that duty exclusively, with no other tasks to perform. The officers primarily watch the inmates and document what occurs, so there is no acceptable excuse for poor documentation. If required procedures (offering inmates hand hygiene before and after meals, releasing the inmates' limbs from restraints twice per day to maintain range of motion in the inmates' extremities, and supervisors checking on the inmates at regular intervals) are not documented, the only assumption that can be made is that the department is not performing these functions. The department's repeated failure to perform these simple functions has been elevated, and upper management in Sacramento is in the process of trying to resolve this problem.

In many cases where deficiencies were noted, the department took corrective action, mainly via staff training. However, because staff had been previously trained on the same deficiencies that continue to occur, the OIG recommended that Richard J. Donovan Correctional Facility take action beyond training in six cases and California Rehabilitation Center take action beyond training in two cases. Both institutions declined to follow the OIG's recommendations in all eight cases. These institutions' refusal to appropriately correct and discipline staff who repeatedly fail to follow policies and procedures may explain why all eight of the cases being reported from Richard J. Donovan Correctional Facility are rated overall insufficient and four of the five cases being reported from California Rehabilitation Center are rated overall insufficient.

In this reporting period, the department placed fewer inmates on contraband surveillance watch compared to the five previous reporting periods (128 in this period compared to 135, 155, 206, 192, and 246 in the five prior reporting periods). The number of inmates kept on contraband surveillance watch beyond 72 hours was consistent (43 in this period, compared to 39 in the prior reporting period and 42 in the reporting period before that).

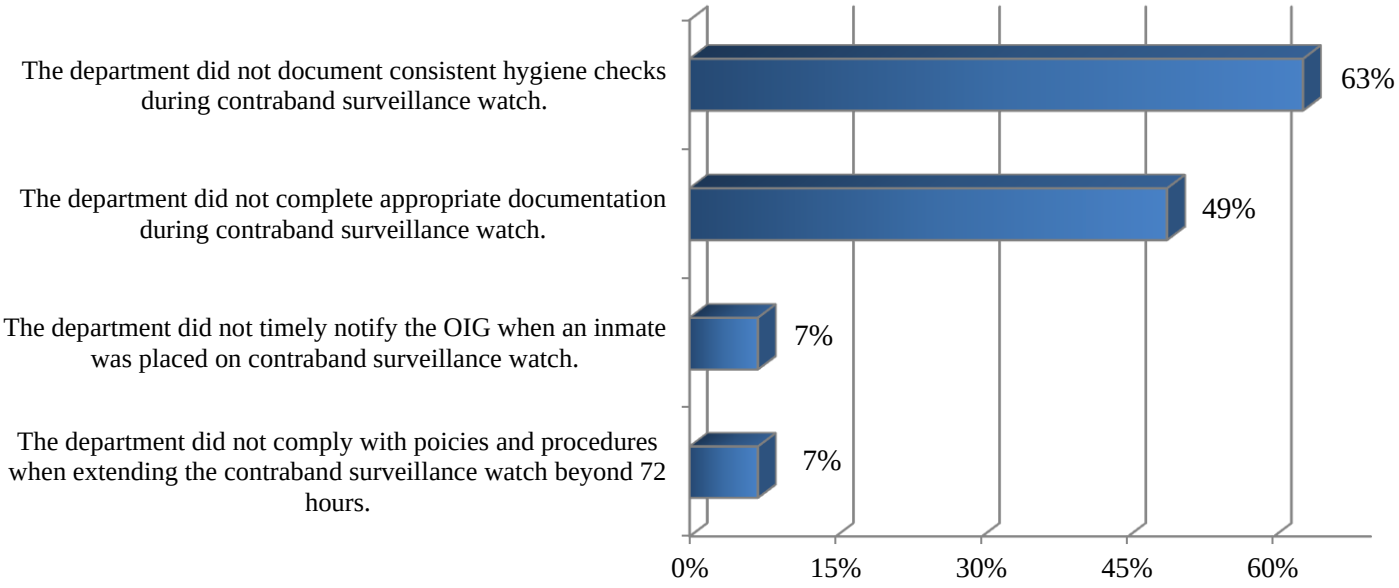
The department kept three inmates on contraband surveillance watch longer than 216 hours in this reporting period, compared with two in the previous reporting period. In one of the cases, Richard J. Donovan Correctional Facility placed the inmate on contraband surveillance watch after he told nurses he swallowed a razor blade. An x-ray confirmed the presence of the razor blade. However, the department recovered no contraband from the inmate during the ten days he was on contraband surveillance watch. The department did not notify the OIG when the inmate was placed on contraband surveillance watch or when an extension was granted and officers failed to appropriately document inmate hygiene, cell inspections, blanket issuance and removal, and supervisory checks. Because officers had previously been trained regarding these procedures, the OIG recommended the hiring authority take further action to address the deficiencies, but the hiring authority declined to do so.

In the second case exceeding 216 hours, officers observed the inmate placing items in his mouth during a visit. The inmate refused to eat or drink for several days and did not produce any bowel movements the next 15 days. On the fifteenth day of contraband surveillance watch, the department recovered six bindles of drugs. The department removed the inmate from contraband surveillance watch the following day, after he had produced three bowel movements free of contraband. The department did not adequately conduct or document supervisory checks or adequately document or provide the inmate with hygiene and range of motion opportunities. The department trained the officers and supervisors.

In the third case exceeding 216 hours, officers observed the inmate swallowing a bindle during a visit. The following day, the inmate produced two bindles of drugs. The department removed the inmate from contraband surveillance watch after ten days, when he had produced three bowel movements free of contraband. The department did not adequately document the incident, conduct supervisory checks, provide the inmate with hygiene opportunities, or complete an internal audit. The department trained officers and supervisors.

The department's decision to place inmates on contraband surveillance watch was within policy in all 43 cases exceeding 72 hours.

Chart 8: *Policy Violations in Contraband Surveillance Watch Cases*



In the 43 contraband surveillance watch cases that extended beyond 72 hours, the vast majority of policy violations involved failures to complete appropriate documentation and failures to perform consistent hygiene checks.

In 27 cases of contraband surveillance watch cases exceeding 72 hours (63 percent), the department failed to complete appropriate documentation concerning inmate hygiene (up from 59 percent in the last reporting period). Despite extensive training, policy violations pertaining to inmate hygiene remain high and compliance is decreasing. The OIG recommends the department consider more serious corrective action or disciplinary action to address the failure to adhere to the Department Operations Manual Section 52050.23.5.

The department did not timely notify the OIG when an inmate was placed on contraband surveillance watch in 3 (7 percent) of the 43 cases exceeding 72 hours, which represents an increase in non-compliance in this area. In the previous reporting period, the department only failed to timely notify the OIG in one case.

The following table details the total number of contraband surveillance watch cases that occurred during this reporting period at each institution. The statistics for contraband recovered and sufficiency ratings include the four cases being reported where the duration of contraband surveillance watch was shorter than 72 hours but were monitored because the inmates required medical attention at outside hospitals.

Table 11: *Contraband Surveillance Watch Cases, by Institution, January–June 2016*

Institution	Number of CSW Cases	Less Than 72 Hours	72 to Less Than 144 Hours	144 to Less Than 216 Hours	216 Hours or More	Number of Cases Rated Sufficient	Number of Cases Rated Insufficient
ASP	1	1	0	0	0	N/A	N/A
CAC	0	0	0	0	0	N/A	N/A
CAL	6	6	0	0	0	2	0
CCC	9	4	5	0	0	4	1
CCI	1	1	0	0	0	N/A	N/A
CCWF	0	0	0	0	0	N/A	N/A
CEN	12	9	3	0	0	5	0
CHCF	0	0	0	0	0	N/A	N/A
CIM	0	0	0	0	0	N/A	N/A
CIW	3	3	0	0	0	N/A	N/A
CMC	1	1	0	0	0	N/A	N/A
CMF	0	0	0	0	0	N/A	N/A
COCF	0	0	0	0	0	N/A	N/A
COCF-LPCC	0	0	0	0	0	N/A	N/A
COCF-NFCF	0	0	0	0	0	N/A	N/A
COCF-TCCF	1	1	0	0	0	N/A	N/A
COR	3	2	1	0	0	0	1
CRC	8	3	5	0	0	1	4
CTF	1	1	0	0	0	N/A	N/A
CVSP	0	0	0	0	0	N/A	N/A
DVI	9	6	3	0	0	2	1
FSP	2	0	0	0	2	0	2
HDSP	4	4	0	0	0	N/A	N/A
ISP	3	3	0	0	0	N/A	N/A
KVSP	5	4	1	0	0	1	0
LAC	3	2	1	0	0	1	0
MCSP	2	0	2	0	0	1	1
NKSP	3	3	0	0	0	N/A	N/A
NYCRC	0	0	0	0	0	N/A	N/A
OHC	0	0	0	0	0	N/A	N/A
PBSP	7	3	4	0	0	4	0
PVSP	2	1	1	0	0	1	0
RJD	12	4	4	3	1	0	8
SAC	3	3	0	0	0	N/A	N/A
SATF	6	4	2	0	0	1	1
SCC	1	1	0	0	0	N/A	N/A
SOL	8	4	4	0	0	4	0
SQ	1	1	0	0	0	N/A	N/A
SVSP	8	7	1	0	0	0	1
VSP	0	0	0	0	0	N/A	N/A
VYCF	2	2	0	0	0	N/A	N/A
WSP	1	1	0	0	0	N/A	N/A
Total CSW Cases	128	85	37	3	3	27	20
		Contraband Recovered: 49 Cases = 58%	Contraband Recovered: 25 Cases = 68%	Contraband Recovered: 1 Case = 33%	Contraband Recovered: 2 Cases = 67%	Sufficient = 57%	Insufficient = 43%

Typically, the department uses waist restraints on inmates placed on contraband surveillance watch in order to prevent destruction or re-ingestion of contraband. Effective May 2, 2016, the department began a trial period of unrestrained contraband surveillance watch at three institutions: California Rehabilitation Center, Kern Valley State Prison, and Calipatria State

Prison. The policy for these institutions now requires that, before mechanical restraints are used, the institution must document a specific safety and security need beyond simply the recovery of contraband, and a captain or higher authority must approve the use of the restraints. The criteria for using mechanical restraints would be met if it appeared an inmate was concealing a weapon, razor blades, or any item that would pose an immediate risk to the safety and security of inmates or staff. Inmates who attempt to defeat the contraband surveillance watch process would also be subject to the application of restraints. Unrestrained inmates would still be monitored according to the remainder of the contraband surveillance watch polices. In this report, subsequent to May 2, 2016, the OIG assessed the department's compliance with policies and procedures at the three "trial period" institutions pursuant to the revised policy for contraband surveillance watch cases.

Field Inquiries

Since its inception, the OIG has provided a process by which inmates, CDCR staff, and the public can report misconduct or lodge complaints. The OIG examines complaints and assigns staff to conduct field inquiries regarding selected complaints at the institutions. On July 1, 2015, the OIG began to collect data regarding CDCR's response to OIG's inquiries to be included in our Semi-Annual Report. In this reporting period, the OIG completed the collection of data concerning 31 field inquiries that were referred to OIG special assistant inspectors general and deputy inspectors general to bring the matters to the attention of the specific institutions and to monitor departmental response at the local level.

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

In this reporting period, the OIG concluded 31 inquiries at 21 institutions. Of the 31 cases, the department sufficiently addressed the OIG's inquiry in 29 cases (94 percent). In one of the two cases where the department's response was not appropriate, an inmate submitted a complaint to the OIG alleging custody staff battered him and that his inmate appeals were not properly handled, but destroyed. The hiring authority completed an inquiry and identified possible staff misconduct based on custody staff allegedly not reporting the use of force. The hiring authority referred the case to the Office of Internal Affairs, but neglected to provide the OIG with a copy of the draft request or notify the OIG when the hiring authority sent the referral to the Office of Internal Affairs. The Office of Internal Affairs declined to open an investigation because the inmate's allegations were not corroborated by any staff reports or inmate witnesses. The OIG concurred with the decision not to investigate the matter. In the second case, an inmate alleged the department failed to conduct an investigation into allegations that unidentified persons sexually assaulted him. Although the department completed an investigation, it did not do so timely, did not notify the OIG of the allegation, and the hiring authority did not timely respond to the OIG's requests for updates regarding the investigation. These two cases aside, the 94 percent responsiveness rating speaks to the working relationship forged between the OIG and the hiring authorities, who are now evidencing an appreciation for the role of oversight and embracing transparency in the prison system greater than ever before.

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 the monitoring activities, the OIG alerts the department to potential risks or problem areas and makes recommendations for improvement. It is the goal of the OIG that this monitoring will help avoid potential abuse, costly litigation, and expensive federal oversight.

Critical incidents as described within this report have the potential for serious consequences for staff, inmates, and the taxpayers at large. As such, OIG oversight provides independent assessment on how the incidents occur, how they are handled, and their outcomes. The department timely notified the OIG of 80 percent of critical incident cases reported in Appendices D1 and E, which is an improvement over the previous reporting period, when the department timely notified the OIG in 61 percent of cases. In addition, the department timely notified the OIG of 94 percent of Deadly Force Investigation Team cases.

The OIG attended 638 use-of-force meetings throughout the State and evaluated a total of 2,873 unique incidents. In the overwhelming number of reviews, the committees took appropriate action. The OIG's new use-of-force monitoring tool allows the capture of more detailed data concerning use-of-force incidents, departmental compliance with policies and procedures, and areas of potential improvement. Review of the initial data reveals that the actual force used by staff almost always complies with policy, with 99 percent of the uses of force found in compliance. The department can improve in areas like report-writing, holding cell procedures, video policy, and timeliness of review of use-of-force incidents.

The OIG continues to monitor the department's implementation of its contraband surveillance watch program. If department staff do not follow documentation and observation policies, serious medical issues may occur. In this reporting period, the department significantly decreased its compliance with contraband surveillance watch policies with 53 percent of the cases that exceeded 72 hours rated sufficient as compared to 64 percent in the last reporting period. As with previous reporting periods, this percentage could be increased with greater focus on improving documentation.

This report details the department's response to the OIG complaint intake process. While many complaints are returned for the complainant to exhaust his or her administrative remedies and many more are resolved informally by OIG headquarters intake staff, some require contact by regional OIG staff with the institution. In the majority (94 percent) of cases where an inquiry was made in the field, the department has been receptive and taken appropriate action.

Because the report details those cases where there is a violation of policy, or the OIG does not concur with the department's action, it is easy to form false perceptions. There are definitely areas for the department to improve, and we have highlighted some emergent issues, such as use

of force at CIW. But the current administration has so far made sincere efforts to discuss and act on the majority of OIG recommendations.

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 being an external outlet to resolve complaints when other processes within the system fail. We also remain focused on monitoring the vital areas of critical incidents, use of force, and contraband surveillance watch and to providing transparency to the California correctional system in these areas.

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 recommendation from Volume II of this Semi-Annual Report, January–June 2016.

Recommendation 2.1: The OIG recommends the department amend DOM Section 51020.19.5 to require the Institutional Executive Review Committee to view all available exercise yard or housing unit video recordings as part of the incident review process.

Recommendation 2.2: The OIG recommends the department amend DOM Sections 51020.4 and 51020.19.6 to require the Department Executive Review Committee to review use-of-force incidents within 60 days of IERC completion in accordance with recent guidance promulgated by senior CDCR management.

Volume II Recommendations from Prior Reporting Periods

The OIG recommended the department implement the following recommendation from Volume II of the prior Semi-Annual Report, July–December 2015.

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

CDCR Response: Partially Implemented

With the disciplinary process being incorporated into the Strategic Offender Management System, when staff issues/serves an inmate a copy of a Rules Violation Report related document, the action has to be entered into SOMS, capturing the time and date of the action. The effective communication sheet for Rules Violation Reports is linked to SOMS. Enhancements are pending which will direct staff to complete the effective communication sheet when an inmate interaction occurs. This will include issuing the final copy of an adjudicated Rules Violation Report. California Code of Regulations, Title 15, Section 3000 addresses the requirement for staff to document effective communication. The department is reviewing the feasibility of inmates signing for receipt of Rules Violation Report copies.

The OIG recommended the department implement the following recommendations from Volume II of the Semi-Annual Report, January–June 2015.

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

CDCR Response: Partially Implemented

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

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

CDCR Response: Partially Implemented

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

Appendices

APPENDIX D1 10
MONITORED DEADLY FORCE INCIDENT CASE SUMMARIES
Central Region

Incident Date: 2015-01-23	Deadly Force Incident

Incident Summary
OIG Case Number: **15-0224-RO**

On January 23, 2015, an officer allegedly unintentionally discharged his personal weapon at his home after cleaning the weapon and attempting to secure it. The discharged round went through a window of his home and struck a neighbor's house.

Disposition
The institution's executive review committee did not review the matter. The hiring authority did not identify staff misconduct and did not refer the matter to the Office of Internal Affairs to determine whether departmental policies were violated.

Incident Assessment
The department's actions following the incident were not adequate because the Office of Internal Affairs did not respond to the scene, adequately cooperate with the OIG, or open an investigation and the hiring authority did not refer the matter to the Office of Internal Affairs for investigation.

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

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

  The hiring authority did not request an investigation.
- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs did not respond to the scene.
- Did the department adequately consult with the OIG regarding the critical incident?

  The Office of Internal Affairs did not respond to the OIG's recommendation to open an investigation.
- Did the OIG independently identify an operational issue or policy violation that resulted in, or should have resulted in, corrective action or a referral to the OIA?

  The OIG identified the need to refer the unintended discharge of a firearm to the Office of Internal Affairs for investigation.
- Did the hiring authority make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?

  The hiring authority was aware of the unintended discharge and neglected to refer the matter to the Office of Internal Affairs.
- Did the hiring authority appropriately determine whether to refer any conduct to the OIA related to the critical incident?

  The hiring authority inappropriately did not refer the matter to the Office of Internal Affairs for investigation.

Central Region

Incident Date: 2015-11-16	Deadly Force Incident

Incident Summary

OIG Case Number: **15-2426-RO**

On November 16, 2015, an inmate broke his cell window with a walker and said he could not feel the left side of his body. When officers conducted an emergency cell entry, the inmate punched an officer. A second officer attempted to strike the inmate's shoulder with a baton but struck the inmate's head when the inmate suddenly moved.

Disposition

The institution's executive review committee determined the use of force was in compliance with departmental policy. The OIG concurred. The institution provided training to a lieutenant regarding timely video-recorded interviews following uses of force.

Incident Assessment

The department's response was not adequate because the hiring authority neglected to notify the Office of Internal Affairs that an inmate had been struck in the head with a baton and the hiring authority did not conduct a timely video-recorded interview of the inmate.

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

Assessment Questions

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

  The hiring authority did not notify the Office of Internal Affairs that an inmate was struck in the head with a baton.

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

  The department did not conduct a timely video-recorded interview of the inmate.

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

  The OIG independently identified that the video-recorded interview was not timely.

Central Region

Incident Date: 2016-02-19	Deadly Force Incident

Incident Summary

OIG Case Number: **16-0560-RO**

On February 19, 2016, an officer fired three less-lethal rounds at five inmates who were fighting on the exercise yard, striking one of the inmates in the head. The inmate received treatment at the institution.

Disposition

The institution's executive review committee determined the officer's use of force complied with policy. The OIG concurred.

Incident Assessment

The department's response was not adequate because an officer did not properly search the inmate and a sergeant delayed completing a report.

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

Assessment Questions

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

  The officer escorting the injured inmate did not search him before taking the inmate to the triage and treatment area, where officers found an inmate-manufactured weapon in the inmate's pocket. An investigative services unit sergeant delayed submitting a report.

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

  An investigative services unit sergeant delayed 21 days before submitting his report.

North Region

Incident Date: 2015-09-03	Deadly Force Incident

Incident Summary

OIG Case Number: **15-1786-RO**

On September 3, 2015, two inmates attacked a third inmate using an inmate-manufactured weapon. Officers used less-lethal rounds and a pepper spray grenade but the inmates continued their attack. The observation officer fired a warning shot from a Mini-14 rifle and stopped the attack. The department transported the third inmate to an outside hospital and the inmate returned to the institution the same day. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force complied with departmental policy. The OIG concurred. The hiring authority identified potential staff misconduct based on the lack of justification to use deadly force and referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs rejected the hiring authority's request and the OIG concurred.

Incident Assessment

The department's actions following the incident were not adequate because the hiring authority did not make a timely decision regarding whether to refer the matter to the Office of Internal Affairs, and then referred the matter without a sufficient basis.

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

Assessment Questions

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

  The hiring authority did not make a timely decision regarding whether to refer any potential misconduct to the Office of Internal Affairs.

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

  The hiring authority referred the matter to the Office of Internal Affairs without a sufficient basis.

Incident Date: 2015-10-15	Deadly Force Incident

Incident Summary

OIG Case Number: **15-2135-RO**

On October 15, 2015, two inmates attacked a third inmate on an exercise yard. The third inmate fell to the ground and the two attacking inmates continued to punch the third inmate in the head. An officer fired one warning shot from a Mini-14 rifle into the ground near the location of the fight and the inmates immediately stopped fighting. The third inmate sustained minor injuries as a result of the attack and received medical treatment at the institution. The OIG responded to the scene.

Disposition

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

Incident Assessment

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

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

North Region

Incident Date: 2015-12-12	Deadly Force Incident

Incident Summary

OIG Case Number: **15-2702-RO**

On December 12, 2015, two inmates attacked a third inmate on an exercise yard. An observation officer saw one of the two attacking inmates make stabbing motions toward the third inmate who was on the ground defenseless, and fired a warning shot from a Mini-14 rifle. However, the inmates continued the assault. Officers deployed pepper spray, which stopped the attack. The department transported the injured inmate to an outside hospital for injuries incurred during the attack and the inmate returned to the institution three days later. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the officer's use of force was in compliance with departmental policy. The OIG concurred. The hiring authority did not identify any staff misconduct. However, the institution provided on-the-job training regarding crime scene preservation to three officers.

Incident Assessment

The department's actions following the incident were not adequate because responding officers did not properly process crime-scene evidence and the hiring authority did not intend to collect an incident report from the officer who fired the Mini-14 rifle.

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

Assessment Questions

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

  After the incident, officers failed to properly process crime-scene evidence and the hiring authority did not intend to collect an incident report from the officer who fired the Mini-14 rifle on the day of the incident and only did so after the OIG recommended it.

