Amarik K. Singh, *Inspector General*

Neil Robertson, *Chief Deputy Inspector General*

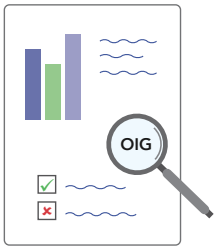
OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

February 2023

2022 Annual Report

A Summary of Reports



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STATE *of* CALIFORNIA
OIG | OFFICE *of the* INSPECTOR GENERAL

***Amarik K. Singh**, Inspector General*
***Neil Robertson**, Chief Deputy Inspector General*

Independent Prison Oversight

Regional Offices

Sacramento
Bakersfield
Rancho Cucamonga

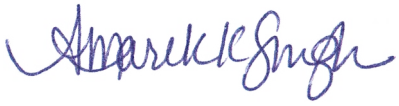
February 21, 2023

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

Dear Governor and Legislative Leaders:

Enclosed please find our annual report summarizing the work the Office of the Inspector General completed in 2022. In 2022, we issued 18 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: 12 reports on medical inspection results; two reports on our monitoring of the department's internal investigations and employee disciplinary process; one report on our monitoring of the department's use of force; one report on our monitoring of the department's staff misconduct complaints process, one special review; and our 2021 annual report.

Respectfully submitted,



Amarik K. Singh
Inspector General

***Gavin Newsom**, Governor*

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Vision

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

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

Mission

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

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

— Amarik K. Singh
Inspector General

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

— State of California
Penal Code section 6125

Organizational Overview and Functions

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

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

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

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

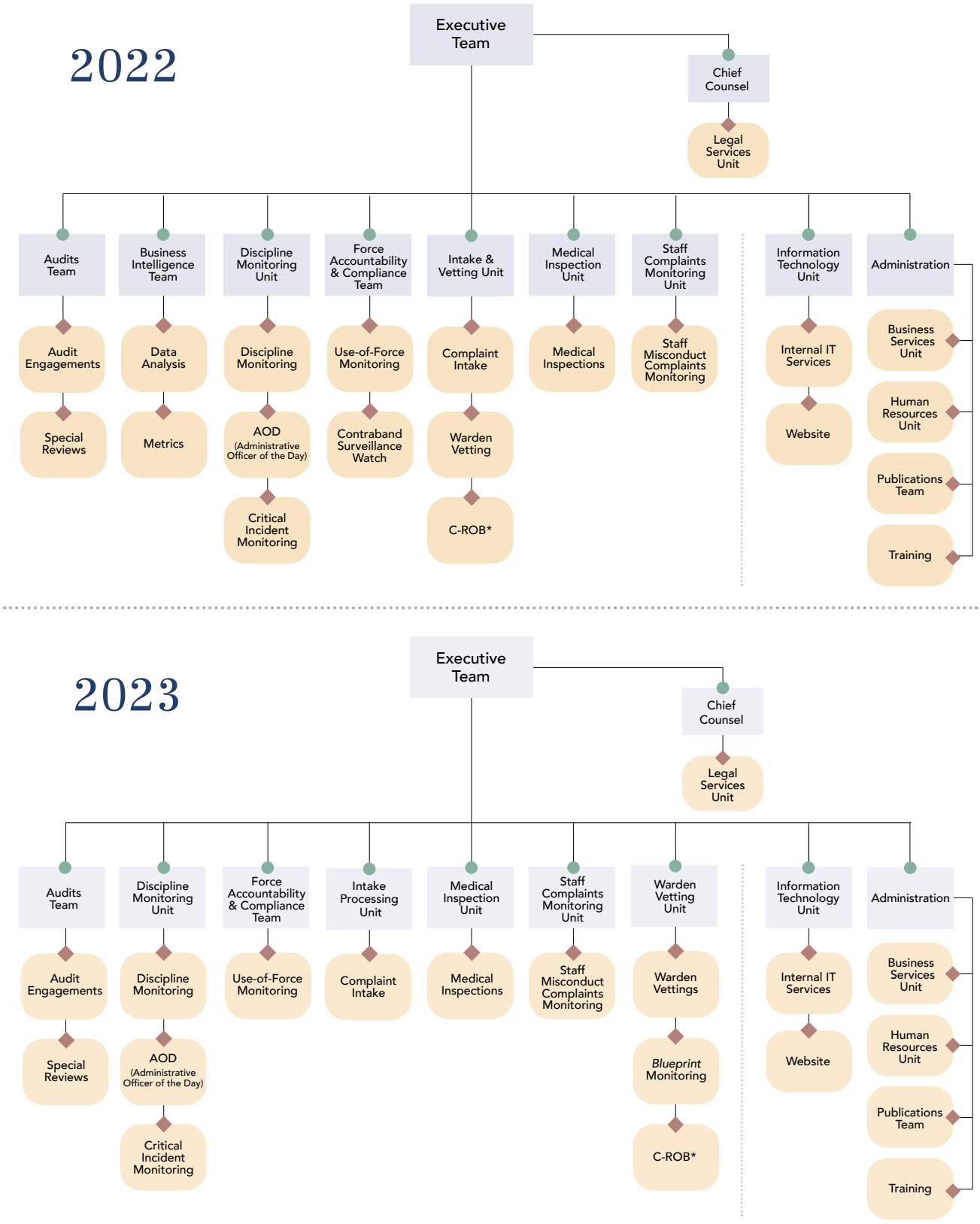
The OIG also employs a cadre of medical professionals, including physicians and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities,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

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

- Conduct medical inspections
- Carry out audits and authorized special reviews
- Staff the complaint hotline and intake unit
- Review, and when appropriate, investigate whistleblower retaliation complaints

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

Figure 1. The Office of the Inspector General Organizational Chart, 2022 and 2023



*C-ROB is the abbreviation for the California Rehabilitation Oversight Board (both charts).

