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

***Neil Robertson**, Chief Deputy Inspector General*

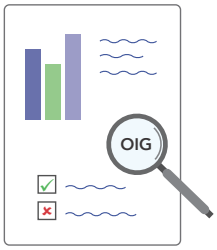
OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2024

2023 Annual Report

A Summary of Publications



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STATE of CALIFORNIA
OIG | OFFICE of the INSPECTOR GENERAL

Independent Prison Oversight

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

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

March 12, 2024

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

Dear Governor and Legislative Leaders:

Enclosed please find our annual report summarizing the work that the Office of the Inspector General completed in 2023. In 2023, we issued 16 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: eight reports on medical inspection results, and one summary report for the medical inspections of Cycle 6; 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 audit report, one special review, and our 2022 annual report. In addition, we introduced a new type of publication, *case blocks*. We published seven sets of these for other operational units.

Respectfully submitted,

Amarik K. Singh
Inspector General

Gavin Newsom, Governor

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

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Contents

Illustrations

Figures

Tables

Exhibits

Foreword

Vision

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

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

Mission

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

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

— Amarik K. Singh
Inspector General

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

— State of California
Penal Code section 6125

Organizational Overview and Functions

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

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

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

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

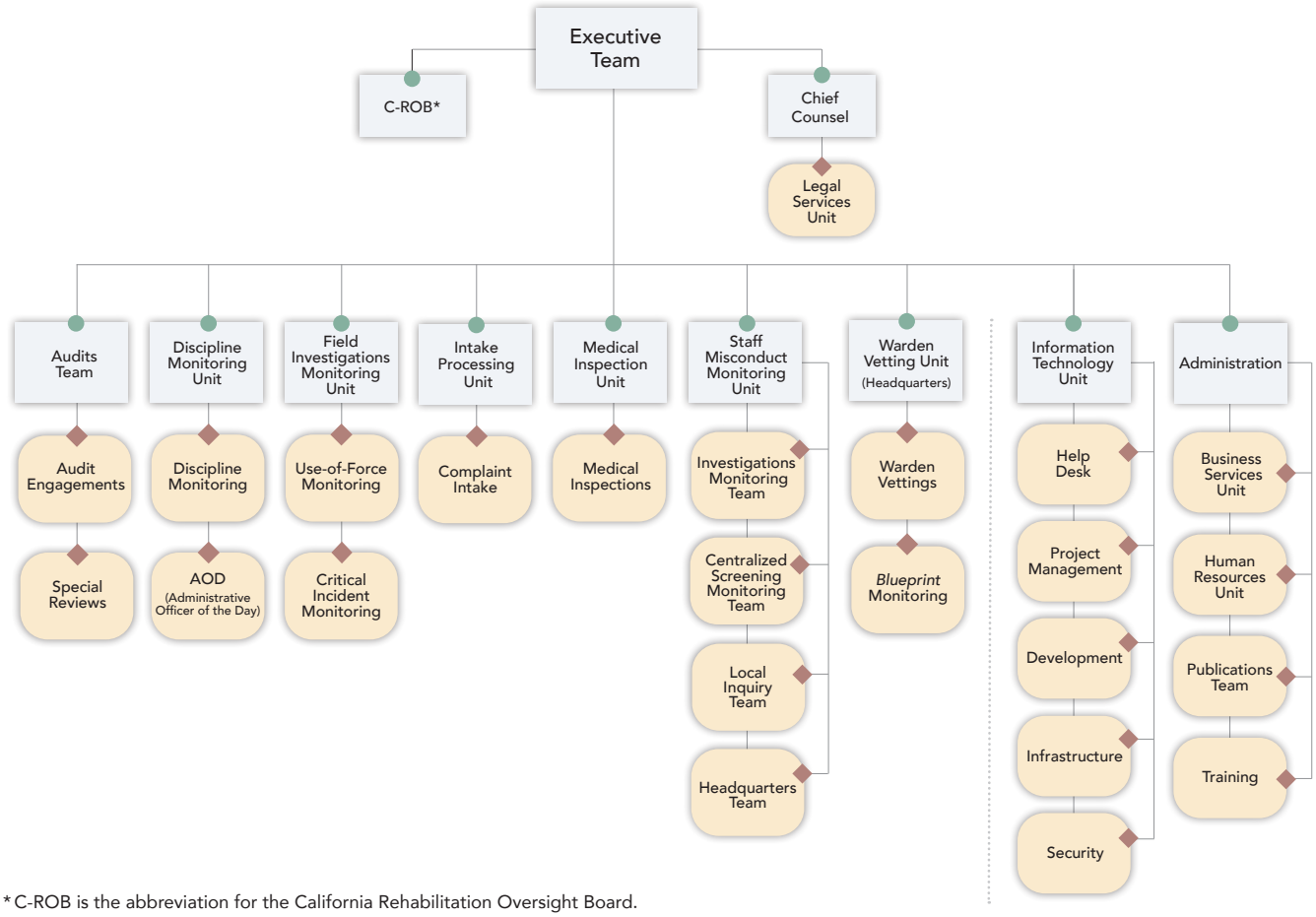
The OIG also employs a cadre of medical professionals, including physicians and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities,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

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

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

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

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



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

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Reports Published in 2023

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 2023. The first report, released in June 2023, covered the July through December 2022 reporting period and the second report, released in September 2023 covered the January through June 2023 reporting period.

During these two periods, the Office of Internal Affairs addressed and made decisions concerning 2,315 referrals for investigation or for authorization to take disciplinary action without an investigation. Of those 2,315 referrals, the Office of Internal Affairs approved 2,139 for investigation or direct disciplinary action. Our staff monitored and assessed the department's more serious internal investigations of alleged employee misconduct, such as cases involving alleged dishonesty, code of silence, use of force, and criminal activity. During these two periods, we monitored and closed 376 cases, which is an increase from the 248 cases we had monitored and closed in the previous two periods.

Unlike in previous reporting periods, we categorized our assessment across three separate indicators instead of six. Each of the three indicators assessed the performance of three departmental entities as follows:

1. Hiring authorities in discovering alleged employee misconduct, in referring the allegations to the Office of Internal Affairs, and in making findings concerning the investigations and allegations;

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

3. Department attorneys in providing legal advice to the Office of Internal Affairs and in representing the department in litigation regarding employee discipline.

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

Internal Affairs' performance, for both the performance of its staff during the Central Intake Panel meetings and the special agent's performance during the investigation. Indicator 3 is used to assess the Employment Advocacy and Prosecution Team (EAPT) attorney's performance during the investigative and disciplinary phases. Previously, the OIG assigned a rating of *superior*, *satisfactory*, or *poor* to each applicable indicator, and an overall rating to each case. As of the 2023–1 reporting period, we have assigned a rating of *sufficient*, *sufficient with recommendations*, or *insufficient* to each applicable indicator, and an overall rating to each case.

In general, a *sufficient* rating means that the OIG did not identify any significant deficiencies. A *sufficient with recommendations* rating means that the OIG found significant deficiencies, but the deficiencies did not appear to cause a negative outcome for either the department or the case under review. An *insufficient* rating means that the OIG found significant deficiencies that caused a negative outcome for either the department or the case.

