

Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

July–December 2013

Volume II



March 2014

**Fairness ♦ Integrity ♦ Respect ♦
Service ♦ Transparency ♦**

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March 2014



FOREWORD

This 18th Semi-Annual Report covers the time period of July through December 2013. Pursuant to California Penal Code Section 6125 et seq., the Office of the Inspector General (OIG) is required to report semi-annually on its oversight of the California Department of Corrections and Rehabilitation's (CDCR or the department) Office of Internal Affairs investigations and the employee discipline process. The OIG's Semi-Annual Reports have primarily served this purpose.

In addition to its oversight of CDCR's employee discipline process, the OIG also uses a real-time monitoring model to provide oversight and transparency in several other areas within the State prison system. Therefore, the OIG is now publishing the Semi-Annual Reports in a two-volume format to allow readers to more easily distinguish the various categories of oversight activity.

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

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

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

TABLE OF CONTENTS

VOLUME II

SUMMARY OF OTHER MONITORING ACTIVITIES	1
MONITORING CRITICAL INCIDENTS.....	2
<i>Monitoring Deadly Force Incidents</i>	<i>4</i>
MONITORING USE OF FORCE.....	7
MONITORING CONTRABAND SURVEILLANCE WATCH.....	10
CONCLUSION	18
VOLUME II RECOMMENDATIONS.....	21
VOLUME II RECOMMENDATIONS FROM PRIOR REPORTING PERIODS	212
APPENDICES.....	25

SUMMARY OF OTHER MONITORING ACTIVITIES

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

Historically, the OIG has maintained response capability 24 hours per day, seven days per week, for any critical incident occurring within the prison system. OIG staff respond on scene (when timely notified) to assess the department's handling of incidents that pose a high risk for the State, staff, or inmates. The factors leading up to each incident, the department's response to the incident, and the outcome of the incident are all assessed and reported; then, if appropriate, recommendations are made by the OIG. To provide transparency into the incidents, these cases are reported in Appendix D. In addition, this report contains an Appendix D2 detailing 18 hunger strike cases monitored primarily during the statewide hunger strike that had potential negative outcomes. During the strike the OIG also monitored weekly activities at all institutions having a large concentration of involved inmates to assure overall adherence to hunger strike policies.

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

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

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

MONITORING CRITICAL INCIDENTS

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

1. Any use of deadly force, including warning shots;
2. Any death or any serious injury that creates a substantial risk of death to an individual in the custody or control of the department,¹ excluding lawful executions;
3. Any on-duty death of a department staff member;
4. Any off-duty death of a department staff member when the death has a nexus to the employee's duties at the department;
5. Any suicide by an adult individual in the custody or control of the department and any suicide or attempted suicide by a juvenile ward in the custody or control of the department;
6. All allegations of rape or sexual assault as defined by the Prison Rape Elimination Act made by an individual in the legal custody or physical control of the department, including alleged staff involvement;
7. Any time an inmate is placed on or removed from contraband surveillance watch;²
8. Any riot or disturbance within an institution or facility that requires a significant number of department staff to respond or mutual aid from an outside law enforcement agency;
9. Any incident of notoriety or significant interest to the public; and
10. Any other significant incident identified by the OIG after proper notification to the department.

The OIG maintains a 24-hour contact number in each region to receive notifications. After notification, the OIG monitors the department's management of the incident, either by responding to the site of the incident or by obtaining the incident reports and following up on scene at a later time. More specifically, the OIG evaluates what caused the incident and the department's immediate response to the incident. The OIG may make recommendations as a result of its review regarding training, policy, or referral for further investigation of potential negligence or misconduct. If the OIG believes the incident should be referred to the Office of Internal Affairs, the decision regarding any referral is also monitored. If the matter is opened for an investigation, the OIG monitors the ensuing investigation. Critical incidents are customarily reported in the Semi-Annual Report following the incident occurrence. However, if an investigation is initiated, a report may be held at the discretion of the Inspector General until the completion if reporting it would potentially negatively impact the integrity of the internal investigation.

During the reporting period, the OIG completed assessments of 133 critical incidents (Appendices D and E). It is important to note that the number of critical incidents within any period is dependent upon the events taking place within the department. This report does not directly correlate to incidents that occurred within this time frame, but rather reflects the number

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

² Contraband surveillance watch cases are summarized on page 10 and detailed in Appendix F.

of incidents the OIG has assessed and closed for the time period. In addition, in order to monitor an incident on scene, the OIG relies on the department to provide timely notification that a critical incident has occurred. However, even when notification is untimely, the OIG still remotely monitors the event by collection of reports and follow-up review.

The total number of monitored critical incidents closed and reported each reporting period by the OIG is displayed in Chart 1. It does not directly reflect the exact number of incidents occurring during each period because the OIG does not report incidents until a final assessment is completed. Some incidents may take longer than others to be resolved.

For cases reported during this period, the department failed to provide required timely notification for 20 percent of the critical incidents. The percentage of delayed notifications is the same as that of the prior reporting period. Delays in notification impact the OIG’s ability to provide real-time, on-site monitoring for critical incidents.

The OIG also monitors critical incidents as they occur in the juvenile system. During this reporting period, there were no critical incident assessments closed involving juvenile facilities.

Chart 1: Monitored Critical Incidents Closed by the OIG Each Reporting Period

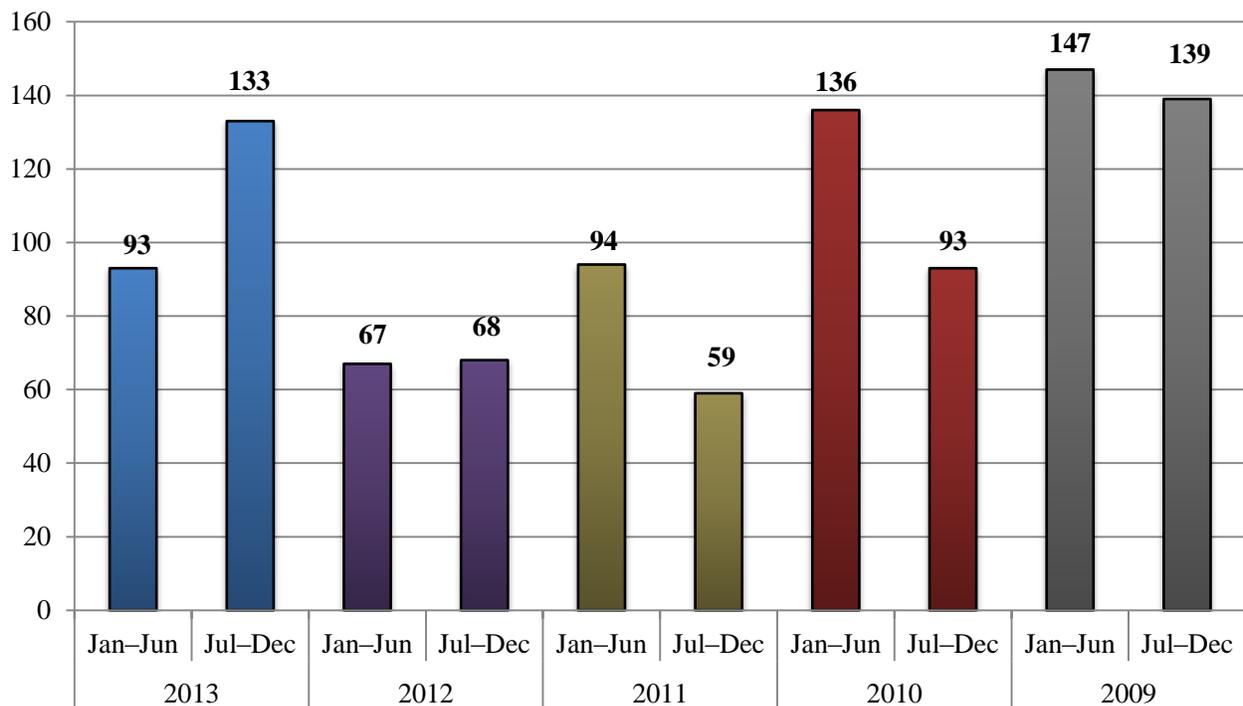
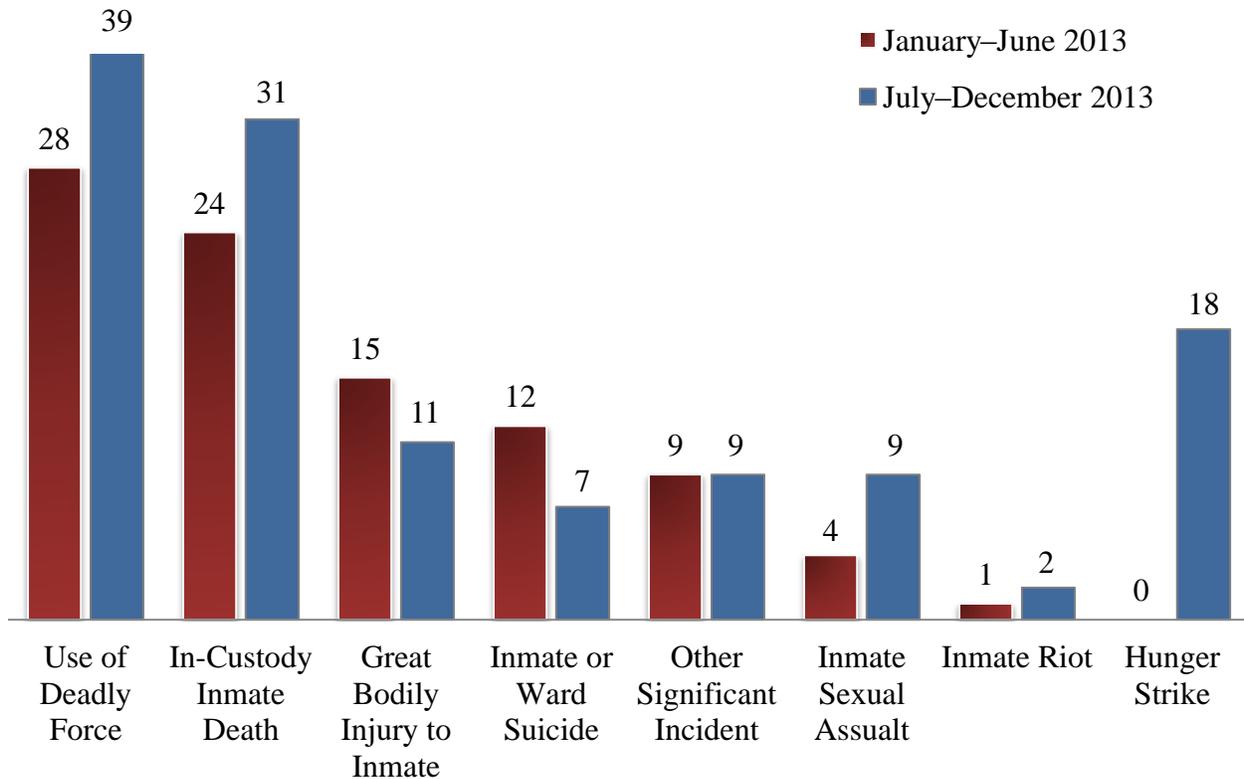


Chart 2: Types of Critical Incidents Closed and Reported This Period



MONITORING DEADLY FORCE INCIDENTS

Deadly force incidents are a sub-type of both critical incidents and use-of-force reviews monitored by the OIG. They automatically result in both an administrative and a criminal investigation if the Office of Internal Affairs chooses to conduct a deadly force investigation, with the only exception being when the force occurs outside the prison and an outside law enforcement agency conducts the criminal investigation. Appendix E contains each use of deadly force case closed in this reporting period, regardless of whether the Office of Internal Affairs was involved.

Any time CDCR staff use deadly force, the department is required to promptly notify the OIG. When timely notice of a deadly force incident is received, OIG staff immediately respond to the incident scene to evaluate the department’s management of the incident and the department’s subsequent deadly force investigations, if initiated.

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

The Office of Internal Affairs Deadly Force Investigation Team is described and regulated by Title 15, California Code of Regulations, Article 1.5, Section 3268(20).

Deadly Force Investigation Teams (DFIT): DFIT is a team of trained department investigators that shall conduct criminal and administrative investigations into every use of deadly force and every death or great bodily injury that could have been caused by a staff use of force, except the lawful discharge of a firearm during weapons qualifications or firearms training, or other legal recreational uses of a firearm. Although defined as deadly force DFIT need not investigate the discharge of a warning shot inside an institution/facility if an Investigative Services Unit Sergeant or above, or an uninvolved Correctional Lieutenant or above confirms that the discharge of deadly force was a warning shot and that no injuries were caused by the shot. All warning shots shall be reported to the Office of Internal Affairs/DFIT and the Bureau of Independent Review (BIR).³

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

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

Because the use of deadly force has such serious implications, the department's use of deadly force has always received the highest level of scrutiny. The OIG monitored 39 deadly force incidents that concluded during this reporting period. The incidents included unintentional head strikes, warning shots, intentional uses of lethal weapons, and other uses of force that could have or did result in great bodily injury or death.

The Office of Internal Affairs responded with a Deadly Force Investigation Team in 11 of the 39 cases the OIG monitored, and in one case outside law enforcement responded to the scene instead of the Deadly Force Investigation Team. During the 39 incidents monitored by the OIG, various types of force were used, and in many cases, a variety of force options were utilized.

³ In July 2011 the BIR was redesignated as the Office of the Inspector General (OIG).

There was one case where the use of lethal force resulted in death. In 15 incidents, less-lethal weapons were fired, unintentionally striking inmates in the head, none of which resulted in death.

In seven of the incidents to which no Deadly Force Investigation Team responded, inmates were transported to outside hospitals for medical treatment of injuries, including lacerations requiring sutures and staples to the head and face, bruising, bleeding, and swelling, sustained from, specifically, correctional officers' unintentional blows to the head.

There were six additional incidents that did not receive a Deadly Force Investigation Team response where unintentional head strikes occurred but did not require outside hospitalization. Although no inmates were killed in the incidents in which department staff inflicted unintentional head strikes, any one of those incidents certainly could have resulted in serious injury and subjected the department to major liability. The department is currently addressing the need for responses to more of these incidents. In response to previous concerns raised by the OIG, on January 16, 2014, the Deputy Director for the Office of Internal Affairs distributed a memorandum to all CDCR extended executive staff, which informed all staff that, pursuant to Title 15 and the Department Operations Manual, the Office of Internal Affairs would respond with a Deadly Force Investigation Team to any strike to the head of a person with a baton or impact munitions. This has significantly expanded the scope and number of cases that the Office of Internal Affairs will now investigate, and is a significant positive development in the investigation of deadly force incidents.

MONITORING USE OF FORCE

The department is tasked with maintaining the safety and security of staff members, inmates, visitors, and the public. At times, this responsibility requires the use of force by sworn correctional officers. In doing so, officers are authorized to use “reasonable force,” defined as “the force that an objective, trained, and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order.” The use of greater force than justified by this standard is deemed “excessive force,” while using any force not required or appropriate in the circumstances is “unnecessary force.” Both unauthorized types of force are categorized as “unreasonable.”⁴

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

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

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

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

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

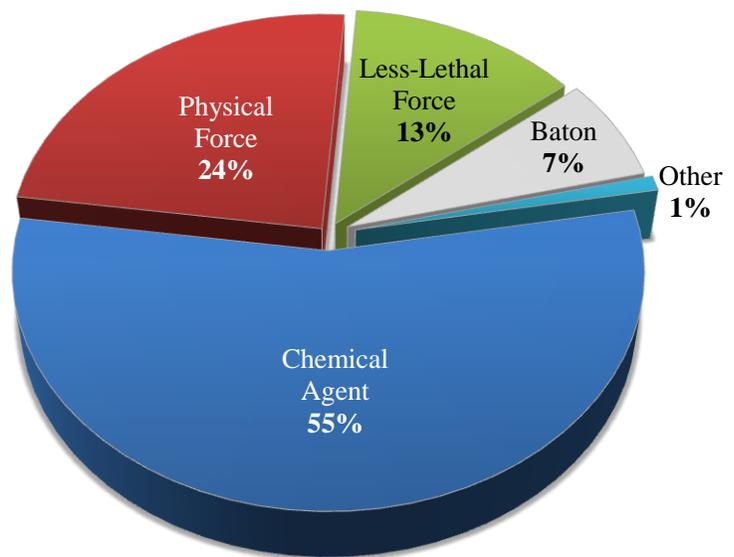
⁴ Department Operations Manual, Chapter 5, Article 2.

The time period covered in this report is July 1, 2013, through December 31, 2013. The OIG continues to attend at least one use-of-force committee meeting each month at each prison, juvenile facility, and parole region.

In July 2012, after collaboration with the OIG, the department developed a new enhanced process for streamlined reviewing of use-of-force incidents. The new process does not require that each case be presented to the Institutional Executive Review Committee, but rather that all stakeholders (including the OIG) review every case, and if no issues are identified, and the case meets specified criteria, the case is forwarded to the warden for recommended action. For any case where an issue is identified by any reviewer, the case will be formally reported and discussed at the Institutional Executive Review Committee. This change required formal approval by the department. Unfortunately, CDCR approval was delayed by class action litigation regarding the use of force against mentally ill inmates. Now that the issues causing delay in implementation of this program have been resolved, the OIG recommends the new use-of-force review process be implemented as soon as possible. In the interim, the OIG has monitored use-of-force meetings at each prison on a monthly basis. The new process will allow the OIG to monitor every use-of-force incident reported by the department and give more scrutiny to more serious incidents and those involving mentally ill inmates all of which will go to the Institutional Executive Review Committee.

The department reported a total of 3,252 incidents involving the use of force and 4,423 applications of force, illustrated by type and frequency in Chart 3, during this reporting period. There were 2,449 applications of chemical agents (55 percent of the total applications of force), including pepper spray, CN tear gas, and CS gas. Batons were used 318 times, physical force 1,048 times, and shots from Mini-14 rifles five times. Less-lethal force, which includes 37mm and 40mm rounds, was used 588 times during this reporting period, accounting for 13 percent of the total 4,423 applications of force.

Chart 3: Types of Force Applied



The OIG attended 278 use-of-force meetings where a total of 1,477 incidents were evaluated. The OIG also monitored an additional 68 incidents involving force apart from the use-of-force meetings. In preparation for a use-of-force meeting, the OIG evaluates all departmental reviews completed prior to the meeting. During the meeting the OIG observes the review process and engages in contemporaneous oversight by raising concerns about the incidents when appropriate,

asking for clarifications if reports are inconsistent or incomplete, and engaging in discussions with the committee about the incidents. Through this process the OIG draws an independent conclusion about whether the force used was in compliance with policies, procedures, and applicable laws and whether the review process was thorough and meaningful.

Through involvement at the use-of-force meetings, the OIG influenced the department's decision to prescribe additional training, pursue adverse action, obtain additional factual clarifications, or make policy changes in 158 individual cases.

Use-of-Force Meetings Attended, Incidents Reviewed, and Recommendations Made

	Adult	Division of Juvenile Justice	Parole	Total
Meetings Attended	257	14	7	278
Incidents Reviewed at the Institutional Executive Review Committee (IERC)	1399	61	17	1477
Incidents Evaluated but No Meeting Attended	68	0	0	68
OIG Recommendations Made	144	9	5	158
Percent of Incidents with OIG Recommendation	10%	15%	29%	10%

In the cases reviewed, the department found the actual force used was within policy 77 percent of the time at adult institutions, 90 percent of the time within the juvenile facilities, and 65 percent of the time in the parole regions.

In 98 percent of adult institution monitored cases, the OIG ultimately concurred with the use-of-force committee decisions. In 100 percent of the juvenile facility and parole region monitored cases, the OIG ultimately concurred with the use-of-force committee decisions. The department has been receptive to OIG input in each individual case.

These numbers are consistent with prior reporting periods and show that of the cases fully prepared for review, the department is able to take meaningful and appropriate action. As noted in previous reports, the department has struggled with timeliness, thorough evaluations, and fact gathering by first- and second-level reviewers. In this reporting period, 23 percent of adult institution cases, 5 percent of juvenile facility cases, and 35 percent of parole region cases had to be deferred because they were not ready for complete review when they were brought to the

use-of-force committee. This indicates an ongoing challenge for the department, which will likely improve once the enhanced use-of-force assessment process is piloted and fully implemented, as OIG recommends. Once the process is fully developed, the OIG will monitor and report on its progress, and anticipates monitoring a much higher percentage of overall cases. In addition, adherence to current policy does not automatically mean that CDCR's policies cannot be improved. The department still has challenges determining when imminent force, as opposed to controlled force, is the best option, especially in cases involving the use of pepper spray to gain compliance with an order absent the risk of imminent harm. The department has indicated it is reviewing these practices.

MONITORING CONTRABAND SURVEILLANCE WATCH

In 2012, citing concerns that CDCR's contraband surveillance watch process was being applied improperly and inconsistently, the Legislature requested the OIG develop a contraband surveillance watch monitoring program. Contraband surveillance watch is a significant budget driver for CDCR because it requires additional staffing for one-on-one observations. Additionally, contraband surveillance watch can subject the State to significant liability if abuses occur or contraband surveillance watch is imposed punitively. On July 1, 2012, the OIG began its formal monitoring of this process. The department's policy for placing an inmate on contraband surveillance watch is found in the Department Operations Manual, Section 52050.23.

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

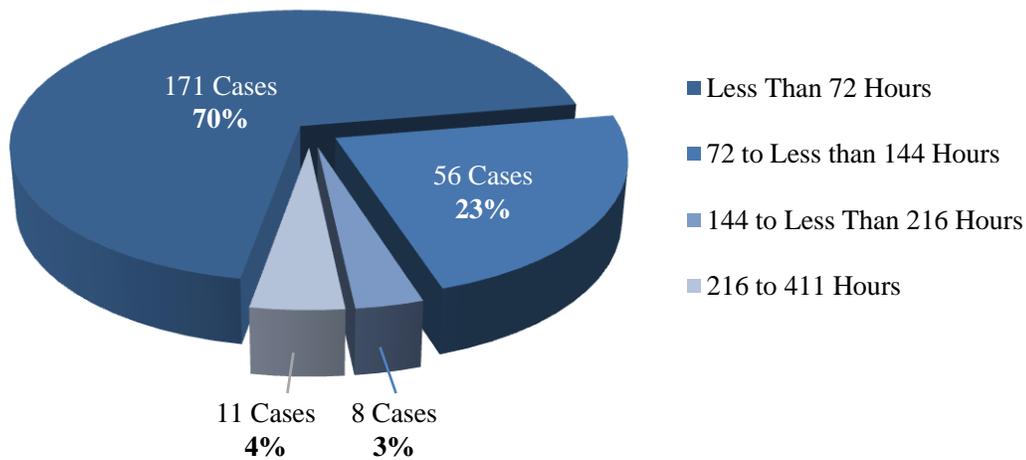
The department notifies the OIG every time an inmate is placed on contraband surveillance watch. Initially, the OIG collects all relevant data, including the name of the inmate, the reason the inmate was placed on contraband surveillance watch, what contraband was actually found, if any, and the dates and times the inmate was placed on and taken off watch. The OIG will respond on scene and formally monitor any contraband surveillance watch where a significant medical problem occurs, regardless of the time the inmate has been on watch. For all other incidents where contraband surveillance watch extends beyond 72 hours, the OIG goes on scene to inspect the condition of the inmate and ensure that the department is following its policies. This on-scene response is repeated at least every 72 hours until the inmate is removed from contraband surveillance watch. Any serious breaches of policy are immediately discussed with institution managers while on scene.

This is the third OIG report on contraband surveillance watch. It should be noted that the OIG's contraband surveillance watch monitoring program will continue to evolve. For example, this

report and the two prior have tried to identify for the department common and frequent lapses in its policies and procedures. The next report will begin displaying overall assessments of the department’s performance in these areas, including notification, documentation, and significant policy violations by staff.

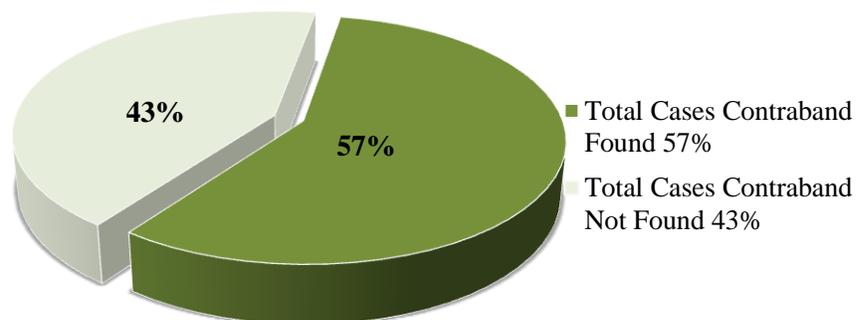
During this reporting period, the OIG was notified of 246 contraband surveillance watch incidents. Of these incidents, inmates were kept on watch longer than 72 hours in 75 incidents, including 8 incidents where inmates were kept on watch from 144 to 216 hours, and 11 incidents longer than 216 hours. This report details the 75 incidents that extended beyond 72 hours. There were no incidents during this reporting period where the OIG went on scene as a result of medical concerns. There were 171 cases that did not extend beyond 72 hours. Of those cases, 64 resulted in contraband being recovered, and 107 did not.

Chart 4: Duration of Contraband Surveillance Watch Cases



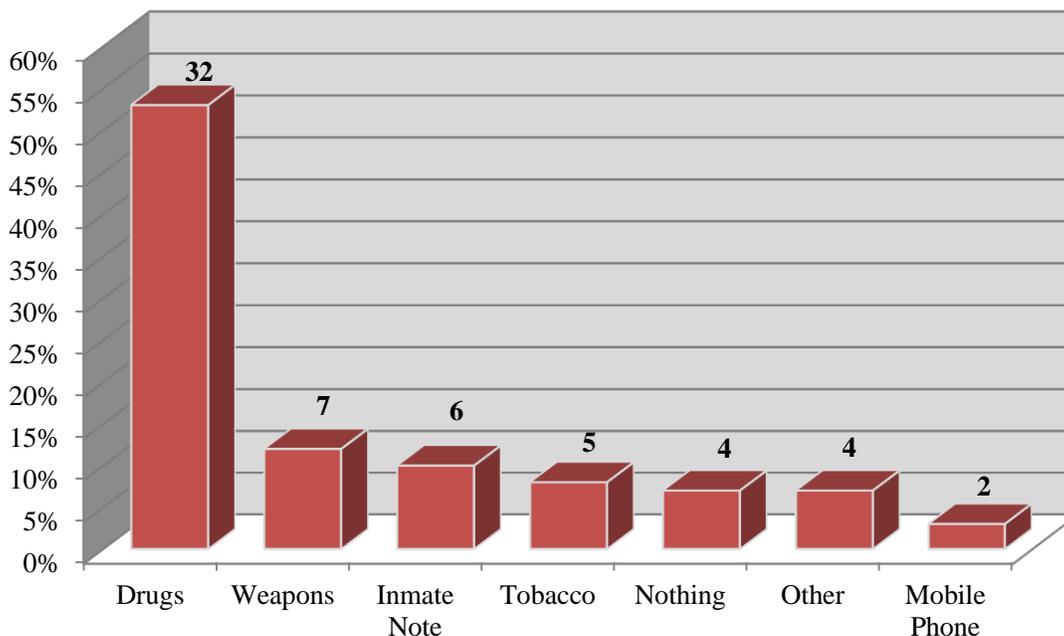
Contraband was found in 57 percent of the 75 monitored contraband surveillance watch cases that extended beyond 72 hours.

Chart 5: Contraband Found in Monitored Contraband Surveillance Watch Cases



As previously noted, this report only covers in detail those contraband surveillance watch cases that extended beyond 72 hours. In over half of the cases monitored (43 of 75), contraband was found. Drugs were recovered in 53 percent of the monitored cases where contraband was found, while another 22 percent of contraband recovered represented weapons and inmate notes.

