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

***Shaun Spillane**, Chief Deputy Inspector General*

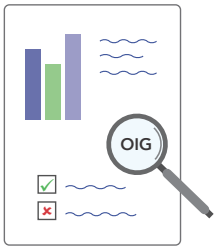
# OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2025

# 2024 Annual Report

*A Summary of Publications*



Electronic copies of reports published by the Office of the Inspector General are available free in portable document format (PDF) on our website.

We also offer an online subscription service.
For information on how to subscribe,
visit **www.oig.ca.gov**.

For questions concerning the contents of this report,
please contact Shaun Spillane, Public Information Officer,
at 916-288-4233.

***Connect with us on social media***


STATE of CALIFORNIA
OIG | OFFICE of the INSPECTOR GENERAL

Independent Prison Oversight

*Amarik K. Singh*, Inspector General
*Shaun Spillane*, Chief Deputy Inspector General

*Regional Offices*
Sacramento
Bakersfield
Rancho Cucamonga

March 3, 2025

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

Dear Governor and Legislative Leaders:

Enclosed please find our annual report summarizing the work that the Office of the Inspector General completed in 2024. In 2024, we issued 20 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: 10 reports on medical inspection results; two reports on our monitoring of the department's internal investigations and employee disciplinary process; one report on our monitoring of the department's use of force; one report on our monitoring of the department's staff misconduct complaints process, two audit reports, one special review, one sentinel case, one semiannual intake report, and our 2023 annual report. In addition, we released 40 case blocks for other operational units.

Respectfully submitted,

Amarik K. Singh
Inspector General

*Gavin Newsom*, Governor

10111 Old Placerville Road, Suite 110
Sacramento, California 95827
Telephone: (916) 288-4212
www.oig.ca.gov

*(This page left blank for reproduction purposes.)*

# Contents

# Illustrations

## *Figures*



## *Tables*



## *Photographs*



## *Exhibits*

# Foreword

## Vision

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

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

## Mission

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

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

*— Amarik K. Singh*
*Inspector General*

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

— *State of California*
***Penal Code section 6125***

# Organizational Overview and Functions

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

The Governor appoints the Inspector General to a six-year term, subject to California State Senate confirmation. The Governor appointed our current Inspector General, Amarik K. Singh, on December 22, 2021; her term will expire on August 25, 2028.

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

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

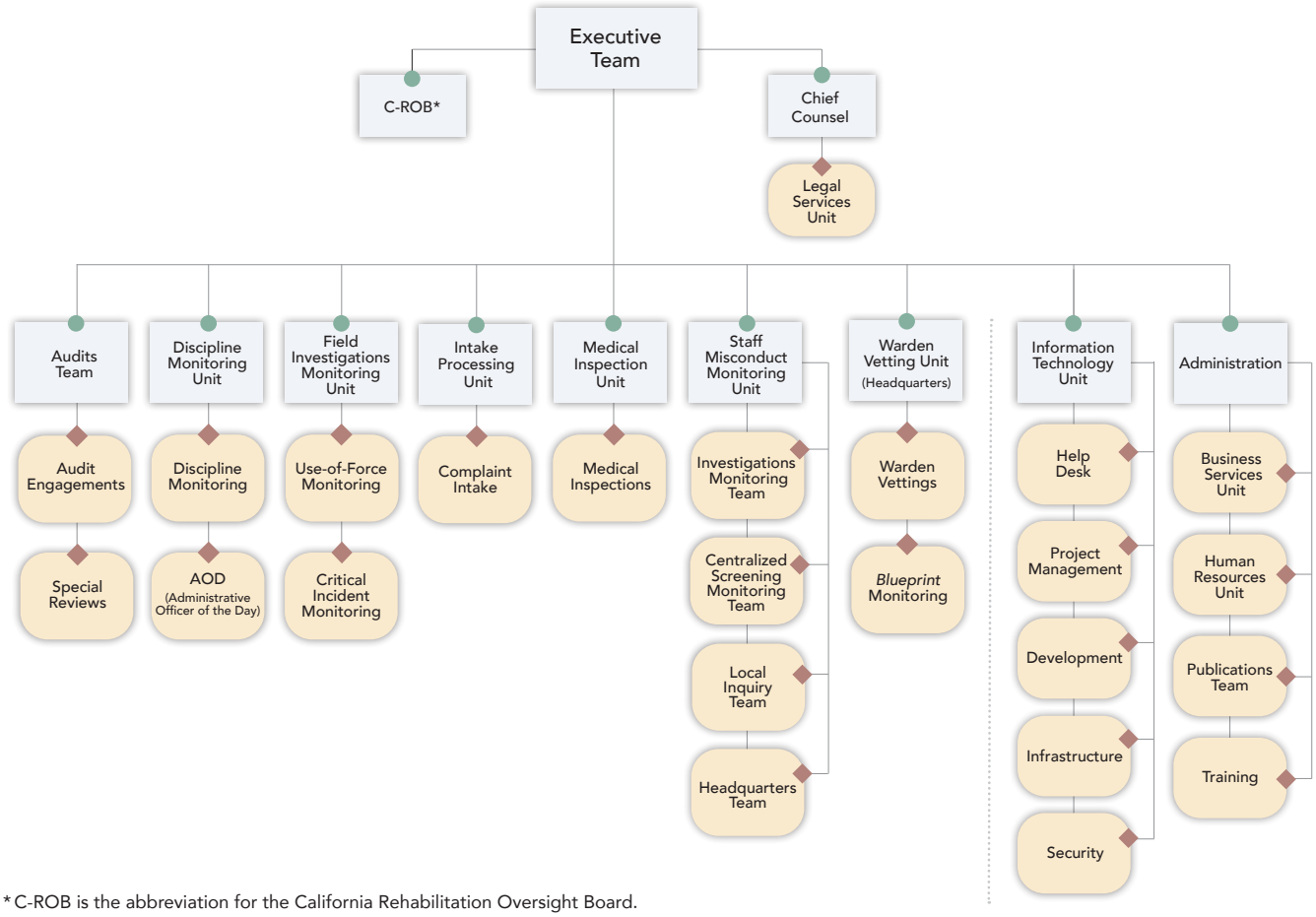
The OIG also employs a cadre of medical professionals, including physicians and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities,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

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

- Conduct medical inspections
- Carry out audits and authorized special reviews
- Staff the complaint hotline and intake unit
- Review, and when appropriate, investigate whistleblower retaliation complaints
- Handle complaints filed directly with the OIG by incarcerated persons, employees, and other stakeholders regarding the department

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

## Figure 1. The Office of the Inspector General Organizational Chart, 2024




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

*(This page left blank for reproduction purposes.)*

# Reports Published in 2024

## Internal Investigations and Employee Discipline Monitoring

The Discipline Monitoring Unit (DMU) attorneys are responsible for the contemporaneous oversight of the department's internal investigations and employee disciplinary process. The California Penal Code requires that the OIG publish its findings at least semiannually. We released two discipline monitoring reports in 2024. The first report, released in April 2024, covered the July through December 2023 reporting period and the second report, released in October 2024 covered the January through June 2024 reporting period.

During those two reporting periods, the Office of Internal Affairs addressed and made decisions concerning 2,227 referrals for investigation or for authorization to take disciplinary action without an investigation. Of those 2,227 referrals, the Office of Internal Affairs approved 2,069 for investigation or direct disciplinary action. Our staff monitored and assessed the department's more serious internal investigations of alleged employee misconduct, such as cases involving alleged dishonesty, code of silence, use of force, and criminal activity. During these two periods, we monitored and closed 394 cases, which was an increase from the 376 cases we had monitored and closed during the previous two reporting periods.

We categorized our assessment across three separate indicators and used each of the three indicators to assess the performance of three departmental entities as follows:

1. The performance of hiring authorities in discovering alleged employee misconduct, in referring allegations to the Office of Internal Affairs, and in making findings concerning investigations, allegations, and disciplinary determinations;

2. The performance of the Office of Internal Affairs in processing and analyzing referrals, and in investigating the allegations; and

3. The performance of department attorneys in providing legal advice to the Office of Internal Affairs and to the hiring authorities, and in representing the department in litigation regarding employee discipline.

