



*Amarik K. Singh, Inspector General*

*Shaun Spillane, Chief Deputy Inspector General*

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# OIG | OFFICE *of the* INSPECTOR GENERAL

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Independent Prison Oversight

March 2025

**The Office of the Inspector General's  
Monitoring in 2024 of the  
Centralized Screening Team  
Process of the California  
Department of Corrections  
and Rehabilitation**

*2024 Annual Report*



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March 4, 2025

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

Dear Governor and Legislative Leaders:

Pursuant to California Penal Code section 6126(i), the Office of the Inspector General (OIG) is responsible for the contemporaneous oversight of staff misconduct screening decisions made by the California Department of Corrections and Rehabilitation (the department). The Centralized Screening Team is an entity within the department that initially reviews complaints the department receives containing allegations of employee misconduct and makes a screening decision. This report concerns the OIG's monitoring of screening decisions the department's Centralized Screening Team made in 2024.

The OIG monitored the Centralized Screening Team's performance in making screening decisions based on whether complaints the department received contained a routine issue or allegations of staff misconduct toward an incarcerated or supervised person. Under departmental policy in 2024, the Centralized Screening Team was required to route allegations in complaints the department received in one of three ways:

- Allegations of staff misconduct that include complex issues requiring specialized investigative skills or resources are routed to the Office of Internal Affairs' Allegation Investigations Unit for a full investigation.
- Allegations of staff misconduct that do not include complex issues requiring specialized investigative skills or resources are routed to the prison or parole office where the alleged misconduct occurred. There, they are assigned to a locally designated investigator for a local inquiry.
- Complaints that do not contain an allegation of staff misconduct are routed to the prison or parole office to be handled as routine matters.

From January 1, 2024, through December 31, 2024, the OIG reviewed and monitored 9,245 complaints to determine whether the Centralized Screening Team identified and routed allegations of staff misconduct to the appropriate entity within the department. The OIG assigned one of three overall ratings for each complaint received: *superior*, *satisfactory*, or *poor*. Of the 9,245 complaints the Centralized Screening Team received and screened,



8,219, or 89 percent, were *satisfactory* decisions, and 1,024, or 11 percent, were *poor* decisions. We found the Centralized Screening Team performed in a *superior* manner when it made screening decisions for two complaints it received.

This report is part one of a three-part series that discusses the department's performance in identifying and addressing allegations of staff misconduct involving incarcerated or supervised people.

Sincerely,

A handwritten signature in blue ink that reads "Amarik K. Singh". The signature is fluid and cursive, with the first name being the most prominent.

Amarik K. Singh  
Inspector General

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## Introduction

An allegation of staff misconduct generally originates from a complaint against any employee of the California Department of Corrections and Rehabilitation (the department) that alleges a violation of a law, a regulation, a departmental policy, or an ethical or professional standard. Any individual, including incarcerated people, supervised people, or third-party individuals or groups, can make an allegation of staff misconduct and submit a complaint to the department.

The department's Centralized Screening Team is responsible for screening each complaint to determine whether it contains an allegation of staff misconduct toward an incarcerated person and then forwarding the complaint to the appropriate departmental entity for resolution. The department maintains a list of the most serious allegations; this is called the allegation decision index. The Centralized Screening Team uses the allegation decision index to determine whether to route a staff misconduct complaint to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

Under departmental policy in 2024,<sup>1</sup> the Centralized Screening Team is required to route an allegation from a complaint in one of three ways:

1. Allegations that are serious in nature and listed on the allegation decision index, or any allegation of misconduct with complex issues, are routed to the Office of Internal Affairs' Allegation Investigations Unit for a full investigation.
2. Allegations of misconduct that are not listed on the allegation decision index and are not complex are routed to the prison or parole office where the alleged misconduct occurred. They are then assigned to a locally designated investigator for a local inquiry.
3. Complaints that do not contain an allegation of staff misconduct are routed to the prison or parole office to be handled as routine matters.

When the nature of an allegation is too unclear to make a screening decision, the Centralized Screening Team is required to conduct a clarification interview with the incarcerated person who filed the complaint. The Centralized Screening Team must log the information obtained during the interview into the department's staff misconduct complaint database. Moreover, the Centralized Screening Team must update the staff misconduct complaint database to track the status of all complaints and to record the disposition of all routing decisions.

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1. The department has implemented emergency regulations that took effect on January 1, 2025, which changed the options for routing allegations.

This report summarizes our monitoring of the department’s Centralized Screening Team’s screening decisions completed from January 1, 2024, through December 31, 2024. 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 [incarcerated person] allegations of staff misconduct and other specialty grievances, examining compliance with regulations, department policy, and best practices.” In this report, we use the terms *grievances* and *complaints* synonymously.

The law requires that we issue reports annually. Hence, this report is part one of a three-part series. Parts two and three will present our assessment and findings of the department’s performance in conducting local inquiries, and our monitoring and assessment of staff misconduct investigations and the employee disciplinary process for those cases.

## The Centralized Screening Monitoring Team

The OIG's Centralized Screening Monitoring Team monitored the department's Centralized Screening Team's screening and routing decisions. We randomly selected complaints and performed research using records, documents, and departmental databases. We analyzed each screening decision to assess how the Centralized Screening Team processed each allegation included in a complaint. If we encountered discrepancies during the screening process, we contacted the department and elevated our concerns. We also monitored interviews Centralized Screening Team staff conducted with incarcerated people to obtain clarification about their allegations. The OIG assessed the performance of departmental staff and assigned an overall rating of *superior*, *satisfactory*, or *poor* to each complaint monitored.

Throughout this process, we used our assessment methodology, which is based on performance-related questions and their responses, to determine the ratings. We used an assessment tool that consisted of an overarching question, with a series of subquestions to determine whether the Centralized Screening Team appropriately screened and referred allegations of employee misconduct and other related complaints.

From the Centralized Screening Team's screening decisions that we monitored in 2024, we produced and published a select number of case blocks monthly. The case blocks included a summary of the incident, the department's screening decision, and the OIG's assessment of the screening decision. These case blocks can be found on the OIG's website.

### Oversight Areas Reported During the 2024 Reporting Period

From January 1, 2024, through December 31, 2024, the department reported<sup>2</sup> it received 208,886 complaints and processed 209,668<sup>3</sup> complaints from incarcerated people, supervised people, and third-party individuals or entities. The department reported it made 210,321<sup>4</sup> screening decisions in 2024 and routed those decisions as follows:

- 186,828 screening decisions were routed and returned to prisons as routine issues.
- 10,891 screening decisions were routed to prisons for a local inquiry.

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2. We received data from the department on January 9, 2025.

3. This number includes 782 complaints processed in 2024 but received before January 1, 2024.

4. The department reported that one source document may contain multiple complaints.

- 11,392 screening decisions were routed to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.
- 1,210 screening decisions were routed to the Office of Internal Affairs.<sup>5</sup>

The OIG reviewed and monitored 9,245 of the 210,321 screening decisions the Centralized Screening Team made to determine whether the Centralized Screening Team routed allegations of staff misconduct to the appropriate entity within the department.