The OIG determines an overall rating for each case we monitor after considering the ratings for each indicator. The overall rating of a case is equal to the rating of the worst performance indicator. For example, if any of the three performance indicators is rated *insufficient*, we rate the entire case *insufficient*. Likewise, if the lowest-rated performance indicator is *sufficient with recommendations*, we rate the entire case *sufficient with recommendations*.

The OIG has also developed compliance- and performance-related questions concerning each indicator. As with our new rating system, these questions have been modified for the 2023-1 reporting period. Our attorneys assigned to monitor each case answered these questions, rated each of the three indicators for each case *sufficient, sufficient with recommendations, or insufficient* using the same rating terminology. We applied this new methodology in the second discipline monitoring report of 2023, issued in September 2023, which covered the January through June 2023 reporting period and thus began a new semiannual cycle. We found the department's performance was *sufficient* in 23 percent of cases, *sufficient with recommendations* in 49 percent of the cases, and *insufficient* in 28 percent of cases we monitored.

However, under our previous assessment criteria, we found that during the July through December 2022 reporting period, each of the three entities performed in a *satisfactory* manner for one performance indicator, but a *poor* manner for the other. For example, hiring authorities performed satisfactorily in discovering allegations of employee misconduct and in referring those allegations to the Office of Internal Affairs in 78 percent of cases we monitored, yet poorly in making investigative and disciplinary findings in 34 percent of cases. The Office of Internal Affairs performed satisfactorily in 78 percent of criminal investigations and in 86 percent of administrative investigations we monitored. Department attorneys performed satisfactorily in providing

legal advice to the department when the Office of Internal Affairs processed employee misconduct referrals and conducted investigations in 89 percent of cases. However, department attorneys performed satisfactorily in providing legal representation during litigation in only 60 percent of cases we monitored.

The OIG also identified and made recommendations regarding the disciplinary process. In our discipline monitoring report released in June 2023, which covered the July through December 2022 reporting period, we made the following two recommendations:

- The department should maintain and install holding cells at all conservation camps so that incarcerated people are not kept in vehicles and exposed to inclement weather when detained on suspicion of violating prison rules. The installation and use of such cells can also reduce the risk of escape and civil liability when an incarcerated person cannot be transferred to other suitable buildings or facilities.

- The department should implement new policies and procedures for quickly dismissing employees who commit serious criminal misconduct. This includes a policy or procedure promoting the use of the unpaid administrative time-off statute.

In our discipline monitoring report released in September 2023, which covered the January through June 2023 reporting period, we made the following recommendation:

- The department should consider drafting disciplinary actions that would allow an administrative law judge to consider multiple theories. Doing so can help the department avoid findings by the State Personnel Board that employees have not received sufficient notice of alleged misconduct. This issue can arise when an administrative law judge makes factual findings that support misconduct, but that are different from what the department alleged in the disciplinary action.

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

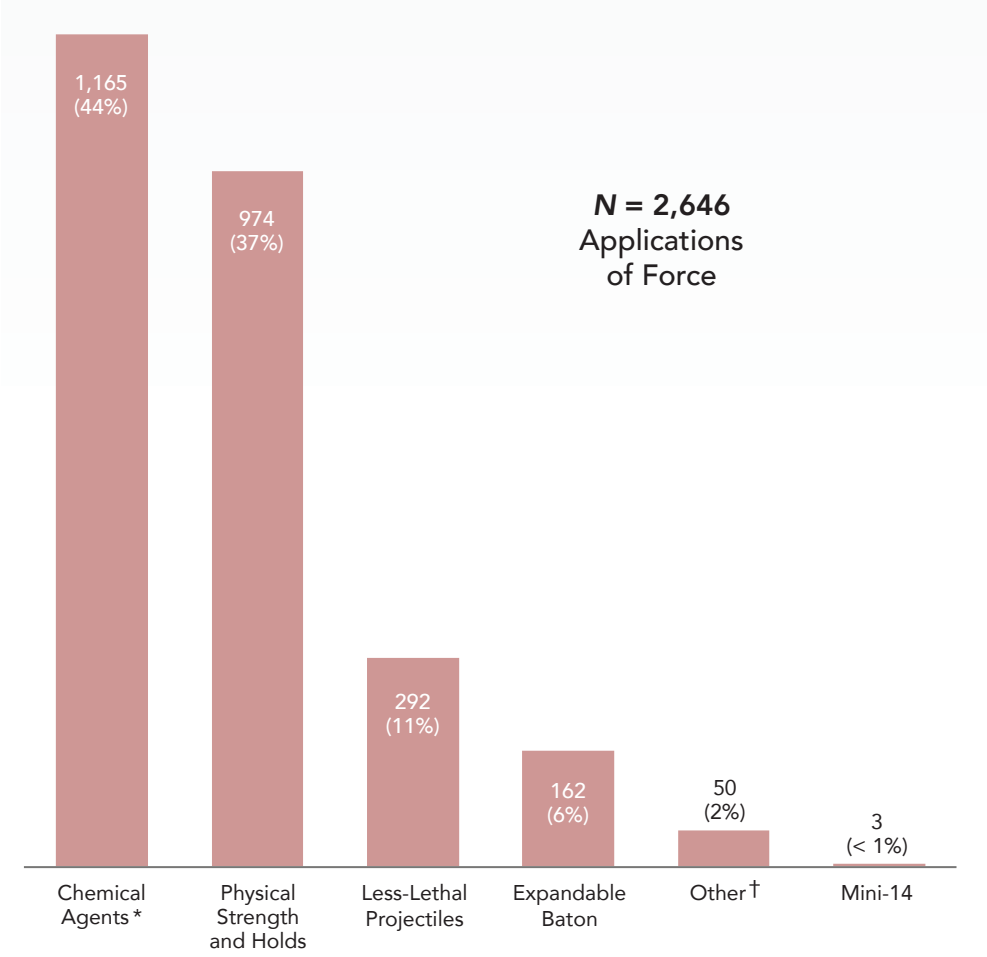
One way in which we fulfilled our oversight mandate was by monitoring the department's process for reviewing use-of-force incidents. Our staff review use-of-force incident reports and related video footage, when available, and attend committee meetings at institutional and departmental levels. Following a review of the use-of-force incident documentation, our inspectors attended executive review committee meetings. During these meetings, they provided real-time feedback and recommendations to the committees. To evaluate the effectiveness of the department's process of handling use-of-force incidents and its compliance with policies and procedures, our staff reviewed various rules and regulations relevant to the department's use-of-force practices. Because we did not personally observe use-of-force incidents, our assessments relied on departmental staff's written accounts of each incident and recordings from fixed cameras or body-worn cameras, when available. Our methodology consists of criteria that we use to identify a sampling of use-of-force incidents that are at a higher risk of being termed significant policy violations or staff misconduct.

