

Robert A. Barton
Inspector General

Office of the Inspector General

SEMI-ANNUAL REPORT

January–June 2013

Volume II



October 2013

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

Office of the Inspector General

SEMI-ANNUAL REPORT

January–June 2013

Volume II



Robert A. Barton
Inspector General

Roy W. Wesley
Chief Deputy Inspector General

James C. Spurling
Chief Counsel

Renee L. Hansen
*Executive Director,
California Rehabilitation Oversight Board
Public Information Officer*

October 2013



FOREWORD

This 17th Semi-Annual Report covers the time period of January through June 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. Traditionally, our semi-annual reports have primarily served this purpose. In addition to its oversight of CDCR's employee discipline process, the Legislature relies on the OIG to use our real-time monitoring model to provide oversight and transparency in several other areas within the state prison system. Therefore, we are now publishing our semi-annual reports in a two-volume format to allow readers to more easily distinguish the various categories of oversight activity.

This is the second report using the two-volume modified format. In the new format, Volume I is a summary of monitored cases in the employee discipline process. Cases are reported at the end of the Investigative Phase and again at the end of the Disciplinary Phase; or, if the matter was resolved entirely within the reporting period, there is a combined assessment. An appendix for each assessment is included in this report. We also include any recommendations made in each phase as we continually strive to add value to the review process. We also assess the sufficiency of each case based on CDCR's overall handling of the case. Our assessment of a case may be based on process, outcome, or both.

Volume II is a summary of OIG monitoring activities other than employee discipline monitoring. Volume II reports our monitoring and assessment of the department's handling of critical incidents, including its handling of incidents involving deadly force. It also reports our monitoring of CDCR's adherence to its contraband surveillance policy, and our monitoring of use-of-force reviews within the department. Since each of these activities is monitored on an ongoing basis, we have combined them all 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.....	9
CONCLUSION	16
VOLUME II RECOMMENDATIONS.....	19
APPENDICES	20
(LISTED BY GEOGRAPHICAL REGION)	
<i>D – Critical Incident Case Summaries.....</i>	<i>21</i>
<i>E – Deadly Force Incident Case Summaries</i>	<i>47</i>
<i>F – Contraband Surveillance Watch Case Summaries</i>	<i>67</i>

SUMMARY OF OTHER MONITORING ACTIVITIES

In addition to our monitoring of the California Department of Corrections and Rehabilitation's (CDCR or the department) employee discipline process as reported in Volume I, the Office of the Inspector General (OIG) also monitors critical incidents, use of force, and contraband surveillance watch within CDCR. We report the results of each of these monitoring activities in this volume of our Semi-Annual Report. This not only reduces the overall number of reports being published and improves efficiency, but also gives the reader a wider view of OIG monitored activities in one place. Volume II reports on these activities for the time period January through June 2013.

Historically, the OIG has maintained response capability 24 hours per day, seven days per week for any critical incident occurring within the prison system. The OIG staff responds 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.

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 department takes a narrower view than the OIG on what incidents of deadly force require a Deadly Force Investigation Team response, and when to launch such a response may also be limited by legitimate budgetary constraints.

The OIG has also historically monitored and reported on use-of-force incidents and CDCR's subsequent review process. In the past, use-of-force assessments were published in a stand-alone report. Since the six-month use-of-force monitoring cycle mirrors the OIG's other monitoring time frames, these assessments will now be incorporated into Volume II of the Semi-Annual Report. 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 detailed 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 will monitor the ensuing investigation.

During the reporting period, the OIG completed assessments of 93 critical incidents (Appendix D). Four of these incidents were referred to the Office of Internal Affairs for potential investigation. 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 during these time frames, but rather reflects the number of incidents the OIG has closed out and assessed for the time period. Additionally, in order for the OIG 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.

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 9 and detailed in Appendix F.

The total number of monitored critical incidents that were closed and reported each year by the OIG is displayed in the following chart. 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 double 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 incidents reported by juvenile facilities.

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

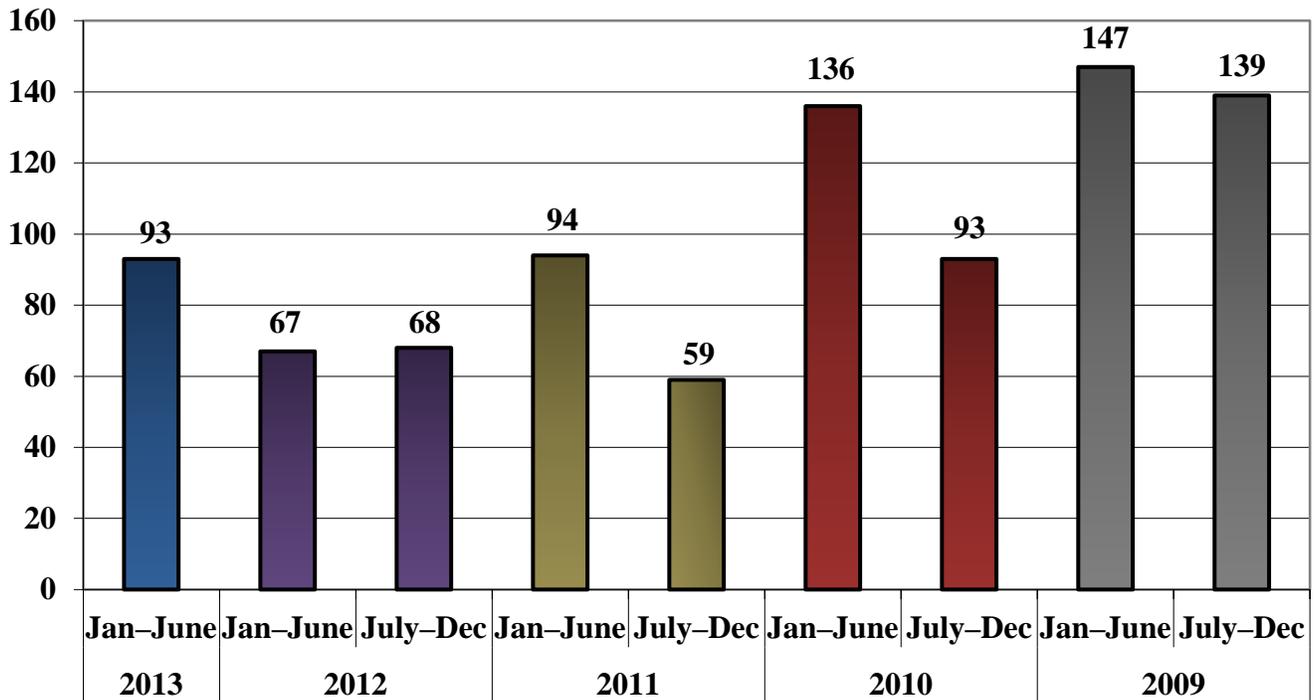
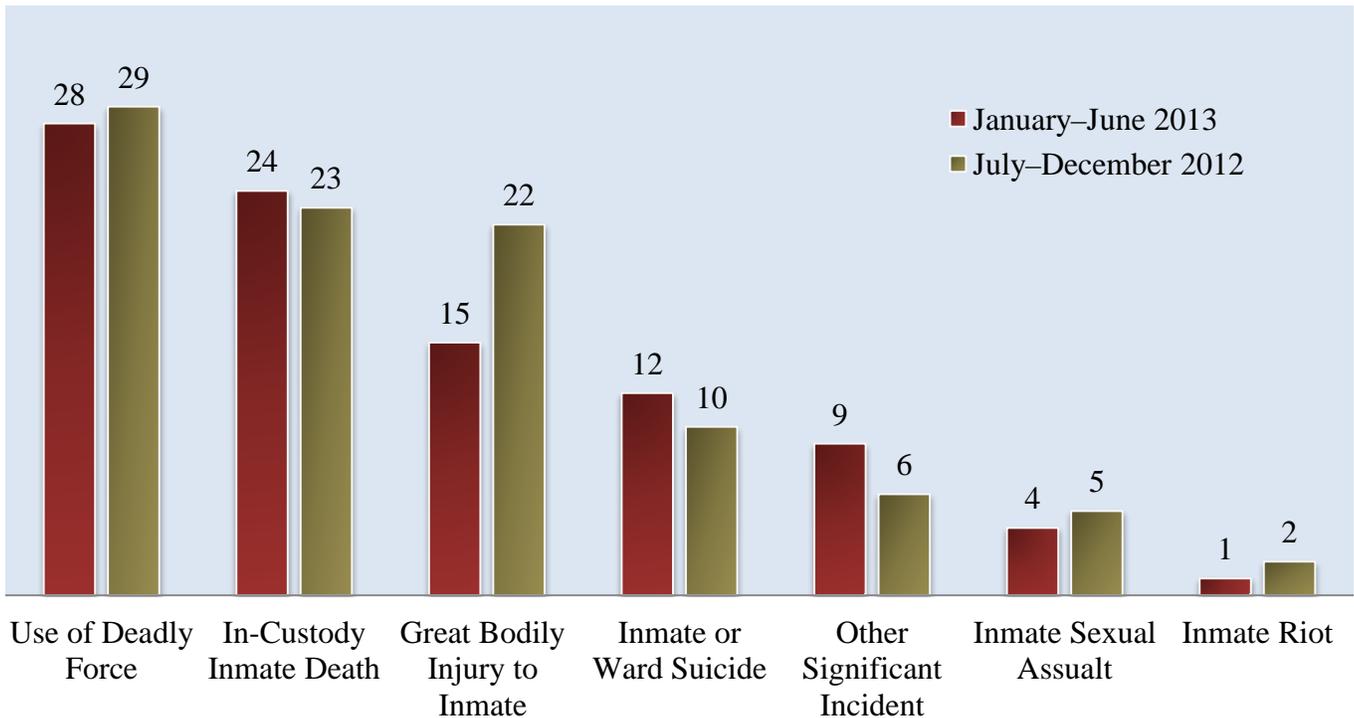


Chart 2: Types of Critical Incidents



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. The OIG has reorganized this report to include an additional appendix containing 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.

Department policy requires criminal and administrative investigations to be immediately conducted on all deadly force incidents. These investigations are conducted by an Office of Internal Affairs Deadly Force Investigation Team. However, the OIG has a more expansive definition than does the department of what constitutes sufficient cause to task the Deadly Force Investigation Team with the investigation of a deadly force incident. The OIG monitors any intentional application of deadly force, including the use of batons or less-lethal weapons used in a lethal manner; for example, when a baton or 40mm round strikes an inmate’s head. Unintentional head strikes and warning shots are also monitored by the OIG as deadly force

incidents due to the potential for death. The Office of Internal Affairs Deadly Force Investigation Team is described and regulated by California Code of Regulations, Title 15, 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 incidents warrants additional scrutiny and review regardless of whether any misconduct is suspected, or whether the ultimate result of the force is an actual death.

All Deadly Force Investigation Team incidents usually require review by the Deadly Force Review Board. The OIG participates as a non-voting member of the department's Deadly Force Review Board. The Deadly Force Review Board reviews those cases where the Office of Internal Affairs utilizes 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 28 deadly force incidents that concluded during this reporting period. The incidents ranged from unintentional head strikes, to warning shots, to intentional uses of lethal weapons.

The Deadly Force Investigation Team has been inconsistent in choosing to investigate unintentional head strikes. The OIA responded with a Deadly Force Investigation Team in 5 of the 28 cases. The first case involved an accidental firing of one round into a wall by an observation booth officer preparing to end his shift. Two other Deadly Force Investigation Team cases involved lethal force: an off-duty officer fired two warning shots from a personal weapon

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

during an altercation with an unknown person on his property, and a parole agent fired four rounds into a suspected high-risk parolee's torso when the parolee refused to drop a weapon. A fourth case involved less-lethal force when a sergeant fired nine less-lethal rounds at an inmate who refused to drop a weapon, unintentionally striking him in the head with the last round. These cases went to the Deadly Force Review Board and the force used against the parolee and the nine less-lethal rounds fired by the sergeant were found to be in compliance with departmental policy. The accidental discharge of a round on duty and the warning shots fired by the off-duty officer were determined to be out of compliance with departmental policy.

The fifth Deadly Force Investigation Team case was an anomaly because it did not go to the Deadly Force Review Board. It involved a parole agent who accidentally shot himself with his duty weapon during an attempt to locate a parolee wanted in a homicide investigation. Initially, the OIA responded with a Deadly Force Investigation Team, but after concluding the lethal force used was inadvertently self-inflicted and was not life threatening, the case was not forwarded to the Deadly Force Review Board but went through the institution's regular use-of-force review.

The remaining 23 incidents where the OIA Deadly Force Investigation Team did not respond were all monitored by the OIG as potential deadly force incidents. Nine of these cases were warning shots. Per the California Code of Regulations section 3268, a Deadly Force Investigation Team need not respond; however, the OIG has the ability to request their response if any misconduct is suspected. There were six cases where a baton strike by an officer using less-lethal force inadvertently struck an inmate in the head. Three of those instances required outside hospitalization for swelling, bruising, and sutures to the head.

The remaining eight potential deadly force incidents each involved the use of a 40mm less-lethal direct impact round being fired at an authorized target zone, but due either to inmate movement or to ricochet of the round, resulted in an unintentional strike to the head. In one of these cases, the inmate was treated at the institution for minor injuries. In the other seven cases, the inmates were sent to outside hospitals with injuries including sutures to head wounds, bruising, swelling, facial fractures, and two incidents of bleeding on the brain. It is unclear to the OIG why one case involving a 40mm head shot merited a Deadly Force Investigation Team response and the others did not.

The OIG recommends a Deadly Force Investigation Team respond to cases involving baton strikes or 40mm impact rounds, even if done unintentionally, in cases involving great bodily injury, as required by policy. As this report shows, three of the baton cases and seven of the direct impact round cases resulted in head injuries requiring outside hospital care. Any of these cases could have resulted in death, and in all ten of them, a Deadly Force Investigation Team should have responded.

These cases are all reported in Appendix E.

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 peace 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 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 response is monitored and reported.

⁴ Department Operations Manual, Chapter 5, Article 2.

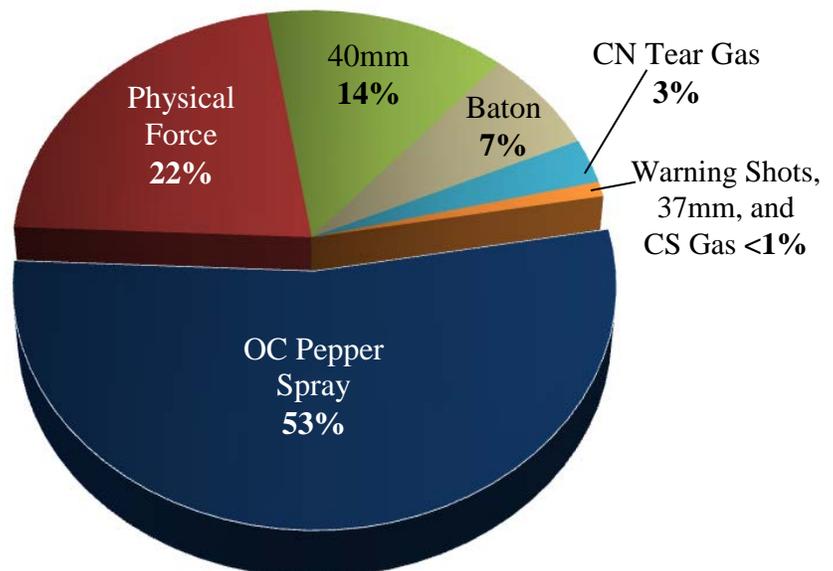
The time period covered in this report is January 1, 2013, through June 30, 2013. During this reporting period and the prior reporting period, the OIG suspended its structured paper reviews of use-of-force incidents. The OIG continues to attend at least one use-of-force committee meeting each month at each prison, juvenile facility, and parole region.

In July 2012, after collaboration with the OIG, the department developed a new enhanced process for reviewing use-of-force incidents. The new process would not require that each case be presented to the Institutional Executive Review Committee, but rather all stakeholders (including the OIG) would review every case, and if no issues were identified, the case would be forwarded to the warden for recommended action. For any case where an issue was identified by any reviewer, the case would be formally reported and discussed at the Institutional Executive Review Committee. This change required formal approval by the department. Unfortunately, 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 expects the new use-of-force review process to be implemented soon. In the interim, we have 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.

During this reporting period the OIG attended 271 use-of-force meetings where a total of 1,617 incidents (50 percent of the total incidents for this period) were evaluated. Generally, each committee meeting evaluates 5 to 15 incidents involving force. The OIG also 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.

For this reporting period, the department reports there were 4,476 applications of force, arising out of 3,219 incidents. Not all incidents are reportable in this time frame, and more than one type or application of force may be used in a single incident. Pepper spray was used in 53 percent of the use-of-force cases, and physical force was applied in 22 percent of incidents. Less-lethal force from 40mm impact rounds was deployed in 14 percent of incidents, totaling 89 percent of the use-of-force incidents. The remaining 11 percent included baton and CN tear gas, with less than one percent involving warning shots, 37mm, or CS gas.

Chart 3: Types of Force in Monitored Incidents



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 177 individual cases. In the cases reviewed, the department found the actual force used was within policy 95 percent of the time at adult institutions, 96 percent of the time within the juvenile facilities, and 100 percent of the time in the parole regions.

In 99 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 has a high rate of policy adherence for actual force used. 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, 24 percent of adult institution cases, 6 percent of juvenile facility cases, and 4 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 scheduled to be piloted November 2013, at select prisons throughout the state, is fully implemented. Once the process is fully developed and piloted, the OIG will monitor and report on its progress, and anticipates monitoring a much higher percentage of overall cases. In addition, policy adherence does not automatically mean that CDCR's policies cannot be improved. The department still has challenges in the use of OC pepper spray 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 the 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. In March 2012 the OIG began a four-month pilot program to develop a method to monitor CDCR's contraband surveillance watch process. 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 when an inmate is placed on contraband surveillance watch. The OIG collects all relevant data, including the name of the inmate, the reason the inmate was placed on contraband surveillance watch, what contraband was actually found, and the dates the inmate was placed on and taken off watch. The OIG only formally monitors incidents where the inmate is kept on contraband surveillance watch longer than 72 hours, unless there is a significant medical problem. The 72-hour period initiates our on-scene monitoring due to the increased potential for significant medical issues beyond that time frame. For those incidents where contraband surveillance watch extends beyond 72 hours or there is a significant medical issue, 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 would be immediately discussed with institution managers while on scene.

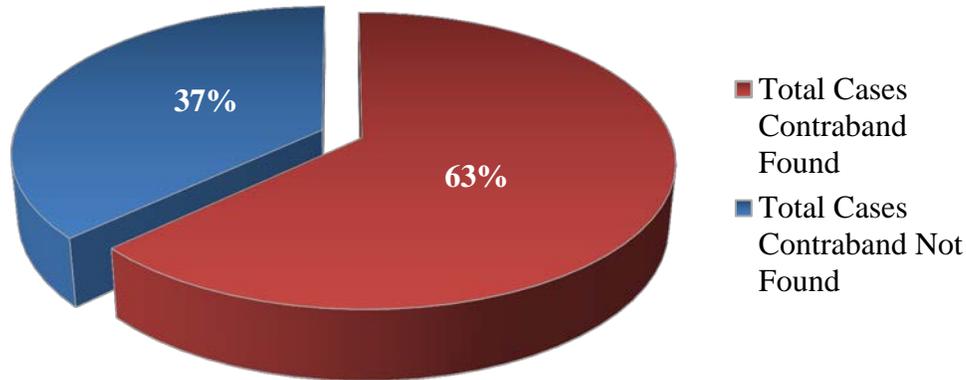
This report is the second OIG report on contraband surveillance watch. It should be noted that the OIG's contraband surveillance watch monitoring program will continue to evolve based on experience in the field. During this reporting period, the OIG was notified of 293 contraband surveillance watch incidents. Of these incidents, inmates were kept on watch longer than 72 hours in 92 incidents, including 15 incidents where inmates were kept on watch longer than 144 hours, and 8 incidents longer than 216 hours. This report covers the 92 incidents that extended beyond 72 hours. There were zero incidents during this reporting period where the OIG went on scene as a result of medical concerns. There were 201 cases that did not extend beyond 72 hours. Of those cases, 43 resulted in contraband being recovered, and 158 did not.