- The Centralized Screening Team made *satisfactory* screening decisions in 8,219 of the 9,245 complaints, or 89 percent.
- The Centralized Screening Team made *poor* screening decisions in 1,024 of the 9,245 complaints, or 11 percent.
- The Centralized Screening Team performed in a *superior* manner when making screening decisions in two of the 9,245 complaints.

**Table 1. The OIG's Ratings of the Centralized Screening Team's Screening Decisions**

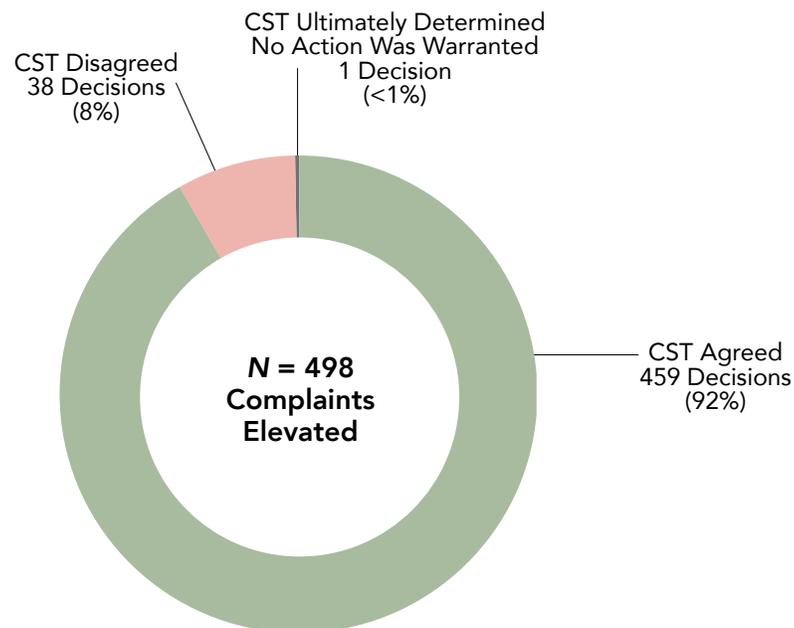
OIG Ratings	Number of Complaints
<i>Superior</i>	2
<i>Satisfactory</i>	8,219
<i>Poor</i>	1,024
<b>Total</b>	<b>9,245</b>

Source: The Office of the Inspector General.

5. The Centralized Screening Team rerouted 1,210 complaints back to the hiring authority, which the hiring authorities then referred to the Office of Internal Affairs because those complaints did not involve an incarcerated person or parolee, and the Centralized Screening Team only processes allegations of staff misconduct toward 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 include allegations involving misconduct toward an incarcerated person or parolee, the Centralized Screening Team shall refer the complaint to the hiring authority for disposition.

When the OIG disagrees with a screening decision involving staff misconduct, we elevate our recommendations to the Centralized Screening Team's management for additional review. This year, we monitored 9,245 and elevated 498 screening decisions, or 5 percent. Of those 498 decisions, the Centralized Screening Team disagreed with the OIG in 38 instances or 8 percent and agreed and implemented our recommendations in 459 decisions we elevated or 92 percent.

**Figure 1. The Frequency With Which the Centralized Screening Team Agreed With the OIG's Recommendations When We Elevated Its Screening Decisions**



Note: CST refers to the department's Centralized Screening Team.

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

The Centralized Screening Team failed to implement our recommendations in 38 decisions we elevated. Below are a few examples we identified.

- On November 4, 2024, a canteen<sup>6</sup> supervisor allegedly allowed incarcerated workers to tax incarcerated people shopping in the canteen to allow them to move to the front of the canteen line.

The Centralized Screening Team referred the allegation to the hiring authority for a local inquiry instead of to the Office of Internal Affairs' Allegation Investigation Unit even though the allegation of soliciting favors or gratuities is listed on the allegation decision index. Following the OIG's elevation, the Centralized Screening Team responded that the allegation "at best" warranted a local inquiry. The Centralized Screening Team upheld its decision.

- On September 27, 2024, an officer allegedly denied an incarcerated person's request to return to his housing unit to use the bathroom when the temperature outside exceeded 100 degrees, which made it impossible to sit on metal toilets on the yard. The incarcerated person alleged other incarcerated people defecated in the outdoor showers. On September 30, 2024, a second officer allegedly denied repeated requests from multiple incarcerated people to use the bathroom in their housing unit because the outdoor temperature exceeded 100 degrees. This resulted in multiple incarcerated people defecating in the outdoor showers. On October 7, 2024, the incarcerated person allegedly told a captain about the ongoing bathroom issues, but the captain allegedly failed to address the problem.

Initially, the Centralized Screening Team referred the allegation that officers did not allow incarcerated people to access a usable toilet, which resulted in incarcerated people creating an unsanitary environment by defecating in the showers, to the hiring authority for a local inquiry. Before the OIG's review, the assigned locally designated investigator disputed the decision, and the Centralized Screening Team routed the claim back to the prison as a routine issue without a sufficient explanation. After the OIG's elevation and request for an explanation of the change in decision, the Centralized Screening Team upheld its decision to route the claim as a routine issue. The Centralized Screening Team responded that allowing incarcerated people to request access to the building would create an unreasonable "free-for-all," even though

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6. *California Penal Code*, Section 5005.

departmental policy already allowed for this exception during heat alerts. The Centralized Screening Team failed to respond to the OIG's second elevation and proceeded with its decision to route the claim as a routine issue.

- On July 2, 2024, after a verbal encounter, officers allegedly used unreasonable force when handcuffing an incarcerated person.

Prison staff who documented the incarcerated person's verbal complaint failed to report specific details, including the incarcerated person's exact statement, the names of involved staff, and specific details about the alleged incident. The Centralized Screening Team also failed to request the details from prison staff. Rather than requesting the information from the prison, the Centralized Screening Team attempted to obtain additional details from the incarcerated person during a clarification interview. When the incarcerated person refused to participate in the interview, the Centralized Screening Team inappropriately determined the unreasonable force allegation was a routine matter despite having access to a rules violation report issued to the incarcerated person that included the necessary details. After the OIG elevated the matter, the Centralized Screening Team agreed that prison staff had failed to document the necessary details in the complaint but upheld its decision that because of the lack of details, it would not process the unreasonable force allegation as an allegation of staff misconduct.