In July 2023, 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 on or after January 1, 2022, and for which the department completed its review on or before December 31, 2022. During this period, we monitored 890 use-of-force incidents that occurred at adult prisons (812), juvenile facilities (47), within the communities where offenders were on parole (17), and those involving the Office of Correctional Safety (14), which acts as a liaison with other law enforcement entities and apprehends fugitives in the community.

Use-of-Force Statistics, 2022

- We monitored 890 incidents that involved 2,646 applications of force (Figure 2, on the next page).
- Chemical agents accounted for 1,165 of the total applications (44 percent), while physical strength and holds accounted for 974 of the total applications (37 percent).
- The remaining force applications consisted of the use of such options as less-lethal projectiles, baton strikes, tasers, and the Mini-14 rifle.

Figure 2. Distribution of the Applications of Force in the 890 Use-of-Force Incidents We Monitored



* Chemical agents include oleoresin capsicum (OC), CN gas, and CS gas.

† Other includes the use of a shield, nonconventional uses of force, and a taser.

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

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

Highlights of Our Use-of-Force Monitoring

While, overall, the department performed adequately in a majority of the 890 incidents we monitored, we expect the department to perform well in all aspects prior to, during, and following each incident, and to proactively identify and address deficiencies once realized. Our July 2023 report provided our stakeholders with transparent assessments of incidents and issues we identified that are of significant concern.

Our report highlighted six incidents of particular concern, including incidents involving possible staff misconduct that the department failed to address; a departmental staff member who failed to provide use-of-

force documentation and video recordings, which impeded our ability to effectively monitor the use-of-force process; and an incident in which a hiring authority refused to request video recordings from an outside law enforcement agency that revealed a departmental agent had used and observed force, but failed to report it.

During the reporting period, we identified 113 incidents in which the involved officers had the opportunity to de-escalate the situation prior to using force. In 44 of those incidents (39 percent), officers failed to effectively communicate with the incarcerated person or did not adequately attempt de-escalation strategies. In 2017, the department implemented mandated training to improve staff communication skills and further its commitment to resolving conflicts and crises at the lowest level when an imminent threat is not present. Until 2020, the department included this training in its required annual training program, but due to the restrictions resulting from the novel coronavirus pandemic (COVID-19), the department removed this portion of the training from the mandatory training schedule. Consequently, we recommend the department reinstate its de-escalation course as mandated training for all custody staff.

During this period, we monitored 466 incidents that were captured on video. While the department did not add fixed or body-worn cameras to any new prisons in 2022, it planned to add body-worn cameras at four prisons and fixed cameras at 11 prisons in 2023. We are encouraged by some of the successes of video-recording implementation. Even so, we indicate in our report our concerns that supervisors and managers did not always evaluate an adequate amount of video recordings during the review process to determine whether staff had fully complied with policy and procedures.

The report provided an update related to two concerns and recommendations made in our prior report that we issued in August 2022. First, the department's supervisors and managers continued to perform poorly when reviewing use-of-force incidents, and identifying policy and training violations. We identified 367 incidents (41 percent) in which one or more reviewers failed to identify policy violations. In our most recent report in 2023, we recommended that the department evaluate its policy to ensure supervisors and managers capture deviations. The department responded that the current policy is sufficient to identify deviations and to hold reviewers accountable when they do not identify any. Despite the department's assurances, we identified that hiring authorities provided corrective action to supervisors and managers who failed to address the deficiencies in only 62 cases (17 percent).

Finally, we identified that the department has yet to implement a policy to ensure that use-of-force incidents deferred during an initial executive review committee meeting are returned to the committee in a timely manner to resolve outstanding issues and close the use-of-force incident. In our prior report issued in August 2022, we noted our concerns

regarding the lack of policy to return incidents to the committee for closure, and we identified several incidents with extensive delays between initial and final reviews. To address unreasonable delays, we recommended that the department develop and implement a policy to require prisons to return deferred incidents to the committee for closure in a timely manner. Despite our recommendation, the department had not implemented a new policy, and many incidents remained in deferred status for several months after the department's initial review.

Medical Inspection Reports: Cycles 6 and 7

Cycle 6

In 2023, the OIG completed its sixth cycle of medical inspections and published eight reports for this unit. We published a report for each of the following seven institutions: Chuckawalla Valley State Prison, Sierra Conservation Center, California Institution for Men, San Quentin State Prison, California City Correctional Facility, Ironwood State Prison, California Health Care Facility, We also published a summary report to conclude Cycle 6. 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**.

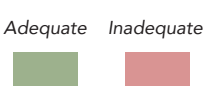
Cycle 7

In 2023, the OIG commenced its seventh cycle of medical inspections and published one report for the following institution: California State Prison, Los Angeles County. Through this report, 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 2023, the OIG also completed inspections of the following institutions: Valley State Prison; Wasco State Prison; California State Prison, Solano; California Rehabilitation Center; California State Prison, Corcoran; California Medical Facility; North Kern State Prison; Richard J. Donovan Correctional Facility; Salinas Valley State Prison; and Substance Abuse Treatment Facility and State Prison, Corcoran. In 2024, we anticipate publishing these Cycle 7 inspection reports and completing or beginning our Cycle 7 inspection process for all remaining institutions.

Table 1 on the following page lists the institutions for which we completed our Cycle 6 and Cycle 7 inspections and issued final reports in 2023, the month each report was published, and our overall rating for each institution.

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

Table 1. The OIG's Medical Inspections for Cycles 6 & 7: Final Reports Published in 2023



Institution Inspected	Publication Month	Overall Rating
Chuckawalla Valley State Prison	January	
Sierra Conservation Center	March	
California Institution for Men	May	
San Quentin State Prison	June	
California City Correctional Facility	June	
Ironwood State Prison	July	
California Health Care Facility	September	
California State Prison, Los Angeles County*	December	

*First published report for Cycle 7.

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

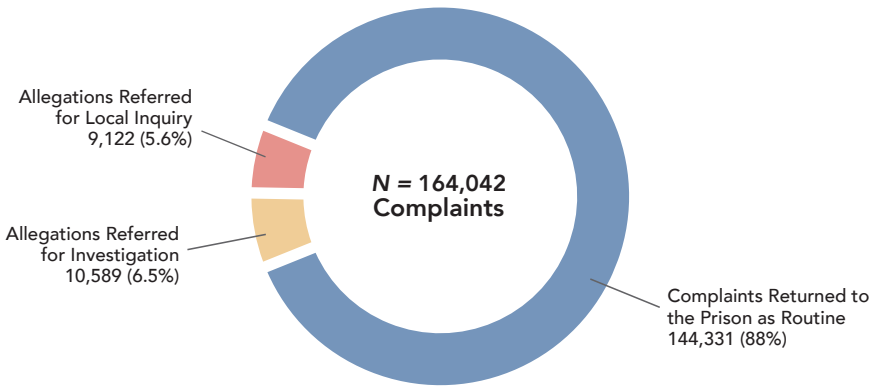
Staff Misconduct Complaints Monitoring

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 staff misconduct complaint screening decisions made by the department's Centralized Screening Team, local inquiry cases completed by prison investigators, and investigations conducted by the Office of Internal Affairs' Allegation Investigation Unit.