Chart 4: Duration of Contraband Surveillance Watch Cases



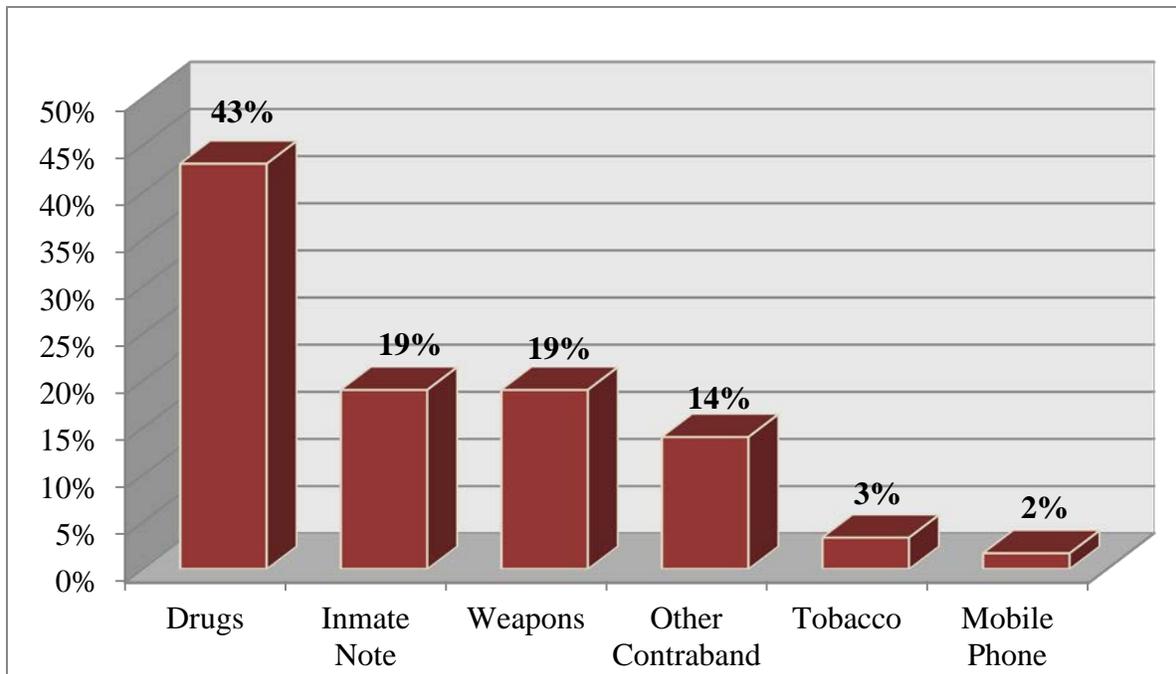
Contraband was found in 63 percent of the 92 monitored contraband surveillance watch cases that extended beyond 72 hours.

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 (58 of the 92), contraband was found. Drugs were recovered in 43 percent of the monitored cases where contraband was found, while another 38 percent of contraband recovered represented weapons and inmate notes.

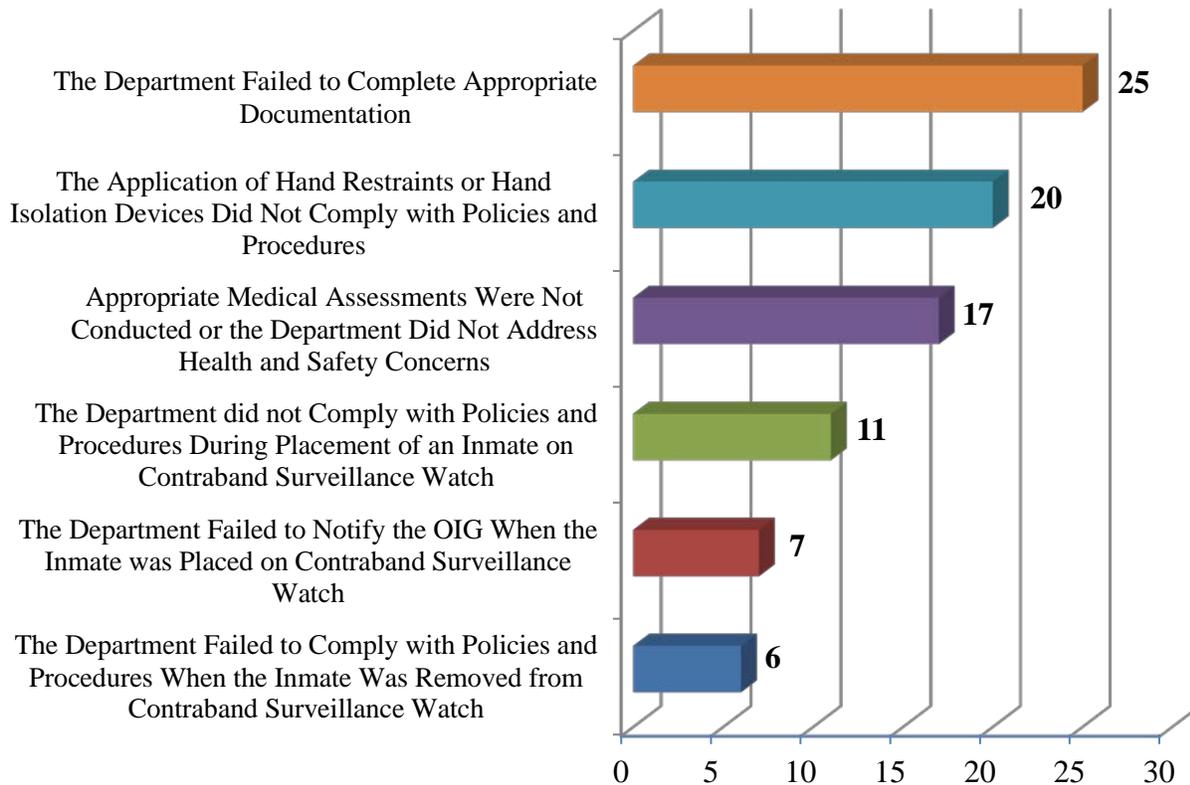
Chart 6: Contraband Type and Frequency in Monitored Cases



The OIG shares the department’s concern that the introduction of contraband such as drugs or weapons into the 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.

While the department’s decision was within policy for placing an inmate on contraband surveillance watch in all the of the 92 monitored cases, there were a total of 86 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 92 monitored contraband surveillance watch cases that extended beyond 72 hours, the majority of process violations involved failures to complete appropriate documentation, incorrect application of hand isolation devices, and failures to conduct medical assessments or address health and safety concerns.

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.

⁵ Department Operations Manual, section 52050.23.1

Chart 8 details the number of contraband surveillance watch cases that occurred during this monitoring period at each institution.

Chart 8: Contraband Surveillance Watch Cases by Institution Jan–June 2013

	Number of CSW Incidents by Institution	Less than 72 Hours	72 to less than 144 hours	144 to less than 216 hours	216 to 373 hours
ASP	6	4	2		
CAL	6	5	1		
CCC	28	19	8	1	
CCI	10	8	2		
CEN	26	19	7		
CIM	2	1	1		
CIW	1	1			
CMC	4	3	1		
CMF	2	1	0		1
COR	10	4	3	1	2
CRC	19	17	2		
CTF	2	2			
CVSP	1	1			
DVI	6	1	2	3	
FSP	8	5	1	2	
FWF	0				
HDSP	4	2	1	1	
ISP	7	6	1		
KVSP	15	12	3		
LAC	14	10	3		1
MCSP	3	3			
NACYCF	9	9			
NCYCC	1	1			
NKSP	5	2	3		
PBSP	14	10	3	1	
PVSP	10	10			
RJD	5	4	1		
SAC	15	9	6		
SATF	1	1			
SCC	3	3			
SOL	6	4		1	1
SQ	12	5	5	2	
SVSP	24	10	10	2	2
VSP	4	3	1		
WSP	10	6	2	1	1
Total CSW Cases	293	201	69	15	8
		Contraband Recovered: 43 Cases = 21%	Contraband Recovered: 39 Cases = 57%	Contraband Recovered: 13 Cases = 87%	Contraband Recovered: 6 Cases = 75%

There were eight cases in this reporting period that extended beyond nine days. In six cases contraband was recovered, including weapons, drugs, a chain, metal pieces, a sewing needle, aluminum foil, and an eyedropper.

The longest duration for contraband surveillance watch this reporting period was 373 hours. The inmate was initially placed on contraband surveillance watch for 332 hours after an X-ray confirmed he ingested razor blades. The inmate was removed from watch in this first case without recovering the contraband, and no policy violations were noted. He was then placed back on a second watch two days later for an additional 373 hours, this time recovering two razor blades. This particular inmate was also on a hunger strike, and requested to remain on contraband surveillance watch until he was transferred due to his fear of attack by other inmates. The department had several policy violations during the 373-hour contraband surveillance watch, including lack of documentation of restraints applied, lack of documentation regarding medical assessment or health and safety concerns, and lack of documentation authorizing the inmate to remain on watch.

In a third case, an inmate was kept on contraband surveillance watch for 351 hours and transported to an outside hospital for a medical procedure to recover the contraband. Prior to the procedure, the inmate passed five razor blades, a dismantled set of nail clippers, pen fillers, and a sewing needle. After an X-ray confirmed all foreign items were removed, the inmate was taken off contraband surveillance watch. The department had several policy violations in this case, including failure to comply with procedures when placing the inmate on watch, failure to conduct medical assessments or address health and safety concerns, and failure to complete appropriate documentation.

A fourth incident lasted 340 hours, and drugs were recovered. This case fully complied with policies and procedures. A fifth case lasted 302 hours, resulting in the inmate being transported to an outside hospital for a medical procedure to recover three razor blades. The inmate was returned to the institution and removed from contraband surveillance watch. The department complied with all policies and procedures in this case.

A sixth contraband surveillance watch case lasted 299 hours and recovered pieces of an envelope clasp, aluminum foil, and a paper clip. After a clear X-ray scan, the inmate was removed from watch. The department failed to timely notify the OIG when the inmate was placed on contraband surveillance watch, and failed to comply with the policies and procedures governing restraints or hand isolation devices.

The seventh and eighth cases that extended beyond nine days included inmates placed on watch for 267 hours and 216 hours, respectively. In the seventh case, nothing was recovered from the inmate. The department failed to follow procedures regarding the application of hand restraints, and failed to complete appropriate documentation. In the eighth case, the inmate passed a metal chain and eyedropper, but was released from watch at 216 hours although he had not yet passed the metal tubing identified by X-ray. Over a month after the inmate was removed from watch, he received a medical procedure to remove the tubing. The department failed to follow procedures when placing the inmate on contraband surveillance watch, and failed to follow procedures when removing the inmate from watch.

Although the department met its criteria in all cases to justify placing an inmate on contraband surveillance watch, there were 86 subsequent policy violations in 46 monitored contraband surveillance watch cases; there were no policy violations in 44 cases. In nearly 30 percent of monitored contraband surveillance watch cases, the department failed to complete appropriate documentation. Another 23 percent of the time, the department failed to properly apply or use restraints and hand isolation devices, and 20 percent of the time, the department failed to conduct appropriate medical assessments to address health and safety concerns.

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.

CONCLUSION

The goal of publishing the OIG's Semi-Annual Report in two volumes was 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, 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 93 critical incidents. There were 20 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. Timely notification insufficiencies have doubled from the prior reporting period, and among the 28 Deadly Force Incidents identified by the OIG, 13 received insufficient ratings, and of these 13, seven were due in part to the department's failure to timely notify the OIG. In addition, there were two insufficient ratings given due to inadequate documentation in combination with other deficiencies, three due to violation of videotaping policy, and others due to untimeliness in reporting and failure to comply with disciplinary procedures.

Among the 65 non-deadly-force critical incidents, only eight resulted in insufficient ratings, seven of which were due to untimely reporting and documentation. One case received an additional explanation for its insufficient rating involving potential staff misconduct leading to an inmate escape that should have been investigated by the Office of Internal Affairs.

As described within this report, the OIG now separates out deadly force incidents in their own appendix. The OIG recommends that the department address its fiscal constraints to allow an Office of Internal Affairs Deadly Force Investigation Team response to any discharge of a firearm. Although the department is not required to investigate confirmed warning shots that do not result in injury, it is the OIG's position that this use of force merits an investigation. As in the past, the OIG will notify the department and recommend on-scene response when OIG monitors believe there is potential misconduct, regardless of the department's fiscal constraints.

The OIG has also discussed with the department the level of scrutiny needed when unconventional deadly force is used, such as an intentional blow to the head from a baton or 40mm round. Certain weapons are classified as less lethal, and training is provided to officers indicating target zones on the human body to reduce the likelihood of inflicting deadly force.

However, there are times when such weapons are *intentionally* used in a lethal manner to prevent the death of another inmate or staff member. The OIG contends that any intentional blow to the head, even if it does not result in serious injury, is still potentially out of policy and potentially a crime if there is no justification to use deadly force. While no such incidents occurred during this

reporting period, they have occurred in the past with mixed response from the department.

There are also times that weapons *unintentionally* strike a potentially lethal zone on a person, such as the head. In this report there were six such instances involving batons, including three instances that required transport to an outside hospital and sutures of head wounds. Nine cases involved less-lethal rounds that struck inmates in the head, sending seven of them to outside hospitals for various degrees of injury, with two not requiring outside hospitalization, including the case that had a Deadly Force Investigation Team response and Deadly Force Review Board hearing.

The OIG recommends that any case where potential deadly force is unintentionally applied, but could potentially cause death or serious injury, receive a deadly force investigation. Again, the department cites lack of resources for the practice of using the inmate's injury report as the determinative factor. Unfortunately, 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 initiate a Deadly Force Investigative Team for all such cases. During this reporting period, excluding the cases where serious injury was ruled out by medical staff at the institution, the department would only have had to conduct ten additional investigations to be in compliance with OIG's position: three baton head strike cases and seven 40mm head shot cases requiring outside hospitalization. Again, the OIG recommends that the department address its fiscal constraints to provide a Deadly Force Investigation Team response to these cases. Failure to do so may result in the same failure that OIG previously reported in the 2006 special report on inmate Provencio's death: specifically, the failure to routinely conduct an administrative investigation of potential staff misconduct arising from an unintentional 40mm head shot that became a deadly force incident.

The use of force 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 our use-of-force monitoring, attended 271 committee reviews, reviewed 1,617 use-of-force incidents (approximately 50 percent of the total incidents), and made 177 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 (24 percent in adult institutions, 6 percent in juvenile facilities, and 4 percent in parole), possibly due to mandates requiring a review within 30 days. The OIG determined at the outset of our use-of-force monitoring that reviews are meaningless in cases that lacked the proper preparation.

The OIG monitoring of contraband surveillance watch continues to evolve, but so far OIG monitoring has been able to identify areas needing improvement. The OIG recommends the department develop a more specific policy that defines the official onset time of the contraband surveillance watch period. For example, 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. It is imperative that the contraband surveillance watch time frame be definitive and measurable, as required by policy.

Lengthy periods of contraband surveillance watch and medical crises were concerns prompting OIG monitoring. However, during this reporting period, the OIG found no instances where the contraband surveillance watch precipitated a medical crisis. There were eight cases an inmate was kept on contraband surveillance watch longer than nine days, although two of those cases involved transfer to an outside hospital. Two of the longer cases (373 and 332 hours) involved the same inmate who was also on a hunger strike and actively requesting placement in an isolation cell. A fourth case was 340 hours in duration, with no policy violations by the department. The remaining three cases all had several policy violations, although none caused medical distress. In addition, two of those three cases did result in recovery of contraband.

While the OIG monitors contraband surveillance watch cases that extend longer than 72 hours, the department is required to provide the OIG with notification any time an inmate is placed on watch. In 37 percent of the monitored cases, contraband was not found; however, there was no evidence that any one of these instances was punitively imposed. Violations of policy and procedure occurred in 51 percent of the contraband surveillance watch cases. This failure to adhere to policy must be immediately addressed and remedial measures implemented through training and holding those responsible for the deficiencies accountable.

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 three recommendations from Volume II of the Semi-Annual Report, January–June, 2013.

The frequency of insufficient ratings has increased from the OIG's last report from 10 percent to nearly 22 percent, although the majority of the problems still revolve around timely notification. Since the last reporting period, 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.

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

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. 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 initiate a Deadly Force Investigative Team for all such cases, yet only one case received such a response.

- 2.2** 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.

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

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 contacted the OIG that contraband surveillance watch was initiated once the inmate was actually placed in isolation with the proper restraints.

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

Violations of policy and procedure occurred in 51 percent of the contraband surveillance watch cases this reporting period. The failure to adhere to policy must be immediately addressed.

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

APPENDICES

Appendix D contains the assessments for 65 critical incidents monitored during this reporting period, listed by geographical region.

Appendix E contains the assessments for 23 deadly force investigative case summaries monitored during the reporting period, listed by geographical region.

Appendix F contains the results and outcomes of 92 OIG-monitored contraband surveillance watch cases during the reporting period, listed by the date the inmate was placed on CSW.

APPENDIX D

CRITICAL INCIDENT CASE SUMMARIES

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2011-01-15	11-0240-RO	In-Custody Inmate Death
Incident Summary On January 15, 2011, officers discovered that an inmate was in distress and appeared confused in his cell. Officers assisted the inmate into a wheelchair and escorted him to the triage treatment area. Medical staff determined the inmate's condition was deteriorating. The inmate was transported to an outside hospital by ambulance where he was pronounced dead after life-saving measures failed.		
Disposition An autopsy determined that the inmate suffered a perforated bowel, through which toxins were released into his system causing his death. The department's Death Review Committee determined that the death was possibly preventable. The committee identified alleged instances where the standard of care was not met because tasks such as vital signs were not documented or completed as required. The committee referred the case to the Medical Oversight Program for an inquiry. Potential staff misconduct was identified. The Office of Internal Affairs opened an investigation because it appeared that a refusal of medical treatment form was possibly falsified by medical and custody staff the day before his death. The OIG did not accept the subsequent case for monitoring because the department's medical system is under federal receivership.		
Overall Assessment		Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department's notification and consultation with 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
2011-09-06	11-2240-RO	Other Significant Incident
Incident Summary On September 6, 2011, officers reported they were escorting an inmate in waist restraints when the inmate slipped off one of his handcuffs and hit one of the officers in the eye with his fist. The officer stated he immediately defended himself by hitting the inmate in the face, causing the inmate to fall to the ground. The officer and responding officers used physical force and control holds to apply handcuffs to the inmate as he resisted by thrashing his body from side to side. Once the inmate was placed in handcuffs he stopped resisting. The attacked officer suffered a broken hand and injury to his eye necessitating transport to a local hospital for treatment. The inmate sustained minor abrasions to his cheek and forearm, and redness to the back of his head.		
Disposition Potential staff misconduct was identified; therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring. The officers were allegedly dishonest when they reported the inmate was in restraints as required by policy and when they failed to report the force they used and observed. Upon completion of the investigation, the institution's executive review committee determined the officers' actions prior to the use of force violated departmental policies and procedures because the inmate was not in restraints, leading to the need to use force; however, the force used complied with departmental policy. The OIG concurred with the committee's review.		
Overall Assessment		Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG agreed with the hiring authority's decision to refer the matter to the Office of Internal Affairs.		

CENTRAL REGION

Incident Date	OIG Case Number	Case Type
2012-04-21	12-0898-RO	In-Custody Inmate Death

Incident Summary

On April 21, 2012, an officer discovered an inmate lying face down and motionless in a dining hall during the morning meal. The officer activated her alarm and waited for custody staff to arrive. Responding officers noticed blood around the inmate's head and started life-saving measures after determining the inmate was not breathing and had no pulse. Medical staff arrived within two minutes of the alarm and took control of the medical emergency. The inmate was transported to the medical clinic. Paramedics arrived and transported the inmate to an outside hospital where he was pronounced dead after life-saving measures failed.

Disposition

The autopsy revealed the cause of death was due to brain swelling that resulted from blunt force head trauma. The deceased inmate was involved in a fist fight. Witnesses said he fell and hit his head on the hard floor after he was struck by another inmate. The assailant voluntarily admitted to fighting with the inmate. Potential staff misconduct was identified; therefore, the matter was referred to the Office of Internal Affairs for investigation and the OIG is monitoring the case. The officer that discovered the inmate allegedly had overly familiar relationships with inmates, neglected her duty as it related to tool control in the kitchen, was insubordinate, and was dishonest to her supervisor.

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 to refer the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2012-05-15	12-1078-RO	Suicide

Incident Summary

On May 15, 2012, an inmate was involved in a cell fight. Officers used pepper spray to stop the fight and then rehousing the inmates in separate cells. Later in the day, the inmate was found hanging by the neck from a shoestring which was tied to the end of his bunk. Responding officers cut down the inmate and began life-saving measures. Medical staff arrived and took over the medical emergency. The inmate was transported to the triage treatment area as life-saving measures continued. The inmate was pronounced dead after life-saving efforts failed.

Disposition

An autopsy was performed and the cause of death was determined to be suicide by hanging. The executive summary suicide report noted a lack of follow-up and an inadequate clinical review. A quality improvement plan was developed and training was provided to mental health staff members. 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 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 not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2012-07-18	12-1684-RO	Other Significant Incident

Incident Summary

On July 18, 2012, an inmate returned to the institution after attending court. While leaving the transport van, the inmate removed his restraints and attacked two officers. During the attack, one officer was slashed in the face, neck, and legs with a six-inch inmate-manufactured weapon. The two officers physically forced the inmate to the ground and reapplied the restraints. The injured officer was transported to a local hospital for treatment.