- On March 9, 2024, an officer allegedly harassed a disabled incarcerated person of a specific race who wore a mobility-impaired vest and remained standing during an alarm after the officer told him to get on the ground. The officer allegedly permitted other incarcerated people of a different race than the first incarcerated person to remain standing during the alarm. The officer allegedly refused to reveal her name to the incarcerated person, and a second officer allegedly refused to provide his badge number when the incarcerated person requested it to file a complaint. After the alarm had cleared, a sergeant allegedly told the first officer she was wrong in suggesting the incarcerated person must sit down despite his mobility impairment. The incarcerated person alleged the first officer frequently acted rudely toward incarcerated people of a specific race and only searched the bunks of incarcerated people of that race.

The Centralized Screening Team inappropriately referred the allegation of racial discrimination to the hiring authority for a local inquiry instead of referring it to the Office of Internal Affairs' Allegation Investigation Unit.

After the OIG disputed the decision, the Centralized Screening Team, arbitrarily cited details not presented in the grievance and upheld its decision based on supposition and conjecture. The Centralized Screening Team determined it was likely the officer did not tell the other incarcerated people to get down during the alarm because she and the first incarcerated person were engaged in an argument.

- On April 26, 2024, an officer allegedly dropped a food item on the floor and placed it on an incarcerated person's food tray. The same officer allegedly failed to provide the incarcerated person with a complaint form on four occasions. Because the incarcerated person was housed in the restricted housing unit, he was unable to pick up the forms himself.

The Centralized Screening Team failed to consider the allegation that the officer had hindered the incarcerated person's ability to report staff misconduct. Although the officer refused to provide complaint forms on four occasions, the Centralized Screening Team failed to identify staff misconduct warranting a referral to the Office of Internal Affairs' Allegation Investigation Unit. After the OIG elevated the issue, the Centralized Screening Team maintained its decision that the alleged staff misconduct was only a routine complaint form request issue. The Centralized Screening Team cited in its response that the officer had reported the housing unit was "out of a few different supplies for a couple of days," but had since received all necessary supplies and issued them to the incarcerated population when available, which is information the Centralized Screening Team obtained after it had made its initial decision. Neither the officer nor the Centralized Screening Team confirmed the "supplies" included complaint forms, nor did they address the incarcerated person's allegation specifically. They only stated staff issued items to the incarcerated population when they were available.

- From November 25, 2024, through December 6, 2024, staff allegedly lost an incarcerated person's legal documents and durable medical equipment, racially profiled the incarcerated person, and denied his request to speak to a lieutenant.

The Centralized Screening Team failed to identify an allegation of racial discrimination and misidentified the allegation that staff had lost legal documents and durable medical equipment as a routine issue, even though it consistently referred similar allegations to the hiring authority for local inquiries. After the OIG elevated the matter, the Centralized Screening Team appropriately referred the allegation that staff had lost the

incarcerated person's prescription eyeglasses and other durable medical equipment to the hiring authority. However, despite the requirement to screen at face value,<sup>7</sup> the Centralized Screening Team did not refer the allegation of racial discrimination as staff misconduct, and it processed the allegation of lost legal documents as a routine property claim. It explained to the OIG, "The claimant does not state he **was** racial[ly] profiled he stated he **felt** racially profiled . . ." (emphasis added). The incarcerated person made three separate statements in his complaint: "I feel racially profiled," "I am being racially profiled," and "I am being racially profiled by 2 facilities." Nevertheless, the Centralized Screening Team only considered the first statement in its decision.

In 468 cases, the Centralized Screening Team agreed with the OIG's recommendations and reconsidered its screening decisions. However, if it were not for the OIG's intervention, the department would have failed to investigate allegations of staff misconduct. Below are examples of instances in which the Centralized Screening Team made an overtly incorrect screening decision but corrected it after the OIG provided a recommendation.

- An incarcerated person alleged, in part, that from September 26, 2024, through September 27, 2024, an officer drove recklessly by swerving in and out of traffic, sped, braked hard, made an illegal U-turn, smoked, drank, and used his mobile phone while transporting an incarcerated person from one prison to another. Moreover, the officer allegedly solicited a sex worker when he stopped the transport vehicle at a gas station.

The Centralized Screening Team incorrectly referred the allegation that the officer drove recklessly to the hiring authority for a local inquiry, even though allegations of negligent or reckless driving are listed on the allegation decision index. The Centralized Screening Team also failed to acknowledge the allegation that an officer had solicited a sex worker while on duty. After the OIG elevated the matter, the Centralized Screening Team inappropriately upheld its original decision. It claimed the incarcerated person could not have seen the speedometer from the transport van's holding cell, that a mountainous winding road would have caused the incarcerated person to move around in the van, and that the incarcerated person did not sustain any injuries. The Centralized Screening Team still did not address the allegation that the officer had

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7. Face-value screening is based only on what the incarcerated person alleged, without question, and regardless of the specific behavior described or the lack of substantiating facts to support the allegation. Face-value screening is based solely on the face of the complaint, rather than the merits of the complaint. We discuss face-value screening further in this report.

solicited a sex worker while on duty. After we elevated the matter a second time, the Centralized Screening Team’s management referred the allegations that an officer drove recklessly and solicited a sex worker to the Office of Internal Affairs’ Allegation Investigation Unit.

- On May 25, 2024, three nurses allegedly failed to provide an incarcerated person with proper medical care and made unprofessional comments toward the incarcerated person. The first nurse allegedly stated to the incarcerated person, “Stop smoking dope,” and “I don’t have time for your theatrics.” The second nurse allegedly stated to the incarcerated person, “Inmates, especially you trannies [*sic*], manipulate your way to the hospital by playing the system.” The third nurse allegedly stated to the incarcerated person, “You heard what my coworkers said: nothing is wrong with you. Your [*sic*] not going to the hospital—bottom line, there is no doctor. I am the doctor!”

The Centralized Screening Team routed the discrimination allegation against one of the nurses to the Office of Internal Affairs’ Allegation Investigation Unit. Although the OIG concurred with the decision, the Centralized Screening Team initially failed to identify the additional allegations that two other nurses had made inappropriate statements to the incarcerated person, that the two nurses denied the incarcerated person medical care, and that one of those nurses deviated from her scope of licensure. After the OIG elevated the matter, the Centralized Screening Team took appropriate steps to amend its decision and referred the allegations against the two nurses to the Office of Internal Affairs’ Allegation Investigation Unit.

- Among numerous other allegations, on November 6, 2024, an incarcerated person wrote, “. . . I wasn’t the person who got the gun in, it got in [by another incarcerated person] & it’s still on [the facility].” Although the incarcerated person did not provide a date in connection with this statement, she bookended the statement with allegations from April 20, 2024, and November 1, 2024. Neither the prison’s Office of Grievances nor the Centralized Screening Team identified the statement as an imminent risk to the safety and security of the prison, and both failed to alert appropriate staff.

The OIG notified the Centralized Screening Team and the Office of Grievances that they had overlooked a risk to the prison’s safety and security. The Centralized Screening Team did not respond, but the Office of Grievances responded it would notify facility staff. Out of an abundance of caution and due to the severity of the safety and security risk, the OIG also directly

notified the hiring authority, who immediately initiated an interview between the prison's investigative services unit and the incarcerated person. In the interview, the incarcerated person reported the statement about the gun stemmed from an incident that had occurred in 2018, and that the gun was not on-site.