In January 2022, the department implemented emergency regulations revising its statewide process for reviewing and processing incarcerated people's allegations of staff misconduct. The purpose of this new process was to increase the department's independence and fairness in reviewing these complaints. On October 20, 2022, the department permanently adopted these regulations.

With the new staff misconduct complaint process, as of January 1, 2022, each prison's grievance office began to forward allegations of staff misconduct to a new unit, the Centralized Screening Team within the Office of Internal Affairs. Beginning May 31, 2022, the Centralized Screening Team reviewed each complaint submitted by incarcerated people and parolees, and assigned staff misconduct allegations one of three categories: 1) routine issue; 2) local inquiry; or 3) investigation. Allegations of staff misconduct were either formally investigated by the new Office of Internal Affairs' Allegation Investigation Unit or returned to the prisons for locally designated investigators to conduct inquiries into the allegations. If the Centralized Screening Team determined that a complaint did not constitute allegations of staff misconduct, the Centralized Screening Team returned the complaint to either the prison or a regional parole office to handle as a routine complaint.

Figure 3. The Department's Actions on Complaints Submitted by Incarcerated People and Parolees



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

Source: The California Department of Corrections and Rehabilitation's Offender Grievance Tracking System.

From January 1, 2022, through December 31, 2022, according to department figures, the Centralized Screening Team received a total of 164,042 complaints from incarcerated people or parolees. In total, it routed 144,331 (88.0 percent) of those allegations as routine issues, 9,122 allegations (5.6 percent) to prisons for a local inquiry, and 10,589 (6.5 percent) to the Office of Internal Affairs for inquiry or investigation.

On May 24, 2023, we published a report concerning our office's monitoring from May 31, 2022, through December 31, 2022, of the department's handling of the screening decisions made by the department's Centralized Screening Team, local inquiry cases completed by prison investigators, and investigations conducted by the Office of Internal Affairs' Allegation Investigation Unit. In addition, for the period from January 1, 2022, through October 26, 2022, we reported on our monitoring of the inquiry cases completed by the Office of Internal Affairs' Allegation Inquiry Management Section pursuant to the department's prior regulatory framework. Finally, we presented our concerns regarding the department's limited retention period for body-worn cameras and video-surveillance recordings.

For each of the cases we monitored, we assessed the performance of departmental staff and provided an overall rating. We assessed the overall screening work of the Centralized Screening Team, the inquiry work of locally designated and Allegation Inquiry Management Section investigators, the investigation work of the Office of Internal Affairs' Allegation Investigation Unit, department attorneys, and hiring authorities to which we assigned the ratings *superior*, *satisfactory*, or *poor.* We used this rating system to evaluate and assess the department's overall performance in five main areas:

- Whether the Centralized Screening Team appropriately screened and referred allegations of employee misconduct and other related complaints;
- Whether the department appropriately conducted inquiries into allegations of employee misconduct;
- Whether the Office of Internal Affairs' Allegation Investigation Unit appropriately conducted investigations;
- Whether the department attorney or employee relations officer properly performed during the investigation, the disciplinary process, and the litigation process; and
- Whether the hiring authority properly determined findings concerning alleged employee misconduct, and properly processed the employee disciplinary case.

Table 2. Ratings of the Centralized Screening Team (CST) Referrals

Ratings	Number of CST Decisions
Superior	1
Satisfactory	1,008
Poor	58
Total	**1,067**

Note: In this reporting period, we monitored and rated 1,067 of the department's CST referrals.

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

Beginning July 1, 2022, through December 31, 2022, the OIG monitored and closed 1,067 grievances which included 1,682 complaints that the Centralized Screening Team received. We found that the department's Centralized Screening Team conducted *satisfactory* screening decisions in 1,008 of the 1,067 grievances (94 percent) we monitored. In 58 complaints (five percent), the Centralized Screening Team's performance was *poor*. In one case, we issued the department a *superior* rating.

From January 1, 2022, through December 31, 2022, the OIG monitored and closed 41 staff misconduct inquiry cases: 19 staff misconduct inquiry cases completed by Office of Internal Affairs' Allegation Inquiry Management Section investigators and 22 staff misconduct inquiry cases completed by locally designated (prison) investigators. In these cases, we assessed the work of investigators and that of the wardens who made decisions regarding the inquiry cases. Of the 19 inquiry cases completed by the Office of Internal Affairs' Allegation Inquiry Management Section, we assessed the work of departmental staff as *poor* in nine cases (47 percent) and *satisfactory* in 10 cases (53 percent). In addition, of the 22 local inquiry cases monitored, we rated the work of departmental staff *poor* in 14 cases (64 percent) and *satisfactory* in eight cases (36 percent). We did not assign any inquiry cases a *superior* rating.

Table 3. The OIG's Ratings of Inquiries Conducted by the Department

Ratings	Number of Local Inquiries	Number of AIMS Inquiries
Superior	0	0
Satisfactory	8	10
Poor	14	9

Note: In this reporting period, we monitored and rated a total of 41 of the inquiries that the department conducted.

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

Table 4. The OIG's Ratings of Investigations Conducted by the Department's Office of Internal Affairs' Allegation Investigation Unit

Ratings	OIA-AIU* Investigations	Department Attorneys	Hiring Authorities
Superior	0	0	0
Satisfactory	3	4	5
Poor	7	6	5

*OIA-AIU is the abbreviation for the Office of Internal Affairs' Allegation Investigation Unit.

Note: In this reporting period, we monitored and rated 10 of the investigations that the department conducted.

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

From May 31, 2022, through December 31, 2022, the OIG monitored and closed 10 staff misconduct investigation cases completed by the Office of Internal Affairs' Allegation Investigation Unit. In these cases, we also assessed the work of the wardens who made findings and decisions regarding the investigation cases and the performance of department attorneys assigned to the cases. We found the performance of departmental staff *poor* in seven of the 10 investigation cases the OIG monitored and *satisfactory* in three of the cases. In addition, we determined the performance of department attorneys in these cases was *poor* in six of 10 cases and *satisfactory* in four of the cases, and the wardens' performance was *poor* in five of 10 cases and *satisfactory* in five of the cases. We did not assign any cases a *superior* rating.

Our monitoring of the department's six prisons equipped with audio-video surveillance systems (AVSS) and body-worn cameras (BWC) revealed that investigators failed to collect video recordings during several local inquiries and investigations. Such failure to obtain recordings is problematic for the adequacy and integrity of inquiries and investigations to substantiate or refute allegations of staff misconduct, and for the department's compliance with court-ordered remedial measures.

In reviewing inquiries and investigations for which investigators did not obtain BWC and AVSS recordings because the recordings had already been purged, it became apparent that the department's current 90-day retention period for video evidence was not sufficient. Although allegations of staff misconduct made by an incarcerated person require that video evidence be retained beyond 90 days, unless an investigator submitted a specific request to review video recordings within the 90-day retention period, aside from any other triggering events, the department automatically deleted the video evidence after 90 days.