CENTRAL REGION

Disposition

The institution's executive review committee determined the officer's use of force was within departmental policy and the OIG agreed. However, potential staff misconduct was identified; therefore, the hiring authority referred the case to the Office of Internal Affairs. Officers allegedly did not follow security protocols that led to the inmate smuggling a weapon into the court, back to the prison, slipping his restraints, and stabbing the officer. The Office of Internal Affairs referred the matter back to the hiring authority for determination of training, corrective action, or disciplinary action. The OIG accepted the case for monitoring.

Overall Assessment

Rating: Sufficient

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG on 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
2012-08-01	12-1811-RO	In-Custody Inmate Death

Incident Summary

On August 1, 2012, an officer responded to a cell after hearing "man down." The officer discovered an inmate in a slumped-over sitting position with a towel around his neck. A second inmate stated there was something wrong with his cellmate. The second inmate was secured and removed from the cell. The first inmate was also removed from the cell. Custody and medical staff administered life-saving measures, without success. Although a possible ligature was found around the first inmate's neck, there were no ligature marks. The cell was secured and treated as a crime scene. The district attorney's investigators and county coroner responded.

Disposition

An autopsy revealed the cause of death was a heart attack during an altercation with a contributing factor of blunt force head trauma. 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 overall response to the incident was adequate 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; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2012-08-28	12-2270-RO	Suicide

Incident Summary

On August 28, 2012, an inmate in the administrative segregation unit was discovered unresponsive in his cell during the evening meal. An officer activated the unit alarm. Responding officers entered the cell and found the inmate with a string tied tightly around his neck concealed by a sheet. Medical staff determined the inmate had no pulse, his body was cold, and in rigor mortis; therefore, life-saving measures were not initiated. The inmate was the sole occupant of the cell.

Disposition

The coroner's autopsy determined the cause of death was asphyxiation by ligature strangulation. In addition, the inmate had a toxic blood level of methamphetamine. The department's Death Review Committee concluded the death was not preventable. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Insufficient

The department's response was not adequate because the department failed to inform the OIG about the incident in a timely manner and failed to adequately document the incident. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.

CENTRAL REGION

Assessment Questions

- Was the OIG promptly informed of the critical incident?
The OIG was not notified until two hours after the incident.
- Was the critical incident adequately documented?
There were inconsistencies in the documentation related to the position of the inmate's body at the time he was discovered, the time the emergency vehicle was requested, and the name of the physician who pronounced the inmate dead.

Incident Date	OIG Case Number	Case Type
2012-09-02	12-2320-RO	Other Significant Incident

Incident Summary

On September 2, 2012, an inmate on suicide watch masturbated in front of a certified nursing assistant. An officer ordered the inmate to stop and he complied. A psychiatrist ordered the inmate placed in a padded safety cell to receive medication due to his agitated behavior and verbal threats toward the officers. The inmate was restrained for the escort. During the escort, the inmate slipped out of his handcuffs and hit an officer in the face. Custody staff used physical force to restrain the inmate and they placed a spit mask over his head. Medical staff injected the inmate with medication and placed him in five point restraints. No serious injuries resulted from the incident.

Disposition

During the institution's executive review committee meeting, the OIG recommended that the case be deferred for clarifications as to why a spit mask was used during this incident. The committee found the use of force to be in compliance; however, it was noted that the spit mask should not have been used, so the officer and sergeant received training. The OIG concurred with the committee's decision. In addition, the OIG found that the officer and sergeant failed to document verbal threats made to them by the inmate prior to the escort. The matter was referred to the hiring authority for review and it was determined that additional training was appropriate to ensure best practices are followed in the future. The OIG concurred with the hiring authority's decisions.

Overall Assessment

Rating: Sufficient

Except for the failure to adequately document the circumstances leading to the need for force and the inappropriate use of the spit mask, 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 not to refer the matter to the Office of Internal Affairs.

OIG Recommendation

The OIG determined that the institution was not maintaining a forced medication log as required by departmental policy. The institution was unaware of the requirement for maintaining the log. The OIG recommended that the institution develop a local operating procedure to ensure a forced medication log would be maintained. The institution agreed and developed a working solution. The OIG made an unannounced visit at a later date and found that medical staff members received training and were adequately maintaining a forced medication log as required by policy.

Incident Date	OIG Case Number	Case Type
2012-10-05	12-2277-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On October 5, 2012, officers observed a group of inmates walking away from the basketball area leaving an inmate lying motionless in a pool of blood. An officer ordered all inmates to get down as the sergeant called for medical response. A skirmish line was formed to provide safety to the fallen inmate due to the threat of a riot. Medical staff provided emergency medical treatment on scene. The inmate was transported to an outside hospital for treatment of a serious head injury and returned to the institution five days later.

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 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
2012-10-09	12-2293-RO	In-Custody Inmate Death

Incident Summary

On October 9, 2012, while conducting institutional security checks, an officer found an inmate unresponsive in his cell. The officer activated the alarm and responding officers and medical staff immediately began emergency medical intervention after determining the inmate was not breathing. The inmate was later pronounced dead at the institution after life-saving efforts failed. The inmate was the sole occupant of the cell.

Disposition

The medical examiner determined the cause of death to be natural due to genetic heart disease. Potential staff misconduct was identified because there was evidence that an officer failed to notice the inmate was dead during an institutional count. 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 because departmental policy did not require that officers ensure that an inmate is responsive during the count. The department recently revised its policy to require officers to count living, breathing inmates.

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 and the OIG agreed.

Incident Date	OIG Case Number	Case Type
2012-12-22	13-0272-RO	Other Significant Incident

Incident Summary

On December 22, 2012, officers observed movement in a restricted area near a minimum support facility after dark. The outside patrol sergeant proceeded to the public roadway to investigate. As he approached the area, a car sped away with lights off. An emergency count revealed that an inmate was missing. Escape procedures were followed and the inmate was captured by correctional and outside law enforcement officers approximately five hours later. The inmate was returned to the institution and placed in administrative segregation pending an investigation. When interviewed the inmate explained he escaped by leaving his dorm, walking through the exercise yard, and jumping the fence.

Disposition

There were no 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	OIG Case Number	Case Type
2013-01-15	13-0248-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On January 15, 2013, two officers noticed two inmates fighting inside their cell. As the officers went towards the cell, they ordered the inmates to stop fighting. When the officers arrived at the cell, they noticed that one inmate was on top of the second inmate, attacking him. The first inmate refused to comply with orders to stop. The officers each discharged a burst of pepper spray at the first inmate's face through the food port, causing him to comply with orders. When the first inmate stepped away from the second inmate, the officers noticed the first inmate was holding an inmate-manufactured weapon and saw blood on both inmates. The officers secured and removed the first inmate. The second inmate sustained multiple stab wounds and was air-lifted to an outside hospital for a higher level of care, but was able to return to the institution two days later.

CENTRAL REGION

Disposition	
The institution's executive review committee determined that the officer's actions during the use of force were not fully within departmental training guidelines because the officers discharged the pepper spray from a distance of less than six feet; however, due to the threat of harm to the second inmate and because the officers were limited in how far they could distance themselves from the inmates inside the cell, the use of force was deemed reasonable to effect compliance. 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
Overall, the department's response to the incident was sufficient. The OIG agreed with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.	

Incident Date	OIG Case Number	Case Type
2013-02-08	13-0411-RO	Other Significant Incident

Incident Summary
On February 8, 2013, two inmates began fighting on an exercise yard. A control booth officer gave several orders for the inmates to get down, but the inmates continued to fight. The control booth officer fired one less-lethal round, with negative results, followed by another order for the inmates to get down, which the inmates ignored. The control booth officer fired a second less-lethal round, with negative results, followed by another order to get down, which the inmates also ignored. The control booth officer fired a third less-lethal round, after which both inmates stopped fighting. One of the inmates reported being struck in the head by one of the less-lethal rounds; however, this claim was not substantiated. The inmate was not seriously hurt during the incident. The OIG was not notified timely, but still responded on scene.

Disposition	
After initial medical examination the inmate stated he thought he was hit in the head; however, the inmate made no allegations of excessive force. The institution's executive review committee determined that the force used was in compliance with the department's policies and procedures. 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 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.	

Incident Date	OIG Case Number	Case Type
2013-03-02	13-0383-RO	Inmate Serious/Great Bodily Injury

Incident Summary
On March 2, 2013, two officers responded to inmates fighting in their cell. The inmates refused to comply with orders to stop. The aggressor threw a fan, striking his cellmate in the head. Subsequently, the aggressor began to comply with the first officer's orders to submit to handcuffing when the cellmate rushed toward him. The aggressor moved away from the cuff port to avoid being rushed by his cellmate, and the second officer discharged pepper spray into the cell striking the cellmate in the face from a distance of two feet. The cellmate stopped his aggression. Both inmates were handcuffed and removed from the cell. Medical evaluations revealed the cellmate had sustained head trauma and was taken to an outside hospital where it was confirmed that both of his orbit bones were fractured. The aggressor suffered only minor injuries.

Disposition	
The institution's executive review committee determined the officer deviated from training guidelines when he deployed the pepper spray at a distance of approximately two feet instead of the recommended minimum distance of six feet; however, due to the confined area and the immediate need to stop the attacker, the committee found the use of force reasonable and the OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.	
Overall Assessment	Rating: Sufficient
The department's response was adequate although they failed to notify the OIG in a timely and sufficient manner. 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
2013-03-05	13-0522-RO	Other Significant Incident

Incident Summary

On March 5, 2013, an inmate was attending a trial when he got up from his seat and struck a correctional officer in the facial area with his fist. The inmate was immediately taken to the ground by officers, placed in mechanical restraints, and returned to the institution. The inmate had a history of getting out of his restraints and assaulting officers, so a high level of security precautions was in place at the time of the assault.

Disposition

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

Overall Assessment

Rating: 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
2013-03-14	13-0526-RO	Inmate Riot

Incident Summary

On March 14, 2013, racial riots erupted on two exercise yards involving a total of 51 inmates. The first riot began on the upper yard. As officers responded, a second riot began on the lower yard as inmates observed the initial riot. Chemical agents and less-lethal rounds were deployed with no effect. Due to the magnitude of the riot and to stop the imminent threat of great bodily injury, an observation officer and a control booth officer transitioned to the Mini-14 rifle, a deadly force option. The control booth officer aimed the weapon at a group of inmates, but did not have a clear shot. The observation officer chambered a round and took aim, but did not fire because the inmates stopped their attack and assumed a prone position. Ten of the involved inmates were transported to outside hospitals for treatment, five of whom were admitted. All inmates returned from the outside hospital to the institution within six days following the incident.

Disposition

The institution's executive review committee determined that one of the deployments of pepper spray was not within the recommended minimum distance; however, the committee decided the force was reasonable because the inmates were running toward the officer at the time of deployment. All other use of force applications were within departmental policy and the OIG concurred. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

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 agreed with the decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-03-21	13-0512-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On March 21, 2013, an officer was removing an inmate's handcuffs to place him in his cell when the inmate spun around and began hitting the officer in the face with his fists. The officer used his arms to block the punches, hitting the inmate in the face and upper body as he attempted to create distance between himself and the inmate. The officer slipped on water and was unable to protect himself as the inmate got on top of him and continued to punch him in the face. A second officer began to hit the inmate on the back of the head with his fists after verbal orders and attempts to pull the inmate off the officer failed. The second officer slipped and the inmate began punching him. A third officer utilized his baton and struck the inmate's shoulder, upper back, and upper arm areas, eventually stopping the attack. The inmate was transported to an outside hospital for treatment of a broken nose and head injuries. The inmate was returned to the institution after two days in the hospital. The injured officers were treated and released.

CENTRAL REGION

Disposition

The institution's executive review committee determined that the inmate was unintentionally struck in the spine with the baton. The committee concluded that the physical force and baton strikes were reasonable based on the circumstances. The committee also noted that the video recorded interview of the inmate was unnecessarily delayed, the incident report was not timely, and the escort policy was not followed, so counseling was provided for the involved officers. The OIG concurred with the committee's decision. 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 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
2011-09-16	11-2334-RO	Suicide
Incident Summary On September 16, 2011, custody staff discovered an inmate lying on the floor of the cell he occupied alone, noting that his head was suspended above the floor by a noose around his neck. Custody and medical staff entered the cell simultaneously and started life-saving measures, but were unsuccessful. The inmate was transported to a local hospital, where he was pronounced dead. Investigative services unit staff responded, and secured and processed the scene.		
Disposition An autopsy determined the cause of death to be asphyxiation due to hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The department's overall response to the incident was adequate 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
2012-02-25	12-0484-RO	In-Custody Inmate Death
Incident Summary On February 25, 2012, while inmates were out of their cells for breakfast, showers, and other scheduled activities inside the housing unit, an inmate was assaulted with an inmate-manufactured weapon. The inmate attempted to defend himself and summon help. Officers responded and began life-saving measures, but the inmate died shortly after the attack. The institution's investigative services unit responded and secured the area as a crime scene.		
Disposition Potential staff misconduct was identified. An officer allegedly neglected his duties when he failed to protect an inmate after he was informed the inmate was the target of a planned assault. Therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.		
Overall Assessment		Rating: Sufficient
The department's notification and consultation with the OIG regarding the incident was sufficient. Further, the investigative services unit adequately responded to the incident and worked collaboratively with the district attorney's office. 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
2012-03-06	12-0541-RO	In-Custody Inmate Death
Incident Summary On March 6, 2012, custody staff responded to a cell due to shouting coming from inside the cell. As an officer arrived and looked through the cell window, he observed one inmate standing and another inmate lying on the floor, unresponsive, in a pool of blood. The inmate on the floor appeared to be breathing on his own, but had sustained numerous injuries to his face and head that were actively bleeding. Medical staff provided life-saving measures and requested a medical air-lift to transport the inmate to an outside hospital. However, due to inclement weather the inmate was transported by an ambulance. Several hours later the inmate died. The department's investigative services unit secured the cell as a crime scene.		
Disposition The coroner concluded the death was due to homicide. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.		
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.		

NORTH REGION

Incident Date 2012-03-08	OIG Case Number 12-0585-RO	Case Type In-Custody Inmate Death
Incident Summary On March 8, 2012, during a security check, an officer found an inmate unresponsive while occupying a mental health crisis bed in the correctional treatment center. Medical staff initiated life-saving measures; however, the inmate was subsequently pronounced dead. The inmate had been previously exhibiting suicidal tendencies and was placed in the correctional treatment center eight days prior to his death. There were no apparent signs of trauma or suicide. The investigative services unit responded and processed the scene.		
Disposition An autopsy determined the cause of death to be ischemic heart disease, an imbalance between the supply and demand of the heart for oxygenated blood. 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 hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.		

Incident Date 2012-04-18	OIG Case Number 12-0885-RO	Case Type In-Custody Inmate Death
Incident Summary On April 18, 2012, while making rounds a registered nurse entered the cell of a single-celled inmate to check his condition. The inmate reported not feeling well. The nurse evaluated the inmate and determined he needed to be seen by a physician. The nurse exited the cell, without securing the cell door, and notified the physician. Before the physician arrived a certified nurse assistant saw the inmate lying unresponsive on the floor in front of his cell. The nurse assistant called a medical emergency and responding medical staff initiated life-saving measures. An ambulance was called but the inmate was declared dead by a physician at the institution before the inmate was transported to an outside hospital. Although there were no signs of trauma, the institution's investigative services unit processed the area as a crime scene.		
Disposition The coroner determined the cause of death was natural, due to cardiopulmonary arrest from a bowel obstruction. Potential staff misconduct was identified due to the nurse allegedly failing to secure the cell door after she exited the cell; therefore, the case was referred to the Office of Internal Affairs for investigation. However, OIA Central Intake determined there was no staff misconduct and rejected the request for investigation. The OIG concurred.		
Overall Assessment		Rating: Sufficient
The department's overall response to the incident was adequate except for the hiring authority's delay referring the matter to the Office of Internal Affairs. 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 agreed.		

Incident Date 2012-05-21	OIG Case Number 12-1145-RO	Case Type Suicide
Incident Summary On May 21, 2012, an officer found a single-celled inmate hanging from overhead pipes in his cell by a sheet attached to his neck. Medical staff responded and performed emergency life-saving measures. The inmate was pronounced dead in the institution's medical treatment center. The institution's investigative services unit secured the cell.		
Disposition The autopsy confirmed the cause of death was hanging and the manner of death was suicide. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs.		

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 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
2012-06-29	12-1545-RO	In-Custody Inmate Death

<p>Incident Summary</p> <p>On June 29, 2012, an officer observed an inmate stumble and fall near a drinking fountain on the exercise yard. The officer notified yard staff as the inmate got up and then fell a second time. The officer then ordered the other inmates on the yard to get down and a medical emergency was announced. Medical staff responded and immediately provided treatment for the inmate, who was unresponsive but still had a pulse. The inmate was taken to the yard clinic on a gurney, but upon reaching the clinic he no longer had a pulse and life-saving measures were initiated. The inmate was transported to the triage treatment area and taken by ambulance to an outside hospital where a physician pronounced him dead. There were no visual physical injuries to the inmate.</p>

<p>Disposition</p> <p>An autopsy, that included toxicology and other laboratory tests, concluded that the inmate's cause of death was "undetermined," but noted that "the possibility of associated fatal cardiac arrhythmia(s) can not be excluded." The inmate's body bore no evidence of trauma. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>
--

Overall Assessment	Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The hiring authority did not refer the matter to the Office of Internal Affairs, and the OIG agreed with the hiring authority's decision.	

Incident Date	OIG Case Number	Case Type
2012-07-25	12-1765-RO	Suicide

<p>Incident Summary</p> <p>On July 25, 2012, a single-celled inmate was found hanging from a noose made from an extension cord. Officers removed the inmate from his cell, placed him on a gurney, and transported him to the triage treatment area for medical treatment. Custody and medical staff initiated life-saving measures; however, the inmate was pronounced dead by a physician.</p>

<p>Disposition</p> <p>The coroner determined the cause of death was suicide by hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs.</p>
--

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 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
2012-08-12	12-1891-RO	Suicide

<p>Incident Summary</p> <p>On August 12, 2012, a single-celled inmate was found in his cell with a sheet tied around his neck. The other end of the sheet was tied to the rail of the top bunk. The inmate was unresponsive to orders from custody staff to remove the noose; consequently, an emergency entry was made into the inmate's cell. Custody staff initiated life-saving measures; however, these attempts failed. Medical staff pronounced the inmate dead.</p>
--

<p>Disposition</p> <p>The autopsy report confirmed the manner of death was suicide by hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>

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 chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.		
Incident Date 2012-08-15	OIG Case Number 12-1906-RO	Case Type In-Custody Inmate Death
Incident Summary		
On August 15, 2012, during the morning meal, custody staff observed a single-celled inmate who appeared to be sleeping on the floor in his cell. The inmate was unresponsive and custody staff conducted an emergency cell entry. The inmate showed signs of rigor mortis; therefore, life-saving measures were not performed. There were no signs of trauma or indications that the inmate committed suicide. The institution's investigative services unit secured the cell as a crime scene.		
Disposition		
An autopsy was performed and the cause of death was determined to be probable seizure-associated sudden death due to chronic major seizure disorder from a prior remote gunshot wound to the head. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with the decision.		
Incident Date 2012-08-16	OIG Case Number 12-1922-RO	Case Type In-Custody Inmate Death
Incident Summary		
On August 16, 2012, officers found a single-celled inmate unresponsive and face down on the floor of his cell. Medical staff provided life-saving measures; however, the inmate was later pronounced dead.		
Disposition		
The coroner's autopsy report listed the cause of death as hypertensive and atherosclerotic cardiovascular disease, with significant findings of 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 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 2012-08-26	OIG Case Number 12-2013-RO	Case Type Suicide
Incident Summary		
On August 26, 2012, a single-celled inmate was discovered hanging from his cell door. Custody staff performed an emergency cell extraction and immediately started life-saving measures. The inmate was later pronounced dead.		
Disposition		
The coroner listed the cause of death as asphyxia secondary to hanging. 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 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.		