These indicators are organized to reflect the performance of the three groups within the department across all stages of the investigative and disciplinary process from a case's inception to its ultimate conclusion. Indicator 1 was used to assess the hiring authority's performance, usually a warden. Indicator 2 was used to assess the Office of Internal

Affairs' performance, both at Central Intake Panel meetings and the special agent's performance during the investigation. Indicator 3 was used to assess the Employment Advocacy and Prosecution Team (EAPT) attorney's performance during the investigative and disciplinary phases.

The OIG has developed compliance- and performance-related questions that we use to assess each indicator. Our attorneys assigned to monitor each case answered these questions and rated each of the three indicators for each case using one of three ratings: *sufficient*, *sufficient with recommendations*, or *insufficient.* The following provides more detail about our rating terminology. In general, a *sufficient* rating means that the OIG did not identify any significant deficiencies. A *sufficient with recommendations* rating means that the OIG found significant deficiencies, but the deficiencies did not appear to cause a negative outcome for either the department or the case under review. An *insufficient* rating means that the OIG found significant deficiencies that caused a negative outcome for either the department or the case. We present our findings for the two reporting periods in Table 1 below.

**Table 1. Rating Percentages for the Reporting Periods July Through December 2023, and January Through June 2024**

| Rating | Rating Period | |
|---|---|---|
| | July Through December 2023 | January Through June 2024 |
| *Sufficient* | 25% | 16% |
| *Sufficient With Recommendations* | 45% | 51% |
| *Insufficient* | 30% | 33% |

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

The OIG also identified and made recommendations regarding the disciplinary process. In our discipline monitoring report released in April 2024, which covered the July through December 2023 reporting period, we made the following recommendations:

- We recommended that Office of Internal Affairs' special agents refrain from asking leading questions, wait for a complete response to a question before asking an interviewee another question, and ask an interviewee all relevant questions before disclosing information from an investigation.
- We also recommended that the department provide advice on a newly enacted California law to guide employees on expectations for off-duty cannabis use and to ensure that employees were receiving proper cannabis testing.

- Finally, we recommended that department attorneys provide the OIG with a draft of the prehearing settlement conference statement for review before filing it with the State Personnel Board, and allow sufficient time to review and provide feedback to the department attorney.

In our discipline monitoring report released in October 2024, which covered the January through June 2024 reporting period, we made the following recommendations:

- We recommended that the department establish policies or guidelines requiring department attorneys to contact stakeholders to ensure that investigative and disciplinary findings conferences would be completed within the time frames set by policy and without undue delay.
- We also recommended that the department extend its body-worn-camera video retention policy to secure important evidence.

In addition to publishing the two discipline monitoring reports, each month, we also publish our findings regarding individual cases on our public-facing website. Visit **www.oig.ca.gov**, click on our **Data Explorer tab**, and then select the section labeled **Case Summaries** to read our findings.

The OIG also monitors several types of critical incidents, including uses of deadly force and unexpected deaths of incarcerated people such as homicides, suicides, and deaths caused by an overdose of narcotics. Our findings regarding the department's performance in handling critical incidents can also be found on our public-facing website.

## Use-of-Force Monitoring

In August 2024, we published the report titled *Monitoring the Use-of-Force Review Process of California Department of Corrections and Rehabilitation*. This report addressed 730 use-of-force incidents that occurred within the California Department of Corrections and Rehabilitation (the department), and for which the department closed its reviews between January 1, 2023, and December 31, 2023. This report also highlighted 14 use-of-force incidents of significance that identified possible staff misconduct.

### *2023 Use-of-Force Statistics*

- We monitored 730 incidents that involved 2,649 applications of force (Figure 2, next page).
- Physical strength and holds accounted for 1,165 of the total applications (44 percent), while chemical agents accounted for 991 of the total applications (37 percent).
- The remaining use-of-force applications consisted of other options such as less-lethal projectiles, baton strikes, nonconventional uses of force, shields, the Mini-14 rifle, and tasers.

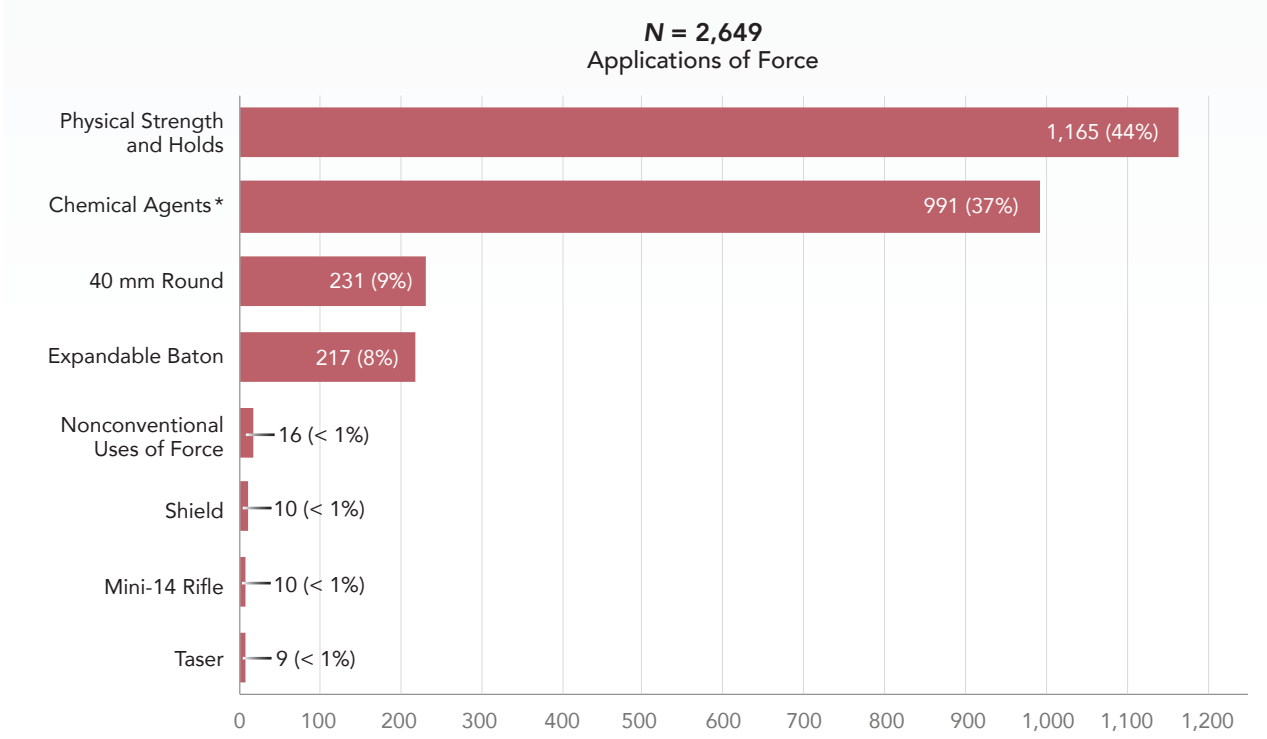
Figure 2 on the next page shows the distribution of the use-of-force applications we monitored during 2023.

In our annual use-of-force report issued the year before, in July 2023, we noted several incidents in which officers did not use de-escalation techniques before a use-of-force incident occurred. Officers' failures to de-escalate these situations often led to the unnecessary use of force. The July 2023 report also identified incidents in which officers used physical force instead of initiating a controlled use of force, even though no imminent threat justified the use of physical force. In our recent August 2024 report, we again highlighted incidents in which officers should have attempted de-escalation techniques before resorting to physical force.

Before 2020, the department's officer training curriculum included standalone de-escalation modules. However, the department abandoned these training modules during the COVID-19 pandemic. In response to our recommendation to reinstate its de-escalation training, the department advised our office that the current training curriculum was adequate and that no additional training would be provided. At the time of our August 2024 report, we continued to emphasize the importance of communication and de-escalation training, and reasserted our recommendation to reinstate it.

Another important issue highlighted in our August 2024 report involved the department's use of body-worn cameras and audio-video surveillance systems, which had recently been implemented at many

**Figure 2. Distribution of the Applications of Force in the 730 Use-of-Force Incidents the OIG Monitored in 2023**




*Chemical agents include oleoresin capsicum (OC), chloroacetophenone (CN) gas, and 2-chlorobenzalmalononitrile (CS) gas.