In our monitored cases, the OIG identified that departmental staff were not always able to preserve the recorded data as potential evidence in an inquiry or investigation because of delays in the department's processes of assigning and starting inquiries and investigations, in its staff requesting pertinent video recordings, and in the processing of video requests by investigation services unit staff. In other instances, the alleged incident took place months before the complaint was filed, and the retention period had lapsed. All these issues were contributing factors to the department's choosing to delete video evidence. However, given that delays like these inevitably occur, the department's 90-day retention period unnecessarily results in the destruction of critical video- and audio-recorded evidence, incomplete inquiries and investigations, and potentially erroneous hiring authority decisions regarding staff misconduct.

For each section of the department's staff misconduct investigation and review process that we monitored in 2022, we provided the department with our findings and recommendations, as outlined in Table 5 on the next page.

Table 5. The OIG's Findings and Recommendations

Findings	Recommendations
Centralized Screening Team Decisions	
The department suffers from deficiencies with its electronic tracking system and has failed to reclassify allegations based on its agreement to the OIG's recommendations.	The OIG recommends that the department resolve issues preventing a direct entry into the electronic tracking system and ensure that allegations it agrees to are reclassified.
The department failed to adequately train screening staff on how to interview incarcerated people.	The OIG recommends that the department provide meaningful training to the Centralized Screening Team analysts in how to conduct clarifying interviews.
Local Inquiry Cases	
Investigators failed to use effective interviewing techniques when conducting interviews by not audio recording each interview.	The OIG recommends that locally designated investigators audio record all interviews.
Inadequate planning resulted in investigators' failure to complete all relevant interviews, to gather and review all relevant documentary evidence, and to prepare complete inquiry reports.	The OIG recommends that locally designated investigators submit an inquiry case plan to an Office of Internal Affairs' Allegation Investigation Unit manager or the investigator's manager, prior to conducting interviews, to encourage thoroughly completed inquiries.
Investigation Cases	
In some cases, hiring authorities inappropriately determined investigations were sufficient and made disciplinary findings in cases where no interviews were conducted at all.	The OIG recommends that the department eliminate video quick-close reports as an option in staff misconduct investigations as they are contrary to regulations which require thorough investigations, are inconsistent with how local prison investigators conduct inquiries into staff misconduct, provide a conclusion regarding the staff misconduct allegation that usurps or undermines the hiring authority's role as the one to determine if there is or is not staff misconduct, and have led to poor recommendations by department attorneys, and poor decisions by hiring authorities.
Body-Worn Camera and Video Surveillance Recordings	
Departmental policy requiring a 90-day retention period for preservation of video may not be long enough to allow investigators to request, review, and preserve all relevant video evidence for staff complaint inquiries and investigations.	The OIG recommends that the department revise its policy to prevent the deletion of video evidence after 90 days for inquiries and investigations. One key change is to increase the minimum video retention and storage policy to one year for all allegations of staff misconduct the Centralized Screening Team refers for an inquiry and investigation.

Source: The Office of the Inspector General.

Audit Reports and Special Reviews

The OIG's Audit Unit published one audit report and one special review in 2023. In our audit report titled *Audit of the Department of Corrections and Rehabilitation's Controlled Substances Contraband Interdiction Efforts*, we determined that the department underutilized canines and electronic drug detection devices at multiple prisons. We found that the canines were not always available at their assigned prisons to conduct searches, and even if they were, the department did not regularly use them to search prison grounds. Similarly, the department did not use electronic drug detection devices to screen for drugs at most prisons despite the devices' proven effectiveness.

We also observed the search process at pedestrian entrances, as well as searches conducted of incarcerated people during work shift changes, after visiting, and during cell searches, and found them lacking. The searches we observed were not always thorough and were unlikely to discover concealed drugs.

Finally, we reviewed investigations conducted by prison investigative services' units to determine the sources of drugs discovered on prison grounds and found that the department had minimal policies and procedures in place for investigating the source of drug discoveries. Furthermore, the investigations we reviewed were generally of poor quality and rarely identified the source of the drugs.

In response to our findings, we made many recommendations. Regarding searches, we recommended that the department develop and implement procedures to effectively use canines to search individuals entering prisons, as well as prison grounds. We also recommended that the department develop policies and procedures to better search staff and their belongings, including using canines. We further recommended that the department clarify methods to search incarcerated people coming from and going to job assignments and use electronic drug detection devices during the searches. Finally, we recommended that the department ensure staff consistently complete and document required cell searches and implement training to reinforce skills and expectations for conducting effective cell searches.

In regard to investigations of the sources of drug discoveries, we recommended that the department establish clear policies, procedures, and guidance for investigating discoveries, and develop and conduct specific training for prison investigators. We also recommended the department establish policies and procedures for properly documenting drug discoveries and improving the quality of its data.

In addition to the audit, the Audit Unit published one special review titled *Special Review: The California Department of Corrections and Rehabilitation's Implementation of the Transgender Respect, Agency, and Dignity Act* (the Act). During our review, we found that the department's

still-evolving process to evaluate transfer requests under the Act has resulted in significant delays and that the vast majority of applicants had not been evaluated for suitability to transfer.

In addition, we found that many incarcerated people at women's prisons expressed safety and privacy concerns living with transferees under the Act. The Act has created tension and a perception of inequity between transferees and those incarcerated people at women's prisons who did not wish to house with transferees in the same cell or dormitory because of safety concerns. The perceived inequity was in part caused by the fact that transferees' perception of health and safety when accepting housing assignments must be given serious consideration under the Act, but the same is not always true for nontransferees.

Finally, we found that the department properly investigated or responded to all allegations of consensual sexual misconduct or assault between transferees and other incarcerated people. Although consensual sexual relationships between transferees and nontransferees was reportedly commonplace, none of the cases we reviewed included alleged rape or attempted rape.

In summary, we recommended that the department develop specific criteria for both evaluating and completing evaluations for transfer requests. On a closely related note, we also recommended that the department develop a plan for reducing its backlog of transfer requests, train staff, and better communicate with those requesting transfers. Finally, we recommended that the department document when and why a transferee requests a bed change and give a copy of the documentation to the requesting transferee.