NORTH REGION

Incident Date	OIG Case Number	Case Type
2012-09-17	12-2151-RO	Suicide
Incident Summary On September 17, 2012, custody staff discovered a single-celled inmate hanging in his cell. Custody staff activated a building alarm and made an emergency entry into the cell. Both custody and medical staff initiated life-saving measures. The inmate was transported to an outside hospital, but was later pronounced dead.		
Disposition The coroner's autopsy report determined the cause of death was asphyxia due to hanging, ruling the death a suicide. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Insufficient
The OIG determined that the department adequately responded to the incident in all critical aspects, except that the department failed to provide timely notification to the OIG. The OIG agreed with the hiring authority's decision not to submit 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 inmate death until five hours after he was pronounced dead.</i></p>		

Incident Date	OIG Case Number	Case Type
2012-10-17	12-2352-RO	In-Custody Inmate Death
Incident Summary On October 17, 2012, during the institutional count, an officer observed an inmate lying on his back in a pool of blood, with his head close to the cell door. The inmate was unresponsive, had a piece of cloth tied around his neck, and appeared to not be breathing. His face had obvious signs of trauma and was covered in blood. The inmate's cellmate was sitting on the lower bunk in the cell. The officer made a radio announcement, activated his alarm, and ordered the cellmate to submit to handcuffs. The cellmate submitted to handcuffs and was removed from the cell. Meanwhile, medical staff responded and initiated life-saving measures and an ambulance responded to the building. Despite life-saving measures, emergency medical responders declared the inmate dead at the institution.		
Disposition The department's independent medical review committee determined the primary cause of death was asphyxiation due to strangulation. 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
2012-10-25	12-2471-RO	Suicide
Incident Summary On October 25, 2012, a single-celled inmate was found in his cell with a noose tied around his neck. The other end of the noose was tied to a wall vent. Responding custody staff initiated an alarm and when sufficient staff were present, entered the cell. Custody staff removed the noose and initiated life-saving measures. Medical staff responded and continued life-saving measures, but the inmate was later pronounced dead by a physician.		
Disposition The autopsy report confirmed the manner of death was 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
<p>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.</p>	

Incident Date	OIG Case Number	Case Type
2012-11-13	12-2602-RO	Suicide

<p>Incident Summary</p> <p>On November 13, 2012, officers discovered a single-celled inmate with a ligature around his neck. An officer activated his alarm for an emergency response. Life-saving measures were unsuccessful and the inmate was declared dead by an institution physician. The investigative services unit and county coroner were notified.</p>
--

<p>Disposition</p> <p>The autopsy report confirmed death by hanging. No misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs.</p>

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

Incident Date	OIG Case Number	Case Type
2012-11-29	12-2759-RO	Suicide

<p>Incident Summary</p> <p>On November 29, 2012, an inmate was found in his cell hanging from a bed sheet attached to a ceiling grate. The inmate was transferred to an outside hospital where he was placed on life support. On December 2, 2012, the inmate was removed from life support and pronounced dead shortly thereafter.</p>
--

<p>Disposition</p> <p>No autopsy was performed because the inmate's family donated the organs. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>

Overall Assessment	Rating: Sufficient
<p>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 not to refer the matter to the Office of Internal Affairs. The OIG concurred with this decision.</p>	

Incident Date	OIG Case Number	Case Type
2012-12-10	12-2834-RO	Inmate Serious/Great Bodily Injury

<p>Incident Summary</p> <p>On December 10, 2012, a control booth officer in the institution's security housing unit failed to observe that an inmate had not returned to his cell after taking a shower. When the officer released another inmate from his cell to take a shower, the first inmate attacked the second inmate with an inmate-manufactured weapon. Officers responded and utilized pepper spray to stop the attack. The second inmate sustained puncture wounds to his back and lacerations to his face.</p>
--

<p>Disposition</p> <p>The institution's executive review committee determined that the use of force complied with departmental policy. However, potential staff misconduct was identified based on the officer's failure to observe that an inmate had not returned to his cell prior to releasing another inmate; therefore, the case was referred to the Office of Internal Affairs. 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.</p>

NORTH REGION

Overall Assessment	Rating: Insufficient
<p>The department's response was not adequate because the department failed to timely notify the OIG of the incident and failed to timely refer the matter to the Office of Internal Affairs. The OIG concurred with the hiring authority's decision to refer the matter to the Office of Internal Affairs.</p>	
Assessment Questions <ul style="list-style-type: none"> • Was the OIG promptly informed of the critical incident? <i>The OIG was notified six hours after the critical incident.</i> • Did the HA make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA? <i>The department learned of potential staff misconduct on December 10, 2012, but the hiring authority did not refer the matter to the Office of Internal Affairs until March 1, 2013, 81 days later.</i> 	

Incident Date 2012-12-12	OIG Case Number 12-2914-RO	Case Type PREA
Incident Summary <p>On December 12, 2012, an out-of-state officer allegedly groped the genital area of an inmate during a pat down search at an out-of-state facility. During the investigation, two other inmates indicated that the same officer inappropriately made contact with their buttocks and genital area during the same search. The inmates were medically and psychologically evaluated.</p>		
Disposition <p>An investigation was conducted by an out-of-state investigator. The allegations were not substantiated.</p>		
Overall Assessment	Rating: Sufficient	
<p>Overall, the department's response to the incident was sufficient. The department provided adequate notification and consultation to the OIG regarding the incident.</p>		

Incident Date 2013-01-24	OIG Case Number 13-0237-RO	Case Type Suicide
Incident Summary <p>On January 24, 2013, custody staff discovered an inmate with a sheet tied around his neck in the cell that he alone occupied. The other end of the sheet was tied to the rail of the top bunk. When the inmate did not respond to custody staff's efforts to communicate with him, they made an emergency entry into the inmate's cell and initiated life-saving measures. The life-saving attempts were unsuccessful and medical staff pronounced the inmate dead.</p>		
Disposition <p>The autopsy report confirmed the manner of death was suicide by hanging. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>		
Overall Assessment	Rating: Sufficient	
<p>The department's overall response to the incident was sufficient 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.</p>		

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-01-26	13-0239-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On January 26, 2013, custody staff discovered an unresponsive inmate on the floor of his cell in the correctional treatment center where he was on suicide precaution status requiring 15 minute welfare checks. Custody staff observed blood splattered throughout the cell in various stages of drying. Custody staff initiated an emergency cell extraction due to the amount of blood and the assumed nature of the inmate's injury. Medical staff discovered the inmate's injury was caused by his intentionally removing several stitches from a previously-treated wound. The inmate was transported to an outside hospital due to the amount of blood loss. Upon return to the institution, the inmate was placed on suicide watch.

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 this case to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-01-26	13-0285-RO	PREA

Incident Summary

On January 26, 2013, an officer allegedly sexually assaulted an inmate during an unclothed body search. The inmate reported the alleged assault on February 10, 2013.

Disposition

Pursuant to departmental policy, the hiring authority referred the case to the Office of Internal Affairs. After review, OIA Central Intake determined that there was not a reasonable belief that misconduct occurred. The OIG concurred with the decision.

Overall Assessment

Rating: Sufficient

Although the department did not promptly notify the OIG of the critical incident, the department's response was satisfactory in all other critical aspects. Pursuant to departmental policy the hiring authority referred the matter to the Office of Internal Affairs. The OIG concurred with the hiring authority's decision.

Incident Date	OIG Case Number	Case Type
2013-01-31	13-0253-RO	In-Custody Inmate Death

Incident Summary

On January 31, 2013, while distributing morning meals, an officer discovered an unresponsive inmate lying face down on his bed. The officer sounded the alarm. Custody and medical staff responded and initiated life-saving measures. However, the inmate was later pronounced dead at the scene. There was no evidence of injuries or trauma on the inmate. The inmate was single-celled.

Disposition

An autopsy report determined the cause of death as hypertensive cardiovascular disease. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The 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.

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-02-01	13-0261-RO	In-Custody Inmate Death
Incident Summary On February 1, 2013, custody staff observed an inmate in his wheelchair who appeared to be sleeping. However, when an officer attempted to wake the inmate he was unresponsive. The officer activated an alarm and initiated life-saving measures. Medical staff also responded and provided emergency treatment; however, the inmate was subsequently pronounced dead.		
Disposition The coroner reported the cause of death to be natural causes. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Insufficient
The department failed to notify the OIG of the incident; however, the department's response was satisfactory in all other critical aspects. The hiring authority chose not to refer the matter to the Office of Internal Affairs; the OIG concurred with this decision.		
Assessment Questions <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The hiring authority failed to notify the OIG of the inmate death.</i></p>		

Incident Date	OIG Case Number	Case Type
2013-02-03	13-0256-RO	In-Custody Inmate Death
Incident Summary On February 3, 2013, an inmate was found breathing but unresponsive on his bunk located in a dormitory. There was blood on a towel found in the cell but the inmate had no visible injuries. Responding custody and medical staff immediately applied life-saving measures but the inmate was pronounced dead at the scene.		
Disposition The coroner's office responded to the scene but did not perform an autopsy based on reports that the inmate had a pre-existing medical condition. 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
2013-02-24	13-0358-RO	In-Custody Inmate Death
Incident Summary On February 24, 2013, an inmate informed custody staff that he had killed his cellmate. Custody staff removed the unresponsive inmate from the cell and began to perform life-saving measures. The inmate was pronounced dead by institution medical staff.		
Disposition The coroner's autopsy report listed the cause of death as strangulation. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs.		
Overall Assessment		Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects. The department adequately notified and consulted with the OIG on the incident. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.		

NORTH REGION

Incident Date	OIG Case Number	Case Type
2013-03-14	13-0470-RO	In-Custody Inmate Death

Incident Summary

On March 14, 2013, an inmate returned to his cell, collapsed and exhibited difficulty breathing. His cellmate called "man down" and propped the inmate on the lower bunk. Responding custody staff rendered life-saving measures, but the inmate was subsequently pronounced dead. There were no signs of trauma or foul play. However, the inmate's cellmate was placed in administrative segregation pending further investigation.

Disposition

The autopsy concluded that the inmate's death was due to dilated cardiomyopathy, noting morbid obesity as a significant condition. 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 hiring authority's decision not to submit the matter to the Office of Internal Affairs.

Incident Date	OIG Case Number	Case Type
2013-03-22	13-0495-RO	In-Custody Inmate Death

Incident Summary

On March 22, 2013, during routine cell checks, officers discovered an inmate kneeling on the floor with his upper body face down on his bunk. The inmate was single celled and there were no signs that the inmate harmed himself. The inmate was transported to an outside hospital and pronounced dead.

Disposition

The coroner's report identified the immediate cause of death as hyponatremia due to acute water intoxication. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

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

Incident Date	OIG Case Number	Case Type
2013-03-25	13-0508-RO	In-Custody Inmate Death

Incident Summary

On March 25, 2013, custody staff observed an inmate lying on an exercise yard. Although the inmate was breathing, he was unresponsive. Medical staff responded to the scene and placed the inmate on a gurney to be transported for medical care. While on the gurney, the inmate stopped breathing and medical staff began life-saving measures and called outside medical emergency services. The institution's fire department responded and assisted with life-saving measures until an ambulance arrived. The inmate was transported by ambulance to an outside hospital where he was pronounced dead.

Disposition

An autopsy determined that the inmate died of hypertensive cardiovascular disease. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.

Overall Assessment

Rating: Sufficient

The OIG determined that the department adequately responded to the incident in all critical aspects. The OIG agreed with the hiring authority's decision to not refer the incident to the Office of Internal Affairs.

SOUTH REGION

Incident Date 2012-01-01	OIG Case Number 12-0062-RO	Case Type Other Significant Incident
<h3>Incident Summary</h3> <p>On January 1, 2012, the institution's fire captain was notified by outside law enforcement that one of the institution's fire trucks was found inoperative and abandoned in a residential neighborhood near the institution. The fire captain conducted a check of the firehouse and discovered that a fire truck and an inmate assigned to the fire crew were missing. The fire captain notified the watch commander and the institution immediately implemented their escape protocol. On January 3, 2012, the inmate was arrested by outside law enforcement and returned to the institution. The institution's investigative services unit interviewed the inmate who admitted parking the fire truck in an area outside of its assigned location and driving away undetected after the inmate count.</p>		
<h3>Disposition</h3> <p>Staff misconduct was identified; however, the case was not referred to the Office of Internal Affairs for investigation. The OIG did not concur with the hiring authority's decision but did not seek a higher level of review.</p>		
<h3>Overall Assessment</h3> <p>The department's overall response to the incident was inadequate, although the department adequately notified and consulted with the OIG. However, the hiring authority failed to make a timely decision and ultimately chose not to refer the matter to the Office of Internal Affairs. The OIG did not concur with this decision but did not seek a higher level of review.</p>		Rating: Insufficient
<h3>Assessment Questions</h3> <ul style="list-style-type: none"> Did the HA make a timely decision regarding whether to refer any conduct related to the critical incident to the OIA? <i>The OIG discussed the fire captain's potential misconduct with the hiring authority several times after the incident occurred in January 2012. In December 2012, nearly 12 months after the incident, the hiring authority chose not to refer the matter to the Office of Internal Affairs.</i> Did the HA appropriately determine whether to refer any conduct to the OIA related to the critical incident? <i>The OIG believed there was potential staff misconduct by the fire captain that the hiring authority should have referred to the Office of Internal Affairs for investigation. Specifically, the fire captain potentially failed to maintain custody over the inmate and maintain accountability of the institution's fire truck, resulting in the inmate's escape. The OIG did not concur with hiring authority's decision but did not seek a higher level of review.</i> 		
<h3>OIG Recommendation</h3> <p>The OIG recommended that the hiring authority modify the post orders for fire captains to address the manner in which the fire trucks are secured. In April 2012, the new post orders became effective and included the requirement that all vehicles be secured in the apparatus bay at the end of the shift, with the roll-up doors secured and all keys secured in the fire captain's office.</p>		

Incident Date 2012-05-17	OIG Case Number 12-1204-RO	Case Type Other Significant Incident
<h3>Incident Summary</h3> <p>On May 17, 2012, two officers conducted conflicting inmate counts on the institution's minimum support facility. The officers failed to report the discrepancy to a supervisor and submitted a cleared count. Approximately four hours later, on May 18, 2012, during the subsequent count by a third officer, it was discovered that an inmate was missing from the minimum support facility. Custody staff notified outside law enforcement of the possible escape and began a search for the missing inmate. During a search of the minimum support facility, the inmate was found hiding on the top shelf in a bathroom. The officers ordered the inmate to get down on the ground; however, the inmate did not comply. Therefore, the officers used pepper spray to gain compliance.</p>		
<h3>Disposition</h3> <p>The institution's executive review committee determined that the use of force was in compliance with departmental policy and the OIG concurred. Potential staff misconduct was identified based on the failure of two officers to conduct an appropriate count and a third officer's failure to conduct an adequate search of the facility after the inmate was discovered missing. The hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs referred the matter back to the hiring authority for disciplinary action and the OIG concurred. The OIG did not accept the case for monitoring.</p>		

SOUTH REGION

Overall Assessment	Rating: Sufficient
<p>Except for the department's failure to timely review the use of force and timely refer the matter to the Office of Internal Affairs, the overall response to the incident was sufficient. 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 and the OIG concurred.</p>	

Incident Date	OIG Case Number	Case Type
2012-07-23	12-1808-RO	In-Custody Inmate Death

<p>Incident Summary</p> <p>On July 23, 2012, a tower officer observed a one-on-one fight on an exercise yard. The officer sounded his alarm and custody staff responded. Both inmates complied with orders to separate without officers having to use force, and were examined by medical staff. One of the inmates was taken to the institution's triage treatment area and later transported to a local hospital for a possible concussion. Three days later the inmate underwent emergency brain surgery and on August 1, 2012, the inmate was removed from life support and pronounced dead.</p>

<p>Disposition</p> <p>The autopsy listed the cause of death as blunt force trauma to the head and the death was determined to be a homicide. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>

Overall Assessment	Rating: Sufficient
<p>Although the department failed to timely notify the OIG about the incident, the delayed notification did not affect the OIG's ability to monitor the case. The department's response to the incident was otherwise sufficient. 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
2012-08-11	12-1903-RO	In-Custody Inmate Death

<p>Incident Summary</p> <p>On August 11, 2012, an inmate reported that his cellmate was lying on the floor and unresponsive. Officers responded to the cell and began life-saving measures. Medical staff arrived and continued life-saving measures. The inmate was transported to an outside hospital and pronounced dead.</p>

<p>Disposition</p> <p>According to the autopsy report, the cause of death was a heroin overdose. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>

Overall Assessment	Rating: Insufficient
<p>The department's overall response to the incident was inadequate. The late notification by the department prevented the OIG from responding on scene. The hiring authority decided not to refer the matter to the Office of Internal Affairs, and the OIG agreed.</p>	

<p>Assessment Questions</p> <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>The incident occurred on August 11, 2012, but the OIG was not notified until August 13, 2012.</i></p>
--

Incident Date	OIG Case Number	Case Type
2012-08-19	12-1944-RO	Inmate Serious/Great Bodily Injury

<p>Incident Summary</p> <p>On August 19, 2012, two inmates were observed fighting on the exercise yard. Six inmates, who initially complied with orders to get down, stood up and ran toward the area to join the fight, refusing orders to get down. An officer fired a less-lethal projectile at the inmate's thigh but inadvertently struck him on the left side of the neck. Despite the shot, the inmate continued to run and started fighting with the other inmates. Multiple responding officers utilized pepper spray and the inmates complied with orders and stopped fighting. The inmate who was struck with the less-lethal round sustained an abrasion on his neck and was treated at the institution.</p>

SOUTH REGION

Disposition

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

Overall Assessment

Rating: Sufficient

Except for the department's failure to review the incident within the appropriate time frames, the OIG determined that the department's response to the incident was adequate. The department informed the OIG about the incident in a timely and sufficient manner. 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
2012-08-20	12-2001-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On August 20, 2012, an officer responded to a cell after hearing loud noises consistent with a fight. The officer observed one inmate standing over his cellmate, attacking him in the upper torso with an inmate-manufactured weapon. The officer announced an alarm and gave verbal orders to get down, but the inmate continued his attack. The officer used pepper spray, effectively stopping the attack. An inmate-manufactured weapon was recovered and the attacked inmate was taken to an outside hospital due to numerous stab wounds to his chest, abdomen, and back. His injuries were not life-threatening and he was later returned to the institution. The other inmate received only minor injuries and was treated at the institution.

Disposition

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

Overall Assessment

Rating: 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; the OIG concurred with this decision.

Incident Date	OIG Case Number	Case Type
2012-08-29	12-2042-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On August 29, 2012, a control booth officer conducting inmate showers heard yelling coming from the shower area and saw inmates moving, but his view was obstructed by inmate clothing, towels, and a plastic bag hanging over the shower door. The officer activated an alarm and announced a possible inmate fight over the institutional radio. Responding custody staff entered the building, removed the obstructions, and observed an inmate standing over another inmate punching him in the face and torso. Officers ordered the inmate to stop fighting and the inmate complied. The inmate who was attacked was transported to the triage treatment area and subsequently to an outside hospital for treatment of numerous puncture wounds and lacerations to his face, neck, and torso. An inmate-manufactured weapon was recovered from the shower area. The inmate's injuries were not life-threatening and he later returned to the institution.

Disposition

Although potential staff misconduct was identified related to the classification of the inmate who was attacked, the hiring authority did not refer the matter to the Office of Internal Affairs for investigation. The OIG did not concur with the hiring authority's decision; however, the decision did not merit a higher level of review because there was no clear departmental policy violation and the hiring authority agreed to provide training to the involved associate warden.

Overall Assessment

Rating: Insufficient

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

SOUTH REGION

Assessment Questions

- Was the OIG promptly informed of the critical incident?

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

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

The institution's classification committee released the inmate who was attacked from administrative segregation to one of the institution's general population facilities despite documentation in the inmate's file that he had been involved in numerous altercations and that he was going to be the victim of a stabbing upon his release from administrative segregation. The OIG recommended to the hiring authority that the hiring authority examine the committee's decision to determine whether there was potential misconduct. The hiring authority agreed and concluded that the committee's decision was discretionary. The OIG disagreed with the hiring authority's decision, but the matter did not merit a higher level of review because there was no clear departmental policy violation and the hiring authority agreed to provide training to the associate warden who was in charge of the committee that authorized the inmate's release from administrative segregation to the general population facility.

Incident Date	OIG Case Number	Case Type
2012-09-19	12-2165-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On September 19, 2012, an inmate was ordered by two officers to return to his housing unit, but refused. Instead, the inmate turned and walked back toward the two officers. The observation officer activated the alarm and both officers ordered the inmate to get down, but he refused. When he reached the two officers, he turned as if to submit to handcuffs. As the officers were handcuffing the inmate, he turned and struck the first officer in the face with his fist and began striking the second officer, at which time the first officer used pepper spray on the inmate, to no avail. Four other officers responded to the incident. The inmate grabbed a pepper spray canister from one of the responding officers and began spraying the officers. The inmate then threw the pepper spray canister at a third officer, striking him in the mouth and chipping his tooth. Custody staff utilized physical force, pepper spray, and a baton to subdue the inmate. The inmate sustained abrasions to his head, a chipped tooth, and a fractured left arm. The inmate was transported to an outside hospital for treatment and later returned to the institution. The officers sustained bruises, abrasions, scratches, and reddened areas to the wrists, head, face, knuckles, and chest, and one officer sustained a chipped front tooth.

Disposition

The institution's executive review committee determined that the use of force was in compliance with departmental policy and the OIG concurred. Potential staff misconduct was identified based on the inmate's allegations of excessive use of force; therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. An investigation was not opened due to insufficient information provided to support the allegations and no reasonable belief that misconduct occurred.