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

  Officers failed to properly process crime-scene evidence.

Incident Date: 2016-02-09	Deadly Force Incident

Incident Summary

OIG Case Number: **16-0457-RO**

On February 9, 2016, 35 inmates participated in a riot on the exercise yard. Officers deployed 21 chemical agents and nine less-lethal rounds. An officer fired a warning shot from a Mini-14 rifle to stop the riot. Several inmates sustained minor injuries due to the riot and received treatment at the institution. The OIG responded to the scene.

Disposition

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

Incident Assessment

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

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

North Region

Incident Date: 2016-03-09	Deadly Force Incident

Incident Summary

OIG Case Number: **16-0851-RO**

On March 9, 2016, an officer unintentionally discharged one round from a handgun while attempting to clear the chamber.

Disposition

The institution's executive review committee determined the discharge was not within departmental policy. The hiring authority identified potential staff misconduct based on the officer's negligent discharge, failure to report the incident, and attempt to conceal the misconduct. Therefore, the hiring authority referred the matter to the Office of Internal Affairs. The Office of Internal Affairs approved the matter for disciplinary action, which the OIG accepted for monitoring. The hiring authority also identified potential staff misconduct because the watch commander did not timely notify the Office of Internal Affairs or the OIG, and an officer and sergeant did not conduct proper armory inventories. The hiring authority provided counseling to the watch commander and letters of instruction to the officer and sergeant.

Incident Assessment

The department's response was not adequate because the hiring authority did not notify the OIG and the Office of Internal Affairs in a timely and sufficient manner preventing the OIG from real-time monitoring of the case. Also, witnesses did not report the incident, the involved officer did not timely report the incident and disposed of the fired casing, and an officer and a sergeant did not properly complete required armory inventories.

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

Assessment Questions

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

  The officer initially did not report the negligent discharge, told responding officers nothing had happened, and disposed of the fired casing. The officer reported the negligent discharge to his sergeant on March 12, 2016, but the institution did not notify the Office of Internal Affairs or the OIG until March 13, 2016.

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

  The officer reported the incident on March 12, 2016. However, the institution did not notify the Office of Internal Affairs until March 13, 2016.

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

  The officer reported the incident on March 12, 2016. However, the institution did not notify the OIG until March 13, 2016.

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

  Officers who heard the gunshot did not notify a supervisor. The officer who negligently discharged the handgun denied having done so, and then disposed of the fired casing. Required armory inventories were not properly completed and it took two days to discover there was a missing cartridge. The institution did not report the incident to the Office of Internal Affairs or the OIG until March 13, 2016.

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

  Prior to consulting with the OIG, the department did not discover that the institution neglected to timely notify the Office of Internal Affairs and the OIG.

North Region

Incident Date: 2016-04-12	Deadly Force Incident

Incident Summary

OIG Case Number: **16-1122-RO**

On April 12, 2016, an officer saw two inmates punching a third inmate and fired his less-lethal weapon at one of the attacking inmate's buttocks, but struck him in the head. The second inmate stopped the attack. The department transported the first inmate to an outside hospital, following which he returned to the institution. The OIG responded to the scene.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy. The OIG concurred. The hiring authority determined that a lieutenant had accidentally transposed the names of involved inmates which resulted in the wrong inmate being initially suspected of battery. The mistake was corrected shortly thereafter when the lieutenant watched the visual recording of the incident with the OIG.

Incident Assessment

The department's actions following the incident were not adequate because the Office of Internal Affairs did not respond to the incident and the department initially inappropriately determined that the inmate who was attacked was a suspect without having reviewed the visual recording of the incident.

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

Assessment Questions

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

  The department initially inappropriately determined that the inmate who was attacked was a suspect without having reviewed the visual recording of the incident.

- Did the OIA adequately respond to the incident?

  The Office of Internal Affairs did not respond to the incident even though the institution informed them that the inmate who was struck in the head lost consciousness.

North Region

Incident Date: 2016-04-20	Deadly Force Incident

Incident Summary

OIG Case Number: **16-1218-RO**

On April 20, 2016, an officer observed three inmates stabbing a fourth inmate with inmate-manufactured weapons and fired one warning shot from a Mini-14 rifle. The officer then fired two less-lethal rounds, one of which struck one of the attacking inmates in the leg. Officers also deployed pepper spray, stopping the attack. The fourth inmate sustained puncture wounds consistent with being stabbed. The department transported the inmate to an outside hospital.

Disposition

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

Incident Assessment

The department's response was not adequate because the department did not notify the OIG in a timely and sufficient manner that a warning shot was fired preventing the OIG from real-time monitoring of the case.

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

Assessment Questions

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

  The department timely notified the OIG of the attempted murder but did not notify the OIG that a warning shot had been fired.

APPENDIX D2 16
INVESTIGATED AND MONITORED DEADLY FORCE INCIDENT CASE SUMMARIES

Central Region

Incident Date: 2015-01-31	Deadly Force Incident

Incident Summary

On January 31, 2015, an officer saw a man chasing a woman running from a residence. When the woman fell, the man straddled and punched the woman. The officer fired a warning shot from his personal handgun into the ground. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. The department did not identify any criminal conduct and did not refer the matter to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **15-0322-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Sustained**	**Letter of Reprimand**	**Letter of Reprimand**

Disposition

The Deadly Force Review Board found that the officer's use of deadly force did not comply with the department's use-of-force policy. The hiring authority imposed a letter of reprimand. The OIG concurred with the hiring authority's determinations. The officer filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement wherein the officer accepted the letter of reprimand and the department agreed to remove it from his official personnel file. The OIG did not concur; however, the settlement terms did not merit a higher level of review because the penalty remained unchanged.

Disciplinary Assessment

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

The department did not comply with policies and procedures governing the disciplinary process because the hiring authority did not timely conduct the disciplinary findings conference and improperly modified the penalty and the department attorney did not cooperate with the OIG.

Assessment Questions

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

  The Office of Internal Affairs completed its investigation and referred the matter to the hiring authority on June 9, 2015. However, the hiring authority did not consult with the OIG and the department attorney regarding the disciplinary determinations until July 6, 2015, 27 days thereafter.

- If there was a settlement agreement, was the settlement consistent with the DOM factors?

  The agreement to modify the penalty was not consistent with departmental policy because there were no flaws, risks, or new evidence to support the modification.

- If the penalty was modified by department action or a settlement agreement, did OIG concur with the modification?

  The OIG did not concur with the penalty modification because there were no flaws, risks, or new evidence to support the modification.

- Did the department attorney or employee relations officer cooperate with and provide continual real-time consultation with the OIG throughout the disciplinary phase?

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

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

  The department delayed conducting the disciplinary findings conference.

Central Region

Incident Date: 2015-03-24	Deadly Force Incident

Incident Summary

On March 24, 2015, an officer allegedly shot and killed a dog who had bitten him and was again advancing toward him. The Office of Internal Affairs did not respond to the scene.

Administrative Investigation

OIG Case Number: **15-0687-IR**

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

Predisciplinary Assessment

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

The department did not comply with procedures governing the pre-disciplinary process because the Office of Internal Affairs did not conduct the investigation with due diligence.

Assessment Questions

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

  The underlying incident took place on March 24, 2015. On April 7, 2015, the Office of Internal Affairs assigned a special agent to conduct the investigation, but he did not complete the investigation until November 23, 2015, 230 days after assignment.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force complied with the department's use-of-force policy. The hiring authority subsequently exonerated the officer. The OIG concurred.

Incident Date: 2015-04-22	Deadly Force Incident

Incident Summary

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

Administrative Investigation

OIG Case Number: **15-0824-IR**

	Findings	Initial Penalty	Final Penalty
1. Weapons	**1. Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department did not comply with policies and procedures governing the pre-disciplinary process because the department attorney did not contact the special agent and the OIG to discuss the investigation in a timely manner, and the Office of Internal Affairs did not take appropriate steps to protect compelled statements, approved the investigative report before receiving feedback from the OIG, and did not prepare a thorough investigative report.

Assessment Questions

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

  The department assigned an attorney on June 5, 2015, but the department attorney did not confer with the OIG until the OIG initiated contact on September 24, 2015, 111 days thereafter.

Central Region

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

  The special agent assigned to the administrative investigation obtained a compelled statement from the officer on May 1, 2015. On May 20, 2015, the special agents assigned to the administrative and criminal cases attended the same inspection and test of the firearm. On October 8, 2015, both agents met to discuss their investigations.

- 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 senior special agent inappropriately approved the investigative report before the OIG provided feedback to the draft report.

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

  The investigative draft report did not include diagrams used in questioning most of the witnesses, including the officer who used deadly force.

- Was the final investigative report thorough and appropriately drafted?

  The final investigative report did not include diagrams used in questioning most of the witnesses, including the officer who used deadly force.

Disposition

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

Incident Date: 2015-07-30	Deadly Force Incident

Incident Summary

On July 30, 2015, an officer allegedly negligently discharged a firearm while in a classroom in the presence of several other staff members. The OIG responded to the scene. The Office of Internal Affairs did not respond to the scene but conducted a criminal investigation. The Office of Internal Affairs did not identify criminal misconduct, but did not refer the matter to the district attorney's office for review as required by departmental policy. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Administrative Investigation	OIG Case Number: **15-1762-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Criminal Act**	1. **N/A**		

Predisciplinary Assessment

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

The department did not comply with procedures governing the investigative process because the Office of Internal Affairs did not respond to the scene, did not timely conduct interviews, did not timely complete the investigation, and did not refer the matter to the district attorney's office as required by departmental policy.

Assessment Questions

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

  The Office of Internal Affairs did not respond to the scene on the day of the incident.

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

  The criminal Deadly Force Investigation Team neglected to conduct any interviews until December 10, 2015, four months after the incident.

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

  The Office of Internal Affairs did not consult with the district attorney's office to determine whether an administrative investigation should be conducted concurrently with the criminal investigation.

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

  The Office of Internal Affairs did not refer the case to the district attorney's office as departmental policy requires.

Central Region

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

  The incident occurred on July 30, 2015, and the Office of Internal Affairs assigned a special agent on August 27, 2015. However, the Office of Internal Affairs did not conduct any interviews until December 10, 2015, four months after the incident, and did not complete the investigation until April 18, 2016, more than seven months after assigning a special agent.

Disposition

Incident Date: 2015-11-05	Deadly Force Incident

Incident Summary

On November 5, 2015, two inmates stabbed another inmate with an inmate-manufactured weapon. An officer fired two rounds from a Mini-14 rifle at the attacking inmates and struck one of the attacking inmates in the hip. The inmates stopped fighting. Officers transported the inmate who had been shot and the inmate who had been stabbed to an outside hospital. Both inmates subsequently returned to the institution. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-2372-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department did not comply with procedures governing the investigative process because the Office of Internal Affairs did not timely complete the investigation. Also, the special agent did not appropriately enter case activity in the case management system.

Assessment Questions

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

  The incident occurred on November 5, 2015, but the special agent did not complete the last interview until December 10, 2015, 35 days later.

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

  The special agent did not account for all of his investigative work in the case management system.

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

  The incident occurred on November 5, 2015, but the Office of Internal Affairs did not complete all interviews within 72 hours and did not submit the report to the district attorney's office until April 7, 2016, 154 days after the incident.

North Region

Incident Date: 2015-03-29	Deadly Force Incident

Incident Summary

On March 29, 2015, an inmate attacked an officer. Three officers used pepper foam and those officers, an additional officer, and a sergeant used physical force to subdue the inmate. Shortly thereafter, the inmate stopped breathing and several nurses and an officer unsuccessfully administered life-saving measures. A physician pronounced the inmate dead. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-0648-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

Administrative Investigation	OIG Case Number: **15-0649-IR**		
	Findings	Initial Penalty	Final Penalty
1. **Use of Deadly Force**	1. **Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department did not comply with policies and procedures governing the pre-disciplinary process because the department's Deadly Force Review Board determined the officers' actions complied with policy before the cause of death was determined, the special agent did not inform the OIG of communications between the Office of Internal Affairs and the medical examiner's office, and the Office of Internal Affairs did not timely complete the investigation.

Assessment Questions

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

  The Office of Internal Affairs concluded the investigation and completed the draft report before the medical examiner's office determined the cause of death.

- Was the final investigative report thorough and appropriately drafted?

  The Office of Internal Affairs concluded the investigation and completed the report before the medical examiner's office determined the cause of death.

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

  The special agent did not inform the OIG of communications between the Office of Internal Affairs and the medical examiner's office regarding the status of the autopsy.

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

  The special agent did not complete the investigation within 90 days of the case assignment.

Disposition

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

Incident Date: 2015-06-19	Deadly Force Incident

Incident Summary

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

Administrative Investigation	OIG Case Number: **15-1232-IR**

North Region

Administrative Investigation	OIG Case Number: **15-1232-IR**		
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	**1. Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

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

Disposition

The Deadly Force Review Board found that the officer's use of deadly force was in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officer and the OIG concurred. The hiring authority provided training to the officer on observation tower procedures.

Incident Date: 2015-07-28	Deadly Force Incident

Incident Summary

On July 28, 2015, a parole agent allegedly negligently discharged his firearm while in his residence. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation	OIG Case Number: **15-1704-IR**		
	Findings	Initial Penalty	Final Penalty
1. Weapons	**1. Sustained**	**Letter of Reprimand**	**Letter of Reprimand**

Predisciplinary Assessment

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

The department did not comply with procedures governing the pre-disciplinary process because the special agent did not complete the investigation in a timely manner.

Assessment Questions

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

  The special agent did not complete the investigation within 90 days of assignment.

Disposition

The Deadly Force Review Board found that the parole agent's use of deadly force was not in compliance with the department's use-of-force policy. The hiring authority issued the parole agent a letter of reprimand. The OIG concurred with the hiring authority's determinations. The parole agent did not file an appeal with the State Personnel Board.

Disciplinary Assessment

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

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

Incident Date: 2015-08-16	Deadly Force Incident

Incident Summary

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

Administrative Investigation	OIG Case Number: **15-1768-IR**

North Region

Administrative Investigation

OIG Case Number: **15-1768-IR**

	Findings	Initial Penalty	Final Penalty
1. **Weapons**	1. **Exonerated**	**No Penalty Imposed**	**No Penalty Imposed**

Predisciplinary Assessment

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

The department did not comply with policies and procedures governing the pre-disciplinary process because the special agent did not conduct thorough interviews, did not prepare an appropriate draft investigative report, and did not timely complete the investigative report. Additionally, the department attorney delayed assessing the deadline for taking disciplinary action, delayed contacting the special agent and the OIG to discuss the investigation, and delayed providing feedback regarding the investigative report. The hiring authority delayed conducting the investigative findings conference.

Assessment Questions

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

  The department attorney was assigned August 17, 2015, but did not make an entry into the case management system regarding the deadline for taking disciplinary action until November 4, 2015, 79 days thereafter.

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

  The department attorney was assigned on August 17, 2015, but did not contact the special agent and the OIG to discuss the elements of a thorough investigation until October 6, 2015, 50 days after assignment.

- Were all of the interviews thorough and appropriately conducted?

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

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

  The Office of Internal Affairs provided the draft report to the department attorney on November 24, 2015. However, the department attorney did not document in the case management system that he reviewed the report and did not provide feedback until December 23, 2015, 29 days after receipt of the report. Also, the department attorney did not identify deficiencies in the report.

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

  The investigative draft report included inappropriate commentary on the evidence and did not accurately quote a document that was presented in the report as a direct quote.

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

  The Deadly Force Review Board forwarded its findings to the hiring authority on March 23, 2016. However, the hiring authority did not consult with the OIG and the department attorney regarding the sufficiency of the investigation and the investigative findings until May 17, 2016, almost two months thereafter.

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

  The special agent did not complete the investigative report within 90 days from case assignment, the department attorney did not timely provide feedback regarding the investigative report, and the hiring authority delayed conducting the investigative findings conference.

Disposition

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

Incident Date: 2015-08-18	Deadly Force Incident

North Region

Incident Summary

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

Administrative Investigation	OIG Case Number: **15-1715-IR**		
	Findings	Initial Penalty	Final Penalty
1. Weapons	**1. Sustained**	**Letter of Reprimand**	**Letter of Reprimand**

Predisciplinary Assessment

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

The department did not comply with procedures governing the pre-disciplinary process because the hiring authority did not timely notify the OIG and the Office of Internal Affairs of the incident and a sergeant mishandled evidence. Additionally, the Office of Internal Affairs initially determined that the deadly force investigation team should not investigate the case, did not timely complete the investigation, and did not refer the case to the district attorney's office as required by policy. Lastly, the department did not timely assign a department attorney to the case.

Assessment Questions

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

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

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

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

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

  A sergeant mishandled evidence when he secured the weapon and reloaded it with the remaining rounds, which the involved officer had removed, and then placed the weapon into a holster.

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

  The Office of Internal Affairs did not timely respond due to late notification by the institution. Also, the Office of Internal Affairs initially refused to classify the incident as deadly force despite the alleged negligent discharge of a firearm. Only after the OIG intervened did the Office of Internal Affairs agreed to investigate the matter as a use of deadly force.

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

  The Office of Internal Affairs initially refused to classify the incident as deadly force despite the alleged negligent discharge of a firearm. Only after the OIG intervened did the Office of Internal Affairs agreed to investigate the matter as a use of deadly force.

- Did the department attorney attend investigative interviews for key witnesses to assess witness demeanor and credibility?

  The department decided to assign an attorney on September 16, 2015, but the assistant chief counsel did not assign an attorney until after the interviews were completed on September 22, 2016.

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

  The Office of Internal Affairs did not refer this case to the district attorney's office as required by departmental policy.

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

  The hiring authority did not timely notify the Office of Internal Affairs and the OIG regarding the incident and the special agent did not complete the investigation within 90 days of assignment.

Disposition

The Deadly Force Review Board found that the officer's use of deadly force was not in compliance with the department's use-of-force policy. The hiring authority sustained the allegation and issued the officer a letter of reprimand. The OIG concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.

North Region

Disciplinary Assessment

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

The department did not comply with procedures governing the disciplinary process because the department attorney did not provide the hiring authority and the OIG with written confirmation of penalty discussions and did not send the OIG a draft of the disciplinary action.

Incident Date: 2016-02-27 — Deadly Force Incident

Incident Summary

On February 27, 2016, a sergeant allegedly failed to provide her handgun to an officer when she left the control booth and then dropped the handgun while conducting a weapons check. The sergeant allegedly discharged one round into the wall. The Office of Internal Affairs and the OIG responded to the scene.

Administrative Investigation

OIG Case Number: **16-0681-IR**

	Findings	Initial Penalty	Final Penalty
1. **Weapons**	1. **Sustained**	**Letter of Reprimand**	**Letter of Reprimand**
2. **Neglect of Duty**	2. **Sustained**		
3. **Misuse of State Equipment or Property**	3. **Not Sustained**		

Predisciplinary Assessment

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

The department's handling of the pre-disciplinary process was substantively insufficient because the department attorney incorrectly assessed the deadline for taking disciplinary action, did not correct the error until OIG intervened, and gave incorrect legal advice to the hiring authority. The draft investigative report was missing a critical exhibit.

Assessment Questions

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

  The department attorney incorrectly assessed the deadline for taking disciplinary action as February 24, 2017, when the deadline was actually February 27, 2017.

- Did the department attorney appropriately determine that the deadline for taking disciplinary action as originally calculated should be modified and consult with the OIG and special agent?

  The department attorney modified the deadline for taking disciplinary action only after the OIG notified her it was incorrect.

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

  The draft investigative report omitted a critical exhibit showing the training the sergeant received on weapon handling.

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

  The department attorney incorrectly advised the hiring authority there was insufficient evidence to add and sustain the allegation that the sergeant failed to turn over her weapon to an officer when she left the control booth.

Disposition

The hiring authority sustained the allegations, except for one that was improperly worded, and issued a letter of reprimand. The OIG concurred with the hiring authority's determinations. The sergeant did not file an appeal with the State Personnel Board.

Disciplinary Assessment

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

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

South Region

Incident Date: 2015-11-13	Deadly Force Incident

Incident Summary

On November 13, 2015, approximately 70 inmates participated in a riot on an exercise yard. An officer saw one inmate hitting and kicking an unresponsive inmate. The officer fired a single round from a Mini-14 rifle, striking the attacking inmate in the thigh. The department transported the inmate with the gunshot wound and an inmate with a fractured arm to an outside hospital. The first inmate returned to the institution the same day and the second inmate returned the next day. A third inmate received treatment at the institution for a laceration. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-2484-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department did not comply with procedures governing the investigative process because the Office of Internal Affairs did not timely complete the investigation.

Assessment Questions

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

  The Office of Internal Affairs did not interview the officer until December 3, 2015, 20 days after the incident.

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

  The Office of Internal Affairs did not timely complete the investigation.

Incident Date: 2015-12-30	Deadly Force Incident

Incident Summary

On December 30, 2015, a sergeant allegedly shot herself in the thigh while undergoing remedial firearms training. The department transported the sergeant to an outside hospital where she was treated for a minor injury and released. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs did not refer the matter to the district attorney's office for review as required by departmental policy. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **15-2927-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department did not comply with procedures governing the investigative process because the Office of Internal Affairs did not timely complete the investigation and did not refer its investigation to the district attorney's office as required by departmental policy.

Assessment Questions

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

  The special agent did not conduct all interviews within 72 hours as required by departmental policy.

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

  The Office of Internal Affairs did not refer the investigation to the district attorney's office as required by departmental policy.

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

  The underlying incident took place on December 30, 2015, at which time the Office of Internal Affairs assigned a special agent to conduct the investigation. However, the special agent did not complete interviews until January 20, 2016, 21 days thereafter and did not complete the investigation until April 19, 2016, 111 days after the incident.

Incident Date: 2016-01-06	Deadly Force Incident

South Region

Incident Summary

On January 6, 2016, an officer, while handling and securing a firearm, allegedly negligently discharged one round from the firearm into the weapons storage locker. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. Although the Office of Internal Affairs did not identify criminal conduct, pursuant to departmental policy, it referred the matter to the district attorney's office for review. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **16-0144-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Sufficient**

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

Incident Date: 2016-02-18	Deadly Force Incident

Incident Summary

On February 18, 2016, an officer allegedly discharged a firearm inside the armory during a weapon safety check. The Office of Internal Affairs responded to the scene and conducted a criminal investigation. The OIG also responded. The Office of Internal Affairs did not refer the matter to the district attorney's office for review as required by departmental policy. The Office of Internal Affairs also opened an administrative investigation, which the OIG accepted for monitoring.