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Reports Published in 2022

In 2022, we issued 18 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: 12 reports on medical inspection results; two reports on our monitoring of the department's internal investigations and employee disciplinary process; one report on our monitoring of the department's use of force; one report on our monitoring of the department's staff misconduct complaints process; one special review; and our 2021 annual report.

Visit our website, **www.oig.ca.gov**, to view our public reports.

Internal Investigations and Employee Discipline Monitoring

The Discipline Monitoring Unit (DMU) attorneys are responsible for the contemporaneous oversight of the department's internal investigations and employee disciplinary process. The California Penal Code requires that the OIG publish its findings at least semiannually. We released two discipline monitoring reports in 2022. The first report, released in May 2022, covered the July through December 2021 reporting period and the second report, released in September 2022, covered the January through June 2022 reporting period.

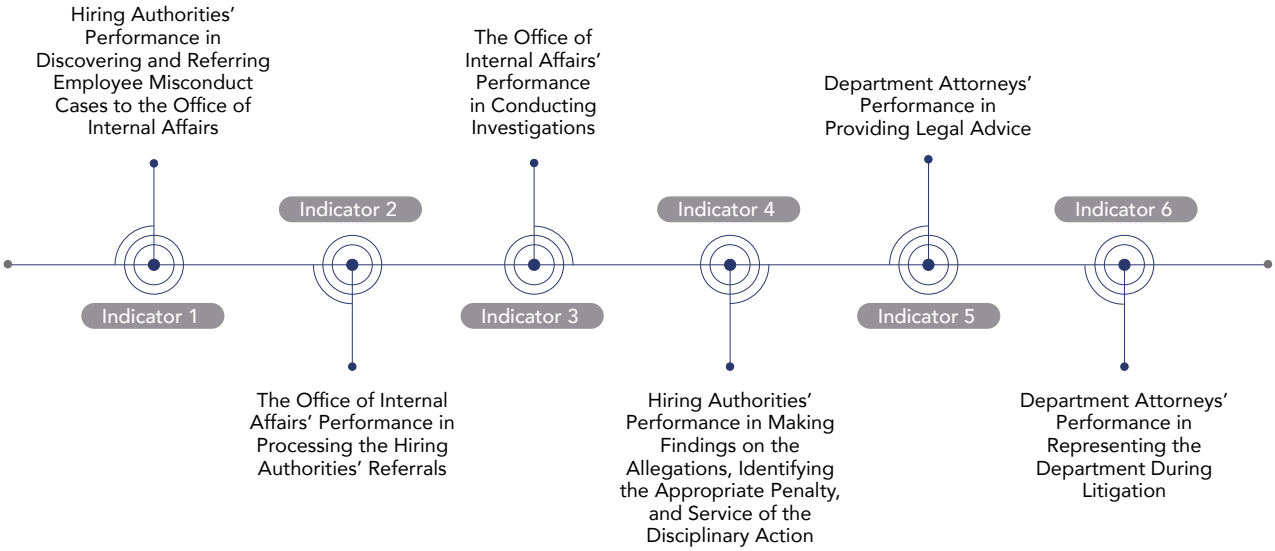
During those two periods, the Office of Internal Affairs addressed and made decisions concerning 2,523 referrals for investigation or for authorization to take disciplinary action without an investigation. Of those 2,523 referrals, the Office of Internal Affairs approved 2,334 for investigation or direct disciplinary action. We identified 340 of these cases to monitor, and our staff monitored and assessed the department's more serious internal investigations of alleged employee misconduct, such as cases involving alleged dishonesty, code of silence, use of force, and criminal activity. During these two periods, we also monitored and closed 248 cases, which is an increase from the 210 cases we had monitored and closed in 2021. In 2022, we identified 392 cases for monitoring. Of those cases, we opened and closed 101 in that calendar year.

As in previous reporting periods, we categorized our assessment across the following six separate indicators:

1. The performance of hiring authorities in discovering alleged employee misconduct and referring the allegations to the Office of Internal Affairs;
2. The performance of the Office of Internal Affairs in processing and analyzing the referrals;
3. The performance of the Office of Internal Affairs in investigating the allegations;
4. The performance of hiring authorities in making findings concerning the investigations and allegations;
5. The performance of department attorneys in providing legal advice to the Office of Internal Affairs;
6. The performance of department advocates in representing the department in litigation regarding employee discipline.

Figure 2 below presents a graphic representation of the above activities.

Figure 2. The Six Indicators the OIG Used to Assess the Department's Internal Investigations and Employee Disciplinary Process in Determining Our Overall Ratings of Departmental Performance



Source: The Office of the Inspector General.

These indicators are organized chronologically. Indicators 1 and 4 are used to assess the hiring authority's performance. Indicators 2 and 3 are used to assess the Office of Internal Affairs' performance. Indicators 5 and 6 are used to assess the Employment Advocacy and Prosecution Team (EAPT) attorney's performance. The OIG assigns a rating of *superior*, *satisfactory*, or *poor* to each applicable indicator, and an overall rating to each case.

The OIG has developed compliance- and performance-related questions concerning each indicator. Our attorneys assigned to monitor each case answered these questions, rated each of the six indicators for each case as *superior*, *satisfactory*, or *poor*, and assigned an overall rating for each case using the same rating terminology. We applied this methodology in two discipline monitoring reports in 2022. We found that during both the July through December 2021 and January through June 2022 reporting periods, the department's overall performance was *poor* in conducting internal investigations and handling the employee disciplinary process. However, in both reporting periods we rated the department's performance in indicators 1, 3, and 5 as *satisfactory*.

DMU staff are currently revamping and consolidating the indicators, questions, and ratings. Once this process is completed, we will have reduced the six indicators to three, one for each stakeholder. This new methodology is scheduled to take effect in 2023.