Overall Assessment

Rating: Sufficient

The department's overall response to the incident was adequate except for the failure to timely refer potential misconduct to the Office of Internal Affairs. The department provided adequate notification and consultation to the OIG regarding the incident. Although the OIG agreed with the decision to submit the matter to the Office of Internal Affairs because the matter warranted further review, after the analysis by OIA Central Intake the OIG agreed with the decision not to open an investigation.

Incident Date	OIG Case Number	Case Type
2012-09-25	12-2259-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On September 25, 2012, an inmate attacked another inmate with an inmate-manufactured weapon. The attacking inmate threw the inmate-manufactured weapon over the fence; however, it was recovered by custody staff. The attacking inmate complied with orders to get down; therefore, no force was used during the incident. The attacked inmate sustained serious puncture wounds to his chest and was airlifted to a local hospital for treatment. The inmate survived and later returned to the institution.

Disposition

Potential staff misconduct was identified surrounding inmate classification and endorsement concerns; 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.

SOUTH REGION

Overall Assessment	Rating: Sufficient
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 to refer the matter to the Office of Internal Affairs and the OIG concurred.	

Incident Date	OIG Case Number	Case Type
2012-09-27	12-2258-RO	Inmate Serious/Great Bodily Injury

<p>Incident Summary</p> <p>On September 27, 2012, an inmate attacked another inmate on an exercise yard with an inmate-manufactured weapon. Custody staff responded and ordered the inmate to drop the weapon and get down. After several orders, the inmate got on the ground but refused to drop the weapon. An officer used physical force to gain compliance. The attacked inmate sustained four puncture wounds to the chest and forearm, and lacerations to his arm and ear. Due to the severity of his injuries, the injured inmate was transported to a local hospital for treatment. The inmate survived the injuries and was later returned to the institution.</p>
--

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

Overall Assessment	Rating: Sufficient
The department's overall response to the incident was adequate except for the department's failure to provide timely notification to the OIG regarding the incident and the institution's executive review committee failing to review the incident in a timely 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
2012-10-02	12-2260-RO	In-Custody Inmate Death

<p>Incident Summary</p> <p>On October 2, 2012, an inmate called custody staff to his cell and told them that he murdered his cellmate. Officers found the cellmate unresponsive underneath a mattress in the cell and initiated life-saving measures. Medical staff arrived on scene and took over life-saving measures while transporting the cellmate to the triage treatment area. The life-saving measures were unsuccessful and the inmate was declared dead.</p>

<p>Disposition</p> <p>The autopsy report revealed the cause of death was strangulation. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</p>
--

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	OIG Case Number	Case Type
2012-10-03	12-2279-RO	Other Significant Incident

<p>Incident Summary</p> <p>On October 3, 2012, five inmates initiated a hunger strike because they believed one of the inmates was not released from custody on his scheduled release date of September 6, 2012. The inmate being held received a rules violation on August 20, 2012, because he was suspected of possessing marijuana for sale within the institution. A hearing related to the charges was held on October 3, 2012, and the charges were dismissed. The inmate was released from custody the following day.</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>
--

SOUTH 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 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
2012-10-05	12-2289-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On October 5, 2012, an officer responded to a cell after hearing a "man down" call. The officer activated his alarm and observed one inmate lying on the floor, bleeding from his face and upper torso area. The other inmate stood by the cell door with blood on his shirt. Custody staff responded and both inmates complied with orders to submit to handcuffs, and were removed from the cell. One inmate was taken to an outside hospital for multiple puncture wounds. His injuries were not life-threatening and he was later returned to the institution. The other inmate also sustained puncture wounds; however, he was medically cleared and returned to administrative segregation. An inmate-manufactured weapon was found in the cell.

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 informed the OIG about the incident in a timely and sufficient manner. 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	12-2278-RO	In-Custody Inmate Death

Incident Summary

On October 7, 2012, an officer observed an inmate lying on an exercise yard, near the medical clinic. The officer requested the assistance of medical staff who responded to the scene and initiated life-saving measures as they transported the inmate to the triage treatment area. Life-saving measures were unsuccessful and the inmate was declared dead.

Disposition

The autopsy results revealed the inmate died of cardiovascular disease. 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 the failure to timely notify the OIG of the critical incident thereby preventing real-time monitoring, the OIG found that the department's overall response to the incident was insufficient. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.	

Assessment Questions

- Was the OIG promptly informed of the critical incident?

The OIG was not notified of the incident until more than three hours after the inmate was pronounced dead.

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2012-10-16	12-2358-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On October 16, 2012, two inmates attacked another inmate with inmate-manufactured weapons on an exercise yard. The observation officer announced an alarm and gave verbal orders to get down, but the inmates continued their attack. Responding officers used pepper spray to stop the attack. Custody staff initiated life-saving measures on the attacked inmate, who was then transported to an outside hospital due to numerous stab wounds to his chest, abdomen, and both thighs. The inmate's injuries were determined to be life-threatening; however, he was later returned to the institution to complete his recovery. The other inmates received minor injuries and were treated at the institution. Two inmate-manufactured weapons were recovered on the exercise yard.

Disposition

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

Overall Assessment

Rating: 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
2012-11-17	12-2681-RO	Inmate Serious/Great Bodily Injury

Incident Summary

On November 17, 2012, an inmate reported to custody staff that he had been battered by two other inmates. The inmate was medically evaluated and it was determined that the inmate sustained minor injuries, including scratches and facial swelling. The inmate was released to custody, pending a transfer to administrative segregation. On November 19, 2012, the inmate was re-evaluated by medical staff and transferred to an outside hospital where it was determined the inmate's injuries were more serious, including a broken nose, a broken jaw, and swelling to both eye sockets. The inmate returned to the institution later that day.

Disposition

No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for 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
2012-12-26	12-2946-RO	PREA

Incident Summary

On December 27, 2012, an inmate alleged that on December 26, 2012, while being removed from the shower, an officer inserted his finger into the inmate's rectum. The department initiated protocols pursuant to the Prison Rape Elimination Act. The inmate was interviewed and taken to an outside hospital for examination.

Disposition

The hiring authority referred the case to the Office of Internal Affairs, in accordance with departmental policy. During an interview, the inmate admitted that he made up the allegation to obtain a transfer to another institution. The medical examination did not show any injury consistent with a sexual assault. The Office of Internal Affairs determined this case did not warrant further investigation. The OIG concurred.

Overall Assessment

Rating: Sufficient

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

SOUTH REGION

Incident Date	OIG Case Number	Case Type
2013-01-21	13-0174-RO	In-Custody Inmate Death
Incident Summary On January 21, 2013, during release for the morning meal, officers in a housing unit responded to inmates calling "man down" and observed an inmate exiting a cell with a blood-stained bandage wrapped around his hand. An officer sounded an alarm and ordered the inmate to get down. The inmate complied and was placed in handcuffs. The inmate's cellmate was found sitting in the corner of the cell unconscious and covered in blood from numerous lacerations to the neck, and trauma to the face and head. Medical staff arrived and initiated life-saving efforts. The inmate was transported to the triage treatment area where outside medical staff took over life-saving efforts. The efforts were unsuccessful and the inmate was pronounced dead.		
Disposition The coroner's autopsy determined the manner of death was homicide caused by blunt force trauma to the head. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.		
Overall Assessment		Rating: Sufficient
The department's response was satisfactory in all critical aspects. The department provided adequate notification and consultation to the OIG regarding the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.		

Incident Date	OIG Case Number	Case Type
2013-03-24	13-0498-RO	PREA
Incident Summary On March 24, 2013, an officer allegedly grabbed an inmate's buttocks and made sexually explicit comments while he pressed his body against hers.		
Disposition Potential staff misconduct was identified based on the allegation of sexual misconduct. The hiring authority referred the case to the Office of Internal Affairs, which declined to open an investigation. The OIG concurred.		
Overall Assessment		Rating: Sufficient
The OIG determined that the department adequately responded to the incident in all critical aspects except that the department did not adequately notify and consult with the OIG on the incident. The hiring authority decided to refer the matter to the Office of Internal Affairs, and the OIG agreed.		

APPENDIX E DEADLY FORCE INCIDENT SUMMARIES CENTRAL REGION

Deadly Force Incidents: **23**
Monitored DFIT: **5**

Incident Date: 2012-11-13	Deadly Force Incident	
Incident Summary On November 13, 2012, while four officers were escorting an inmate through an exercise yard, between 40 and 50 inmates rushed the inmate and the four officers, attacking the officers and stabbing the inmate in the back and the thigh areas with an inmate-manufactured weapon. The four officers tried to protect the inmate and themselves by using pepper spray, batons, and physical force. A code three alarm was announced and nearly 100 staff members responded to the incident. The inmates refused numerous orders to get on the ground. The observation officer fired one lethal round as a warning shot in a safe location. The warning shot caused the inmates to stop the attack. The inmate who was attacked sustained 11 puncture wounds and scratches but no life-threatening 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.		OIG Case Number: 12-2614-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

CENTRAL REGION

Incident Date: 2012-12-02	Deadly Force Incident
Incident Summary OIG Case Number: 12-2862-RO On December 2, 2012, two inmates began fighting near the top of the stairs on the upper tier of a housing unit. The control booth officer ordered the inmates to get down, but they continued to fight. The officer fired three less-lethal rounds at the thighs of both inmates to stop the fight. During the incident, one of the inmates was inadvertently struck in the head by one of the rounds. The inmate was transported to an outside hospital for treatment of bleeding on the brain and returned to the institution after three days. The hiring authority did not timely notify the Office of Internal Affairs or the OIG of the incident.	
Disposition The institution's executive review committee determined that the use of force was within policy and there was a lack of evidence to support the inmate's claim that the officer deliberately aimed and fired the less-lethal round at the inmate's head. Further, after review of the entire incident, 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: Insufficient
<p>The department's response to the incident was inadequate because the hiring authority failed to timely notify the OIG or the Office of Internal Affairs about the potential deadly force aspect of this incident. The hiring authority also failed to conduct a videotaped interview of the injured inmate until over a month after the incident.</p> Assessment Questions <ul style="list-style-type: none">• Was the OIG promptly informed of the critical incident? <i>The OIG was not notified until more than four hours after the incident.</i>• Was the HA's response to the critical incident appropriate? <i>The videotaped interview with the injured inmate was not completed within 48 hours as required by policy. The interview was not conducted until over a month after the incident.</i>• Did the department adequately consult with the OIG regarding the critical incident? <i>The department did not timely consult with the OIG after the incident. The OIG would have recommended that the deadly force investigation team respond to the incident and open an investigation had the department consulted with the OIG.</i>	

CENTRAL REGION

Incident Date: 2013-01-17	Deadly Force Incident
Incident Summary OIG Case Number: 13-0241-RO On January 17, 2013, two inmates began to attack a third inmate. After the inmates failed to comply with orders to get down, the observation officer fired three less-lethal rounds aiming at the lower extremities of the assailants. The first round missed, the second round struck one of the attackers in the right thigh, and the third round inadvertently struck one of the aggressors in the back. The inmates continued to attack the third inmate. An officer deployed a pepper spray blast grenade, but the assault continued. The observation officer fired a fourth less-lethal round that due to the assailant's rapid movement, accidentally struck him in the head stopping the attack. The inmate shot in the head with the less-lethal round received two sutures at the prison.	
Disposition The institution's executive review committee determined that the use of force complied with policies and procedures. The OIG did not concur, as an officer involved in the incident was the camera operator for the videotaped interview of the inmate, which is against departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.	
Incident Assessment The department's response was not adequate because the department failed to inform the OIG about the incident in a timely and sufficient manner. And, the department failed to notify the Office of Internal Affairs. Additionally, the institution's executive review committee failed to identify that an officer involved in the incident was the camera operator in the videotaped interview of the inmate, which is against departmental policy. 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">• Was the OIG promptly informed of the critical incident? <i>The OIG was not notified until over four hours after the incident.</i>• Was the HA's response to the critical incident appropriate? <i>The Office of Internal Affairs was not notified of the incident.</i>• Did the use-of-force review committee adequately review and respond to the incident? <i>Departmental policy provides that the videotaped interview shall be conducted by persons not involved in the incident.</i>	
OIG Recommendation The OIG recommended that the incident commander receive training on selecting a camera operator that is uninvolved in the incident. The hiring authority agreed with the OIG's recommendation.	

CENTRAL REGION

Incident Date: 2013-01-24	Deadly Force Incident
Incident Summary OIG Case Number: 13-0243-RO	
<p>On January 24, 2013, two inmates began fighting in the dayroom of a housing unit. An officer activated his personal alarm and ordered the inmates to stop fighting, but they continued to fight. The control booth officer fired two less-lethal rounds at the lower extremities of the inmates. It is unknown where the first round struck; however, the second round inadvertently struck one of the combatants in the head due to his rapid movement. After the second shot, both inmates stopped fighting and assumed prone positions. The inmate struck in the head was transported to an outside hospital and received treatment for multiple facial fractures near the eye and a laceration requiring sutures. The inmate returned to the institution the following day. The other inmate received minor injuries from the fight. The institution failed to timely notify the Office of Internal Affairs.</p>	
Disposition <p>The institution's executive review committee determined the 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.</p>	
Incident Assessment	Rating: Insufficient
<p>The institution failed to inform the OIG in a timely and sufficient manner, preventing the OIG from real-time monitoring of the case. The institution also failed to timely notify the Office of Internal Affairs.</p>	
Assessment Questions <ul style="list-style-type: none"> • Was the OIG promptly informed of the critical incident? <p style="margin-left: 20px;"><i>The OIG was not notified until the following day.</i></p> • Was the HA's response to the critical incident appropriate? <p style="margin-left: 20px;"><i>The institution failed to timely notify the Office of Internal Affairs.</i></p> 	

Incident Date: 2013-02-09	Deadly Force Incident
Incident Summary OIG Case Number: 13-0338-RO	
<p>On February 9, 2013, two inmates began fighting and continued after officers ordered them to stop. Officers sounded their alarm and the inmates initially stopped fighting and got down. The fight continued after one of the inmates got back up and resumed attacking the other inmate. The control booth officer fired one less-lethal impact round at the lower extremities of one of the inmates and both inmates stopped fighting. It was later determined that the less-lethal round struck the inmate in the head causing bleeding in the temple area. The injured inmate was transported to a local hospital for treatment and returned to the institution the same day. The inmate received four sutures to close the wound on his temple. 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.</p>	
Disposition <p>The institution's executive review committee determined that the impact to the inmate's head was accidental. The committee also determined that the video recorded interview was not completed within the required 48 hours due to a miscommunication between the medical department and the incident commander. 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.</p>	
Incident Assessment	Rating: Sufficient
<p>Except for the lack of timeliness of the videotaped interview of the inmate, the OIG determined that the department's response to the incident was adequate. 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.</p>	

NORTH REGION

Incident Date: 2011-09-13		Deadly Force Incident	
Incident Summary On September 13, 2011, an off-duty officer allegedly violated the department's use-of-force policy when he fired two warning shots from his personal weapon during an altercation with a transient who allegedly trespassed on the officer's property. 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.			
Administrative Investigation		OIG Case Number: 11-2303-IR	
1. Use of Deadly Force	Findings 1. Sustained	Initial Penalty Salary Reduction	Final Penalty Letter of Reprimand
Investigative Assessment Overall, the department's investigative process sufficiently complied with policies and procedures.			Rating: Sufficient
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. The hiring authority subsequently sustained the allegation and determined only a letter of reprimand should be issued. The department attorney elevated the matter to a higher level of review. After a higher level of review confirmed the allegation should be sustained, the officer was served a 5 percent salary reduction for six months. The OIG concurred. Following the <i>Skelly</i> hearing, the hiring authority determined the allegation should not be sustained and withdrew the disciplinary action entirely. The department attorney again elevated the matter to a higher level of review. At the second higher level of review, the department determined the allegation should be sustained but reduced the penalty to a 5 percent salary reduction for three months. The officer filed an appeal with the State Personnel Board. Prior to the hearing, the department entered into a settlement agreement with the officer and reduced the penalty to an official letter of reprimand. The OIG did not agree with the settlement but did not seek a higher level of review because two such reviews had already occurred.			
Disciplinary Assessment			Rating: Insufficient
The hiring authority failed to appropriately sustain the allegation and impose a proper penalty leading to the need for a higher level of review on two separate occasions. Although the allegation was sustained after a higher level of review, and a reasonable penalty imposed, the department subsequently entered into a settlement agreement and reduced the penalty.			
Assessment Questions <ul style="list-style-type: none"> Did the HA, who participated in the disciplinary conference, select the appropriate penalty based on the sustained allegations? <i>The hiring authority initially selected the appropriate penalty based on the sustained allegation at the findings conference. However, before the disciplinary action was served, he decided to reduce the penalty to an official letter of reprimand. The department attorney requested a higher level of review as a result.</i> Did the department attorney provide to the HA and OIG written confirmation of penalty discussions? <i>The department attorney did not provide written confirmation of penalty discussions to the hiring authority and the OIG.</i> Was the OIG provided with a draft of the pre-hearing settlement conference statement prior to it being filed? <i>The OIG was not provided with a draft of the pre-hearing settlement conference statement prior to it being filed.</i> If the case settled, did the department attorney or disciplinary officer properly complete the CDC Form 3021? <i>The department attorney did not complete the CDC Form 3021.</i> If the penalty was modified by department action or a settlement agreement, did OIG concur with the modification? <i>The OIG did not concur with the reduced penalty but did not seek a higher level of review as two such reviews had already occurred.</i> 			

NORTH REGION

Incident Date: 2012-07-21		Deadly Force Incident	
Incident Summary On July 21, 2012, a sergeant allegedly used deadly force on an inmate after the inmate refused to comply with orders to drop a weapon following a cell fight. The sergeant fired nine 40 mm rounds with the final round striking the inmate in the head. It was alleged that the sergeant did not maintain the required distance when firing and also fired at an unauthorized zone on the inmate's body. The hiring authority notified the department's deadly force investigation team, which responded to the scene and conducted an investigation. The OIG was notified and responded to the scene as well.			
Criminal Investigation		OIG Case Number: 12-1763-IR	
Investigation Assessment			Rating: Sufficient
Overall, the department's investigative process sufficiently complied with policies and procedures.			
Administrative Investigation		OIG Case Number: 12-1771-IR	
1. Discharge of Lethal Weapon	Findings 1. Exonerated	Initial Penalty No Penalty Imposed	Final Penalty No Change
Investigative Assessment			Rating: Sufficient
Overall, the department's investigative process sufficiently complied with policies and procedures.			
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			Rating: Sufficient
Overall, the department sufficiently complied with policies and procedures.			

Incident Date: 2011-10-31		Deadly Force Incident	
Incident Summary		OIG Case Number: 11-2655-RO	
On October 31, 2011, a riot involving approximately 200 inmates occurred on an exercise yard. Responding officers fired five rounds from the Mini-14 rifle as warning shots into designated safe areas. Numerous less-lethal rounds were also used to stop the riot. One inmate suffered a stabbing injury consistent with the fighting. 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.			
Disposition The institution's executive review committee found the use of force complied with departmental policy. The OIG concurred. Potential staff misconduct was identified for an officer's failure to complete an incident report. Therefore, the hiring authority referred the case to the Office of Internal Affairs for investigation. The Office of Internal Affairs returned the case to the hiring authority for disciplinary action, which the OIG accepted for monitoring.			
Incident 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 referred the matter to the Office of Internal Affairs; the OIG concurred with this decision.			