Note: Percentages may not sum to 100 percent due to rounding.

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

of the department's prisons. Body-worn cameras and fixed audio-video surveillance systems were not available at all prisons at the time this report was published; however, the department advised its plan was to continue installing them at additional prisons each year. In our July 2023 report, we noted supervisors and managers often failed to review and evaluate an adequate number of video recordings during their review process to determine whether staff had fully complied with policies and procedures. Again, in our July 2023 use-of-force report, we noted that access to an appropriate number of video recordings would have assisted departmental reviewers in determining whether staff had attempted to communicate with the incarcerated person to resolve the situation without using force.

In our August 2024 report, our inspectors found several additional issues involving body-worn cameras. In several incidents, officers failed to activate body-worn cameras while in the presence of incarcerated people, thereby precluding incidents from being captured on video, and subsequently, officers drafted reports that contradicted video-recorded evidence. The department also refused to hold supervisors and managers

accountable for failing to identify potential staff misconduct in their review of use-of-force incidents.

The department's policies require staff to consider using controlled force when no imminent threat is present. We attended a departmentally mandated remedial training session that was provided to in-service training representatives from each prison, at which time we learned training personnel emphasized that the department's operations manual only authorized staff to use immediate force if an imminent threat was present. Although the department has provided custody staff with remedial training, we continue to catalogue and review incidents in which officers used immediate force instead of controlled force when no imminent threat was present. No wardens, associate wardens, or captains attended this remedial training session. Because people from these classifications ultimately decide whether each use of force complied with departmental policy, their attendance at these trainings was critical.

### *2024 Use-of-Force Reporting*

In 2024, the OIG began reporting use-of-force incidents at regular intervals throughout the year, through a format we call *case blocks*. This change in our reporting structure allowed our staff to more frequently highlight significant use-of-force incidents as our inspectors closed them out, as opposed to waiting to release that information in an annual report. This new, accelerated reporting schedule has allowed us more flexibility to report the outcome of our efforts. Doing so is especially useful for cases we may have closed months before we would have released that information in an annual report. Producing case block publications provide our stakeholders and the public with cogent, timely reports that show how the department is handling use-of-force incidents at prisons.

From January 1, 2024, through December 31, 2024, our inspectors monitored 427 use-of-force incidents at all 33 prisons, the Division of Adult Parole Operations, and the Office of Correctional Safety. Of the 427 incidents we monitored in 2024, we considered the 33 incidents we reported on in our case blocks to be of the highest significance.

Overall, the most significant issue we identified was that officers and medical staff failed to report or timely report the use of force they had used or witnessed. This concern occurred in 16 of the significant incidents we published; we recommended the hiring authority refer these incidents for investigation. However, hiring authorities agreed to refer only three of these incidents for an investigation for failure to report the force used or witnessed. Failure to report force—either used or witnessed—has been an ongoing issue for the department, one our staff have raised in our two most recently published use-of-force reports. Prompt departmental reporting is essential to accurately document use-of-force incidents, especially considering those reports can serve as evidence in potential cases that may be opened for uses of force.

Departmental policy requires all staff who use or witness force to write a report on the same day the incident occurred, detailing the type of force.

Our inspectors also identified eight incidents in which departmental staff allegedly used excessive or unnecessary force. Departmental policy prohibits excessive and unnecessary force because such actions can contribute to injuries to both incarcerated people and prison staff. Our inspectors recommended that the department refer these eight incidents for investigation. However, departmental management agreed to refer only four of those incidents for investigation and declined to refer the remaining four incidents. In one case, officers used unnecessary physical force against an incarcerated person when no imminent threat was present. In this case, an incarcerated person in restraints was on the ground. Officers picked him up, and dragged and forced him to walk across a prison yard. On reviewing video footage of the incident, OIG inspectors identified the unnecessary use-of-force and also noted that the officers did not report their use of force. Our staff recommended that the hiring authority refer the officers for investigation, and the hiring authority agreed.

Another additional area of concern our inspectors identified was custody staff's failure to perform their duties in accordance with policy. In five of the significant incidents we published, staff failed to perform their duties, which contributed to the need for custody staff to use force. In one incident, our inspectors identified a control booth officer failed to secure housing unit doors, which allowed unauthorized incarcerated people to enter the housing unit and attack another incarcerated person using an inmate-manufactured weapon. The group of incarcerated people inflicted such significant injuries on their victim that he was transported to an outside hospital for additional care. The prison hiring authority initially recommended that the officer receive training; however, we recommended that the hiring authority refer the matter for investigation. Our inspector identified the officer's actions led to this significant assault. If the officer had followed policy and ensured the housing unit was secure, the prison would likely have avoided this use-of-force incident. The hiring authority ultimately agreed with the OIG and referred the control booth officer who failed to secure the housing unit door for investigation.

Beginning in 2025, the OIG will no longer issue an annual use-of-force report. Our office will adjust how we monitor and report on the department's handling of use-of-force incidents. This adjustment is designed to effectively align with recent changes concerning how departmental staff review use-of-force incidents. While we intend to continue periodically reporting significant incidents in our published case blocks, this year, our office will incorporate use-of-force incident monitoring activities into our staff misconduct reports, which are scheduled to be published semiannually.

## Medical Inspection Reports: Cycle 7

In 2024, the OIG continued its seventh cycle of medical inspections and published a total of 10 institutional medical inspection reports. In 2023, the OIG published one report for California State Prison, Los Angeles County, and at the beginning of 2024, the OIG published the second Cycle 7 report for Valley State Prison. However, following the publication of this report, the OIG retroactively amended the format of our reporting to bifurcate the overall institution ratings into individual ratings for the case review and compliance components of each report for greater clarity regarding our findings. Consequently, the OIG amended and republished the two reports for California State Prison, Los Angeles County, and Valley State Prison.

In addition, using this new format, the OIG published eight more reports for the following institutions: Wasco State Prison; California State Prison, Solano; California Rehabilitation Center; California State Prison, Corcoran; California Medical Facility; North Kern State Prison; Richard J. Donovan Correctional Facility; and Substance Abuse Treatment Facility and State Prison, Corcoran. Table 2 on the next page lists the institutions for which we completed our Cycle 7 inspections and issued our final reports in 2024, the month each report was published, and our overall individual component ratings for each institution. Through these reports, the OIG made several recommendations to the department to further improve the delivery of medical care to its patients; these recommendations can be viewed on the OIG's dashboard at www.oig.ca.gov.

In 2024, the OIG also completed all inspections of the following 14 additional institutions: Salinas Valley State Prison; California Correctional Institution; Avenal State Prison; Kern Valley State Prison; Central California Women's Facility; Correctional Training Facility; Centinela State Prison; Folsom State Prison; High Desert State Prison; California Institution for Women; California Men's Colony; Pelican Bay State Prison; Calipatria State Prison; and California State Prison, Sacramento. In 2025, we anticipate publishing these Cycle 7 inspection reports, completing our Cycle 7 inspections for all seven remaining institutions, and beginning our Cycle 8 inspection process.

Table 1 on the following page lists the institutions for which we completed our Cycle 7 inspections and issued final reports in 2024, the month each report was published, and our case review and compliance ratings for each institution.







Styling for the bifurcated rating seals used in MIU reports as introduced for Cycle 7.

## Table 2. The OIG's Medical Inspections for Cycle 7: Final Reports Published in 2024

*Adequate* *Inadequate*

| Institution Inspected | Publication Month | Overall Rating | |
|---|---|---|---|
| | | Case Review | Compliance |
| California State Prison, Los Angeles County | June | Inadequate | Inadequate |
| Valley State Prison | June | Adequate | Inadequate |
| Wasco State Prison | June | Inadequate | Inadequate |
| California State Prison, Solano | June | Adequate | Inadequate |
| California State Prison, Corcoran | August | Inadequate | Inadequate |
| California Medical Facility | August | Inadequate | Inadequate |
| California Rehabilitation Center | September | Adequate | Inadequate |
| North Kern State Prison | November | Adequate | Inadequate |
| Richard J. Donovan Correctional Facility | December | Adequate | Inadequate |
| Substance Abuse Treatment Facility and State Prison, Corcoran | December | Adequate | Inadequate |

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

## Staff Misconduct Monitoring

Pursuant to California Penal Code section 6126 (i), the Inspector General "shall provide contemporaneous oversight of grievances that fall within the department's process for reviewing and investigating inmate allegations of staff misconduct and other specialty grievances, examining compliance with regulations, department policy, and best practices."[1] In this report, we use the terms grievances and complaints synonymously. The law requires that we issue reports annually. This section covers the OIG's monitoring and assessment of the department's handling of its staff misconduct complaint process from January 1, 2023, through December 31, 2023.