Complaint Intake

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

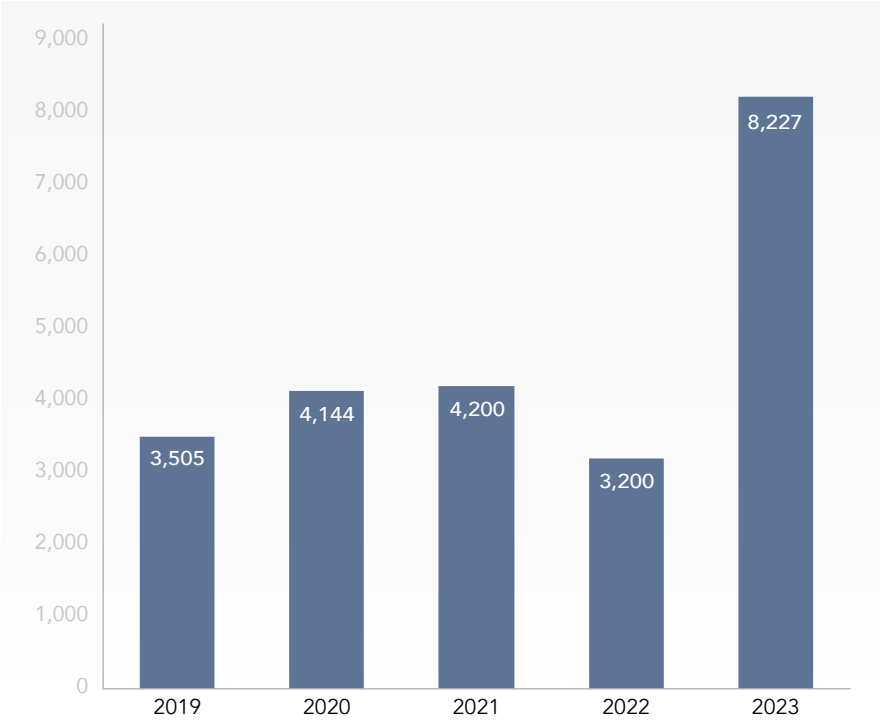
In 2023, we received 8,227 complaints (Figure 4, next page). This was a 157 percent increase from the 3,200 complaints received in 2022. We can attribute this increase to several factors, including the department's distribution of tablets for incarcerated persons from August 2021 through September 2023 (with 19 prisons becoming operational with tablets in 2023); our distribution of new OIG posters statewide with a new confidential speed dial feature for phones; and our Intake staff having made 10 visits to institutions where we could interact directly with advisory councils for incarcerated persons (i.e., Inmate Advisory Council (IAC); each prison has multiple IACs, typically one for each facility, with three to five per prison).

Our Intake staff assign a unique identification number for complaints received that we use to document and maintain records for in our case activity database. In 2023, we reviewed and closed 6,699 of the 8,227 complaints received. In addition, some incarcerated people often submit numerous complaints which typically include duplicate allegations previously reviewed and closed by Intake staff. In 2023, we completed our review of 1,246 duplicative complaint issues received from 22 complainants. In 2024, our staff will continue working to resolve the remaining 282 complaints (three percent) pending from 2023.

In November 2023, Intake published its initial *Impact Case Blocks* to highlight select intake complaints. This select group led to a positive change or an impact as raised by the complainant. When Intake staff review a complaint, this may result in our office requesting that the Office of Internal Affairs consider opening an investigation into an allegation of staff misconduct or that our Staff Misconduct Monitoring Unit (SMMU) begin monitoring inquiries or investigations for an allegation. One of the complaints highlighted in the case blocks involved a parolee never having been compensated for lost and damaged property. Intake staff located documentation supporting this claim, contacted departmental staff about the delayed payment, and received notification when the parolee received compensation; Intake's *Impact Case Blocks* may be found **on our website**.

Approximately 81 percent of the complaints we received in 2023 were submitted by incarcerated people across the State, while 15 percent

Figure 4. Total Number of Complaints the OIG Received Over the Past Five Years, From 2019 Through 2023



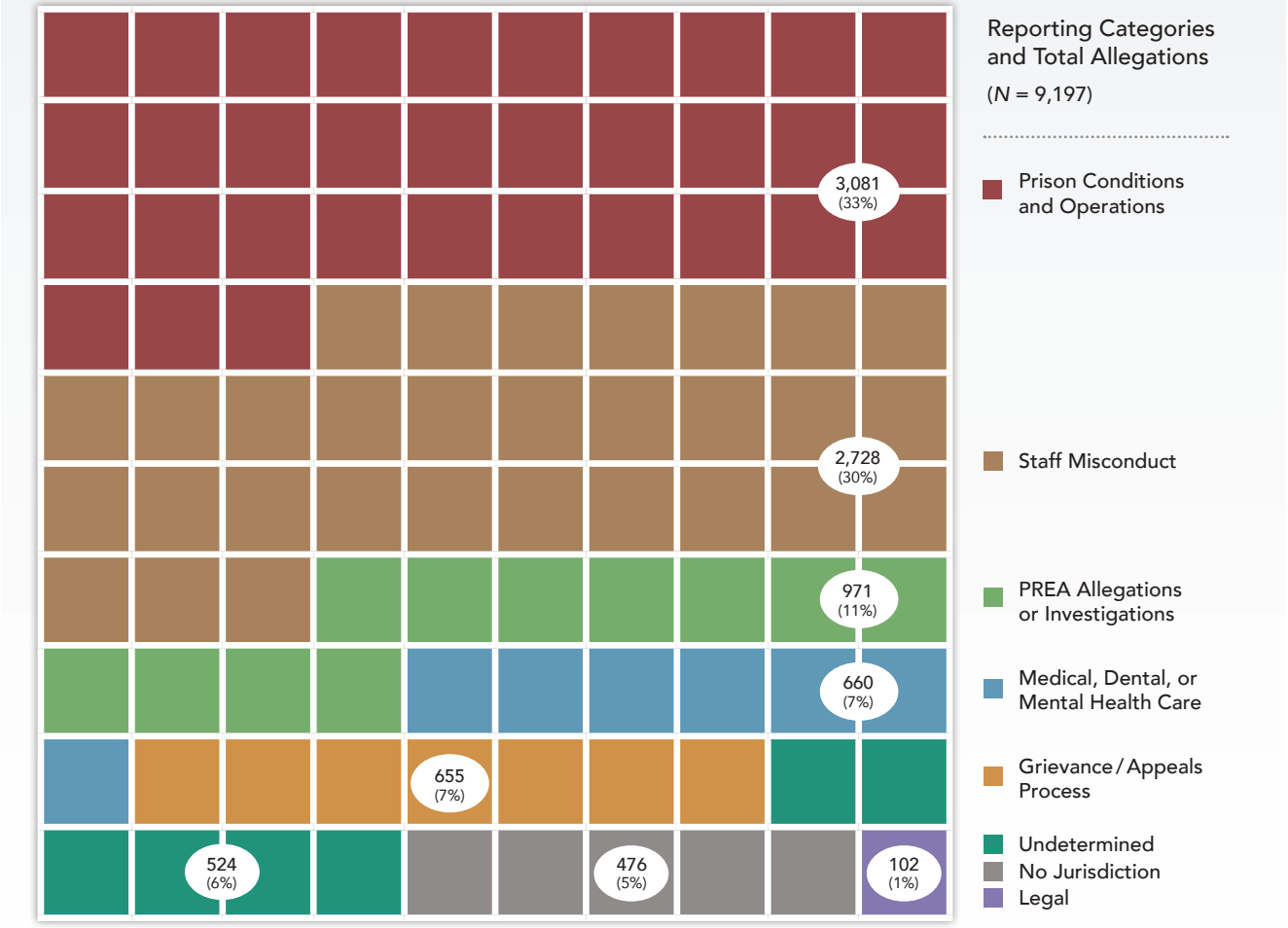
Source: The Office of the Inspector General Tracking and Reporting System.

were submitted by citizens. The OIG received the remaining complaints from departmental employees, anonymous people, parolees, or other individuals. We received about 50 percent of the complaints through voicemail (via phone and tablet), more than 38 percent by mail, 12 percent from our website, and the remainder in person.