NORTH REGION

Incident Date: 2012-09-20	Deadly Force Incident
Incident Summary OIG Case Number: 12-2177-RO <p>On September 20, 2012, several successive riots and disturbances erupted at an institution. Initially, several inmates attacked another inmate, causing a riot to erupt inside a building. Officers utilized pepper spray to stop the riot. However, as custody staff gained control of the riot, a second riot involving over 100 inmates erupted on the exercise yard adjacent to the building. Officers utilized blast dispersion grenades in an effort to stop the incident. Further, an officer in an observation tower observed inmates punching and swinging in a downward motion toward an inmate who was on the ground. The officer fired one warning shot from a Mini-14 rifle which stopped the attack. The inmates temporarily complied with orders to get down, but then quickly got up and rushed to another area of the exercise yard where other inmates were on the ground. The same officer then fired a second warning shot from the Mini-14 rifle, stopping most of the inmates. However, a smaller group of inmates still refused orders to get down and continued moving toward inmates on the ground. The same officer then fired one less-lethal round which did not strike the intended target, but had the desired effect of stopping the inmates. The inmate who was attacked sustained serious injuries and was transported to an outside hospital for treatment. Meanwhile, as officers escorted another inmate for a medical evaluation the inmate broke away from the escort and attacked a group of rival inmates causing another disturbance. Officers utilized physical force to subdue the inmate and stop the disturbance. Later, as different inmates returned from their work and educational programs and learned of the earlier incidents, they attacked each other resulting in another disturbance. Due to the magnitude and number of incidents officers from a nearby institution responded and provided assistance. As officers were responding to the multiple incidents, an employee from the nearby institution reported observing a person wearing what appeared to be inmate clothing running in the community. Both institutions conducted an emergency inmate count which cleared. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The OIG responded on scene.</p>	
Disposition <p>The institution's executive review committee found that the use of force was in compliance with the department's use-of-force policy. No staff misconduct was identified; therefore, the case was not referred to the to the Office of Internal Affairs. The OIG concurred with both decisions.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's response to the incident was insufficient. The department failed to adequately notify the OIG of the incident. The institution's executive review committee failed to timely finalize its decision regarding the use of force, and the institution's investigative services unit failed to confirm in writing its determination that the shots fired were warning shots, as required by departmental policy.</p>	
Assessment Questions <ul style="list-style-type: none">● Was the OIG promptly informed of the critical incident?<p><i>The department did not adequately notify the OIG. The Office of Internal Affairs notified the OIG that warning shots had been fired, but was unable to provide other pertinent information and the institution failed to provide timely notification to the OIG.</i></p>● Did the investigative services unit, or equivalent investigative personnel, adequately respond to the critical incident?<p><i>Although the institution's investigative services unit verbally notified the Office of Internal Affairs of its determination that the officer fired warning shots, it did not confirm its determination in writing as required by departmental policy.</i></p>● Did the use-of-force review committee adequately review and respond to the incident?<p><i>The incident occurred on September 20, 2012; however, the institution's executive review committee did not finalize its decision until February 4, 2013, 138 days later. The committee finalized its decision while clarifications were still pending, two reports had not been submitted, and over 50 medical reports of inmate injuries remained outstanding.</i></p>● Was the critical incident adequately documented?<p><i>Overall, the officers who responded to the incident submitted timely and thorough reports, including the officer who fired two warning shots and one less-than lethal round. However, clarifications were not obtained in a timely manner and over 50 inmate medical reports of injury were not provided to the institution's executive review committee.</i></p>● Did the department adequately consult with the OIG regarding the critical incident?<p><i>The institution's executive review committee failed to provide the OIG adequate notice of the institution's executive review committee meeting.</i></p>	

NORTH REGION

OIG Recommendation

The OIG recommended the hiring authority ensure the investigative service's unit receive training and comply with departmental policy requiring the investigative services unit to provide the Office of Internal Affairs written confirmation of warning shots. The hiring authority concurred with the recommendation.

Incident Date: 2012-10-23

Deadly Force Incident

Incident Summary

OIG Case Number: 12-2443-RO

On October 23, 2012, two inmates began attacking a third inmate on the exercise yard. An officer fired a warning shot from a Mini-14 rifle into a wall effectively stopping the attack. The inmate who was attacked was treated at the triage treatment area and released. The attacking inmates were uninjured. 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: 2012-10-22

Deadly Force Incident

Incident Summary

OIG Case Number: 12-2444-RO

On October 22, 2012, an inmate descended the stairs from an upper tier and approached the floor officers from behind as they were seated at an officers' station on the dayroom floor. Suddenly and without warning the inmate struck an officer with his fist in the back of the officer's head. The officer stood up, stepped back, and drew his baton. A second officer stood up, drew his pepper spray, and ordered the inmate to get down. The inmate refused to comply with orders and assumed a fighting stance with fists raised above his chest, stepping toward the first officer. The first officer struck the inmate in his left shoulder area with the baton. Due to the inmate's movement, he was inadvertently struck with the baton on his left side of his face. The second officer sprayed the inmate with pepper spray in the face and upper torso. The inmate stopped his attack and assumed a prone position on the ground. Responding custody staff arrived, took control of the inmate, and placed him in handcuffs. While in a prone position and in restraints, the inmate continued to resist by thrashing his body and kicking his legs from side to side. A sergeant ordered the inmate to be placed in leg restraints and a spit mask for custody staff safety. Medical staff responded and provided medical assistance to the inmate. The inmate was transported to the triage treatment area and subsequently to an outside hospital for treatment. It was determined the injuries were not life-threatening and the inmate later returned to the institution. Although the Office of Internal Affairs was notified of the incident, their practice is 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 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: 2012-11-02	Deadly Force Incident
<p>Incident Summary OIG Case Number: 12-2544-RO</p> <p>On November 2, 2012, as officers were returning an inmate to his assigned cell, the inmate became agitated, assumed a fighting stance, and stepped in the direction of an officer. The officer immediately ordered the inmate to get down. When the inmate refused to comply, officers used baton strikes and pepper spray to gain compliance. One of the baton strikes deflected off the inmate's left shoulder, impacting the back of his head. As the inmate was being escorted from the initial incident, he suddenly turned his head to the right and spit blood on the left leg of an escorting officer. The escorting officers physically forced the inmate to the ground. The inmate was then transported to the medical clinic for treatment and evaluation of his injuries. The inmate received four staples to close a laceration on the back of his head. The institution did not notify the Office of Internal Affairs.</p>	
<p>Disposition</p> <p>The institution's executive review committee determined that the use of force was within departmental policy. No staff misconduct was identified; therefore, the matter was not referred to the Office of Internal Affairs.</p>	
<p>Incident Assessment</p> <p>Although the department notified the OIG of the incident, the department failed to notify the OIG of the inadvertent baton strike to the inmate's head and the resulting injury. The OIG agreed with the decision not to submit the matter to the Office of Internal Affairs.</p>	<p>Rating: Insufficient</p>
<p>Assessment Questions</p> <ul style="list-style-type: none"> Was the OIG promptly informed of the critical incident? <p><i>Although the department notified the OIG of the incident, the department failed to notify the OIG of the inadvertent baton strike to the inmate's head and the resulting injury. The OIG only learned of the head injury three days later from the daily reports.</i></p>	

Incident Date: 2013-01-15	Deadly Force Incident
<p>Incident Summary OIG Case Number: 13-0156-RO</p> <p>On January 15, 2013, a sergeant assigned as a range instructor allegedly negligently discharged one round from a state issued handgun during a classroom demonstration. The discharged round pierced a metal door but there were no staff injuries as a result of the shooting. The Office of Internal Affairs was notified of the incident; however, they did not respond. The OIG responded on scene.</p>	
<p>Disposition</p> <p>Potential staff misconduct was identified because the sergeant allegedly negligently discharged a firearm; therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.</p>	
<p>Incident Assessment</p> <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 to refer the matter to the Office of Internal Affairs.</p>	<p>Rating: Sufficient</p>

NORTH REGION

Incident Date: 2013-02-06	Deadly Force Incident
Incident Summary OIG Case Number: 13-0277-RO <p>On February 6, 2013, a psychologist observed an inmate on his knees with his hand in his pants reaching toward his anus. The psychologist alerted an officer who responded to the cell. The responding officer observed the inmate kneeling in a large pool of fluid and noted a smell of feces and urine. The officer announced a medical emergency and requested additional custody staff respond. Responding custody staff gave the inmate orders to show his hands and submit to hand restraints. The inmate refused and continued to reach toward his anus while groaning as if in pain. A sergeant utilized pepper spray to stop the inmate, but the inmate continued to refuse orders and reach toward his anus. An emergency cell extraction was performed and three officers entered the cell to subdue the inmate. However, the inmate resisted. One officer attempted to stop the inmate by utilizing a protective shield, but the inmate continued to resist. Another officer used physical force by striking the inmate on the side of his rib cage. A third officer used his expandable baton to strike the inmate in the shoulder area. The officer also inadvertently struck the inmate on the back of the neck and behind the left ear. After being struck behind the ear, the inmate stopped resisting. The inmate was restrained and taken to the triage treatment area for medical treatment. The inmate suffered abrasions, swelling, and redness to the head, neck, shoulders, back, and right knee. The inmate had also pulled a portion of his intestines out of his rectum. One officer was inadvertently struck with the baton on the top of the head. The officer was taken to an outside hospital for treatment. The OIG responded to the scene. 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.</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. The OIG concurred.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's response was insufficient. When the OIG responded on scene the hiring authority advised the OIG that the inmate was not struck in the head with a baton when, in fact, it was already confirmed that the inmate had been struck in the head behind his left ear. Further, the Office of Internal Affairs failed to dispatch a deadly force investigation team.</p>	
Assessment Questions <ul style="list-style-type: none">● Was the HA's response to the critical incident appropriate?<p><i>The hiring authority failed to obtain critical information regarding the incident or confirm that the inmate was struck in the head with a baton. When the OIG responded on scene the hiring authority insisted that the inmate was not struck in the head with a baton despite custody staff reporting otherwise and photographs depicting the inmate's injuries. Furthermore, when the OIG conducted another on-scene visit the following day the hiring authority indicated that he was still not aware that the inmate had been struck in the head with a baton.</i></p>● Did the OIA adequately respond to the incident?<p><i>The Office of Internal Affairs was notified that an officer struck the inmate in the head with a baton during the incident, but did not dispatch a deadly force investigation team.</i></p>● Was the critical incident adequately documented?<p><i>During the incident, an officer used physical force and struck the inmate in the side of the ribs. Although the officer reported his own use of force, no other involved staff members reported observing the officer strike the inmate. Despite multiple levels of use-of-force reviews, staff members were not asked to clarify whether they observed the officer strike the inmate. Clarifications were not requested until the OIG recommended that the institution's executive review committee request clarifications.</i></p>● Did the department adequately consult with the OIG regarding the critical incident?<p><i>The lieutenant who initially contacted the OIG indicated that the inmate was struck in the head with a baton during the incident. The hiring authority later advised another OIG monitor that the inmate was not struck in the head with a baton. The information available at the time indicated that the inmate was struck in the head with a baton.</i></p>	

NORTH REGION

Incident Date: 2013-03-17	Deadly Force Incident
Incident Summary OIG Case Number: 13-0472-RO On March 17, 2013, an officer observed two inmates fighting on the fifth tier of a housing unit. The officer ordered the inmates to stop fighting and fired one less-lethal 40 mm direct impact round. However, the inmates continued to fight. The officer fired another less-lethal 40 mm direct impact round. The round ricocheted off a railing and struck one of the inmates in the head. The inmate was then observed in the prone position on the ground. The other inmate was observed running from the area. The inmate who was struck in the head was transported to an outside hospital for evaluation and treatment, following which he returned to the institution. The OIG was not notified in a timely manner, but responded when notified. Although the Office of Internal Affairs was notified of the incident, 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.	
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 not adequate because the institution failed to timely notify the OIG thereby preventing the OIG from real-time monitoring of the case.	Rating: Insufficient
Assessment Questions <ul style="list-style-type: none">● Was the OIG promptly informed of the critical incident? <i>The incident occurred on the evening of March 17, 2013; however, the OIG was not notified until the morning of March 18, 2013.</i>● Did the department adequately consult with the OIG regarding the critical incident? <i>The department failed to timely notify the OIG of the incident thereby preventing real-time monitoring of the case.</i>	

SOUTH REGION

Incident Date: 2011-05-31		Deadly Force Incident	
Incident Summary On May 31, 2011, while an observation booth officer was preparing to end his shift, he removed his firearm from his holster and accidentally discharged one round into a wall.			
Administrative Investigation		OIG Case Number: 11-1592-IR	
1. Discharge of Lethal Weapon	Findings 1. Sustained	Initial Penalty Salary Reduction	Final Penalty Modified Salary Reduction
Investigative Assessment			Rating: Sufficient
Overall, the department substantially complied with policies and procedures. The Office of Internal Affairs dispatched a deadly force investigation team to the incident. The OIG also responded on scene.			
Disposition The department's independent Deadly Force Review Board found that the discharge of the round was not in compliance with the department's use-of-force policy. The case was referred to the hiring authority for further action. The hiring authority imposed a 10 percent salary reduction for 18 months. The OIG concurred. The officer filed an appeal with the State Personnel Board. However, after the pre-hearing settlement conference the department entered into a settlement agreement with the officer due to his remorse and acceptance of responsibility. The department agreed to reduce the penalty to a 10 percent salary reduction for five months. Based on the officer's remorse and acceptance of responsibility, the OIG concurred.			
Disciplinary Assessment			Rating: Sufficient
The department's disciplinary process sufficiently complied with policies and procedures.			

SOUTH REGION

Incident Date: 2011-09-20		Deadly Force Incident	
Incident Summary On September 20, 2011, a parole agent allegedly neglected his duty when he accidentally shot himself during an attempt to locate a parolee wanted in a homicide investigation.			
Administrative Investigation		OIG Case Number: 11-2376-IR	
1. Use of Deadly Force	Findings 1. Sustained	Initial Penalty Salary Reduction	Final Penalty No Penalty Imposed
Investigative Assessment Overall, the department's investigative process sufficiently complied with policies and procedures. The Office of Internal Affairs dispatched a deadly force investigation team to the incident. The OIG also responded on scene.			Rating: Sufficient
Disposition The hiring authority determined sufficient evidence existed to sustain the allegation and set the penalty at a 10 percent salary reduction for three months. The OIG concurred with the hiring authority's determination. After a <i>Skelly</i> hearing, the hiring authority agreed to reduce the penalty to a letter of reprimand given that the parole agent raised questions regarding the training he had received and expressed remorse for his conduct. The OIG concurred. The parole agent filed an appeal with the State Personnel Board. Following a hearing, the State Personnel Board revoked the letter of reprimand in part because of the department attorney's failure to present the necessary available evidence to sustain the allegations.			
Disciplinary Assessment The department attorney failed to comply with the department's policies and procedures governing the disciplinary process. The department attorney failed to provide the OIG with a draft of the pre-hearing settlement conference statement prior to it being filed. At the State Personnel Board hearing, the department attorney failed to present the necessary available evidence regarding the allegations, including evidence regarding the applicable policies the parole agent allegedly violated. These failures were documented in the State Personnel Board's decision revoking the disciplinary action.			Rating: Insufficient
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 a CMS entry 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> Was the OIG provided with a draft of the pre-hearing settlement conference statement prior to it being filed? <i>The OIG was not provided with a draft of the pre-hearing settlement conference statement prior to it being filed.</i> Did the department's advocate present the necessary available evidence regarding the allegations at the hearing? <i>The department attorney failed to present evidence of the parole agent's training, failed to present evidence regarding the applicable policies that the department alleged the parole agent violated, and failed to present the testimony of the special agent who conducted the investigation. These failures were cited in the State Personnel Board's decision as part of the basis for the decision to revoke the disciplinary action.</i> If the SPB's decision did not uphold all of the factual allegations sustained by the HA, did the OIG concur with the SPB's decision? <i>The OIG concurred with the State Personnel Board's decision because the department attorney failed to present necessary evidence to sustain the allegations.</i> If the penalty modification was the result of an SPB decision, did the OIG concur with the modification? <i>The OIG concurred with the State Personnel Board's decision because the department attorney failed to present necessary evidence to sustain the allegations.</i> 			

SOUTH REGION

Incident Date: 2012-02-17		Deadly Force Incident	
Incident Summary <p>On February 17, 2012, five parole agents were attempting to locate a high-risk parolee who had recently cut off his global positioning system monitoring device. One parole agent walked toward the area where the team believed they had located the parolee. The parolee approached the parole agent, produced a knife, and threatened to kill the parole agent, at which time the parole agent ordered the parolee to drop the weapon. The parolee moved toward the parole agent and, fearing for his safety, the parole agent fired four rounds from his firearm into the parolee's torso. The parolee received medical treatment and survived. The Office of Internal Affairs dispatched a deadly force investigation team to the incident. The OIG also responded to the scene.</p>			
Administrative Investigation		OIG Case Number: 12-0454-IR	
1. Use of Deadly Force	Findings 1. Exonerated	Initial Penalty No Penalty Imposed	Final Penalty No Change
Investigative Assessment			Rating: Sufficient
Overall, the department's investigative process sufficiently complied with policies and procedures.			
Disposition <p>The department's independent Deadly Force Review Board found that the discharges of the lethal rounds complied with the department's use-of-force policy. The hiring authority subsequently exonerated the parole agent and the OIG concurred.</p>			
Disciplinary Assessment			Rating: Insufficient
The department failed to comply with policies and procedures governing the disciplinary process. Specifically, the consultation regarding the sufficiency of the investigation and investigative findings did not take place until 98 days after the department's independent Deadly Force Review Board issued a decision.			
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 department's independent Deadly Force Review Board issued its decision on October 25, 2012; however, the hiring authority did not consult with the department attorney and the OIG concerning the sufficiency of the investigation and the investigative findings until January 31, 2013, 98 days after receipt of the decision.</i> Was the disciplinary phase conducted with due diligence by the department? <i>The hiring authority failed to timely conduct the investigative findings conference.</i> 			

Incident Date: 2012-01-12	Deadly Force Incident
---------------------------	-----------------------

SOUTH REGION

Incident Summary

OIG Case Number: 12-0142-RO

On January 12, 2012, an inmate attacked an officer on the exercise yard by punching him in the head and face. A second inmate attacked another officer who used pepper spray to stop the attack but was unsuccessful. The second inmate took the officer's radio and swung it at the officer as a weapon. The observation officer fired one lethal round as a warning shot and a responding officer used an expandable baton to gain compliance and stop the attack. One of the inmates was inadvertently struck in the head with the baton and sustained minor injuries that were treated at the institution. One of the officers who was attacked was transported to an outside hospital for treatment and was released the same day. The other officer was treated at the institution for minor injuries. Both of the involved inmates filed complaints with the institution alleging that officers used excessive force during the incident. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots, or unless less-lethal force is inadvertently used in a lethal manner or inadvertently causes potential lethal injury. The OIG was also notified.

Disposition

The institution's executive review committee determined the uses of force to be in compliance with departmental policy and the OIG concurred. At the urging of the OIG, the hiring authority provided training to sergeants and lieutenants on obtaining public safety statements from officers after the use of deadly force. Although the hiring authority did not sufficiently address the inmates' complaints of excessive force until 11 months after the incident, the OIG concurred with the decision not to refer the matter to the Office of Internal Affairs.

Incident Assessment

Rating: Insufficient

The department's response was not adequate because the officers involved failed to adequately document the use of force and the on-scene supervisor failed to timely obtain a public safety statement from the officer who used deadly force. The department did not adequately consult with the OIG during the review of the use of force and allegations of excessive force. The institution did not complete review of the inmates' complaints until nearly 11 months after the incident.

SOUTH REGION

Assessment Questions

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

The on-scene supervisor failed to obtain a public safety statement from the officer who used deadly force as required by departmental policy. The investigative services unit obtained the public safety statement but it was approximately 90 minutes after the incident.

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

The investigative services unit confirmed the use of deadly force was a warning shot but failed to provide written confirmation of the determination to the deadly force investigation team as required by departmental policy.

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

The institution's executive review committee closed its review of the incident without reviewing the allegations of excessive force as required by departmental policy. The OIG recommended to the hiring authority that the review of the incident be suspended until the allegation inquiries were completed but the recommendation was disregarded.

- Was the critical incident adequately documented?

The officers involved failed to adequately document the uses of force. The investigative services unit failed to provide written confirmation to the deadly force investigation team of the determination that the use of deadly force was a warning shot. The inmates' allegations of excessive force were not adequately addressed until the OIG urged the hiring authority to obtain clarifications and to document one of the inmate's allegations on videotape 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 hiring authority's initial review and closure of the incident and allegations was timely. However, because the allegations of excessive force were not adequately addressed, the OIG urged the hiring authority to obtain additional interviews and clarifications, which were not obtained until nearly 11 months after the incident.

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

During the initial review of the incident at the institution's executive review committee meeting in March 2012 it was revealed that both of the involved inmates made allegations of excessive force. The OIG advised the hiring authority that departmental policy requires all allegations of excessive force to be reviewed by the institution's executive review committee and recommended that the review of the incident be suspended until completion of the allegation inquiries. The hiring authority deferred the review of the incident but it was later discovered that the incident was closed by the institution's executive review committee in April 2012 without consultation with the OIG and while the allegation inquiries were still pending.

Incident Date: 2012-09-04

Deadly Force Incident

Incident Summary

OIG Case Number: 12-2086-RO

On September 4, 2012, a control booth officer discharged two less-lethal rounds in response to another officer being attacked by an inmate while the officer was searching the inmate. Three other officers were attacked by approximately 15 other inmates. The officers being attacked deployed pepper spray with no effect. Approximately 15 additional inmates ran from their locations on the exercise yard and joined in the attack on the four officers who had been taken to the ground. The observation booth officer discharged two lethal rounds as warning shots which ended the riot. The four officers received non-life threatening injuries from the attack and were transported to a local hospital for treatment. No inmates were injured. The OIG was timely notified and responded to the scene of the incident. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots.