- On October 25, 2024, a parole agent allegedly pushed a supervised person down a flight of stairs.

The Centralized Screening Team failed to consider the allegation that a parole agent had pushed a supervised person down a flight of stairs to be an allegation of staff misconduct. The Centralized Screening Team acknowledged the supervised person alleged unreasonable force; however, it arbitrarily concluded, "It is claimant's belief that they were pushed but claimant does not say they were pushed." Multiple staff involved in the incident reported the supervised person had stated, "You guys pushed me." After the OIG elevated the matter, the Centralized Screening Team appropriately referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit.

- On June 27, 2024, an officer allegedly made threats over the public address system to have "gang members" rape an incarcerated person. That night, "someone" allegedly sexually assaulted the incarcerated person.

The Centralized Screening Team routed an allegation against another incarcerated person for sexual assault but did not identify any allegation against the officer. After the OIG elevated the matter, the Centralized Screening Team conducted an unnecessary clarification interview based on an illegible sentence in the complaint even though we had only quoted the legible sentence in our dispute. Subsequently, the Centralized Screening Team illogically determined the allegation that the officer had publicly threatened to have "gang members" rape an incarcerated person was not staff misconduct because the incarcerated person "did not witness any rapes." However, the Centralized Screening Team simultaneously identified an allegation that another incarcerated person sexually assaulted the incarcerated person after the officer allegedly made the threat. After we elevated the matter a second time, the Centralized Screening Team's management agreed the officer's alleged threat alone warranted a referral to the Office of Internal Affairs' Allegation Investigation Unit.

- On April 15, 2024, a nurse allegedly failed to schedule an appointment for an incarcerated person to see either a nurse or a physician after the incarcerated person reported

continued shortness of breath with any exertion. The nurse allegedly documented that medical staff saw the incarcerated person for the issue the day before, while the incarcerated person documented he had not been seen since March 13, 2024. On April 22, 2024, the incarcerated person experienced a medical emergency consisting of shortness of breath and had to be transported to an outside hospital. The incarcerated person later died at the hospital.

The Centralized Screening Team determined the allegation against the nurse to be a “practice issue” and a “departure from policy,” not involving an incarcerated person. The OIG disagreed with the Centralized Screening Team’s assertion that misconduct that had potentially contributed to an incarcerated person’s death “did not involve an incarcerated person.” However, although the Centralized Screening Team did not refer the allegation to the Office of Internal Affairs’ Allegation Investigation Unit, it did refer the allegation to another unit within the Office of Internal Affairs for an investigation, so the OIG did not dispute the matter.

As discussed earlier in this report, the OIG publishes monthly notable screening decisions consisting of examples of cases in which the Centralized Screening Team performed satisfactorily, cases in which the Centralized Screening Team made overtly incorrect decisions, and cases in which the Centralized Screening Team and the OIG disagreed on screening decisions.

## The Department Has Generated Duplicative Case Numbers on Hundreds of Grievances, Thereby Inflating the Reported Number of Complaints Submitted by the Incarcerated Population, and Has Unnecessarily Duplicated Its Own Reviews of Certain Complaints

On May 2, 2024, the Legislature criticized the department for the number of complaints submitted by incarcerated people under its care.

**120,000 complaints in a single year, that's concerning . . . especially considering that we have a shrinking prison population . . . it does not make sense . . . 120,000 complaints, whether small complaints or big complaints, that's a problem.<sup>8</sup>**

During the OIG's monitoring of the department's screening decisions, we found that because of its inefficient business processes that failed to track the number of unique<sup>9</sup> complaints it received, the department overreported the number of complaints it received. Specifically, the department regularly created two, and sometimes created three or more grievance records, hereinafter referred to as *log numbers*, for a single complaint form. We found four common occurrences in which the department assigned secondary log numbers to the same complaint form. Below are the four common occurrences we found:

1. reassigning the complaint form from one prison to another,
2. creating both a log number and a direct-entry record based on the same complaint form,
3. remedying a dispute after a decision letter has already been sent to the incarcerated person who had filed the complaint, and
4. handling complaints related to the reasonable accommodation panel.

### Reassignments

When an incarcerated person submits a complaint at one prison about an incident that occurred at another prison, the department must reassign

8. The Honorable Aisha Wahab, California State Senator, Senate Budget and Fiscal Review Subcommittee No. 5 on Corrections, Public Safety, Judiciary, Labor and Transportation, May 2, 2024.

9. We consider unique complaints to be individual complaints, including when an incarcerated person submits multiple complaints of the same allegation. Additional log numbers the department creates for the existing complaint are *not* considered unique complaints.

the allegation to the prison where the incident occurred. As a result, the department generates two separate log numbers for the single grievance, thereby overreporting its volume of grievances. In doing so, it causes inconsistencies and duplicates work.

For example, on August 23, 2022, an incarcerated person submitted a staff misconduct complaint form alleging that on August 4, 2022, officers threw him into a cell, which caused him to hit his head and suffer a laceration to his eyebrow at Prison 1. The Prison 1 Office of Grievances assigned the complaint a log number of 01 at Prison 1, and the Centralized Screening Team reassigned the unreasonable force allegation to Prison 2 because it believed the unreasonable force occurred at Prison 2. The Prison 2 Office of Grievances then opened log number 02 at Prison 2. On September 7, 2022, the Centralized Screening Team reassigned the unreasonable force allegation back to Prison 1 because the incarcerated person was housed at Prison 1 on the date of the incident. The Office of Grievances at Prison 1 then opened log number 03, and on September 14, 2022, the Centralized Screening Team incorrectly referred the unreasonable force allegation to the hiring authority for a local inquiry at Prison 1 rather than referring it to the Office of Internal Affairs' Allegation Investigation Unit for an investigation.

On January 30, 2024, the Centralized Screening Team sent the incarcerated person an amended decision letter for log number 03, indicating the Centralized Screening Team had failed to assign the complaint to the correct prison before processing the allegation. The Prison 1 Office of Grievances then created log number 04 at Prison 1, which the Centralized Screening Team immediately reassigned to Prison 2 for a local inquiry into the unreasonable force allegation. This reassignment resulted in the creation of log number 05.<sup>10</sup>

On February 7, 2024, the Centralized Screening Team, once again, reassigned the unreasonable force allegation from Prison 2 back to Prison 1, and for the first time, correctly determined the allegation warranted a referral to the Office of Internal Affairs' Allegation Investigation Unit. The Prison 1 Office of Grievances opened log number 06 at Prison 1, and the Centralized Screening Team finally referred the unreasonable force allegation to the Office of Internal Affairs' Allegation Investigation Unit for an investigation on February 9, 2024, six log numbers and 535 calendars days after the Centralized Screening Team first received the complaint.