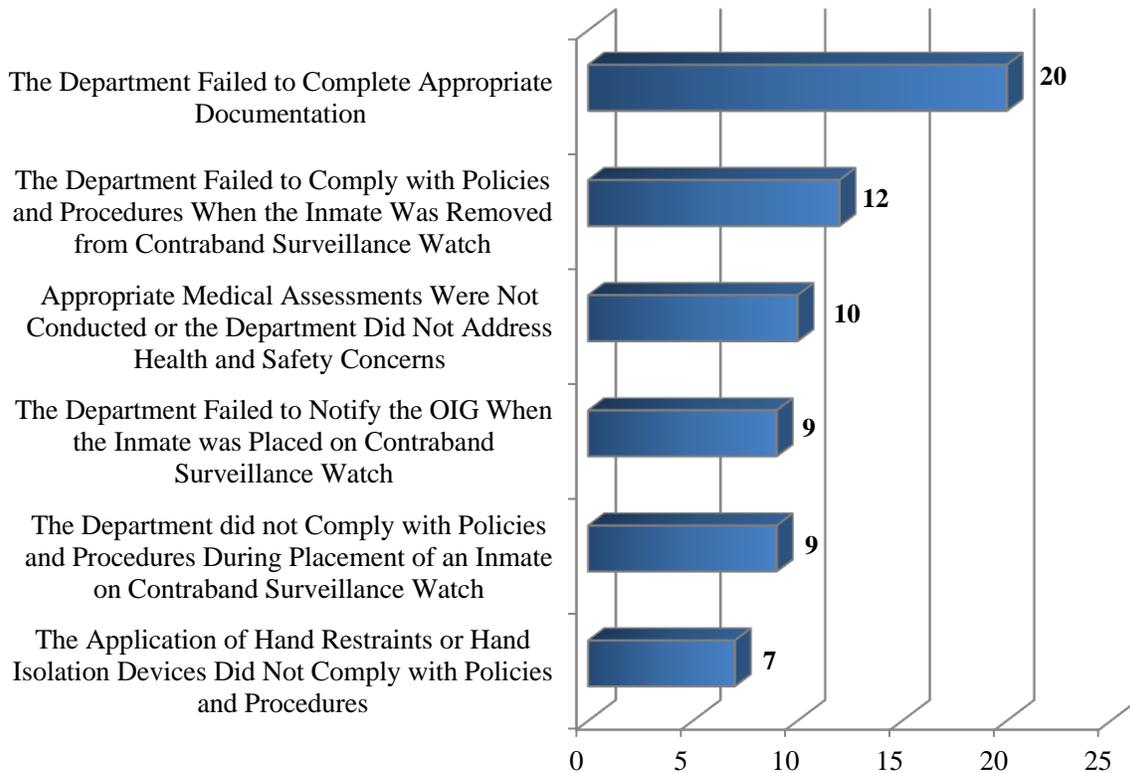
Chart 6: Contraband Type and Frequency in Monitored Cases



The OIG shares the department’s concern that the introduction of contraband such as drugs or weapons into an institution jeopardizes safety and security. The OIG also shares the concern of the Legislature that the contraband surveillance watch process should not be administered inhumanely or punitively. In this report, the positive trend seems to be that, overall, fewer inmates required contraband surveillance watch placement than in the prior period (246 compared to 293), and of those, fewer were required to stay on watch beyond the 72 hour period (75 compared to 92), and the overall percentage of contraband found was higher (43 percent compared to 34 percent).

While the department’s decision was within policy for placing an inmate on contraband surveillance watch in all the of the 75 monitored cases, there were a total of 67 subsequent policy violations, with most cases having one or more policy violations during the time the inmate was on contraband surveillance watch.

Chart 7: Policy Violations in Contraband Surveillance Watch Cases



In the 75 monitored contraband surveillance watch cases that extended beyond 72 hours, the majority of process violations involved failures to complete appropriate documentation, failures to comply with policies and procedures when removing an inmate from contraband surveillance watch, and failures to conduct medical assessments or address health and safety concerns.

In nearly 27 percent of monitored contraband surveillance watch cases, the department failed to complete appropriate documentation. In 16 percent of the cases, the department failed to comply with policies and procedures when the inmate was removed from contraband surveillance watch, and 13 percent of the time the department failed to conduct appropriate medical assessments to address health and safety concerns. The department both failed to notify the OIG when an inmate was placed on contraband watch and failed to comply with policies and procedures when an inmate was placed on contraband surveillance watch 12 percent of the time, and in 9 percent of the cases, the department failed to properly apply or use restraints and hand isolation devices.

To address these deficiencies, the department should ensure that each institution conduct thorough training for all custody staff. This should include supervisor training so that those tasked with ensuring compliance with policies and procedures are also fully familiar with and enforcing those policies and procedures.

In addition, when failures to comply with policies and procedures are identified, those responsible should be held accountable through the department's disciplinary process. Without

accountability, remediation is unlikely. The OIG is committed to monitoring this process to avoid abuses and accomplish the legitimate goals of contraband surveillance watch.

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

Chart 8: Contraband Surveillance Watch Cases by Institution July–December 2013

Institution	Number of CSW Incidents by Institution	Less Than 72 Hours	72 to Less Than 144 Hours	144 to Less Than 216 Hours	216 Hours or More
ASP	5	4	1		
CAL	10	9	1		
CCC	25	14	9	1	1
CCI	3	1	2		
CCWF	1	1			
CEN	16	8	6	2	
CIM	3	3			
CIW	3	2		1	
CMC	5	5			
CMF	1	1			
COCF	2	2			
COR	12	7	4	1	
CRC	13	8	5		
CTF	5	3	2		
DVI	5	3	1	1	
FSP	5	3	1	1	
HDSP	5	1	3		1
ISP	5	4	1		
KVSP	14	13	1		
MCSP	1	1			
NACYCF	16	13	3		
NKSP	9	7	1		1
OHC	3	3			
PBSP	11	10	1		
PVSP	6	3	1		2
RJD	6	4	1		1
SAC	5	4			1
SATF	7	5	2		
SCC	3	3			
SOL	4	4			
SQ	12	5	3	1	3
SVSP	18	12	5		1
WSP	7	5	2		
Total CSW Cases	246	171	56	8	11
		Contraband Recovered: 64 Cases = <u>37%</u>	Contraband Recovered: 29 Cases = <u>17%</u>	Contraband Recovered: 7 Cases = <u>88%</u>	Contraband Recovered: 7 Cases = <u>64%</u>

Contraband surveillance watch is not meant to be a long-term event. As time passes, risks increase and it becomes a very costly practice. Nevertheless, there are some instances that may warrant it. For that reason the OIG is reporting the following summaries of the 11 incidents of contraband surveillance watch during this reporting period that lasted over 216 hours (nine days):

The longest duration for contraband surveillance watch this reporting period lasted 1,241 hours (nearly 52 days), when an inmate with a long history of ingesting dangerous objects swallowed a pen with razor blades attached to both ends, which was confirmed by x-ray. Because this inmate had undergone nearly 40 previous surgeries to remove foreign objects from his abdomen in the past, he had developed severe scar tissue that, according to physicians who monitored this case, hindered their ability to successfully remove the current object from the inmate, but also prevented the object from moving through the inmate's gastrointestinal system. The inmate was to be transferred to another facility, which was severely delayed because the other facility refused to take an inmate with known contraband inside his body. He was eventually transferred to a facility operated by the Department of State Hospitals, where the OIG does not have jurisdiction to monitor the case, which technically ended the contraband surveillance watch period.

In a second incident, a 411-hour contraband surveillance watch incident that the OIG assessed as insufficient due to the department's failure to provide various documents, an inmate was witnessed ingesting several bindles, two of which the inmate vomited shortly thereafter, and the others he produced via medical intervention after the 17-day ordeal. The inmate produced a total of about 11.5 grams of methamphetamine.

A third incident involved a 366-hour contraband surveillance watch where an inmate produced two rolled-up kites, a bundle of string, a tattoo motor, a tattoo shaft, a bottle of ink, and a six-inch shank made of plastic with a metal tip. The department fully complied with policies and procedures during this case.

A fourth contraband surveillance watch incident lasted 286 hours. Information was provided to the department that an inmate's family visitor was planning to introduce a large amount of drugs as contraband into the institution. The suspected receiving inmate was placed on contraband surveillance watch, and the department recovered two bindles from the inmate. The first contained 57.0 grams of methamphetamine, heroin, and "china white." A subsequent bindle contained 24.4 grams of methamphetamine and 5.9 grams of marijuana.

A fifth incident involved an inmate placed on contraband surveillance watch due to suspicion that the inmate was in possession of drugs, which was confirmed by x-ray, after the inmate was observed acting suspiciously and handling fecal matter in a holding cell. After 267 hours of contraband surveillance watch, however, no contraband was recovered, and x-rays indicated there were no solid foreign bodies inside the inmate. The OIG noted several documentation violations, but the overall assessment was sufficient.

A sixth case involved an inmate observed swallowing an unknown substance, and he claimed he had swallowed tobacco. He was placed on contraband surveillance watch, during which the

department failed to follow specific hygiene and documentation policies. After almost 11 days (261 hours), no contraband was recovered from the inmate.

A seventh contraband surveillance watch case was initiated after suspicion, and later x-ray confirmation, that an inmate had ingested a razor blade. After more than ten days (255 hours) on contraband surveillance watch, during which the OIG noted several documentation violations, the inmate was taken off contraband surveillance watch, but no contraband was recovered.

In an eighth contraband surveillance watch case resulting in a 252-hour incident in which an inmate swallowed three razor blades, the inmate was sent to an outside hospital for treatment, but returned seven days later before all the razors were recovered. The inmate was placed in administrative segregation, then moved to the institution's medical treatment center. Eventually, x-rays revealed that there were no more foreign objects within the inmate's body, although not all three of the razors were recovered, leading the medical staff at the institution to conclude that pieces were "missed." The OIG noted extreme lack of documentation during the time the inmate was in the outside hospital, including no documentation of searches, no documentation of taping of clothing, and no documentation of hygiene. There were times not accounted for, injuries to the inmate not documented, and forms not completed. The department also failed to properly notify the OIG.

The ninth case that extended beyond nine days involved nine bindles containing a total of 2.8 grams of heroin passed to an inmate by a female visitor, who was later arrested. The inmate ingested the bindles, and the drugs were recovered after 241 hours of contraband surveillance watch. During this incident, the department failed to properly document the review of the contraband surveillance watch area for approximately 30 watch periods, but no other policy violations were identified.

A tenth incident involved an inmate who was observed swallowing what was later confirmed to be several bindles of drugs. After nearly ten days (235 hours) on contraband surveillance watch, the department recovered 1.5 grams of heroin, 1.2 grams of marijuana, and 4.7 grams of methamphetamine. The OIG noted no policy or procedure violations during this incident.

The eleventh and final incident lasted 231-hours, and was deemed by the OIG to have been sufficiently conducted by the department. An inmate committed an act of battery with the intention of being sent to administrative segregation, where he intended to introduce contraband. The department learned of this intention. The inmate was placed on contraband surveillance watch, then he admitted to having swallowed methamphetamines. He was transported to a hospital, where he tested positive for methamphetamines and marijuana, and where he admitted to having two balloons in his body. After more than nine days, the department recovered eight bindles containing marijuana, kites, and narcotics.

VOLUME II CONCLUSION

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

Critical incidents as described within this report have the potential for serious consequences for staff, inmates, and the taxpayers at large. As such, OIG oversight provides independent assessment on how the incidents occur, how they are handled, and their outcomes. The OIG makes recommendations to avoid or mitigate similar incidents in the future. The OIG assessed the department on the 133 critical incidents. There were 32 insufficient ratings overall. In 20 percent of the critical incidents, the department failed to timely notify the OIG, thus preventing the performance of this oversight role.

The OIG has also increased its response to inmate Prison Rape Elimination Act complaints against staff and has discovered that while policy requires such complaints to be sent automatically to the Office of Internal Affairs, not all of them follow the same process as other complaint requests. The OIG at the time of this report is in discussions with the Office of Internal Affairs and the Division of Adult Institutions regarding the current process and will be reporting in more detail in the next Semi-Annual Report. Any Prison Rape Elimination Act cases referred for investigation against staff are to be monitored by the OIG.

There is another category of critical incidents being reported separately this cycle in Appendix D2. As a result of the statewide hunger strike, the OIG regularly visited and observed staff interaction at those prisons with the largest concentrations of involved inmates. In an effort to avoid any potentially harmful outcomes, the OIG specifically monitored several of those cases as detailed in this appendix. All 18 hunger strike cases that were monitored as critical incidents, listed in Appendix D2, received a rating of sufficient.

Among the 39 Deadly Force Incidents identified by the OIG, 11 did receive a Deadly Force Investigation Team response from the Office of Internal Affairs, and 17 others were warning shot cases. It is not the policy of the department, however, to respond to warning shots, so there remains a discrepancy between the number of cases the OIG responds to as deadly force and the number of cases the department responds to as deadly force.

Of the 28 cases that did *not* receive a Deadly Force Investigation Team response, but that the OIG *did* monitor, 11 received insufficient ratings by the OIG. Two cases involved incidents the OIG deemed particularly serious and especially warranting of Deadly Force Investigation Team responses due to major head injuries to inmates. One insufficient rating was due to the department failing to videotape a post-incident interview within a policy-prescribed time frame. One case was insufficient because the department failed to adequately document the incident. In three insufficient incidents, the rating was due to inadequate notification to the Office of Internal

Affairs, and in one incident, the rating was due to untimely notification to the OIG. Two incidents were insufficient because of a combination of inadequate and untimely notification to both the OIG and the Office of Internal Affairs, and in one incident, the department failed entirely to notify the OIG, but the OIG happened to review daily logs at that facility and learned of the incident during that review. The January 16, 2014, memorandum distributed by the Office of Internal Affairs significantly expanded the scope and number of cases that the Office of Internal Affairs will now investigate. This is a significant positive development in the willingness of the Office of Internal Affairs to investigate deadly force incidents.

Among the 94 non-deadly-force critical incidents, 21 critical incidents received insufficient ratings. The details for those ratings can be found in Appendix D1.

The use-of-force monitoring for this time frame has been reported in a general manner without specific appendices. As discussed, the OIG has focused efforts on assisting the department in the development of an enhanced use-of-force review process. The OIG continued use-of-force monitoring, attended 278 committee reviews, reviewed 1,477 use-of-force incidents (approximately 45 percent of the total incidents), and made 158 recommendations for training, adverse action, additional factual clarifications, or policy development that impacted the department's decisions in individual cases.

From these reviews and prior reports, it is apparent that the department has several institutions failing to make timely reviews due to the sheer volume of cases. In addition, cases requiring more time for evaluation or more detailed assessment are being prematurely passed on at lower review levels, perhaps to meet deadlines. Many cases arrive at committee only to be deferred (23 percent in adult institutions, 5 percent in juvenile facilities, and 35 percent in parole), possibly due to mandates requiring a review within 30 days. The OIG determined at the outset of use-of-force monitoring that reviews are meaningless in cases that lacked the proper preparation. The OIG continues to urge the department to implement the new process.

The OIG monitoring of contraband surveillance watch continues to evolve. It is clear that since monitoring began, the OIG can report that the department is following its policy in determining whom to put on watch, but, unfortunately, these reports have identified areas still needing improvement. If documentation and observation policies are not followed, serious medical issues could occur. If the process does not maintain policy integrity, there may also be a waste of departmental resources.

The OIG actively monitors contraband surveillance watch cases that extend longer than 72 hours, including on-scene observation. However, the department is required to provide the OIG notification any time an inmate is placed on watch, and the OIG monitors when the watch ends. In order to be effective in preventing drug trafficking and weapons assaults on staff and inmates, it is imperative that policies be followed controlling contraband surveillance watch. The practice is worthless if observation is not maintained or if policy violations allow for destruction of contraband before it is seized.

Oversight is a critical element for the transparency of the California corrections system. As this Semi-Annual Report reflects, the OIG continues to provide recommendations to the department

with the goal of the department's processes continuing to improve. The OIG is committed to monitoring the vital areas of critical incidents, use of force, and contraband surveillance watch, and to providing transparency to the California correctional system.

VOLUME II RECOMMENDATIONS

The OIG recommends the department implement the following recommendation from Volume II of the Semi-Annual Report, July–December 2013.

Recommendation 2.1 was prompted by the fact the department does not apply a consistent statewide policy addressing the investigation of the source of discovered narcotics at its institutions. In a contraband surveillance watch case monitored this reporting period, an inmate was air-lifted to a higher level of care, where he was on a respirator and diagnosed with pneumonia. The inmate was discovered to have secreted a large amount of heroin. The institution failed to investigate the source of the heroin, missing an opportunity to stop future similar occurrences.

Investigations into the source of discovered narcotics would assist in prosecuting those who introduce contraband, and ultimately reducing the introduction of narcotics and other contraband into the State's institutions. While many local institutions are diligent in this regard, the OIG has monitored cases where there has been very little or no effort made to determine the source of narcotics in cases of overdoses or persons placed on contraband watch.

2.1 The OIG recommends the department, including the Department of Juvenile Justice, implement a statewide policy directing the investigative services unit at each institution to investigate the origin of narcotics whenever they are discovered during contraband surveillance watch, cell searches, or overdose. This would include, but not be limited to, obtaining visitor logs and surveillance video as it pertains to the inmate or ward in question. If such a policy is in existence, additional training is necessary to ensure it is followed statewide.

Implementation Response Requested
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VOLUME II RECOMMENDATIONS FROM PRIOR REPORTING PERIODS

The OIG recommended the department implement the following recommendations from Volume II of the prior Semi-Annual Report, January–June 2013.

The OIG made this recommendation due to the frequency of insufficient ratings for critical incidents, although the majority of the problems still revolve around timely notification. The department is continuing to do an adequate job overall in responding to and taking appropriate action in the aftermath of critical incidents, but the department needs to expend more effort on prompt reporting.

- The OIG recommends refresher training for all wardens and institution administrative officers of the day on the requirement and process for prompt notification to the OIG on all critical incidents.

Partially Implemented

The department has partially implemented this recommendation, and plans full implementation in 2014. The department is currently revising its notification matrices to ensure all critical incidents are captured on the worksheet. Training will be provided to wardens and administrative officers after the notification matrix is approved.

During the first reporting period of 2013, there were three cases involving unintentional baton strikes to the head that required transport to an outside hospital. Seven cases involved less-lethal rounds that unintentionally struck inmates in the head, requiring outside hospitalization. There were at least two similar cases in this reporting period. The seriousness of head injuries is not always immediately apparent. The consequence to human life as well as the liability exposure to the State should justify a Deadly Force Investigative Team response for all such cases, yet only one case received such a response this reporting period.

- The OIG recommends that for any intentional or unintentional use of force that results in serious injury, the Office of Internal Affairs send a Deadly Force Investigation Team.

Partially Implemented

On January 16, 2014, the Deputy Director for the Office of Internal Affairs distributed a memorandum to CDCR executive staff informing all staff that, pursuant to Title 15 and the Department Operations Manual, the Office of Internal Affairs would respond with a Deadly Force Investigation Team to any strike to the head of a person with a baton and/or impact munitions. This has expanded the scope and number of cases that the Office of Internal Affairs will now investigate. This is a significant positive development in department's willingness to investigate deadly force incidents.

- The OIG recommends the department provide sufficient funding to send a Deadly Force Investigation Team to each of these types of cases.

Recommendation Under Review

The department is reviewing the specifics related to additional use of force event review and investigation, and possible referral to the Deadly Force Review Board. Whether funding is an issue is currently under review.

The OIG has received notifications that inmates were placed on contraband surveillance watch upon placement in a holding cell prior to transport to the isolation area, while other institutions informed the OIG that contraband surveillance watch was initiated once the inmate was actually placed in isolation with the proper restraints. Department policy requires authorization by the warden or a higher administrator to keep an inmate on contraband surveillance watch longer than 72 hours.⁵ Consistency is needed in determining and documenting the time inmates are placed on contraband surveillance watch. Some institutions begin the clock when the inmate is placed in an isolation cell with appropriate restraints, while other institutions start the clock when an inmate is suspected to have contraband and is escorted to a holding cell.

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

Substantially Implemented

The department is in the process of developing a more detailed guideline to determine the most appropriate time to initiate the contraband surveillance watch procedures. Full implementation is expected in 2014.

Violations of policy and procedure occurred in 51 percent of the contraband surveillance watch cases in the January–June, 2013, reporting period, and continued in the current report. The failure to adhere to policy must be immediately addressed.

- The OIG recommends the department ensure that each institution conduct thorough training for all custody staff on all policies and procedures of contraband surveillance watch. This should include supervisor training so those tasked with ensuring compliance are also fully familiar with and enforcing those policies and procedures.

Substantially Implemented

The department is providing training to all wardens, managers, and supervisors regarding contraband surveillance watch policy and procedures. Full implementation is expected in 2014.

⁵ Department Operations Manual, Section 52050.23.1

APPENDICES

Appendix D contains the assessments for 94 critical incidents monitored during this reporting period, listed by geographical region.

D1 displays the assessments of the 76 non-hunger-strike critical incidents monitored during this reporting period.

D2 displays the assessments of the 18 hunger strike incidents monitored during this reporting period.

Appendix E contains the assessments for 39 deadly force investigative case summaries monitored during the reporting period, listed by geographical region.

Appendix F contains the results and outcomes of 75 OIG-monitored contraband surveillance watch cases during the reporting period, listed by the date the inmate was placed on CSW.

APPENDIX D1 CRITICAL INCIDENT CASE SUMMARIES

76

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2010-01-06	10-0038-RO	Inmate Serious/Great Bodily Injury
Incident Summary On January 6, 2010, two inmates attacked a third inmate on an exercise yard. One inmate used an inmate-manufactured weapon and the other used hands and fists. One officer fired a less-lethal round and another officer used pepper spray to stop the assault. One of the inmates was hit in the head by the ricocheting less-lethal round, but did not suffer any significant injuries. The inmate who was being attacked by the two other inmates suffered serious injuries, was taken to an outside hospital, and later returned to the institution. An officer allegedly supplied the inmate-manufactured weapon to the inmates.		
Disposition The institution's executive review committee determined that the use of force was in compliance with departmental policy. The OIG concurred. Potential staff misconduct was identified against one of the officers as it was alleged that he provided the inmates with an inmate-manufactured weapon that was used in the assault; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring. The case was also referred to the district attorney's office, which did not file charges against the officer.		
Overall Assessment		Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority decided to refer the matter to the Office of Internal Affairs, and the OIG agreed.		

Incident Date	OIG Case Number	Case Type
2011-09-24	11-2431-RO	In-Custody Inmate Death
Incident Summary On September 24, 2011, an officer was conducting a security check when he observed an inmate lying down and motionless on an administrative segregation unit exercise yard. The officer activated the alarm and summoned emergency medical response. Medical staff determined a higher level of care was required and the inmate was air-lifted to an outside hospital. The inmate died on March 26, 2012, due to a lung infection that developed while hospitalized for treatment for a severe head injury.		
Disposition The coroner determined the inmate died of pneumonia related to valley fever following a traumatic brain injury. The department's Death Review Committee determined the death was preventable due to mental health staff's failure to recognize signs and symptoms, to assume responsibility of the inmate, to communicate effectively with the inmate, and other serious problems in the mental health care of the inmate. In the month preceding the assault, the inmate was fearful for his safety and complained about his cellmate multiple times to mental health care providers. No policy violations were identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the department requested a clinical peer review for the involved mental health staff.		
Overall Assessment		Rating: Insufficient
The department's overall response to the incident was inadequate because it failed to timely notify the OIG and failed to secure all of the potential evidence following the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs. The OIG concurred with this decision because officers had limited training on processing crime scenes.		
Assessment Questions <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <i>The OIG was not informed of the incident until over two hours after it had occurred.</i> Was the HA's response to the critical incident appropriate? <i>Officers failed to secure the hair shaver as evidence. Officers assumed the assailant used his fist to injure his cellmate during the attack because his hand was broken and lacerated by the cellmate's tooth. The examining physician later stated the mechanism of injury was from a shaver used to repeatedly strike the inmate in the head and face.</i> 		

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2012-04-28	12-0955-RO	In-Custody Inmate Death

Incident Summary

On April 28, 2012, as officers were securing cell door food ports after completing the morning meal, an inmate asked officers to remove his cellmate from his cell. Officers observed the inmate lying face down on the cell floor, so they activated the alarm. The inmate that alerted officers of the incident was removed from the cell. Custody and medical staff initiated life-saving measures on the unresponsive inmate. The inmate was transported to the triage treatment area via the emergency response vehicle while life-saving efforts were continued. Paramedics arrived and took over the medical emergency. The inmate was pronounced dead after life-saving efforts failed. The cellmate was placed in the administrative segregation unit pending an investigation into the death of his cellmate.

Disposition

An autopsy was performed and the cause of death was identified as ligature strangulation. The department completed an in-cell homicide inquiry and determined that both inmates were appropriately housed together at the time of the incident and had shared a cell for 163 days. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2012-05-16	12-1086-RO	In-Custody Inmate Death

Incident Summary

On May 16, 2012, an officer found an inmate unresponsive in the top bunk of his assigned cell during the institutional standing count. The officer activated an alarm and responding officers removed the cellmate from the cell. Upon further inspection, a second officer noted the inmate was lying in a large pool of blood. A registered nurse entered the cell and determined the presence of rigor mortis. The emergency medical response was halted and the cell was sealed as a crime scene. Outside law enforcement was summoned to the institution to process the crime scene. Upon completion of processing the crime scene, the inmate's body was released to the coroner's office, and an autopsy was scheduled for the following day.

Disposition

Although the incident was initially treated as a homicide, the autopsy revealed the manner of death was suicide and the cause of death was injury to the left internal jugular vein due to a neck wound. A suicide note was found during the investigation, and a jagged scar consistent with a past self-inflicted laceration was found on the inmate's wrist. Potential staff misconduct was identified based on medical staff's on-scene response; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG did not accept for monitoring. The OIG reviewed the department's suicide review report and concurred with its recommendation and plan to improve the mental health screening process.

Overall Assessment

Rating: Sufficient

With the exception of the medical staff response, the department's overall response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2012-05-16	12-1213-RO	Contraband Watch

Incident Summary

On May 16, 2012, an inmate was placed on contraband surveillance watch because he could not pass the metal detector upon his arrival to the institution from another prison. After no bowel movements for three days and the inmate's refusal to relinquish the contraband items, a search warrant was obtained. The inmate was transported to a local hospital where an x-ray confirmed the inmate had metal secreted in his anal cavity. The inmate refused to voluntarily drink a laxative, so a nasogastric tube was inserted to administer a laxative under a doctor's supervision. When the nasogastric tube was inserted, the inmate's arms were placed in soft restraints to ensure he did not hurt himself or others; however, he became uncooperative by moving his head and body from side to side and moving his feet. Three officers and a sergeant used the physical force necessary to hold the inmate still. The inmate had a bowel movement that yielded razor blades, a paper clip, a comb, and written material.

CENTRAL REGION

Disposition

Potential staff misconduct was identified. The sergeant allegedly neglected to report the use of force upon returning to the institution from the hospital; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs did not open an investigation, but returned the case to the hiring authority for corrective or disciplinary action. The OIG concurred with the decision and accepted this case for monitoring.

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

The inmate was placed on contraband surveillance watch on May 16, 2012; however, the OIG was not informed until May 19, 2012, three days later.

- Was the critical incident adequately documented?

Upon return to the institution, medical staff failed to conduct a medical evaluation and officers who used physical force failed to submit timely reports. A sergeant failed to report the use of force to the incident commander and did not submit a report until ordered to do so by management staff.

Incident Date	OIG Case Number	Case Type
2012-08-17	12-2273-RO	Inmate Riot

Incident Summary

On August 17, 2012, two riots erupted simultaneously in a housing unit and dining hall involving approximately 60 inmates. Officers used pepper spray and less-lethal impact rounds to stop the riots. Numerous inmate-manufactured weapons were recovered. One inmate was thrown off of a second tier and had to be air-lifted to an outside hospital for a life-threatening head injury. Eight other inmates were transported to outside hospitals via ambulance for serious injuries. None of the serious injuries was caused by the use of force. All of the inmates were returned to the institution after treatment.

Disposition

After the OIG's discussion with the hiring authority, the institution's executive committee changed its decision to reflect that the incident was not in full compliance with departmental policy. Training was provided to ensure that the officer understood the criteria for the less-lethal impact round target zones. The incident commander also received training to ensure reports submitted are consistent and to obtain clarifications if they are not. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The department's overall response to the incident was adequate. The OIG did not concur with the initial documentation of the incident and the determination by the institutional executive review committee that the incident was in full compliance with policy. The medical reports conflicted with the injuries listed in the incident report. In addition, the officer aimed the less-lethal impact rounds at the upper bodies of the inmates to stop a fistfight, which is against policy unless the criteria for deadly force is met. The department agreed to obtain clarifications from officers and medical staff. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2012-09-01	12-2271-RO	In-Custody Inmate Death

Incident Summary

On September 1, 2012, custody staff found an inmate unresponsive in his cell and sounded the alarm. Medical staff responded to the cell and determined the inmate had a pulse and was breathing, but the inmate appeared unconscious. The inmate was transported to the triage treatment area where he stopped breathing. Advanced life-saving measures were initiated and an ambulance was called. The inmate's pulse returned while en route to an outside hospital, but he was pronounced dead hours later after life-saving efforts failed. Prior to his death, on August 14, 2012, the inmate and two other inmates were attacked on the exercise yard by 29 inmates. The inmate was treated for injuries over the following week and returned to his cell.