Disposition

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

Incident Assessment

Rating: Sufficient

The department's response was satisfactory in all critical aspects. The department adequately notified and consulted with the OIG on 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: 2012-11-17	Deadly Force Incident
Incident Summary OIG Case Number: 12-2654-RO	
On November 17, 2012, two inmates attacked another inmate on the exercise yard. After an alarm was sounded and orders were given for inmates to get on the ground, a third inmate ran across the yard to the site of the incident and began punching and kicking the inmate being attacked. An officer in a control booth fired a less-lethal round at one of the involved inmates, but missed his intended target. The inmate being attacked was knocked to the ground and was being kicked in the head area by all three attacking inmates. The observation officer fired one lethal round as a warning shot, stopping the attack. The inmate who was attacked was taken to an outside hospital for head and facial trauma and returned to the institution the same day. The other involved inmates sustained minor injuries consistent with fighting and were treated at the institution. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The OIG was timely notified and responded on scene.	
Disposition	
The institution's executive review committee determined 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.	
Incident Assessment	Rating: Sufficient
The department's overall response 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.	

Incident Date: 2012-11-20	Deadly Force Incident
Incident Summary OIG Case Number: 12-2669-RO	
On November 20, 2012, two inmates attacked another inmate on an exercise yard. An officer fired two less-lethal rounds, aiming at the legs of the attacking inmates, but was unable to determine where the rounds struck. The inmates continued their attack and responding officers used pepper spray to gain compliance. Two of the inmates sustained no injuries. One of the inmates sustained a laceration to the back of his head that required sutures. He was treated at the institution, but two hours later he began to vomit and feel ill. The inmate was transported to an outside hospital where it was determined that he had bleeding on his brain and that the injury may have been caused by one of the less-lethal rounds. The inmate returned to the institution two days later. Although the Office of Internal Affairs was notified, the department failed to respond on scene. The department adequately notified the OIG.	
Disposition	
The institution's executive review committee determined that the use of force was in compliance departmental policy. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.	
Incident Assessment	Rating: Insufficient
Although the Office of Internal Affairs was notified they failed to respond on scene. The department also failed to follow departmental policy regarding videotaped interviews. The department provided adequate notification and consultation to the OIG regarding the incident.	
Assessment Questions	
<ul style="list-style-type: none">• Did the OIA adequately respond to the incident? <i>The Office of Internal Affairs failed to respond on scene.</i>• Was the critical incident adequately documented? <i>The department conducted a videotaped interview with the injured inmate in a timely manner but the interviewer failed to indicate the date and time of the interview, and did not introduce himself or the camera operator, in accordance with departmental policy.</i>	

SOUTH REGION

Incident Date: 2012-12-08	Deadly Force Incident
Incident Summary OIG Case Number: 12-2804-RO	
<p>On December 8, 2012, an officer fired a warning shot from a rifle after he observed ten inmates attack another inmate, who fell motionless to the ground, on the exercise yard. The warning shot had the desired effect of stopping the fight. The inmate who was beaten to the ground sustained serious injuries to his head and was air-lifted to receive a higher level of medical care. He later returned to the institution. As a result of the fight, a riot involving approximately 100 inmates erupted in a nearby dining hall. Officers utilized eight less-lethal direct impact rounds to stop the riot. Nine inmates who sustained physical injuries as a result of the fighting were sent to nearby hospitals for medical treatment. Although the Office of Internal Affairs was notified of the incident, their practice is not to respond on scene to warning shots. The OIG was timely notified and responded on scene to the incident.</p>	
Disposition	
<p>The institution's executive review committee determined that the use of force complied with the department's policies and procedures. No staff misconduct was identified; therefore, the case was not referred to the Office of Internal Affairs for investigation.</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 on the incident. The OIG concurred with the hiring authority's decision not to refer the matter to the Office of Internal Affairs.</p>	

Incident Date: 2012-12-14	Deadly Force Incident
Incident Summary OIG Case Number: 12-2865-RO	
<p>On December 14, 2012, an inmate attacked another inmate with an inmate-manufactured weapon when they were released from their cells for showers. An officer discharged one less-lethal round, aiming at the thigh of the attacking inmate, but inadvertently struck the attacked inmate on the left side of the face. The inmates continued to fight, causing responding staff to use pepper spray to gain compliance. The attacked inmate sustained bruising and swelling to his left cheek from the less-lethal round and several puncture wounds to his abdomen and back. The inmate was transported to an outside hospital for treatment where it was determined his injuries were not life-threatening and later returned to the institution. The inmate-manufactured weapon was located near 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. No staff misconduct was identified. The OIG concurred.</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>	

SOUTH REGION

Incident Date: 2013-01-30	Deadly Force Incident
Incident Summary OIG Case Number: 13-0250-RO	
<p>On January 30, 2013, an officer observed two inmates fighting on an exercise yard. The officer activated an alarm and ordered the inmates to get down. Both inmates ignored the commands and continued fighting. The observation officer fired three less-lethal impact rounds, aiming at the legs of the fighting inmates, but missed his intended target. The first two rounds struck the ground near the inmates but the third round inadvertently struck one of the inmates in the back of the head. Both inmates continued fighting, at which time other officers utilized pepper spray to stop the fight and gain compliance. The inmate who was struck in the head sustained a bruise and bleeding to the back of his head. He was transported to a local hospital for treatment and evaluation and returned to institution the same day. The other inmate sustained minor injuries consistent with fighting. The institution failed to notify the Office of Internal Affairs despite the potential lethal injury caused by the use of less-lethal force. The institution also failed to timely notify the OIG thereby preventing the OIG from responding on scene.</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. The OIG concurred.</p>	
Incident Assessment	Rating: Insufficient
<p>The department's response 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"> • Was the OIG promptly informed of the critical incident? <p style="margin-left: 20px;"><i>The incident occurred on January 30, 2013, but the OIG was not notified until the following day, January 31, 2013.</i></p> • Was the HA's response to the critical incident appropriate? <p style="margin-left: 20px;"><i>Departmental policy requires that the institution notify the Office of Internal Affairs when an inmate sustains a serious injury due to the use of force. The institution failed to notify the Office of Internal Affairs about this incident.</i></p> 	

Incident Date: 2013-03-04	Deadly Force Incident
Incident Summary OIG Case Number: 13-0384-RO	
<p>On March 4, 2013, two inmates attacked another inmate on an exercise yard. The observation officer sounded the yard alarm and ordered the inmates to get down but they continued to fight. The three inmates fell to the ground and one inmate began making stabbing motions toward the back of the inmate being attacked, who was lying face-down on the ground. The observation officer fired one lethal round as a warning shot but the inmates continued the attack. Another officer fired one less-lethal round at the leg of one of the attacking inmates. The round missed the intended target and struck the ground, but the inmates stopped the attack and complied with orders. The attacked inmate suffered several puncture wounds to his stomach, chest, and back, but it was determined the injuries were not serious and he was treated at the institution. 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. No staff misconduct was identified. The OIG concurred.</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>	

SOUTH REGION

Incident Date: 2013-04-13	Deadly Force Incident
<p>Incident Summary OIG Case Number: 13-0546-RO</p> <p>On April 13, 2013, an inmate involved in a fight with another inmate failed to comply with orders to stop fighting. An officer deployed pepper spray. The inmate turned toward another officer, striking the officer's arm with his fist. The officer struck the inmate's arm with his expandable baton. The inmate continued to pursue the officer. The control booth officer deployed less-lethal force nine times. Other officers deployed additional pepper spray. The inmate continued to advance on the officer who again struck the inmate with his expandable baton on the left arm and left back shoulder area. The inmate advanced again until the officer struck the inmate with the expandable baton aiming at his back left shoulder, but was deflected by the inmate who was struck in the back of the head. The inmate finally complied with orders to stop resisting. No officers were injured. The inmate received a broken right hand and required stitches in his shin area and the back of his head. He was transported to an outside hospital with non-life-threatening injuries and later returned to the institution. The Office of Internal Affairs was notified and responded to the scene. However, the Office of Internal Affairs did not conduct an investigation because it was determined the head strike was unintentional. The department adequately notified the OIG and the OIG also responded on scene.</p>	
<p>Disposition</p> <p>The institution's executive review committee determined that the use of force complied with the department's policies and procedures. No staff misconduct was identified and the case was not referred to the Office of Internal Affairs for investigation. The OIG concurred.</p>	
<p>Incident Assessment</p> <p>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.</p>	<p>Rating: Sufficient</p>

Incident Date: 2013-04-19	Deadly Force Incident
<p>Incident Summary OIG Case Number: 13-0575-RO</p> <p>On April 19, 2013, an officer observed an inmate attacking another inmate on an exercise yard. The attack continued despite numerous orders to stop. The observing officer sounded an alarm and all inmates were ordered down. The officer then fired a warning shot from a rifle after he observed the attacked inmate being punched and kicked in the head while he was on the ground. The warning shot stopped the fight. The attacked inmate sustained cuts and abrasions to his head and neck. 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 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.</p>	<p>Rating: Sufficient</p>

APPENDIX F CONTRABAND SURVEILLANCE WATCH CASE SUMMARIES

CENTRAL REGION

Date Placed on Contraband Watch 2013-01-25	Date Taken off Contraband Watch 2013-01-29	Reason for Placement Suspicious Activity	Contraband Found Other
Incident Summary			13-05111-CWRM
On January 25, 2013, the department placed an inmate on contraband surveillance watch for possible ingestion of metal nail clippers or pieces of nail clippers. The inmate was removed from contraband surveillance watch on January 29, 2013, four days later. During that time, the department recovered pieces of a metal nail clipper 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 did not properly place the inmate on contraband surveillance watch and the policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly. Health and safety concerns, medical assessments, and required documentation were not properly completed by the department.			

Date Placed on Contraband Watch 2013-01-27	Date Taken off Contraband Watch 2013-02-07	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-05171-CWRM
On January 27, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 7, 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 policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly and the department failed to properly remove the inmate from contraband surveillance watch. The department did not complete the appropriate documentation.			

Date Placed on Contraband Watch 2013-01-28	Date Taken off Contraband Watch 2013-02-01	Reason for Placement Suspected Weapons	Contraband Found Drugs
Incident Summary			13-05191-CWRM
On January 28, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 1, 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.			

CENTRAL REGION

Date Placed on Contraband Watch 2013-02-14	Date Taken off Contraband Watch 2013-02-18	Reason for Placement Suspected Weapons	Contraband Found Inmate Note
Incident Summary			13-05371-CWRM
<p>On February 14, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 18, 2013, four days later. During that time, the department recovered a heavy duty staple, part of a paper clip, and an inmate note from the inmate.</p>			
Incident Assessment			
<p>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 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.</p>			

Date Placed on Contraband Watch 2013-02-05	Date Taken off Contraband Watch 2013-02-09	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-05391-CWRM
<p>On February 5, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 9, 2013, four days later. During that time, the department recovered nothing from the inmate because he was able to retrieve the contraband and ingest it while under surveillance. The inmate is pending a disciplinary hearing for refusing a drug test.</p>			
Incident Assessment			
<p>The department did not provide timely notification the OIG when the inmate was placed on contraband surveillance watch and failed to sufficiently comply with policies and procedures. The policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly.</p>			

Date Placed on Contraband Watch 2013-02-18	Date Taken off Contraband Watch 2013-02-26	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-05661-CWRM
<p>On February 18, 2013, an inmate swallowed three razor blades in an effort to harm himself. On February 26, 2013, the items were removed from the inmate by medical intervention.</p>			
Incident Assessment			
<p>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.</p>			

CENTRAL REGION

Date Placed on Contraband Watch 2013-03-14	Date Taken off Contraband Watch 2013-03-17	Reason for Placement Suspected Weapons	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-05781-CWRM

On March 14, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on March 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. Medical assessments and health and safety concerns were not properly addressed by the department.

Date Placed on Contraband Watch 2013-04-10	Date Taken off Contraband Watch 2013-04-17	Reason for Placement Suspicious Activity	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-06341-CWRM

On April 10, 2013, the department placed an inmate on contraband surveillance watch based on confidential information that the inmate had secreted unidentified contraband. The inmate was removed from contraband surveillance watch on April 17, 2013, seven 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 policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly.

Date Placed on Contraband Watch 2013-04-10	Date Taken off Contraband Watch 2013-04-16	Reason for Placement Suspicious Activity	Contraband Found Drugs
---	---	---	---------------------------

Incident Summary 13-06351-CWRM

On April 10, 2013, the department placed an inmate on contraband surveillance watch after receiving confidential information that the inmate had contraband secreted in his anal cavity. The inmate was removed from contraband surveillance watch on April 16, 2013, six 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 2013-04-17	Date Taken off Contraband Watch 2013-04-20	Reason for Placement Suspected Inmate Note	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-06501-CWRM

On April 17, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on April 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 complete the appropriate documentation.

CENTRAL REGION

Date Placed on Contraband Watch 2013-04-17	Date Taken off Contraband Watch 2013-04-20	Reason for Placement Suspected Inmate Note	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary

13-06511-CWRM

On April 17, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on April 20, 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. Health and safety concerns, medical assessments, and required documentation were not properly completed by the department.

Date Placed on Contraband Watch 2013-04-17	Date Taken off Contraband Watch 2013-05-02	Reason for Placement Suspected Weapons	Contraband Found 1. Other 2. Weapons
---	---	---	--

Incident Summary

13-06521-CWRM

On April 17, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 2, 2013, 15 days later. During that time, the department recovered five razor blades, a dismantled set of nail clippers, pen fillers, paperclips, and a sewing needle 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 2013-02-03	Date Taken off Contraband Watch 2013-02-06	Reason for Placement Suspicious Activity	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary

13-06571-CWRM

On February 3, 2013, the department placed an inmate on contraband surveillance watch because officers noticed an unidentified object protruding from the inmate's rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on February 6, 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 2013-04-22	Date Taken off Contraband Watch 2013-04-26	Reason for Placement Suspected Drugs	Contraband Found Drugs
---	---	---	---------------------------

Incident Summary 13-06631-CWRM

On April 22, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on April 26, 2013, four days later. During that time, the department recovered two types of illegal drugs from the inmate. While the inmate was on contraband surveillance watch an officer did not provide constant visual observation of the inmate thereby enabling the inmate to remove the restraints and retrieve contraband from his person. The officer also did not adequately document removal of the restraints during meal time.

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. Potential staff misconduct was identified. Therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.

Date Placed on Contraband Watch 2013-05-07	Date Taken off Contraband Watch 2013-05-13	Reason for Placement Suspicious Activity	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-06991-CWRM

On May 7, 2013, the department placed an inmate on contraband surveillance watch after he was seen swallowing an unknown object. The inmate was removed from contraband surveillance watch on May 13, 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 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 2013-05-18	Date Taken off Contraband Watch 2013-05-24	Reason for Placement Suspected Drugs	Contraband Found 1. Drugs 2. Inmate Note
---	---	---	--

Incident Summary 13-07171-CWRM

On May 18, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 24, 2013, six days later. During that time, the department recovered drugs and an inmate note from the inmate.

Incident Assessment

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

CENTRAL REGION

Date Placed on Contraband Watch 2013-05-30	Date Taken off Contraband Watch 2013-06-12	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-07271-CWRM
On May 30, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on June 12, 2013, 13 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 2013-01-23	Date Taken off Contraband Watch 2013-01-26	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-07301-CWRM
On January 23, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on January 26, 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 policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly. The department did not complete the appropriate documentation.			

Date Placed on Contraband Watch 2013-06-08	Date Taken off Contraband Watch 2013-06-12	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-07371-CWRM
On June 8, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on June 12, 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. Medical assessments and health and safety concerns were not properly addressed by the department.			

Date Placed on Contraband Watch 2013-06-13	Date Taken off Contraband Watch 2013-06-18	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-07401-CWRM
On June 13, 2013, the department placed an inmate on contraband surveillance watch after he attempted to swallow an unknown object, and then flushed it down the toilet. The inmate was removed from contraband surveillance watch on June 18, 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 policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly.			

CENTRAL REGION

Date Placed on Contraband Watch 2013-02-01	Date Taken off Contraband Watch 2013-02-04	Reason for Placement Suspected Weapons	Contraband Found Other
Incident Summary On February 1, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 4, 2013, three days later. During that time, the department transferred the inmate to an outside hospital and a piece of metal from an eyeglass frame was surgically removed from the inmate. The inmate also had a paperclip hidden underneath his skin.			13-07901-CWRM
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 2012-12-27	Date Taken off Contraband Watch 2013-01-10	Reason for Placement Suspected Weapons	Contraband Found Nothing
Incident Summary			12-04611-CWRM
On December 27, 2012, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on January 10, 2013, 14 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 2013-01-03	Date Taken off Contraband Watch 2013-01-08	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-04671-CWRM
On January 3, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on January 8, 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.			

Date Placed on Contraband Watch 2013-01-08	Date Taken off Contraband Watch 2013-01-17	Reason for Placement Suspicious Activity	Contraband Found Other
Incident Summary			13-04801-CWRM
On January 8, 2013, the department placed an inmate on contraband surveillance watch after the inmate broke his eye glasses and swallowed the glass and metal piece. The inmate was removed from contraband surveillance watch on January 17, 2013, eight days later. During that time, the department recovered broken glass from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-01-12	Date Taken off Contraband Watch 2013-01-28	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-04991-CWRM
On January 12, 2013, the department placed an inmate on contraband surveillance watch after he reported he had swallowed razor blades. The inmate was removed from contraband surveillance watch on January 28, 2013, 16 days later. During that time, the department recovered weapons 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 2013-01-16	Date Taken off Contraband Watch 2013-01-22	Reason for Placement Suspected Weapons	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary

13-05011-CWRM

On January 16, 2013, the department placed an inmate on contraband surveillance watch due to the belief that the inmate secreted a melted plastic weapon in his body. The inmate was removed from contraband surveillance watch on January 22, 2013, six 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 complete the appropriate documentation.

Date Placed on Contraband Watch 2013-01-19	Date Taken off Contraband Watch 2013-01-23	Reason for Placement Suspicious Activity	Contraband Found Drugs
---	---	---	---------------------------

Incident Summary

13-05021-CWRM

On January 19, 2013, the department placed an inmate on contraband surveillance watch after the inmate was observed on video surveillance swallowing an unknown item during visiting. The inmate was removed from contraband surveillance watch on January 23, 2013, three days later. During that time, the department recovered marijuana 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. Health and safety concerns, medical assessments, and required documentation were not properly completed by the department.

Date Placed on Contraband Watch 2013-01-19	Date Taken off Contraband Watch 2013-01-27	Reason for Placement Suspected Drugs	Contraband Found Other
---	---	---	---------------------------

Incident Summary

13-05031-CWRM

On January 19, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on January 27, 2013, eight days later. During that time, the department recovered pieces of a bindle from the inmate.

Incident Assessment

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

Date Placed on Contraband Watch 2013-01-20	Date Taken off Contraband Watch 2013-01-23	Reason for Placement Suspected Drugs	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary

13-05051-CWRM

On January 20, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on January 23, 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 did not properly place the inmate on contraband surveillance watch and the policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly. Health and safety concerns, medical assessments, and required documentation were not properly completed by the department.