This single complaint an incarcerated person had submitted on August 23, 2022, resulted in six different log numbers over the course of two years. The department counted the log numbers as though it had received six distinct complaints instead of one. Furthermore, because the department lacks a method of tracking and linking log numbers assigned to a single, original complaint form, it failed to readily identify that it had

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10. Log number 05 was the first log number in this chain of log numbers that fell into the OIG's sample. We then also monitored the decision for log number 06.

routed this complaint between two prisons and unnecessarily reassigned it several times.

Of the 9,245 complaints the OIG monitored, we processed at least 320 reassignments.<sup>11</sup>

### Direct Entries

Complaints the hiring authority submits to the Centralized Screening Team via the central repository<sup>12</sup> are labeled “direct entry.” Direct entries usually stem from either a verbal complaint by an incarcerated person or a complaint (either written or verbal) from a third-party group or individual. However, upon receiving allegations of unreasonable force or staff sexual misconduct, prison staff must interview the incarcerated person within 48 hours of receiving the complaint. When an incarcerated person’s written staff misconduct grievance is the first notification of such an allegation, the Office of Grievances and Centralized Screening Team are responsible for requesting that appropriate prison staff promptly conduct the required interview. The OIG found this practice caused prison staff to create an unnecessary direct-entry duplicate of the staff misconduct grievance instead of including the additional details in the original grievance record.

On September 3, 2024, a prison (Prison 1) received a complaint from an incarcerated person alleging an officer touched the incarcerated person inappropriately during a clothed body search, and a lieutenant and a second officer allegedly ignored the incarcerated person’s report of the first officer’s alleged sexual misconduct. Prison 1’s Office of Grievances notified prison staff to interview the incarcerated person about the alleged staff sexual misconduct on September 4, 2024. Simultaneously, Prison 1 reassigned the complaint to Prison 2, where the incident allegedly occurred, which led the department to generate a second log number for this complaint. Prison 2 staff conducted the required interview with the incarcerated person, but instead of reporting the relevant information back to Prison 1’s Office of Grievances to include in the staff misconduct record, they created a new direct-entry record—a third record—also stemming from the same complaint form. In the direct-entry record, the staff member documented, “[Prison 1] ISU [investigative services unit] was notified of a possible PREA [Prison Rape Elimination Act] violation. This followed a complaint submitted via [a staff misconduct grievance form] to the [Prison 1] Office of Grievances . . .” Moreover, the Centralized Screening Team referred this direct-entry record to the Office of Internal Affairs’ Allegation Investigation Unit for an investigation of staff sexual misconduct. However, after the

11. We manually documented this number of cases to be reassignments. However, because these complaints are difficult to identify, there may have been more that we failed to manually capture.

12. A central repository is a secure collection location for submission of staff misconduct allegations documented or received by departmental staff. A central repository may be either a physical location at a work site or an email address provided for the purpose of submitting allegations of staff misconduct.

complaint was reassigned to Prison 2, the Centralized Screening Team had contradictorily determined the allegation to be a routine matter and not staff sexual misconduct.

This single complaint form resulted in three distinct records, and the Centralized Screening Team informed us that “Even though it stems from a [grievance log] many of the institutions also create the [direct entries] to go with them, we just note them as sub[sequent] sources [to the existing grievance log].”

Of the 9,245 complaints monitored by the OIG, we processed two duplicative case records the department had unnecessarily created. After the Office of Grievances requested an interview for the written complaint, the department unnecessarily created a duplicative record to document the interview rather than adding to the existing complaint record. Although we only found two duplicative case records the department unnecessarily created, we are concerned this is a widespread issue because we were only able to monitor 4 percent of the total complaints the department received.

### Disputes

If any departmental stakeholder or the OIG disputes a screening decision the Centralized Screening Team has made, the department creates a new log number. The department informed us the Centralized Screening Team cannot make the change in the existing entry once it has issued a decision letter. Thus, the Centralized Screening Team must create a new log number and grievance record to amend its error in the original complaint.

In one case, an incarcerated person submitted an 18-page staff misconduct complaint in which the Centralized Screening Team identified a single routine allegation about a power outage. The OIG disputed the Centralized Screening Team’s decision within two business days because the complaint included several staff misconduct allegations. The OIG recommended the Centralized Screening Team rereview the entirety of the complaint. Subsequently, the Centralized Screening Team rereviewed the complaint and conducted a clarification interview with the incarcerated person, which identified 15 additional allegations. The Centralized Screening Team determined 13 of the previously unidentified allegations, such as unreasonable force, sexual harassment, and dishonesty, warranted referrals to the Office of Internal Affairs’ Allegation Investigation Unit. However, by the time the Centralized Screening Team rescreened the complaint, interviewed the incarcerated person, and identified the additional allegations, the prison’s Office of Grievances had already sent the incarcerated person a decision letter regarding the power outage allegation. Therefore, the Centralized Screening Team could not correct the errors in the existing case, but had to open a new grievance log number to address all the allegations.

Surprisingly, the department creates a new grievance record when any case is disputed after the Office of Grievances has already sent a decision letter to the incarcerated person. The process also applies to amended decision letters<sup>13</sup> authored by the Centralized Screening Team. The OIG monitored at least 632 log numbers that had been opened because an amended decision was disputed.

### Reasonable Accommodation Responses

Effective September 3, 2024, the department elected to create two separate log numbers for any complaint that also required a response from the reasonable accommodation panel.<sup>14</sup> In one complaint, an incarcerated person reported that, because of his visual impairment, he could not lock the locker in his bunk area. Therefore, the incarcerated person requested a lock “a blind person could use.”

The department assigned the single complaint two distinct log numbers. It processed the first log number as a routine complaint concerning the incarcerated person’s inability to lock up any personal items, and it processed the second log number for the reasonable accommodation panel to address the request for a special lock. See Exhibit 1: Reasonable Accommodation Request below.

### Exhibit 1. Reasonable Accommodation Request

STATE OF CALIFORNIA REASONABLE ACCOMMODATION REQUEST CDCR 1824 (Rev. 09/17)		DEPARTMENT OF CORRECTIONS AND REHABILITATION	
INSTITUTION (Staff use only)		LOG NUMBER (Staff Use Only)	DATE RECEIVED BY STAFF:
*****TALK TO STAFF IF YOU HAVE AN EMERGENCY*****			SEP 03 2024
DO NOT use a CDCR 1824 to request health care or to appeal a health care decision. This may delay your access to health care. Instead, submit a CDC 7362 or a CDCR 602-HC			
INMATE'S NAME (Print)	CDCR NUMBER	ASSIGNMENT	HOUSING
INSTRUCTIONS:			
<ul style="list-style-type: none"> <li>You may use this form if you have a physical or mental disability or if you believe you have a physical or mental disability.</li> <li>You may use this form to request a specific reasonable accommodation which, if approved, will enable you to access and/or</li> </ul>			

Source: California Department of Corrections and Rehabilitation

13. An amended decision letter is a document sent to an incarcerated person notifying the incarcerated person that a previous screening decision regarding a claim the incarcerated person made has been changed. The document also contains information regarding the new decision and how the claim will be processed.