CENTRAL REGION

Disposition

An autopsy was performed and the cause of death was determined to be a ruptured spleen due to blunt force injuries from the assault that occurred two weeks earlier. Although the department's Death Review Committee concluded that the death was not preventable, it noted that during the emergency medical response, the nurse's initial assessment was insufficient. Although staff were provided training, no staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2012-10-07	12-2287-RO	Contraband Watch

Incident Summary

On October 7, 2012, a registered nurse found an inmate on contraband surveillance watch lying down, unresponsive, with blood by his mouth. The inmate was transported to a community hospital via ambulance. The decision was made to air-lift the inmate to a higher level of care where he was on a respirator and diagnosed with pneumonia. The inmate was returned to the institution after 11 days of hospitalization.

Disposition

While at the outside hospital, a bundle of heroin weighing 5.63 grams was recovered from the inmate. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

With the exception of the failure to investigate the origin of the heroin found, the department's overall response to the incident was sufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

OIG Recommendation

The OIG recommended that the hiring authority ensure that visitor logs and surveillance video be reviewed and used as evidence to support the prosecution of visitors that introduce narcotics into the institution. The hiring authority agreed with the recommendation.

Incident Date	OIG Case Number	Case Type
2012-11-19	12-2659-RO	In-Custody Inmate Death

Incident Summary

On November 19, 2012, custody staff responded to a cell after an inmate exited his cell and alerted staff that he awoke to find his cellmate unresponsive. Custody staff found the cellmate unresponsive and began life-saving measures. Custody staff and responding medical staff continued life-saving measures while transporting the inmate to the triage treatment area on a gurney. The inmate was pronounced dead soon after arriving at the triage treatment area. There were no obvious signs of trauma to the inmate. The cause of death was unknown and an autopsy was scheduled.

Disposition

The coroner determined that the cause of death was an accidental overdose of narcotics. The emergency medical response review committee determined that a nurse did not start oxygen on the inmate during the emergency, resulting in on-the-job training for the nurse. Staff misconduct was not identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

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

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-01-02	13-0043-RO	In-Custody Inmate Death
<h3>Incident Summary</h3> <p>On January 2, 2013, officers observed two inmates attacking a third inmate in the dayroom of a housing unit. The alarm was sounded and the inmates complied with orders to get down. Officers determined that the third inmate was unresponsive and medical staff called for an ambulance. Medical staff initiated emergency medical care immediately after the area was secured and they determined that the injured inmate had a weak pulse and sparse breathing. The inmate stopped breathing prior to the arrival of the ambulance, and medical staff began advanced life-saving measures. The inmate was transported to an outside hospital where he was later pronounced dead after life-saving measures failed.</p>		
<h3>Disposition</h3> <p>The coroner determined the manner of death was homicide and the cause of death was blunt force head trauma. A combined death review summary was completed to evaluate the medical response to the emergency and determined that there were no deviations from standards of care. Staff misconduct was not identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>		
<h3>Overall Assessment</h3>		Rating: Insufficient
<p>Because of failure to provide timely notification of the incident, which prevented the OIG from responding to the institution, the OIG found that the department's response to the incident was insufficient. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.</p>		
<h3>Assessment Questions</h3> <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The OIG was not notified until two hours after the inmate was transported to an outside hospital and it was determined the inmate was not breathing.</i></p>		

Incident Date	OIG Case Number	Case Type
2013-01-12	13-0159-RO	In-Custody Inmate Death
<h3>Incident Summary</h3> <p>On January 12, 2013, custody staff sounded the alarm after discovering an inmate unresponsive in his cell. The cellmate advised that the inmate had been sweating profusely and slurring his speech. Custody staff began life-saving measures after determining the inmate was not breathing. Medical staff relieved the officers upon arrival and applied an automated external defibrillator. The inmate was then transported to the emergency room of the on-site hospital and later pronounced dead after life-saving efforts failed.</p>		
<h3>Disposition</h3> <p>The coroner determined the cause of death was an irregular heartbeat with a toxic blood level of methamphetamine. The department conducted a combined death review summary to evaluate the medical response to the emergency and determined that there were no deviations from the standard of care. The department's investigative services unit was able to identify the visitor who introduced the methamphetamine into the institution. The visitor was successfully prosecuted for voluntary manslaughter and sentenced to six years in state prison. Staff misconduct was not identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>		
<h3>Overall Assessment</h3>		Rating: Insufficient
<p>The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.</p>		
<h3>Assessment Questions</h3> <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The OIG did not respond on scene due to late notification. The OIG was not notified until more than two hours after the incident occurred.</i></p>		

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-02-12	13-0339-RO	Inmate Serious/Great Bodily Injury
Incident Summary On February 12, 2013, while conducting the evening meal, a control booth officer accidentally opened three cell doors of rival gang members to the inmates eating dinner. The inmates from one of the cells closed the door and refused to come out. The inmates from the other two cells began walking toward the inmates eating. Officers sounded the alarm as the inmates began fighting. Officers used pepper spray and less-lethal impact rounds to stop the fight. One of the inmates who had his door opened was seriously injured and transported to an outside hospital via ambulance. The inmate received multiple lacerations to his face, head, right arm, and torso. The inmate was returned to the institution the next day.		
Disposition The institution's executive review committee found the use of force in compliance with departmental policy. The control booth officer's actions were found to be out of compliance because he inadvertently opened the wrong cell doors resulting in a riot involving rival gangs. The hiring authority issued a letter of instruction and the OIG concurred.		
Overall Assessment		Rating: Insufficient
The department's response was not adequate because it failed to provide timely notification to the OIG of the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG concurred.		
Assessment Questions <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The OIG was not notified of this incident, but learned of the incident after reading a daily report.</i></p>		

Incident Date	OIG Case Number	Case Type
2013-02-13	13-0407-RO	In-Custody Inmate Death
Incident Summary On February 13, 2013, officers discovered an inmate alone in his cell, hanging from a light fixture with an inmate-manufactured noose around his neck. Officers entered the cell and cut the noose to release the inmate and initiated life-saving measures. The inmate was taken to the triage treatment area, then transported in an ambulance to an outside hospital where he was later pronounced dead by an emergency room physician. Although the cellmate was on an exercise yard at the time the inmate was found hanging, the cell was secured and treated as a crime scene.		
Disposition The autopsy report indicated the cause of death was hanging and the manner of death was suicide. The department's suicide review report indicated the inmate had adequate mental health care prior to death. A subsequent search of the inmate's property revealed a suicide note. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Insufficient
The department's overall response to the incident was inadequate because a lieutenant failed to document his interview of the cellmate and also failed to clarify who instructed him to return the cellmate to the cell before it was determined the death was a suicide. The department adequately notified and consulted with the OIG on the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.		
Assessment Questions <ul style="list-style-type: none"> Was the critical incident adequately documented? <p><i>The investigative services unit lieutenant failed to document his interview with the cellmate and failed to clarify who instructed him to return the cellmate to the cell before the incident was determined a suicide. The OIG requested these reports; however, the reports were not provided.</i></p>		

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-02-23	13-0351-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On February 23, 2013, an inmate refused orders to comply with the dress code as he entered the dining hall. When he was ordered to submit to handcuffs, the inmate struck the officer in the face with his fist. The alarm was activated and the officer attempted to pull the inmate to the ground. The inmate pushed back, causing the officer to fall and strike his head on the floor. The inmate straddled the officer and repeatedly struck the officer in the face. A second and third officer were unable to pull the inmate off of the first officer. The third officer struck the inmate in the head with his fists with no effect. The third and a fourth officer pulled the inmate off of the officer, but the inmate continued to resist. The first officer stood up and saw the inmate attempting to get back up, so he kicked the inmate's torso twice causing the inmate to stop resisting. The inmate was transported to an outside hospital and received seven sutures to his head. The first officer received facial injuries, and the third officer broke his hand.

Disposition

Potential staff misconduct was identified based on the first officer kicking the inmate twice in the torso; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The case was referred back to the hiring authority to take action, without an investigation, which the OIG accepted for monitoring.

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority decided to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2013-02-26	13-0560-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On February 26, 2013, a nurse observed an inmate in distress during the evening medication line. She believed the inmate was beginning to have a seizure so she activated the alarm. During the alarm, it became apparent the inmate was not having a seizure, but acting bizarrely. As officers ordered him to submit to handcuffs, the inmate jumped up and moved toward the officers. Pepper spray was directed at the inmate's face, but the inmate turned away and ran. As officers pursued the inmate, he appeared to be punching himself in the stomach. The inmate was cornered near a housing unit and refused orders to get down. He then began to charge toward the officers. Pepper spray, batons, and physical force were used to gain control of the inmate. The inmate was unintentionally struck in the head with a baton during the incident. Medical staff determined that the inmate had several puncture wounds to his abdomen that appeared to be self-inflicted. Officers recovered an inmate-manufactured weapon in the area of the incident and a second inmate-manufactured weapon on the inmate. The inmate was transported to an outside hospital for treatment, returned two days after, placed in the outpatient housing unit at the institution, and evaluated by mental health staff.

Disposition

The institution's executive review committee determined the use of force was in compliance with the department's use-of-force policy, and the OIG concurred. The baton strike to the inmate's head occurred because of the inmate's movement. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Insufficient

Because of failure to provide timely notification to the OIG of the incident, the OIG found that the department's response to the incident was insufficient. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

The institution never notified the OIG about the incident. The OIG learned of the incident while monitoring incidents involving the use of force.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-04-14	13-0561-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On April 14, 2013, two officers were escorting an administrative segregation inmate from the medical clinic to his assigned cell when he attempted to break away from the escort and kick at one of the officers. One officer forced the inmate to the ground in a prone position to maintain control while the inmate continued to kick at the second officer. The second officer struck the inmate in the right ankle with his expandable baton, but the inmate continued to kick and refused orders to stop. The officer struck the inmate again in the right ankle with his expandable baton, and the inmate stopped kicking. The inmate was medically evaluated and transported to a local hospital where it was determined that the inmate had a broken bone in his lower leg. No officers were injured.

Disposition

The inmate was admitted to the outside hospital and returned to the institution two days after treatment. The inmate alleged the officers used excessive and unnecessary force. The institution's executive review committee determined the use of force was within departmental policy except for proper applications of restraints following the incident and failure to videotape all of the inmate's injuries. The OIG pointed out that the video-taped interview was not completed within 48 hours as required. The committee concurred with the OIG and provided training to the officers. In response to the inmate's appeal, the institution completed a confidential inquiry. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The department's overall response to the incident was adequate except for the failure to timely interview the inmate and document all of his injuries. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-05-04	13-0610-RO	On-Duty Death of Staff

Incident Summary

On May 4, 2013, a stationary engineer failed to check in with his supervisor and did not answer the phone at the power plant, so a welfare check was requested. An officer arrived at the power plant and found the stationary engineer's relief and three officers attempting to unlock the gate to gain access to the stationary engineer who was lying on the ground and not moving. An officer requested an ambulance via radio. The relief climbed the fence, retrieved keys from the stationary engineer's pocket, and opened the gate for responding staff. Medical staff began life-saving efforts until relieved by paramedics. The employee was pronounced dead after life-saving efforts failed.

Disposition

The autopsy revealed that the cause of death was a blockage in the stationary engineer's arteries and the death was determined to be unavoidable. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-05-29	13-2343-RO	Other Significant Incident

Incident Summary

On May 29, 2013, an inmate refused to leave a small holding cell when ordered to do so by two officers and a sergeant. The inmate told them that he needed a cell move. They attempted to talk the inmate into exiting the holding cell, but he still refused. The first officer hit the inmate in the face with his fist stating the inmate raised his fists to his chest and advanced toward him. The inmate reacted by hitting the officer with an open hand in the face, causing the officer to step backwards. The sergeant requested assistance via radio. The second officer attempted to spray the inmate with pepper spray, but it failed to disperse. The first and second officers forced the inmate to the back of the holding cell. The first officer attempted to force the inmate to the ground and reported that he was hit in the head by the inmate. Meanwhile, the second officer repeatedly struck the inmate on the head with the pepper spray canister. The inmate was pulled from the holding cell, forced to the ground, and placed in restraints with the assistance of responding staff. During the incident, the first officer sustained a small laceration to the top of his head.

CENTRAL REGION

Disposition
 The institution's executive review committee determined the use of force was in compliance with departmental policy. The OIG did not concur because potential staff misconduct was identified in that custody staff failed to close the cell door and consider a controlled use of force. At the recommendation of the OIG, the hiring authority referred the case to the Office of Internal Affairs for investigation; however, the Office of Internal Affairs refused to open an investigation. The OIG did not agree with this decision.

Overall Assessment **Rating: Insufficient**
 The department's overall response to the incident was inadequate. The investigative services unit did not properly investigate the incident and the incident was not adequately documented. In addition, the hiring authority initially failed to identify potential staff misconduct and refer the matter to the Office of Internal Affairs until urged to do so by the OIG. The Office of Internal Affairs then refused to open an investigation.

Assessment Questions

- Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?
The investigative services unit staff did not photograph the inmate's injuries and did not collect the pepper spray canister as potential evidence.
- Did the use-of-force review committee adequately review and respond to the incident?
The OIG expressed concerns that custody staff failed to close the cell door and consider a controlled use of force when the inmate refused to exit the cell.
- Was the critical incident adequately documented?
Custody staff reports did not adequately describe relevant details of the incident.
- Did the HA make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA?
The hiring authority did not refer the case to the Office of Internal Affairs until the OIG recommended referral when the OIG became aware of the incident, nearly three months after the incident .
- Did the HA appropriately determine whether to refer any conduct to the OIA related to the critical incident?
The hiring authority did not refer this case to the OIA for investigation until the OIG made the recommendation.
- Did OIA Central Intake make an appropriate initial determination regarding the case?
OIA Central Intake declined to open an investigation. The OIG did not concur because an investigation was needed to determine how the incident transpired as described by custody staff. Some of the assertions described in the reports appeared to be physically impossible.

Incident Date 2013-06-06	OIG Case Number 13-1793-RO	Case Type In-Custody Inmate Death
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Incident Summary
 On June 6, 2013, custody staff responded to a cell and discovered an unresponsive inmate after the cellmate yelled "man down." The unresponsive inmate had a slight amount of blood around his nose, but no other signs of trauma. The unresponsive inmate was taken to an outside hospital where he was later pronounced dead.

Disposition
 The evidence from an autopsy revealed that the cause of death was drug overdose. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs for investigation.

Overall Assessment **Rating: Sufficient**
 The OIG determined that the department adequately responded to the incident in all critical aspects.

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2013-07-22	13-1350-RO	Suicide

Incident Summary

On July 22, 2013, an inmate housed in a security housing unit was discovered hanging from braided sheets tied through holes in his cell door by an officer conducting security checks. The officer activated the alarm and an emergency cell entry was completed. Officers immediately initiated life-saving measures on the unresponsive inmate. Medical staff responded and continued life-saving efforts as he was transported to the triage treatment area via the emergency response vehicle. The inmate was pronounced dead after life-saving efforts failed. The inmate did not leave a suicide note, had no history of suicide attempts, and was not a participant in the prison's Mental Health Delivery System. The 32-year-old inmate had been in prison since 1999, when, at age 18, he was convicted of first-degree attempted murder and was sentenced to 15-years-to-life in prison. In 2004, while in prison, the inmate received an additional 18-years-to-life sentence for attempting to murder another inmate. In 2007, again while in prison, the inmate was charged with the murder of his cellmate and his capital murder trial was scheduled to begin in August 2013. On July 12, 2010, the inmate was validated as a prison gang member resulting in an indeterminate security housing unit term. The inmate had filed several grievances in recent years related to his desire for access to religious materials, his single-cell status, and medical issues related to continuing stomach problems. From September 25, 2011, until October 13, 2011, the inmate joined several other inmates in a statewide hunger strike. On July 8, 2013, the inmate again participated in a mass hunger strike in which inmates were protesting the conditions in the security housing unit. On July 15, 2013, the inmate signed a refusal for medical evaluation related to the hunger strike and made a note that said he was not participating in the hunger strike, but was waiting for his religious kosher meal. On July 21, 2013, the inmate was seen by staff consuming his evening meal, indicating he was no longer participating in the hunger strike. On July 22, 2013, the morning of his death, the inmate was evaluated by a nurse for his ongoing stomach complaints. The nurse consulted with a physician and the inmate was given a prescription for medication to relieve his symptoms. Shortly after the inmate died, accusations surfaced alleging that the inmate had not committed suicide, but had starved to death. The last time he was weighed before the hunger strike was on June 24, 2013, at which time he weighed 177 pounds. On the day of his death, the 5-foot-9-inch inmate weighed 171 pounds.

Disposition

An autopsy was performed and the cause of death was determined to be suicide by hanging. The executive death review report concluded that the death was not preventable and that the standard of care during the emergency was met. The report did, however, identify an opportunity for improvement. Specifically, when the inmate was seen by a nurse on July 22, 2013, the morning of his death, the nurse called the physician who prescribed medication for his stomach symptoms. However, the physician did not write a supporting progress note or order a follow-up appointment. The executive summary of suicide report was inconclusive regarding why the inmate took his own life, but provided four possible scenarios or mindsets that could have motivated the inmate to commit suicide. Specifically, the report speculated that 1) the inmate intended to make a suicidal gesture to bring attention to the inmate hunger strike, but did not intend to die; 2) the inmate was feeling despondent about his future with his trial for the murder of his cellmate scheduled to go forward and the district attorney planning to seek the death penalty, so he could have been using suicide as an escape; 3) the inmate decided to not let the State of California determine when his life would end, and made that decision himself; and 4) the inmate received an order to kill himself from the prison gang to draw media attention to the hunger strike. The report also noted that the inmate had not consistently been offered ten hours of yard time each week as required, and recommended that the institution provide training and education to staff to address this issue in the future. On July 9, 2013, the inmate filed a grievance requesting to see a medical specialist for evaluation of his stomach issues. However, the appeal was not resolved because the inmate died prior to the response due date of August 19, 2013. The case was not referred to the Office of Internal Affairs for investigation, and the OIG concurred with that decision.

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-08-12	13-1693-RO	Other Significant Incident

Incident Summary

On August 12, 2013, an officer returning from a transportation assignment was securing her 40-caliber sidearm. She placed the muzzle of the firearm in a tube designed to safely capture bullets in case of an accidental discharge. While clearing the firearm, a round accidentally discharged into the tube. The safety tube functioned correctly and there were no injuries.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs. The officer received training on how to properly clear her weapon prior to storage. The OIG concurred with this decision.

CENTRAL REGION

Overall Assessment	Rating: Sufficient
Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the decision not to submit the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-08-15	13-1695-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On August 15, 2013, an officer noticed an inmate-manufactured weapon near a cell during the morning meal. The officer looked in the cell and observed one inmate being strangled by a second inmate. The officer activated her alarm and additional officers responded. The second inmate complied with orders to stop, was handcuffed, and was removed from the cell. The first inmate was placed on a stretcher and moved to the medical clinic where he was evaluated. The inmate was transported by helicopter to an outside hospital for a higher level of care. It was later determined the first inmate sustained loss of consciousness, a cranial fracture, and numerous other injuries, including his eye coming out of the socket. The first inmate underwent lengthy surgery to treat the trauma to his head. He was returned to the institution after spending two weeks at outside hospitals. The second inmate also sustained numerous injuries and stab wounds, but none of the injuries required removal to an outside hospital. No additional weapons were identified.

Disposition

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

Overall Assessment	Rating: Sufficient
The department sufficiently responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-08-22	13-1859-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On August 22, 2013, officers observed an inmate stabbing another inmate on an exercise yard. The alarm was sounded and officers responded to the incident resulting in the inmate stopping the attack. The inmate sustained multiple stab wounds to his upper torso resulting in a collapsed lung and severe blood loss due to a severed artery in his arm. The injured inmate was transported to an outside hospital for treatment and returned approximately seven days later. The inmate who assaulted him was placed in administrative segregation pending an investigation.

Disposition

No staff misconduct was identified; therefore the case was not referred to the Office of Internal Affairs for investigation. The Emergency Medical Response Review Committee determined that training was needed related to documentation of the first responder form. The OIG concurred with the review.

Overall Assessment	Rating: Sufficient
Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.	

Incident Date	OIG Case Number	Case Type
2013-08-30	13-2021-RO	PREA

Incident Summary

On August 30, 2013, an officer allegedly entered the cell of an inmate who was on suicide watch and raped the inmate. The inmate was transferred to another institution and arrived there on August 31, 2013. On September 4, 2013, the inmate reported the alleged rape to a clinical psychologist. The inmate was interviewed and the sexual assault response team arranged for an evaluation. The inmate later refused to be medically evaluated.

Disposition

Although the Office of Internal Affairs was notified of the alleged rape, an investigation was not opened because the inmate refused to be medically examined and refused further efforts to preserve evidence. The OIG concurred with the disposition.

CENTRAL REGION

Overall Assessment	Rating: Sufficient
The department's overall response to the incident was adequate in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The hiring authority decided to refer the matter to the Office of Internal Affairs, and the OIG concurred.	

Incident Date 2013-09-01	OIG Case Number 13-1925-RO	Case Type Other Significant Incident
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Incident Summary
On September 1, 2013, officers discovered that an inmate assigned to a minimum support facility was missing. The inmate had climbed a fence between count times. Escape procedures were immediately activated. Outside law enforcement agencies and surrounding residents were notified. The inmate was apprehended on September 12, 2013, by an outside law enforcement agency and returned to custody on the same date.

Disposition
There were no departmental policy violations associated with the inmate's escape and no staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment	Rating: Sufficient
The department's response was satisfactory in all critical aspects. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	

Incident Date 2013-09-19	OIG Case Number 13-2064-RO	Case Type Inmate Serious/Great Bodily Injury
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Incident Summary
On September 19, 2013, an officer observed two inmates standing over a third inmate punching and kicking him. The control booth officer gave orders for the inmates to stop and get down, but they ignored the orders. The officer discharged three less-lethal rounds at the lower legs of the two assailants, but did not see where the rounds struck. The shots were not effective in stopping the attack, so responding staff used pepper spray, which was effective, and the inmates assumed a prone position. One of the assailants reported that he was struck in the side of the head by one of the less-lethal rounds after it had ricocheted off the wall. He was medically evaluated and the injury was determined not to be serious, so he was returned to his assigned cell.

Disposition
Although the institution's executive review committee determined that the use of force was within departmental policy and the impact to the inmate's head was accidental, it identified two training issues. The officer who shot the less-lethal rounds failed to identify the specific point of contact, and the incident commander did not follow the local process for determining whether an inmate sustained serious bodily injury. Both staff members received training. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG agreed with the determinations.

Overall Assessment	Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the decision not to submit the matter to the Office of Internal Affairs.	

Incident Date 2013-11-01	OIG Case Number 13-2369-RO	Case Type Contraband Watch
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Incident Summary
On November 1, 2013, an institution's investigative services unit received information from an anonymous source that an inmate would attempt to smuggle drugs into the prison's administrative segregation unit. On the following day, an inmate battered another inmate with a weapon and was taken to the administrative segregation unit for housing. Based on the information received the previous day, the inmate was placed on contraband surveillance watch. On November 3, 2013, the inmate exhibited symptoms of being under the influence of drugs. As a result, the inmate was taken to an outside hospital for continued observation and care. An x-ray was negative; however, a urinalysis confirmed the presence of drugs in his system. The inmate stayed at the hospital until November 10, 2013, during which time staff members recovered eight bindles containing inmate notes and drugs.

CENTRAL REGION

Disposition No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the decision not to submit the matter to the Office of Internal Affairs.		
Incident Date 2013-11-09	OIG Case Number 13-2421-RO	Case Type In-Custody Inmate Death
Incident Summary On November 9, 2013, an officer was conducting the afternoon count when he discovered a makeshift curtain that prevented him from seeing into a cell. The inmate failed to respond to the cell front. A second officer arrived and had the control booth officer open the door. The officer found the inmate sitting unresponsive on the desk stool. The inmate was slumped over with his head on the top of the lower storage cubicle. The other officer announced a medical emergency via his radio, and activated his personal alarm. The officers determined the inmate was not breathing and began life-saving measures until medical staff relieved them. After life-saving measures failed, a physician at the institution pronounced the inmate dead. A syringe, a spoon, and packaging with what appeared to be residue from a controlled substance were found in the cell. An injection site was found on the inmate's right arm.		
Disposition The autopsy revealed the death was due to respiratory arrest caused by a drug overdose. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.		

NORTH REGION

Incident Date	OIG Case Number	Case Type
2011-11-26	11-2869-RO	Suicide

Incident Summary

On November 26, 2011, a single-celled inmate was found hanging from a cloth noose attached to the left corner of the top bunk. Officers removed the inmate from his cell, placed him on a gurney, and transported him to the triage treatment area. Custody and medical staff initiated life-saving measures, which were unsuccessful. The inmate was pronounced dead by an institution physician.

Disposition

The coroner determined the cause of death was hanging and the manner of death undetermined. Potential staff misconduct was identified; therefore, the case was referred to the Office of Internal Affairs for investigation. A physician allegedly failed to properly order medications. In addition, a nurse allegedly failed to activate the emergency response system in a timely manner and failed to respond to the scene with emergency response equipment. The Office of Internal Affairs opened an investigation; however, the OIG did not accept the case for monitoring.

Overall Assessment

Rating: Sufficient

The department's overall response to the incident was adequate in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2012-07-28	12-1785-RO	Suicide

Incident Summary

On July 28, 2012, officers discovered an inmate with a noose made out of a bed sheet around his neck and attached to the light fixture in his cell. The officers cut the material from around the inmate's neck and immediately began life-saving measures. Responding emergency medical personnel also attempted to revive the inmate but were unsuccessful.

Disposition

The autopsy report revealed that the inmate's cause of death was by strangulation. Potential staff misconduct was identified. Custody staff allegedly failed to follow protocols to place the inmate in an intake cell, conduct 30-minute welfare checks, sound an alarm or use the emergency call number, sign post orders, obtain supervisor approval prior to obtaining keys, properly secure photographs of the scene, allow the physician access to the inmate's body, and timely document that the inmate had previously torn his sheets into strips. Therefore, the matter was referred to the Office of Internal Affairs, which opened an investigation. The OIG accepted the case for monitoring.

Overall Assessment

Rating: Sufficient

The OIG determined that the department adequately responded to the incident in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority decided to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2012-08-17	12-1949-RO	In-Custody Inmate Death

Incident Summary

On August 17, 2012, an inmate assigned to a fire camp reported to an officer that he was suffering from a headache, nausea, and profuse sweating. The inmate was escorted to the Medical Emergency Response Team tent for a medical evaluation. The inmate presented to the medical staff with complaints of nausea, vomiting, lightheadedness, and headache. Medical staff treated the inmate with intravenous fluids and monitored him for two hours. When the inmate was cleared to return to his unit, he vomited. Medical staff provided additional treatment and released the inmate back to his unit. The following morning custody staff found him unresponsive but with a pulse and breathing. The inmate was transported to an outside hospital for advanced medical care. He continued to be unresponsive and was placed on a ventilator. The inmate was declared brain dead on August 19, 2012.

Disposition

An autopsy was performed by the coroner's office who determined the cause of death was anoxic encephalopathy due to complications of heatstroke. The department's Death Review Committee concluded the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

NORTH REGION

Overall Assessment	Rating: Sufficient
<p>The OIG determined that the department adequately responded to the incident in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.</p>	

Incident Date	OIG Case Number	Case Type
2012-08-17	12-1950-RO	Suicide

Incident Summary

On August 17, 2012, an officer conducting a security check of a housing unit approached a cell occupied by a single inmate and saw the inmate hanging by a noose around his neck. The noose was attached to an air vent in the cell. An alarm was activated and officers entered the cell, cut the noose, and started performing life-saving measures, which were unsuccessful. The inmate was pronounced dead after life-saving measures failed.