NORTH REGION

Date Placed on Contraband Watch 2013-01-20	Date Taken off Contraband Watch 2013-01-27	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-05071-CWRM
<p>On January 20, 2013, the department placed an inmate on contraband surveillance watch after the inmate was observed by an officer swallowing something given to him by his female visitor. The inmate was removed from contraband surveillance watch on January 27, 2013, seven days later. During that time, the department recovered nothing from the inmate.</p>			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-01-18	Date Taken off Contraband Watch 2013-02-01	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-05081-CWRM
<p>On January 18, 2013, the department placed an inmate on contraband surveillance watch because the inmate was seen swallowing an unknown object while at work. The inmate was removed from contraband surveillance watch on February 1, 2013, 14 days later. During that time, the department recovered drugs from the inmate.</p>			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-01-30	Date Taken off Contraband Watch 2013-02-07	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-05211-CWRM
<p>On January 30, 2013, the department placed an inmate on contraband surveillance watch after the inmate admitted to placing razor blades in his rectum. The inmate was removed from contraband surveillance watch on February 7, 2013, eight days later. During that time, the department recovered two razor blades and pornographic material from the inmate.</p>			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-02-09	Date Taken off Contraband Watch 2013-02-13	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-05291-CWRM
<p>On February 9, 2013, the department placed an inmate on contraband surveillance watch after the inmate was seen swallowing an unknown object during visiting. The inmate's visitor was searched and custody staff recovered two bindles containing suspected narcotics. The inmate was removed from contraband surveillance watch on February 13, 2013, four days later. During that time, the department recovered two bindles of heroin from the inmate.</p>			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

NORTH REGION

Date Placed on Contraband Watch 2013-02-11	Date Taken off Contraband Watch 2013-02-15	Reason for Placement Suspicious Activity	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary

13-05301-CWRM

On February 11, 2013, the department placed an inmate on contraband surveillance watch. The inmate was seen with unknown items in his pocket. When approached by an officer about the items, the inmate swallowed them. The inmate was removed from contraband surveillance watch on February 15, 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 2013-02-14	Date Taken off Contraband Watch 2013-02-20	Reason for Placement Suspicious Activity	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary

13-05441-CWRM

On February 14, 2013, the department placed an inmate on contraband surveillance watch because, during an unclothed body search, an officer observed plastic wrap protruding from the inmate's rectum. The inmate was removed from contraband surveillance watch on February 20, 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 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 2013-02-16	Date Taken off Contraband Watch 2013-02-19	Reason for Placement Suspected Weapons	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary

13-05451-CWRM

On February 16, 2013, the department placed an inmate on contraband surveillance watch after the inmate reportedly swallowed razor blades and reported that he wanted to harm himself. The inmate was removed from contraband surveillance watch on February 19, 2013, three 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 2013-02-16	Date Taken off Contraband Watch 2013-02-19	Reason for Placement Suspected Drugs	Contraband Found Drugs
---	---	---	---------------------------

Incident Summary

13-05461-CWRM

On February 16, 2013, the department placed an inmate on contraband surveillance watch after the inmate was observed swallowing unknown objects whole without chewing and acting suspiciously. The inmate was removed from contraband surveillance watch on February 19, 2013, three days later. During that time, the department recovered one bundle containing suspected marijuana and another bundle containing suspected methamphetamine 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 2013-02-17	Date Taken off Contraband Watch 2013-02-21	Reason for Placement Suspected Drugs	Contraband Found Inmate Note
Incident Summary			13-05471-CWRM
<p>On February 17, 2013, the department placed an inmate on contraband surveillance watch because he was observed running and swallowing a bindle with unknown contents. The inmate was removed from contraband surveillance watch on February 21, 2013, four days later. During that time, the department recovered an inmate note from the inmate.</p>			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-03-09	Date Taken off Contraband Watch 2013-03-13	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-05681-CWRM
<p>On March 9, 2013, the department placed an inmate on contraband surveillance watch after an officer observed the inmate take a foreign object from a visitor, place it in his mouth, and swallow it. The inmate was removed from contraband surveillance watch on March 13, 2013, four days later. During that time, the department recovered drugs from the inmate.</p>			
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 2013-03-10	Date Taken off Contraband Watch 2013-03-14	Reason for Placement Suspicious Activity	Contraband Found Inmate Note
Incident Summary			13-05701-CWRM
<p>On March 10, 2013, the department placed an inmate on contraband surveillance watch because, during a random cell search, the inmate was discovered with an inmate-manufactured weapon and during a subsequent unclothed body search officers observed lubricant on the inmate's rectum. The inmate was removed from contraband surveillance watch on March 14, 2013, four days later. During that time, the department recovered an inmate note from the inmate.</p>			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-03-18	Date Taken off Contraband Watch 2013-03-25	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-05841-CWRM
<p>On March 18, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on March 25, 2013, seven days later. During that time, the department recovered drugs from the inmate.</p>			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

NORTH REGION

Date Placed on Contraband Watch 2013-03-17	Date Taken off Contraband Watch 2013-03-21	Reason for Placement Suspicious Activity	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-05851-CWRM

On March 17, 2013, the department placed an inmate on contraband surveillance watch because he was seen swallowing unknown objects provided by a visitor during visiting. The inmate was removed from contraband surveillance watch on March 21, 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 2013-03-19	Date Taken off Contraband Watch 2013-03-22	Reason for Placement Suspicious Activity	Contraband Found Inmate Note
---	---	---	---------------------------------

Incident Summary 13-05871-CWRM

On March 19, 2013, the department placed an inmate on contraband surveillance watch after an officer observed him swallowing an unidentified object during a cell search. The inmate was removed from contraband surveillance watch on March 22, 2013, three days later. During that time, the department recovered an inmate note 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 2013-03-19	Date Taken off Contraband Watch 2013-03-26	Reason for Placement Suspicious Activity	Contraband Found Inmate Note
---	---	---	---------------------------------

Incident Summary 13-05881-CWRM

On March 19, 2013, the department placed an inmate on contraband surveillance watch after officers noticed lubricant around the inmate's rectum during a search. The inmate was removed from contraband surveillance watch on March 26, 2013, seven 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 2013-03-19	Date Taken off Contraband Watch 2013-03-23	Reason for Placement Suspicious Activity	Contraband Found Other
---	---	---	---------------------------

Incident Summary 13-05901-CWRM

On March 19, 2013, the department placed an inmate on contraband surveillance watch. During an unclothed body search custody staff observed lubricant around the inmate's anus. The inmate was removed from contraband surveillance watch on March 23, 2013, four days later. During that time, the department recovered an inmate-manufactured hypodermic syringe 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 2013-03-18	Date Taken off Contraband Watch 2013-03-26	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-05911-CWRM
On March 18, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on March 26, 2013, eight 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 2013-03-20	Date Taken off Contraband Watch 2013-03-23	Reason for Placement Suspected Inmate Note	Contraband Found 1. Drugs 2. Other 3. Weapons
Incident Summary			13-05951-CWRM
On March 20, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on March 23, 2013, three days later. During that time, the department recovered drugs, weapons, headphones, staples, a lighter, and a metal cap from a pen from the inmate.			
Incident Assessment			
The department adequately complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-03-22	Date Taken off Contraband Watch 2013-03-26	Reason for Placement Suspected Inmate Note	Contraband Found Inmate Note
Incident Summary			13-06041-CWRM
On March 22, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on March 26, 2013, four days later. During that time, the department recovered inmate notes from the inmate.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-04-04	Date Taken off Contraband Watch 2013-04-07	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-06161-CWRM
On April 4, 2013, the department placed an inmate on contraband surveillance watch because the inmate swallowed an object during a cell search. The inmate was removed from contraband surveillance watch on April 7, 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.			

NORTH REGION

Date Placed on Contraband Watch 2013-04-05	Date Taken off Contraband Watch 2013-04-10	Reason for Placement Suspected Weapons	Contraband Found Inmate Note
Incident Summary			13-06201-CWRM
On April 5, 2013, the department placed an inmate on contraband surveillance watch because the institution received confidential information that the inmate was in possession of contraband. The inmate was removed from contraband surveillance watch on April 10, 2013, five 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 2013-04-05	Date Taken off Contraband Watch 2013-04-11	Reason for Placement Suspected Weapons	Contraband Found 1. Inmate Note 2. Weapons
Incident Summary			13-06221-CWRM
On April 5, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on April 11, 2013, six days later. During that time, the department recovered weapons and 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 2013-04-05	Date Taken off Contraband Watch 2013-04-10	Reason for Placement Suspected Weapons	Contraband Found Inmate Note
Incident Summary			13-06231-CWRM
On April 5, 2013, the department placed an inmate on contraband surveillance watch because the institution received confidential information that the inmate was in possession of contraband. The inmate was removed from contraband surveillance watch on April 10, 2013, five 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 did not complete the appropriate documentation.			

Date Placed on Contraband Watch 2013-04-18	Date Taken off Contraband Watch 2013-04-23	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-06531-CWRM
On April 18, 2013, an inmate was absent from his work area and found in another area where tobacco wrappings and a lighter package were found. During an unclothed body search officers recovered rolling papers and a lighter, and saw lubricant around the inmate's rectum. The department placed the inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on April 23, 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.			

NORTH REGION

Date Placed on Contraband Watch	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-04-19	2013-04-24	Suspected Weapons	Nothing

Incident Summary

13-06541-CWRM

On April 19, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on April 24, 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	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-04-26	2013-04-30	Suspected Tobacco	1. Drugs 2. Tobacco

Incident Summary

13-06691-CWRM

On April 26, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on April 30, 2013, four days later. During that time, the department recovered drugs and tobacco 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	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-04-28	2013-05-02	Suspicious Activity	Drugs

Incident Summary

13-06701-CWRM

On April 28, 2013, the department placed an inmate on contraband surveillance watch because the inmate was seen in visiting taking something from a visitor and attempting to secrete the item. A visitor admitted giving something to the inmate. The inmate was removed from contraband surveillance watch on May 2, 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	Date Taken off Contraband Watch	Reason for Placement	Contraband Found
2013-04-29	2013-05-02	Suspicious Activity	Nothing

Incident Summary

13-06711-CWRM

On April 29, 2013, the department placed an inmate on contraband surveillance watch because officers noticed lubricant around the inmate's rectum during an unclothed body search. The inmate was removed from contraband surveillance watch on May 2, 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.

NORTH REGION

Date Placed on Contraband Watch 2013-04-26	Date Taken off Contraband Watch 2013-05-08	Reason for Placement Suspected Weapons	Contraband Found Other
---	---	---	---------------------------

Incident Summary

13-06841-CWRM

On April 26, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 8, 2013, 12 days later. During that time, the department recovered two small pieces of an envelope clasp, a small piece of aluminum foil, and a paper clip 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 policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly.

Date Placed on Contraband Watch 2013-05-09	Date Taken off Contraband Watch 2013-05-15	Reason for Placement Suspected Tobacco	Contraband Found 1. Drugs 2. Tobacco
---	---	---	--

Incident Summary

13-06901-CWRM

On May 9, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 15, 2013, six days later. During that time, the department recovered drugs and tobacco 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 2013-05-11	Date Taken off Contraband Watch 2013-05-14	Reason for Placement Suspected Drugs	Contraband Found Drugs
---	---	---	---------------------------

Incident Summary

13-06951-CWRM

On May 11, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 14, 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 inmate was not properly placed on 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 and address health and safety concerns.

NORTH REGION

Date Placed on Contraband Watch 2013-05-13	Date Taken off Contraband Watch 2013-05-16	Reason for Placement Suspicious Activity	Contraband Found Weapons
Incident Summary			13-07001-CWRM
<p>On May 13, 2013, the department placed an inmate on contraband surveillance watch because officers saw the inmate swallow an unknown substance before a cell search. The inmate was removed from contraband surveillance watch on May 16, 2013, three days later. During that time, the department recovered weapons from the inmate.</p>			
Incident Assessment <p>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. Health and safety concerns, medical assessments, and required documentation were not properly completed by the department.</p>			

Date Placed on Contraband Watch 2013-05-13	Date Taken off Contraband Watch 2013-05-20	Reason for Placement Suspicious Activity	Contraband Found Weapons
Incident Summary			13-07011-CWRM
<p>On May 13, 2013, the department placed an inmate on contraband surveillance watch because he was observed by an officer swallowing unidentified items during a cell search. On May 14, 2013, the department recovered the metal tip of a weapon from the inmate. The inmate was removed from contraband surveillance watch on May 20, 2013, seven days later at which time x-rays confirmed no further contraband.</p>			
Incident Assessment <p>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 and address health and safety concerns.</p>			

Date Placed on Contraband Watch 2013-05-13	Date Taken off Contraband Watch 2013-05-20	Reason for Placement Suspected Weapons	Contraband Found 1. Inmate Note 2. Weapons
Incident Summary			13-07021-CWRM
<p>On May 13, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 20, 2013, seven days later. During that time, the department recovered razor blades and an inmate note from the inmate.</p>			
Incident Assessment <p>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 inmate was not correctly placed on contraband surveillance watch.</p>			

NORTH REGION

Date Placed on Contraband Watch 2013-05-13	Date Taken off Contraband Watch 2013-05-20	Reason for Placement Suspicious Activity	Contraband Found Inmate Note
Incident Summary			13-07061-CWRM
On May 13, 2013, the department placed an inmate on contraband surveillance watch because, during an unclothed body search, the inmate appeared to have placed contraband in his rectum. On May 19, 2013, the department recovered three inmate notes. The inmate was removed from contraband surveillance watch on May 20, 2013, seven days after placement.			
Incident Assessment			
The department sufficiently complied with policies and procedures. No staff misconduct was identified.			

Date Placed on Contraband Watch 2013-05-13	Date Taken off Contraband Watch 2013-05-17	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-07071-CWRM
On May 13, 2013, the department placed an inmate on contraband surveillance watch because, during an unclothed body search, the inmate appeared to have placed contraband in his rectum. The inmate was removed from contraband surveillance watch on May 17, 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.			

Date Placed on Contraband Watch 2013-05-17	Date Taken off Contraband Watch 2013-05-23	Reason for Placement Suspected Weapons	Contraband Found Nothing
Incident Summary			13-07091-CWRM
On May 17, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 23, 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 2013-05-19	Date Taken off Contraband Watch 2013-05-22	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-07101-CWRM
On May 19, 2013, the department placed an inmate on contraband surveillance watch after officers saw the inmate place an object in his rectum during visiting. The inmate was removed from contraband surveillance watch on May 22, 2013, three 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.			

NORTH REGION

Date Placed on Contraband Watch 2013-05-19	Date Taken off Contraband Watch 2013-05-26	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-07111-CWRM
On May 19, 2013, the department placed an inmate on contraband surveillance watch because officers saw the inmate place an unknown item in his mouth and swallow it during visiting. The inmate was removed from contraband surveillance watch on May 26, 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 2013-05-19	Date Taken off Contraband Watch 2013-05-25	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-07121-CWRM
On May 19, 2013, the department placed an inmate on contraband surveillance watch because, during visiting, a visitor was seen passing an unknown item to the inmate while kissing. The inmate was removed from contraband surveillance watch on May 25, 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 2013-05-20	Date Taken off Contraband Watch 2013-05-23	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-07131-CWRM
On May 20, 2013, the department placed an inmate on contraband surveillance watch because officers saw the inmate place an unknown object in his mouth. The inmate was removed from contraband surveillance watch on May 23, 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 2013-05-30	Date Taken off Contraband Watch 2013-06-04	Reason for Placement Suspicious Activity	Contraband Found Mobile Phone
Incident Summary			13-07231-CWRM
On May 30, 2013, the department placed an inmate on contraband surveillance watch after he failed a metal detector and admitted to secreting a mobile phone in his rectum. The inmate was removed from contraband surveillance watch on June 4, 2013, five days later. During that time, the department recovered a mobile phone 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 2013-05-25	Date Taken off Contraband Watch 2013-05-29	Reason for Placement Suspicious Activity	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-07261-CWRM

On May 25, 2013, the department placed an inmate on contraband surveillance watch because officers suspected the inmate swallowed an unknown object because of his behavior. The inmate was removed from contraband surveillance watch on May 29, 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 2013-06-15	Date Taken off Contraband Watch 2013-06-20	Reason for Placement Suspected Weapons	Contraband Found Weapons
---	---	---	-----------------------------

Incident Summary 13-07431-CWRM

On June 15, 2013, the department placed an inmate on contraband surveillance watch after the inmate admitted that he swallowed a razor blade. The inmate was removed from contraband surveillance watch on June 20, 2013, five days later. During that time, the department recovered two razor blades 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 2013-06-25	Date Taken off Contraband Watch 2013-06-28	Reason for Placement Suspected Drugs	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-07551-CWRM

On June 25, 2013, the department placed an inmate on contraband surveillance watch because he was observed swallowing an unknown object during a cell search by officers. The inmate was removed from contraband surveillance watch on June 28, 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 policies and procedures regarding the documentation or use of restraints or hand-isolation devices, were not followed correctly.

Date Placed on Contraband Watch 2013-06-25	Date Taken off Contraband Watch 2013-06-28	Reason for Placement Suspected Drugs	Contraband Found Nothing
---	---	---	-----------------------------

Incident Summary 13-07561-CWRM

On June 25, 2013, the department placed an inmate on contraband surveillance watch because he was observed swallowing an unknown object during a cell search. The inmate was removed from contraband surveillance watch on June 28, 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.

SOUTH REGION

Date Placed on Contraband Watch 2013-01-27	Date Taken off Contraband Watch 2013-01-30	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-05121-CWRM
On January 27, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on January 30, 2013, three 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 2013-02-03	Date Taken off Contraband Watch 2013-02-07	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-05261-CWRM
On February 3, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 7, 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.			

Date Placed on Contraband Watch 2013-02-12	Date Taken off Contraband Watch 2013-02-16	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-05331-CWRM
On February 12, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 16, 2013, four 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.			

Date Placed on Contraband Watch 2013-02-16	Date Taken off Contraband Watch 2013-02-22	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-05381-CWRM
On February 16, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 22, 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.			

SOUTH REGION

Date Placed on Contraband Watch 2013-02-17	Date Taken off Contraband Watch 2013-02-21	Reason for Placement Suspected Weapons	Contraband Found Weapons
Incident Summary			13-05481-CWRM
On February 17, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on February 21, 2013, four days later. During that time, the department recovered weapons 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 2013-02-27	Date Taken off Contraband Watch 2013-03-08	Reason for Placement Suspicious Activity	Contraband Found Other
Incident Summary			13-05601-CWRM
On February 27, 2013, the department placed an inmate on contraband surveillance watch because the inmate reported swallowing copper tubing which x-rays confirmed. The inmate was removed from contraband surveillance watch on March 8, 2013, nine days later, at which time he was transferred to a different institution for a higher level of care. During that time, the department recovered a chain and eye dropper from the inmate. The copper tubing was not yet recovered but was later surgically removed at an outside hospital.			
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 2013-03-02	Date Taken off Contraband Watch 2013-03-05	Reason for Placement Suspicious Activity	Contraband Found Nothing
Incident Summary			13-05621-CWRM
On March 2, 2013, the department placed an inmate on contraband surveillance watch because officers observed the inmate swallow an unknown substance. The inmate was removed from contraband surveillance watch on March 5, 2013, three 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 2013-03-17	Date Taken off Contraband Watch 2013-03-21	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-05801-CWRM
On March 17, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on March 21, 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.			

SOUTH REGION

Date Placed on Contraband Watch 2013-04-11	Date Taken off Contraband Watch 2013-04-14	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-06371-CWRM
<p>On April 11, 2013, the department placed an inmate on contraband surveillance watch because, during a search, officers observed the inmate swallow an unknown object. The inmate was removed from contraband surveillance watch on April 14, 2013, three days later. During that time, the department recovered drugs from the inmate.</p>			
Incident Assessment			
<p>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 conduct appropriate medical assessments, address health and safety concerns, and complete the appropriate documentation.</p>			

Date Placed on Contraband Watch 2013-04-30	Date Taken off Contraband Watch 2013-05-03	Reason for Placement Suspected Weapons	Contraband Found Nothing
Incident Summary			13-06741-CWRM
<p>On April 30, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 3, 2013, three days later. During that time, the department recovered nothing from the inmate.</p>			
Incident Assessment			
<p>The department did not provide timely notification the OIG when the inmate was placed on contraband surveillance watch and failed to sufficiently comply with policies and procedures. The inmate was not correctly placed on contraband surveillance watch. Health and safety concerns, medical assessments, and required documentation were not properly completed by the department.</p>			

Date Placed on Contraband Watch 2013-05-03	Date Taken off Contraband Watch 2013-05-09	Reason for Placement Suspected Weapons	Contraband Found Nothing
Incident Summary			13-06771-CWRM
<p>On May 3, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 9, 2013, six days later. During that time, the department recovered nothing from the inmate.</p>			
Incident Assessment			
<p>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. Potential staff misconduct was identified. Therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.</p>			

SOUTH REGION

Date Placed on Contraband Watch 2013-05-10	Date Taken off Contraband Watch 2013-05-13	Reason for Placement Suspected Drugs	Contraband Found Nothing
Incident Summary			13-06981-CWRM
On May 10, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 13, 2013, three days later. During that time, the department recovered nothing from the inmate.			
Incident Assessment			
The department did not provide timely notification 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 2013-05-16	Date Taken off Contraband Watch 2013-05-21	Reason for Placement Suspected Weapons	Contraband Found Nothing
Incident Summary			13-07081-CWRM
On May 16, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on May 21, 2013, five 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 2013-06-01	Date Taken off Contraband Watch 2013-06-05	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-07321-CWRM
On June 1, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on June 5, 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. Potential staff misconduct was identified; therefore, the case was referred to the Office of Internal Affairs for investigation. An investigation was opened, which the OIG accepted for monitoring.			

Date Placed on Contraband Watch 2013-06-15	Date Taken off Contraband Watch 2013-06-19	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-07411-CWRM
On June 15, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on June 19, 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.			

SOUTH REGION

Date Placed on Contraband Watch 2013-06-23	Date Taken off Contraband Watch 2013-06-28	Reason for Placement Suspicious Activity	Contraband Found Drugs
Incident Summary			13-07531-CWRM
On June 23, 2013, the department placed an inmate on contraband surveillance watch after he was observed during visiting placing an unknown object in his mouth. The inmate was removed from contraband surveillance watch on June 28, 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 2013-06-23	Date Taken off Contraband Watch 2013-06-27	Reason for Placement Suspected Drugs	Contraband Found Drugs
Incident Summary			13-07541-CWRM
On June 23, 2013, the department placed an inmate on contraband surveillance watch. The inmate was removed from contraband surveillance watch on June 27, 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.			



SEMI-ANNUAL REPORT
January–June 2013
Volume II

OFFICE OF THE INSPECTOR GENERAL

Robert A. Barton
INSPECTOR GENERAL

Roy W. Wesley
CHIEF DEPUTY INSPECTOR GENERAL

STATE OF CALIFORNIA
October 2013