The OIG also identified and made recommendations regarding the disciplinary process. In our discipline monitoring report released in May 2022 which covered the July through December 2021 reporting period, we made the following recommendation:

1. In situations where the Office of Internal Affairs returns cases to the hiring authority as a *direct action* case, the department should develop a policy to ensure that hiring authorities have the benefit of information regarding mitigating and aggravating factors before these authorities are required to sign off on a disciplinary decision. The hiring authority should have the opportunity to have a locally designated investigator, such as an investigative services unit lieutenant, take a recorded oral statement from the employee, thereby allowing the employee to provide any mitigating information he or she wants the hiring authority to consider before making a disciplinary decision.

In our discipline monitoring report released in September 2022, which covered the January through June 2022 reporting period, we made the following recommendations:

1. The department should assess all potential deadlines for taking disciplinary action when beginning investigations and endeavor to conclude the disciplinary process by the most conservative date.

2. The EAPT should implement a clear policy requiring that EAPT attorneys send all disciplinary actions to the hiring authority within 25 days of the investigative and disciplinary findings conference unless a delay is approved by a supervisor.

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

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

Use-of-Force Monitoring

Another means by which we fulfilled our oversight mandate was by monitoring the department's process for reviewing use-of-force incidents. Our staff review use-of-force incident reports and corresponding video footage, when available, and attend committee meetings at institutional and departmental levels. Our staff are nonvoting members of the committees who provide real-time feedback and, when necessary, provide recommendations to the committee chairs on compliance-related matters. We used a monitoring methodology to assess whether departmental staff complied with the department's use-of-force policies and training prior to, during, and following each incident we monitored. Our methodology consisted of 11 units of measurement we call *performance indicators* (indicators). We developed a series of compliance questions for each indicator and, based on the collective answers, assigned a rating of *superior*, *satisfactory*, or *poor* to each indicator, as well as to the overall incident. This tool aggregates information, allowing our staff to offer an in-depth analysis of incidents and to identify problematic trends that we observed over the reporting period.

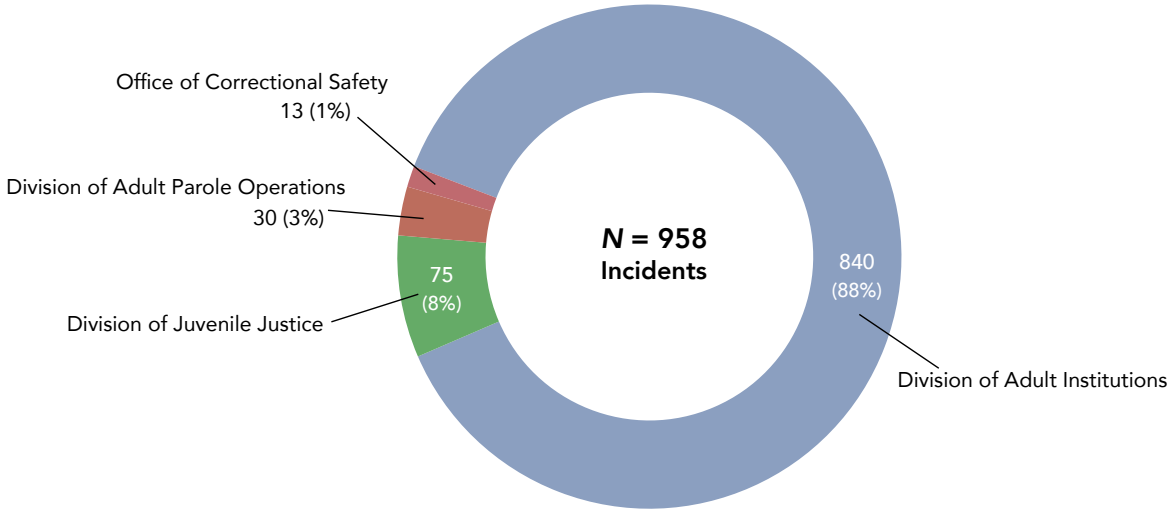
In August 2022, we published the report titled *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation.* This publication covered our monitoring of use-of-force incidents that occurred during the period from January 1, 2021, through December 31, 2021.

Use-of-Force Statistics, 2021

- The OIG monitored 958 of the 6,596 use-of-force incidents that occurred (15 percent).
- The OIG attended 754 of the 1,550 review committee meetings (49 percent).
- Approximately 88 percent of the use-of-force incidents we monitored (840 of 958) occurred at adult institutions, and the remaining 12 percent involved juvenile facilities (75), parole regions (30), and the Office of Correctional Safety (13).

- The 958 incidents that we monitored involved 3,163 applications of force (Figure 3, below). Physical strength and holds accounted for 1,297 of the total applications (41 percent), while chemical agents accounted for 1,249 of the total applications (39 percent). The remaining 20 percent of force applications consisted of the use of such options as less-lethal projectiles, baton strikes, tasers, and the Mini-14 rifle.

Figure 3. Distribution of the 958 Use-of-Force Incidents the OIG Monitored, by Division and Other Entities



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

Highlights of Our Use-of-Force Monitoring

We monitored 958 of the department's 6,596 use-of-force incidents and concluded the department's performance was *satisfactory* overall. We assessed the department's performance as *superior* in seven incidents, *satisfactory* in 771 incidents, and *poor* in 180 incidents. In the seven incidents in which we assessed the department's performance as *superior*, staff performed exceptionally well in multiple areas, such as attempting to de-escalate the situation prior to using force, decontaminating involved incarcerated people and the exposed area following the use of chemical agents, and describing in the required reports the force used and observed. In the 180 incidents in which we assessed the department's overall performance as *poor*, we identified

multiple failures within a single incident, such as custody staff not following decontamination protocols after using chemical agents, medical staff not evaluating incarcerated persons as soon as practical following an incident, and the levels of review failing to identify and address policy violations. The incidents in which we assessed the department's performance as *poor* also included incidents in which we identified a single violation that was particularly egregious, such as officers using unnecessary force, or staff failing to recognize and address an incarcerated person's allegation of unreasonable force.