Disposition

The autopsy report indicated the cause of death was suicide by hanging. Potential staff misconduct was identified due to the possibility that staff did not properly follow instructions for additional welfare checks on the inmate and allegedly falsified an inmate count log; therefore, the matter was referred to the Office of Internal Affairs, which opened an investigation. The OIG accepted the case for monitoring.

Overall Assessment	Rating: Insufficient
<p>The department's overall response was not adequate because OIA Central Intake failed to add an allegation of dishonesty or making false or misleading statements. However, the department informed the OIG about the incident in a timely and sufficient manner. The hiring authority decided to refer the matter to the Office of Internal Affairs, and the OIG agreed.</p>	

Assessment Questions

- Did OIA Central Intake make an appropriate initial determination regarding the case?
OIA Central intake did not identify or add an allegation of dishonesty or making false or misleading statements.
- Would the appropriate initial determination or reconsideration determination have been made by OIA Central Intake and/or OIA Chief without OIG intervention?
OIA Central Intake failed to make the appropriate initial determination by failing to add an allegation of dishonesty or making false or misleading statements. Upon the urging of the OIG and the department attorney, and elevating the matter to a higher level of review, the hiring authority added and sustained an allegation of making false or misleading statements.

Incident Date	OIG Case Number	Case Type
2012-09-15	12-2138-RO	In-Custody Inmate Death

Incident Summary

On September 15, 2012, two inmates attacked another inmate on an exercise yard. Officers used a less-lethal direct impact round and pepper spray to stop the attack. Meanwhile, a riot involving approximately 30 inmates erupted on the same exercise yard. Staff utilized less-lethal direct impact rounds and pepper spray to quell the attack and the riot. The inmate being attacked in the first incident died from the attack. The institution's investigative services unit processed the area as a crime scene. Inmate-manufactured weapons were found near the area where the first attack occurred and multiple weapons were found near the area where the riot occurred. Inmate-manufactured weapons were also discovered in the housing unit.

Disposition

The autopsy concluded that the cause of death was multiple stab wounds resulting in death within minutes of the attack and that the manner of death was homicide. The institution's executive review committee determined that the use of force was within departmental policy. The OIG concurred with these findings. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment	Rating: Sufficient
<p>Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.</p>	

NORTH REGION

Incident Date	OIG Case Number	Case Type
2012-10-07	12-2292-RO	In-Custody Inmate Death
Incident Summary On October 7, 2012, custody staff found an inmate lying on the floor of the housing unit restroom and summoned medical assistance. The inmate was transported via gurney to the infirmary where a physician determined the inmate required transport to an outside hospital. Medical staff determined the inmate had injuries consistent with being involved in a physical altercation. The injuries included a laceration with active bleeding under his chin, swollen and abraded areas on his head, and abrasions on his back and left knuckles. As the ambulance arrived on institutional grounds, the inmate suffered cardiac arrest. Medical staff and paramedics performed life-saving measures and stabilized the inmate. The inmate was then transported by ambulance to a local hospital where he was subsequently pronounced dead.		
Disposition The autopsy report indicated the cause of death was internal bleeding caused by a perforated spleen. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Insufficient
The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG concurred.		
Assessment Questions <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The OIG was not timely notified of the incident.</i></p>		

Incident Date	OIG Case Number	Case Type
2013-01-23	13-0172-RO	In-Custody Inmate Death
Incident Summary On January 23, 2013, an inmate informed an officer that his cellmate was unconscious. The cellmate was discovered on the upper bunk with no pulse. Life-saving measures failed and the cellmate was pronounced dead. The inmate initially stated that his dead cellmate had been threatening him because he is a registered sex offender. He stated that when he woke up that morning, his cellmate was standing over him and because he felt threatened, he got up and began punching the cellmate until the cellmate was unconscious, at which point he placed the cellmate on the upper bunk. Approximately one month later, the inmate wrote a detailed confession indicating his initial story was false and that he had murdered his cellmate by choking him because he had damaged his compact disc player.		
Disposition The autopsy report indicated the inmate died of asphyxia due to a neck hold. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.		

Incident Date	OIG Case Number	Case Type
2013-03-05	13-0391-RO	In-Custody Inmate Death
Incident Summary On March 5, 2013, an inmate reportedly fell out of his lower level bunk onto the cell floor. His cellmate called for assistance and medical staff responded, administered emergency medical care, and arranged for transportation to an outside hospital where the inmate died in the emergency room. The cellmate was removed from the cell and placed in administrative segregation pending investigation. The cell was secured as a possible crime scene.		
Disposition The coroner did not perform an autopsy in this case because all evidence supported the conclusion that the inmate's death was the result of natural causes resulting from chronic underlying medical conditions. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with these determinations.		

NORTH REGION

Overall Assessment	Rating: Sufficient
Overall, the department's response to the incident was sufficient.	

Incident Date	OIG Case Number	Case Type
2013-03-06	13-0393-RO	In-Custody Inmate Death

Incident Summary

On March 6, 2013, an inmate with chronic lymphocytic leukemia began having trouble breathing. His cellmate alerted custody staff and an alarm was activated. The inmate was unable to talk and stopped breathing shortly after medical staff arrived. Medical staff started life-saving measures. An ambulance arrived shortly thereafter, but the inmate could not be revived and was pronounced dead.

Disposition

The autopsy determined that the inmate's primary cause of death was chronic lymphocytic leukemia. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Insufficient

The department failed to timely notify the OIG, impeding the ability of the OIG to conduct a proper and thorough on-scene assessment of the department's response to the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

The OIG was not promptly informed of the critical incident. The OIG was notified almost three hours after the inmate had been pronounced dead.

Incident Date	OIG Case Number	Case Type
2013-03-08	13-0430-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On March 8, 2013, during an escort within the institution, an inmate became resistive toward custody staff, which resulted in the use of physical force. Custody staff forced the inmate to the ground and restrained him. During the incident the inmate lost three teeth and sustained a broken jaw.

Disposition

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

Overall Assessment

Rating: Sufficient

The OIG determined that the department adequately responded to the incident in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-04-14	13-0554-RO	Suicide

Incident Summary

On April 14, 2013, while conducting a security check of condemned inmates, an officer saw an inmate hanging from a sheet tied to the cell door. An alarm was sounded and custody staff assembled an emergency cell extraction team. The inmate, who was unresponsive, was released from the sheet and custody staff began life-saving measures. Medical and fire-fighting staff responded and rendered additional medical assistance. An ambulance also arrived and transported the inmate to an outside hospital where he was pronounced dead shortly thereafter.

Disposition

The department's Death Review Committee deemed the inmate's death a suicide by hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

NORTH REGION

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

Incident Date	OIG Case Number	Case Type
2013-05-03	13-0609-RO	PREA

Incident Summary

On May 6, 2013, an inmate alleged that on May 3, 2013, he was alone in his cell when he felt something being inserted into his buttocks. The inmate had taken psychotropic medication earlier in the day. After the alleged incident, the inmate stated he heard a door slam. The inmate was unable to identify any assailant, but stated he believed it was one of two officers or one of two inmates. Prison Rape Elimination Act protocols were instituted and the inmate was taken to an outside hospital for tests and evidence collection, and then returned to the institution.

Disposition

Evidence of a possible sexual assault was preserved in the event the identity of a potential assailant is known in the future. The case was referred to the Office of Internal Affairs for investigation for further investigation.

Overall Assessment	Rating: Sufficient
Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The matter was referred to the Office of Internal Affairs for further investigation.	

Incident Date	OIG Case Number	Case Type
2013-05-04	13-0614-RO	In-Custody Inmate Death

Incident Summary

On May 4, 2013, an officer discovered a single-celled inmate unresponsive in his cell. Officers carried the inmate to a lower tier where medical staff performed life-saving measures. Life-saving measures continued as the inmate was transported to the triage treatment area. The life-saving measures were unsuccessful and the inmate was declared dead.

Disposition

The coroner determined the cause of death was hypertensive and atherosclerotic cardiovascular disease. Potential staff misconduct was identified related to the lack of life-saving measures being initiated by custody staff prior to the inmate being moved to a lower tier. Therefore, the case was referred to the Office of Internal Affairs. The Office of Internal Affairs returned the case to the hiring authority to take disciplinary action without an investigation. The OIG did not accept the case for monitoring.

Overall Assessment	Rating: Sufficient
The department's response was satisfactory except that the involved officers did not begin life-saving measures immediately and waited for medical staff to arrive. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.	

Incident Date	OIG Case Number	Case Type
2013-05-06	13-0635-RO	In-Custody Inmate Death

Incident Summary

On May 6, 2013, an officer observed a non-responsive inmate in his cell, with a cord wrapped around the inmate's neck and cloth material sticking out of his mouth. The officer sounded an alarm, and, once sufficient officers were present, they entered the cell. Medical staff examined the inmate, initiated life-saving measures, and transported the inmate to the institution's medical treatment area. The inmate was subsequently pronounced dead.

NORTH REGION

Disposition

The autopsy report indicated that the inmate's death was due to asphyxia due to ligature strangulation. Potential staff misconduct was identified based on the untimely response to the medical emergency and the inappropriate use of the automated external defibrillator; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs declined to open an investigation. The institution ordered and placed protective shields in all of its housing units to ensure that the shields are readily available when staff must enter an occupied cell during an emergency. The institution also modified its alarm response policies to provide medical staff and the emergency response vehicle direct access to housing units. Additionally, the institution provided training to involved medical staff on the appropriate use of the automated external defibrillator.

Overall Assessment

Rating: Insufficient

The OIG determined that the department's response to the incident was inadequate because 24 minutes elapsed between when staff discovered the unresponsive inmate and when first responders first entered the cell. Additionally, responding medical staff did not use an automated external defibrillator on the inmate until the inmate arrived at the medical treatment area. Finally, the emergency response vehicle took 15 minutes to transport the inmate from the housing unit to the medical treatment area. The department informed the OIG about the incident in a timely and sufficient manner. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Did the HA timely respond to the critical incident?

Twenty-four minutes elapsed between when the officer discovered the unresponsive inmate and when first responders first entered the cell. Additionally, responding medical staff did not use an automated external defibrillator on the inmate until the inmate arrived at the medical treatment area. Finally, the emergency response vehicle took 15 minutes to transport the inmate from the housing unit to the medical treatment area.

Incident Date	OIG Case Number	Case Type
2013-05-23	13-0694-RO	PREA

Incident Summary

On May 23, 2013, an inmate alleged that an officer grasped his genitals while conducting a clothed body search.

Disposition

The hiring authority did not identify potential staff misconduct. The hiring authority did not believe the case met the Prison Rape Elimination Act reporting requirements; therefore, the hiring authority did not refer the case to the Office of Internal Affairs. The OIG did not concur with this decision.

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the department failed to notify the OIG of the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG did not concur with this decision.

Assessment Questions

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

The institution did not inform the Office of Internal Affairs of the incident.

- Was the OIG promptly informed of the critical incident?

The institution did not inform the OIG of the incident. The OIG learned of the incident through a department daily report.

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

The department's policies and procedures require that reports alleging staff-on-offender sexual assault incidents shall be immediately referred to the Office of Internal Affairs for investigation. The hiring authority failed to follow reporting policies as no referral to the Office of Internal Affairs was made.

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

The hiring authority failed to follow the department's policies and procedures regarding the referral of the case to the Office of Internal Affairs.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-05-28	13-0700-RO	In-Custody Inmate Death

Incident Summary

On May 28, 2013, an inmate was found lying on the cell floor and his cellmate had dried blood on his hands. The cellmate informed custody staff that he murdered the inmate at midnight, and the body was discovered by custody staff hours later. Medical and custody staff immediately initiated life-saving measures, which continued until the inmate was pronounced dead. The dead inmate's body was in a state of rigor mortis with lividity at the time of discovery.

Disposition

The autopsy revealed the cause of death was asphyxia by neck compression. Rigor mortis and lividity were present when the dead inmate's body was discovered during the morning release. The first watch post orders required hourly security and welfare checks of all inmates as a suicide-prevention method. The officer conducting the hourly security and welfare checks allegedly failed to notice a dead inmate lying on the cell floor. As potential staff misconduct was identified, the hiring authority referred the matter to the Office of Internal Affairs for investigation. An Office of Internal Affairs investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: Sufficient

The department's overall response to the incident was adequate in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The hiring authority chose to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-05-31	13-0725-RO	In-Custody Inmate Death

Incident Summary

On May 31, 2013, a registered nurse and a custody officer attempted to contact an inmate to determine why he did not report for a second time in one week for his medical treatments. The inmate was found sitting on his bunk with his feet on the floor and his upper body lying across the bed. The inmate was unresponsive. Additional custody and medical staff responded, placed the inmate onto a gurney, and initiated life-saving measures. Life-saving measures continued while the inmate was transported to the institution's emergency room where a physician and other medical staff continued to administer medical treatment. The inmate was subsequently pronounced dead.

Disposition

No autopsy was performed; however, the Death Review Committee listed the primary cause of death as end-stage renal disease and a secondary cause as coronary artery disease. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department adequately notified the OIG of the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-06-12	13-0816-RO	In-Custody Inmate Death

Incident Summary

On June 12, 2013, an inmate was found unresponsive in his cell during the inmate count. Officers performed life-saving measures, which failed. The cellmate was removed from the cell and the investigative services unit treated the cell as a crime scene. No obvious injuries were seen on either the dead inmate or the cellmate. A hypodermic needle and drugs were found in the cell.

Disposition

The autopsy report indicated the inmate died of a drug overdose. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-06-26	13-1094-RO	In-Custody Inmate Death

Incident Summary

On June 26, 2013, an inmate told an officer that his cellmate was sick. The officer observed the cellmate lying on his bed, unresponsive. The officer activated his alarm and responding medical staff assessed the inmate's condition and initiated life-saving measures. The inmate was subsequently pronounced dead. The institution's investigative services unit responded and secured the area as a crime scene.

Disposition

No autopsy was performed; however, the department's Death Review Committee listed the cause of death as probable arrhythmia due to diabetes mellitus. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-02	13-1095-RO	Inmate Riot

Incident Summary

On July 2, 2013, as inmates were returning from their evening meal, a riot involving multiple inmates occurred on the exercise yard. Initially, the fight involved three or four inmates but expanded as additional inmates became involved. Custody staff used numerous chemical agent grenades and less-lethal 40 mm rounds to stop the violence. The inmates involved in the riot were medically evaluated and re-housed in the administrative segregation unit. One inmate required medical attention for a facial laceration and was transported to a local hospital for treatment. He was released back to the institution the same day. No staff injuries were reported.

Disposition

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

Overall Assessment

Rating: Sufficient

The OIG determined that the department adequately responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-07-11	13-1307-RO	Other Significant Incident

Incident Summary

On July 11, 2013, an inmate started exhibiting irregular eating habits. On July 19, 2013, the inmate was transferred from the institution's correctional treatment center to an outside hospital due to medical complications related to irregular eating and weight loss of 50 pounds. The inmate reported that he was not on a hunger strike, but did not feel like eating. The institution received an order authorizing the institution's chief medical executive to make healthcare decisions on behalf of the inmate. On August 19, 2013, the inmate was released from the correctional treatment center having gained 25 pounds while under medical care.

Disposition

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

Overall Assessment

Rating: Insufficient

The department's overall response to the incident was inadequate because it failed to timely notify the OIG of the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

NORTH REGION

Assessment Questions

- Was the OIG promptly informed of the critical incident?

The OIG was not informed of the critical incident. The OIG learned of the event through the department's daily report.

Incident Date	OIG Case Number	Case Type
2013-07-19	13-1293-RO	PREA

Incident Summary

On July 19, 2013, an inmate reported that after a verbal exchange with an officer, the officer escorted the inmate into an elevator and allegedly pushed him against a wall, reached inside the inmate's pants, and inserted a finger into the inmate's rectum. The inmate was transported to an outside hospital for a sexual assault examination, but the inmate refused the examination.

Disposition

Pursuant to departmental policy, the hiring authority referred the matter to the Office of Internal Affairs. The Office of Internal Affairs determined there was no evidence to support a reasonable belief that any staff misconduct occurred. Therefore, the Office of Internal Affairs did not open the case for investigation.

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-07-28	13-1404-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On July 28, 2013, two inmates attacked another inmate with inmate-manufactured weapons on an exercise yard. The inmates failed to follow responding officers' orders to stop their actions and get on the ground. Officers utilized chemical agents and one less-lethal 40 mm direct impact round to stop the assault. The attacked inmate was air-lifted to an outside hospital for difficulty breathing and treatment of numerous puncture and laceration injuries to his neck, back, and facial areas. He later returned to the institution. Medical staff also provided first aid to the other two inmates involved in the attack. The two inmates incurred abrasions and swelling to their hands and facial areas. All other inmates were safely removed from the yard and returned to their assigned cells. Two inmate-manufactured weapons were discovered near the incident.

Disposition

The institution's executive review committee determined the force was appropriate but out of compliance with departmental policy due to the officer not properly identifying the zone point of aim with the less-lethal weapon. Training was provided to the officer. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The department's response was satisfactory in all critical aspects. The department's notification to and consultation with the OIG regarding the incident was sufficient. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-08-12	13-1641-RO	Other Significant Incident

Incident Summary

On August 12, 2013, an inmate physically assaulted a physician in the clinic. The inmate was found with an inmate-manufactured weapon. Physical force was used to gain control of the inmate and place him in restraints. The physician was medically evaluated and transported home. The inmate sustained cuts and abrasions to his hands.

Disposition

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

NORTH REGION

Overall Assessment	Rating: Sufficient
The department's response was satisfactory in all critical aspects. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-08-26	13-1821-RO	PREA

Incident Summary

On August 26, 2013, an inmate alleged he was subjected to sexual harassment by an officer during an un clothed body search when the officer ordered him to bend over and spread his buttocks and then made inappropriate comments of a sexual nature about the inmate's anatomy, as well as inappropriate comments of a sexual nature toward the inmate.

Disposition

Potential staff misconduct was identified based on the officer's disrespectful and sexually inappropriate remarks; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment	Rating: Sufficient
Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-09-07	13-1940-RO	In-Custody Inmate Death

Incident Summary

On the evening of September 6, 2013, an officer used pepper-spray on an inmate after he refused to relinquish his food port. The inmate was single-celled in a mental health crisis unit and had a tracheostomy tube in his neck. He was reported to be in a state of intermittent agitation and distress throughout the night and nurses saw him manipulating the stoma where his tracheostomy tube should have been. Custody staff decided not to perform a cell extraction. On September 7, 2013, at 5:07 a.m., the inmate was found dead in his cell. An autopsy determined the cause of death was asphyxia due to food and fecal material placed in the tracheostomy stoma by the inmate.

Disposition

The autopsy report stated the cause of death was asphyxia. Potential staff misconduct has been identified based on the circumstances of the use of force and the failure to remove the inmate from his cell in order to provide medical treatment after he was seen manipulating the stoma where his tracheostomy tube had been. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment	Rating: Sufficient
The department timely notified the OIG and the OIG responded on scene. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-09-14	13-2017-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On September 14, 2013, a fight broke out between two inmates on the tier outside their cells. Four less-lethal 40 mm direct impact rounds and pepper spray were used to stop the fight. It was initially thought that one of the direct impact rounds struck an inmate in the face, but this turned out to not be the case. The inmate had an old injury and scar to his cheek area that was reinjured in the fight. Two direct impact rounds struck an inmate in the upper torso area. In both instances, the officer who fired the shots was aiming for the inmate's legs. No serious or life-threatening injuries resulted from the use of force.

Disposition

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

NORTH REGION

Overall Assessment	Rating: Sufficient
Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.	

Incident Date	OIG Case Number	Case Type
2013-09-14	13-2018-RO	Other Significant Incident

Incident Summary

On September 14, 2013, an inmate was disruptive and verbally confrontational in the visiting room. The inmate's visit was terminated and he was escorted to the search area. The inmate refused to submit to a search and handcuffs. The inmate turned suddenly and punched an officer in the eye and repeatedly hit the officer with clenched fists in the face and head area. An alarm was sounded and a responding sergeant and officer each hit the inmate in the face with clenched fists in order to stop the attack on the first officer. Eventually the inmate was restrained and escorted to his cell by uninvolved staff. A strong odor of alcohol was detected and the inmate admitted that he had been drinking.

Disposition

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

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

SOUTH REGION

Incident Date 2012-05-12	OIG Case Number 12-1103-RO	Case Type Contraband Watch
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Incident Summary

On May 12, 2012, an officer observed an inmate retrieve an item from the waistband of his visitor and place the item in his mouth. Officers searched the inmate and discovered seven bindles of suspected heroin in a bag of chips. The inmate admitted to swallowing a bindle of heroin and was placed on contraband surveillance watch. On May 14, 2012, the inmate complained of an inability to defecate and was transported to an outside hospital for a higher level of care, where he produced a bowel movement containing one bindle of suspected heroin. On May 15, 2012, the inmate returned to the institution and was returned to contraband surveillance watch during which time he produced four bowel movements free of contraband. Despite the four bowel movements free of contraband, the inmate was not removed from contraband surveillance watch until the following day, May 16, 2012.

Disposition

Potential staff misconduct was identified based on the failure to document the approval to extend the inmate on contraband surveillance watch beyond 72 hours, failure to document the inmate's activities while on contraband surveillance watch, and failure to release the inmate from contraband surveillance watch after it was reasonable to believe the inmate was contraband free. The OIG urged the hiring authority to address the deficiencies but the hiring authority took no action. During this time, the department placed a new hiring authority at the institution but the deadline had passed for taking action against the officers; therefore, the matter was not referred to the Office of Internal Affairs for investigation. However, at the urging of the OIG, the new hiring authority provided training to all custody and supervisory staff regarding the department's contraband surveillance watch policies and procedures.

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the inmate's activities while on contraband surveillance watch were not adequately documented, the extension beyond the initial 72 hours was not documented, and the inmate was kept on contraband surveillance watch after it was reasonable to believe he was contraband free. Also, the department failed to consult with the OIG about the incident in a sufficient manner. The OIG did not concur with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Was the critical incident adequately documented?

There is no documentation that the warden or chief deputy warden approved the extension of contraband surveillance watch beyond the initial 72 hours, as required by departmental policy. Additionally, the inmate's activities were not adequately documented during the contraband surveillance watch, as required by departmental policy.

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

The OIG met with the hiring authority at different times after the incident urging the hiring authority to address the deficiencies, but no action was taken. The department placed a new hiring authority at the institution who was receptive to the OIG's concerns, but the deadline for taking any action against the involved officers had passed.

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

Potential staff misconduct was discovered related to the lack of documentation for the contraband surveillance watch incident. The OIG urged the hiring authority on several occasions to address the matter, but no action was taken until a new hiring authority was placed at the institution. By the time the new hiring authority was apprised of the potential misconduct, the deadline had passed for taking action against the officers.

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

The hiring authority in place at the time of the incident failed to address the numerous deficiencies despite recommendations by the OIG. The new hiring authority agreed with the OIG's concerns and implemented a training program directed to all custody staff regarding contraband surveillance watch policies and procedures.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2012-10-24	12-2417-RO	Suicide

Incident Summary

On October 24, 2012, while conducting cell checks, officers observed a single-celled inmate lying on his bunk with a sheet hanging from the bunk in a manner that obscured the view of the inmate's head. The inmate did not respond to the officer's orders. The officer summoned a sergeant who entered the cell. Upon entering the cell and removing the sheet, officers discovered the inmate had a sheet tied around his neck. The inmate did not have a pulse and his body was cold and rigid. Medical staff was summoned to the cell who initiated life-saving measures. The inmate was transported to the triage treatment area where life-saving measures continued, but the inmate was declared dead.

Disposition

The coroner determined the cause of death was suicide by ligature strangulation. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. However, the coroner's investigator informed the department's medical staff that the inmate had likely been dead for several hours prior to custody staff finding him. At the time of the incident, departmental policy did not require officers to count living, breathing inmates but the hiring authority ordered training to all custody staff regarding the prohibition of a sheet or other items that obstruct the view of the inside of a cell. The department recently revised its policy to require officers to count living, breathing inmates.

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2012-11-11	12-2739-RO	Contraband Watch

Incident Summary

On November 11, 2012, officers conducted an unclothed body search of an inmate returning from family visiting and observed lubricant around the inmate's rectum. The inmate relinquished one bundle of tobacco and was placed on contraband surveillance watch. On November 14, 2012, the inmate was removed from contraband surveillance watch, prior to the inmate having a bowel movement and prior to the recovery of any contraband. Later that day, after the inmate had been removed from contraband surveillance watch, officers searched the inmate and his cell and recovered two additional bundles of tobacco.

Disposition

Potential staff misconduct was identified based on removing the inmate from contraband surveillance watch prior to the inmate having a bowel movement or officers recovering contraband, and the conflicting documentation regarding the events. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the department failed to follow policy with regard to removing the inmate from contraband surveillance watch. The department provided adequate notification and consultation to the OIG regarding the incident. Although untimely, the hiring authority referred the matter to the Office of Internal Affairs. The OIG concurred with this decision.

SOUTH REGION

Assessment Questions

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

The department removed the inmate from contraband surveillance watch prior to the inmate having a bowel movement and prior to the recovery of any contraband, contrary to departmental policy.

- Was the critical incident adequately documented?

The department failed to adequately document the removal of the inmate from contraband surveillance watch. The initial documentation reported that the inmate was removed from contraband surveillance watch after a bowel movement that produced several bindles of tobacco. Several days later it was discovered this report was inaccurate, and a second report was generated, stating that the inmate was removed from contraband surveillance watch prior to having a bowel movement and prior to officers recovering any contraband. Several hours after being removed from contraband surveillance watch, officers discovered two bindles of tobacco in the inmate's possession.

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

The possible misconduct was discovered on November 27, 2012; however, the hiring authority did not refer the matter to the Office of Internal Affairs until June 24, 2013, nearly seven months after discovery.

Incident Date	OIG Case Number	Case Type
2012-11-22	12-2686-RO	Other Significant Incident

Incident Summary

On November 22, 2012, a nurse observed an inmate assigned to a mental health crisis bed cutting his neck with a razor blade. The nurse summoned an officer, who responded and ordered the inmate to relinquish the razor blade. The inmate complied and dropped three razor blades through the food port to the floor. The inmate was removed from the cell and treated at the institution for his self-inflicted lacerations to the right side of his neck, left calf, and both forearms. The inmate reported to staff that he had secreted the three razor blades in his rectum prior to being assigned to a mental health crisis bed.

Disposition

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

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2012-11-27	13-0238-RO	Other Significant Incident

Incident Summary

On November 27, 2012, two inmates were placed in the same cell in an administrative segregation unit. Within minutes, the inmates began fighting and officers utilized pepper spray to stop the fight. The inmates sustained minor injuries consistent with fighting and were treated at the institution.

Disposition

The institution's executive review committee determined the force used during the incident was in compliance with departmental policy, and the OIG concurred. Based on the OIG's recommendation, the hiring authority ordered training to supervisors and managers regarding departmental policy on double-celling inmates in administrative segregation. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.

Overall Assessment

Rating: Sufficient

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2012-12-20	12-2911-RO	In-Custody Inmate Death
Incident Summary On December 20, 2012, officers responded to a "man down" call from a cell. The officers discovered an unresponsive inmate lying on his bunk and activated the alarm. The cellmate was secured and removed from the cell and officers initiated life-saving measures on the unresponsive inmate. Responding officers placed the inmate on a gurney and continued life-saving efforts as they transported the inmate to the triage treatment area. Medical staff took over life-saving efforts and the inmate was transported to an outside hospital where he was declared dead. There were no visible injuries to either inmate.		
Disposition The coroner determined the manner of death was natural, caused by cardiovascular disease. Potential staff misconduct was identified based on the failure of medical staff to ensure the inmate received his physician-ordered medications; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.		
Overall Assessment		Rating: Insufficient
The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.		
Assessment Questions <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The OIG was not notified of the incident until two hours after the inmate was pronounced dead.</i></p>		

Incident Date	OIG Case Number	Case Type
2013-01-10	13-0142-RO	PREA
Incident Summary On January 10, 2013, an inmate alleged that an officer sexually assaulted him by inserting his finger into the inmate's rectum through the cell's food port. The inmate was under constant direct observation for suicide watch at the time of the alleged incident. The inmate was interviewed but was not taken to an outside hospital for examination.		
Disposition Potential staff misconduct was identified based on the inmate's allegations that an officer sexually assaulted him; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation as required by departmental policy. The Office of Internal Affairs declined to open an investigation and the OIG concurred based on the lack of evidence to support the inmate's allegations. The hiring authority also ordered training for staff to ensure future compliance with departmental policy regarding protocols to be followed after an inmate's allegation of sexual assault. The OIG also concurred with this decision.		
Overall Assessment		Rating: Insufficient
The department's response was not adequate. The institution failed to timely notify the OIG and failed to follow required departmental policy following an allegation of sexual misconduct against staff members. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.		