Criminal Investigation	OIG Case Number: **16-0581-IR**	Allegation: **Criminal Act**

Investigation Assessment

Rating: **Insufficient**

The department did not comply with policies and procedures governing the investigative process because the Office of Internal Affairs did not interview a key witness, timely determine whether an interview completed in the administrative investigation could be used in the criminal investigation, or refer the case to the district attorney's office. The special agent prepared an inadequate draft investigative report.

Assessment Questions

- Were all of the interviews thorough and appropriately conducted?

  The special agent did not interview a key witness or ascertain whether the interview of that witness completed in the administrative investigation could be used in the criminal investigation until the OIG recommended doing both.

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

  The special agent did not include the interview of a critical witness in the draft investigative report.

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

  The Office of Internal Affairs did not refer the case to the district attorney's office for review pursuant to departmental policy.

APPENDIX E
NON-DEADLY FORCE
CRITICAL INCIDENT CASE SUMMARIES

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CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-07-18	**15-1451-RO**	**In-Custody Inmate Death**

Incident Summary

On July 18, 2015, an officer discovered an unresponsive inmate slumped in a cell by himself. The officer helped nurses transport the inmate to the triage and treatment area, but did not initiate life-saving efforts due to obvious signs of death.

Disposition

An autopsy determined the inmate died from a heroin overdose. The department's Death Review Committee determined the death was not preventable. The department determined the emergency response was appropriate. The hiring authority did not identify any staff misconduct. The hiring authority did not attempt to identify the source of the heroin.

Overall Assessment

The department's response was not adequate because an officer counted the inmate as alive less than two hours before an officer discovered the inmate dead with rigor mortis and the hiring authority refused to refer the matter to the Office of Internal Affairs.

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

Assessment Questions

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

  An officer counted the inmate as alive less than two hours before another officer discovered the inmate dead with rigor mortis. The hiring authority refused to refer the matter to the Office of Internal Affairs to determine whether the officer properly performed the count.

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

  The investigative services unit did not attempt to identify the source of the heroin.

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

  The OIG independently identified that the hiring authority should refer the matter to the Office of Internal Affairs to determine whether the officer properly performed the count.

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

  The hiring authority did not refer the officer's conduct to the Office of Internal Affairs to investigate whether he properly performed the count.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-07-20	**15-2163-RO**	**Other Significant Incident**

Incident Summary

On July 20, 2015, an officer charged an inmate with battery on a peace officer without serious injury because the inmate bumped the officer with a food tray. On September 22, 2015, the department found the inmate guilty, although there was no evidence it was intentional, because the inmate did not disprove the violation.

Disposition

After the OIG elevated the matter to the director of the division of adult of institutions, the department dismissed the disciplinary action against the inmate and restored the inmate's privileges. The district attorney declined to file criminal charges against the inmate.

Overall Assessment

The department's response was not adequate because the officer filed a rules violation report without sufficient evidence, reviewers did not ensure there was sufficient evidence before proceeding to hearing, the hearing officer found the inmate guilty without evidence of intent and improperly shifted the burden to the inmate to disprove the violation, and the hiring authority did not consult with the OIG before the inmate filed an appeal. The investigative services unit erroneously determined the inmate's conduct met the requirement for pursuing criminal charges.

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

Assessment Questions

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

  The officer filed a rules violation report without evidence of intent and the reviewing sergeant and lieutenant allowed the rules violation to proceed, despite a lack of evidence. The rules violation hearing officer improperly shifted the burden of proof to the inmate. Even though the OIG brought the problems to the hiring authority's attention, the hiring authority did not prevent the inmate from being improperly punished.

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

  The hiring authority refused to independently review the incident and consult with the OIG regarding potential staff misconduct and the inmate's improper punishment before the inmate filed an appeal.

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

  The officer improperly filed a rules violation report, the reviewers allowed it to go forward despite lack of evidence, and the hearing officer found the inmate guilty without evidence of intent and improperly shifted the burden of proof to the inmate. The investigative services unit erroneously determined the inmate's conduct met the requirement for pursuing criminal charges.

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

  The hiring authority did not consider whether there was misconduct by the officer for filing the rules violation report, the reviewers for allowing it to go forward, or the hearing officer for shifting the burden of proof to the inmate.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-08-26	**15-1767-RO**	**In-Custody Inmate Death**

Incident Summary

On August 26, 2015, an officer found an inmate collapsed on the floor next to his bed, conscious, pale, and perspiring heavily. Four nurses transported the inmate to the triage and treatment area where the inmate began to vomit blood. The department transported the inmate to an outside hospital but a physician pronounced the inmate dead during transport.

Disposition

An autopsy determined the inmate died of natural causes. The department's Death Review Committee concluded the inmate's death was natural, unexpected, and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-09-07	**15-1802-RO**	**In-Custody Inmate Death**

Incident Summary

On September 7, 2015, an inmate found his cellmate unresponsive on the floor. Two officers and a nurse performed life-saving measures and transported the cellmate to the triage and treatment area, where a physician pronounced him dead.

Disposition

An autopsy and the department's Death Review Committee concluded that the cause of death was a drug overdose. The hiring authority identified several investigative deficiencies based on the failures to secure the crime scene and initiate a crime scene log, and moving the body before the deputy coroner arrived. The department provided training to the investigative services unit staff.

Overall Assessment

The department's actions following the incident were not adequate because the investigative services unit did not properly respond to the incident.

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

Assessment Questions

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

  The investigative services unit did not establish, secure, and preserve the crime scene or establish a crime scene log, and moved the body after the inmate was pronounced dead and before the deputy coroner arrived.

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

  The investigative services unit did not secure and preserve the crime scene or ensure a crime scene log was initiated, and conducted a search of the inmate's cell before outside law enforcement arrived. The investigative services unit also examined and moved the inmate's body and obtained fingerprints before the coroner's investigator arrived.

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

  The OIG identified the need for training regarding establishing, securing, and preserving crime scenes and leaving bodies undisturbed while waiting for the coroner.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-09-14	**15-1910-RO**	**In-Custody Inmate Death**

Incident Summary

On September 14, 2015, an inmate informed an officer he needed medical attention. An officer and two nurses transported the inmate to the triage and treatment area. The inmate stopped breathing and a nurse initiated life-saving measures. Paramedics arrived and pronounced the inmate dead.

Disposition

An autopsy revealed the cause of death was acute myocardial infarction due to years of atherosclerotic coronary artery disease. The department's Death Review Committee concluded that the death was possibly preventable because a physician did not respond adequately to an abnormal heart test result. The department provided training to the physician.

Overall Assessment

The department's actions prior to the incident were not adequate because a physician did not adequately respond to an abnormal test result.

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

Assessment Questions

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

  A physician did not respond appropriately to an abnormal heart test two days before the inmate's death.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-09-15	**15-1911-RO**	**In-Custody Inmate Death**

Incident Summary

On September 15, 2015, an officer saw an inmate collapse in a dayroom. The inmate was unconscious and convulsing. The officer called an emergency medical response, and a nurse and officers transported the inmate to the triage and treatment area. A nurse determined the inmate was not breathing and life-saving efforts were initiated. The institution called an ambulance, which transported the inmate to an outside hospital where he was pronounced dead.

Disposition

The coroner determined the cause of death was hypertensive, atherosclerotic cardiovascular disease. The department's Death Review Committee determined the death was unexpected and not preventable. The emergency medical response review committee determined that a nurse did not comply with emergency medical response procedures or properly document vital signs. The nurse's hiring authority provided training. After consulting the OIG, the hiring authority acknowledged that a crime scene was not established and provided training to the officer.

Overall Assessment

The department's response was not adequate because a nurse did not properly document vital signs or timely contact outside emergency medical services and an officer did not immediately establish a crime scene.

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

Assessment Questions

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

  A nurse did not adequately document vital signs or timely contact outside emergency medical services after life-saving measures were initiated and an officer did not establish a crime scene.

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

  An officer did not establish a crime scene.

- Was the critical incident adequately documented?

  A nurse did not adequately document vital signs.

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

  The OIG identified that an officer did not establish a crime scene.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-09-23	**15-1959-RO**	**In-Custody Inmate Death**

Incident Summary

On September 23, 2015, an officer observed an unresponsive inmate slumped over on his lower bunk. Two officers performed life-saving measures until four nurses arrived and continued life-saving measures while the officers and nurses transported the inmate to the triage and treatment area. Paramedics arrived, continued life-saving efforts, and transported the inmate to an outside hospital where a physician pronounced him dead.

Disposition

An autopsy revealed that the cause of death was an accidental overdose of fentanyl. The department's Death Review Committee identified inadequate emergency response documentation during the incident but determined that the death was not preventable. The department provided training to five nurses who failed to adequately document the medical emergency. The emergency medical response review committee found the response to the emergency was appropriate. The department took appropriate steps to identify the source of the drugs.

Overall Assessment

The department's response was not adequate because the institution did not timely notify the OIG, nurses did not adequately document the emergency medical response, and the emergency medical response review committee did not identify the deficient documentation.

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

Assessment Questions

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

  The department did not notify the OIG until more than two hours after the incident.

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

  The department did not adequately document the emergency medical response and the emergency medical response review committee did not identify this deficiency.

- Was the critical incident adequately documented?

  Nurses did not adequately document the emergency medical response.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-10-04	**15-2028-RO**	**Suicide**

Incident Summary

On October 4, 2015, an officer discovered a cell window covered with paper. The inmate did not respond to orders to remove the covering. A sergeant and two officers opened the cell door and found an inmate hanging from a shelf. Officers lowered the inmate and two nurses arrived to perform life-saving measures. Paramedics also responded and the inmate was pronounced dead.

Disposition

An autopsy determined the cause of death was ligature strangulation and the manner of death was suicide. The department's Suicide Case Review Committee determined the suicide was not foreseeable but was preventable. The hiring authority identified potential staff misconduct based on a nurse's alleged failure to perform life-saving measures, abandonment of the patient, and dishonesty in documenting the life-saving measures; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG did not accept for monitoring.

Overall Assessment

The department's response was not adequate because the department delayed calling outside emergency medical services, life-saving efforts were allegedly stopped while the inmate was being transported, nurses allegedly left the inmate with officers instead of providing nursing care, and a nurse allegedly falsified documentation of the life-saving measures performed.

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

Assessment Questions

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

  The department delayed calling outside emergency medical services. In addition, life-saving efforts were allegedly stopped while the inmate was being transported to the triage and treatment area, nurses allegedly left the inmate with officers instead of providing nursing care, and a nurse allegedly falsified documentation of the life-saving measures performed.

Incident Date	OIG Case Number	Case Type
2015-10-11	**15-2099-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On October 11, 2015, an officer saw two inmates fighting in a cell, ordered them to stop, and removed them from the cell. An ambulance transported one of the inmates to an outside hospital for stab wounds to the torso and he returned to the institution the next day. The institution placed the cellmate in administrative segregation and referred the case to the district attorney's office.

Disposition

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

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-10-13	**15-2112-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On October 13, 2015, an officer observed an inmate stomping on his cellmate's head inside a cell. Three officers and a sergeant removed the attacking inmate from the cell. An ambulance transported the unresponsive cellmate to an outside hospital and he returned to the institution the next day.

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-10-21	**15-2167-RO**	**In-Custody Inmate Death**

Incident Summary

On October 21, 2015, an officer saw an inmate having a possible seizure. The inmate attempted to get up, complained of shortness of breath, and stopped breathing. Two nurses arrived and initiated life-saving measures. Paramedics responded and continued life-saving measures until a physician from an outside hospital pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the cause of death was probable ruptured abdominal aortic aneurysm and the death was not preventable. The committee identified that a physician did not conduct recommended screening for an abdominal aortic aneurysm and the hiring authority provided training to the physician.

Overall Assessment

The department's actions prior to and following the incident were not adequate because the department did not conduct recommended preventative screening or timely notify the OIG.

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

Assessment Questions

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

  The department did not notify the OIG until two hours after the inmate's death.

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

  A physician at the inmate's prior institution did not conduct the recommended screening for abdominal aortic aneurysm during his initial medical evaluation.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-10-25	**15-2208-RO**	**In-Custody Inmate Death**

Incident Summary

On October 25, 2015, an officer and two nurses entered a cell to administer medications and found an inmate unresponsive and under a blanket. A nurse tried to rouse the inmate, causing the blanket to move, which revealed the inmate's head covered with a plastic bag and a torn sheet wrapped around the bed rail and the inmate's neck and right wrist. Due to signs of rigor mortis, the officer and nurses did not initiate life-saving measures.

Disposition

An autopsy determined the cause of death was asphyxiation and the Statewide Mental Health Program suicide report stated the suicide was preventable. The hiring authority identified potential staff misconduct based on an officer's alleged failure to conduct an adequate count; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs did not approve an investigation but approved taking direct disciplinary action against the officer, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to and after the incident were not adequate because an officer counted the inmate as alive one hour before the inmate was discovered dead with rigor mortis and the Office of Internal Affairs refused to approve an investigation.

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

Assessment Questions

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

  An officer counted the inmate as alive one hour before the inmate was discovered dead with rigor mortis and the Office of Internal Affairs refused to approve an investigation to determine the time of death and manner in which the officer conducted the count.

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

  The OIG determined the matter should be referred to the Office of Internal Affairs to determine whether the officer appropriately performed the count.

- If the hiring authority submitted a request for reconsideration to the OIA, was an appropriate decision made regarding the request?

  When the hiring authority asked the Office of Internal Affairs to reconsider its original decision to impose discipline without an investigation, the Office of Internal Affairs neglected to approve an investigation to determine the inmate's time of death and how the officer performed the count.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-11-04	**15-2326-RO**	**In-Custody Inmate Death**

Incident Summary

On November 4, 2015, an inmate arrived at the institution complaining of severe weakness and fatigue. Shortly after arrival, the department transported the inmate to an outside hospital, where he died the following day.

Disposition

The coroner did not perform an autopsy due to a pre-existing medical condition. The department's Death Review Committee determined the death was natural, unpreventable, and due to an infectious disease. The emergency medical response review committee identified that two nurses did not adequately document the inmate's initial assessment. The hiring authority for the nurses provided training.

Overall Assessment

The department's actions during the incident were not adequate because two nurses did not document the inmate's initial assessment.

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

Assessment Questions

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

  Two nurses failed to document the initial assessment of the inmate's condition.

Incident Date	OIG Case Number	Case Type
2015-11-10	**15-2384-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On November 10, 2015, two officers deployed pepper spray at two inmates who were fighting. A third inmate also began fighting and a third officer fired two less-lethal rounds, aiming for one of the inmate's thighs. The first officer struck an inmate with a baton, quelling the fight. During a subsequent medical evaluation, an inmate alleged he was struck in the head by a less-lethal round.

Disposition

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

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-11-11	**15-2371-RO**	**In-Custody Inmate Death**

Incident Summary

On November 11, 2015, an inmate reported to officers that his cellmate was dead. The officers observed the cellmate with a noose tied around his neck. An officer and a nurse unsuccessfully performed life-saving measures. A paramedic arrived and pronounced the cellmate dead. The investigative services unit and outside law enforcement investigated the homicide.

Disposition

An autopsy determined the cause of death was strangulation and the manner of death was homicide. The department's Death Review Committee concluded the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was not adequate because the institution did not timely request an ambulance.

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

Assessment Questions

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

  During the incident, nurses did not timely request an ambulance.

Incident Date	OIG Case Number	Case Type
2015-11-13	**15-2425-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On November 13, 2015, two inmates attacked a third inmate in a housing unit. An officer fired two less-lethal rounds at one of the attacking inmates, inadvertently striking the inmate in the face. The department transported the inmate to an outside hospital and the inmate returned to the institution the following day.

Disposition

The institution’s executive review committee determined that the officer's use of force complied with policy and the OIG concurred. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-11-21	**15-2546-RO**	**In-Custody Inmate Death**

Incident Summary

On November 21, 2015, two officers found an unresponsive inmate lying on his bunk. The inmate was cold to the touch and stiff, but had no obvious signs of trauma. A nurse initiated life-saving measures but due to obvious signs of rigor mortis and dependent lividity, life-saving measures were stopped and a paramedic pronounced the inmate dead.

Disposition

An autopsy determined the cause of death was cardiac dysrhythmia. The department's Death Review Committee determined the death was natural, unexpected, and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was not adequate because an officer counted the inmate as alive six hours before the inmate was discovered dead with rigor mortis and the hiring authority refused to refer the matter to the Office of Internal Affairs to determine whether the officer properly performed the count.

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

Assessment Questions

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

  An officer counted the inmate as alive six hours before the inmate was discovered dead with rigor mortis and evidence suggested the inmate was not alive during the count. Additionally, the hiring authority refused to refer the matter to the Office of Internal Affairs to determine whether the officer properly performed the count.

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

  The OIG independently identified that an officer may have performed a count improperly.

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

  The hiring authority inappropriately decided not to refer the matter to the Office of Internal Affairs to investigate whether an officer properly performed a count.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-12-07	**15-2642-RO**	**In-Custody Inmate Death**

Incident Summary

On December 7, 2015, an officer found an inmate unresponsive in his cell. A nurse and an officer entered the cell and the nurse began life-saving measures until paramedics arrived and continued the efforts. After life-saving measures failed, a physician from an outside hospital pronounced the inmate dead.

Disposition

The coroner determined the cause of death was ischemic heart disease due to severe atherosclerotic coronary artery disease and the manner of death was natural. The department's Death Review Committee determined the death was unexpected and not preventable. The emergency medical response review committee concluded the emergency response was adequate. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-12-07	**15-2656-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On December 7, 2015, an inmate punched an officer in the face. The officer struck the inmate in the head with his pepper spray canister, stopping the attack. The inmate was treated at the triage and treatment area, receiving ten staples to close the head wound.

Disposition

The institution’s executive review committee determined the use of force was within policy. However, the committee found that a lieutenant did not follow protocols for identifying serious bodily injury and the institution provided training to the lieutenant. The OIG concurred. The hiring authority referred the matter to the district attorney's office.

Overall Assessment

The department's response following the incident was not adequate because a lieutenant did not identify the seriousness of the inmate's injuries.

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

Assessment Questions

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

  A lieutenant did not identify the seriousness of the inmate's injuries.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-12-12	**15-2710-RO**	**Inmate Serious/Great Bodily Injury**

Incident Summary

On December 12, 2015, two officers discovered an unresponsive inmate on the floor of his cell in a pool of blood. The officers removed the cellmate and a nurse treated the injured inmate. The department transported the injured inmate to an outside hospital. The inmate returned to the institution more than four months later. The institution placed the cellmate in administrative segregation and referred the case to the district attorney's office.

Disposition

The department's in-cell assault review concluded the department complied with policy when housing the two involved inmates. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions prior to and following the incident were not adequate because the department changed the status of the inmate who was attacked from single-cell to double-cell and did not adequately document the decision. The department did not document considering the inmate's history of victimization or risk of continued victimization as required by policy, or provide specific policy guidelines for transitioning an inmate's housing status, despite the OIG's prior recommendations. And, the institution's in-cell assault review was inadequate.

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

Assessment Questions

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

  The department inappropriately changed the status of the inmate who was attacked from single-cell to double-cell and did not document the decision adequately. The department did not consider or document the inmate's history of victimization or risk of continued victimization as required by policy, despite three prior incidents with cellmates. And, the institution's in-cell assault review was inadequate because it only considered the attacked inmate's history of disciplinary offenses and not his history of being a victim.

- Was the critical incident adequately documented?

  The department did not adequately document its decisions to change the inmate from single-cell to double-cell status or document consideration of the inmate's history of victimization or risk of continued victimization.

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

  The OIG identified that the department changed the status of the inmate who was attacked from single-cell to double-cell and did not adequately document the decision.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-12-24	**15-2899-RO**	**Suicide**

Incident Summary

On December 24, 2015, an officer discovered an inmate alone in his cell hanging from a noose secured to a bookshelf. The officer entered the cell and began life-saving measures. The inmate was transported to the clinic where a physician pronounced the inmate dead.

Disposition

An autopsy concluded the cause of death was ligature strangulation and the manner of death was suicide. The department's Death Review Committee determined that the inmate's death was not medically preventable. The Statewide Mental Health Program suicide report indicated that the suicide was foreseeable and preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-12-25	**16-0149-RO**	**Hunger Strike**

Incident Summary

On December 25, 2015, an inmate initiated a hunger strike to protest housing conditions. As of January 14, 2016, the inmate had lost 9 percent of his body weight. On January 20, 2016, the department transported the inmate to an outside hospital where medical staff slowly re-introduced him to food, thus ending his hunger strike.

Disposition

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

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-01-03	**16-0324-RO**	**Hunger Strike**

Incident Summary

On January 3, 2016, an inmate initiated a hunger strike because he did not like State food. During the hunger strike, the department transported the inmate to an outside hospital three times for stomach pain. The inmate remained on the hunger strike until the department released him on parole on February 20, 2016, at which time he was transported to an outside hospital. The inmate lost approximately 23 percent of his body weight during the hunger strike.

Disposition

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

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-01-25	**16-0284-RO**	**In-Custody Inmate Death**

Incident Summary

On January 25, 2016, an inmate informed an officer his cellmate was dead. Two officers and a sergeant opened the cell door and saw the cellmate lying on the floor in a pool of blood. Officers removed the inmate from his cell. An officer, sergeant, and nurse performed life-saving measures on the cellmate, which continued while transporting the cellmate to the correctional treatment center. Paramedics arrived and continued life-saving measures until a physician at an outside hospital pronounced the cellmate dead. The department referred the case to the district attorney.

Disposition

The coroner determined the cause of death was hemorrhage due to multiple stab wounds and the manner of death was homicide. The department's Death Review Committee found the death was not medically preventable. The in-cell homicide review concluded the institution complied with policy when housing the two involved inmates, but identified that a lieutenant did not adequately complete the initial housing review. The hiring authority provided training to the lieutenant.

Overall Assessment

The department's response was not adequate because the department's in-cell homicide review did not consider either inmate's history of victimization and the initial housing review was not thoroughly documented.