During this reporting period, we identified 40 instances in which we believed officers had the opportunity, but did not adequately attempt to de-escalate a potentially dangerous situation prior to using force. We also identified 69 incidents (seven percent) in which staff's actions (or failure to act) unnecessarily contributed to the need to use force. This is a significant increase from last year, when we identified this issue in four percent of the incidents we monitored.

We found that supervisors performed poorly when conducting video-recorded interviews following an incarcerated person's allegation of unreasonable force, or when an incarcerated person sustained serious bodily injury that may have been caused by staff's use of force. We identified that staff failed to conduct a video-recorded interview within the mandatory time frame in 28 of the 123 incidents (23 percent) that required an interview. In addition, we identified that staff failed to video record visible or alleged injuries in 33 of the 105 applicable incidents (31 percent) in which injuries were visible or alleged.

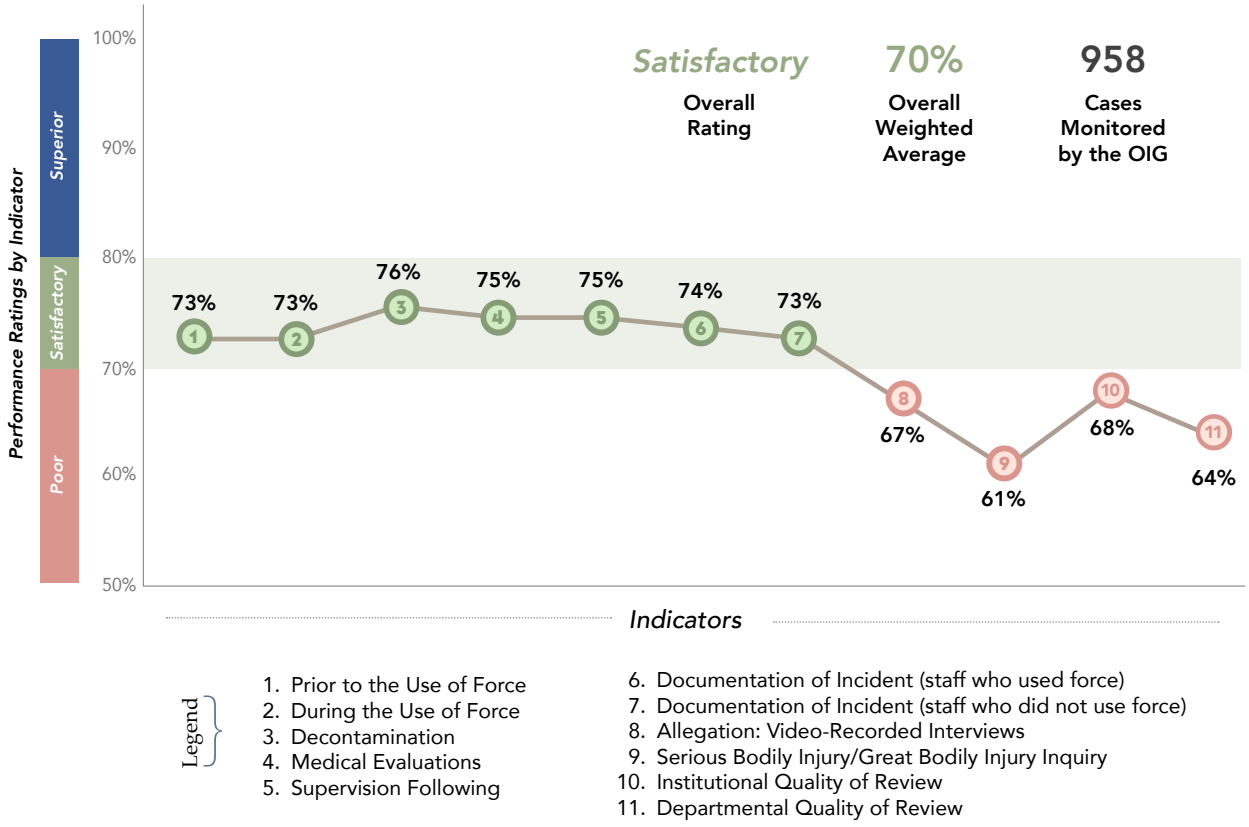
Another area of concern we identified was the persistent inadequacy of supervisors' and managers' reviews following a use-of-force incident. Departmental policy requires multiple levels of review to ensure that deviations from policy and training are identified and corrected. Of the 958 incidents we monitored during this period, we found 444 incidents (46 percent) in which one or more reviewers failed to identify a deviation from policy or training.

We also found that the department lacks a policy requirement for institutions' executive review committees to rereview an incident after deferring it during an initial review. Departmental policy requires the institutions' executive review committees to review every use-of-force incident and every allegation of unreasonable force within 30 days of the incident to ensure that policy and training violations are addressed timely. During this reporting period, the department deferred 247 incidents after an initial

review, with an average of 56 days between the initial review and subsequent action.

Finally, we identified that the department's executive review committees did not review all incidents which met the criteria for review. Departmental policy requires the department's executive review committees to review incidents involving a warning shot and incidents in which an incarcerated person sustained serious or great bodily injury that could have been caused by staff's use of force. We monitored all 29 incidents reviewed by the Division of Adult Institution's executive review committees, and we identified another 11 incidents that met the criteria for review, but which were not reviewed. Figure 4 presents our overall rating of the department's reviewing of the incidents referenced above.