SOUTH REGION

Assessment Questions

- Was the OIG promptly informed of the critical incident?

The inmate reported the allegation on January 10, 2013, but the OIG was not notified until the following day, January 11, 2013.

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

The department failed to take the inmate to an outside hospital for an examination and failed to immediately notify the investigative services unit and Office of Internal Affairs as required by departmental policy.

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

The incident occurred on January 10, 2013; however, the hiring authority did not refer the matter to the Office of Internal Affairs until February 4, 2013. Departmental policy requires an allegation of sexual misconduct against staff to be immediately referred to the Office of Internal Affairs for investigation.

Incident Date	OIG Case Number	Case Type
2013-01-22	13-0178-RO	In-Custody Inmate Death

Incident Summary

On January 22, 2013, an officer conducting security checks observed an inmate's window covered, obstructing the view of the cell. The officer called out the inmate's name but the inmate did not respond. The officer opened the door and found the inmate lying on the floor of the cell with a syringe in her arm and not breathing. Officers activated an alarm and initiated life-saving measures. The inmate was taken to an outside hospital where she was treated for a drug overdose. The inmate returned to the institution the same day and was admitted to the outpatient housing unit for recovery. On January 24, 2013, the inmate was found unresponsive in her cell by an officer. The officer summoned medical personnel who initiated life-saving measures. The inmate was transported to an outside hospital where she was pronounced dead.

Disposition

An autopsy revealed the manner of death was natural, caused by years of chronic drug abuse. A toxicology test revealed positive results for amphetamines and opiates. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The OIG determined that the department adequately responded to the incident in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-03-16	13-0473-RO	In-Custody Inmate Death

Incident Summary

On March 16, 2013, an inmate called officers to his cell and informed the officers that his cellmate had thrown all of his property on the floor of the cell. Officers questioned the inmate then escorted the inmate to the triage treatment area for a mental health assessment based on his behavior. The inmate was compliant during the escort and was placed in a holding cell upon arrival at the triage treatment area. Medical staff arrived approximately five minutes later and discovered the inmate unresponsive on the floor of the holding cell. Medical staff initiated life-saving measures and the inmate was transported to a local hospital where he was treated, but ultimately died on March 18, 2013.

Disposition

The coroner determined the manner of death was natural, caused by anoxic encephalopathy due to prolonged cardiopulmonary arrest. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The department failed to timely notify the OIG about the incident; however, the department's response was satisfactory in all other critical aspects. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2013-03-27	13-0500-RO	In-Custody Inmate Death

Incident Summary

On March 27, 2013, officers discovered an inmate lying on the floor, unresponsive, in his assigned cell. Custody and medical staff administered life-saving measures, but the inmate was later pronounced dead. There were no signs of trauma; however, the inmate's cellmate was placed in administrative segregation pending further investigation. During a cell search custody staff found an inmate-manufactured syringe and methamphetamine.

Disposition

The autopsy report determined the cause of death was heroin toxicity due to chronic drug abuse. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The OIG determined that the department adequately responded to the incident in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-04-17	13-0562-RO	In-Custody Inmate Death

Incident Summary

On April 17, 2013, custody staff found an inmate in the outpatient housing unit sitting on the floor of his cell, attempting to get back on his bed. Medical staff were summoned who responded and attended to the inmate who was exhibiting signs of respiratory distress. Medical staff initiated life-saving measures and the inmate was transported by ambulance to an outside hospital where he died approximately eight hours later.

Disposition

According to the autopsy report, the manner of death was natural, caused by cardiovascular disease. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.

Overall Assessment

Rating: Sufficient

Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-05-12	13-0637-RO	In-Custody Inmate Death

Incident Summary

On May 12, 2013, officers responded to an inmate's call of "man down" and discovered his cellmate on the ground. Medical staff began life-saving measures without success. There was no observable trauma, sign of a struggle, or drug paraphernalia.

Disposition

The autopsy report stated the inmate died as a result of natural causes related to a congenitally enlarged heart. No staff misconduct was identified; therefore the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The OIG determined that the department adequately responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2013-05-24	13-0696-RO	In-Custody Inmate Death

Incident Summary

On May 24, 2013, an inmate called "man down" from his cell. Custody staff responded to the cell and found the inmate's unresponsive cellmate in a semi-seated position on the floor. Custody staff summoned medical assistance, opened the cell door, and initiated life-saving measures. Medical staff arrived and took over life-saving measures. The inmate was transported to the triage treatment area where he was pronounced dead. There were no signs of injury or trauma, but a syringe was found on the floor near the body.

Disposition

An autopsy determined the cause of death was an accident caused by heroin intoxication with hypertension as a contributing factor. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for Investigation.

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-05-27	13-0760-RO	PREA

Incident Summary

On May 27, 2013, two officers allegedly pushed an inmate into the shower and physically assaulted him. One of the officers also allegedly sexually assaulted the inmate while the other officer held him down. Medical staff allegedly failed to respond when notified of the incident.

Disposition

No staff misconduct was identified related to the inmate's allegation of sexual assault by custody staff, but potential staff misconduct was identified based on the failure of medical staff to respond when notified of the incident. The hiring authority for custody staff referred the case to the Office of Internal Affairs for investigation, which was declined. The OIG concurred with this decision based on the insufficiency of the evidence. The hiring authority for the medical staff did not refer the case against medical staff to the Office of Internal Affairs, but did provide training to all medical staff on appropriate handling and reporting of cases involving sexual assault. The OIG did not concur with the decision not to refer the case for investigation, but did concur in the decision to provide training.

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the department failed to notify the OIG in a timely and sufficient manner, preventing the OIG from real-time monitoring of the case, failed to adequately document the case, and failed to appropriately determine whether potential staff misconduct should be referred to the Office of Internal Affairs.

Assessment Questions

- Was the OIG promptly informed of the critical incident?

The OIG was not notified until the day after the date of discovery.

- Was the critical incident adequately documented?

The department failed to document the use of the Initial Contact Checklist, the Custody Supervisor Checklist, the Victim of Sexual Crime form, the Request for Authorization of Temporary Removal for Medical Treatment form, Interdisciplinary Progress Notes, and a Suicide Assessment form.

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

The hiring authority for medical staff inappropriately determined that the incident was a training issue and did not refer the medical staff to the Office of Internal Affairs.

SOUTH REGION

Incident Date 2013-05-28	OIG Case Number 13-0830-RO	Case Type PREA
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Incident Summary

On May 28, 2013, two officers allegedly used unreasonable physical force to put an inmate on the ground where one of the officers then allegedly forced several items into the inmate's rectum while the other officer held him down. The inmate allegedly sustained blunt force trauma to his anal area but received no medical treatment. The inmate allegedly reported the incident to a psychiatric technician that day. On May 29, 2013, the inmate allegedly reported the incident to a licensed vocational nurse. It was alleged that neither the psychiatric technician nor the licensed vocational nurse properly responded to the notification.

Disposition

Potential staff misconduct was identified regarding the inmate's allegations that two officers used unnecessary force on him and one of the officers sexually assaulted him. Further potential staff misconduct was identified regarding the inmate's allegations that two medical staff failed to act when the inmate reported the incident. The Office of Internal Affairs opened an investigation, which the OIG accepted for monitoring.

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the department failed to notify the OIG, preventing the OIG from real-time monitoring of the case. The OIG agreed with the decision to submit the matter to the Office of Internal Affairs.

Assessment Questions

- Did the HA timely respond to the critical incident?
The incident occurred on May 28, 2013, but the hiring authority did not respond until May 31, 2013, three days after the incident.
- Was the OIG promptly informed of the critical incident?
The department failed to notify the OIG of the incident.
- Was the HA's response to the critical incident appropriate?
The hiring authority failed to initiate timely departmental protocols and failed to timely refer the matter to the Office of Internal Affairs.
- Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?
The incident occurred on May 28, 2013, but the investigative services unit did not respond until May 31, 2013, three days after the incident. On June 3, 2013, the investigative services unit inappropriately recommended no further investigation.
- Was the critical incident adequately documented?
The department did not initiate timely departmental protocols and failed to document the use of the Initial Contact Checklist, the Custody Supervisor Checklist, the Victim of Sexual Crime form, the Request for Authorization of Temporary Removal for Medical Treatment form, Interdisciplinary Progress Notes, and a Suicide Risk Assessment form.

Incident Date 2013-05-31	OIG Case Number 13-0717-RO	Case Type In-Custody Inmate Death
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Incident Summary

On May 31, 2013, an officer found an unconscious inmate lying on the dayroom floor. The officer observed an inmate running from the scene. The officer activated his alarm and medical staff responded and transported the injured inmate to the triage treatment area where he received life-saving measures without success.

Disposition

According to the autopsy report, the inmate died from internal bleeding due to multiple rib fractures sustained in an attack by other inmates. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

SOUTH REGION

Overall Assessment	Rating: Sufficient
Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.	

Incident Date	OIG Case Number	Case Type
2013-06-01	13-0730-RO	Contraband Watch

Incident Summary

On June 1, 2013, officers observed an inmate swallow items passed to him by his visitor. Officers searched the visitor and found a bundle that tested positive for heroin. The inmate was placed on contraband surveillance watch. On June 3, 2013, the inmate was placed in hand isolation devices after it was discovered that the inmate had a bowel movement in his jumpsuit and was able to retrieve bindles from his pant leg. On June 5, 2013, the inmate was found with feces on his leg and the tape removed from his pant leg. The inmate appeared to be under the influence and complained of not feeling well. He was transported to the triage treatment area for evaluation and was ultimately taken to an outside hospital for a higher level of care due to a possible overdose. The inmate recovered and returned to the institution the following day.

Disposition

Potential staff misconduct was identified based on officers' failure to supervise and search the inmate while on contraband surveillance watch; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the matter to the hiring authority to take action without an investigation. The OIG accepted the case for monitoring.

Overall Assessment	Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-08-26	13-1839-RO	Other Significant Incident

Incident Summary

On August 26, 2013, officers responded to a dormitory after hearing a "man down" call. The officers found an inmate unconscious and initiated life-saving measures. The officers requested the assistance of medical staff who responded to the scene and stabilized the inmate. The inmate was transported to a local hospital where it was discovered the inmate had fresh needle marks on his arm and opiates in his blood stream. The inmate's condition was unstable and he was placed on a ventilator. The inmate survived and returned to the institution on September 5, 2013.

Disposition

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

Overall Assessment	Rating: Sufficient
The department's overall response to the incident was adequate in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-09-01	13-2319-RO	PREA

Incident Summary

On September 1, 2013, an inmate refused a sergeant's order to return to her housing unit from the yard. The sergeant grabbed the inmate's arm to escort her to the housing unit but the inmate pulled away and the sergeant and inmate fell to the ground. The inmate sustained minor injuries and alleged the sergeant used excessive force. Additionally, the inmate alleged the sergeant made a sexually explicit comment to her during the incident.

SOUTH REGION

Disposition

The institution's executive review committee identified potential staff misconduct based on the sergeant's alleged use of unnecessary force and the allegation that the sergeant made a sexually explicit comment to the inmate during the incident; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the matter to the hiring authority to take action without an investigation for the use of unnecessary force only. The OIG accepted the case for monitoring.

Overall Assessment

Rating: Insufficient

The department's overall response to the incident was inadequate because they failed to timely notify the OIG of the incident and failed to comply with departmental policy regarding allegations of sexual misconduct against staff. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.

Assessment Questions

- Did the HA timely respond to the critical incident?

The inmate reported the alleged misconduct on September 1, 2013, but the institution did not address the inmate's allegations until the OIG raised the issue at the institution's executive review committee on October 15, 2013. Departmental policy requires immediate notification to the Office of Internal Affairs when an inmate makes an allegation against staff members involving sexual misconduct.

- Was the OIG promptly informed of the critical incident?

The incident occurred on September 1, 2013, but the OIG did not become aware of the incident until October 15, 2013, during the institution's executive review committee meeting.

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

The institution failed to immediately notify the Office of Internal Affairs of the inmate's allegation of sexual misconduct as required by departmental policy.

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

Departmental policy requires the institution's executive review committee to suspend its review of the incident when an investigation is warranted by the Office of Internal Affairs. The inmate's allegations of misuse of force and sexual misconduct required a referral to the Office of Internal Affairs, yet the institution's executive review committee continued its review and closed the incident.

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

The inmate made the allegation of sexual misconduct on September 1, 2013, but the incident was not referred to the Office of Internal Affairs until November 13, 2013.

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

The OIG recommended to the hiring authority that the inmate's allegations immediately be referred to the Office of Internal Affairs and that the institution's executive review committee suspend its review of the incident as required by departmental policy. Despite the recommendations, the hiring authority continued to request clarifications from involved staff and the institution's executive review committee reviewed and closed the incident. The hiring authority subsequently referred the matter to the Office of Internal Affairs for investigation.

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

The OIG recommended that the case be opened for a full investigation to address inconsistencies in the reports regarding both the use of force and the sexual misconduct. OIA Central Intake refused to open an investigation and returned the matter to the hiring authority to take action without an investigation and regarding the use of force allegation only.

SOUTH REGION

Incident Date 2013-09-18	OIG Case Number 13-2047-RO	Case Type Suicide
<p>Incident Summary</p> <p>On September 18, 2013, an officer observed a blanket obstructing the view of the bunk area of a single-celled inmate during a security check in a housing unit. The officer removed the blanket and discovered the inmate hanging from the upper bunk with a plastic bag around his head. The officer activated his personal alarm and a cut-down tool was used to remove the noose from the inmate's neck. Officers removed the inmate from the cell and initiated life-saving measures. Medical staff arrived and took over life-saving efforts, but were unsuccessful. The inmate was transported to the triage and treatment area where a physician pronounced him dead.</p>		
<p>Disposition</p> <p>The coroner determined the cause of death was asphyxia due to suicide. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>		
<p>Overall Assessment</p> <p>The OIG determined that the department adequately responded to the incident in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The OIG concurred with the decision not to submit the matter to the Office of Internal Affairs.</p>		<p>Rating: Sufficient</p>

APPENDIX D2

HUNGER STRIKE CASE SUMMARIES

18

Incident Date	OIG Case Number	Case Type
2013-07-05	13-1790-RO	Hunger Strike
Incident Summary On July 5, 2013, an inmate stopped eating and participated in a mass hunger strike. On July 28, 2013, the inmate was transferred to another institution with a hospital on grounds due to excessive weight loss. On August 9, 2013, he was admitted to an outside hospital for evaluation and returned to the institution's hospital the next day. On August 21, 2013, the inmate ended his hunger strike and began eating. The inmate was discharged from the institution's hospital on September 26, 2013.		
Disposition No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the decision not to submit the matter to the Office of Internal Affairs.		

Incident Date	OIG Case Number	Case Type
2013-07-07	13-1509-RO	Hunger Strike
Incident Summary On July 7, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. The inmate continued to refuse meals and on July 14, 2013, medical staff determined the inmate's condition was serious. Due to chest pains the inmate was transported to an outside hospital for a higher level of care. On July 16, 2013, the inmate returned to the institution in stable condition but continued to refuse his meals. On July 23, 2013, the inmate accepted a meal, ending his hunger strike. On July 25, 2013, the inmate again refused his meals, and on August 7, 2013, the inmate was transported to an outside hospital for a higher level of care due to abdominal pain, where he accepted a meal and ended his hunger strike. The inmate returned to the institution the same day in stable condition.		
Disposition No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The department's overall response to the incident was adequate in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.		

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1495-RO	Hunger Strike
Incident Summary On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. On July 31, 2013, the inmate was transported to an outside hospital for evaluation after he refused to be examined in the institution's triage treatment area. The inmate accepted meals at the hospital and returned to the institution on August 1, 2013, in stable condition. On August 2, 2013, the inmate reinitiated his hunger strike. On August 8, 2013, the inmate experienced weakness and fainting and was transported to an outside hospital for a higher level of care. The inmate accepted meals and returned to the institution the same day in stable condition.		
Disposition No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department informed the OIG about the incident in a timely and sufficient manner. The hiring authority chose not to refer the matter to the Office of Internal Affairs and the OIG concurred.		

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1497-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. On July 29, 2013, the inmate was transported to an outside hospital to be evaluated for signs of dehydration after fainting from the probable effects of not eating. The inmate returned to the institution on July 30, 2013, in stable condition and started to accept meals.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1502-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. On July 26, 2013, the inmate was transported to an outside hospital for a higher level of care due to dehydration and abdominal pain. The inmate returned to the institution on July 27, 2013, in stable condition and was returned to his housing unit. On July 31, 2013, the inmate accepted his meals thereby ending his hunger strike.

Disposition

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

Overall Assessment

Rating: Sufficient

The department's response was satisfactory in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1505-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. The inmate continued to refuse meals and on July 25, 2013, medical staff determined the inmate's condition was serious. Due to abdominal pain and dehydration, the inmate was transferred to an outside hospital for a higher level of care, where he accepted meals. The inmate returned to the institution the same day in stable condition. Subsequently, on July 29, 2013, the inmate began another hunger strike, which ended on July 30, 2013, with no medical complications.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1506-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. The inmate continued to refuse meals and on July 20, 2013, the inmate sustained a head injury when he fell from an upper bunk. Medical staff determined the inmate's refusal to eat contributed to his fall and the inmate was transported to an outside hospital for a higher level of care, where he accepted meals. The inmate returned to the institution the same day in stable condition.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1507-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. The inmate continued to refuse meals and on July 20, 2013, medical staff determined the inmate's condition was serious. Due to chest and abdominal pains, the inmate was transported to an outside hospital for a higher level of care. The inmate returned to the institution the same day in stable condition but continued to refuse meals. On August 5, 2013, the inmate accepted meals, ending his participation in the hunger strike.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1508-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. The inmate continued to refuse meals and on July 18, 2013, medical staff determined the inmate's condition was serious. Due to excessive weight loss, the inmate was transported to an outside hospital for a higher level of care where he accepted meals and ended his hunger strike. The inmate was discharged the following day and transported to a nearby institution for a level of care that was not available at his initial institution. On July 23, 2013, the inmate returned to his initial institution in stable condition.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1710-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. The inmate continued to refuse meals and on August 5, 2013, medical staff determined the inmate's condition was serious. Due to excessive weight loss and dehydration the inmate was transported to an outside hospital for a higher level of care, where he accepted meals and ended his hunger strike. The inmate was discharged the following day and transported to a nearby institution for a level of care that was not available at his initial institution. On August 9, 2013, the inmate returned to his initial institution in stable condition.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1713-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. The inmate continued to refuse meals and on August 1, 2013, medical staff determined the inmate's condition was serious. Due to dehydration and weakness, the inmate was transported to an outside hospital for a higher level of care where he ultimately accepted meals. The inmate returned to the institution the same day in stable condition and ended his hunger strike.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1721-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate began a hunger strike. On August 19, 2013, he was transported to an outside hospital due to his need for a higher level of medical care. The inmate was subsequently treated and returned to the institution. On September 4, 2013, the inmate ended his hunger strike and started to take meals as monitored by the medical staff.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1791-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate stopped eating and participated in a mass hunger strike. On August 22, 2013, the inmate was admitted to the institution's hospital because he refused his food tray for 42 days and refused all medical evaluations. Upon admission into the hospital, the inmate ended his hunger strike and began eating. The inmate was discharged from the hospital on August 29, 2013.

Disposition

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

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-07-08	13-1792-RO	Hunger Strike

Incident Summary

On July 8, 2013, an inmate stopped eating and participated in a mass hunger strike. On August 22, 2013, the inmate was admitted to the institution's hospital because he refused his food tray for 42 days and refused all medical evaluations. Upon admission to the hospital, the inmate ended his hunger strike and began eating. The inmate was discharged from the hospital on August 29, 2013.

Disposition

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

Overall Assessment**Rating: Sufficient**

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

Incident Date**2013-07-11****OIG Case Number****13-1498-RO****Case Type****Hunger Strike****Incident Summary**

On July 11, 2013, an inmate refused his meals as a participant in a statewide mass hunger strike. On July 27, 2013, the inmate was transported to an outside hospital for a higher level of care due to lightheadedness, weakness, and excessive weight loss. On July 28, 2013, the inmate returned to the institution in stable condition and began to accept meals and ended his hunger strike.

Disposition

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

Overall Assessment**Rating: Sufficient**

Overall, the department's response to the incident was sufficient. The department adequately notified and consulted with the OIG on the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date**2013-07-19****OIG Case Number****13-1633-RO****Case Type****Hunger Strike****Incident Summary**

On July 19, 2013, an inmate initiated a hunger strike due to issues related to his medical care. The inmate subsequently stated he was also participating in the mass hunger strike. The inmate was transported to an outside hospital for a higher level of care on October 8, 2013, and returned to the institution on October 10, 2013. The inmate was again transported to an outside hospital on October 21, 2013, for reported chest pains. He returned to the institution later that same day. Medical staff continued to monitor the inmate and he was subsequently transferred to a hospital facility on November 6, 2013, where he ended his hunger strike.

Disposition

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

Overall Assessment**Rating: Sufficient**

Overall, the department's response to the incident was sufficient. The department's notification to and consultation with the OIG regarding the incident was sufficient.

Incident Date**2013-08-25****OIG Case Number****13-2118-RO****Case Type****Hunger Strike****Incident Summary**

On August 25, 2013, an inmate declared he was on a hunger strike. The inmate's last documented meal was the evening meal on that same date. The inmate was transferred to another institution on September 16, 2013, for a higher level of care. On October 10, 2013, the Superior Court approved a temporary conservatorship, granting the institution's chief medical officer the authority to make medical decisions on the inmate's behalf. The same day, the inmate was transported to an outside hospital and a feeding tube was inserted into the inmate. The inmate returned to the institution on October 16, 2013, and continued to refuse to eat on his own, but did not obstruct the institution's force feeding. On October 24, 2013, the court extended by one-year the conservatorship over the inmate.

Disposition

The department's response was satisfactory in all critical aspects. Once the force feeding process began, the department removed the inmate from hunger strike status although the inmate refused to voluntarily eat. The OIG did not concur with the decision to remove the inmate from hunger strike status.

Overall Assessment**Rating: Sufficient**

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

Incident Date 2013-10-21	OIG Case Number 13-2341-RO	Case Type Hunger Strike
<p>Incident Summary</p> <p>On October 21, 2013, an inmate began a hunger strike by refusing to eat or drink. The inmate was subsequently transferred to the correctional treatment center for monitoring by medical staff and then returned to his assigned housing unit where he continued his hunger strike. On November 12, 2013, the inmate was found in possession of food. The inmate ended his hunger strike on November 16, 2013.</p>		
<p>Disposition</p> <p>No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>		
<p>Overall Assessment</p> <p>Overall, the department's response to the incident was sufficient. The department informed the OIG about the incident in a timely and sufficient manner.</p>		<p>Rating: Sufficient</p>

APPENDIX E

DEADLY FORCE INCIDENT SUMMARIES

CENTRAL REGION

Deadly Force Incidents: **28**
Monitored DFIT: **11**

Incident Date: 2012-06-26	Deadly Force Incident
Incident Summary OIG Case Number: 12-1505-RO <p>On June 26, 2012, a riot erupted on an exercise yard involving approximately 91 inmates. Officers used verbal orders, pepper spray, less-lethal impact rounds, and deadly force to stop the riot. The inmates did not stop fighting until a control booth officer fired one warning shot and the yard observation officer fired two warning shots from a Mini-14 rifle. Forty-five inmates received minor injuries during the riot and two inmates were transported to outside hospitals following the incident. One of the inmates required hospitalization because he began to have seizures following the riot and the other had lacerations to his face from an inmate-manufactured weapon. Both inmates were returned to the institution after they received medical treatment. There were no inmate injuries that resulted from the use of force. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG and the OIG responded on scene.</p>	
Disposition <p>The institution's executive review committee determined that although the use of force was in compliance with departmental policy, the officer failed to properly carry the Mini-14 rifle during inmate movement as required by policy. Training was provided to the officer. No staff misconduct was identified. The OIG concurred with the hiring authority's decisions.</p>	
Incident Assessment <p>The department's response was satisfactory in most critical aspects except that officers were relieved from duty prior to completing their reports and the department did not obtain clarification reports to address conflicting information. The department adequately notified and consulted with the OIG regarding the incident.</p>	Rating: Sufficient

Incident Date: 2012-07-04	Deadly Force Incident
Incident Summary OIG Case Number: 12-1647-RO <p>On July 4, 2012, as inmates were released from their cells for the evening meal, three inmates began attacking a fourth inmate, hitting him in the head and upper torso. The three inmates ignored officers' orders to stop their attack and began stomping the fourth inmate's head after he fell to the floor. The control booth officer fired two less-lethal direct impact rounds which stopped the incident. The officer was unable to determine where the two rounds struck. However, one of the inmate attackers sustained an injury to his head consistent with being struck with a direct impact round. As a result, that inmate and the fourth inmate, who was attacked, were transported to an outside hospital for a higher level of care. The inmate that was attacked sustained facial fractures, remained unconscious, and was placed on a ventilator. He returned to the institution after 36 days in the hospital. The inmate struck by the direct impact round was treated and returned to the institution five days later. The hiring authority failed to timely notify the Office of Internal Affairs.</p>	
Disposition <p>The institution's executive review committee determined the use of force was in compliance with departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.</p>	
Incident Assessment <p>The department's response to the incident was insufficient because the institution failed to timely notify the OIG thereby preventing the OIG from real-time monitoring of the case. The institution also failed to timely notify the Office of Internal Affairs.</p>	Rating: Insufficient
Assessment Questions <ul style="list-style-type: none"> • Did the institution timely notify the Office of Internal Affairs of the incident? <p><i>The Office of Internal Affairs was not notified of the incident until two hours and 50 minutes after the incident occurred, effectively precluding an on-scene response.</i></p> • Was the OIG promptly informed of the critical incident? <p><i>The OIG was not notified until two hours and 31 minutes after the incident occurred, effectively precluding the OIG from responding on scene.</i></p> 	

CENTRAL REGION

Incident Date: 2012-08-01	Deadly Force Incident
<p>Incident Summary OIG Case Number: 12-1812-RO</p> <p>On August 1, 2012, an inmate allegedly attacked and tried to strangle a nurse as she was providing him with medical treatment. Eight officers responded to rescue the nurse. The inmate refused orders to stop and all the officers used physical force on the inmate to try to free the nurse. During the incident, three of the officers also used baton strikes, but the inmate continued to resist. Ultimately, the inmate released the nurse then grabbed nearby equipment cords. Despite orders to stop, the inmate still resisted. A combination of physical force and baton strikes was utilized to subdue and restrain the inmate. It was later discovered that one of the officers intentionally struck the inmate's head with a baton to try to gain compliance, with negative results. The inmate sustained scratches and abrasions, bruising and swelling to his fingers, and bleeding to his mouth and elbow. Although none of the inmate's injuries were life-threatening, he was taken to an outside hospital for further care and returned to the institution the same day. Although the Office of Internal Affairs was notified of the incident, they did not respond. The department adequately notified the OIG, and the OIG responded on scene.</p>	
<p>Disposition</p> <p>The institution's executive review committee determined that the use of force complied with departmental policy. The baton strikes were deemed reasonable, as they were needed to try to subdue the inmate who was attacking the nurse and gain compliance. The OIG concurred. The incident was also referred to the department's executive review committee. That committee also determined that the use of force complied with departmental policy. However, it was noted that a video-taped interview is required to be completed within 48 hours and a lieutenant did not complete it until 12 days after the incident. As a result, the lieutenant received training. The OIG concurred.</p>	
<p>Incident Assessment</p> <p>The department's response to the incident was inadequate. The institution notified the Office of Internal Affairs. However, even though an officer intentionally aimed the baton at an inmate's head and struck him in the head, the Office of Internal Affairs determined that the incident did not warrant a deadly force investigation team response. The department adequately notified and consulted with the OIG.</p>	<p>Rating: Insufficient</p>
<p>Assessment Questions</p> <ul style="list-style-type: none"> • Did the OIA adequately respond to the incident? <p><i>Because the officer intentionally struck the inmate in the head with the baton, the OIG believes a deadly force investigation was warranted by the Office of Internal Affairs.</i></p>	