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

Assessment Questions

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

  The department's in-cell homicide review did not consider either inmate's history of victimization, as required by policy, and the initial housing review was not thoroughly documented.

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

  The OIG identified that the department's in-cell homicide review did not consider either inmate's history of victimization, as required by policy.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-01-27	**16-0492-RO**	**Suicide**

Incident Summary

On January 27, 2016, an officer discovered a cell door window covered, removed the covering, and observed an inmate alone in the cell hanging from a noose. A sergeant and five officers entered the cell and lowered the inmate. A licensed psychiatric technician responded and initiated life-saving measures. The department transported the inmate to an outside hospital where he was placed on life support. A physician pronounced the inmate dead on January 29, 2016.

Disposition

The coroner determined the cause of death was anoxic brain injury due to hanging. The department's Death Review Committee found the death was unexpected and not medically preventable. The Statewide Mental Health Program suicide report identified that a newly-assigned clinician did not timely meet with the inmate regarding his treatment plan. The hiring authority for mental health provided training to 16 clinicians. The emergency medical response review committee identified that nurses did not timely apply the automated external defibrillator or initiate rescue breathing, and failed to adequately communicate the inmate's condition to triage and treatment area nurses. The hiring authority for the nurses provided training.

Overall Assessment

The department's response was not adequate because a clinician did not meet with the inmate until more than two months after being assigned, four nurses did not comply with emergency response protocols, and the department did not timely notify the OIG.

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

Assessment Questions

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

  The department did not notify the OIG until more than four hours after the inmate was pronounced dead.

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

  The department's actions were not adequate because a clinician did not meet with the inmate until more than two months after being assigned, four nurses did not comply with emergency response protocols, and the department did not timely notify the OIG.

Incident Date	OIG Case Number	Case Type
2016-03-18	**16-0883-RO**	**Inmate Riot**

Incident Summary

On March 18, 2016, approximately 200 inmates participated in a riot in a dormitory housing unit and officers used less-lethal force to regain control. No inmates were seriously injured.

Disposition

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

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-03-18	**16-0938-RO**	**Hunger Strike**

Incident Summary

On March 18, 2016, an inmate began a hunger strike because he wanted to be transferred to another institution. On March 24, 2016, the department transported the inmate to an outside hospital. The inmate ended his hunger strike on March 25, 2016, after losing 26 pounds.

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2016-04-12	**16-1109-RO**	**Hunger Strike**

Incident Summary

On April 12, 2016, an inmate refused to eat due to having no appetite. The inmate ended the hunger strike on April 21, 2016. During that time, the inmate lost 15 percent of the inmate's body weight.

Disposition

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

Overall Assessment

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

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-04-22	**16-1327-RO**	**Other Significant Incident**

Incident Summary

On April 22, 2016, an inmate told an officer that she swallowed tweezers and fingernail clippers. The department transported the inmate to an outside hospital where a physician surgically removed the items from her stomach. The inmate returned to the institution nine days later.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions following the incident were not adequate because the department did not notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case.

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

Assessment Questions

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

  The department did not notify the OIG of the attempted suicide. The OIG discovered the incident through review of the department's daily reports.

Incident Date	OIG Case Number	Case Type
2016-05-02	**16-1392-RO**	**Other Significant Incident**

Incident Summary

On May 2, 2016, an inmate reported swallowing two razor blades. The department transported the inmate to the triage and treatment area where x-rays confirmed the presence of razor blades. The department placed the inmate on suicide watch and transferred the inmate to a mental health crisis bed at another institution.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions following the incident were not adequate because the department did not notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case.

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

Assessment Questions

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

  The department did not notify the OIG until the day after the department identified the inmate's actions as an attempted suicide.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2014-12-14	**14-2827-RO**	**In-Custody Inmate Death**

Incident Summary

On December 14, 2014, officers discovered an inmate unresponsive in his cell. Two sergeants, an officer, and a nurse performed life-saving measures. An ambulance arrived and paramedics continued life-saving efforts but they were unsuccessful. A physician from an outside hospital pronounced the inmate dead.

Disposition

The coroner determined that the inmate died from an amphetamine overdose. The medical examiner discovered 13 bindles containing methamphetamine, marijuana, and folded papers inside the inmate during the autopsy. The department's Death Review Committee determined that the department's medical response met the standard of care. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The department took appropriate steps to identify the source of the drugs that caused the overdose.

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

Incident Date	OIG Case Number	Case Type
2015-01-17	**15-0205-RO**	**In-Custody Inmate Death**

Incident Summary

On January 17, 2015, medical technical assistants found an unresponsive inmate alone in his cell. They entered the cell, determined the inmate was not breathing, and initiated life-saving measures, which failed, and a physician pronounced the inmate dead.

Disposition

The autopsy reported the cause of death as a heart attack due to a blood clot. The department's Death Review Committee determined the death was not preventable. The department also evaluated the medical response and determined that the responding nurse rather than emergency room staff should have called paramedics. The hiring authority provided training to the nurse.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-01-22	**15-0223-RO**	**Other Significant Incident**

Incident Summary

On January 22, 2015, officers ordered an inmate who appeared to be intoxicated to submit to a clothed body search. The inmate reached toward his waist band and an officer used physical force to restrain him and the inmate fell to the ground. An ambulance transported the inmate to an outside hospital for a head injury and later to another hospital for a higher level of care, following which the inmate returned to the institution.

Disposition

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

Overall Assessment

The department's actions following the incident were not adequate because the institution did not notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case.

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

Assessment Questions

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-01-25	**15-2552-RO**	**Other Significant Incident**

Incident Summary

On January 25, 2015, outside law enforcement arrested an officer for brandishing a firearm during a physical confrontation with an acquaintance. The officer had a second firearm concealed in his vehicle for which he did not have a permit. The officer was subsequently convicted of a misdemeanor offense for carrying a concealed weapon in his vehicle without a valid permit.

Disposition

The hiring authority identified potential staff misconduct based on the officer's alleged misuse of a concealed weapon and possession of a concealed weapon in his vehicle without a valid permit. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring. Based on the OIG's recommendation, the hiring authority suspended the officer's privilege to carry a concealed weapon.

Overall Assessment

The department's actions following the incident were not adequate because the hiring authority delayed referring the matter to the Office of Internal Affairs and also restored the officer's privilege to carry a concealed weapon after he was convicted of possession of a concealed weapon. The hiring authority's supervisor supported the decision.

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

Assessment Questions

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

  The department learned of the alleged misconduct on January 25, 2015, but the hiring authority did not refer the matter to the Office of Internal Affairs until November 10, 2015, 289 days after the date of discovery.

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

  The hiring authority and the hiring authority's supervisor initially failed to suspend the officer's privilege to carry a concealed weapon after he was convicted for a misdemeanor weapons offense and did so only after the OIG recommended the department do so.

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

  The hiring authority did not refer the matter to the Office of Internal Affairs until approximately nine months after discovering the potential misconduct.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-03-22	**15-0601-RO**	**Critical Incident**

Incident Summary

On March 22, 2015, 36 inmates participated in a riot on the exercise yard. Officers used chemical agents and 30 less-lethal rounds to stop the riot. Three inmates were treated at an outside hospital for serious injuries and other inmates were treated at the institution. Two inmates alleged being hit in the head by less-lethal rounds. One of the inmates received treatment for a dislocated lens of the eye and the second inmate received sutures for a laceration on his head.

Disposition

The institution's executive review committee determined that the officers' uses of force complied with departmental policy. The OIG concurred. The department conducted an inquiry based on an inmate's allegation of excessive force from being hit in the head with a less-lethal round. The hiring authority did not identify any staff misconduct and could not determine whether the inmate's eye injury was caused by a less-lethal round.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-04-28	**15-0845-RO**	**In-Custody Inmate Death**

Incident Summary

On April 28, 2015, an officer discovered an unresponsive inmate lying on a top bunk. Officers removed the inmate and cellmate from the cell. A sergeant and nurse performed life-saving measures. Paramedics arrived and assumed life-saving measures until pronouncing the inmate dead.

Disposition

An autopsy determined the inmate died from an overdose of a prescribed drug and morphine. The department's Death Review Committee concluded the inmate's death was unexpected and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions following the incident were not adequate because the department did not investigate how the inmate obtained the morphine.

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

Assessment Questions

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

  The department did not investigate the source of the drugs that led to the inmate's death.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-04-28	**15-0846-RO**	**In-Custody Inmate Death**

Incident Summary

On April 28, 2015, an inmate told officers he was having trouble breathing. The officers transported the inmate to the triage and treatment area where he became unresponsive and officers and nurses performed life-saving measures. Paramedics arrived and contacted a physician at an outside hospital who pronounced the inmate dead.

Disposition

An autopsy determined the inmate died of cardiovascular disease. The department's Death Review Committee found that the inmate's death was natural, expected, and not preventable. The department provided training to the responding nurse who did not assess the inmate's vital signs or administer oxygen.

Overall Assessment

The department's response was not adequate because the first nurse at the scene did not assess the inmate's vital signs or administer oxygen.

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

Assessment Questions

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

  The first nurse at the scene did not assess the inmate's vital signs and administer oxygen to the inmate before transporting him to the triage and treatment area.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-04-30	**15-0874-RO**	**In-Custody Inmate Death**

Incident Summary

On April 30, 2015, an officer discovered an unresponsive inmate in his cell and officers initiated life-saving measures. A nurse arrived and continued life-saving efforts until relieved by paramedics. A physician pronounced the inmate dead after life-saving efforts failed. The department later learned the inmate was dead for at least two hours before being discovered.

Disposition

An autopsy determined the inmate died of a heart attack and the department's Death Review Committee determined the death was possibly preventable. The hiring authority for the physician provided counseling. The hiring authority for the officers identified potential staff misconduct based on officers' failure to verify the presence of a live inmate during security checks and referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the case to the hiring authority for direct disciplinary action, which the OIG accepted for monitoring.

Overall Assessment

The department's actions prior to and following the incident were not adequate because officers did not properly conduct security checks and a physician did not review the inmate's medical records. The hiring authority for the officers did not timely refer the matter to the Office of Internal Affairs and the hiring authority for the physician did not properly document corrective action taken. The Office of Internal Affairs did not open an investigation or include all relevant allegations.

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

Assessment Questions

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

  Officers conducting security checks did not discover that the inmate was dead. A physician did not review chart notes documenting the inmate's complaints of chest pain before examining the inmate. The hiring authority for the officers delayed referring the matter to the Office of Internal Affairs and the hiring authority for the physician did not document corrective action taken.

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

  The OIG identified the officers' failure to verify the presence of a live inmate when they made security checks.

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

  The department learned of potential staff misconduct on April 30, 2015, but the hiring authority for the officers did not refer the matter to the Office of Internal Affairs until January 22, 2016, more than eight months after the date of discovery.

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

  The OIG disagreed with the Office of Internal Affairs' decision not to investigate a second officer's potential misconduct, not to add a dishonesty allegation, and not to open an investigation because evidence supported keeping the second officer as a subject of the investigation and adding the allegation, and there were questions supporting the need for an investigation.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-05-06	**15-1409-RO**	**PREA**

Incident Summary

On May 6, 2015, an officer allegedly reached through the handcuff port of an inmate's cell and inappropriately touched the inmate's stomach and groin area.

Disposition

The institution's Prison Rape Elimination Act review committee determined the inmate's allegation was unsubstantiated. The hiring authority provided department-mandated training to all employees regarding processing and investigating sexual misconduct allegations.

Overall Assessment

The department's actions following the incident were not adequate because the department did not timely respond to the incident, timely notify or adequately consult with the OIG, timely complete its investigation, or make a timely determination regarding whether to refer any conduct to the Office of Internal Affairs.

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

Assessment Questions

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

  The hiring authority was aware of the allegation on May 7, 2015, but did not complete the review of alleged sexual misconduct until January 29, 2016, more than eight months later.

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

  The department was aware of the inmate's allegation on May 7, 2015, but did not notify the OIG until July 13, 2015.

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

  The department did not timely review the inmate's allegation.

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

  The investigative services unit did not timely complete the investigation of the inmate's allegation.

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

  The hiring authority did not timely respond to the OIG's requests for updates regarding the investigation.

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

  The hiring authority was aware of the allegation on May 7, 2015, but did not make a final decision regarding whether to refer any conduct to the Office of Internal Affairs until January 29, 2016.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-05-15	**15-1007-RO**	**In-Custody Inmate Death**

Incident Summary

On May 15, 2015, an officer discovered an unresponsive inmate in his cell. Officers and a nurse initiated life-saving measures and transported the inmate to the triage and treatment area where life-saving measures continued. Paramedics arrived and pronounced the inmate dead.

Disposition

An autopsy determined the inmate died from a seizure disorder. The department's Death Review Committee determined the death was possibly preventable because modifications made to the inmate's medication regimen could have possibly prevented a terminal seizure. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-05-25	**15-1052-RO**	**Suicide**

Incident Summary

On May 25, 2015, an inmate attempted to hang himself with an electrical cord. Officers cut the cord but the inmate resisted the officers. The officers restrained the inmate and placed him in a wheelchair, following which he lost consciousness. Officers and nurses began life-saving measures, which failed, and a physician pronounced the inmate dead.

Disposition

An autopsy determined the cause of death was acute cerebral hypoxia caused by a ligature wrapped tightly around the neck and the manner of death was suicide. The department's Death Review Committee concluded that the death was probably preventable. The suicide report concluded that the suicide was preventable and foreseeable. The hiring authority identified that a physician did not properly consider treatment options or document the inmate's mental health record. Additionally, nurses inappropriately placed the inmate in a cell with an inadequate level of care, did not promptly initiate rescue breathing, did not sufficiently communicate with physicians, and delayed starting 15-minute checks on the inmate. The hiring authority provided training to physicians and nurses.

Overall Assessment

The department's actions prior to and during the incident were not adequate because a physician did not properly consider treatment options or document the inmate's mental health record. Also, nurses did not sufficiently communicate with physicians, delayed starting 15-minute checks, placed the inmate in inappropriate housing, did not initiate one-on-one suicide watch, and did not promptly initiate rescue breathing.

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

Assessment Questions

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

  Prior to the incident, a physician did not properly consider treatment options or document the inmate's mental health record, nurses did not properly communicate with physicians, and nurses delayed starting 15-minute checks on the inmate. Despite a psychiatrist's order to place the inmate in a mental health crisis bed, nurses placed the inmate in alternative housing with access to an exposed electrical cord and without one-on-one suicide watch as required. During the incident, nurses did not promptly initiate rescue breathing.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-05-26	**15-1053-RO**	**In-Custody Inmate Death**

Incident Summary

On May 26, 2015, an inmate asked a nurse to check his blood sugar and vital signs. The nurse took the inmate's vital signs and administered oxygen. A short time later, the inmate complained of chest pain and the nurse administered additional oxygen. Ten minutes later, the inmate became unresponsive and nurses performed life-saving measures as an ambulance transported the inmate to an outside hospital where a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee determined the cause of death was unexpected, sudden, and unpreventable cardiac arrest. The department provided training and counseled a physician regarding on-call responsibility.

Overall Assessment

The department's actions prior to the incident were not adequate because the on-call physician was unavailable to nurses in the hours prior to the inmate's death.

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

Assessment Questions

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

  The department's emergency medical response review committee found that nurses were unable to contact the on-call physician despite multiple attempts.

Incident Date	OIG Case Number	Case Type
2015-06-29	**15-1292-RO**	**In-Custody Inmate Death**

Incident Summary

On June 29, 2015, officers responded to a request for assistance and found an inmate gasping for air. Officers removed the inmate's cellmate from the cell and a nurse and officers transported the inmate to the triage and treatment area where he became combative and then unresponsive. Nurses and officers began life-saving measures but were unsuccessful and a physician pronounced the inmate dead.

Disposition

An autopsy determined the inmate died of an accidental methamphetamine overdose. The medical examiner found ten plastic bags, six of which were open, in the inmate's stomach during the autopsy. The hiring authority did not identify staff misconduct. The department took appropriate steps to identify the source of the drugs.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-07-03	**15-1539-RO**	**Hunger Strike**

Incident Summary

On July 3, 2015, an inmate began a hunger strike, alleging issues with his property. On July 29, 2015, the department transferred the inmate to the outpatient housing unit where he could be closely monitored. The inmate remained on hunger strike as of December 11, 2015, when a clinical assessment confirmed the inmate's weight remained stable over years of hunger strikes and medical care was appropriate. The inmate ended the hunger strike on February 2, 2016.

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-07-07	**15-1913-RO**	**Suicide**

Incident Summary

On July 7, 2015, an officer discovered an inmate on the floor of his cell with a cord around his neck and tied to the top bunk. A second officer responded and they cut the cord from the inmate's neck and initiated life-saving measures. Nurses responded and continued life-saving measures. Paramedics transported the inmate to an outside hospital where a physician pronounced the inmate dead.

Disposition

The medical examiner determined the cause of death was hanging. The department's Death Review Committee determined nurses and physicians met the standard of care. The suicide review committee concluded the suicide was preventable. The institution identified potential staff misconduct based on an officer's failure to perform security and welfare checks and making false entries on a form, and the failure of the first officer and a second officer to immediately enter the cell. The institution dismissed the first officer and provided training to the second officer regarding alarm response procedures. The institution also replaced faulty medical equipment. The department also recommended the institution provide training to all officers regarding the tool used to cut a noose and proposed changing the restrictions on certain work groups and privilege groups to allow inmates sufficient time out of their cells to diminish the likelihood of mental health decompensation. The institution implemented the department's recommendations.

Overall Assessment

The institution's response was not adequate because an officer did not perform required security and welfare checks and falsified a form. Also, officers did not immediately enter the cell and could not immediately locate the necessary emergency tools. The institution had malfunctioning medical equipment and did not provide medical records to department reviewers in a timely manner.

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

Assessment Questions

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

  The institution had malfunctioning medical equipment and did not provide medical records to department reviewers in a timely manner. An officer did not perform required security and welfare checks and falsified a form. Officers could not immediately locate the tool used to cut the noose and did not immediately enter the cell.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-07-12	**15-1420-RO**	**In-Custody Inmate Death**

Incident Summary

On July 12, 2015, an officer found an inmate in his cell, unresponsive but breathing. The department transported the inmate to an outside hospital where on July 13, 2015, medical tests determined the inmate was brain-dead. On July 16, 2015, a physician removed the inmate from life support and pronounced the inmate dead.

Disposition

An autopsy determined the inmate died from a methamphetamine overdose. The hiring authority identified a lack of policy directing custody staff who observe an inmate suspected of being under the influence of a substance to immediately notify a supervisor and medical staff. The hiring authority instituted such a policy and provided training regarding the policy to custody staff.

Overall Assessment

The department's actions prior to and after the incident were not adequate because the department did not adequately monitor the inmate, evaluate his condition, or assess whether he was in medical distress, and the investigative services unit did not investigate how the inmate obtained drugs.

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

Assessment Questions

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

  An officer suspected the inmate was intoxicated but officers did not have the inmate medically evaluated to determine whether he was intoxicated or having a medical emergency. Officers did not find the unresponsive inmate until more than two hours later. The investigative services unit failed to investigate how the inmate obtained the drugs.

Incident Date	OIG Case Number	Case Type
2015-08-16	**15-1631-RO**	**In-Custody Inmate Death**

Incident Summary

On August 16, 2015, an inmate reported to an officer that he had severe back pain. Nurses transported the inmate to the triage and treatment area. The department transported the inmate to an outside hospital where he became unresponsive and a physician pronounced him dead.

Disposition

The department's Death Review Committee determined the cause of death was probable septic shock. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-08-27	15-1758-RO	In-Custody Inmate Death

Incident Summary

On August 27, 2015, an officer responded to a cell after an inmate requested assistance for his cellmate. Additional officers arrived and found the second inmate not breathing and without a pulse. The officers immediately began life-saving measures. Two institutional fire captains arrived and continued life-saving measures until paramedics relieved them. A physician subsequently pronounced the inmate dead.

Disposition

The coroner determined the inmate died of coronary artery disease. The department's Death Review Committee concluded the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-08-31	15-1765-RO	In-Custody Inmate Death

Incident Summary

On August 31, 2015, officers observed two inmates attacking a third inmate on an exercise yard and deployed chemical agents to stop the attack. The third inmate sustained multiple stab wounds to his chest and back. Nurses initiated life-saving measures. The department transferred the inmate to an outside hospital where a physician pronounced him dead. The department referred the case to the district attorney's office.

Disposition

The department's Death Review Committee concluded that the inmate's death was from multiple stab wounds to the anterior chest. The institution's executive review committee determined that the use of force complied with policy. OIG concurred. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-09-01	**15-1769-RO**	**In-Custody Inmate Death**

Incident Summary

On September 1, 2015, an officer and a psychiatric technician discovered an inmate unresponsive in his cell. The psychiatric technician, the officer, and a second officer initiated life-saving measures. A nurse arrived and, with the assistance of a sergeant and five officers, continued life-saving measures while transporting the inmate to the triage and treatment area. An outside fire department arrived and the inmate was pronounced dead.

Disposition

The department's Death Review Committee determined the inmate died of cardiac dysrhythmias, coronary artery disease, and congestive heart failure. The department took appropriate steps to identify and address the systemic communication problems between mental health and medical staff, which contributed to the inmate not being seen for nine months.

Overall Assessment

The department's actions prior to the incident were not adequate because medical and mental health staff did not communicate with each other regarding the inmate's condition and did not treat the inmate for nine months, and medical testing was not conducted.

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

Assessment Questions

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

  Prior to the inmate's death, medical and mental health staff did not communicate with each other regarding the inmate's condition and did not treat the inmate for nine months, and a psychiatrist ordered testing that was not conducted.

Incident Date	OIG Case Number	Case Type
2015-09-03	**15-1795-RO**	**Other Significant Incident**

Incident Summary

On September 3, 2015, a parole agent drove a State vehicle over what was later determined to be a person. After traveling several miles, the vehicle became inoperable. The parole agent timely notified his supervisor of the incident and condition of the vehicle. The supervisor learned of media reports of a pedestrian being struck by a hit-and-run driver and instructed the parole agent to immediately contact outside law enforcement. Outside law enforcement responded to the scene and investigated.