### *Oversight Areas Reported During the 2023 Reporting Period*

From January 1, 2023, through December 31, 2023, the department reported receiving 183,051 complaints from incarcerated people, parolees, and third-party individuals or entities.[2] The department reported that it made the following screening decisions for the complaints it received in 2023:[3]

- 158,162 complaints routed and returned to prisons as routine issues[4]
- 12,520 complaints of staff misconduct routed to prisons for a local inquiry
- 11,149 complaints of staff misconduct routed to the Office of Internal Affairs' Allegation Investigation Unit for an investigation

We assessed the overall screening decisions of the department's Centralized Screening Team; the inquiry work of locally designated investigators; and the investigations conducted by the Office of Internal Affairs and the employee disciplinary process handled by hiring authorities and department attorneys. We utilized an assessment

1. Any person can submit a complaint of staff misconduct when they believe departmental staff have engaged in behavior that resulted in a violation of law, policy, regulation, or procedure, or an ethical or professional standard. Incarcerated people and parolees can file a CDCR Form 602-1, a CDCR Form 602-HC, Health Care grievance, or a CDCR Form 1824, Reasonable Accommodation Request. Third parties can submit a Citizen's Complaint in writing. The *California Code of Regulations* (CCR), Title 15, sections 3486(a)(1), 3486(b), and 3417.
2. Due to the department's phased roll out of the staff misconduct process, 6,237 complaints bypassed the Centralized Screening Team. Effective November 30, 2023, all staff misconduct complaints are routed through the Centralized Screening Team.
3. The Centralized Screening Team rerouted 1,220 complaints to hiring authorities because those complaints did not involve an incarcerated person or parolee. Per CCR, Title 15, section 3486.1 (b), "allegations of staff misconduct not involving an inmate or parolee" shall not be referred to the Centralized Screening Team. If a complaint is received by the Centralized Screening Team that does not contain allegations involving misconduct toward an inmate or parolee, the Centralized Screening Team shall refer the complaint to the hiring authority for disposition.
4. Refers to any complaint received by the Centralized Screening Team that is not identified as an allegation of staff misconduct.

tool that consisted of five overarching questions each with a series of subquestions and provided an overall rating of *superior*, *satisfactory*, or *poor* to each complaint monitored.

The OIG analyzed each screening decision of the Centralized Screening Team to assess how the department processed each allegation included in a complaint. A complaint may contain one or more allegations of staff misconduct.

Between January 1, 2023, and December 31, 2023, the Centralized Screening Team received and screened 176,814 complaints. Of those complaints, the OIG reviewed and monitored 6,953 complaints. We assessed whether the Centralized Screening Team appropriately identified and referred allegations of staff misconduct to the appropriate entity within the department. In 2023, we concluded the following:

- The Centralized Screening Team conducted satisfactory screening decisions in 6,248 of the 6,953 complaints, or 90 percent.
- The Centralized Screening Team made poor screening decisions in 701 of the 6,953 complaints, or 10 percent.
- The Centralized Screening Team performed in a superior manner when making screening decisions in four of the 6,953 complaints.

The OIG randomly selected the department's local inquiries for monitoring. Local inquiries are conducted by locally designated investigators who are based in the prison or parole office where the complaint originated and who gather evidence and facts in the form of a confidential allegation inquiry report.

Between January 1, 2023, and December 31, 2023, the department conducted 7,903 local inquiries. Of those local inquiries, the OIG monitored 113 inquiry cases. We assessed whether the performance of locally designated investigators and the wardens who made decisions regarding the inquiry cases was sufficient, complete, and unbiased. Overall, the department performed poorly in conducting staff misconduct inquiry cases.

- The department performed poorly in 77 of the 113, or 68 percent, of the inquiry cases.
- The department performed satisfactorily in 36 of the 113, or 32 percent, of the inquiry cases.
- In no inquiry cases did the department perform in a superior manner when conducting inquiries.

The OIG monitored the department's most significant staff misconduct investigations, such as those involving allegations that staff members were dishonest, used unreasonable force, retaliated against others, or

engaged in sexual misconduct. We monitored cases from the start of investigations until the conclusion of the cases. If an investigation led to discipline of an employee, then our attorneys continued to monitor the employee discipline process until its conclusion.

Between January 1, 2023, and December 31, 2023, the department completed 7,124 investigations. Of those investigations, the OIG monitored 121 staff misconduct investigations and the employee disciplinary process for those cases. The OIG evaluated the performance of Office of Internal Affairs investigators, department attorneys, and the wardens who made decisions regarding the investigation cases. Overall, the department performed poorly in conducting staff misconduct investigations and the disciplinary process.

- The department performed poorly in 77 of the 121, or 64 percent, of the investigation cases.
- The department performed satisfactorily in 44 of the 121, or 36 percent, of the investigation cases.
- The department did not perform in a superior manner in any investigation cases.

For each section of the department's staff misconduct investigation and review process that we monitored in 2023, we provided the department with our recommendations, as outlined in the table on the next page.

## Table 3. The OIG's Staff Misconduct Monitoring Unit Recommendations

| *Centralized Screening Team Decisions* |
|---|
| • The department should clarify departmental policy in writing to require screeners to ask the complainant questions during a clarification interview to obtain sufficient information to ultimately make an informed screening decision about the allegation. |
| • The OIG recommends that the department focus more quality-control attention on claims initially identified as routine matters. We also recommend the department establish clear policy requiring medical subject matter experts review only claims related to medical treatment, and custody subject matter experts review claims related to custody and correctional issues, such as use of force, even when the person alleged to have committed misconduct is a medical employee. |
| • The OIG recommends that the department require locally designated investigators to complete a conflict-of-interest review and acknowledge that they do not have an actual or potential conflict of interest before an inquiry begins. The OIG recommends the department adopt its already-existing conflict-of-interest form, used by the Office of Internal Affairs. |
| *Local Inquiry Cases* |
| • The OIG renews the recommendation made in our 2022 annual report that locally designated investigators audio-record all interviews.* |
| • The OIG recommends that the department amend its policy to permit investigators the independence and authority to identify, obtain, and review all video-recorded evidence that they have determined to be potentially relevant to their inquiry. |
| • Hiring authorities should receive training on how to conduct thorough reviews of allegation inquiry reports and on departmental policy to ensure that they make proper staff misconduct determinations. |
| • The OIG recommends that the department implement a policy requiring locally designated investigators and hiring authorities to complete the local inquiry process within 90 days of the date the Centralized Screening Team receives an allegation. |
| • The OIG recommends that the department develop, implement, and maintain a policy and process to require meaningful communication with the OIG during the course of each local inquiry to enable the OIG to perform its statutorily required monitoring activities. The OIG also recommends that the department hold employees accountable for failing to communicate with the OIG. |
| *Investigation Cases* |
| • The OIG recommends that the department require all members of an Office of Internal Affairs investigation team, including managers, to complete conflict-of-interest forms and recuse themselves from working on investigations in which they have a conflict of interest with—or bias for or against—any of the subjects or witnesses of an investigation. |
| • The OIG recommends that the department eliminate the use of summarized investigation reports which allow investigators to close staff misconduct investigations without conducting any interviews. |
| • The OIG recommends that the department expand its video-recording retention policy by increasing the minimum retention time for all recordings to one year to ensure that relevant video-recorded evidence is available for staff misconduct investigations. |
| • The OIG recommends that investigators determine the independent recollection of a witness before presenting him or her with video evidence. |
| • The OIG recommends that, during recorded interviews, Office of Internal Affairs investigators properly document which video file and which portion of the video file—including a time stamp—the investigator presents to the subject or witness during an interview. |
| • The OIG recommends that the Office of Internal Affairs conduct interviews in confidential settings. The OIG recommends that the Office of Internal Affairs investigators order subjects and witnesses to maintain the confidentiality of investigations while investigations are pending. |
| • The OIG recommends that the department issue a specific policy concerning the time frame in which a hiring authority, such as warden, must conduct an investigative and disciplinary findings conference after receipt of an Office of Internal Affairs investigation report. |
| • The OIG recommends that the department require its investigators, department attorneys, and wardens, or staff designated by a warden, to enter and maintain accurate information in its staff misconduct database. Moreover, the OIG recommends that the department establish a clear policy as to which departmental personnel are responsible for updating and maintaining specific information in the database to ensure that the records are timely and accurate. |

* *Monitoring the Staff Misconduct Investigation and Review Process of the California Department of Corrections and Rehabilitation: 2022 Annual Report.*

Source: The Office of the Inspector General.