Incident Date: 2012-10-25	Deadly Force Incident
<p>Incident Summary OIG Case Number: 12-2472-RO</p> <p>On October 25, 2012, an observation officer saw an inmate with an inmate-manufactured weapon attacking another inmate on an exercise yard. Approximately ten other inmates joined the altercation. The officer fired multiple less-lethal rounds and a single warning shot from a Mini-14 rifle to stop the attack. The warning shot caused all inmates to stop fighting and lay on the ground. No inmates were injured. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG and the OIG responded on scene.</p>	
<p>Disposition</p> <p>The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.</p>	
<p>Incident Assessment</p> <p>The department's response was satisfactory in all critical respects. The department adequately notified and consulted with the OIG regarding the incident.</p>	<p>Rating: Sufficient</p>

CENTRAL REGION

Incident Date: 2012-12-02	Deadly Force Incident
Incident Summary OIG Case Number: 12-2857-RO On December 2, 2012, two inmates began attacking a third inmate on an exercise yard. Officers ordered all inmates to get down. However, the two inmates did not stop their attack on the third inmate who was now on the ground in a fetal position. As officers responded to the area of the attack, the yard observation officer fired one warning shot from the Mini-14 rifle. It is unclear whether the inmates stopped their attack prior to or after the Mini-14 rifle was discharged. The three inmates involved in the incident received scratches and abrasions and were rehoused in different buildings. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG and the OIG responded on scene.	
Disposition The institution and department executive review committees determined the use of force was in compliance with departmental policy; however, the OIG did not concur. The OIG determined there was insufficient information to determine whether the use of force complied with departmental policy. Without clarifying reports it is unknown whether there was potential staff misconduct that should have been referred to the Office of Internal Affairs.	
Incident Assessment	Rating: Insufficient
The department's response was inadequate because the department failed to sufficiently clarify the circumstances leading to the warning shot. The hiring authority did not accept the OIG's recommendation to obtain clarification reports.	
Assessment Questions <ul style="list-style-type: none">● Was the HA's response to the critical incident appropriate? <i>Although the OIG conveyed the importance to the hiring authority of obtaining sufficient clarification reports to determine if the use of force was reasonable, the hiring authority disregarded the OIG's recommendation.</i>● Did the use-of-force review committee adequately review and respond to the incident? <i>The institution's executive review committee and the department's executive review committee failed to identify the need for clarification reports. The OIG did not concur with their findings because without further clarification, it was unclear whether the use of deadly force complied with departmental policy. The OIG found the responding sergeant's report conflicted with the observation officer's report.</i>● Was the critical incident adequately documented? <i>Conflicting information in different reports was never clarified. The responding sergeant documented that he observed all three inmates standing, facing each other, and refusing orders to get down prior to hearing the discharge of the Mini-14 rifle. This was different from the report of the shooting officer, who reported seeing the inmate unable to defend himself while lying on his back. Other responding officers were not clear in their reports about the inmates' actions prior to and during the discharge of the Mini-14 rifle.</i>● Did the HA make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA? <i>The institution and department review processes took over eight months to complete.</i>● Did the HA appropriately determine whether to refer any conduct to the OIA related to the critical incident? <i>The hiring authority disregarded the written eyewitness account of the sergeant who observed the behavior of the inmates during the warning shot. The sergeant's account provided supporting evidence that inappropriate use of a Mini-14 rifle may have occurred. Without an investigation or further clarification questions to other officers that witnessed the incident, the potential misconduct could not be evaluated.</i>● Did the department adequately consult with the OIG regarding the critical incident? <i>Although the hiring authority consulted with the OIG, the hiring authority disregarded the sergeant's eyewitness account of the incident and the OIG's recommendation to obtain clarifications regarding the conflicting accounts of the incident.</i>	

CENTRAL REGION

Incident Date: 2013-04-25	Deadly Force Incident
Incident Summary OIG Case Number: 13-0596-RO On April 25, 2013, officers observed two inmates attacking another inmate with inmate-manufactured weapons on an exercise yard. An observation officer discharged four less-lethal rounds at the attacking inmates. Another observation tower officer fired one additional less-lethal round. Officers utilized a pepper spray grenade to assist in quelling the attack. One of the attacking inmates was inadvertently struck in the head with a less-lethal round, possibly losing consciousness temporarily. He was sent to an outside hospital for evaluation. The other attacker alleged wrist pain as a result of being struck by a less-lethal round. The inmate who was being attacked sustained multiple stab and slash wounds and was transported to an outside hospital for treatment. The inmates were later returned to the institution. Although the Office of Internal Affairs was notified of the incident, they did not respond. The department adequately notified the OIG and the OIG responded on scene.	
Disposition The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.	
Incident Assessment The department's response was satisfactory, except that the Office of Internal Affairs failed to respond on scene even though an inmate was struck in the head with a less-lethal round. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	Rating: Insufficient
Assessment Questions <ul style="list-style-type: none">• Did the OIA adequately respond to the incident? <p style="text-align: center;"><i>The Office of Internal Affairs was notified; however, chose not to respond on scene to the incident.</i></p>	

Incident Date: 2013-06-26	Deadly Force Incident
Incident Summary OIG Case Number: 13-1692-RO On June 26, 2013, three inmates began fighting on the exercise yard. The observation officer gave orders to the inmates to stop fighting, which the inmates ignored. The observation officer fired a less-lethal round, aiming at one of the inmate's left thigh, but the inmates continued to fight. After the inmates continued to ignore the observation officer's repeated orders to stop fighting, the observation officer fired three more less-lethal rounds, aiming at another inmate's right thigh. After the fourth less-lethal round was fired, the inmates stopped fighting. One of the inmates claimed that he was struck in the head by one of the less-lethal rounds. That inmate was taken to the triage treatment area for evaluation and it was determined that he sustained a laceration to his head. The possible less-lethal strike to the head appeared to be unintentional. The OIG received timely notification and responded on scene. The Office of Internal Affairs was also notified but did not respond on scene.	
Disposition No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The institution's executive review committee determined that staff action prior to, during, and after the use of force was in compliance with departmental policies. The OIG concurred.	
Incident Assessment The department's response was satisfactory in all critical aspects. The Department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	Rating: Sufficient

CENTRAL REGION

Incident Date: 2013-08-14	Deadly Force Incident
Incident Summary OIG Case Number: 13-1694-RO On August 14, 2013, four inmates attacked two other inmates on an exercise yard. Two officers used three less-lethal rounds and three pepper spray grenades to stop the attacks. One of the less-lethal rounds struck an inmate's shoulder then ricocheted, striking the inmate in the face, resulting in an injury that required sutures. Although the Office of Internal Affairs was notified, it is the department's practice not to respond on scene unless less-lethal force is intentionally used in a lethal manner or inadvertently causes potential lethal injury. The department adequately notified the OIG and the OIG responded on scene.	
Disposition The institution's executive review committee determined that the use of force was within policy and the impact to the inmate's head was inadvertent. The OIG concurred with the committee's conclusions. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.	
Incident Assessment	Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident.	

Incident Date: 2013-09-02	Deadly Force Incident
Incident Summary OIG Case Number: 13-1895-RO On September 2, 2013, officers observed two inmates attacking a third inmate in the dayroom. The alarm was sounded and the inmates were ordered to stop and get down, but they ignored the officers and continued their assault. The control booth officer fired one less-lethal round at the right leg of one of the assailants, but the attack continued. The officer fired a second less-lethal round at the left leg of one of the assailants, causing the inmates to stop their attack and get down. The inmate who was under attack told officers that he was hit in the head by the less-lethal round. The injured inmate received four sutures above his right eye. Although the Office of Internal Affairs was notified, it is the department's practice not to respond on scene unless less-lethal force is intentionally used in a lethal manner or inadvertently causes potential lethal injury. The OIG received timely notification and responded on scene.	
Disposition The institution's executive review committee determined that the use of force was within policy and the impact to the inmate's head was inadvertent. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG agreed with the determinations.	
Incident Assessment	Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department's notification and consultation to the OIG regarding the incident was sufficient.	

Incident Date: 2013-09-03	Deadly Force Incident
Incident Summary OIG Case Number: 13-1899-RO On September 3, 2013, an officer observed two inmates standing over a third inmate punching and kicking him. The control booth officer gave orders for the inmates to stop and get down, but they ignored the orders. The officer discharged one less-lethal 40 mm round at the right thigh of one of the assailants, but the round missed and struck a cell door. After the shot, both inmates assumed a prone position. One of the assailants reported that he was struck in the side of the head by the round that ricocheted off the cell door. He was medically evaluated and returned to his assigned cell.	
Disposition The institution's executive review committee determined that the use of force was within policy and the impact to the inmate's head was accidental. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG agreed with the determinations.	
Incident Assessment	Rating: Sufficient
The OIG determined that the department's overall response to the incident was adequate although the OIG learned of the incident the following day. For future similar incidents, the department has been advised to notify the OIG immediately.	

CENTRAL REGION

Incident Date: 2013-08-18	Deadly Force Incident
Incident Summary OIG Case Number: 13-1906-RO	
On August 18, 2013, officers attempted to conduct a cell search and asked the two inmates to exit the cell. One of the inmates stood up, grabbed an unknown object, and advanced toward the officers. The officers used pepper spray on the inmate while the second inmate dropped an object in the toilet. The pepper spray was ineffective. The inmates ignored verbal commands to get down and began hitting officers with closed fists and elbows. The control booth officer fired one less-lethal round to stop the assault, but the inmates did not stop. Officers were finally able to stop and restrain the inmates using a baton and physical force. One of the inmates received an inadvertent strike to his head with a baton and was transferred to an outside hospital for stitches and later returned to the institution. The institution failed to notify the Office of Internal Affairs or the OIG.	
Disposition	
The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.	
Incident Assessment	Rating: Insufficient
The department's response was not adequate because of the failure to notify the OIG in a timely and sufficient manner, preventing the OIG from real-time monitoring of the case. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	
Assessment Questions	
<ul style="list-style-type: none">• Did the institution timely notify the Office of Internal Affairs of the incident? <i>The OIG recommended that the institution contact the Office of Internal Affairs, but the Office of Internal Affairs was never contacted.</i>• Was the OIG promptly informed of the critical incident? <i>The OIG was not notified until two hours after the incident.</i>	

Incident Date: 2013-09-06	Deadly Force Incident
Incident Summary OIG Case Number: 13-1937-RO	
On September 6, 2013, two inmates began fighting during the dayroom program. The control booth officer fired two less-lethal rounds aiming for the lower extremities. Officers did not see where the rounds struck. One inmate suffered a laceration with active bleeding and swelling to his head, which appeared to be consistent with a less-lethal round. The second inmate suffered an abrasion, swelling, and bruising to his abdomen, which was also consistent with a less-lethal round. Both inmates told officers they were struck by direct impact rounds. There was no serious bodily injury, and both inmates were treated at the institution. Although the Office of Internal Affairs was notified, it is the department's practice not to respond on scene unless less-lethal force is intentionally used in a lethal manner, or inadvertently causes a potential life-threatening injury. The department adequately notified the OIG, and the OIG responded to the scene.	
Disposition	
The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.	
Incident Assessment	Rating: Sufficient
The department's overall response to the incident was adequate in all critical aspects. The department provided sufficient notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	

CENTRAL REGION

Incident Date: 2012-04-09		Deadly Force Incident	
Incident Summary On April 9, 2012, during a foot pursuit, a parolee refused orders to get down and began to turn toward a parole agent while reaching into a bag the parolee was carrying. The parole agent aimed and discharged a lethal round at the parolee at large who had a history of firearms possession. Although the shot missed the parolee, the parolee complied with continued orders to get down. After the parolee was secured, a handgun was recovered from the parolee's bag. The department's deadly force investigation team and the OIG were timely notified and both responded on scene.			
Administrative Investigation		OIG Case Number: 12-0875-IR	
1. Use of Deadly Force	Findings 1. Exonerated	Initial Penalty No Penalty Imposed	Final Penalty No Change
Investigative Assessment			Rating: Insufficient
The special agent and department attorney failed to comply with the department's policies and procedures governing the investigative process. The special agent failed to complete the investigation within 90 days and failed to inform the OIG of the date of the presentation to the department's independent Deadly Force Review Board. The department attorney failed to adequately assess the relevant deadlines and failed to adequately consult with the OIG throughout the investigative phase.			
Assessment Questions <ul style="list-style-type: none"> • Within 21 calendar days, did the department attorney make an entry into CMS accurately confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time? <i>The department attorney made an entry into CMS. However, he merely stated that he assessed the date of the incident, discovery date, and the deadline for taking disciplinary action without indicating the actual dates.</i> • No later than 21 calendar days following assignment of the case, did the department attorney contact the assigned special agent and the monitor to discuss the elements of a thorough investigation of the alleged misconduct? <i>On April 23, 2012, the department attorney was assigned to this case. The OIG attempted contact with the department attorney, sending an introductory e-mail on May 11, 2012. However, no efforts were made by the department attorney to include the OIG in the initial case conference between the department attorney and the special agent on May 14, 2012.</i> • Did the department attorney provide written confirmation summarizing all critical discussions about the investigative report to the special agent with a copy to the OIG? <i>The department attorney did not provide the OIG a copy of the written confirmation sent to the special agent regarding the investigative report.</i> • Was the OIA investigation, or subject only interview, conducted with due diligence? <i>The special agent was assigned on April 9, 2012; however, the investigation was not completed until August 17, 2012, 130 days after assignment.</i> • Did the special agent cooperate with and provide continual real-time consultation with the OIG? <i>The special agent failed to advise the OIG of the date the case would be presented to the department's independent Deadly Force Review Board.</i> • Did the department attorney cooperate with and provide continual real-time consultation with the OIG throughout the investigative phase? <i>The department attorney had very minimal contact with the OIG.</i> 			
Disposition The department's independent Deadly Force Review Board found that the discharge of the lethal round was in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the parole agent and the OIG concurred.			
Disciplinary Assessment			Rating: Insufficient
The department failed to conduct the findings and penalty conference in a timely manner regarding the initial deadly force allegation. The findings and penalty conference was eventually conducted after supplemental allegations were added. The OIG monitored those allegations separately.			
Assessment Questions <ul style="list-style-type: none"> • Did the HA timely consult with the OIG and department attorney (if applicable), regarding the sufficiency of the investigation and the 			

CENTRAL REGION

investigative findings?

The findings and penalty conference was never conducted with the OIG in this case. However, the OIG monitored a related case regarding potential departmental policy violations aside from the justification for the use of deadly force. The findings and penalty conference for that case was timely held. At that time, the parole agent was exonerated of the original allegation that his use of deadly force was not in compliance with departmental policy.

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

The findings and penalty conference was never conducted with the OIG in this case. However, the OIG monitored allegations that arose from this underlying deadly force incident. The findings and penalty conference for that case was timely held. At that time, the parole agent was exonerated of the original allegation that his use of deadly force was not in compliance with departmental policy.

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

The department failed to conduct the investigative findings and disciplinary determinations in a timely manner.

CENTRAL REGION

Incident Date: 2013-02-26		Deadly Force Incident	
Incident Summary On February 26, 2013, several inmates attacked each other, inciting a fight among many inmates in the dayroom. Officers ordered the inmates to stop fighting and assume a prone position. Three groups of inmates refused the orders, and an officer fired three less-lethal 40 mm direct impact rounds, striking two inmates. One of the two inmates was inadvertently hit in the head and required emergency medical intervention at an outside hospital. He was returned to the institution several days later. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.			
Criminal Investigation		OIG Case Number: 13-0394-IR	
Investigation Assessment			Rating: Sufficient
Overall, the department sufficiently complied with policies and procedures governing the investigative process.			
Administrative Investigation		OIG Case Number: 13-0395-IR	
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Change
Investigative Assessment			Rating: Sufficient
The department's investigative process sufficiently complied with policies and procedures.			
Disposition			
The department's independent Deadly Force Review Board found the officer's actions were within policy. The hiring authority subsequently exonerated the officer and the OIG concurred.			
Disciplinary Assessment			Rating: Insufficient
The hiring authority failed to comply with the department's policies and procedures governing the disciplinary process. The hiring authority conducted the findings and penalty conference without notifying or consulting with the OIG.			
Assessment Questions			
<ul style="list-style-type: none"> Did the disciplinary officer make an entry into CMS prior to the findings conference accurately confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time? <i>The disciplinary officer did not make an entry into CMS confirming relevant dates.</i> Did the HA timely consult with the OIG and department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? <i>The hiring authority did not consult with the OIG regarding the sufficiency of the investigation and the investigative findings.</i> Did the department attorney or disciplinary officer cooperate with and provide continual real-time consultation with the OIG throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? <i>The disciplinary officer failed to notify the OIG of the findings and penalty conference.</i> Did the HA cooperate with and provide continual real-time consultation with the OIG throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? <i>The hiring authority failed to notify the OIG of the findings and penalty conference.</i> 			

CENTRAL REGION

Incident Date: 2013-06-10		Deadly Force Incident	
Incident Summary On June 10, 2013, three inmates attacked another inmate on the exercise yard. The inmate being attacked fell to the ground unresponsive while the three attacking inmates continued to hit and kick the inmate being attacked with feet and fists. An officer fired one lethal round as a warning shot without result. The same officer then fired one lethal round for effect, missing all subjects, but stopping the attack. Remnants from the bullet shot for effect struck an uninvolved inmate in the knee. The uninvolved inmate received only minor abrasions and scratches and was treated at the institution. The inmate who was attacked received non-life-threatening injuries. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.			
Criminal Investigation		OIG Case Number: 13-0784-IR	
Investigation Assessment			Rating: Insufficient
The Office of Internal Affairs and the hiring authority failed to comply with the department's policies and procedures governing the investigative process. The hiring authority failed to timely obtain a public safety statement. The Office of Internal Affairs failed to timely and properly conduct percipient witness interviews and failed to prepare a timely and appropriately drafted investigative report.			
Assessment Questions <ul style="list-style-type: none"> Was the HA's response to the critical incident appropriate? <i>The hiring authority obtained an untimely public safety statement three hours after the critical incident.</i> Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours as required by the DOM? <i>The special agent did not conduct all relevant interviews within 72 hours of the incident.</i> Were all of the interviews thorough and appropriately conducted? <i>The witness interviews did not include a diagram prepared by each witness to identify their location at the time of the incident.</i> Was the investigative draft report provided to the OIG for review thorough and appropriately drafted? <i>The special agent omitted a portion of statements made by two officers that contradicted critical observations made by all other officers regarding the position of the inmate being attacked during the use of deadly force.</i> Was the OIA investigation, or subject only interview, conducted with due diligence? <i>The special agent was assigned the case on June 11, 2013, but did not complete the investigation until September 11, 2013, 92 days after assignment.</i> Was the investigation thorough and appropriately conducted? <i>The special agent did not conduct all relevant interviews within 72 hours of the incident and did not have any witnesses draw a diagram indicating their location at the time of the incident.</i> 			
Administrative Investigation		OIG Case Number: 13-0806-IR	
1. Use of Deadly Force	Findings 1. Exonerated	Initial Penalty No Penalty Imposed	Final Penalty No Change
Investigative Assessment			Rating: Insufficient
The department failed to comply with the department's policies and procedures governing the investigative process. The hiring authority failed to timely obtain a public safety statement and the Office of Internal Affairs failed to complete the investigation in a timely manner.			
Assessment Questions <ul style="list-style-type: none"> Was the HA's response to the critical incident appropriate? <i>The hiring authority obtained an untimely public safety statement three hours after the critical incident.</i> Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours as required by the DOM? <i>Interviews took longer than 72 hours to completed. Interviews were conducted from June 12, 2013 until July 9, 2013.</i> 			

CENTRAL REGION

- Was the OIA investigation, or subject only interview, conducted with due diligence?

The special agent was assigned on June 11, 2013; however, the investigation was not completed until December 17, 2013, over six months later.

- Was the investigation thorough and appropriately conducted?

There were delays during the investigation. The interviews were not completed in a timely manner and it took over six months to complete the investigation.

Disposition

The department's independent Deadly Force Review Board found no violation of departmental policy and the hiring authority subsequently exonerated the officer. The OIG concurred.

Disciplinary Assessment

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

Rating: Sufficient

NORTH REGION

Incident Date: 2012-05-20	Deadly Force Incident
Incident Summary OIG Case Number: 12-1173-RO <p>On May 20, 2012, a riot involving approximately six inmates erupted on an exercise yard. Officers used chemical agents to stop the incident, but the inmates continued to fight and incited additional inmates to riot. Approximately 40 inmates became involved in the riot. Several inmates attacked an inmate by repeatedly kicking him in the head and hitting him. The inmate was unable to defend himself. An officer assigned to an observation post fired a warning shot from a Mini-14 rifle which did not stop the attack. Subsequently, two other officers each fired a warning shot from Mini-14 rifles from separate observation posts. Responding officers used pepper spray and baton strikes to stop the attack and riot. The inmate sustained head trauma and was air-lifted to an outside hospital for treatment. He returned to the institution two days later and received treatment in the institution's correctional treatment center for seven more days. He was then discharged from care. There were no staff injuries. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG.</p>	
Disposition <p>The institution's executive review committee determined the use of force was in compliance with departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.</p>	
Incident Assessment <p>The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.</p>	Rating: Sufficient

Incident Date: 2012-07-06	Deadly Force Incident
Incident Summary OIG Case Number: 12-1596-RO <p>On July 6, 2012, officers observed three inmates on an exercise yard stab and kick another inmate. Officers utilized two less-lethal direct impact rounds to stop the attack, but the inmates continued the attack. An officer then fired a warning shot from the Mini-14 rifle, which struck the designated safe target area and stopped the attack. No staff nor inmates were struck by the Mini-14 round. When staff responded to provide aid to the inmate who had been attacked, an inmate-manufactured weapon used during the attack was found lodged in the inmate's chest. The inmate was taken to the correctional treatment center for medical care and safe removal of the weapon. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG.</p>	
Disposition <p>The institution's executive review committee determined that the use of force was within policy. The OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>	
Incident Assessment <p>The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.</p>	Rating: Sufficient

NORTH REGION

Incident Date: 2012-08-16	Deadly Force Incident
Incident Summary OIG Case Number: 12-1947-RO	
<p>On August 16, 2012, 45 inmates were involved in a riot involving inmate-manufactured weapons on an exercise yard. Responding officers utilized less-lethal 40 mm rounds and pepper spray to stop the rioting; however, the inmates continued to riot. An officer fired one warning shot from the Mini-14 rifle into a safe area. The inmates stopped their actions and got on the ground. Custody staff recovered 15 inmate-manufactured weapons. Forty-two inmates were treated at the medical clinic and released back to their assigned housing unit. Three inmates were transported to the correctional treatment center for a higher level of medical care. One of the three inmates received seven puncture wounds to the left side of his back and was subsequently air-lifted to an outside medical center. He was treated and returned to the institution later that day. The remaining two inmates received medical treatment at the correctional treatment center and were returned to their housing unit. No staff members were injured. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots.</p>	
Disposition	
<p>The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's response was not adequate because the department failed to notify the OIG thereby preventing the OIG from real-time monitoring of the case.</p>	
Assessment Questions	
<ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The hiring authority failed to report the incident to the OIG. The OIG learned of the incident by reviewing the department's daily report the following day.</i></p>	

Incident Date: 2012-08-20	Deadly Force Incident
Incident Summary OIG Case Number: 12-1998-RO	
<p>On August 20, 2012, a fight involving two inmates occurred on an exercise yard. The exercise yard was ordered down and all inmates complied except the two inmates involved in the fight and two other inmates who were not involved. All four inmates eventually laid down in a prone position. The two inmates involved in the fight were removed from the yard without incident. The other two inmates were ordered to stand up to be escorted off of the yard. Once standing, one of the inmates hit an officer in the face with his fist. Another officer used physical force to take the inmate to the ground. The second inmate then hit a sergeant in the face multiple times with his fists. The sergeant and responding custody staff took the second inmate to the ground. All remaining inmates on the yard, approximately 25 to 30, then jumped to their feet and rushed the responding custody staff. Multiple custody staff were assaulted by the attacking inmates. A control booth officer fired a warning shot from his state-issued rifle which caused some of the inmates to get down; however, they immediately got back up again. The control booth officer then fired a second warning shot at which time all inmates got down in a prone position. The injured custody staff and inmates were taken to the correctional treatment center. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG and the OIG responded on scene.</p>	
Disposition	
<p>The institution's executive review committee determined that the use of force was in compliance with departmental policy. The OIG concurred. Potential staff misconduct was identified based on two nurses' failure to properly document an inmate's complaints of excessive force following the incident; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG did not accept for monitoring.</p>	
Incident Assessment	Rating: Sufficient
<p>The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.</p>	

NORTH REGION

Incident Date: 2012-11-27	Deadly Force Incident
Incident Summary OIG Case Number: 12-2704-RO On November 27, 2012, a riot erupted on an exercise yard involving approximately 16 inmates. Staff used pepper spray, less-lethal direct impact rounds, and one warning shot from a Mini-14 rifle to stop the riot. One inmate sustained serious head and jaw injuries from the fighting and was taken by ambulance to an outside hospital, treated, and returned to the institution. There were no staff injuries and no serious injuries to inmates from the use of force. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG, and the OIG responded on scene.	
Disposition The institution's executive review committee determined that all use of force was within departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred with these determinations.	
Incident Assessment	Rating: Sufficient
The OIG determined that the institution adequately responded to the incident in all critical aspects. The institution provided adequate notification and consultation to the OIG regarding the incident.	

Incident Date: 2013-04-11	Deadly Force Incident
Incident Summary OIG Case Number: 13-0544-RO On April 11, 2013, multiple inmates began fighting in a dayroom. Officers gave multiple orders for the inmates to get down and stop fighting, but the inmates continued to fight. The control booth officer observed one inmate being choked by another inmate. The officer fired one warning shot from a state-issued Mini-14 rifle into a dayroom wall, which stopped the fight. There were no injuries. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG and the OIG responded on scene.	
Disposition The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.	
Incident Assessment	Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.	

Incident Date: 2013-06-06	Deadly Force Incident
Incident Summary OIG Case Number: 13-0751-RO On June 6, 2013, an officer observed two inmates punching and stabbing another inmate. The officer fired a warning shot into a yard wall from a Mini-14 rifle, which had the desired effect of stopping the attack. The inmate who was attacked sustained non-life-threatening puncture wounds. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The department adequately notified the OIG and the OIG responded on scene.	
Disposition The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.	
Incident Assessment	Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.	