Disposition

Outside law enforcement determined that the parole agent did strike the pedestrian but he was not at fault because he was not the first person to strike the pedestrian. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-09-04	**15-2114-RO**	**Hunger Strike**

Incident Summary

On September 4, 2015, an inmate began a hunger strike because he wanted to report alleged staff misconduct that occurred at his previous institution. The inmate ended his hunger strike on September 18, 2015, but resumed his hunger strike later that day. The department interviewed the inmate regarding his allegations but he continued his hunger strike. On October 18, 2015, the department transferred the inmate to the correctional treatment center where he ended his hunger strike the same day.

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-09-29	**15-1977-RO**	**In-Custody Inmate Death**

Incident Summary

On September 29, 2015, an officer discovered an inmate alone in his cell hanging from a noose. He and responding officers entered the cell, cut the noose, and initiated life-saving measures that were unsuccessful, and a physician pronounced the inmate dead.

Disposition

The medical examiner determined the cause of death was asphyxiation by hanging. The forensic psychological autopsy concluded the suicide was preventable but not foreseeable. The department's Death Review Committee determined that after the inmate was found, his death was not medically preventable. The hiring authority identified that a social worker had not properly documented the inmate's medical record and had prematurely changed the inmate's level of mental health care. Additionally, a nurse did not immediately apply the automated external defibrillator and the automated external defibrillator did not work properly. The hiring authority ordered training for all mental health staff and replaced the defective automated external defibrillator.

Overall Assessment

The department's actions were not adequate because a social worker did not properly document the inmate's medical record and prematurely changed the inmate's level of mental health care, a nurse did not immediately apply the automated external defibrillator, the automated external defibrillator did not work properly, and the department did not adequately consult with the OIG.

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

Assessment Questions

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

  Prior to the incident, a social worker did not properly document the inmate's medical record and prematurely changed the inmate's level of mental health care. During the incident, a nurse did not immediately apply the automated external defibrillator and the automated external defibrillator did not work properly.

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

  The department failed to timely respond to the OIG's request for information after the incident.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-18	**15-2146-RO**	**Suicide**

Incident Summary

On October 18, 2015, an officer found an inmate hanging from a noose in his cell. Another officer and two nurses lowered the inmate and performed life-saving measures. Two additional officers assisted with life-saving measures until paramedics arrived and continued life-saving measures. A paramedic called a physician at an outside hospital and the physician pronounced the inmate dead.

Disposition

An autopsy determined the cause of death was asphyxia due to hanging. The department's Death Review Committee determined the medical standard of care was met. The Suicide Case Review Committee determined the suicide was not foreseeable or preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

The department's actions following the incident were not adequate because the investigative services unit did not adequately secure and process the scene.

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

Assessment Questions

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

  The investigative services unit failed to process the scene.

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

  The investigative services unit failed to process the scene.

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

  The OIG identified that custody officers processed the scene instead of investigative services unit officers.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-19	**15-2531-RO**	**Other Significant Incident**

Incident Summary

On October 19, 2015, a parolee-at-large murdered a parolee while the parolee was assisting special agents with the Office of Correctional Safety to apprehend the parolee-at-large.

Disposition

The department identified potential staff misconduct based on the special agents' failure to adhere to the policies and procedures regarding operational plans, provide adequate safeguards for the parolee, and properly handle evidence. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's response was not adequate because special agents placed the parolee in danger and lost evidence, the department did not timely notify the OIG of the incident or subsequent witness interviews, and the Office of Internal Affairs initially did not agree to open a criminal investigation.

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

Assessment Questions

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

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

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

  The department placed a parolee in unnecessary danger, resulting in the parolee's death by allowing the parolee to interact with an armed and dangerous parolee-at-large who had previously threatened to kill the first parolee. Also, the department did not implement an adequate operation plan to apprehend the parolee-at-large, mishandled and lost evidence at the scene of the murder, and interviewed witnesses without informing the OIG.

- Would the appropriate initial determination or reconsideration determination have been made by the OIA without OIG intervention?

  Initially, the Office of Internal Affairs refused to consider potential criminal allegations against the parole agents. As a result of OIG intervention, the Office of Internal Affairs finally referred the matter to an outside law enforcement agency, which conducted a criminal investigation.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-25	**15-2225-RO**	**In-Custody Inmate Death**

Incident Summary

On October 25, 2015, an officer observed an inmate unresponsive alone in his cell. Officers and a nurse began life-saving measures and transported the inmate to the triage and treatment area where life-saving measures were unsuccessful and a physician pronounced the inmate dead.

Disposition

The department's Death Review Committee identified the cause of death as severe aortic stenosis and determined the death was not preventable. The department provided training to the responding nurse regarding emergency medical response procedures.

Overall Assessment

The department's response was not adequate because nurses did not timely obtain and use the automated external defibrillator.

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

Assessment Questions

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

  The responding nurse was not aware that she had access to the locked room where the automated external defibrillator was located. As such, nurses did not use the defibrillator until seven minutes after the medical response began.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-31	**15-2286-RO**	**Suicide**

Incident Summary

On October 31, 2015, an officer found an inmate hanging from a noose in his cell. Officers lowered the inmate from the noose, removed him from the cell, and began life-saving measures. Three officers, a sergeant, and two nurses provided life-saving measures until paramedics arrived and continued life-saving measures. A paramedic called a physician at an outside hospital and the physician pronounced the inmate dead.

Disposition

An autopsy concluded that the inmate died of asphyxiation by hanging. The suicide review report concluded that the death was not foreseeable or preventable. The hiring authority identified potential staff misconduct based on an officer's alleged failure to properly conduct the required inmate count and timely respond to other inmates' calls for assistance; therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's response was not adequate because an officer allegedly did not conduct a proper count or timely respond to inmates' calls for assistance and officers did not adequately secure the scene. The hiring authority delayed referring potential staff misconduct to the Office of Internal Affairs.

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

Assessment Questions

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

  The investigative services unit did not properly secure the scene and an officer allegedly failed to conduct a proper count and timely respond to inmates' calls for assistance. The hiring authority delayed referring potential staff misconduct to the Office of Internal Affairs.

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

  The investigative services unit failed to secure the scene with crime scene tape.

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

  The department learned of the alleged misconduct on November 2, 2015, but the hiring authority did not refer the matter to the Office of Internal Affairs until December 22, 2015, 50 days after the date of discovery.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-11-24	**15-2575-RO**	**In-Custody Inmate Death**

Incident Summary

On November 24, 2015, two nurses were treating an inmate for constipation when the inmate became unresponsive and stopped breathing. The nurses initiated life-saving measures and a physician subsequently pronounced the inmate dead.

Disposition

The coroner's report did not identify a cause of death but indicated the inmate was under a physician's care at the time of death. The department's Death Review Committee determined the inmate's death was natural, unexpected, and not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-12-24	**15-2872-RO**	**In-Custody Inmate Death**

Incident Summary

On December 24, 2015, an officer discovered an unresponsive inmate in his cell. Officers removed the inmate from his cell and initiated life-saving measures. A nurse arrived and continued life-saving measures until paramedics arrived. A paramedic pronounced the inmate dead after life-saving efforts failed.

Disposition

The autopsy report revealed the inmate died from atherosclerotic cardiovascular disease. The department's Death Review Committee determined the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-01-05	**16-0420-RO**	**Hunger Strike**

Incident Summary

On January 5, 2016, an inmate initiated a hunger strike as a protest to his confinement in administrative segregation. On February 8, 2016, the department placed the inmate on suicide watch for demonstrating self-injurious behavior. On February 10, 2016, the institution transferred the inmate to a mental health crisis bed at another institution. On February 22, 2016, the inmate ended the hunger strike.

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2016-02-28	**16-0646-RO**	**In-Custody Inmate Death**

Incident Summary

On February 28, 2016, an officer discovered an inmate lying on a cell floor. Officers and nurses performed life-saving measures until paramedics arrived and a physician pronounced the inmate dead.

Disposition

An autopsy determined that the inmate died from heart disease. The department's Death Review Committee determined the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-03-22	**16-1223-RO**	**Hunger Strike**

Incident Summary

On March 22, 2016, an inmate initiated a hunger strike because he wanted a transfer to another institution. As of April 26, 2016, the inmate had lost 16 percent of his body weight. On April 26, 2016, the inmate ended the hunger strike.

Disposition

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

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-03-27	15-0641-RO	In-Custody Inmate Death

Incident Summary

On March 27, 2015, an inmate reported that his cellmate was having a seizure. Officers and a nurse initiated life-saving measures and transported the inmate to the triage and treatment area. Paramedics responded and called a physician at an outside hospital who pronounced the inmate dead.

Disposition

The coroner determined the manner of death was accidental, caused by prescription medication toxicity. The institution's emergency medical response review committee identified a deficiency in a nurse's evaluation of the inmate's symptoms prior to his death. The hiring authority for the nurse provided training. The department's Death Review Committee determined the death was possibly preventable and requested a case conference to address possible inadequate communication between physicians, failure to follow the primary care model, and consideration of medication interactions. The hiring authority providing training to the physicians.

Overall Assessment

The department's actions prior to the incident were not adequate because a nurse and physicians did not adequately address and respond to the inmate's medical condition.

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

Assessment Questions

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

  A nurse did not properly evaluate the inmate's symptoms prior to his death and physicians did not adequately communicate regarding the inmate's condition, did not follow the primary care model, and did not consider medication interactions.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-06-30	**15-1313-RO**	**Other Significant Incident**

Incident Summary

On June 30, 2015, a sergeant and an officer found an unresponsive inmate lying on the floor of a cell. The sergeant and officers entered the cell and found a sheet around the inmate's neck and the loose end of the sheet in the toilet. The inmate was not breathing. Officers and a nurse resuscitated the inmate and the department transported her to an outside hospital for evaluation. The inmate returned to the institution the same day and the department placed her in a mental health crisis bed.

Disposition

The hiring authority identified a deficiency in the institution's policy regarding security and welfare checks that resulted in potential gaps of time exceeding 35 minutes between checks. The hiring authority immediately amended the institution's policy. The hiring authority also identified that an officer did not document two security checks and a sergeant did not correct the behavior. The hiring authority took corrective action against the sergeant but not the officer. After the OIG recommended it, the hiring authority also took corrective action against the officer.

Overall Assessment

The department's actions prior to and after the incident were not adequate because officers had allowed more than 35 minutes to pass between security checks, an officer did not document required security checks, and a sergeant did not correct the officer. After the incident, the hiring authority did not take corrective action to remedy the officer's failure until the OIG made the recommendation to do so.

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

Assessment Questions

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

  Prior to the incident, the institution's local policy allowed for gaps in time that exceeded the requirement for timely security checks, an officer did not document two security checks, and a sergeant did not correct the officer. After the incident, the hiring authority initially did not take corrective action to remedy the officer's failure.

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

  The OIG recommended that an officer receive corrective action for failing to document two required security checks several hours before the incident.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-08-11	**15-1617-RO**	**In-Custody Inmate Death**

Incident Summary

On August 11, 2015, officers responded to an inmate's report that his cellmate was not breathing. Officers removed the cellmate from the cell and a sergeant and three nurses initiated life-saving measures. The department transported the cellmate to the triage and treatment area where paramedics were able to restore a heart rate. Paramedics then transported him to an outside hospital where he died three days later.

Disposition

The coroner concluded that the inmate's death was accidental, caused by methamphetamine toxicity. The department's preliminary death review determined the death was not preventable. The emergency medical response review committee identified that nurses failed to adequately document the incident. The hiring authority for the nurses provided training. The institution took steps to identify the source of the drugs but was unable to do so.

Overall Assessment

The department's response was not adequate because the department did not notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case and nurses did not adequately document the medical emergency.

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

Assessment Questions

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

  The department did not notify the OIG of the inmate's condition and transport to an outside hospital until August 14, 2015.

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

  The department's actions were not appropriate because nurses did not adequately document the medical emergency.

- Was the critical incident adequately documented?

  The emergency medical response review committee identified deficiencies in the charting of the medical emergency in the triage and treatment area.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-08-28	**15-1739-RO**	**Other Significant Incident**

Incident Summary

On August 28, 2015, a nurse observed an inmate wrap a cloth bandage around the inmate's neck. A sergeant and officers entered the cell and the sergeant removed the bandage from the inmate's neck. Officers escorted the inmate to a secure area for a medical and mental health evaluation.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-09-10	**15-1844-RO**	**In-Custody Inmate Death**

Incident Summary

On September 10, 2015, three inmates fought on an exercise yard. Officers and a sergeant fired eight less-lethal rounds and deployed pepper spray. One inmate sustained a stab wound to his neck and was air-lifted to an outside hospital where a physician pronounced him dead. The two other inmates sustained injuries consistent with fighting, and one of the inmates had a stomach wound consistent with being struck by a less-lethal round. The investigative services unit recovered an inmate-manufactured weapon from the scene and the yard's surveillance camera depicted a fourth inmate stabbing the inmate who died. The department referred the case to the district attorney for prosecution.

Disposition

The coroner determined the manner of death was homicide and the cause of death was a stab wound to the neck. The department's Death Review Committee determined the death was not medically preventable. The institution's executive review committee determined the use of force was within policy. The OIG concurred. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-09-21	**15-1949-RO**	**Other Significant Incident**

Incident Summary

On September 21, 2015, officers placed an inmate in a holding cell after officers observed a fight with another inmate. A sergeant and an officer saw the inmate tie one end of a shoelace to the top of the holding cell and the other end around the inmate's own neck. The sergeant and the officer entered the cell and used physical force to stop the inmate's actions. Officers escorted the inmate to the triage and treatment area for a minor neck injury.

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-09-26	**15-1974-RO**	**Other Significant Incident**

Incident Summary

On September 26, 2015, an officer saw an inmate tying one end of a shirt around a sink and the other end around the inmate's own neck. The inmate began to kneel down in an attempt to tighten the noose. Officers entered the cell to remove the shirt from around the inmate's neck. The inmate punched and kicked at the officers, necessitating physical force to remove the noose. The inmate did not sustain any injuries.

Disposition

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

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-09-29	**15-1979-RO**	**Other Significant Incident**

Incident Summary

On September 29, 2015, a social worker saw an inmate choking in a cell. Officers entered the cell and discovered cuts to the inmate's arms and the inmate reported swallowing a razor blade. The department transported the inmate to an outside hospital, following which the inmate returned to the institution. On September 30, 2015, the department placed the inmate on contraband surveillance watch after an x-ray confirmed the presence of a razor blade. The department removed the inmate from contraband surveillance watch on October 3, 2015.

Disposition

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

Overall Assessment

The department's response was satisfactory in all critical aspects.

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

Incident Date	OIG Case Number	Case Type
2015-10-11	**15-2080-RO**	**Other Significant Incident**

Incident Summary

On October 11, 2015, an officer observed an inmate standing on a bunk with a sheet tied around the inmate's neck and the other end tied to a light fixture. The inmate jumped off the bunk, the sheet pulled away from the light fixture, and the inmate fell to the floor. Officers entered the cell and removed the sheet from the inmate's neck. The department transported the inmate to an outside hospital due to a possible seizure. The inmate returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-14	**15-2125-RO**	**Other Significant Incident**

Incident Summary

On October 14, 2015, an officer found an inmate vomiting in a cell. The inmate reported swallowing a large amount of prescription medication. A sergeant and nurse transported the inmate to the triage and treatment area. The inmate's cellmate reported feeling suicidal and also swallowing a large amount of prescription medication. The department transported both inmates to an outside hospital and they returned to the institution the next day.

Disposition

A social worker did not evaluate one of the inmates for referral to a higher level of care with the Department of Mental Health after the suicide attempt. The hiring authority for the social worker provided training.

Overall Assessment

The department's response was not adequate because the department did not notify the OIG of the incident preventing the OIG from real-time monitoring of the case and a social worker did not ensure one of the inmates was evaluated for referral to a higher level of care.

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

Assessment Questions

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

  The department did not notify the OIG of the incident.

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

  After the incident, a social worker did not ensure one of the inmates was evaluated for referral to a higher level of care with the Department of Mental Health.

Incident Date	OIG Case Number	Case Type
2015-10-15	**15-2122-RO**	**Other Significant Incident**

Incident Summary

On October 15, 2015, inmates notified an officer of a fire in a cell. The officer responded to the cell with a fire extinguisher and began to extinguish the fire when he saw an inmate on the bunk. A second inmate entered the cell and assisted the first inmate out of the cell while the officer continued to extinguish the fire. The institution’s fire department evacuated the building and the department transported the inmate to the triage and treatment area. The inmate sustained no injuries.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-17	**15-2185-RO**	**Other Significant Incident**

Incident Summary

On October 17, 2015, an inmate awoke to a sound of kicking at the cell door. The inmate saw the cellmate hanging from a noose and lowered the cellmate to the floor. The inmate reported the incident to an officer the next day. A sergeant interviewed the cellmate, who denied the incident, but a medical evaluation revealed minor injuries to the cellmate's face and neck.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-10-19	**15-2187-RO**	**Other Significant Incident**

Incident Summary

On October 19, 2015, an officer saw an inmate in a cell, bleeding from a cut to the wrist. A sergeant and officers and escorted the inmate to the triage and treatment area where the inmate was treated for a self-inflicted cut to the wrist.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Assessment Questions

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

  The department did not notify the OIG until approximately two hours and thirty minutes after the incident.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-20	**15-2165-RO**	**Other Significant Incident**

Incident Summary

On October 20, 2015, an officer discovered an inmate cutting the inmate's wrist with a razor blade. The inmate dropped the razor blade and submitted to handcuffs. The department transported the inmate to the triage and treatment area where the inmate was treated for superficial cuts to the arm.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-10-20	**15-2166-RO**	**In-Custody Inmate Death**

Incident Summary

On October 20, 2015, an officer discovered an unresponsive inmate lying on his bunk holding an inmate-manufactured syringe. Officers and a nurse initiated life-saving measures and transported the inmate to the triage and treatment area. Paramedics arrived and consulted with a physician at an outside hospital, who pronounced the inmate dead.

Disposition

The coroner determined the manner of death was accidental, caused by a drug overdose. The department's Death Review Committee found that the inmate's death was not preventable. The hiring authority did not identify any staff misconduct. The institution took steps to identify the source of the drugs but was unable to do so.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-20	**15-2181-RO**	**Other Significant Incident**

Incident Summary

On October 20, 2015, an officer discovered an inmate with a bloody arm inside a cell . The inmate complied with orders to wrap a towel around the wound and the department transported the inmate to an outside hospital for self-inflicted cuts to the arm and abdomen. The inmate returned to the institution the following day.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Assessment Questions

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

  The department did not notify the OIG until nearly two hours after a physician determined the inmate attempted suicide.

Incident Date	OIG Case Number	Case Type
2015-10-23	**15-2221-RO**	**Other Significant Incident**

Incident Summary

On October 23, 2015, an officer responded to loud noises in the shower and found an inmate crying, with a string loosely tied around the neck, threatening to commit suicide. The officer saw the inmate place the inmate's hands near the inmate's neck and used physical force to remove the string. Another officer escorted the inmate to the triage and treatment area. The inmate did not sustain any injuries.

Disposition

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

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-24	**15-2222-RO**	**Other Significant Incident**

Incident Summary

On October 24, 2015, an inmate gave an officer a piece of cloth tied in a noose and told the officer that the inmate's cellmate was threatening self-harm. The officer found the cellmate crying in the cell and escorted the cellmate to the triage and treatment area.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-10-24	**15-2224-RO**	**In-Custody Inmate Death**

Incident Summary

On October 24, 2015, an inmate told a nurse that he consumed a large amount of an anti-inflammatory medication. A physician determined the inmate required a higher level of care and the department transported the inmate to an outside hospital, where he died on October 26, 2015.

Disposition

The coroner determined the inmate's death was natural, caused by liver disease. The department's Death Review Committee identified that the first responder delayed arriving to the incident and a nurse in the triage and treatment area delayed contacting the on-call physician. The delays resulted in delayed emergency transport to an outside hospital. The hiring authority for the first responder and nurse elected not to take any action in response to the identified deficiencies. The OIG did not concur with the hiring authority's decision.

Overall Assessment

The department's response to the incident was not adequate because the department did not notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case, the first responder did not timely arrive at the scene, and a nurse did not timely contact the on-call physician.

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

Assessment Questions

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

  The first responder delayed 10 minutes in arriving to the incident.

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

  The department did not notify the OIG until nearly four hours after the inmate died.

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

  The first responder did not timely respond to the incident and a nurse in the triage and treatment area did not timely contact the on-call physician for orders, resulting in a delay in the emergency transport.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-10-30	**15-2277-RO**	**Other Significant Incident**

Incident Summary

On October 30, 2015, a sergeant and officers used pepper spray and physical force to stop an inmate from tying a garment around the inmate's own neck. The inmate did not sustain any injuries.

Disposition

The institution's executive review committee determined the use of force complied with policy. The OIG concurred. The hiring authority for the mental health clinicians found that the primary clinician did not contact the inmate for two of the required five consecutive days following discharge from a mental health crisis bed. The hiring authority provided training to all mental health clinicians.

Overall Assessment

The department's actions following the incident were not adequate because the primary clinician did not provide required contact with the inmate following discharge from a mental health crisis bed as policy required.

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

Assessment Questions

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

  The primary clinician did not provide contact with the inmate for two of the required five consecutive days following discharge from a mental health crisis bed.

Incident Date	OIG Case Number	Case Type
2015-11-09	**15-2364-RO**	**Other Significant Incident**

Incident Summary

On November 9, 2015, an inmate informed an officer that the inmate's cellmate was suicidal. The officer found the cellmate sitting on the floor in a pool of blood. A nurse and a second officer transported the cellmate to the triage and treatment area, following which the department transported the cellmate to an outside hospital for treatment of a self-inflicted arm wound. The inmate returned to the institution the following day.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-11-09	**15-2643-RO**	**Hunger Strike**

Incident Summary

On November 9, 2015, an inmate initiated a hunger strike to protest his pending transfer to another institution. On December 7, 2015, the inmate ended his hunger strike. The inmate had lost 22 pounds, which was 11 percent of his body weight.

Disposition

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

Overall Assessment

The department's response was not adequate because the department did not notify the OIG when the inmate lost more than 10 percent of his body weight preventing the OIG from real-time monitoring of the case. The department's documentation contained conflicting information regarding the date the inmate ended the hunger strike.

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

Assessment Questions

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

  The department did not notify the OIG when the inmate lost more than 10 percent of his body weight.

- Was the critical incident adequately documented?