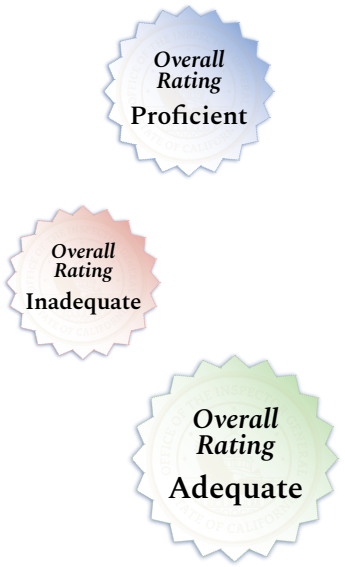
Figure 4. The OIG's Overall Rating of the Department's Reviewing of Its Use-of-Force Incidents



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

Medical Inspection Reports: Cycle 6

In 2022, the OIG continued its sixth cycle of medical inspections and published twelve reports, one for each of the following institutions: Calipatria State Prison; Central California Women's Facility; Centinela State Prison; Kern Valley State Prison; Pelican Bay State Prison; California Institution for Women; California Men's Colony; High Desert State Prison; Correctional Training Facility; California State Prison, Sacramento; Pleasant Valley State Prison; and Mule Creek State Prison. Below, Table 1 lists the institutions for which we completed our Cycle 6 inspections and issued final reports in 2022, the month each report was published, and our overall rating for each institution. Through those reports, the OIG made several recommendations to the department to further improve the delivery of medical care to its patients; these recommendations can be viewed on the OIG's dashboard at www.oig.ca.gov. In 2022, the OIG also completed inspections of the following institutions: Chuckawalla Valley State Prison; Sierra Conservation Center; California Institution for Men; San Quentin State Prison; California City Correctional Facility; California Health Care Facility, Stockton; and Ironwood State Prison. We anticipate publishing the remaining Cycle 6 inspection reports in 2023 and beginning our Cycle 7 inspections.



Styling for the rating seals used in MIU reports as introduced for Cycle 6

Table 1. The OIG's Cycle 6 Medical Inspections: Final Reports Published in 2022

Adequate *Inadequate*

Institution Inspected	Publication Month	Overall Rating
Central California Women's Facility	January	
Centinela State Prison	February	
Kern Valley State Prison	February	
Pelican Bay State Prison	March	
California Institution for Women	April	
California Men's Colony	July	
High Desert State Prison	August	
Calipatria State Prison	August	
Correctional Training Facility	September	
California State Prison, Sacramento	October	
Pleasant Valley State Prison	November	
Mule Creek State Prison	November	

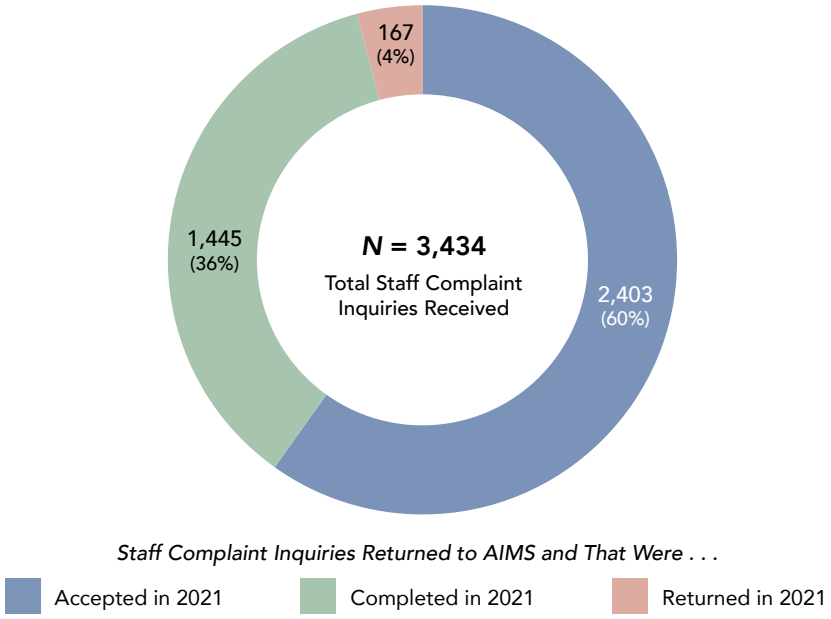
Source: The Office of the Inspector General medical inspection results.

Staff Misconduct Complaints Monitoring

Initial Report

Pursuant to Penal Code section 6126 (i), the OIG provided contemporaneous oversight of the "department's process for reviewing and investigating inmate allegations of staff misconduct" and other grievances. This responsibility included our monitoring of inquiry cases completed by the department's Office of Internal Affairs' Allegation Inquiry Management Section. On September 29, 2022, we published a report concerning our office's monitoring of the department's handling of staff complaint allegations in 2021. In 2021, the Allegation Inquiry Management Section received 3,434 staff complaint inquiry cases from wardens (Figure 5, below).

Figure 5. Staff Misconduct Complaint Inquiries Received and Processed by the Office of Internal Affairs' Allegation Inquiry Management Section in 2021



Source: The California Department of Corrections and Rehabilitation's Office of Internal Affairs' Allegation Inquiry Management Section.

The Allegation Inquiry Management Section completed 1,445 inquiry cases. OIG inspectors monitored 28 inquiry cases. As to the 28 monitored inquiry cases, we assessed the department's overall performance as *poor* in 17 of the cases, or 60 percent. For the remaining 11 cases, or 39 percent, we determined the

department performed *satisfactory* work in completing the cases. We identified two key concerns in our monitoring. First, we found that the overall performance of Allegation Inquiry Management Section staff in performing inquiry cases was *poor*, especially in how staff conducted interviews, collected evidence, and prepared inquiry reports. Second, we expressed concern regarding wardens reaching inappropriate decisions, or their decisions not being supported by the evidence, in six of the 28 cases we monitored.