14. Reasonable accommodations are modifications to programs, services, or activities, or the issuance of assistive devices, which make it possible for a qualified incarcerated person with a disability to achieve equal access to the department’s programs, services, or activities, without imposing an undue hardship on the department or posing a direct threat to the health, safety, or security of the incarcerated person, parolee, staff, prison, or anyone else. The reasonable accommodation panel is the group of individuals who determine an incarcerated person’s eligibility for reasonable accommodations.

From September 3, 2024, through December 31, 2024, the OIG monitored 54 complaints<sup>15</sup> for which the department created two separate log numbers. To accurately count unique grievances, the Centralized Screening Team reported it could subtract any “RAP [reasonable accommodation panel] only” complaints from the total number of complaints received for the year based on the reasonable accommodation panel claim.

Before September 3, 2024, any complaint requiring a response from the reasonable accommodation panel included a reasonable accommodation panel claim. However, this was not true for all complaints received after September 3, 2024, due to inconsistencies across prisons’ respective Offices of Grievances. The department often included the reasonable accommodation panel claim in the initial grievance record rather than creating a separate, distinct log number for the reasonable accommodation panel claim. Because of this inconsistency, subtracting reasonable accommodation panel complaints would likely result in subtracting too many complaints from the total.

On October 11, 2024, the department confirmed it has no way of tracking unique grievance form submissions. When it created multiple records for the same complaint form, it did not link those additional records to the original records in its database.

At a minimum, the OIG monitored 1,008 duplicative grievance log records, which the department could not track or link to the original source record to determine the number of unique complaints it received in 2024. Moreover, every time the department creates a duplicative record, the Centralized Screening Team must rereview the complaint because the duplicative record does not note that the Centralized Screening Team had previously reviewed the complaint. The department has done itself a disservice by allowing these inefficient business processes that result in duplicating reviews and overinflating the number of complaints submitted by the incarcerated population.

### *Recommendations*

- The OIG recommends the department consider ending its practice of creating new log numbers and instead implement a practice of reopening the original log number to make corrections.
- The OIG recommends the department develop a method of linking reassigned complaints and reasonable accommodation responses to ensure that the complaint is assigned to the correct entity and to accurately track and report unique complaints.

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15. These 54 cases are not included in the OIG’s total of 9,245, as we discontinued our monitoring of any RAP-only complaint and added the associated non-RAP-related complaint for monitoring.

## The OIG Determined the Centralized Screening Team Failed to Properly Screen Complaints at “Face-Value” in 15 Percent of the Cases We Monitored

Effective March 19, 2024, the Centralized Screening Team implemented “face-value screening” at two<sup>16</sup> of the 33 departmental prisons.<sup>17</sup> On May 1, 2024, the Centralized Screening Team began screening complaints from the six *Armstrong*<sup>18</sup> prisons at face value. Although the department does not have a definition of “face-value screening,” it reported its intent to route complaints based only on what the incarcerated person alleged, without question, and regardless of the specific behavior described, lack of substantiating facts to support the allegation, or other appropriate and plausible reasons for the alleged misconduct. The OIG became aware of the face-value screening process in May 2024, when we began reviewing claims the Centralized Screening Team summarized by referencing a decision “based on face value.” On May 17, 2024, we asked Centralized Screening Team managers about the new verbiage, and they informed us that the Centralized Screening Team screens all complaints according “to the regulations and the remedial plan,” but screens the complaints from eight prisons based solely on the “face” of the complaint, rather than the merits of the complaint.

The OIG tracked all complaints we monitored and elevated from March 19, 2024, through December 31, 2024, at those eight prisons. As displayed in the table on the next page, we elevated 208 complaints, which we determined the Centralized Screening Team did not screen at face value.

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16. These two prisons are California State Prison, Sacramento, and Folsom State Prison.

17. California City Correctional Facility closed in March 2024, and Chuckawalla Valley State Prison closed in October 2024.

18. The six *Armstrong* prisons are California Institution for Women; California State Prison, Corcoran; California State Prison, Los Angeles County; Kern Valley State Prison; Richard J. Donovan Correctional Facility; and Substance Abuse Treatment Facility and State Prison, Corcoran.

**Table 2. Face-Value Screening Decisions Monitored and Elevated by the OIG**

Prison	Number of Cases Monitored by the OIG at Face Value	Number of Elevated Decisions Based on Face-Value Screening
California Institution for Women	116	5
California State Prison, Corcoran	239	21
California State Prison, Los Angeles County	507	32
California State Prison, Sacramento	361	20
Folsom State Prison	76	3
Kern Valley State Prison	236	10
Richard J. Donovan Correctional Facility	698	76
Substance Abuse Treatment Facility and State Prison, Corcoran	531	41
<b>Total</b>	<b>2,764</b>	<b>208</b>

Note: Elevations included, but were not limited to, allegations of staff sexual misconduct, use of force, falsification of documents, introducing contraband into the prison, retaliation for filing grievances, discrimination, and harassment.

Source: The Office of the Inspector General.

Of the 208 complaints the OIG elevated, the Centralized Screening Team agreed and amended its screening decision in 200 complaints or 96 percent.

Several examples of complaints we determined the Centralized Screening Team did not assess at face value are included below.

In one example as noted in Exhibit 2, the Centralized Screening Team referred the allegation of harassment for a local inquiry. The OIG did not concur and recommended referring the allegation to the Office of Internal Affairs' Allegation Investigation Unit.

### Exhibit 2. Excerpt From an Incarcerated Person's Complaint

NOTE: Attach documents that help support your complaint (identify the documents if you do not have them).

Harassment by C/O [REDACTED] THIS IS A  
CITIZEN COMPLAINT.

Source: The California Department of Corrections and Rehabilitation.

We advised that if the Centralized Screening Team disagreed with our recommendation, it should at least conduct a clarification interview with the incarcerated person who submitted the complaint regarding the alleged harassment. The Centralized Screening Team declined to conduct an interview, claiming the local inquiry referral of the allegation of harassment was “at face value.” The OIG disagreed with the Centralized Screening Team’s decision because “harassment” is listed on the allegation decision index and, therefore, warrants a referral to the Office of Internal Affairs’ Allegation Investigation Unit for an investigation, not to the hiring authority for a local inquiry.

In another example noted below in Exhibit 3, the Centralized Screening Team failed to refer to the Office of Internal Affairs’ Allegation Investigation Unit an incarcerated person’s allegation that he had received a rules violation report in retaliation for filing staff misconduct complaints.