  Medical records documented the inmate ended the hunger strike on December 7, 2015, but a sergeant completed a different form on December 9, 2015, reporting the inmate ended his hunger strike.

Incident Date	OIG Case Number	Case Type
2015-11-11	**15-2418-RO**	**Other Significant Incident**

Incident Summary

On November 11, 2015, an inmate reported self-inflicted cuts to an officer. A sergeant and a nurse responded to the cell. The department transported the inmate to an outside hospital where four sutures were used to close self-inflicted lacerations on both arms. The inmate returned to the institution the same day.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-11-13	15-2419-RO	Other Significant Incident

Incident Summary

On November 13, 2015, a social worker observed an inmate climbing on the sink in a cell with a rope around the inmate's neck and tied to a light fixture. The inmate refused orders to get down from the sink. A sergeant deployed pepper spray and the inmate got down from the sink. Officers escorted the inmate to the correctional treatment center.

Disposition

The hiring authority identified potential staff misconduct based on the sergeant's decision to use pepper spray on an inmate trying to hang herself; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs declined to open an investigation. The OIG did not concur.

Overall Assessment

The department's actions were not adequate because the hiring authority did not refer the sergeant's potential misconduct to the Office of Internal Affairs in a timely manner and the Office of Internal Affairs declined to open an investigation.

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

Assessment Questions

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

  The hiring authority did not refer the potential misconduct to the Office of Internal Affairs until 60 days after it was discovered.

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

  The OIG disagreed with the Office of Internal Affairs' decision not to open an investigation because there was a reasonable belief misconduct occurred, supporting the need for an investigation.

Incident Date	OIG Case Number	Case Type
2015-11-14	15-2420-RO	Other Significant Incident

Incident Summary

On November 14, 2015, a lieutenant, a sergeant, and officers saw an inmate tying a piece of cloth to the top of a cell and making a noose with the other end. The inmate put on the noose and the sergeant cut the cloth from the top of the cell. The lieutenant and an officer used physical force to stop the inmate's actions. Officers escorted the inmate to the triage and treatment area for treatment of minor self-inflicted neck injuries.

Disposition

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

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-11-17	**15-2427-RO**	**Other Significant Incident**

Incident Summary

On November 17, 2015, an officer saw an inmate cutting the inmate's own arm with a razor blade in a cell. A second officer responded and the first officer provided first aid to the inmate. A sergeant and a nurse transported the inmate to the triage and treatment area where 35 sutures were used to close the wound.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-11-24	**15-2557-RO**	**Other Significant Incident**

Incident Summary

On November 24, 2015, two inmates started a fire in their cell. An officer activated his alarm and used a fire extinguisher to extinguish the fire. Officers removed the two inmates from their cell and evacuated all inmates from the housing unit due to smoke. Outside emergency and fire crews responded. Several inmates were treated at the institution for smoke inhalation. The department transported the two inmates who started the fire to outside hospitals and they returned to the institution the same day.

Disposition

The hiring authority identified a deficiency in the manner in which officers were called to the emergency and provided training to sergeants and lieutenants. The hiring authority also identified a lack of plastic handcuffs and disposable respirator masks during the incident and implemented a system to ensure these items are available. The hiring authority also had the fire exit door and exhaust fans tested and repaired.

Overall Assessment

The department's actions were not adequate because sergeants and lieutenants did not summon officers to the emergency according to alarm response procedures and the fire exit door and exhaust fans did not function properly.

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

Assessment Questions

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

  Sergeants and lieutenants did not summon officers to the emergency according to alarm response procedures and the fire exit door and exhaust fans in the unit did not function properly during the emergency.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-11-24	**15-2571-RO**	**In-Custody Inmate Death**

Incident Summary

On November 24, 2015, an inmate informed an officer that he was not feeling well. Nurses transported the inmate to the triage and treatment area where he informed the nurses that he had ingested methamphetamine. The inmate's heart stopped and nurses and a paramedic initiated life-saving measures. The department life-flighted the inmate to an outside hospital where he was placed on life-support. On November 29, 2015, a physician removed the inmate from life-support and pronounced the inmate dead.

Disposition

The coroner determined the death was accidental, caused by methamphetamine overdose. The department's Death Review Committee determined the death was not preventable. The hiring authority did not identify any staff misconduct. The institution took steps to identify the source of the drugs but was unable to do so.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2015-12-02	**15-2581-RO**	**Other Significant Incident**

Incident Summary

On December 2, 2015, an inmate refused to exit a cell for transfer to a different institution. Minutes later, the inmate's cellmate alerted an officer that the inmate was trying to commit suicide. The officer saw a rubber band and a torn sheet around the inmate's neck. The officer and a sergeant removed the cellmate from the cell and saw that the inmate was unresponsive. Officers removed the rubber band and transported the inmate to the triage and treatment area and then to an outside hospital. The inmate returned to the institution the same day and sustained no injuries.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-12-16	**16-0786-RO**	**PREA**

Incident Summary

On December 16, 2015, an officer allegedly asked and a physician allegedly performed a body cavity search of an inmate for possible contraband, which included digital penetration of the inmate's vagina, without complying with departmental policy. No contraband was located. Neither the nurse who observed the procedure nor the physician documented the search in the inmate's medical record.

Disposition

The hiring authority identified potential staff misconduct based on the inmate's allegation of sexual assault by medical staff during a body cavity search. Therefore, the hiring authority referred the matter to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, but only as to the physician's failures to document the inmate's medical record regarding the incident, seek authorization, and use proper medical equipment. The OIG accepted the case for monitoring but did not concur with the Office of Internal Affairs' decision because the Office of Internal Affairs should have opened an investigation regarding the potential failure of the officer, nurse, and physician to comply with all departmental policies regarding body cavity searches. The OIG elevated the issue to Office of Internal Affairs' management, who also made an incorrect decision regarding the scope and subjects of the investigation.

Overall Assessment

The department's actions prior to, during, and after the incident were not adequate because custody and medical staff did not comply with critical departmental policies regarding body cavity searches, the special agent did not consult with the OIG before finalizing and submitting her inquiry memorandum, and her memorandum failed to reference relevant departmental policies. Also, although the facts warranted an investigation as to the officer and the nurse and additional allegations as to the physician, the Office of Internal Affairs authorized only a limited investigation as to the physician.

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

Assessment Questions

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

  The department did not comply with policies requiring justification and authorization before conducting a body cavity search and policies requiring proper supervision and medical documentation during the search. Also, the OIG disagreed with the Office of Internal Affairs' decision to not open an investigation into the possible misconduct by the nurse and the officer and to not address all the potential misconduct by the physician.

- Was the critical incident adequately documented?

  The special agent who conducted the inquiry did not identify all relevant departmental policies regarding body cavity searches.

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

  The special agent did not consult with the OIG regarding the contents of the memorandum regarding her inquiry before submitting it to the Office of Internal Affairs.

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

  The OIG identified that the officer and medical staff failed to articulate probable cause for the body cavity search, the department lacked proper authorization to conduct a body cavity search, and the department failed to properly supervise the process.

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

  The Office of Internal Affairs did not open an investigation regarding the failure of the officer, the nurse, and the physician to comply with all departmental policies regarding body cavity searches.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-12-28	**16-0111-RO**	**Other Significant Incident**

Incident Summary

On December 28, 2015, an inmate informed an officer that another inmate was exhibiting self-injurious behavior. The officer found the second inmate standing in a cell with one end of a noose tied loosely around the inmate's neck and the other end tied around an overhead pipe. The inmate refused orders to remove the noose, but allowed the officer to remove it, and officers escorted the inmate to the triage and treatment area.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2016-01-13	**16-0272-RO**	**Other Significant Incident**

Incident Summary

On January 13, 2016, an inmate swallowed pills and informed an officer. The department transported the inmate to the triage and treatment area and later to an outside hospital. The inmate returned to the institution on January 15, 2016.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Assessment Questions

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

  The department did not notify the OIG until six days after the mental health provider determined the inmate attempted suicide.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-01-14	**16-0398-RO**	**Hunger Strike**

Incident Summary

On January 14, 2016, an inmate initiated a hunger strike because he wanted to be in a cell by himself. On February 12, 2016, the inmate ended the hunger strike. The inmate lost approximately 29 pounds, or 15 percent of his body weight.

Disposition

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

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2016-01-16	**16-0232-RO**	**Other Significant Incident**

Incident Summary

On January 16, 2016, two inmates began fighting on an exercise yard. Officers used less-lethal rounds and pepper spray to stop the fight. Nurses treated both inmates for minor injuries consistent with fighting. One inmate sustained a minor head injury and stated the injury may have been caused by a less-lethal round.

Disposition

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

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-01-22	**16-0301-RO**	**Other Significant Incident**

Incident Summary

On January 22, 2016, an inmate reported swallowing a toothbrush to a psychologist. The department placed the inmate on suicide watch and later transported the inmate to an outside hospital. The inmate returned to the institution the following day after a negative x-ray.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Assessment Questions

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

  The department did not notify the OIG until approximately two hours after a department psychiatrist determined the inmate attempted suicide.

Incident Date	OIG Case Number	Case Type
2016-01-26	**16-0322-RO**	**Other Significant Incident**

Incident Summary

On January 26, 2016, an inmate swallowed pills then informed an officer. The officer and a nurse transported the inmate to the triage and treatment area.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Assessment Questions

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

  The department did not notify the OIG until nearly two hours after a psychologist determined the inmate attempted suicide.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-01-27	**16-0643-RO**	**Hunger Strike**

Incident Summary

On January 27, 2016, an inmate initiated a hunger strike to protest alleged mistreatment by staff and alleged missing property at his prior institution. As of March 7, 2016, the inmate had lost 16 percent of his body weight. On March 10, 2016, the inmate ended the hunger strike.

Disposition

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

Overall Assessment

The department's response was not adequate because the department did not notify the OIG preventing the OIG from real-time monitoring of the case.

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

Assessment Questions

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

  The department did not notify the OIG that the inmate had been on hunger strike for ten consecutive days and did not notify the OIG when the inmate lost more than 10 percent of his body weight.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-02-01	**16-0350-RO**	**Other Significant Incident**

Incident Summary

On February 1, 2016, custody staff conducted a controlled cell extraction of a pregnant inmate who was two weeks past her due date and had refused medical treatment for several weeks. The inmate kicked the officers, and officers used physical force to place the inmate on a gurney. An ambulance transported the inmate to an outside hospital and she returned to the institution on February 4, 2016. The inmate delivered her baby, and neither the inmate nor the baby sustained injuries.

Disposition

The institution's executive review committee determined the use of force complied with departmental policy, but found that the lieutenant and sergeant did not ensure that a custody staff member remained at the cell door to monitor the inmate after it was determined that a cell extraction would be conducted. During the video recording of the incident, an officer video recorded a portion of the clinical intervention, in violation of departmental policy. The hiring authority provided training to the lieutenant, sergeant, and officer. The OIG concurred.

Overall Assessment

The department's response was not adequate because an officer did not remain at the cell door to monitor the inmate when it was determined a cell extraction would be conducted and an officer videotaped a portion of the clinical intervention.

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

Assessment Questions

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

  The department's actions were not adequate because custody supervisors did not ensure that an officer remained at the cell to monitor the inmate and an officer video recorded a portion of the clinical intervention.

Incident Date	OIG Case Number	Case Type
2016-02-02	**16-0469-RO**	**Other Significant Incident**

Incident Summary

On February 2, 2016, an inmate punched an officer, rendering the officer unconscious. A lieutenant and second officer used physical force to restrain the inmate, and were injured. The department transported the lieutenant and the officers to an outside hospital where they were treated and released the same day. The department transported the inmate to an outside hospital, following which he returned to the institution. The department referred the case to the district attorney.

Disposition

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

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-02-15	**16-0525-RO**	**Other Significant Incident**

Incident Summary

On February 15, 2016, an officer observed an inmate sitting on a bunk with a shoelace tied around the inmate's neck. A sergeant and officers entered the cell, and the sergeant cut the shoelace from the inmate's neck. Officers escorted the inmate to the triage and treatment area for treatment of minor injuries.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2016-02-17	**16-0539-RO**	**Other Significant Incident**

Incident Summary

On February 17, 2016, an officer responded to an inmate banging on a cell door and observed the inmate's cellmate sitting on a chair, bleeding from the arm. Officers escorted the cellmate to the triage and treatment area and later to an outside hospital where 16 sutures were needed to close the self-inflicted lacerations. The inmate returned to the institution the same day.

Disposition

The department's interdisciplinary treatment team re-classified the inmate's actions as non-suicidal, self-injurious behavior. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-02-24	**16-0605-RO**	**In-Custody Inmate Death**

Incident Summary

On February 24, 2016, inmates alerted an officer that another inmate needed medical assistance. The officer found the inmate on the floor and helped him get up from the floor. Nurses transported the inmate to the triage and treatment area, following which the department transported him to an outside hospital where a physician pronounced him dead.

Disposition

The coroner determined the cause of death was a heart attack. The department's Death Review Committee determined the death was not preventable. The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Assessment Questions

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

  The department did not notify the OIG until nearly 90 minutes after the inmate died.

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

  The department did not provide the OIG with a copy of the incident report until nearly three weeks after the incident and after the OIG requested it three times.

Incident Date	OIG Case Number	Case Type
2016-02-25	**16-0621-RO**	**In-Custody Inmate Death**

Incident Summary

On February 25, 2016, a boulder struck an inmate firefighter in the head while the inmate was working on a fire in the community. The inmate was air-lifted to an outside hospital and died on February 26, 2016.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-03-13	**16-0804-RO**	**Other Significant Incident**

Incident Summary

On March 13, 2016, a lieutenant observed an inmate in a cell with a bloody hand and lacerated arm. The lieutenant and an officer escorted the inmate to the triage and treatment area, following which the department transported the inmate to an outside hospital for treatment of the self-inflicted wound. The inmate returned to the institution a few hours later.

Disposition

The hiring authority did not identify any staff misconduct.

Overall Assessment

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

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

Incident Date	OIG Case Number	Case Type
2016-03-29	**16-0996-RO**	**In-Custody Inmate Death**

Incident Summary

On March 29, 2016, an officer discovered an unresponsive inmate alone in his cell. A nurse and an officer initiated life-saving measures. The department transported the inmate to an outside hospital where he died the following day.

Disposition

An autopsy determined the manner of death was accidental, caused by fentanyl intoxication. The department's emergency medical response review committee determined the emergency response was adequate. The hiring authority did not identify any staff misconduct. The institution took steps to identify the source of the drugs but was unable to do so.

Overall Assessment

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

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-04-04	**16-1036-RO**	**Other Significant Incident**

Incident Summary

On April 4, 2016, on officer observed an inmate swallow pills and a cut on the inmate's arm. Additional officers responded and escorted the inmate to the triage and treatment area.

Disposition

The hiring authority for the psychiatric technician determined the psychiatric technician's failure to conduct the daily contact on the fourth day following the incident was due to an inadequate procedure to notify mental health clinicians who work on weekends or holidays of the inmates requiring daily contact. The hiring authority developed a new notification procedure and provided training to all mental health providers.

Overall Assessment

The department's response was not adequate because the department did not notify the OIG in a timely and sufficient manner, preventing the OIG from real-time monitoring of the case, and a psychiatric technician did not provide contact with the inmate on one of the required five days following the incident.

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

Assessment Questions

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

  The department did not notify the OIG until more than two hours after a psychologist determined the inmate attempted suicide.

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

  A psychiatric technician did not provide contact with the inmate on one of the required five days following the incident.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-05-20	**16-1658-RO**	**Other Significant Incident**

Incident Summary

On May 20, 2016, an officer allegedly negligently discharged his holstered personal firearm inside an institutional firearms storage locker.

Disposition

The hiring authority identified potential staff misconduct based on the negligent discharge of a firearm; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

The department's response was not adequate because the department did not timely notify the Office of Internal Affairs or the OIG and did not collect and properly examine the firearm involved.

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

Assessment Questions

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

  The department learned of the incident on May 20, 2016, but the hiring authority did not notify the Office of Internal Affairs until May 21, 2016, one day later.

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

  The department learned of the incident on May 20, 2016, but the hiring authority did not notify the OIG until May 21, 2016, one day later.

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

  The department did not timely notify the Office of Internal Affairs and the OIG.

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

  The investigative services unit did not collect and properly examine the firearm involved.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-05-24	**16-1651-RO**	**Hunger Strike**

Incident Summary

On May 24, 2016, the department transported an inmate who had been on hunger strike since May 6, 2016, to an outside hospital due to dehydration. The inmate returned to the institution the same day. As of May 27, 2016, the inmate had lost 12 percent of his body weight. On June 1, 2016, the inmate ended his hunger strike.

Disposition

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

Overall Assessment

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

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

APPENDIX F 47
CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-12-22	**2015-12-26**	**Suspected Drugs**	**Nothing**

Incident Summary 15-15217-CWRM

On December 22, 2015, the department placed an inmate on contraband surveillance watch after officers observed suspected drugs in the inmate's rectum during an unclothed body search. The department removed the inmate from contraband surveillance watch on December 26, 2015, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-04-02	**2016-04-06**	**Suspicious Activity**	**Nothing**

Incident Summary 16-15282-CWRM

On April 2, 2016, the department placed an inmate on contraband surveillance watch after officers observed him swallow bindles of suspected drugs. The department removed the inmate from contraband surveillance watch on April 6, 2016, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers and sergeants did not complete adequate documentation. The hiring authority provided training to sergeants and officers for the inadequate documentation.

Assessment Questions

- Did the department complete appropriate documentation?

  Sergeants and officers did not consistently document supervisory and hygiene checks.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hygiene checks.

- Overall, did the department substantially comply with CSW policies and procedures?

  Sergeants and officers did not consistently document supervisory and hygiene checks.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to sergeants and officers for the inadequate documentation.

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-05-04	**2016-05-08**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15304-CWRM

On May 4, 2016, the department placed an inmate on contraband surveillance watch after the inmate told an an officer that he secreted bindles of drugs in his rectum. The department transported the inmate to an outside hospital because it was suspected that the bindles may have ruptured. The department removed the inmate from contraband surveillance watch after he returned to the institution on May 8, 2016. 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. The department did not complete adequate documentation. The hiring authority provided training to correctional supervisors, officers, and a nurse to address these deficiencies.

Assessment Questions

- Did the department conduct required medical assessments?

  A nurse did not complete a medical assessment on the inmate.

- Did the department comply with policies and procedures when the inmate's placement on CSW was extended beyond the initial 72 hours?

  A counselor supervisor did not ensure a 72-hour extension was completed and that the OIG was notified of the extension.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document the inmate had access to proper hygiene.

- Did the department complete appropriate documentation?

  Sergeants and officers did not adequately document supervisory checks or the opportunity for proper hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  Supervisory checks, access to proper hygiene, a medical assessment, and a 72-hour extension were not adequately documented.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to a counselor supervisor, a nurse, sergeants, and officers regarding documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-05-22	**2016-05-26**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15317-CWRM

On May 22, 2016, the department placed an inmate on contraband surveillance watch after officers saw him swallow bindles during a visit. The department removed the inmate from contraband surveillance watch on May 26, 2016, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Sufficient

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

CENTRAL REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-05-27	**2016-05-30**	**Suspected Weapons**	**Mobile Phone**

Incident Summary

16-15320-CWRM

On May 27, 2016, the department placed an inmate on contraband surveillance watch after he could not pass the metal detector during random searches. The department removed the inmate from contraband surveillance watch on May 30, 2016, three days later. During that time, the department recovered a mobile phone from the inmate.

Incident Assessment

Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-12-04	**2015-12-08**	**Suspicious Activity**	**Mobile Phone**

Incident Summary 15-15198-CWRM

On December 4, 2016, the department placed an inmate on contraband surveillance watch after the inmate failed to pass a metal detector. The department removed the inmate from contraband surveillance watch on December 8, 2016, four days later. During that time, the department recovered a cell phone from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-12-16	**2015-12-21**	**Suspected Weapons**	**1. Inmate Note** **2. Weapons**

Incident Summary 15-15207-CWRM

On December 16, 2015, the department placed an inmate on contraband surveillance watch after receiving information the inmate was in possession of an inmate-manufactured weapon. The department removed the inmate from contraband surveillance watch on December 21, 2015, five days later. During that time, the department recovered a weapon 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
2015-12-16	**2015-12-21**	**Suspected Weapons**	**Inmate Note**

Incident Summary 15-15210-CWRM

On December 16, 2015, the department placed an inmate on contraband surveillance watch after receiving information the inmate was in possession of an inmate-manufactured weapon. The department removed the inmate from contraband surveillance watch on December 21, 2015, five days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-12-16	**2015-12-20**	**Suspected Weapons**	**Nothing**

Incident Summary 15-15211-CWRM

On December 16, 2015, the department placed an inmate on contraband surveillance watch after receiving information the inmate was in possession of an inmate-manufactured weapon. The department removed the inmate from contraband surveillance watch on December 20, 2015, four days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-12-16	**2015-12-22**	**Suspected Weapons**	**Nothing**

Incident Summary — 15-15212-CWRM

On December 16, 2015, the department placed an inmate on contraband surveillance watch after receiving information the inmate was in possession of an inmate-manufactured weapon. The department removed the inmate from contraband surveillance watch on December 22, 2015, six days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment — Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-12-17	**2015-12-21**	**Suspicious Activity**	**1. Drugs** **2. Inmate Note**

Incident Summary — 15-15213-CWRM

On December 17, 2015, the department placed an inmate on contraband surveillance watch after officers observed him ingesting a bindle of suspected drugs and officers recovered suspected methamphetamine. The department removed the inmate from contraband surveillance watch on December 21, 2015, four days later. During that time, the department recovered an inmate note and drugs from the inmate.