## Audit Reports and Special Reviews

California Penal Code section 6126, subdivisions (b) and (c), authorize the OIG to initiate audits of departmental policies, practices, and procedures. In 2024, the OIG's Audits Unit issued two audit reports regarding the department's operational practices concerning release date calculations and how the department prevents, detects, and responds to escapes. In addition, the unit conducted a special review regarding the department's redirection of backlogged allegations of staff misconduct to be processed as routine grievances, consequently violating regulations.

### *Audit of the California Department of Corrections and Rehabilitation's Release Date Calculations*

On August 15, 2024, the OIG issued an audit report evaluating the department's process for ensuring the accuracy of sentencing-term release dates and determining whether the department correctly applied time credits—those earned, forfeited, and restored—in its calculation of release dates, in accordance with applicable laws, regulations, and guidelines.

During our audit, we examined the accuracy and consistency of prison release date calculations for incarcerated people with determinate sentences and evaluated the department's processes and procedures related to those calculations.

The results of our audit showed that since 2004, the department has released approximately 2,300 incarcerated individuals either early or late, which has led to litigation against the department. According to our review of incarcerated people released between July 1, 2022, and June 30, 2023, four cases contained calculation errors that could have led to early or late releases had the errors been overlooked. Furthermore, we found the department mistakenly released an incarcerated person without requiring a court-ordered parole period.

While calculation errors leading to early or late releases are a recurring problem, the causes of the errors vary. Extremely complex and frequently changing sentencing laws are a significant factor in inaccurate release date calculations. Other factors include a multitude of different credit-earning rates and the corresponding misapplication of credits in calculations, errors in court documents, inadequate training materials, high staff vacancy rates in case records departments, and a lack of supervisory review of initial release date calculations. Moreover, when erroneous release date calculations result in early or late releases, analysts who make such errors do not always receive training to improve their skills.

Finally, we concluded that the department's policies and procedures regarding release date calculations had not been updated since 1993, and training regarding how to perform release date calculations had not been standardized or centralized.

In summary, we recommended that the department analyze current sentencing laws, and also identify specific areas in which sentencing laws should be clarified and work with stakeholders to clarify those areas to reduce calculation errors. In addition, we recommended the department work with county courts to obtain access to electronically available legal documents that courts are required to provide. We also recommended that department require managers and supervisors review release date calculations completed after incarcerated people transfer to their first mainline prison, ensure release date calculations are completed accurately, and review release date calculations after triggering events at predetermined intervals. We also recommended that the department evaluate the classification specifications and job duties of staff in case records areas to determine how those descriptions can be revised to attract and retain a greater number of highly qualified staff. Finally, we recommended that the department update staff training for release date calculations.

### *Audit of the California Department of Corrections and Rehabilitation's Processes and Procedures for Preventing, Detecting, and Responding to Escapes*

On November 21, 2024, the OIG issued a report titled *Audit of the California Department of Corrections and Rehabilitation's Processes and Procedures for Preventing, Detecting, and Responding to Escapes.* Our office released two versions reporting the results of our audit: a confidential version addressed to the Secretary of the department, and a public version omitting select information contained in the confidential report. We issued these two versions of the report to protect the safety and security of the department's prisons and facilities.

In this audit, we reviewed the department's classification process used to screen incarcerated people for being at risk of escape and observed physical security layouts and protocols for incarcerated-people counts. We reviewed documentation on select escapes that occurred between January 1, 2022, and December 31, 2023, from minimum-support facilities and conservation camps—the only locations with reported escapes during the audit period. Last, we assessed both the security recommendations made by managers at affected facilities and the corrective action taken to address the escapes. The audit did not include a review of escapes or attempted escapes from community reentry programs.

Overall, few incarcerated people (less than one percent of the population) have escaped from departmental prisons or conservation camps. The number of escapes that occurred in the last five years is less than one percent of the total prison and camp population. Although the number of escapes is low, the department must take every precaution to prevent them to protect the safety and security of prisons, prison staff, incarcerated people, and the public. The risks and consequences of just

one escape can be severe and tragic, resulting in injury and harm to prison staff or to the public.

We reviewed 12 escapes during our audit period and found the department's count procedures were effective in detecting missing incarcerated people and initiating emergency counts to confirm escapes. Moreover, departmental staff effectively conducted the required searches of housing and yard areas after escapes were suspected. However, staff did not always follow departmental policy and procedures when carrying out the escape pursuit plan.

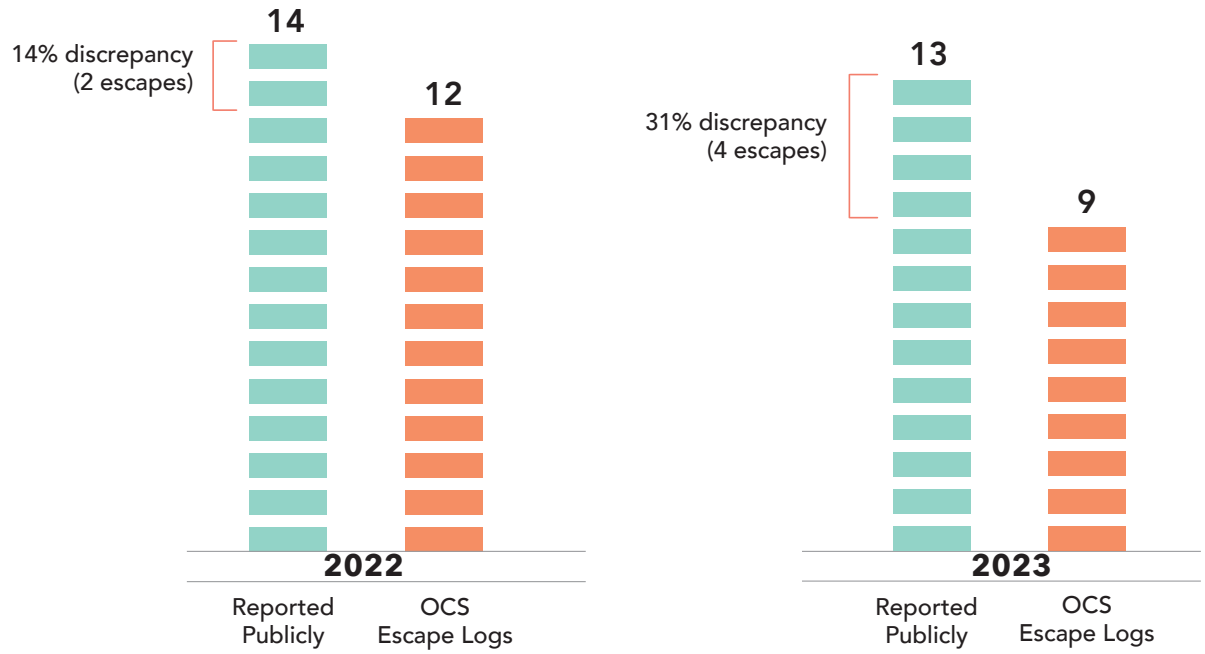
In addition, we identified several instances in which prisons or conservation camps did not follow all required escape pursuit activities. For example, incident commanders failed to notify designated departmental units of escapes, assign additional central control staff to pursue the escapee, retrieve and review escapees' records, or notify escapees' documented victims.

We also found that staff did not prepare after-action reports after all escapes as required by departmental policy and guidelines. After-action reports summarize the incident, provide a time line of key events that occurred both before and after the escape, identify deficiencies that contributed to the escape, and recommend corrective action to address the deficiencies.