### Exhibit 3. Excerpt From Prison Staff’s Summary of a Third-Party Complaint

█████ alleged he received a Rules Violation Report in retaliation for previously filing a sexual harassment complaint. █████ also alleged policy violations related to an RVR Hearing for RVR # █████. Specifically, the Hearing Lieutenant denied █████’s request for AVSS footage and witness testimony. █████ claimed he missed work to grieve the death of his mother.

Source: The California Department of Corrections and Rehabilitation.

The Centralized Screening Team also found the incarcerated person’s staff sexual misconduct allegations had been handled under a prior complaint, and based on a report by the prison’s investigative services unit, the Centralized Screening Team determined the allegation of staff sexual misconduct did not to meet Prison Rape Elimination Act criteria. The Centralized Screening Team based its screening decision for the most recent complaint on the same report rather than considering the complaint at face value, and routed the allegation as a routine issue. After the OIG disputed the decision, the Centralized Screening Team referred both the retaliation and staff sexual misconduct allegations to the Office of Internal Affairs’ Allegation Investigation Unit.

In another example depicted in Exhibit 4, an incarcerated person alleged a staff member provided incarcerated people with tobacco.

### Exhibit 4. Excerpt From an Incarcerated Person’s Complaint

her three times on this subject of smoking by inmates with impunity in the month of Oct. The smokers are being provided with a substantial amount of tobacco by a staff member.

Source: The California Department of Corrections and Rehabilitation.

The Centralized Screening Team failed to identify the incarcerated person's statement as an allegation at all, and therefore, did not refer the allegation at face value. After the OIG elevated the issue, the Centralized Screening Team appropriately referred to the Office of Internal Affairs' Allegation Investigation Unit the allegation that a staff member had provided tobacco to incarcerated people.

In another example shown in Exhibit 5, the Centralized Screening Team referred an incarcerated person's allegation that a sergeant had conducted an unclothed body search of the incarcerated person in front of others to the hiring authority for a local inquiry, instead of identifying the allegation as staff sexual misconduct.

#### Exhibit 5. Excerpt From an Incarcerated Person's Complaint

was lead to the A salty 'port cage where I was made to strip completely naked with the cage door open and the courtesy blocker not blocking my private parts for all to see. Per Title 15

Source: The California Department of Corrections and Rehabilitation

After the OIG disputed the decision, the Centralized Screening Team conducted a clarification interview with the incarcerated person and subsequently referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit.

In another example shown in Exhibit 6 below, the Centralized Screening Team failed to identify and refer an incarcerated person's allegation that an officer had assaulted multiple incarcerated people as an allegation of staff misconduct.

#### Exhibit 6. Excerpt From an Incarcerated Person's Complaint

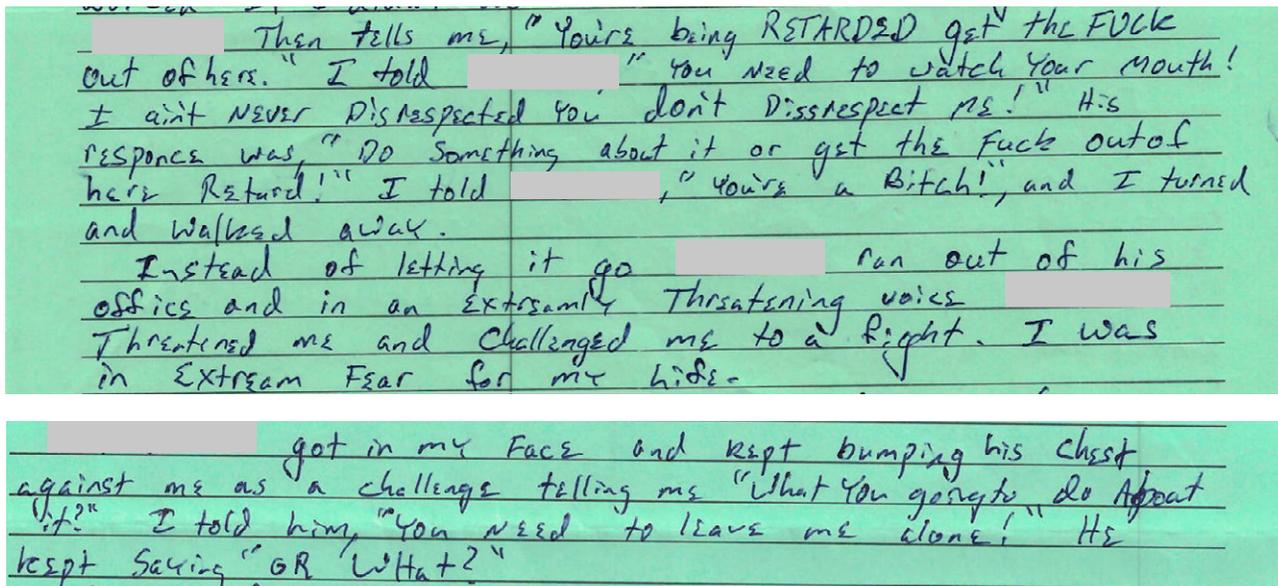
Incarcerated persons of his choice. An because [redacted] has been observed assaulting various incarcerated persons on the [redacted] Yard, we are asking to have him [redacted]

Source: The California Department of Corrections and Rehabilitation.

After the OIG disputed the matter, the Centralized Screening Team referred the unreasonable force allegation to the Office of Internal Affairs' Allegation Investigation Unit.

In this last example shown in Exhibit 7, the Centralized Screening Team only referred to the hiring authority the allegations that the counselor had used discriminatory language and unreasonable force, engaged in threatening behavior, and created an opportunity for harm even though the allegations, if taken at face value, were listed on the allegation decision index.

### Exhibit 7. Excerpts From an Incarcerated Person's Complaint



Source: The California Department of Corrections and Rehabilitation.

After the OIG disputed the decision, the Centralized Screening Team appropriately referred all allegations against the counselor to the Office of Internal Affairs' Allegation Investigation Unit.

For the 2024 monitoring period, we rated the Centralized Screening Team's decisions *poor* overall in 11 percent of cases, and we determined its decisions specific to these eight prisons (3,650 complaints) were *poor* in 15 percent of cases. That is an alarmingly high rate of *poor* routing decisions, especially when the Centralized Screening Team should have based its decision solely on the face value of the complaint.

Screening a complaint on its face, rather than on its merits, should be straightforward. If the incarcerated person alleged anything listed on the allegation decision index, including but not limited to staff sexual misconduct, unreasonable force, discrimination, harassment, or dishonesty, the Centralized Screening Team should refer the allegation to the Office of Internal Affairs' Allegation Investigation Unit.

### *Recommendation*

The OIG recommends the Centralized Screening Team train its staff to accurately identify allegations it receives in complaints and not minimize them. The OIG made a standing request to be included in any substantive training with the Centralized Screening Team, and we were neither informed of nor invited to attend any training related to face-value screening.