In response to these complaints, our staff often conducted inquiries into the allegations 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 complaints, we advised complainants about how they could more fully 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 2023 pertained to such issues as staff misconduct; prison conditions, policies, or operations; the appeals and grievance process; the Prison Rape Elimination Act (known as PREA); or health care concerns. A complaint can frequently contain multiple allegations of improper activity occurring within the department. Figure 5 on the next page shows the distribution of the top five complaint allegation categories we received.

Figure 5. Distribution of Allegations the OIG Received in 2023: Percentages and Total Amounts



Definitions

Prison Conditions and Operations

Complaints that involve concerns with prison conditions, such as incorrect release date calculations, missing property, access to rehabilitative programs, or the visiting process.

Staff Misconduct and Grievance/Appeals Process

Complaints that involve concerns with processing of grievances and appeals and allegations of staff misconduct by departmental staff.

Prison Rape Elimination Act (PREA)

Allegations that an incarcerated person was subjected to sexual harassment or misconduct by incarcerated persons or staff, or made PREA complaints that were not handled appropriately.

Medical, Dental, or Mental Health

Complaints that involve concerns with access to medical, dental, or mental health services or objection to a decision that has a material adverse effect on an incarcerated person's physical or mental well-being.

Undetermined

Complaints that do not identify a specific concern, allegation, or request, such as incarcerated people requesting to be interviewed or making general statements about their incarceration.

No OIG Jurisdiction

Allegations that fall outside OIG jurisdiction, such as complaints involving county jails, federal prisons, or local law enforcement.

Legal

Requests for various types of legal assistance, including access to public records, and allegations of retaliation by departmental staff.

Source: Definitions and data generated by the Office of the Inspector General.

Prison Rape Elimination Act

In 2023, we received 864 complaints involving alleged sexual misconduct or assault, known as PREA allegations, from incarcerated people, family members, and other third parties. In accordance with federal PREA standards, we forwarded these allegations of sexual abuse and sexual harassment to both the respective hiring authority and PREA compliance manager, allowing the person who reported the allegation to remain anonymous if requested.

In 2023, the department also notified our Intake staff of 589 PREA allegations involving alleged sexual abuse and sexual harassment incidents. The reports included, in part, allegations of nonconsensual sexual acts, abusive sexual acts, sexual harassment, and sexual misconduct. The department tracks and reports statistics on these alleged incidents annually **on its website**, and posts PREA audit reports of the prisons.

Inmate Advisory Council (IAC) Meetings

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

During 2023, our intake staff met with IACs at 10 institutions to educate council members about the OIG's mission and to solicit input. While most council representatives were aware of our office, there was a lack of understanding of our functions and how we elevate and notify the department about concerns that are brought to our attention. Accordingly, in all our meetings, we provided an overview of the OIG, addressed confidentiality concerns, and explained how to contact us. Our staff also provided how we may be able to assist incarcerated people with specific issues.

The council representatives discussed many concerns and issues that they felt were not being adequately addressed at the institution. The most common issues raised involved the grievance and staff misconduct processes and institutional culture. We also received positive feedback from several IACs regarding their institution or interactions with departmental staff.

Grievance and Staff Misconduct Processes

Generally, the primary issues of concern that many of the IAC representatives identified concerned the department's handling of grievances (presented on CDCR Form 602-1) and allegations of staff misconduct. The councils expressed concern regarding how long it can take for the grievance process to be resolved, grievance issues that are

never addressed, and a perceived lack of transparency and accountability throughout the process.

At one institution, some incarcerated people who had filed grievances did not always receive an acknowledgment from the Office of Grievances for having done so. Without having received a grievance log number, an incarcerated person cannot track whether the grievance was received or learn about the status of a grievance decision. In another instance, an IAC representative mentioned receiving a response from the Office of Grievances after the department's 60-day deadline had passed; however, the date identified on the response letter showed the Office of Grievances had responded timely. Furthermore, the Office of Appeals' second-level review, at times, allows time constraints to expire without conducting any review; thus, the grievance issue is never addressed. In addition, IAC representatives at several institutions stated that they preferred the hard-copy request form that the department used in the past, which provided a receipt. Incarcerated people could use the form to document that a request had been filed and reviewed by staff and a supervisor, prior to submitting a grievance form.

IAC members also noted that they believed the grievance process is not confidential, and some incarcerated people are subject to retaliation for filing grievances. One IAC member cited a situation wherein he had submitted a grievance in the grievance lockbox and was confronted the next day by the officer identified in the complaint. There was a perception that the facility captain's office technician, who was typically tasked with retrieving grievance forms from lockboxes, was subsequently sharing grievance information with custody staff. Another IAC member alleged having submitted a staff complaint and then, was interviewed. During the investigative interview conducted via video conference, the investigator instructed custody staff to leave the confidential interview room, but custody staff remained in the room without the investigator's knowledge. Thus, the IAC member declined to be interviewed as he feared retaliation. Intake staff referred this concern to our office's SMMU, whose staff subsequently monitored the department's investigation for this case that included a reinterview of the incarcerated person in a confidential setting.

Institutional Culture

The IACs at most institutions expressed concerns that incarcerated people were not treated with dignity and respect by some departmental staff. IAC representatives discussed the perception of a generally negative culture, an attitude that was perceived among some staff and directed toward incarcerated people. The IACs cited retaliatory practices when members or other incarcerated people filed grievances, negative outcomes when they were sent to the restricted housing unit (RHU), and discourteous treatment directed toward incarcerated people and visitors.

IAC members shared several examples of these concerns. For example, after an incarcerated person submitted a staff misconduct grievance against an officer, IAC members stated that some of them were subject to unannounced cell searches, loss of programs, or transfer to another institution. This created fear among the incarcerated population and concern over whether it would be worthwhile to file a grievance.

In November 2023, the department implemented emergency regulations that applied to its RHU. The regulations included reforms limiting these units' use to incarcerated people who have engaged in violence in prison or have expressed serious safety or security concerns. IAC members shared ongoing concerns when they were placed in restricted housing. One example described the following scenario: When an incarcerated person was sent to the RHU, custody staff allowed the persons' cellmate to "pack [up]" the belongings of the person sent to the RHU. This has created problems when cellmates do not have a good relationship, and property is found to have gone missing when they return from the RHU. Another example: After reporting a PREA violation, an alleged victim of sexual misconduct or harassment would be placed in the RHU. Then, for reporting misconduct, the victim's property would become permanently "lost" in retaliation—directly or indirectly—as a further punishment meted out by custody staff. One IAC member stated that whenever an incarcerated person was sent to the RHU, a designated officer should be required to account for, pack, and secure that person's property.