Incident Assessment — Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-12-27	**2015-12-31**	**Suspicious Activity**	**Drugs**

Incident Summary — 15-15221-CWRM

On December 27, 2015, the department placed an inmate on contraband surveillance watch after officers observed him place unknown objects into his mouth during visiting. The department removed the inmate from contraband surveillance watch on December 31, 2015, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment — Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-01-02	**2016-01-08**	**Suspicious Activity**	**Nothing**

Incident Summary — 16-15223-CWRM

On January 2, 2016, the department placed an inmate on contraband surveillance watch because an officer saw the inmate swallow an unknown object during a search. The department removed the inmate from contraband surveillance watch on January 8, 2016, six days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment — Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-01-18	**2016-01-21**	**Suspicious Activity**	**Inmate Note**

Incident Summary

16-15229-CWRM

On January 18, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate take an unknown object from his pocket and swallow it. The department removed the inmate from contraband surveillance watch on January 21, 2016, three days later. During that time, the department recovered three bindles containing 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
2016-02-02	**2016-02-06**	**Suspected Weapons**	**Inmate Note**

Incident Summary

16-15236-CWRM

On February 2, 2016, the department placed an inmate on contraband surveillance watch after officers received information that he had secreted a weapon. The department removed the inmate from contraband surveillance watch on February 6, 2016, four days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment

Insufficient

The department did not comply with policies and procedures governing contraband surveillance watch because the department did not timely notify the OIG when placing the inmate on contraband surveillance watch. The hiring authority provided training to supervisors.

Assessment Questions

- Did the department timely notify the OIG Regional AOD when the inmate was placed on CSW?

  The department notified the OIG 20 hours after placing the inmate on contraband surveillance watch.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not timely notify the OIG.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The OIG identified the institution's failure to timely notify the OIG when placing the inmate on contraband surveillance watch.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-02-06	**2016-02-22**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15242-CWRM

On February 6, 2016, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow a bindle during visiting. The department removed the inmate from contraband surveillance watch on February 22, 2016, 16 days later. During that time, the department recovered six bindles of marijuana and methamphetamine from the inmate.

Incident Assessment

Insufficient

The department did not comply with policies and procedures governing contraband surveillance watch. The department did not adequately conduct or document supervisory checks or adequately document or provide the inmate with hygiene and range of motion opportunities. The department provided training to the officers and supervisors to address the deficiencies.

Assessment Questions

- Did the department complete appropriate documentation?

  The department did not conduct supervisory welfare checks on several occasions.

- Did application of restraints comply with CSW policies and procedures?

  Officers did not adequately document range of motion.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not adequately document offering the inmate the opportunity to wash his hands.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not substantially comply with contraband surveillance watch policies and procedures related to range of motion, hand hygiene, and supervisory checks.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The OIG identified that the department did not adequately document range of motion, hand hygiene, and supervisory checks.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-02-16	**2016-02-21**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15249-CWRM

On February 16, 2016, the department placed an inmate on contraband surveillance watch after an officer saw the inmate place an item in his mouth and swallow it. The department removed the inmate from contraband surveillance watch on February 21, 2016, five days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-02-18	**2016-02-22**	**Suspicious Activity**	**Inmate Note**

Incident Summary

16-15255-CWRM

On February 18, 2016, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow an unknown object during an unclothed body search. The department removed the inmate from contraband surveillance watch on February 22, 2016, four days later. During that time, the department recovered inmate notes from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-02-28	**2016-03-05**	**Suspicious Activity**	**Drugs**

Incident Summary

16-15263-CWRM

On February 28, 2016, the department placed an inmate on contraband surveillance watch after an officer observed bindles in the inmate's mouth during an unclothed body search. The inmate surrendered one bindle, which tested positive for methamphetamine, but swallowed the remaining bindles. The department removed the inmate from contraband surveillance watch on March 5, 2016, six days later. During that time, the department recovered additional methamphetamine from the inmate.

Incident Assessment

Insufficient

The department did not comply with policies and procedures governing contraband surveillance watch. The department did not adequately conduct or document required supervisory checks, and provided training to address this deficiency.

Assessment Questions

- Did the department complete appropriate documentation?

  The department did not conduct supervisory welfare checks on several occasions.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not substantially comply with contraband surveillance watch policies and procedures based on supervisory check requirements.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The OIG identified the lack of supervisory checks.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority found that officers failed to document removing the inmate's blanket on one occasion and failed to document dental hygiene and blanket issuance on two occasions. The hiring authority provided training to the officers.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-03-02	**2016-03-06**	**Suspected Drugs,Tobacco,Suspicious Activity**	**1. Drugs** **2. Tobacco**

Incident Summary

16-15265-CWRM

On March 2, 2016, the department placed an inmate on contraband surveillance watch after officers observed lubricant around the inmate's rectum during an unclothed body search. The department removed the inmate from contraband surveillance watch on March 6, 2016, four days later. During that time, the department recovered tobacco and drugs from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not conduct a required medical assessment or adequately document activities during contraband surveillance watch. The department provided training to address the deficiencies.

Assessment Questions

- Did the department complete appropriate documentation?

  Officers did not consistently sign in on the daily activity documentation.

- Did application of restraints comply with CSW policies and procedures?

  Officers did not adequately document range of motion.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not adequately document hand hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not complete a required medical evaluation or adequately document hand hygiene, range of motion, cell inspections, or sign-in on the daily activity documentation.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The OIG identified the lack of documentation.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified that officers did not document a cell inspection, range of motion, or sign in on the daily activity documentation. The hiring authority provided training to the officers.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-03-10	**2016-03-14**	**Suspicious Activity**	**Drugs**

Incident Summary

16-15270-CWRM

On March 10, 2016, the department placed an inmate on contraband surveillance watch after an officer observed lubricant around the inmate's rectum during an unclothed body search. The department removed the inmate from contraband surveillance watch on March 14, 2016, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-03-12	**2016-03-18**	**Suspected Weapons**	**Mobile Phone**

Incident Summary

16-15275-CWRM

On March 12, 2016, the department placed an inmate on contraband surveillance watch after the inmate failed to pass a metal detector. The department removed the inmate from contraband surveillance watch on March 18, 2016, six days later. During that time, the department recovered a mobile phone from the inmate.

Incident Assessment

Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-03-13	**2016-03-23**	**Suspicious Activity**	**Drugs**

Incident Summary

16-15276-CWRM

On March 13, 2016, the department placed an inmate on contraband surveillance watch after officers observed the inmate swallow a bindle during a visit. The department removed the inmate from contraband surveillance watch on March 23, 2016, ten days later. During that time, the department recovered two bindles of marijuana from the inmate.

Incident Assessment

Insufficient

The department did not comply with policies and procedures governing contraband surveillance watch. The department did not complete adequate documentation, conduct supervisory checks, provide the inmate with proper hygiene opportunities, or timely complete an internal audit. The department provided training to the officers and supervisors to address the deficiencies.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not adequately document hand washing opportunities.

- Did the department complete appropriate documentation?

  The department did not adequately document supervisory checks and did not document the presence or absence of contraband discovered during a bowel movement.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not adequately complete documentation and an associate warden did not timely complete an internal audit document.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified that an associate warden did not timely complete an internal audit document, sergeants did not adequately document supervisory checks, and officers did not document the presence or absence of contraband discovered during a bowel movement.

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-04-15	**2016-04-19**	**Suspected Weapons**	**1. Inmate Note** **2. Weapons**

Incident Summary 16-15291-CWRM

On April 15, 2016, the department placed an inmate on contraband surveillance watch after he failed to pass a metal detector. The department removed the inmate from contraband surveillance watch on April 19, 2016, four days later. During that time, the department recovered inmate notes and weapons from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-04-22	**2016-04-26**	**Suspected Mobile Phone**	**Mobile Phone**

Incident Summary 16-15295-CWRM

On April 22, 2016, the department placed an inmate on contraband surveillance watch after the inmate failed to pass a metal detector test. The department removed the inmate from contraband surveillance watch on April 26, 2016, four days later. During that time, the department recovered a mobile phone from the inmate.

Incident Assessment Sufficient

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

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-05-07	**2016-05-10**	**Suspected Drugs**	**Drugs**

Incident Summary

16-15306-CWRM

On May 7, 2016, the department placed an inmate on contraband surveillance watch after an officer observed a bulge in the inmate's cheek after the inmate received a kiss from a visitor. The department removed the inmate from contraband surveillance watch on May 10, 2016, three 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. The department did not obtain approval to extend contraband surveillance, conduct a required medical evaluation, provide opportunities for inmate hygiene, or adequately conduct or document supervisory checks. The department provided training to address the deficiencies.

Assessment Questions

- Did the department conduct required medical assessments?

  The department did not complete the initial medical evaluation until one hour after placement.

- Did the department complete appropriate documentation?

  The assigned officer did not sign in and a correctional supervisor did not document conducting an inmate check during one shift.

- Did the department comply with policies and procedures when the inmate's placement on CSW was extended beyond the initial 72 hours?

  The department did not obtain the proper authorization to extend the inmate's placement on contraband surveillance watch.

- Did the department comply with policies and procedures governing hygiene requirements?

  The department did not adequately document hand washing opportunities.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not obtain the proper authorization to extend the inmate on contraband surveillance watch after 72 hours, did not perform a timely medical evaluation, and did not complete required documentation.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified that the department did not obtain the proper authorization to extend the inmate on contraband surveillance watch after 72 hours, did not perform a timely medical evaluation, and did not complete required documentation and also identified untimely notification to the OIG. The department provided training to all officers and supervisors assigned to the contraband surveillance watch.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-06-19	**2015-06-22**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15064-CWRM

On June 19, 2015, the department placed an inmate on contraband surveillance watch after the inmate reported swallowing a razor blade and an x-ray confirmed the presence of a foreign object. The department removed the inmate from contraband surveillance watch on June 22, 2015, three days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not timely notify the OIG and officers did not complete adequate documentation. The hiring authority provided training to four officers but did not address all of the deficiencies and did not provide training to all involved officers. The OIG recommended further action based on prior training, but the hiring authority declined.

Assessment Questions

- Did the department timely notify the OIG Regional AOD when the inmate was placed on CSW?

  The department did not notify the OIG until two hours and fifteen minutes after placing the inmate on contraband surveillance watch.

- Did the department comply with policies and procedures when the inmate was placed on CSW?

  Officers did not document an unclothed body search prior to placing the inmate on contraband surveillance watch.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document the inmate was afforded the opportunity to wash his hands prior to meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not consistently document the issuance and removal of a blanket, hand hygiene, trash removal, dental hygiene, supervisory checks, and range of motion.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not adequately document the initial unclothed body search, hand hygiene, trash removal, dental hygiene, restraint checks, restraint hygiene, range of motion, supervisory checks, blanket issuance and removal, and request for additional staff when the inmate had a bowel movement.

- If the OIG identified a policy violation or issue that resulted in, or should have resulted in, corrective action, including training, did the department take corrective action or provide training?

  The hiring authority addressed some but not all of the documentation deficiencies.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to officers for inadequate documentation related to blanket removal and the initial search of the isolated area.

- Did the OIG make a recommendation to the hiring authority?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-07-03	**2015-07-09**	**Suspected Weapons**	**Weapons**

Incident Summary

15-15076-CWRM

On July 3, 2015, the department placed an inmate on contraband surveillance watch after an inmate told officers that he swallowed razor blades and an x-ray confirmed the presence of a foreign object. The department removed the inmate from contraband surveillance watch on July 9, 2015, six days later. During that time, the department recovered a razor blade from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately document hygiene. The hiring authority did not identify the deficiency but provided training to the officers after the OIG presented the hiring authority with the deficiency.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hand washing before meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not consistently document hand washing before meals and after using the restroom.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The OIG identified that officers did not consistently document hand washing before meals and after using the restroom.

- Did the OIG make a recommendation to the hiring authority?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-07-06	**2015-07-12**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15077-CWRM

On July 6, 2015, the department placed an inmate on contraband surveillance watch after a psychiatric technician observed the inmate swallow razor blades. The department removed the inmate from contraband surveillance watch on July 12, 2015, six days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately document inmate hygiene. The hiring authority provided training to officers for not documenting the issuance and removal of a blanket and for not documenting inmate hygiene. The OIG recommended further action based on prior training provided to the officers, but the hiring authority declined.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hand washing before meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not adequately document inmate hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not consistently document hand washing before meals and after using the restroom.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The OIG identified that officers did not consistently document hand washing before meals and after using the restroom.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to officers regarding documentation of blanket issuance and removal.

- Did the OIG make a recommendation to the hiring authority?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-06	**2015-08-13**	**Suspected Weapons**	**Weapons**

Incident Summary

15-15098-CWRM

On August 6, 2015, the department placed an inmate on contraband surveillance watch after the inmate informed officers that he swallowed a razor blade. The department removed the inmate from contraband surveillance watch on August 13, 2015, seven days later. During that time, the department recovered a razor blade from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately document hygiene and supervisory checks. The hiring authority provided training to the officers. Two of the officers had previously received documented training regarding contraband surveillance watch. The OIG recommended further corrective action for these officers, but the hiring authority declined.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hand washing prior to meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not adequately document the initial search of the isolated area or inmate hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  The OIG identified the lack of documentation.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to sergeants and officers related to the inadequate documentation.

- Did the OIG make a recommendation to the hiring authority?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-06	**2015-08-14**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15100-CWRM

On August 6, 2015, the department placed an inmate on contraband surveillance watch after he informed staff that he swallowed a razor blade . The department removed the inmate from contraband surveillance watch on August 14, 2015, eight days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not consistently document inmate hygiene or range of motion, and there were gaps where there was no documentation regarding the inmate's activities. Supervisors did not consistently document required checks. The hiring authority provided training to a lieutenant, four sergeants, and ten officers. The OIG recommended further action, but the hiring authority declined.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hand washing prior to meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not adequately document inmate hygiene, blanket issuance and removal, supervisor reviews, and range of motion.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to a lieutenant, four sergeants, and ten officers for inadequate documentation.

- Did the OIG make a recommendation to the hiring authority?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-10	**2015-08-20**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15101-CWRM

On August 10, 2015, the department placed an inmate on contraband surveillance watch after the inmate informed nurses that he swallowed a razor blade. The department removed the inmate from contraband surveillance watch on August 20, 2015, ten days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not timely notify the OIG when placing the inmate on contraband surveillance watch or when extending contraband surveillance watch. An officer allowed a hospital chaplain to enter the inmate's room while the inmate was on contraband surveillance watch at an outside hospital. Officers did not adequately document cell inspections or hygiene. The hiring authority provided training to a sergeant and eleven officers. The OIG recommended further action based on prior training, but the hiring authority declined.

Assessment Questions

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document hand washing prior to meals and after using the restroom.

- Did the department timely notify the OIG Regional AOD when the inmate was placed on CSW?

  The department notified the OIG two hours and six minutes after placing the inmate on contraband surveillance watch.

- Did the department complete appropriate documentation?

  Officers did not consistently document hygiene.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not timely notify the OIG of the inmate's initial placement on contraband surveillance watch and did not timely notify the OIG of the second extension on contraband surveillance watch. Officers did not consistently document hygiene, cell inspections, blanket issuance and removal, and supervisory checks.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to officers and a sergeant for inadequate documentation during the incident.

- Did the OIG make a recommendation to the hiring authority?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  Based on prior training provided to officers, the OIG recommended that the hiring authority take further action to address the deficiencies, but the hiring authority declined.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-08-24	**2015-08-30**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15110-CWRM

On August 24, 2015, the department placed an inmate on contraband surveillance watch because an x-ray revealed the possible presence of razor blades in the inmate's stomach. The department removed the inmate from contraband surveillance watch on August 30, 2015, six days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch because the department did not adequately process the request to extend the inmate on contraband surveillance watch.

Assessment Questions

- Did the department comply with policies and procedures when the inmate's placement on CSW was extended beyond the initial 72 hours?

  The department released the inmate from contraband surveillance watch on August 30, 2015, because the authorization to extend the inmate had not been processed.

- Did the department complete appropriate documentation?

  The department did not timely process the request to extend the inmate on contraband surveillance watch.

- Did the department comply with policies and procedures governing the inmate's removal from CSW?

  The department removed the inmate from contraband surveillance watch despite an x-ray confirming two foreign objects in his stomach. The inmate remained under supervision at the hospital and returned to contraband surveillance watch the following day.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not timely process the request to extend the inmate on contraband surveillance watch and prematurely released the inmate from contraband surveillance watch.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified the failure to process the request to extend contraband surveillance watch. However, the hiring authority did not provide training because the administrative officer of the day no longer works at the institution.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-09-01	**2015-09-07**	**Suspected Drugs,Suspicious Activity**	**Drugs**

Incident Summary

15-15122-CWRM

On September 1, 2015, the department placed an inmate on contraband surveillance watch after officers discovered two packages of methamphetamine in his cell and officers observed lubricant around the inmate's anal cavity. The department removed the inmate from contraband surveillance watch on September 7, 2015, six days later. During that time, the department recovered methamphetamine from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not completely document hygiene, blanket issuance and removal, trash removal, range of motion, and supervisory checks. The hiring authority provided training to officers related to the range of motion deficiency only. The OIG recommended further action based on the additional deficiencies identified by the OIG, but the hiring authority did not take further action.

Assessment Questions

- Did the department complete appropriate documentation?

  Officers did not consistently document hand hygiene, range of motion, trash removal, blanket issuance and removal, and supervisory checks.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not consistently document hand hygiene prior to meals and after restroom use, blanket issuance and removal, trash removal, supervisory checks, and range of motion.

- If the OIG identified a policy violation or issue that resulted in, or should have resulted in, corrective action, including training, did the department take corrective action or provide training?

  The hiring declined to address the deficiencies identified by the OIG.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority identified deficiencies only in the documentation of the range of motion, and provided training to the officers.

- Did the OIG make a recommendation to the hiring authority?

  The OIG recommended further action, based on the training that had already been provided to the involved officers. The hiring declined to address the deficiencies identified by the OIG.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  The OIG recommended further action, based on the training that had already been provided to the involved officers. The hiring declined to address the deficiencies identified by the OIG.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-10-01	**2015-10-06**	**Suspicious Activity**	**Nothing**

Incident Summary

15-15149-CWRM

On October 1, 2015, the department placed an inmate on contraband surveillance watch after the inmate refused to comply with an unclothed body search. The department removed the inmate from contraband surveillance watch on October 6, 2015, five days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not place the inmate in restraints when they placed the inmate on contraband surveillance watch and did not completely document hygiene and range of motion. The hiring authority provided training to the officers.

Assessment Questions

- Did the department complete appropriate documentation?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom and did not consistently document range of motion.

- Did the department comply with policies and procedures when the inmate was placed on CSW?

  Officers did not place the inmate in restraints until nearly three hours after they placed him on contraband surveillance watch.

- Did application of restraints comply with CSW policies and procedures?

  Officers did not place the inmate in restraints until nearly three hours after they placed him on contraband surveillance watch.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals and after using the restroom.

- Overall, did the department substantially comply with CSW policies and procedures?

  The department did not place the inmate in restraints until nearly three hours after the contraband surveillance watch began. Officers did not adequately document the incident.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to officers for not adequately documenting inmate hygiene and range of motion.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-11-12	**2015-11-15**	**Suspected Drugs**	**Nothing**

Incident Summary

15-15187-CWRM

On November 12, 2015, the department placed an inmate on contraband surveillance watch after officers observed the inmate placing an unknown object into his mouth. The department removed the inmate from contraband surveillance watch on November 15, 2015, three days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. The department did not obtain proper authorization before applying leg restraints and did not appropriately document range of motion or hygiene. The hiring authority issued employee counseling records and provided training to address some deficiencies. However, the hiring authority declined to take further action to address the hygiene deficiencies despite the OIG's recommendation.

Assessment Questions

- Did the department complete appropriate documentation?

  Officers did not consistently document hand hygiene prior to meals.

- Did application of restraints comply with CSW policies and procedures?

  The department placed the inmate in leg restraints without proper authorization.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands prior to meals.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers placed the inmate in leg restraints without proper authorization. Officers did not consistently document hand hygiene prior to meals.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not consistently document hand hygiene prior to meals.

- If the OIG identified a policy violation or issue that resulted in, or should have resulted in, corrective action, including training, did the department take corrective action or provide training?

  The OIG recommended the hiring authority take corrective action based on the lack of documentation regarding hand hygiene but the hiring authority declined.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  Officers initially placed the inmate in leg restraints without proper justification and authorization. The hiring authority issued employee counseling records to a lieutenant, a sergeant, and an officer. The hiring authority provided training to an officer for inadequate documentation related to releasing the inmate's hands for range of motion.

- Did the OIG make a recommendation to the hiring authority?

  The OIG recommended the hiring authority take corrective action based on the lack of documentation regarding hand hygiene.

- If the OIG made a recommendation to the hiring authority, did the hiring authority implement the recommendation?

  The OIG recommended the hiring authority take corrective action based on the lack of documentation regarding hand hygiene but the hiring authority declined.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2015-11-20	**2015-11-23**	**Suspected Weapons**	**Nothing**

Incident Summary

15-15191-CWRM

On November 20, 2015, the department placed an inmate on contraband surveillance watch after an x-ray revealed a foreign body in the shape of a razor blade in his abdomen. The department removed the inmate from contraband surveillance watch on November 23, 2015, three days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch. Officers did not adequately document whether an initial cell search and unclothed body search were conducted when the department placed the inmate on contraband surveillance watch, whether the inmate was issued proper attire, when a mattress and blanket were issued and removed, or the inmate's hygiene. The hiring authority provided training and written counseling to address the deficiencies.

Assessment Questions

- Did the department comply with policies and procedures when the inmate was placed on CSW?

  Officers did not document an initial cell search, unclothed body search, and issuance of proper contraband surveillance watch attire.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was allowed to wash his hands with soap and water prior to eating meals and after using the restroom.

- Did the department complete appropriate documentation?

  Officers did not adequately document hygiene and blanket and mattress issuance and removal. Officers did not document an initial cell search, unclothed body search, and issuance of proper contraband surveillance watch attire.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not adequately document the incident.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not document an initial cell search, unclothed body search, and issuance of proper contraband surveillance watch attire.

- If the OIG identified a policy violation or issue that resulted in, or should have resulted in, corrective action, including training, did the department take corrective action or provide training?

  The hiring authority did not address the deficiencies related to the initial cell search, unclothed body search, and issuance of proper contraband surveillance watch attire.

- Did the hiring authority identify a policy violation or issue and take corrective action, including training?

  The hiring authority provided training to two officers for not documenting blanket removal and to a sergeant for removing a mattress. The hiring authority issued an employee counseling record to an officer for not adequately documenting hand hygiene.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-01-16	**2016-01-21**	**Suspicious Activity**	**Nothing**

Incident Summary

16-15230-CWRM

On January 16, 2016, the department placed an inmate on contraband surveillance watch after an officer in the visiting area observed the inmate reach into a bag and then place his hand in his pants. The department removed the inmate from contraband surveillance watch on January 21, 2016, five days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Insufficient

The department did not sufficiently comply with policies and procedures governing contraband surveillance watch because officers did not adequately document hygiene, cell inspections, restraint checks, observations regarding the inmate's use of the restroom, and supervisory checks. The hiring authority took no action related to the deficiencies.