Even when after-action reports were completed, the department did not always require deficiencies identified during escapes to be corrected. Managers recommended specific actions to correct deficiencies related to six of the 12 escapes we reviewed. However, we found the recommendations for corrective actions were not fully implemented in three of the six cases. Examples of deficiencies the department did not address were issuing a press release with incorrect information, failing to provide staff training, and not communicating with the California Department of Forestry and Fire Protection—which jointly operates the conservation camps with the department—to correct delayed telematics reporting on a stolen vehicle. Addressing deficiencies that managers found to have contributed to the escape is critical to prevent future incidents.

Finally, we found inconsistencies between the escape data the department had publicly reported and the data it provided for our audit, in part because there was no central location or source in which escapes and attempted escapes were tracked and monitored. Without a consistent and accurate source of information to report and track escapes, the department's publicly reported escape statistics may be inaccurate. In addition, the department's ability to effectively respond to and monitor escapes is reduced. Figure 3 on the next page shows the discrepancy in the number of escapes the department publicly reported and the number of escapes documented in the department's Office of Correctional Safety escape logs.

**Figure 3. Discrepancies in the Department's Reporting of Incarcerated Person Escapes in 2022 and 2023**




Note: OCS stands for the Office of Correctional Safety.

Source: Departmental COMPSTAT reports and OCS escape logs for the period from January 1, 2022, through December 31, 2023.

We recommended that the department ensure after-action reports be prepared after all escapes, document the name of the staff member who prepared each after-action report and the date each report was prepared, and require that managers document their review of after-action reports. We also recommended that the department implement policies and procedures to ensure corrective action is taken to address issues identified in after-action reports. Finally, we recommended that the department develop a central tracking system to collect and report all escapes and attempted escapes.

### *Special Review: The Department Violated Its Regulations by Redirecting Backlogged Allegations of Staff Misconduct to Be Processed as Routine Grievances*

On January 29, 2024, we issued a special review to shed light on one particularly problematic decision the department made when determining how to address a backlog of staff misconduct complaints it had amassed under its prior process for handling incarcerated people's allegations of staff misconduct. We found the department's decision violated both the department's regulations and its policy for screening

and investigating grievances received from incarcerated people who alleged staff misconduct.

Our office monitors the department's process for reviewing and investigating incarcerated people's allegations of staff misconduct. We issue annual reports that assess several facets of the department's overall statewide staff misconduct process. We became aware of the department's decision to address the staff misconduct complaint backlog during our monitoring of the department's handling of staff misconduct allegations. At that time, we received a departmental memorandum outlining a directive to convert backlogged grievances containing allegations of staff misconduct into "routine grievances" and redirect them to be handled by prison grievance offices. After receiving this memorandum, we reviewed a backlog of staff misconduct allegations the department had received from February 24, 2022, through February 27, 2023, which the department closed pursuant to this directive. From this backlog of 595 cases, we performed detailed analyses of 22 grievances for which the statutes of limitation had expired before the grievances were redirected and 71 grievances that prison staff closed after the grievances were redirected.

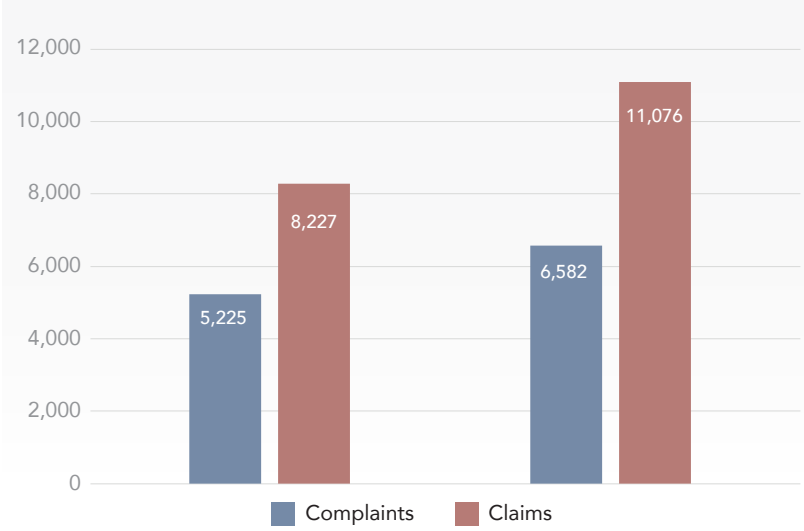
Our review found the department's decision to redirect those grievances to its prisons circumvented control measures that had been implemented to prevent prison authorities from making potentially biased decisions when responding to allegations of staff misconduct. The redirection resulted in a wasteful duplication of efforts and misallocation of resources because departmental staff had already determined the grievances contained allegations of misconduct and had referred the grievances for allegation inquires or investigations. The department also allowed the statute of limitations for taking disciplinary action to expire in many grievances, and prison staff who reviewed the grievances did not always adequately address or investigate complaints that its Centralized Screening Team had already determined included allegations of staff misconduct.

## Complaint Intake

The OIG maintains a statewide complaint intake process that provides a point of contact regarding allegations of improper activity that take place within the department. Our Intake Processing Unit (Intake) receives complaints from incarcerated people, supervised people,[5] their families, departmental employees, advocacy groups, and other complainants. Complaints are submitted via letter, toll-free phone call, State-issued tablet, or our website. We strive to screen all complaints within one business day of receipt to identify potential safety concerns, serious medical or mental health concerns, or reports of sexual abuse.

In 2024, we received 6,582 complaints, a 26 percent increase from 2023. A complaint may contain one or more claims submitted for our review. From the nearly 6,600 complaints we received, we processed 11,076 claims (see Figure 4, below), which was an average of more than 900 monthly claims. This is a 35 percent increase from the 8,227 claims we processed in 2023.

**Figure 4. Total Number of Complaints and Claims the OIG Received in 2023 and 2024**

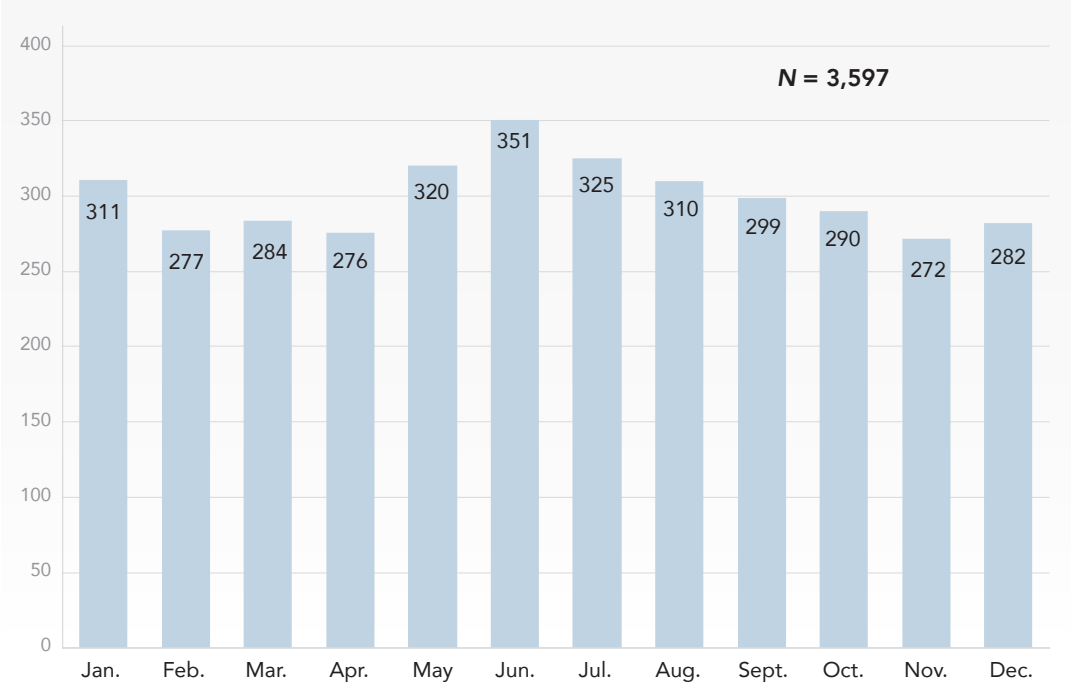



Source: The Office of the Inspector General Tracking and Reporting System.