NORTH REGION

Incident Date: 2013-07-07	Deadly Force Incident	
Incident Summary On July 7, 2013, 31 inmates began fighting on an exercise yard. Officers gave multiple orders to get down and stop fighting, but the inmates continued to fight. Officers used three pepper spray grenades and fired two less-lethal 40 mm rounds, but the inmates continued fighting. An officer fired one warning shot into a nearby wall, and the inmates got down for a short time, but then rose and resumed fighting. A fourth pepper spray grenade was used and the inmates finally complied with orders to stay down. There were no serious inmate injuries. The hiring authority failed to timely notify the Office of Internal Affairs. The hiring authority adequately notified the OIG, and the OIG responded on scene.		OIG Case Number: 13-1154-RO
Disposition The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.		
Incident Assessment The department did not adequately notify the Office of Internal Affairs regarding the incident. The notification occurred more than three hours after the incident. However, the department adequately notified and consulted with the OIG regarding the incident.		Rating: Insufficient
Assessment Questions <ul style="list-style-type: none"> Did the institution timely notify the Office of Internal Affairs of the incident? <p><i>The institution did not notify the Office of Internal Affairs until more than three hours after the incident.</i></p>		

Incident Date: 2013-08-11	Deadly Force Incident	
Incident Summary On August 11, 2013, during the evening meal, one inmate attacked another inmate. Officers utilized one pepper spray grenade and two less-lethal rounds to stop the attack. One of the less-lethal rounds inadvertently struck an uninvolved inmate in the back of his head, causing a laceration to his head. The inmate was taken to an outside hospital where he received staples for the head wound. The inmate was released from the hospital and returned to the institution. The Office of Internal Affairs was not notified of the incident.		OIG Case Number: 13-1628-RO
Disposition The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.		
Incident Assessment The department 's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG regarding the incident.		Rating: Sufficient

NORTH REGION

Incident Date: 2013-10-08	Deadly Force Incident
Incident Summary OIG Case Number: 13-2215-RO On October 8, 2013, a riot occurred on an exercise yard involving approximately 17 inmates. The inmates appeared to separate into three groups fighting in the same general area. One inmate was observed lying on the ground unconscious with another inmate repeatedly kicking him in the head area as another inmate was hitting him in the head and upper torso area. The officer stationed in the observation post fired one warning shot from a Mini-14 rifle, which did not have any effect on the involved inmates. The unconscious inmate continued to lie on the ground and not defend himself as the two inmates continued to batter him. During this time, the other inmates continued to fight. The officer fired a second warning shot in the same general area, which was also not effective. A third warning shot was fired, which had the effect of stopping the incident, and all combatants ceased their activity and lay on the ground in the prone position. Responding staff placed the unconscious inmate on a medical cart and transported him to the institution's medical treatment station where he regained consciousness. However, medical staff determined that he needed further medical evaluation and he was sent to a local hospital for additional treatment. The inmate later returned to the institution after being treated for injuries sustained during the incident. Although the Office of Internal Affairs was notified of the incident, the normal practice is not to respond on scene to warning shots. The department adequately notified the OIG and the OIG responded on scene.	
Disposition The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.	
Incident Assessment The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with OIG regarding the incident.	Rating: Sufficient

NORTH REGION

Incident Date: 2012-09-19		Deadly Force Incident	
Incident Summary <p>On September 19, 2012, a riot involving over 80 inmates erupted on an exercise yard. Officers observed inmates striking each other with their fists, feet, and inmate-manufactured weapons. Officers used chemical agents and 40 mm launchers to stop the attack. However, the inmates continued to fight. A control tower officer observed eight to ten inmates punching and kicking another inmate who was on the ground. The officer fired one warning shot from his Mini-14 rifle. This had the desired effect of stopping the attack. A second officer in an observation tower observed several inmates attack and beat another inmate who was not defending himself. The second officer fired one warning shot from his Mini-14 rifle. A third officer in the observation tower observed the same attack and also fired one warning shot. The warning shots had the desired effect of stopping the attack. A fourth officer in a control tower observed an inmate stabbing another inmate in the stomach and fired one warning shot which had the desired effect of stopping the attack. The fourth officer then observed several inmates stomping, kicking, and punching another inmate who was on the ground and not defending himself. The officer fired one less-lethal 40 mm round at one of the attackers, striking the attacker. The inmate stopped his attack and fell to the ground. The fourth officer then observed another group of inmates stomping and kicking an inmate who was unresponsive. The officer fired another less-lethal 40 mm round, but missed his intended target. However, the fighting stopped. Thirteen inmates were taken to outside hospitals for medical treatment for stab wounds and blunt force injuries, following which they returned to the institution. The inmate who was struck by the less-lethal round was included in those taken to an outside hospital for treatment, following which he also returned to the institution. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.</p>			
Criminal Investigation		OIG Case Number: 12-2173-IR	
Investigation Assessment			Rating: Insufficient
The department's investigative process did not sufficiently comply with policies and procedures. The Office of Internal Affairs did not conduct its investigation with due diligence.			
Assessment Questions			
<ul style="list-style-type: none"> Was the OIA investigation, or subject only interview, conducted with due diligence? <p><i>The Office of Internal Affairs began the deadly force investigation on September 19, 2012, the same day that deadly force was utilized. However, the investigation was not completed until February 3, 2013, over six months after the incident.</i></p>			
Administrative Investigation		OIG Case Number: 12-2174-IR	
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Change
Investigative Assessment			Rating: Insufficient
The Office of internal Affairs failed to complete the investigation in a timely manner and the department attorney failed to provide written feedback regarding the investigative report.			
Assessment Questions			
<ul style="list-style-type: none"> Did the department attorney provide written confirmation summarizing all critical discussions about the investigative report to the special agent with a copy to the OIG? <p><i>The department attorney did not provide written confirmation summarizing critical discussions about the investigative report to the special agent with a copy to the OIG.</i></p> <ul style="list-style-type: none"> Was the OIA investigation, or subject only interview, conducted with due diligence? <p><i>The Office of Internal Affairs began the deadly force investigation on September 19, 2012, the same day that deadly force was utilized. However, the investigation was not completed until February 21, 2013, over five months after the incident.</i></p>			
Disposition			
The department's independent Deadly Force Review Board found that the discharges of lethal rounds complied with the department's use-of-force policy. The hiring authority subsequently exonerated the officers and the OIG concurred.			
Disciplinary Assessment			Rating: Sufficient
The department's disciplinary process sufficiently complied with policies and procedures.			

NORTH REGION

Incident Date: 2012-10-31		Deadly Force Incident	
Incident Summary <p>On October 31, 2012, three inmates began attacking an inmate on the exercise yard. The inmate being attacked was on the ground being kicked and punched. Two officers fired one warning shot each. All three attackers then complied with orders to lie down in a prone position. A few seconds later one of the three attackers got up and began kicking the victim in the head. One of the officers fired a shot for effect and hit the attacker in the hip. The inmate who was attacked and the inmate who was shot were transported to an outside hospital. The inmate who was attacked was returned to the institution later the same day. The inmate who was shot was returned to the institution's correctional treatment center on November 10, 2012. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.</p>			
Criminal Investigation		OIG Case Number: 12-2526-IR	
Investigation Assessment			Rating: Insufficient
<p>The department's response was not adequate because the investigation was not completed within 90 days of the initial assignment. The special agent was assigned on October 31, 2012, but the investigation was not completed until April 5, 2013, more than five months after the initial assignment.</p>			
Assessment Questions <ul style="list-style-type: none"> Was the OIA investigation, or subject only interview, conducted with due diligence? <i>The investigation was not completed within ninety days as required by the department's policies and procedures.</i> 			
Administrative Investigation		OIG Case Number: 12-2527-IR	
	Findings	Initial Penalty	Final Penalty
1. Discharge of Lethal Weapon	1. Exonerated	No Penalty Imposed	No Change
Investigative Assessment			Rating: Insufficient
<p>The department's response was not adequate because the investigation was not completed within 90 days of the initial assignment. The special agent was assigned on October 31, 2012 but the investigation was not completed until April 5, 2013, more than five months after the initial assignment. In addition, the department attorney failed to make any entry into the case management system confirming relevant dates and failed to provide written confirmation to the OIG summarizing critical discussions about the investigative report.</p>			
Assessment Questions <ul style="list-style-type: none"> Within 21 calendar days, did the department attorney make an entry into CMS accurately confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time? <i>The department attorney did not make any entry into CMS confirming relevant dates.</i> Did the department attorney provide written confirmation summarizing all critical discussions about the investigative report to the special agent with a copy to the OIG? <i>The department attorney did not provide written confirmation to the OIG summarizing critical discussions about the investigative report. Also, the department attorney did not make any entries in the case management system indicating any discussions occurred with the special agent regarding the investigative report.</i> Was the OIA investigation, or subject only interview, conducted with due diligence? <i>The special agent was assigned on October 31, 2012, but the investigation was not completed until April 5, 2013, more than five months after the initial assignment.</i> 			
Disposition <p>The department's independent Deadly Force Review Board found that the discharge of the lethal rounds were in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officers and the OIG concurred.</p>			
Disciplinary Assessment			Rating: Sufficient
<p>The department's disciplinary process sufficiently complied with policies and procedures.</p>			

NORTH REGION

Incident Date: 2012-11-09		Deadly Force Incident	
Incident Summary <p>On November 9, 2012, two inmates attacked a third inmate on an exercise yard. One inmate was stabbing the third inmate with an inmate-manufactured weapon. Both of the inmates who were attacking were kicking the third inmate in the head and upper torso. The tower officer shot one of the attacking inmates in the head with a lethal round which resulted in the inmate's death. The second attacking inmate complied with orders to get down and was uninjured. The third inmate was treated at the triage treatment area for puncture wounds. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.</p>			
Criminal Investigation		OIG Case Number: 12-2601-IR	
Investigation Assessment			Rating: Sufficient
The department's investigative process sufficiently complied with policies and procedures.			
Administrative Investigation		OIG Case Number: 12-2697-IR	
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Change
Investigative Assessment			Rating: Sufficient
The department's investigative process sufficiently complied with policies and procedures.			
Disposition			
The department's independent Deadly Force Review Board found that the discharge of the lethal round was in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officer and the OIG concurred.			
Disciplinary Assessment			Rating: Sufficient
The department complied with policies and procedures governing the disciplinary process.			

NORTH REGION

Incident Date: 2012-11-16		Deadly Force Incident	
Incident Summary On November 16, 2012, an off-duty sergeant allegedly negligently discharged his personal firearm in a movie theater. A member of the public was reportedly struck with a metal fragment but was not injured. The sergeant was contacted by local law enforcement but not arrested. The sergeant notified the institution of the incident and his contact with local law enforcement.			
Criminal Investigation		OIG Case Number: 12-2773-IR	
Investigation Assessment			Rating: Sufficient
The department's investigative process sufficiently complied with policies and procedures.			
Administrative Investigation		OIG Case Number: 12-2772-IR	
	Findings	Initial Penalty	Final Penalty
1. Neglect of Duty 2. Discharge of Lethal Weapon	1. Sustained 2. Sustained	Letter of Reprimand	No Change
Investigative Assessment			Rating: Sufficient
Overall, the department's investigative process sufficiently complied with policies and procedures.			
Disposition The hiring authority determined there was sufficient evidence to sustain the allegations and issued an official letter of reprimand. The OIG concurred. At the <i>Skelly</i> hearing the sergeant took responsibility for his actions and described remedial measures he took to ensure that his misconduct would not occur again. After the <i>Skelly</i> hearing, the hiring authority shortened the amount of time the official letter of reprimand would remain in the sergeant's official personnel file from three years to one year. The OIG concurred because it was not a significant penalty reduction and because of the mitigating factors presented at the <i>Skelly</i> hearing.			
Disciplinary Assessment			Rating: Insufficient
The hiring authority and department attorney failed to comply with policies and procedures governing the disciplinary process. The hiring authority failed to timely consult with the OIG and department attorney regarding the sufficiency of the investigation and disciplinary determinations. The hiring authority and department attorney were not adequately prepared to discuss the investigative findings at the consultation. Furthermore, the department attorney did not give appropriate legal consultation to the hiring authority regarding the investigative findings and disciplinary determinations. Finally, the draft disciplinary action provided to the OIG was not appropriately drafted.			
Assessment Questions <ul style="list-style-type: none"> Did the HA timely consult with the OIG and department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? <i>The case was returned to the hiring authority on July 26, 2013, but the hiring authority did not consult with the OIG and department attorney regarding the sufficiency of the investigation and the investigative findings until September 11, 2013, 47 days later.</i> If the HA consulted with the OIG concerning the sufficiency of the investigation and the investigative findings, was the HA adequately prepared? <i>The hiring authority did not adequately review the recommendation from the Deadly Force Review Board prior to the consultation with the OIG concerning the sufficiency of the investigation and the investigative findings.</i> Did the VA provide appropriate legal consultation to the HA regarding the sufficiency of the investigation and investigative findings? <i>The department attorney did not provide appropriate legal consultation to the hiring authority regarding the sufficiency of the evidence, the investigative findings and the significance of the recommendation from the Deadly Force Review Board.</i> Did the HA timely consult with the OIG and the department attorney (if applicable) regarding disciplinary determinations prior to making a final decision? <i>The case was returned to the hiring authority on July 26, 2013, but the hiring authority did not consult with the OIG and the department attorney regarding the disciplinary determinations until September 11, 2013, 47 days later.</i> Did the department attorney provide appropriate legal consultation to the HA regarding disciplinary determinations? <i>The department attorney did not provide appropriate legal consultation to the hiring authority regarding the appropriate penalty by failing to adequately consider all of the factors and evidence relating to the disciplinary determinations.</i> 			

NORTH REGION

- Was the draft disciplinary action provided to the OIG for review appropriately drafted as described in the DOM?

The department attorney failed to describe how the officer discharged his weapon and failed to allege that the officer failed to handle the weapon with care in the draft disciplinary action. The OIG made recommendations to the department attorney to address these issues.

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

The hiring authority failed to conduct the findings and disciplinary determinations in a timely manner.

NORTH REGION

Incident Date: 2013-03-27		Deadly Force Incident	
Incident Summary <p>On March 27, 2013, an inmate attacked an officer in a dining hall with an inmate-manufactured weapon, stabbing the officer in his head and neck area. A sergeant and an officer used physical force to restrain the inmate, take him to the ground, and disarm him of the weapon. Simultaneously, in the same dining hall, a second inmate attacked a second officer with his fists, striking the officer in the face and upper torso area. Another sergeant and another officer each struck the second inmate in the head multiple times with their batons, took him to the ground, and restrained him, preventing further attack. The sergeant reported hearing someone yell, "weapon," before he struck the inmate in the head but the officer did not. The second inmate had three lacerations to his head and was taken to an outside hospital where he received 12 sutures. He returned to the institution the same day. Neither officer received serious injury. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.</p>			
Criminal Investigation		OIG Case Number: 13-0506-IR	
Investigation Assessment			Rating: Insufficient
<p>The department's response was not adequate. The department notified the OIG of the staff assault and consulted with the OIG, which was already present at the institution. However, the manager on scene failed to immediately notify the hiring authority that one of the inmates was struck in the head with a baton. The Office of Internal Affairs also failed to immediately notify the hiring authority that a deadly force investigation team would be investigating the use of force. Instead the hiring authority learned this from a union representative. The department also failed to timely take adequate photographs after the incident of one of the inmates who was scheduled to be immediately transferred to another institution.</p>			
Assessment Questions <ul style="list-style-type: none"> Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours as required by the DOM? <p><i>The deadly force investigation team special agent conducted two witness interviews more than 72 hours after the incident.</i></p>			
Administrative Investigation		OIG Case Number: 13-0507-IR	
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Change
Investigative Assessment			Rating: Sufficient
<p>Overall, the department sufficiently complied with policies and procedures.</p>			
Disposition <p>The department's independent Deadly Force Review Board found no violation of departmental policy, and the hiring authority subsequently exonerated the sergeant and officer. The OIG concurred with the department's determination as to the sergeant's use of deadly force. However, the OIG did not concur with the department's decision regarding the officer's use of deadly force because the officer failed to articulate an immediate threat of great bodily injury or death that would justify the use of deadly force. The OIG did not seek a higher level of review.</p>			
Disciplinary Assessment			Rating: Sufficient
<p>Overall, the department sufficiently complied with policies and procedures.</p>			

SOUTH REGION

Incident Date: 2013-02-04	Deadly Force Incident
Incident Summary OIG Case Number: 13-0273-RO <p>On February 4, 2013, two inmates were observed fighting in the dining hall. Officers activated the alarm and ordered both inmates to get down. Both inmates ignored the commands and continued fighting. An officer fired a less-lethal round at the thigh of one of the involved inmates. The round missed the intended target and the inmates continued fighting. The officer fired a second less-lethal round, aiming at the thigh of one of the involved inmates. The round missed the intended target and struck one of the fighting inmates on the side of the head. The inmates stopped fighting and got on the ground. The inmate who was struck in the head was transported to a local hospital for observation and treatment due to a laceration and swelling where the round struck. He returned to the institution later that day. The other involved inmate was not injured during the incident. The Office of Internal Affairs was not notified of the incident.</p>	
Disposition <p>The institution's executive review committee determined the use of force was in compliance with departmental policy, but training was provided to an officer who failed to identify himself while operating the camera during the injured inmate's video-taped interview. No staff misconduct was identified. The OIG concurred.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's response was not adequate because the institution failed to notify the Office of Internal Affairs. The department adequately notified and consulted with the OIG regarding the incident.</p>	
Assessment Questions <ul style="list-style-type: none"> • Did the institution timely notify the Office of Internal Affairs of the incident? <p style="text-align: center;"><i>The institution failed to notify the Office of Internal Affairs of the incident as required by departmental policy.</i></p>	

Incident Date: 2013-05-24	Deadly Force Incident
Incident Summary OIG Case Number: 13-0693-RO <p>On May 24, 2013, approximately 20 inmates began fighting on the exercise yard. Officers sounded the yard alarm and gave multiple orders for the inmates to get down, but the orders were ignored. Approximately 20 more inmates got up and joined the fight. Officers fired six less-lethal rounds and utilized pepper spray, but the inmates continued fighting. The observation officer observed an inmate on the ground being kicked in the head by several inmates and fired one lethal round as a warning shot, but the inmates continued the attack. The observation officer fired a second lethal round as a warning shot, causing all inmates to stop fighting and get on the ground. Two inmates suffered non-life-threatening injuries, including superficial slashing wounds, and other inmates sustained minor injuries consistent with fighting. The inmates were treated by medical staff at the institution. Although the Office of Internal Affairs was notified of the incident, its practice is not to respond on scene to warning shots. The OIG was timely notified and responded on scene.</p>	
Disposition <p>The institution's executive review committee determined that the use of force was in compliance with departmental policy. The OIG concurred, except for the supervisor's failure to timely obtain a public safety statement from the officer who used deadly force. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation and the OIG concurred.</p>	
Incident Assessment	Rating: Sufficient
<p>The department's overall response to the incident was satisfactory in all critical aspects except that the responding supervisor failed to timely obtain a public safety statement from the officer who used deadly force. In addition, the officer who used deadly force failed to adequately justify the use of deadly force in his initial written report. The OIG was instrumental in convincing the institution's executive review committee to obtain supplemental reports from the officer until all questions were addressed.</p>	

SOUTH REGION

Incident Date: 2013-06-29	Deadly Force Incident
Incident Summary OIG Case Number: 13-1005-RO	
<p>On June 29, 2013, an observation officer fired two less-lethal rounds to stop two inmates from fighting on an exercise yard. One round hit the ground and the other round hit an inmate in the leg before bouncing off and hitting another inmate in the head. The first inmate received superficial injuries to his leg and was treated by medical staff at the institution. The inmate that was hit on the head suffered a laceration and was treated at an outside hospital, following which he returned to the institution. Although the Office of Internal Affairs was notified, it is the department's practice not to respond on scene unless less-lethal force is intentionally used in a lethal manner or inadvertently causes potential lethal injury. The department adequately notified the OIG and the OIG responded on scene.</p>	
Disposition	
<p>The institution's executive review committee determined that the use of force complied with the departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.</p>	
Incident Assessment	Rating: Sufficient
<p>Overall, the department's response to the incident was sufficient. The department informed the OIG about the incident in a timely and sufficient manner.</p>	

Incident Date: 2013-06-28	Deadly Force Incident
Incident Summary OIG Case Number: 13-1142-RO	
<p>On June 28, 2013, two officers ordered a resistive inmate to submit to handcuffs. The inmate initially complied but then turned and punched officers. The first officer drew his baton, gave the inmate orders to get down, and, obtaining no compliance, struck the inmate's thighs twice, with no results. The inmate attempted to pull the second officer down and the first officer struck the inmate with his baton on his right shoulder when the inmate refused orders to stop his attack. A subsequent baton strike inadvertently struck the inmate's head. The inmate continued his attack before finally complying with orders to stop. Both officers received superficial injuries. The inmate received a laceration to the back of his head, was treated at an outside hospital, and returned to the institution. Neither the Office of Internal Affairs nor the OIG were timely notified.</p>	
Disposition	
<p>Potential staff misconduct was identified as the injuries sustained by the inmate were inconsistent with the statements provided by the officers; therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's overall response to the incident was inadequate because the department failed to provide timely notification to the Office of Internal Affairs and the OIG, preventing a timely response.</p>	
Assessment Questions	
<ul style="list-style-type: none"> • Did the institution timely notify the Office of Internal Affairs of the incident? <i>The department failed to timely notify the Office of Internal Affairs, preventing a timely response.</i> • Was the OIG promptly informed of the critical incident? <i>The OIG was not promptly informed of the critical incident and did not become aware of it until the day after the incident occurred.</i> 	

SOUTH REGION

Incident Date: 2013-07-19	Deadly Force Incident
Incident Summary OIG Case Number: 13-1427-RO	
<p>On July 19, 2013, two inmates attacked another inmate with a weapon on the exercise yard. Officers ordered the inmates to get down with negative results. Officers utilized a baton, pepper spray, and a pepper spray blast grenade to stop the attack. One of the baton strikes inadvertently struck one of the attacking inmates in the head, resulting in a four-centimeter laceration. The inmate was escorted to the triage treatment area where he received six staples to close the laceration. Although no weapon was found, the inmate who was attacked sustained puncture wounds to his torso and was treated at the institution. The department failed to notify the Office of Internal Affairs.</p>	
Disposition <p>The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's overall response to the incident was not adequate because the department failed to notify the OIG in a timely manner, thereby preventing the OIG from responding on scene, and failed to notify the Office of Internal Affairs.</p>	
Assessment Questions <ul style="list-style-type: none"> • Did the institution timely notify the Office of Internal Affairs of the incident? <p style="margin-left: 20px;"><i>The institution failed to notify the Office of Internal Affairs about the incident as required by departmental policy.</i></p> • Was the OIG promptly informed of the critical incident? <p style="margin-left: 20px;"><i>The incident occurred on July 19, 2013; however, the OIG was not notified until July 29, 2013, ten days later.</i></p> • Was the HA's response to the critical incident appropriate? <p style="margin-left: 20px;"><i>The institution failed to notify the Office of Internal Affairs about the incident as required by departmental policy.</i></p> 	

Incident Date: 2013-08-05	Deadly Force Incident
Incident Summary OIG Case Number: 13-1496-RO	
<p>On August 5, 2013, two inmates attacked a third inmate as he entered a dining hall. Officers gave the inmates several orders to get down, but the inmates continued to fight. The observation booth officer fired two less-lethal rounds. One less-lethal round struck the inmate being attacked on his left foot, causing swelling. The second less-lethal round inadvertently struck an attacking inmate in the right side of his head, causing a laceration, bleeding, and swelling, without loss of consciousness. Officers also used pepper spray, which caused the inmates to stop fighting. The inmate struck in the head was transported to an outside hospital for sutures and returned to the institution. Although the institution notified the Office of Internal Affairs, it is the department's practice not to respond on scene unless less-lethal force is intentionally used in a lethal manner or inadvertently causes a potentially lethal injury. The institution notified the OIG and the OIG responded on scene.</p>	
Disposition <p>The institution's executive review committee determined that the use of force was in compliance with departmental policy. No staff misconduct was identified. The OIG concurred.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's response was not adequate. Although the Office of Internal Affairs was notified, it did not respond to the incident despite the potential lethal injury caused by the use of less-lethal force. The department did, however, adequately notify and consult with the OIG regarding the incident.</p>	
Assessment Questions <ul style="list-style-type: none"> • Did the OIA adequately respond to the incident? <p style="margin-left: 20px;"><i>Although the Office of Internal Affairs was notified, it did not respond to the incident despite the potential lethal injury caused by the use of less-lethal force.</i></p> 	

SOUTH REGION

Incident Date: 2012-01-04		Deadly Force Incident	
Incident Summary On January 4, 2012, a parole agent allegedly fired several shots at a parolee after the parolee shot and wounded another parole agent. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. Pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.			
Criminal Investigation		OIG Case Number: 12-0075-IR	
Investigation Assessment			Rating: Sufficient
Outside law enforcement conducted the investigation. The department complied with its policies and procedures pertaining to officer-involved shootings conducted by outside law enforcement.			
Administrative Investigation		OIG Case Number: 12-0059-IR	
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Change
Investigative Assessment			Rating: Sufficient
The department's investigative process sufficiently complied with policies and procedures.			
Disposition			
The department's independent Deadly Force Review Board found that the discharge of the lethal rounds was in compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the parole agent and the OIG concurred.			
Disciplinary Assessment			Rating: Sufficient
The department's disciplinary process sufficiently complied with policies and procedures.			

SOUTH REGION

Incident Date: 2012-04-26		Deadly Force Incident	
Incident Summary <p>On April 26, 2012, two inmates started fighting inside a dining hall. In an attempt to stop the fighting, an officer fired one less-lethal round, which missed the inmates. A second officer fired one round from a Mini-14 rifle into the wall behind the inmates approximately 12 feet from the ground as a warning shot. The inmates still did not stop fighting. The first officer fired a second less-lethal round, which again missed the inmates. A sergeant ran into the dining hall and used pepper spray on the inmates, who then stopped fighting. There were no inmate injuries. Although the Office of Internal Affairs was timely notified of the incident, they failed to respond on scene. The OIG responded on scene. The department's deadly force investigation team eventually conducted a criminal investigation. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.</p>			
Criminal Investigation		OIG Case Number: 12-1636-IR	
Investigation Assessment			Rating: Insufficient
<p>The department's investigative process did not sufficiently comply with policies and procedures. Although promptly notified of the incident in which the officer allegedly fired a warning shot in a location where warning shots are not permitted, the Office of Internal Affairs chose not to immediately respond to the scene and only became involved nearly three months after the incident. As a result, interviews did not begin until nearly four months after the incident.</p>			
Assessment Questions <ul style="list-style-type: none"> Did the OIA adequately respond to the incident? <i>Although promptly notified of the incident, the Office of Internal Affairs did not respond to the scene.</i> Was the matter referred to OIA as soon as reasonably practical, within 45 calendar days of the date of discovery? <i>The date of discovery was April 26, 2012; however, the hiring authority did not refer the matter to the Office of Internal Affairs until June 23, 2012, 58 days after the date of discovery.</i> Upon arrival at the scene, did the Deadly Force Investigation Team special agent adequately perform the required preliminary tasks? <i>The deadly force investigation team did not respond to the scene and, therefore, did not perform the required preliminary tasks.</i> Did the criminal Deadly Force Investigation Team special agent conduct all interviews within 72 hours as required by the DOM? <i>The criminal deadly force investigation team did not respond to the scene. The interviews did not begin until nearly four months after the incident.</i> 			
Administrative Investigation		OIG Case Number: 12-1610-IR	
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Sustained	Salary Reduction	No Change
Investigative Assessment			Rating: Insufficient
<p>The Office of Internal Affairs and the department attorney failed to comply with the department's policies and procedures governing the investigative process. After being timely notified, the Office of Internal Affairs failed to respond on scene and also failed to timely open an investigation. The department attorney did not make an entry into CMS confirming relevant dates. The special agent failed to notify the department attorney of the interview of the officer who used deadly force. The draft investigative report was not thorough because it failed to include the interview of a witness. Following the recommendation of the OIG, the witness was interviewed.</p>			
Assessment Questions <ul style="list-style-type: none"> Did the OIA adequately respond to the incident? <i>The use of deadly force occurred on April 26, 2012. The Office of Internal Affairs was timely notified of the incident, but did not respond on scene and did not make the determination that the case should be opened as a deadly force investigation until July 3, 2012, nearly two and one-half months after the incident.</i> Within 21 calendar days, did the department attorney make an entry into CMS accurately confirming the date of the reported incident, the date of discovery, the deadline for taking disciplinary action, and any exceptions to the deadline known at the time? <i>The department attorney did not make an entry into CMS confirming relevant dates.</i> 			

SOUTH REGION

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

The department attorney did not attend the interview of the officer who used deadly force because the special agent failed to notify the department attorney of the interview.

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

The draft investigative report was not thorough as it failed to include an interview of the sergeant who ultimately stopped the inmate fight and who observed the inmates near the end of the fight. The OIG recommended that the sergeant be interviewed and, after consultation with the special agent and the senior special agent, the sergeant was interviewed and the final report was modified to include information regarding the interview.

- Did the special agent cooperate and provide real-time consultation with the department attorney throughout the investigative phase?

The special agent failed to notify the department attorney of the interview of the officer who used deadly force.

Disposition

The department's independent Deadly Force Review Board found that the discharge of the lethal round was not in compliance with the department's use-of-force policy and the case was referred to the hiring authority for further action. The hiring authority sustained the allegation and imposed a 5 percent salary reduction for 13 months. The OIG concurred. The officer filed an appeal with the State Personnel Board. The officer expressed remorse and appropriate insight into his conduct during settlement discussions. Therefore, the hiring authority agreed to modify some language in the disciplinary action and to remove the disciplinary action from the official personnel file after 18 months without any change in the salary reduction. The OIG concurred because the officer gained appropriate insight into his conduct and expressed remorse, and there was no change to the salary reduction.

Disciplinary Assessment

Rating: Insufficient

The department's disciplinary process did not sufficiently comply with policies and procedures. The department attorney provided inappropriate legal advice to the hiring authority regarding the nature of the use of deadly force and the applicable factors for determining the appropriate penalty, and prepared a draft disciplinary action that demonstrated a continued misunderstanding of use of deadly force and the misconduct involved. The hiring authority failed to properly draft the penalty confirmation form. Following recommendations by the OIG, the hiring authority made the proper findings and penalty determination, and the disciplinary action was properly completed.