Assessment Questions

- Did the department complete appropriate documentation?

  Officers did not consistently document restraint and cell checks at the beginning of each shift or consistently document hygiene. Officers also did not document that the inmate appeared to reinsert an object into his rectum three times while on contraband surveillance watch, and made incomplete entries regarding the inmate's use of the restroom.

- Did the department comply with policies and procedures governing hygiene requirements?

  Officers did not consistently document that the inmate was afforded an opportunity to wash his hands before meals and after using the restroom.

- Overall, did the department substantially comply with CSW policies and procedures?

  Officers did not consistently document restraint and cell checks at the beginning of each shift or consistently document hygiene. Officers also did not document that the inmate appeared to reinsert an object into his rectum three times while on contraband surveillance watch, and made incomplete entries regarding the inmate's use of the restroom.

- Did the OIG identify a policy violation or issue that resulted in, or should have resulted in, corrective action, including training?

  Officers did not adequately document hygiene and observations of the inmate.

- If the OIG identified a policy violation or issue that resulted in, or should have resulted in, corrective action, including training, did the department take corrective action or provide training?

  The hiring authority did not address the deficiencies the OIG identified.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-01-17	**2016-01-18**	**Suspicious Activity**	**Nothing**

Incident Summary

16-15231-CW

On January 17, 2016, an officer discovered two bindles of methamphetamine on an inmate's visitor after visitation. The department placed the inmate on contraband surveillance watch after the inmate asked how drugs could be removed from his system. On January 18, 2016, the department transported the inmate to an outside hospital after he complained of abdominal pain. The department removed the inmate from contraband surveillance watch the same day, after a negative x-ray. During that time, the department recovered no contraband from the inmate.

Incident Assessment

Sufficient

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

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-02-10	**2016-02-10**	**Suspected Drugs**	**Nothing**

Incident Summary 16-15245-CW

On February 10, 2016, the department placed an inmate on contraband surveillance watch after he informed a supervisor he was feeling ill and had swallowed suspected drugs. The department transported the inmate to an outside hospital, following which he returned to the institution. The department removed the inmate from contraband surveillance watch the same day. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-02-20	**2016-02-24**	**Suspicious Activity**	**Drugs**

Incident Summary 16-15252-CWRM

On February 20, 2016, the department placed an inmate on contraband surveillance watch because an officer observed the inmate reach into pants after a visitor gave him an unknown item. The department removed the inmate from contraband surveillance watch on February 24, 2016, 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
2016-02-21	**2016-02-23**	**Suspected Drugs**	**Drugs**

Incident Summary 16-15253-CW

On February 21, 2016, an inmate told a nurse that he swallowed several bindles of heroin. The department transported the inmate to an outside hospital and placed the inmate on contraband surveillance watch after an x-ray revealed foreign objects in his abdomen. The department removed the inmate from contraband surveillance watch on February 23, 2016, two days later. During that time, the department recovered six bindles of 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
2016-02-21	**2016-02-23**	**Suspected Drugs**	**Drugs**

Incident Summary 16-15254-CW

On February 21, 2016, an inmate told a nurse that he swallowed several bindles of heroin. The department transported the inmate to an outside hospital and placed the inmate on contraband surveillance watch after an x-ray revealed foreign objects in his abdomen. The department removed the inmate from contraband surveillance watch on February 23, 2016, two days later. During that time, the department recovered seven bindles of heroin from the inmate.

Incident Assessment Sufficient

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

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-04-04	**2016-04-08**	**Suspicious Activity**	**1. Drugs** **2. Inmate Note**

Incident Summary 16-15283-CWRM

On April 4, 2016, the department placed an inmate on contraband surveillance watch after two officers observed the inmate reach into his pocket and place an unknown object into his mouth. The department removed the inmate from contraband surveillance watch on April 8, 2016, four days later. During that time, the department recovered two inmate notes and 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
2016-05-01	**2016-05-04**	**Suspicious Activity**	**Nothing**

Incident Summary 16-15300-CWRM

On May 1, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate place an unknown object in his mouth and swallow it. The department removed the inmate from contraband surveillance watch on May 4, 2016, three days later. During that time, the department recovered no contraband from the inmate.

Incident Assessment Sufficient

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

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2016-05-03	**2016-05-07**	**Suspected Drugs**	**Drugs**

Incident Summary 16-15302-CWRM

On May 3, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate swallow a bindle. The department removed the inmate from contraband surveillance watch on May 7, 2016, 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
2016-05-15	**2016-05-20**	**Suspicious Activity**	**Drugs**

Incident Summary 16-15311-CWRM

On May 15, 2016, the department placed an inmate on contraband surveillance watch after an officer observed the inmate with a bindle of suspected drugs in his mouth. The department removed the inmate from contraband surveillance watch on May 20, 2016, five days later. During that time, the department recovered one bindle containing heroin from the inmate.

Incident Assessment Sufficient

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

APPENDIX G 31
FIELD INQUIRY CASE SUMMARIES
CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-02-23	**15-0413-FI**	**Field Inquiry**

Incident Summary
On February 23, 2015, an inmate's mother submitted a complaint to the OIG alleging her son was the victim of sexual abuse by another inmate and that her son lost credits and privileges because he reported sexual abuse. On March 12, 2015, the inmate submitted a complaint to the OIG alleging the department mishandled his report of sexual assault.

Disposition
The institution sufficiently investigated and resolved the inmate's report of an alleged sexual assault by another inmate. The OIG concurred with the institution's findings. However, the OIG expressed concern regarding officers' inappropriate comments during the inmate's interview and recommended the hiring authority provide required Prison Rape Elimination Act training. The hiring authority confirmed the officers received the required training.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-04-15	**15-0781-FI**	**Field Inquiry**

Incident Summary
On April 15, 2015, an inmate submitted a complaint to the OIG alleging that inmates in the kitchen were forced to urinate in trash cans or floor drains because they had no access to bathrooms at certain times and that the kitchen did not have soap or paper towels available to inmates.

Disposition
In response to the complaint, the institution changed the local policy to require officers to provide hourly bathroom breaks for kitchen workers and to ensure the bathroom is stocked with soap and paper towels.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-04-19	**15-0812-FI**	**Field Inquiry**

Incident Summary
On April 19, 2015, an inmate's sister submitted a complaint to the OIG alleging that the institution did not address her brother's safety concern although he had notified officers of the safety concern. The brother subsequently fought with the other inmate and both sustained burns when struggling over a pot of boiling water during the fight.

Disposition
The inmate's sister had also complained to the department and the institution conducted a confidential inquiry. In response to the complaint, the institution determined the inmate's appeal had been incorrectly treated as an allegation of staff misconduct when it should have been treated as an inmate allegation review. The institution then conducted the allegation review.

Overall Assessment
Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-08-27	15-1737-FI	Field Inquiry

Incident Summary

On August 27, 2015, an inmate submitted a complaint to the OIG alleging an Office of Internal Affairs' special agent concealed information regarding an investigation from the OIG and that a senior special agent threatened to retaliate against the inmate if the inmate reported the allegation.

Disposition

The hiring authority conducted an inquiry which failed to yield sufficient evidence to warrant conducting a full investigation.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-10-29	15-2316-FI	Field Inquiry

Incident Summary

On October 29, 2015, an inmate submitted a complaint to the OIG alleging he was battered by custody staff and his inmate appeals were destroyed instead of properly handled.

Disposition

The OIG determined the inmate's appeals were appropriately reviewed and the hiring authority agreed to install lock boxes to reduce the risk that appeals were not properly handled. The hiring authority identified potential staff misconduct based on custody staff allegedly not reporting the use of force. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs did not open an investigation.

Overall Assessment

Rating: **Insufficient**

The department did not sufficiently address the matter because the hiring authority neglected to provide the OIG with the request for investigation sent to the Office of Internal Affairs.

Assessment Questions

- **Did the department adequately consult with the OIG regarding the field inquiry?**

  The hiring authority did not provide the OIG with a copy of the draft request for investigation prior to forwarding to the Office of Internal Affairs and did not notify the OIG when the request was sent.

Incident Date	OIG Case Number	Case Type
2015-11-15	15-2412-FI	Field Inquiry

Incident Summary

On November 15, 2015, a State Senate staff member submitted a complaint to the OIG alleging inmates were strip-searched in front of staff members of the opposite sex and denied food and restrooms for eight hours.

Disposition

The hiring authority identified potential staff misconduct based on allegations of excessive force, failure to report force, and sexual harassment. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2015-12-15	15-2691-FI	Field Inquiry

Incident Summary

On December 15, 2015, an inmate's parents submitted a complaint to the OIG alleging their son was not receiving proper mental health treatment, that he was ignored when he expressed suicidal thoughts, and that he did not receive mental health care until after he tried to hang himself. They also alleged the inmate was watching R-rated movies, saw his clinician in a setting without privacy, and moved to a non-mental health yard without regard for his safety concerns.

Disposition

The institution sufficiently investigated and resolved the allegations and the department ultimately transferred the inmate to another institution to better accommodate his mental health and safety concerns. The OIG concurred with the institution's actions.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-12-29	15-2340-FI	Field Inquiry

Incident Summary

On December 29, 2015, an inmate submitted a complaint to the OIG alleging custody staff battered him because he had previously reported staff misconduct.

Disposition

After the OIG consulted with the hiring authority, the hiring authority forwarded the inmate's allegations to the Office of Internal Affairs for inclusion in an already-open investigation, which the OIG had accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2016-01-14	16-0433-FI	Field Inquiry

Incident Summary

On January 14, 2016, an inmate submitted a complaint to the OIG alleging his cellmate sexually assaulted him. However, the department did not timely notify the OIG of the inmate's complaint.

Disposition

The hiring authority addressed the inmate's allegation and provided training to the involved staff on notification requirements.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate's complaint and the OIG's field inquiry regarding the department's untimely notification to the OIG.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2016-02-24	**16-0616-FI**	**Field Inquiry**

Incident Summary

On February 24, 2016, an inmate submitted a complaint to the OIG alleging a sergeant rubbed the inmate's hand against his genitals twice and the institution did not address her complaints. The institution did not notify the OIG.

Disposition

The hiring authority conducted an inquiry and found insufficient evidence for a referral to the Office of Internal Affairs. The hiring authority agreed to ensure the OIG is timely notified of similar complaints in the future.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry regarding the inmate's complaint and the untimely notification to the OIG.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-05-11	15-0961-FI	Field Inquiry

Incident Summary

On May 11, 2015, an inmate submitted a complaint to the OIG alleging that he was denied time out of his cell and that some of his property, including a radio, was missing when he arrived to his current institution from another institution. The inmate further alleged that his appeals had not been processed.

Disposition

The hiring authority did not identify any staff misconduct. The department responded to the inmate's appeal by providing the inmate with a replacement radio, which he disputed was not substantially the same as his missing radio. The institution subsequently offered the inmate another radio, which he accepted.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-07-20	15-1477-FI	Field Inquiry

Incident Summary

On July 20, 2015, an inmate submitted a complaint to the OIG alleging that the department did not conduct an investigation into allegations that unidentified persons sexually assaulted him.

Disposition

The department's institutional Prison Rape Elimination Act review committee determined that the inmate's allegation was unsubstantiated. The OIG concurred.

Overall Assessment

Rating: **Insufficient**

The department did not sufficiently address the matter because the investigative services unit did not timely complete an investigation into the allegation and the hiring authority did not timely review the inmate's allegation or adequately cooperate with the OIG.

Assessment Questions

- **Did the department adequately complete the documents that the OIG reviewed in connection with the OIG's field inquiry?**

  The hiring authority was aware of the allegation on May 21, 2015, but did not complete the review of the allegation of sexual misconduct until January 29, 2016, more than eight months later.

- **Did the investigative services unit or equivalent investigative personnel adequately respond to the OIG's field inquiry?**

  The investigative services unit did not timely notify the OIG of the allegation and did not timely complete the investigation into the inmate's allegation.

- **Did the department adequately consult with the OIG regarding the field inquiry?**

  The hiring authority did not timely respond to the OIG's requests for updates regarding the investigation.

- **Was the department's overall response to the OIG's field inquiry appropriate?**

  Despite the OIG's field inquiry, the hiring authority did not timely review the inmate's allegations, delaying both before and after the OIG's inquiry.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-09-16	15-1927-FI	Field Inquiry

Incident Summary

On September 16, 2015, an inmate submitted a complaint to the OIG alleging that an appeals coordinator failed to process three complaints of sexual harassment against three officers in order to protect them. The inmate also reported having a learning disability and alleged that a counselor, case worker, and the program office staff refused to assist him in filing appeals.

Disposition

The department processed the inmate's complaints and, pending departmental policy changes, the institution changed local policies to ensure Prison Rape Elimination Act allegations submitted through the appeals process are timely and appropriately addressed. The hiring authority determined that the inmate did not request or require assistance in filing the complaints.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-10-21	15-2278-FI	Field Inquiry

Incident Summary

On October 21, 2015, an inmate submitted a complaint to the OIG alleging a cook touched him inappropriately. The department did not notify the OIG.

Disposition

The hiring authority addressed the inmate's allegation and trained staff on the Prison Rape Elimination Act and the OIG notification criteria.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate's complaint and the OIG's field inquiry regarding the department's untimely notification to the OIG.

Incident Date	OIG Case Number	Case Type
2015-10-22	16-0504-FI	Field Inquiry

Incident Summary

On October 22, 2015, an inmate submitted a complaint to the OIG alleging a certified nursing assistant sexually harassed him. The institution did not notify the OIG.

Disposition

The hiring authority provided training to lieutenants and administrative officers of the day regarding the OIG's notification requirements for Prison Rape Elimination Act allegations.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate’s complaint and the OIG’s field inquiry regarding the department’s untimely notification to the OIG.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2015-12-02	15-2700-FI	Field Inquiry

Incident Summary

On December 2, 2015, an inmate submitted a complaint alleging that an officer made inappropriate sexual comments and squeezed his genitals, buttocks, and chest during clothed body searches. The department did not notify the OIG.

Disposition

Before the OIG's inquiry, the hiring authority had identified potential staff misconduct based on allegations of improper clothed body searches. Therefore, the hiring authority referred the case to the Office Of Internal Affairs for investigation. The Office of Internal Affairs did not open an investigation. Although the department's inquiry did not reveal any staff misconduct, the hiring authority provided training in conducting clothed body searches and agreed to ensure that staff timely notify the OIG of such allegations.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate's complaint and the OIG's field inquiry regarding the department's untimely notification to the OIG.

Incident Date	OIG Case Number	Case Type
2015-12-03	15-2594-FI	Field Inquiry

Incident Summary

On December 3, 2015, an inmate submitted a complaint to the governor's office, which was routed to the OIG for response, alleging he was not provided with adequate assistance with a medical disability, resulting in pain, injury, and exposure to unsanitary living conditions.

Disposition

The OIG's clinicians reviewed the inmate's medical records and found he was receiving appropriate care. In addition, the OIG independently conducted an unannounced inspection of the inmate's living unit and found conditions to be sanitary.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2016-01-08	16-0162-FI	Field Inquiry

Incident Summary

On January 8, 2016, an inmate notified the OIG that he had filed an appeal with the department alleging officers made repeated sexual comments toward him, in violation of the Prison Rape Elimination Act. The department did not notify the OIG of the allegations.

Disposition

The department provided training to the institution's administrative officers of the day pertaining to Prison Rape Elimination Act notification.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate's complaint and the OIG's field inquiry regarding the department's untimely notification to the OIG.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-01-24	15-2033-FI	Field Inquiry

Incident Summary

On January 24, 2016, an inmate submitted a complaint alleging a psychologist had him masturbate for her enjoyment and then when he refused to continue doing so, retaliated by filing a false rules violation report.

Disposition

The hiring authority determined the inmate's complaint to be unfounded and ensured the inmate is not on the psychologist's caseload. The hiring authority also determined that the rules violations report was appropriate. The OIG concurred.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2016-01-27	16-0316-FI	Field Inquiry

Incident Summary

On January 27, 2016, an inmate submitted a complaint to the OIG alleging he was being transferred to another institution in retaliation for reporting staff misconduct.

Disposition

Before the OIG received the complaint, the hiring authority identified potential staff misconduct based on nine officers and two sergeants allegedly retaliating against several inmates and threatening them with disciplinary action, transfers, and assaults after they reported staff misconduct. In addition, three of the nine officers allegedly made sexual comments to the inmates during unclothed body searches. The hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2016-02-09	16-0423-FI	Field Inquiry

Incident Summary

On February 9, 2016, an inmate's wife submitted a complaint to the OIG alleging a lieutenant harassed and threatened her husband because she and the lieutenant had a brief casual relationship which she ended.

Disposition

The institution conducted an inquiry and the hiring authority identified no staff misconduct.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2016-02-17	16-0594-FI	Field Inquiry

Incident Summary

On February 17, 2016, an inmate submitted a complaint to the OIG alleging that officers beat and sexually assaulted him. The department did not notify the OIG.

Disposition

The hiring authority provided training regarding critical incident notification requirements.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate's complaint and the OIG's field inquiry regarding the department's untimely notification to the OIG.

Incident Date	OIG Case Number	Case Type
2016-03-02	16-0800-FI	Field Inquiry

Incident Summary

On March 2, 2016, an inmate alleged that while he slept, his cellmate put his hands underneath his clothing and touched his genitals and buttocks. The department did not notify the OIG.

Disposition

The hiring authority opened an inquiry into the inmate's allegations and directed custody staff to provide timely notification to the OIG.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate's complaint and the OIG's field inquiry regarding the department's untimely notification to the OIG.

Incident Date	OIG Case Number	Case Type
2016-03-07	16-0844-FI	Field Inquiry

Incident Summary

On March 7, 2016, an inmate submitted a complaint to the OIG alleging that the department was not following hunger strike protocols that require that a captain interview an inmate every five days following the beginning of a hunger strike. The department did not notify the OIG.

Disposition

In response to the complaint, the institution changed its procedure to require the public information officer to ensure that hunger strike conferences with captains are properly documented. Additionally, the institution provided training to managers on hunger strike notification requirements.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the inmate's complaint and the OIG's field inquiry regarding the department's untimely notification to the OIG.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-06-05	15-1153-FI	Field Inquiry

Incident Summary

On June 5, 2015, an inmate submitted a complaint to the OIG alleging the department did not adequately address his appeal related to an allegation of excessive force.

Disposition

The institution's executive review committee determined the use of force complied with departmental policy. Based on the OIG's recommendation, the hiring authority conducted an inquiry into the inmate's allegation and determined there was insufficient evidence to support the claim. The hiring authority provided training to a lieutenant for not conducting a timely video-recorded interview in response to the inmate's allegation.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Assessment Questions

- **Did the department adequately complete the documents that the OIG reviewed in connection with the OIG's field inquiry?**

  The department did not timely conduct a video-recorded interview with the inmate after the inmate alleged excessive force.

Incident Date	OIG Case Number	Case Type
2015-09-18	15-1849-FI	Field Inquiry

Incident Summary

On September 18, 2015, a private citizen submitted a complaint to the OIG alleging that an inmate received an unwarranted rules violation for being in possession of authorized tools.

Disposition

The hiring authority conducted an inquiry and determined that the tools in the inmate's possession were unauthorized inmate-manufactured tools.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-09-24	15-1969-FI	Field Inquiry

Incident Summary

On September 24, 2015, an inmate's family member submitted a complaint to the OIG alleging the inmate was being disciplined for positive drug tests that were a result of lawfully prescribed medication.

Disposition

The OIG confirmed with the laboratory supervisor that the prescription medication would not have caused the inmate's positive drug results. However, the OIG also determined that in two of the inmate's rules violation reports, the department did not comply with procedures for addressing inmate assertions that a positive drug test was the result of a prescribed medication. The department revoked those two rules violation reports and provided training to all hearing officers regarding the procedures. The OIG also recommended that custody staff clearly document when inmates are afforded the opportunity to challenge positive drug tests as set forth in the department's procedures. The department agreed to train custody staff to provide this added documentation.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2015-11-23	15-2731-FI	Field Inquiry

Incident Summary

On November 23, 2015, an inmate submitted a complaint to the OIG alleging a nurse yelled profanities toward the inmate.

Disposition

The hiring authority identified potential staff misconduct based on a nurse being discourteous to an inmate. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs opened an investigation, which the OIG did not accept for monitoring.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2015-12-24	15-2926-FI	Field Inquiry

Incident Summary

On December 24, 2015, the OIG received an anonymous complaint alleging that the department was informed that a lieutenant slapped a female officer on the buttocks but the department failed to take action.

Disposition

The department reviewed the allegation of sexual harassment, interviewed the alleged victim, and determined the allegation was false.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Incident Date	OIG Case Number	Case Type
2016-01-04	16-0007-FI	Field Inquiry

Incident Summary

On January 4, 2016, an inmate submitted a complaint to the OIG alleging that officers used excessive force on another inmate.

Disposition

The institution's executive review committee determined the force used during the incident was in compliance with departmental policy. The department conducted an inquiry regarding the inmate's allegations and determined there was insufficient evidence to support the allegations. The OIG concurred.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

Assessment Questions

- **Did the department adequately complete the documents that the OIG reviewed in connection with the OIG's field inquiry?**

  The hiring authority provided training to a lieutenant because he did not adequately record the inmate's alleged injuries during the initial video-recorded interview.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2016-04-08	**16-1086-FI**	**Field Inquiry**

Incident Summary

On April 8, 2016, the OIG received a complaint from an inmate's mother stating someone struck the inmate with a "lock in a sock," but the department inappropriately determined the matter should not be referred to the district attorney's office for possible prosecution.

Disposition

Following consultation with the OIG, the department reevaluated the memorandum of understanding with the local district attorney's office and referred the matter to the district attorney's office for possible prosecution.

Overall Assessment

Rating: **Sufficient**

The department sufficiently addressed the OIG's field inquiry.

SEMI-ANNUAL REPORT

January–June 2016

Volume II

OFFICE OF THE INSPECTOR GENERAL

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STATE OF CALIFORNIA
September 2016