Of the 6,582 complaints received in 2024, 55 percent were received via our OIG hotline/voicemail line (phone and tablet); 28 percent were received by mail; and 17 percent were received through email, our website, and in person. Our office's hotline received an average of 300 complaints monthly in 2024, for a total of 3,597 complaints (see Figure 5, next page).

5. *Supervised person* is a term the department uses to refer to various categories of individuals paroled from the State's prison system.

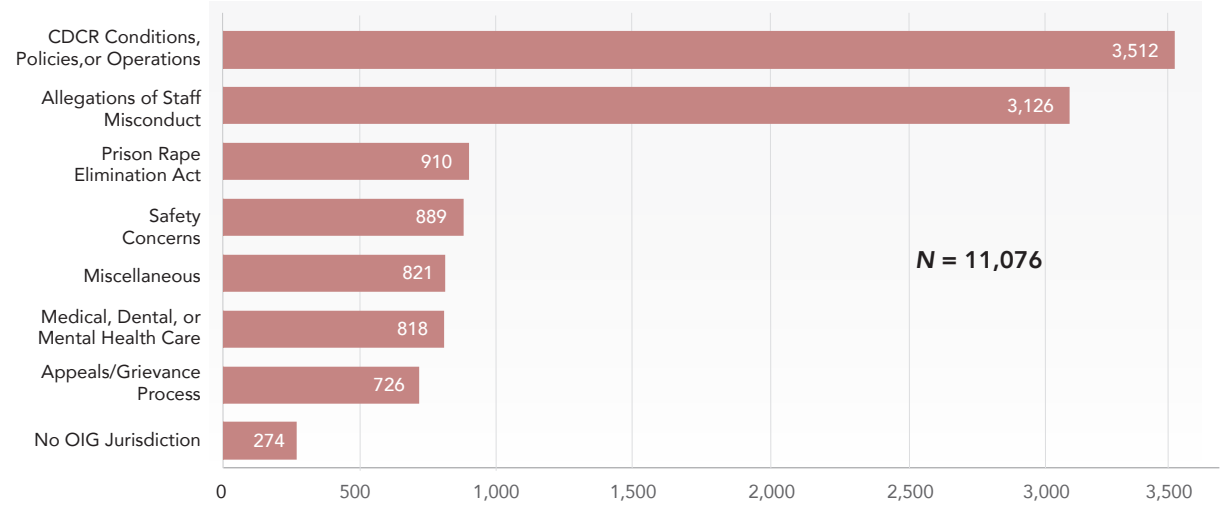
**Figure 5. Complaints Received by the OIG Hotline in 2024**




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

Approximately 75 percent of the complaints we received in 2024 were submitted by incarcerated people or supervised people, while 25 percent were submitted by others, such as private citizens, departmental employees, and advocacy groups. The most common types of claims we received in 2024 pertained to prison conditions, policies, or operations; allegations of staff misconduct; the Prison Rape Elimination Act (PREA); and safety concerns. Complaints frequently included multiple claims of improper activity occurring within the department. Below, Figure 6 shows the distribution of claim categories we received.

**Figure 6. Categories of Complaints the OIG Received in 2024**




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

Our Intake staff create a unique identification number for each complaint received to document our case activity. In 2024, we reviewed and closed 6,450 of the 6,582 complaints received, a completion rate of 98 percent. Some incarcerated people submitted numerous complaints with duplicative claims, which our Intake staff had previously reviewed and closed. In 2024, we completed our review of 1,163 duplicative complaints received from 42 complainants. In 2025, our staff will continue working to resolve the remaining 132 complaints (2 percent) pending from 2024.

In response to these complaints, our staff often conducted inquiries by accessing information from various departmental databases, reviewing the department's policies and procedures, and requesting relevant documentation from the department. However, many complaints lacked the details needed to clearly identify and properly research the claims. After our review or inquiry into such complaints, we usually advised complainants about how they could address their concerns with the department or recommended that they provide us with more details. Typically, the OIG provides a written response to complainants outlining this information or technical assistance to resolve the complaint issue.

OIG Intake staff prepare impact case blocks throughout the year, which are published on a regular basis. The case blocks showcase select complaints that our Intake staff received; these complaints may have resulted in a positive change or impact or highlight an area of concern. The initial work Intake staff undertake can lead to the OIG requesting the Office of Internal Affairs to open an investigation into an allegation of staff misconduct or result in the OIG's Staff Misconduct Monitoring Unit commencing to monitor inquiries or investigations.

In one example, an anonymous complainant provided Intake staff with last names and locations of several incarcerated people who allegedly possessed weapons and intended to kill an officer. We immediately notified the warden of the safety concern, and within 45 minutes, seven weapons ranging from 3-¾ inches to 7 inches in length were confiscated from two cells. Pictured here is a photograph of five of the makeshift weapons found in one of the cells. In 2024, our office published 24 Intake impact case blocks; they can be accessed at **www.oig.ca.gov/publications/**.


Photo 1. Five makeshift weapons found in Cell Nº 1 (photographed by departmental staff on 7-29-24).

## *Prison Rape Elimination Act*

In accordance with U.S. Federal Prison Rape Elimination Act (PREA) standards, the OIG

forwards allegations of sexual abuse or sexual harassment, commonly referred to as PREA allegations, to the hiring authority and to the PREA compliance manager. Allegations may be received from incarcerated people, supervised people, family members, and other third parties.

Following a notification, typically, the department reviews the allegations and will interview the involved parties. The expectation is that the department will evaluate the information and initiate an investigation if necessary. If alleged victims are dissatisfied with how the PREA investigation was handled, they can file a complaint with our office after they have exhausted all administrative remedies.

In 2024, the OIG received 910 complaints designated as involving a PREA allegation. The OIG sent 538 PREA notifications alleging sexual abuse or sexual harassment to the appropriate parties for processing. When multiple PREA allegations were received within a short period of time, they were sent as a single notification. In addition, some complaints did not meet PREA reporting criteria, such as those not involving an incarcerated person and disputing how an investigation was handled, or those disagreeing with the results of a completed investigation.

### *Inmate Advisory Council (IAC) Meetings*

As part of our complaint intake duties, we actively work to gain knowledge of local and departmentwide issues through participating in periodic meetings with inmate advisory councils (IACs) at institutions throughout the State.

During 2024, the OIG's Intake staff met with departmental IAC representatives at 21 institutions to educate them about the OIG's mission as well as to solicit input.[6] While most council representatives were aware of our office, we learned representatives lacked an understanding of our functions and how our staff elevate and notify the department of concerns brought to our attention. Accordingly, during all our meetings, OIG staff provided an overview of the OIG, addressed confidentiality concerns, and explained how to contact this office. Council representatives discussed concerns and issues they felt were not adequately being addressed at the institutional level and shared some positive feedback. Our staff also provided information about how we may be able to assist them with specific issues.

In July 2024, Intake published its initial semiannual report, which summarized our meetings with the IACs. Find it, along with all future such reports, at **www.oig.ca.gov/publications/**.

6. Between October 2023 and November 2024, Intake staff visited all institutions that were not scheduled for closure that year.

## Whistleblower Retaliation Claims

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

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

In 2024, the OIG received 20 retaliation complaints. We completed analyses of 19 complaints and determined that none stated the legally required elements of a whistleblower retaliation claim. We also completed analyses of the complaint pending from 2023, which did not state the legally required elements of a whistleblower retaliation claim. We are still in the process of reviewing the materials pertaining to one complaint we received in 2024.