Assessment Questions

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

The department attorney mischaracterized the use of deadly force and failed to identify the proper allegations despite the findings made by the department's independent Deadly Force Review Board. In addition, the department attorney failed to identify any use-of-force disciplinary matrix category.

- Did the department attorney provide appropriate legal consultation to the HA regarding disciplinary determinations?

The department attorney failed to identify any discipline specifically related to the use of deadly force and provided incorrect legal advice regarding factors for determining the appropriate penalty, including that the conduct was not intentional because the officer did not intend to violate policy.

- Was the CDCR Form 403 documenting the penalty properly completed?

The penalty confirmation form was not properly completed. The form listed the conduct as both "intentional" and "unintentional" and "premeditated" and "not premeditated" which did not reflect the decision of the hiring authority.

- Was the draft disciplinary action provided to the OIG for review appropriately drafted as described in the DOM?

The draft disciplinary action included an inapplicable allegation, mischaracterized the warning shot, confused the use of less-lethal force and lethal force, and failed to accurately characterize a warning shot as an intentional discharge of a firearm.

SOUTH REGION

Incident Date: 2013-02-03		Deadly Force Incident	
Incident Summary <p>On February 3, 2013, two inmates attacked a third inmate on an exercise yard. One of the two attacking inmates used slashing and stabbing motions toward the third inmate with an inmate-manufactured weapon. Orders to stop the fighting were ineffective. One officer fired one less-lethal round, which failed to stop the fight. A second officer fired one lethal round from a Mini-14 rifle for effect at the inmate wielding the inmate-manufactured weapon, striking the inmate in the abdomen and causing injury. The inmate who was struck with the lethal round was treated at an outside hospital and returned to the institution. The department's deadly force investigation team responded to the scene and conducted a criminal investigation. The OIG also responded. Although no criminal conduct was identified, pursuant to departmental policy, the matter was referred to the district attorney's office for review. The department also opened an administrative investigation, which the OIG accepted for monitoring.</p>			
Criminal Investigation		OIG Case Number: 13-0267-IR	
Investigation Assessment			Rating: Sufficient
The department's investigative process sufficiently complied with policies and procedures.			
Administrative Investigation		OIG Case Number: 13-0268-IR	
	Findings	Initial Penalty	Final Penalty
1. Use of Deadly Force	1. Exonerated	No Penalty Imposed	No Change
Investigative Assessment			Rating: Sufficient
The department's investigative process sufficiently complied with policies and procedures.			
Disposition			
The department's independent Deadly Force Review Board found the discharge of the lethal round was in full compliance with the department's use-of-force policy. The hiring authority subsequently exonerated the officer and the OIG concurred.			
Disciplinary Assessment			Rating: Sufficient
The department's disciplinary process sufficiently complied with policies and procedures.			

APPENDIX F CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

75

CENTRAL REGION

Date Placed on Contraband Watch 2013-06-27	Date Taken off Contraband Watch 2013-07-03	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-07701-CWRM
On June 27, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 03, 2013, six days later. During that time, a supervisor failed to check on the inmate during first watch, as required by departmental policy. The department recovered weapons from the inmate while he was on contraband surveillance watch.			
Incident Assessment			
The department did not provide timely notification to the OIG when the inmate was placed on contraband surveillance watch and failed to sufficiently comply with policies and procedures.			

Date Placed on Contraband Watch 2013-06-27	Date Taken off Contraband Watch 2013-07-03	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-07711-CWRM
On June 27, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 03, 2013, six days later. During that time, the department recovered weapons from the inmate.			
Incident Assessment			
Although the department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch, the department substantially complied in all other critical aspects.			

Date Placed on Contraband Watch 2013-07-10	Date Taken off Contraband Watch 2013-07-13	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-07851-CWRM
On July 10, 2013, the department placed an inmate on contraband surveillance watch because an officer saw the inmate retrieve an unknown object from under the cell door, place it in his mouth, and swallow it. The inmate was removed from contraband surveillance watch on July 13, 2013, three days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

CENTRAL REGION

Date Placed on Contraband Watch 2013-07-15	Date Taken off Contraband Watch 2013-07-18	Reason for Placement Suspected Weapons	Contraband Found Nothing
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Incident Summary 13-07951-CWRM

On July 15, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 18, 2013, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The department did not conduct appropriate medical assessments and address health and safety concerns.

Date Placed on Contraband Watch 2013-07-15	Date Taken off Contraband Watch 2013-07-18	Reason for Placement Suspected Weapons	Contraband Found Nothing
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Incident Summary 13-07971-CWRM

On July 15, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 18, 2013, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. Medical assessments and health and safety concerns were not properly addressed by the department.

Date Placed on Contraband Watch 2013-07-30	Date Taken off Contraband Watch 2013-08-03	Reason for Placement Suspected Weapons	Contraband Found Weapons
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Incident Summary 13-08231-CWRM

On July 30, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 3, 2013, four days later. During that time, the department recovered weapons from the inmate.

Incident Assessment

The department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch and did not adequately comply with policies and procedures in other critical aspects. The department did not conduct appropriate medical assessments and address health and safety concerns.

Date Placed on Contraband Watch 2013-08-11	Date Taken off Contraband Watch 2013-08-15	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary 13-08281-CWRM

On August 11, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 15, 2013, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. Medical assessments and health and safety concerns were not properly addressed by the department.

CENTRAL REGION

Date Placed on Contraband Watch 2013-08-16	Date Taken off Contraband Watch 2013-08-27	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-08391-CWRM
On August 16, 2013, the department placed an inmate on contraband surveillance watch after officers observed him with fecal matter on his hands and clothing while in a holding cell. The inmate was removed from contraband surveillance watch on August 27, 2013, 11 days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-08-16	Date Taken off Contraband Watch 2013-08-20	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-08461-CWRM
On August 16, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 20, 2013, four days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-08-17	Date Taken off Contraband Watch 2013-08-20	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-08471-CWRM
On August 17, 2013, the department placed an inmate on contraband surveillance watch because the inmate reported swallowing a cement object. The inmate was removed from contraband surveillance watch on August 20, 2013, three days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The department did not conduct appropriate medical assessments and address health and safety concerns.			

Date Placed on Contraband Watch 2013-08-20	Date Taken off Contraband Watch 2013-08-23	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-08491-CWRM
On August 20, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 23, 2013, three days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

CENTRAL REGION

Date Placed on Contraband Watch 2013-08-20	Date Taken off Contraband Watch 2013-08-23	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-08501-CWRM
On August 20, 2013, an inmate was placed on contraband surveillance watch because an officer saw the inmate swallow a bindle that appeared to contain a white substance. The inmate was removed from contraband surveillance watch on August 23, 2013, three days later after submitting to an x-ray that was negative for contraband.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-08-25	Date Taken off Contraband Watch 2013-08-28	Reason for Placement Suspected Weapons	Contraband Found Nothing
Incident Summary			13-08611-CWRM
On August 25, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 28, 2013, three days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The policies and procedures regarding the documentation or use of restraints or hand-isolation devices were not followed correctly. Medical assessments and health and safety concerns were not properly addressed by the department.			

Date Placed on Contraband Watch 2013-10-13	Date Taken off Contraband Watch 2013-10-30	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-09231-CWRM
On October 13, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on October 30, 2013, 17 days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The department did not conduct appropriate medical assessments and address health and safety concerns.			

Date Placed on Contraband Watch 2013-10-20	Date Taken off Contraband Watch 2013-10-25	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-09371-CWRM
On October 20, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on October 25, 2013, five days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The policies and procedures regarding the documentation or use of restraints or hand-isolation devices were not followed correctly. Medical assessments and health and safety concerns were not properly addressed by the department.			

CENTRAL REGION

Date Placed on Contraband Watch 2013-10-30	Date Taken off Contraband Watch 2013-11-03	Reason for Placement Suspected Inmate Note	Contraband Found Inmate Note
Incident Summary			13-09521-CWRM
On October 30, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on November 03, 2013, four days later. During that time, the department recovered an inmate note from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-11-02	Date Taken off Contraband Watch 2013-11-12	Reason for Placement Suspected Drugs	Contraband Found 1. Drugs 2. Inmate Note
Incident Summary			13-09531-CWRM
On November 02, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on November 12, 2013, 10 days later. During that time, the department recovered several inmate notes and drugs from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-11-28	Date Taken off Contraband Watch 2013-12-05	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-09951-CWRM
On November 28, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on December 05, 2013, seven days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

NORTH REGION

Date Placed on Contraband Watch 2013-06-08	Date Taken off Contraband Watch 2013-07-30	Reason for Placement Suspected Weapons	Contraband Found Nothing
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Incident Summary

13-07451-CWRM

On June 08, 2013, the department placed an inmate on contraband surveillance watch because the inmate reported swallowing a pen with razor blades attached to both ends. The inmate was transferred to the Department of State Hospitals on July 30, 2013. At the time of transfer, the department confirmed by x-ray that the contraband was still within his body. After medical consultation, it was determined that it was medically contraindicated to surgically remove the contraband.

Incident Assessment

The department did not provide timely notification to the OIG when the inmate was placed on contraband surveillance watch and failed to sufficiently comply with policies and procedures. The inmate was not properly placed on and removed from contraband surveillance watch and the policies and procedures regarding the documentation or use of restraints or hand-isolation devices were not followed correctly. The appropriate documentation was not completed by the department.

Date Placed on Contraband Watch 2013-06-27	Date Taken off Contraband Watch 2013-07-01	Reason for Placement Suspicious Activity	Contraband Found Tobacco
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Incident Summary

13-07651-CWRM

On June 27, 2013, the department placed an inmate on contraband surveillance watch because he was observed with lubricant around his rectum. The inmate was removed from contraband surveillance watch on July 1, 2013, four days later. During that time, the department recovered tobacco from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-06-30	Date Taken off Contraband Watch 2013-07-06	Reason for Placement Suspicious Activity	Contraband Found Nothing
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Incident Summary

13-07721-CWRM

On June 30, 2013, the department placed an inmate on contraband surveillance watch because officers saw an object protruding from the inmate's rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on July 06, 2013, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The department failed to properly remove the inmate from contraband surveillance watch. The appropriate documentation was not completed by the department.

NORTH REGION

Date Placed on Contraband Watch 2013-07-02	Date Taken off Contraband Watch 2013-07-06	Reason for Placement Suspicious Activity	Contraband Found Mobile Phone
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Incident Summary

13-07761-CWRM

On July 2, 2013, the department placed an inmate on contraband surveillance watch because the inmate failed a hand-held metal detector. The inmate was removed from contraband surveillance watch on July 6, 2013, four days later. During that time, the department recovered two mobile phones from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The inmate was not properly removed from contraband surveillance watch.

Date Placed on Contraband Watch 2013-07-13	Date Taken off Contraband Watch 2013-07-19	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary

13-07921-CWRM

On July 13, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 19, 2013, six days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department adequately complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-07-12	Date Taken off Contraband Watch 2013-07-17	Reason for Placement Suspected Weapons	Contraband Found Other
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Incident Summary

13-07931-CWRM

On July 12, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 17, 2013, five days later. During that time, the department recovered three metal screws from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-07-16	Date Taken off Contraband Watch 2013-07-22	Reason for Placement Suspicious Activity	Contraband Found Nothing
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Incident Summary

13-07981-CWRM

On July 16, 2013, the department placed an inmate on contraband surveillance watch because during an unclothed body search, officers observed the inmate with a bindle in his mouth. When ordered to spit it out, the inmate swallowed it. The inmate was removed from contraband surveillance watch on July 22, 2013, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Except for the untimely notification to the OIG regarding placement of the inmate on contraband surveillance watch, the department substantially complied with policies and procedures.

NORTH REGION

Date Placed on Contraband Watch 2013-07-18	Date Taken off Contraband Watch 2013-08-02	Reason for Placement Suspected Weapons	Contraband Found 1. Inmate Note 2. Other 3. Weapons
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Incident Summary

13-07991-CWRM

On July 18, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 2, 2013, 15 days later. During that time, the department recovered weapons, inmate notes, string, and tattoo equipment from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-07-20	Date Taken off Contraband Watch 2013-07-23	Reason for Placement Suspicious Activity	Contraband Found Nothing
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Incident Summary

13-08021-CWRM

On July 20, 2013, the department placed a ward on contraband surveillance watch because the ward reported swallowing a paperclip. The ward was removed from contraband surveillance watch on July 23, 2013, three days later. During that time, the department recovered nothing from the ward.

Incident Assessment

The department adequately complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-08-04	Date Taken off Contraband Watch 2013-08-14	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary

13-08191-CWRM

On August 04, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 14, 2013, ten days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-08-05	Date Taken off Contraband Watch 2013-08-09	Reason for Placement Suspicious Activity	Contraband Found Drugs
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Incident Summary

13-08221-CWRM

On August 5, 2013, the department placed an inmate on contraband surveillance watch because, during a cell search, officers observed him flushing items down the toilet in his cell and discovered a cell phone. The inmate was removed from contraband surveillance watch on August 9, 2013, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The policies and procedures regarding the documentation or use of restraints or hand-isolation devices were not followed correctly.

NORTH REGION

Date Placed on Contraband Watch 2013-08-10	Date Taken off Contraband Watch 2013-08-17	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-08261-CWRM
On August 10, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 17, 2013, seven days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-08-13	Date Taken off Contraband Watch 2013-08-16	Reason for Placement Suspected Inmate Note	Contraband Found Inmate Note
Incident Summary			13-08331-CWRM
On August 13, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 16, 2013, three days later. During that time, the department recovered an inmate note from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-08-14	Date Taken off Contraband Watch 2013-08-17	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-08371-CWRM
On August 14, 2013, the department placed a ward on contraband surveillance watch. The ward was removed from contraband surveillance watch on August 17, 2013, three days later. During that time, the department recovered nothing from the ward.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-08-18	Date Taken off Contraband Watch 2013-08-23	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-08441-CWRM
On August 18, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 23, 2013, five days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

NORTH REGION

Date Placed on Contraband Watch 2013-08-18	Date Taken off Contraband Watch 2013-08-29	Reason for Placement Suspected Weapons	Contraband Found Nothing
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Incident Summary 13-08451-CWRM

On August 18, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 29, 2013, 11 days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The inmate was not properly placed on contraband surveillance watch. The department did not complete the appropriate documentation.

Date Placed on Contraband Watch 2013-08-06	Date Taken off Contraband Watch 2013-08-12	Reason for Placement Suspected Mobile Phone	Contraband Found Mobile Phone
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Incident Summary 13-08481-CWRM

On August 6, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 12, 2013, six days later. During that time, the department recovered a mobile phone from the inmate.

Incident Assessment

Except for the untimely notification to the OIG regarding placement of the inmate on contraband surveillance watch, the department substantially complied with policies and procedures.

Date Placed on Contraband Watch 2013-08-25	Date Taken off Contraband Watch 2013-09-04	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary 13-08601-CWRM

On August 25, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 4, 2013, 10 days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-08-31	Date Taken off Contraband Watch 2013-09-03	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary 13-08641-CWRM

On August 31, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 3, 2013, three days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The policies and procedures regarding the documentation or use of restraints or hand-isolation devices were not followed correctly. The appropriate documentation was not completed by the department.

NORTH REGION

Date Placed on Contraband Watch 2013-09-04	Date Taken off Contraband Watch 2013-09-09	Reason for Placement Suspected Weapons	Contraband Found Nothing
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Incident Summary

13-08721-CWRM

On September 04, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 09, 2013, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The inmate was not properly removed from contraband surveillance watch. The department did not complete the appropriate documentation.

Date Placed on Contraband Watch 2013-09-08	Date Taken off Contraband Watch 2013-09-13	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary

13-08781-CWRM

On September 8, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 13, 2013, five days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department adequately complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-09-11	Date Taken off Contraband Watch 2013-09-17	Reason for Placement Suspected Drugs	Contraband Found Nothing
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Incident Summary

13-08841-CWRM

On September 11, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 17, 2013, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-09-15	Date Taken off Contraband Watch 2013-09-20	Reason for Placement Suspected Tobacco	Contraband Found Nothing
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Incident Summary

13-08871-CWRM

On September 15, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 20, 2013, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The department failed to properly place and remove the inmate from contraband surveillance watch. The appropriate documentation was not completed by the department.

NORTH REGION

Date Placed on Contraband Watch 2013-09-19	Date Taken off Contraband Watch 2013-09-22	Reason for Placement Suspected Tobacco	Contraband Found 1. Drugs 2. Tobacco
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Incident Summary 13-08931-CWRM

On September 19, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 22, 2013, three days later. During that time, the department recovered drugs and tobacco from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-09-21	Date Taken off Contraband Watch 2013-09-25	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary 13-08961-CWRM

On September 21, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 25, 2013, four days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The policies and procedures regarding the documentation or use of restraints or hand-isolation devices were not followed correctly.

Date Placed on Contraband Watch 2013-09-26	Date Taken off Contraband Watch 2013-09-29	Reason for Placement Suspicious Activity	Contraband Found Drugs
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Incident Summary 13-09041-CWRM

On September 26, 2013, the department placed an inmate on contraband surveillance watch because a nurse saw the inmate swallow a bundle containing an unknown substance. The inmate was removed from contraband surveillance watch on September 29, 2013, three days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The department did not complete the appropriate documentation.

Date Placed on Contraband Watch 2013-10-03	Date Taken off Contraband Watch 2013-10-07	Reason for Placement Suspicious Activity	Contraband Found Nothing
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Incident Summary 13-09131-CWRM

On October 03, 2013, the department placed an inmate on contraband surveillance watch because during an unclothed body search, the inmate was observed with a string protruding from his mouth. When ordered to spit it out, he swallowed it. The inmate was removed from contraband surveillance watch on October 07, 2013, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department adequately complied with policies and procedures. No staff misconduct was identified.

NORTH REGION

Date Placed on Contraband Watch 2013-10-06	Date Taken off Contraband Watch 2013-10-13	Reason for Placement Suspicious Activity	Contraband Found 1. Drugs 2. Tobacco
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Incident Summary 13-09141-CWRM

On October 06, 2013, the department placed an inmate on contraband surveillance watch because he was seen kissing his visitor and appeared to be exchanging contraband during the kiss. The inmate was removed from contraband surveillance watch on October 13, 2013, seven days later. During that time, the department recovered drugs and tobacco from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-10-10	Date Taken off Contraband Watch 2013-10-14	Reason for Placement Suspected Weapons	Contraband Found Weapons
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Incident Summary 13-09191-CWRM

On October 10, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on October 14, 2013, four days later. During that time, the department recovered weapons from the inmate.

Incident Assessment

The department adequately complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-10-21	Date Taken off Contraband Watch 2013-10-25	Reason for Placement Suspicious Activity	Contraband Found Inmate Note
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Incident Summary 13-09381-CWRM

On October 21, 2013, the department placed an inmate on contraband surveillance watch because he was seen inserting an unknown object into his rectum. The inmate was removed from contraband surveillance watch on October 25, 2013, four days later. During that time, the department recovered an inmate note from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-10-25	Date Taken off Contraband Watch 2013-10-30	Reason for Placement Suspicious Activity	Contraband Found Nothing
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Incident Summary 13-09431-CWRM

On October 25, 2013, the department placed an inmate on contraband surveillance watch because he was seen placing an object in his rectum. The inmate was removed from contraband surveillance watch on October 30, 2013, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department adequately complied with policies and procedures. No staff misconduct was identified.

NORTH REGION

Date Placed on Contraband Watch 2013-10-28	Date Taken off Contraband Watch 2013-11-09	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-09461-CWRM
On October 28, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on November 09, 2013, 12 days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-11-04	Date Taken off Contraband Watch 2013-11-09	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-09581-CWRM
On November 04, 2013, the department placed an inmate on contraband surveillance watch because he was seen swallowing an unknown object. The inmate was removed from contraband surveillance watch on November 09, 2013, five days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-11-06	Date Taken off Contraband Watch 2013-11-10	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-09641-CWRM
On November 06, 2013, the department placed an inmate on contraband surveillance watch because custody staff observed lubricant around the inmate's rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on November 10, 2013, four days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-11-14	Date Taken off Contraband Watch 2013-11-17	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-09691-CWRM
On November 14, 2013, the department placed an inmate on contraband surveillance watch because officers saw him place an unknown object in his rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on November 18, 2013, four days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The appropriate documentation was not completed by the department.			

NORTH REGION

Date Placed on Contraband Watch 2013-11-16	Date Taken off Contraband Watch 2013-11-27	Reason for Placement Suspected Tobacco	Contraband Found Nothing
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Incident Summary 13-09721-CWRM

On November 16, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on November 27, 2013, 11 days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-12-07	Date Taken off Contraband Watch 2013-12-11	Reason for Placement Suspected Tobacco	Contraband Found 1. Drugs 2. Tobacco
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Incident Summary 13-09991-CWRM

On December 07, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on December 11, 2013, four days later. During that time, the department recovered tobacco and drugs from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The appropriate documentation was not completed by the department.

Date Placed on Contraband Watch 2013-12-12	Date Taken off Contraband Watch 2013-12-18	Reason for Placement Suspicious Activity	Contraband Found Other
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Incident Summary 13-10121-CWRM

On December 12, 2013, the department placed a ward on contraband surveillance watch because the ward failed a metal detector. The ward was removed from contraband surveillance watch on December 18, 2013, six days later. During that time, the department recovered a lighter from the ward.

Incident Assessment

The department sufficiently complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch 2013-12-14	Date Taken off Contraband Watch 2013-12-19	Reason for Placement Suspected Drugs	Contraband Found Nothing
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Incident Summary 13-10141-CWRM

On December 14, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on December 19, 2013, five days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The appropriate documentation was not completed by the department.

SOUTH REGION

Date Placed on Contraband Watch 2013-07-25	Date Taken off Contraband Watch 2013-07-29	Reason for Placement Suspected Drugs	Contraband Found Nothing
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Incident Summary

13-08091-CWRM

On July 25, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 29, 2013, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The inmate was not properly placed on contraband surveillance watch. The department did not complete the appropriate documentation.

Date Placed on Contraband Watch 2013-07-26	Date Taken off Contraband Watch 2013-07-29	Reason for Placement Suspected Drugs	Contraband Found Drugs
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Incident Summary

13-08121-CWRM

On July 26, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on July 29, 2013, three days later. During that time, the department recovered drugs from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The department failed to properly place and remove the inmate from contraband surveillance watch. The appropriate documentation was not completed by the department.

Date Placed on Contraband Watch 2013-08-03	Date Taken off Contraband Watch 2013-08-07	Reason for Placement Suspected Drugs	Contraband Found Nothing
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Incident Summary

13-08181-CWRM

On August 3, 2013, the department placed an inmate on contraband surveillance watch after he was observed swallowing an object provided by a visitor. The inmate was removed from contraband surveillance watch on August 7, 2013, four days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The department failed to properly place the inmate on and remove the inmate from contraband surveillance watch and the policies and procedures regarding the documentation or use of restraints or hand-isolation devices were not followed correctly. The department did not conduct appropriate medical assessments, address health and safety concerns, and complete the appropriate documentation.

SOUTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-08-14	2013-08-17	Suspicious Activity	Nothing

Incident Summary

13-08351-CWRM

On August 14, 2013, the department placed an inmate on contraband surveillance watch after officers discovered four individual bindles in the inmate's possession containing heroin and methamphetamine. During an unclothed body search, the officers further discovered lubricant around the inmate's anal cavity. The inmate was removed from contraband surveillance watch on August 17, 2013, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The department failed to properly remove the inmate from contraband surveillance watch. The appropriate documentation was not completed by the department.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-08-14	2013-08-17	Suspicious Activity	Nothing

Incident Summary

13-08361-CWRM

On August 14, 2013, the department placed an inmate on contraband surveillance watch after custody staff observed lubricant around his anal cavity during an unclothed body search. The inmate was removed from contraband surveillance watch on August 17, 2013, three days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The inmate was not properly removed from contraband surveillance watch. The department did not complete the appropriate documentation.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-08-24	2013-08-30	Suspected Inmate Note	Nothing

Incident Summary

13-08541-CWRM

On August 24, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on August 30, 2013, six days later. During that time, the department recovered nothing from the inmate.

Incident Assessment

The department adequately complied with policies and procedures. No staff misconduct was identified.

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-09-05	2013-09-09	Suspicious Activity	Inmate Note

Incident Summary

13-08731-CWRM

On September 5, 2013, the department placed an inmate on contraband surveillance watch after he was discovered with two bindles in his mouth during an unclothed body search. The inmate was removed from contraband surveillance watch on September 9, 2013, four days later. During that time, the department recovered an inmate note from the inmate.

Incident Assessment

Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The department failed to comply with policies and procedures when placing the inmate on and removing the inmate from contraband surveillance watch. The department did not complete the appropriate documentation.

SOUTH REGION

Date Placed on Contraband Watch 2013-09-07	Date Taken off Contraband Watch 2013-09-13	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-08761-CWRM
On September 7, 2013, the department placed an inmate on contraband surveillance watch because the inmate was seen inserting an unknown object into his rectum and had lubricant around his anus. The inmate was removed from contraband surveillance watch on September 13, 2013, six days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-09-14	Date Taken off Contraband Watch 2013-09-18	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-08861-CWRM
On September 14, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 18, 2013, four days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-09-20	Date Taken off Contraband Watch 2013-09-25	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-08941-CWRM
On September 20, 2013, the department placed an inmate on contraband surveillance watch after the inmate was observed swallowing an object that appeared to be a bindle. The inmate was removed from contraband surveillance watch on September 25, 2013, five days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The department failed to properly place and remove the inmate from contraband surveillance watch.			

Date Placed on Contraband Watch 2013-09-23	Date Taken off Contraband Watch 2013-09-27	Reason for Placement Suspected Drugs	Contraband Found Tobacco
Incident Summary			13-09011-CWRM
On September 23, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on September 27, 2013, four days later. During that time, the department recovered tobacco from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

SOUTH REGION

Date Placed on Contraband Watch 2013-09-23	Date Taken off Contraband Watch 2013-10-01	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-09031-CWRM
On September 23, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on October 1, 2013, eight days later. During that time, the department recovered a weapon from the inmate.			
Incident Assessment			
The department did not provide timely notification to the OIG when the inmate was placed on contraband surveillance watch and failed to sufficiently comply with policies and procedures. The appropriate documentation was not completed by the department.			

Date Placed on Contraband Watch 2013-09-28	Date Taken off Contraband Watch 2013-10-02	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-09071-CWRM
On September 28, 2013, the department placed an inmate on contraband surveillance watch after he was observed swallowing an item that he retrieved from his pant leg. The inmate was removed from contraband surveillance watch on October 02, 2013, four days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The department did not complete the appropriate documentation.			

Date Placed on Contraband Watch 2013-11-03	Date Taken off Contraband Watch 2013-11-09	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-09571-CWRM
On November 03, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on November 09, 2013, six days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
Except for the untimely notification to the OIG regarding placement of the inmate on contraband surveillance watch, the department substantially complied with policies and procedures.			

Date Placed on Contraband Watch 2013-11-03	Date Taken off Contraband Watch 2013-11-09	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-09611-CWRM
On November 03, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on November 09, 2013, six days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
Although the department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch, the department substantially complied in all other critical aspects.			

SOUTH REGION

Date Placed on Contraband Watch 2013-11-30	Date Taken off Contraband Watch 2013-12-04	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-09891-CWRM
On November 30, 2013, the department placed an inmate on contraband surveillance watch because officers saw lubricant around his rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on December 04, 2013, four days later. During that time, the department recovered drugs from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-12-07	Date Taken off Contraband Watch 2013-12-12	Reason for Placement Suspected Weapons	Contraband Found Nothing
Incident Summary			13-10001-CWRM
On December 07, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on December 12, 2013, five days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
Although the department provided adequate notification to the OIG when placing the inmate on contraband surveillance watch, it did not sufficiently comply with policies and procedures in other critical aspects. The inmate was not properly placed on contraband surveillance watch. The department did not conduct appropriate medical assessments, address health and safety concerns, and complete the appropriate documentation.			

Date Placed on Contraband Watch 2013-12-08	Date Taken off Contraband Watch 2013-12-19	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-10021-CWRM
On December 08, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on December 19, 2013, 11 days later. During that time, the department recovered pieces of razor blades from the inmate.			
Incident Assessment			
The department did not sufficiently comply with policies and procedures, although it did provide timely notification to the OIG when the inmate was placed on contraband surveillance watch. The department failed to properly remove the inmate from contraband surveillance watch. The appropriate documentation was not completed by the department.			



SEMI-ANNUAL REPORT
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STATE OF CALIFORNIA
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