Special Review

The OIG published one special review in 2022, titled *Special Report: The California of Department of Corrections and Rehabilitation's Processing of Disabled Incarcerated Persons' Staff Misconduct Allegations at the Richard J. Donovan Correctional Facility*. In it, we examined the department's processing of staff misconduct allegations at Richard J. Donovan Correctional Facility in San Diego, California, that were submitted in 2020 and 2021 by disabled incarcerated people.

From August 2020 through July 2021, a small group of OIG attorneys monitored inquiry cases completed by both Office of Internal Affairs investigators and prison investigators supervised by the Office of Internal Affairs which investigated staff misconduct allegations submitted by this group of disabled incarcerated people. During the monitoring period, the department completed 257 inquiry cases, and OIG attorneys monitored 204 of these cases. As to the 204 monitored inquiry cases, we assessed the department's work in completing these inquiry cases as *poor* in 186 cases, or 91 percent. For the remaining 18 cases, or nine percent, we determined the department performed *satisfactory* work in completing the inquiry cases.

We made four key findings. First, we found that the department delayed in completing the inquiry cases, including not completing most of the cases before deadlines to take disciplinary action against the involved staff members had passed. This prevented the imposition of any disciplinary action against those staff members. Second, we found that the overall quality of the investigators' work was *poor* due to deficient interviews, improper evidence collection, or inaccurate or incomplete inquiry reports. Third, we determined that investigators compromised the confidentiality of several of the inquiry cases by conducting interviews in nonconfidential locations or by

> "Justice delayed is justice denied."
>
> *—William E. Gladstone (1809–1898)*

unnecessarily revealing confidential information to witnesses or subjects during the cases. Finally, we found that a warden who had reviewed the inquiry cases made several inappropriate decisions regarding the cases, including decisions not supported by the evidence, decisions for cases in which he did not fully review the evidence, and decisions for cases in which he was not an impartial decision-maker.

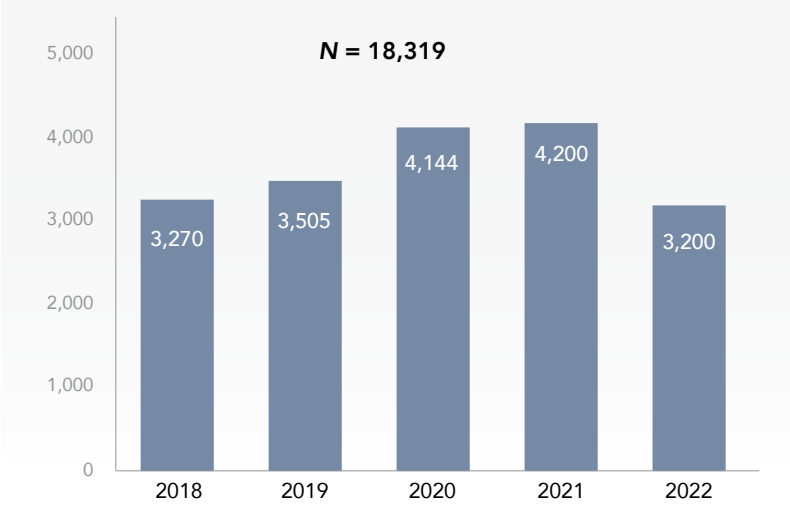
Other OIG Operational Units: Status Updates

Complaint Intake

The OIG maintains a statewide complaint intake process that provides a point of contact for expressing allegations of improper activity that take place within the department. We receive complaints from incarcerated people, parolees, family members of incarcerated people and parolees, departmental employees, advocacy groups, and other complainants. Complaints are submitted via letter, toll-free phone call, or our website. We strive to screen all complaints within one business day of receipt to identify safety concerns, medical or mental health concerns, or reports of sexual abuse.

In 2022, we received over 3,200 complaints (Figure 6, below). For nearly every complaint, our staff created a unique identification number and documented our response. Of these, we reviewed and closed just over 3,000 complaints. In 2023, our staff will continue working to resolve the approximately 200 complaints that remain pending from 2022. In addition, in 2022 we concluded a review of about 1,100 complaints received in 2021 or previous years.

Figure 6. Total Number of Complaints the OIG Received Over the Past Five Years, From 2018 Through 2022



Note: The OIG temporarily adjusted its process in 2022 to consolidate duplicative complaints, resulting in a reduced number of complaints. In addition, most unintelligible voice messages were not tracked by our office. The number of complaints received in 2022 as shown above is a minimum approximation.

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

Although the quantity of complaints appears to have declined when compared with previous years as shown in Figure 6 (previous page), this decline was due in part to a temporary adjustment in how we documented correspondence. Specifically, several people submitted numerous complaints with duplicative allegations. Because our staff had already addressed these concerns, and to alleviate resource constraints, we consolidated many of these duplicative complaints. For example, in December 2022, one complainant called us 29 times. The complainant believed she was being personally targeted and monitored. She alleged correctional staff and other incarcerated persons were conspiring against her and tampering with the phones, computers, and tablets she used. In one complaint, she wanted us to "look into" an officer who was using Microsoft Word on a computer, despite her also stating that she didn't know what the officer was writing. In addition to duplicative complaints, we received many voicemail messages in which the caller hung up without speaking or made unintelligible sounds during the entire recording. We did not create a unique identification number in our tracking and reporting system for most of these complaints.