Moreover, one main way for incarcerated people to connect with their family and friends was through regular in-person visitation. Several IACs highlighted concerns that their members or other incarcerated people had faced in 2023. These included the following concerns:

- Visitors were processed slowly, which sometimes took several hours.
- Incarcerated people were called for visiting at the exact time of "pill call," which reduced the time available for incarcerated people to enjoy the visit.
- Some family-visiting units were unavailable because they were being used instead for storage space, thus limiting the units available for overnight visits.
- Visiting staff assignments were ever-changing and included inexperienced staff, which resulted in an inconsistent application of policy, such as the judgmental enforcement of whether visitors' attire was considered "very tight, form-fitting" and thus not allowed.

Another example alleged that a visiting officer intentionally separated children by placing them in the children's play area of the visiting room, far away from their parents, so the incarcerated parents could not easily watch their children. IAC members strongly believed that this type of

treatment served as a sign of general disrespect directed toward visitors and their family members, which created a negative cultural atmosphere in the prisons.

Positive Feedback From IACs

Typically, IACs meet quarterly with the warden and monthly with members of the warden's management team, including a facility captain and other supervisors. We asked IACs what was going well at their institution, and they shared the following types of information with us:

- Members think highly of the warden, and it is the best administration they have seen at the institution.
- The warden is working with staff and incarcerated people to improve relationships and communication.
- The warden is a proponent of the California Model and resolves issues.

IAC representatives also made positive comments about both staff and available resources, including the following observations:

- There are more good staff who treat incarcerated people like humans beings and work to create a good culture.
- There is better communication with staff, and issues regarding packages and property get resolved without grievances.
- A sergeant was instrumental in recently assisting with a suicidal incarcerated person; the sergeant was able to speak with [the person] and properly dealt with the stressful situation.
- There are more programming opportunities than in the past. The outside programming is positive, and tablets provide additional course offerings.
- Tablets have allowed incarcerated people to get back in touch with family to whom they had not spoken in years.

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.

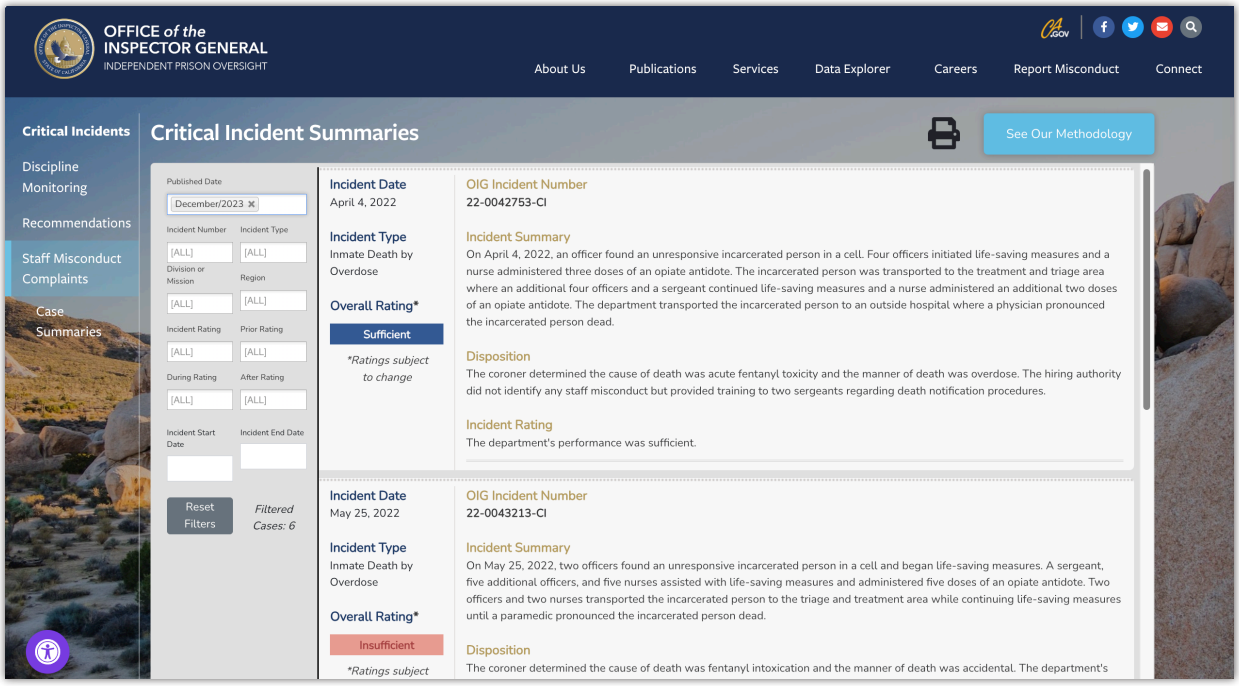
In 2023, the OIG received 22 retaliation complaints. We completed analyses of 21 complaints and determined that none stated the legally required elements of a whistleblower retaliation claim. We are still in the process of reviewing the materials pertaining to one complaint we received in late 2023.

Recommendations Made to the Department

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

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

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



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Appendix: Publications Released in 2023

Annual and Semiannual Reports

- *2022 Annual Report: A Summary of Reports* (February 21, 2023)
- *Monitoring the Staff Misconduct Investigation and Review Process of the California Department of Corrections and Rehabilitation, 2022 Annual Report* (May 24, 2023)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, July – December 2022* (June 19, 2023)
- *Monitoring the Use-of-Force Review Process of the California Department of Corrections and Rehabilitation* (July 3, 2023)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation, January – June 2023* (September 29, 2023)

Medical Inspection Reports: Cycle 6 Results

- Chuckawalla Valley State Prison (January 30, 2023)
- Sierra Conservation Center (March 10, 2023)
- California Institution for Men (May 5, 2023)
- San Quentin State Prison (June 27, 2023)
- California City Correctional Facility (June 29, 2023)
- Ironwood State Prison (July 12, 2023)
- California Health Care Facility (September 27, 2023)
- Cycle 6 Medical Inspection Summary Report (November 6, 2023)

Medical Inspection Reports: Cycle 7 Results

- California State Prison, Los Angeles County (December 4, 2023)

Audit Reports and Special Reviews

- *Audit of the Department of Corrections and Rehabilitation's Controlled Substances Contraband Interdiction Efforts, Audit Report Nº 21-01* (January 11, 2023)
- *Special Review: The California Department of Corrections and Rehabilitation's Implementation of the Transgender Respect, Agency, and Dignity Act* (August 31, 2023)

Field Team Case Blocks

- *August 2023 Centralized Screening Monitoring Team Case Blocks* (October 9, 2023)
- *September 2023 Centralized Screening Monitoring Team Case Blocks* (November 1, 2023)
- *October 2023 Intake Unit Impact Case Blocks* (November 21, 2023)
- *January Through September 2023 Local Inquiry Team Case Blocks* (November 27, 2023)
- *October 2023 Local Inquiry Team Case Blocks* (December 4, 2023)
- *October 2023 Centralized Screening Monitoring Team Case Blocks* (December 11, 2023)
- *November 2023 Centralized Screening Monitoring Team Case Blocks* (December 20, 2023)

2023
Annual Report

A Summary of Publications

OFFICE *of the* INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Neil Robertson
Chief Deputy Inspector General

STATE *of* CALIFORNIA
March 2024

OIG