## The Department Unnecessarily Wasted Time and Resources by Rerouting Grievances Multiple Times in Contradiction of Policy and Best Practices to Clear a Backlog at Two Prisons

In January 2024, the department established a strike team to address a backlog of local inquiry cases at two prisons. During the initial screening of those cases, the Centralized Screening Team had determined the cases included allegations of staff misconduct that were not listed on the allegation decision index and, therefore, routed the cases to the prisons where the alleged misconduct occurred for a local inquiry. The OIG became aware of the department's strike team when we observed an increase in the number of cases that included amended decision letters. When we raised our finding regarding the increase in amended decision letters, the Centralized Screening Team advised us the letters were related to a strike team the department had created to address a backlog of local inquiry cases at two prisons. The strike team was tasked with reviewing the backlog to determine whether the Centralized Screening Team's original decision to refer the case for a local inquiry was appropriate, and if so, the prison would conduct a local inquiry. Based on its review, the strike team could either proceed with the local inquiry, request to route the allegations to the prison to conduct a routine fact-finding, or route the allegations to the Office of Internal Affairs' Allegation Investigation Unit to conduct an investigation. Centralized Screening Team managers stated they reviewed all the cases the strike team had submitted for rerouting.

The OIG requested the department provide us with all information related to the cases the strike team and the Centralized Screening Team had reviewed. We reviewed a total of 370 cases the prisons had returned to the Centralized Screening Team. Of the 370 cases we reviewed, the Centralized Screening Team changed the routing designation from local inquiry to routine fact-finding in 229 cases.

Based on our review of the 229 cases the strike team changed from a local inquiry to a routine fact-finding, we disagreed with 48 of the decisions. We determined most of the decisions we disagreed with contained allegations of staff misconduct and should have remained at the local-inquiry level. Moreover, we found some cases included allegations of staff misconduct listed on the allegation decision index that warranted a referral to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. The OIG elevated the 48 decisions that we disagreed with back to the Centralized Screening Team for reconsideration. The Centralized Screening Team agreed with us in all 48 cases in which we disputed the decision for routine fact-finding. Of the 48 cases, 26 were referred back to the prisons for the local inquiry process, and 10 were referred to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. Although we only disagreed with 48 of the 292 initial

rerouting decisions or 16 percent of decisions the Centralized Screening Team had made, the error rate was much higher when compared to the rest of the Centralized Screening Team's routing decisions we reviewed in 2024, which resulted in an 8 percent disagreement rate. However, we commend the Centralized Screening Team for considering our feedback, as it eventually agreed with every dispute we elevated regarding these cases.

In addition to the department's poor initial rerouting decisions, the OIG is also concerned with the department's apparent waste of resources. The department unnecessarily reviewed and processed 36 cases multiple times to reanalyze the secondary routing decision. Because prisons unnecessarily requested to reroute cases that clearly met the criteria for staff misconduct, the department experienced long delays and wasted several weeks. After the prisons' rerouting requests were made, the Centralized Screening Team and the OIG analyzed the complaints multiple times until, finally, the complaints were either returned to the corresponding prison to proceed with its original decision, or routed to the Office of Internal Affairs for an investigation.

Lastly, because the prisons caused extensive delays in addressing grievances, we found that the legal deadline for taking disciplinary action had expired in four of the 10 cases we had recommended the department refer to the Office of Internal Affairs' Allegation Investigation Unit for an investigation. Therefore, the department could not impose any discipline on subject employees in those cases, even if the allegations were found to be true. Below are two examples of cases the department eventually referred for investigation after the deadline to take disciplinary action had passed.

In one case, an incarcerated person alleged that an officer of a certain race would not let him go to the dayroom on Wednesday and Thursday and advised the incarcerated person he must either remain in his cell or go outside because of his Americans with Disabilities Act (ADA) worker status. The incarcerated person stated the officer allowed other ADA workers out of their cells and in the dayroom whenever they wanted because they were the same race as the officer. The incarcerated person further stated the officer did not like the incarcerated person because he was of another race. The Centralized Screening Team's original decision to refer the case for a local inquiry was amended by the strike team for a routine fact-finding. The OIG elevated the case back to the Centralized Screening Team based on the incarcerated person's allegations that the officer had discriminated against the incarcerated person based on his race. The Centralized Screening Team then appropriately referred the allegations to the Office of Internal Affairs' Allegation Investigation Unit. A total of 545 calendar days elapsed from when the department had initially received the case on December 14, 2022, until the case was referred to the Office of Internal Affairs' Allegation Investigation Unit for an investigation on June 11, 2024. During this delay, the one-year

statute of limitations passed, which precluded the department from imposing discipline if the investigation were to uncover sufficient evidence to support claims of staff misconduct.

In another case, an incarcerated person alleged a sergeant and officers used chemicals in an attempt to poison him while he was in his cell. The incarcerated person further alleged that after being transferred to another facility within the prison, officers enlisted other incarcerated people to put chemicals in his food, drinks, bowls, and cups. The incarcerated person alleged he had been poisoned multiple times to the extent he required medical attention.

The Centralized Screening Team initially routed this complaint for a local inquiry. Subsequently, the strike team amended the decision and routed the complaint as a routine issue. The OIG reviewed the amended decision and elevated the case back to the Centralized Screening Team stating the incarcerated person's allegation that staff had tampered with his food was factually plausible, as was the allegation that staff had used other incarcerated people to commit acts on the staff's behalf. The Centralized Screening Team then appropriately referred the case to the Office of Internal Affairs' Allegation Investigation Unit. A total of 460 calendar days elapsed from the time the department initially received the case on November 2, 2022, until it referred the case to the Office of Internal Affairs' Allegation Investigation Unit for an investigation on February 5, 2024. During the delay, the one-year statute of limitations passed, thereby precluding the department from imposing discipline against the sergeant and officers if the investigation were to uncover sufficient evidence to support claims of staff misconduct.

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## The OIG's Recommendations to the Department Regarding Its Centralized Screening Team Process

- The OIG recommends the department consider ending its practice of creating new log numbers and instead implement a practice of reopening the original log number to make corrections.
- The OIG recommends the department develop a method of linking reassigned complaints and reasonable accommodation responses to ensure that the complaint is assigned to the correct entity and to accurately track and report unique complaints.
- The OIG recommends the Centralized Screening Team train its staff to accurately identify allegations it receives in complaints and not minimize them. The OIG made a standing request to be included in any substantive training with the Centralized Screening Team, and we were neither informed of nor invited to attend any training related to face-value screening.

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**The Office of the Inspector General's  
Monitoring in 2024 of the  
Centralized Screening Team Process  
of the California Department of Corrections  
and Rehabilitation**

*2024 Annual Report*

OFFICE *of the* INSPECTOR GENERAL

*Amarik K. Singh*  
Inspector General

*Shaun Spillane*  
Chief Deputy Inspector General

STATE of CALIFORNIA  
March 2025

**OIG**