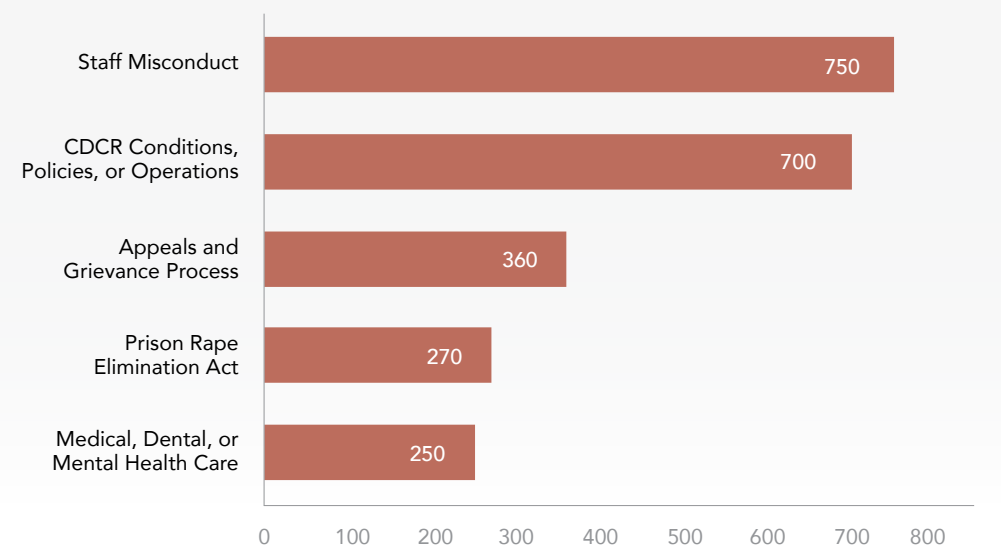
About 80 percent of the complaints we received in 2022 were submitted by incarcerated people across the State, while roughly 12 percent were submitted by citizens. The OIG received the remaining complaints from departmental employees, anonymous people, parolees, Department of Juvenile Justice wards, or other individuals. We received more than 60 percent of the complaints by mail, about 30 percent through voicemail messages, and the remainder through our website or via email.

In response to these complaints, our staff often conducted inquiries by accessing information from various departmental databases, reviewing the department's policies and procedures, or requesting relevant documentation from the prisons. However, we frequently received complaints that lacked the details needed to clearly identify and research the allegation. After our review or inquiry into the complaint, we usually advised complainants about how they could address their concerns with the department or recommended that they provide us with more details. We provided a written response or contacted the complainant by phone for complaints that required a response.

The most frequent types of allegations we received in 2022 pertained to issues such as staff misconduct; prison conditions, policies, or operations; the appeals and grievance process; the Prison Rape Elimination Act; and health care concerns. A complaint can frequently contain multiple allegations of improper

activity occurring within the department. Figure 7 below shows the distribution of the top five complaint allegations we received.

Figure 7. Top Five Complaint Allegations Received by the OIG in 2022



Note: Amounts in this chart are approximations.

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

For example, the Governor's Office requested that we review a complaint that alleged staff misconduct. Specifically, the anonymous party alleged that departmental staff had failed to check the incarcerated people who were known to be associated with security threat groups (gangs) for weapons prior to releasing them to the yard. A subsequent riot resulted in six incarcerated people being stabbed. To address this complaint, we contacted the prison, reviewed departmental policies, and inspected documentation related to the incident. We found that the department had been enforcing its policy of integrated housing (the *California Code of Regulations* (CCR), Title 15, section 3269.1), which directs that an incarcerated person's race shall not be used as a primary factor in determining housing. Instead, pursuant to this policy, "Housing assignments shall be determined in a manner that ensures the safety, security, treatment, and rehabilitative needs of the inmate are considered, as well as the safety and security of the public, inmates, staff, and institutions." Because the incident is still under investigation, we will monitor the subsequent use-of-force review process and provide appropriate recommendations to the department, including corrective or disciplinary action for staff, if necessary.

In another complaint regarding living conditions at a prison, a citizen alleged that the air conditioning system in a prison housing unit was broken. To address the complaint, we contacted the prison to determine whether the air conditioning had been working and if not, to obtain a status update for the repairs. The prison provided a copy of the work order for the repairs and confirmed the air conditioning system was operating properly.

Complainant concerns with the appeals and grievance process usually involved a disagreement with how the department handled a grievance or appeal. Complaints also commonly involved grievances that were still in progress. To ensure that the department had the opportunity to address complainants' concerns before we intervened, we typically advised complainants who had not yet filed a grievance to exhaust the department's grievance process first. We also received a substantial number of complaints expressing dissatisfaction with the department's delays in responding to grievances. In one instance, we received a complaint that an incarcerated person had been incorrectly documented as a member of a particular gang, despite the department's records which clearly stated this documentation was an error. Although the complainant had filed many grievances, his grievances and appeals were rejected. After we contacted the prison about this issue, the department removed the gang identifier from the incarcerated person's records.

In 2022, we received about 270 complaints involving alleged sexual misconduct or assault, commonly referred to as Prison Rape Elimination Act (PREA) allegations, from incarcerated people, family members, and other third parties. In one such complaint, an incarcerated person alleged having been raped by another incarcerated person; however, the prison initially found the PREA allegation to be unsubstantiated. We requested information from the prison, conducted a preliminary review of the prison's investigation, and found significant discrepancies. After expressing our concerns to the prison, the prison reopened the case, charged the alleged suspect with rape, and submitted the case to the District Attorney's Office for criminal prosecution.

One area in which our office makes a significant impact is through our service in assisting incarcerated people who need health care. In one case, we received correspondence from an incarcerated person stating that he had been contemplating suicide by hanging and believed suicide to be the only option. We immediately reached out to the prison to help the incarcerated person obtain access to mental health care. A few months later, we received a

note from the incarcerated person thanking our staff for saving his life.

At the end of 2022, we reevaluated our intake processes and implemented changes that resulted in more timely responses to complainants. To further improve response time and the thoroughness of our reviews, we look forward to adding additional staff members. Furthermore, we are exploring opportunities to expand our monitoring of PREA allegations and other substantiated, critical issues identified through the complaint process.