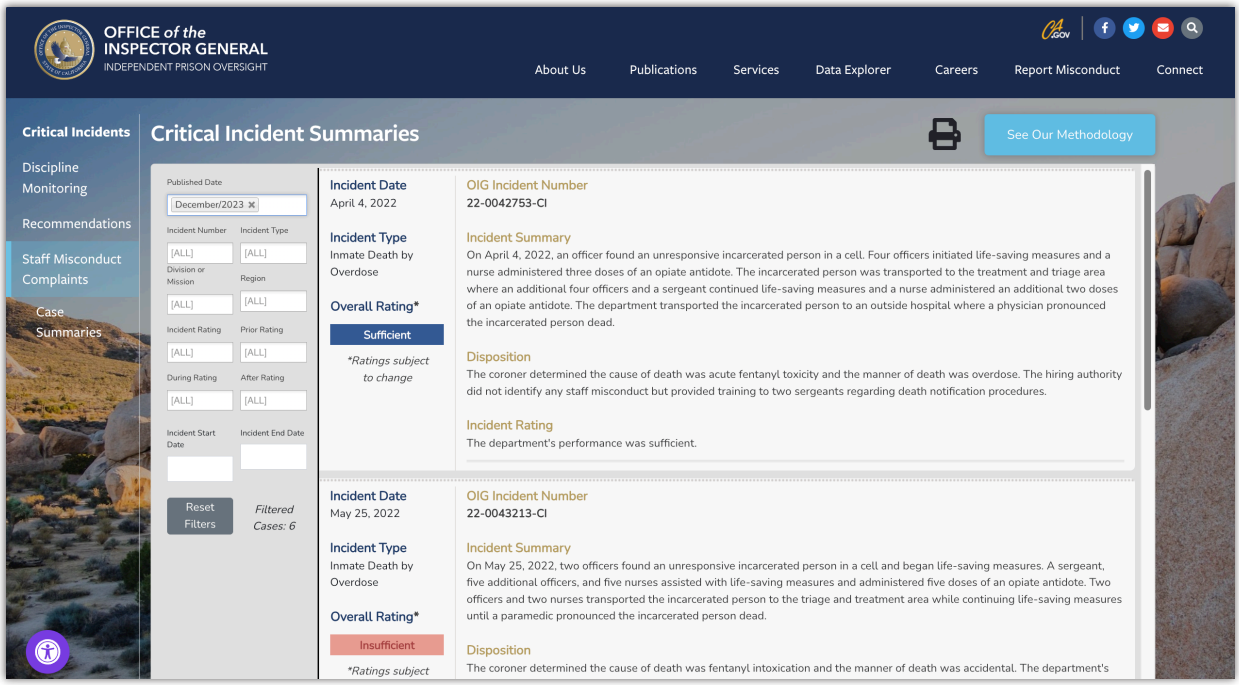
*(This page left blank for reproduction purposes.)*

# Recommendations Made to the Department

In 2023, the OIG published 16 formal reports, some of which contained recommendations. These recommendations promote greater transparency, process improvements, increased accountability, and higher adherence to policies and constitutional standards. Details concerning the vast number of recommendations made to the department are available on our dashboards, which can be accessed at our website.

If viewing this report on our website, clicking on the image below will take the reader to the main interactive dashboard web page. Choose from among several filter options to select a specific group of recommendations: publication year, service (authorized/special review; employee discipline monitoring, and use-of-force monitoring), general topic, associated entity, report title, and report number. A separate dashboard is also available on our site that lists the medical inspection report recommendations we have made to both California Correctional Health Care Services and the department.

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



*(This page left blank for reproduction purposes.)*

# Appendix: Publications Released in 2024

## Annual and Semiannual Reports

- *2023 Annual Report: A Summary of Publications* (March 12, 2024)
- *13th Blueprint Monitoring Report: The OIG's Monitoring of the Delivery of the Reforms Identified by the Department of Corrections and Rehabilitation in Its Report Titled* The Future of California Corrections: A Blueprint to Save Billions of Dollars, End Federal Court Oversight, and Improved the Prison System *and Its* Update (March 11, 2024)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation: Semiannual Report, July–December 2023* (April 16, 2024)
- *The Office of the Inspector General Monitoring in 2023 of the California Department of Corrections and Rehabilitation's Staff Misconduct Complaint Screening, Inquiry, Investigation, and Employee Disciplinary Processes*: 2023 Annual Report and Fact Sheet (April 25, 2024)
- *Intake Processing Unit: Semiannual Report, January–June 2024* (July 22, 2024)
- *2023 Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation* (August 22, 2024)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation: Semiannual Report, January–June 2024* (October 30, 2024)

## Periodical Reports

### *Sentinel Cases*

- *The Department Entered Into a Settlement Agreement Allowing a Correctional Administrator to Return to Work Despite Strong Evidence the Administrator Engaged in Serious Misconduct, Including Sexual Harassment, Racism, and Intimidation* Sentinel Case No. 24–01 (October 17, 2024)

## Medical Inspection Reports: Cycle 7 Results

- California State Prison, Los Angeles County (June 14, 2024)
- Valley State Prison (June 14, 2024)
- Wasco State Prison (June 21, 2024)
- California State Prison, Solano (June 21, 2024)
- California State Prison, Corcoran (August 7, 2024)
- California Medical Facility (August 19, 2024)
- California Rehabilitation Center (September 9, 2024)
- North Kern State Prison (November 27, 2024)
- Richard J. Donovan Correctional Facility (December 4, 2024)
- Substance Abuse Treatment Facility and State Prison at Corcoran (December 9, 2024)

## Audit Reports and Special Reviews

- *Special Review: The Department Violated Its Regulations by Redirecting Backlogged Allegations of Staff Misconduct to Be Processed as Routine Grievances* (January 29, 2024)
- *Audit of the California Department of Corrections and Rehabilitation's Release Date Calculations, Audit Report Nº 23-01* (Report and Fact Sheet) (August 15, 2024)
- *Audit of the Department of Corrections and Rehabilitation's Processes and Procedures for Preventing, Detecting, and Responding to Escapes, Audit Report Nº 23-02* (Report and Fact Sheet) (November 21, 2024)

## Field Team Case Blocks

### *Centralized Screening Monitoring Team*

- December 2023 Case Blocks (February 7, 2024)
- January 2024 Case Blocks (March 26, 2024)
- February 2024 Case Blocks (April 5, 2024)
- March 2024 Case Blocks (May 14, 2024)
- April 2024 Case Blocks (June 3, 2024)
- May 2024 Case Blocks (July 17, 2024)

- June 2024 Case Blocks (August 19, 2024)
- July 2024 Case Blocks (September 3, 2024)
- August 2024 Case Blocks (October 7, 2024)
- September 2024 Case Blocks (November 18, 2024)
- October 2024 Case Blocks (December 16, 2024)

### *Local Inquiry Team*

- November 2023 Case Blocks (January 10, 2024)
- October 2023–November 2023 Retrospective Reviews (January 16, 2024)
- December 2023 Retrospective Reviews (February 5, 2024)
- December 2023 Case Blocks (February 5, 2024)
- January 2024 Case Blocks (February 26, 2024)
- January 2024 Retrospective Reviews (February 26, 2024)
- February 2024 Retrospective Reviews (April 16, 2024)
- February 2024 Case Blocks (April 16, 2024)
- March 2024 Case Blocks (May 6, 2024)
- March 2024 Retrospective Reviews (May 6, 2024)
- April 2024 Case Blocks (June 10, 2024)
- April 2024 Retrospective Reviews (June 10, 2024)
- May 2024 Case Blocks (July 23, 2024)
- June 2024 Case Blocks (August 19, 2024)
- July 2024 Case Blocks (September 3, 2024)
- August 2024 Case Blocks (October 7, 2024)
- September 2024 Case Blocks (November 5, 2024)

### *Intake Processing Unit*

- March 2024 Impact Case Blocks (March 25, 2024)
- May 2024 Impact Case Blocks (July 22, 2024)
- August 2024 Impact Case Blocks (October 21, 2024)

*Use-of-Force Team*

- February 2024 Case Blocks (March 28, 2024)
- February–March 2024 Case Blocks (April 23, 2024)
- March–April 2024 Case Blocks (May 21, 2024)
- April 2024 Case Blocks (June 5, 2024)
- May 2024 Case Blocks (July 23, 2024)
- June 2024 Case Blocks (August 26, 2024)
- July 2024 Case Blocks (September 23, 2024)
- August 2024 Case Blocks (October 16, 2024)
- September–December 2024 Case Blocks (December 30, 2024)

# 2024
# Annual Report

## *A Summary of Publications*

OFFICE *of the* INSPECTOR GENERAL

*Amarik K. Singh*
Inspector General

*Shaun Spillane*
Chief Deputy Inspector General

STATE *of* CALIFORNIA
March 2025

OIG