Prison Rape Elimination Act

In 2022, the department notified us of reports regarding serious incidents, including those involving alleged sexual misconduct or assault, commonly referred to as PREA allegations. The reports included allegations of nonconsensual sexual acts, abusive sexual acts, sexual harassment, and sexual misconduct. We received more than 1,400 sexual incident reports. The department also notified us of more than 500 incidents related to sexual misconduct and assault, or sexual harassment allegations. The department tracks and reports statistics on these incidents annually on its website, **www.cdcr.ca.gov**, and posts PREA audit reports of its prisons.

Whistleblower Retaliation Claims

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

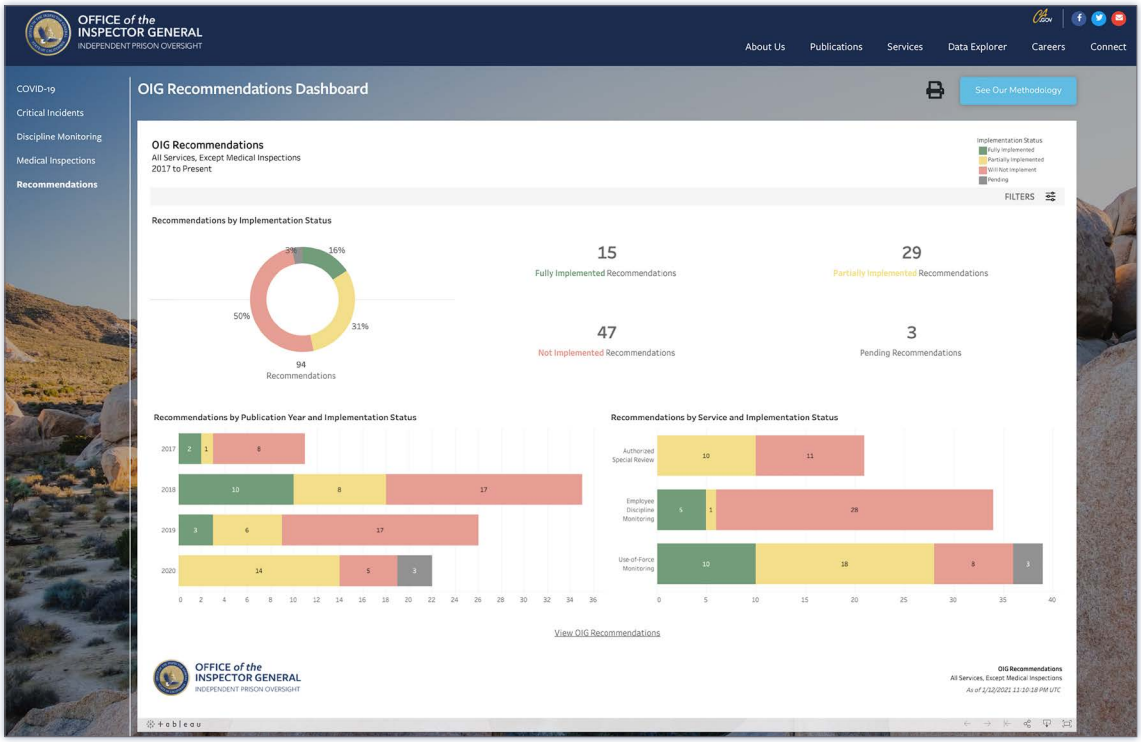
Due to public misperception regarding what constitutes whistleblower retaliation, few complaints present the legally required elements to state an actionable claim of whistleblower retaliation. To counteract this misunderstanding, we engage with complainants to educate them regarding the elements of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

In 2022, the OIG received 23 retaliation complaints. We completed analyses of all the complaints and determined that none stated the legally required elements of a whistleblower retaliation claim. We also completed analyses of the two complaints pending from 2021. Neither stated the legally required elements of a whistleblower retaliation claim.

Recommendations Made to the Department

In 2022, the OIG published 18 formal reports, some of which contained recommendations. These recommendations promote greater transparency, process improvements, increased accountability, and higher adherence to policies and constitutional standards. Details concerning the vast number of recommendations made to the department are available on our dashboards, which can be accessed at our website, **www.oig.ca.gov**. If viewing this report on our website, clicking on the image below will take the reader to the main interactive dashboard web page. Choose from among several filter options to select a specific group of recommendations: publication year, service (authorized/special review; employee discipline monitoring, and use-of-force monitoring), general topic, associated entity, report title, and report number. A separate dashboard is also available on our site that lists the medical inspection report recommendations we have made to both California Correctional Health Care Services and the department.

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



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Appendix: Publications Released in 2022

Annual and Semiannual Reports

- *2021 Annual Report: A Summary of Reports* (February 2, 2022)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, July–December 2021* (May 19, 2022)
- *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation* (August 16, 2022)
- *Monitoring the Internal Investigations and Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, January–June 2021* (September 28, 2022)
- *Monitoring the Staff Complaints Process of the California Department of Corrections and Rehabilitation* (September 29, 2022)

Medical Inspection Reports: Cycle 6 Results

- Central California Women's Facility (January 28, 2022)
- Centinela State Prison (February 18, 2022)
- Kern Valley State Prison (February 25, 2022)
- Pelican Bay State Prison (March 14, 2022)
- California Institution for Women (April 29, 2022)
- California Men's Colony (July 29, 2022)
- High Desert State Prison (August 19, 2022)
- Calipatria State Prison (August 26, 2022)

- Correctional Training Facility (September 15, 2022)
- California State Prison, Sacramento (October 19, 2022)
- Pleasant Valley State Prison (November 7, 2022)
- Mule Creek State Prison (November 22, 2022)

Special Reviews

- *The California Department of Corrections and Rehabilitation's Processing of Disabled Incarcerated Persons' Allegations of Staff Misconduct at the Richard J. Donovan Correctional Facility* (March 1, 2022)

2022
Annual Report

A Summary of Reports

OFFICE *of the* INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
February 2023

OIG