Quarterly 2025 Intake Processing Unit Impact Case Blocks
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The Office of the Inspector General (the OIG), pursuant to statute, maintains an Intake Processing Unit that receives complaints from the incarcerated population and the public. Staff in the Intake Processing Unit respond to complaints the OIG receives through U.S. Postal mail, phone calls (toll-free hotline), and inquiries through our website, which can exceed 1,000 monthly claims. Below are 18 complaints the Intake Processing Unit reviewed and closed between March 2025 and May 2025. These cases highlight the OIG's impact and efforts to resolve each complainant's concerns.

Incident Date
May 1, 2025

Case Type
Prison Rape Elimination Act (PREA) Confidentiality; Rules Violation Report (RVR)

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0099289-PI

Complaint Summary
On May 1, 2025, the OIG received a complaint from an anonymous incarcerated person (complainant) claiming he was issued and found guilty of a rules violation report (RVR) for making false Prison Rape Elimination Act (PREA) allegations.

OIG Actions
The OIG reviewed departmental records and located an RVR which referenced "numerous false allegations" of PREA violations allegedly made by the complainant on November 21, 2024, and February 3, 2025. The OIG did not receive any complaints on November 21, 2024, containing alleged PREA violations at the prison where the complainant was housed. The OIG had received a complaint on February 3, 2025, containing alleged PREA violations at the same prison where the complainant was housed. The February 3, 2025 complaint, which an anonymous incarcerated person left by voicemail, alleged three incarcerated people were using drugs, engaging in sexual activity, and arguing loudly. The anonymous incarcerated person threatened to take matters into his own hands since departmental staff were not addressing the issue. On February 4, 2025, the OIG notified the warden of the potential safety threat against the three incarcerated people and the allegation that they possessed contraband.

The prison's Investigative Services Unit (ISU) subsequently interviewed confidential sources (incarcerated people) who identified an incarcerated person as the source of the anonymous OIG complaint. The ISU identified one call made from the complainant's State-issued tablet to the OIG on November 21, 2024; however, the personal identification number (PIN) used belonged to a second incarcerated person, indicating that the call to our office was not made by the complainant. The ISU also identified two calls made from the complainant's State-issued tablet to the OIG on February 3, 2025. Although no PIN was entered by an incarcerated person for either call, ISU determined the call was made by the complainant since it came from his State-issued tablet.

On February 25, 2025, the prison's ISU concluded an investigation that determined the complainant made a false PREA allegation. The complainant was subsequently found guilty of willfully delaying a peace officer in the performance of their duties, as the false complaint

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caused an investigator to spend time interviewing witnesses and reviewing phone call logs. The complainant was given a 90-day credit loss for being the anonymous source who was believed to have contacted the OIG about an alleged PREA and safety concern.

The OIG treats information and sources reported to our office in a confidential manner. Information or correspondence from any person reporting information to the OIG shall not be disclosed to the department without permission from the complainant, if known, unless imminent safety and security concerns are identified. The search to identify sources of anonymous complaints made to our office is a breach of confidentiality that undermines the very purpose of reporting allegations in an anonymous manner.

Furthermore, Federal PREA Standard 115.51 states that for any individual reporting PREA complaints to our office, the responsible agency shall immediately forward reports of sexual abuse and sexual harassment to departmental officials, allowing the incarcerated person to remain anonymous upon request. Federal PREA Standard 115.78 (f) further states that "For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation."

On May 23, 2025, the Inspector General elevated these confidentiality concerns to departmental executives for their consideration to review the RVR regarding the anonymous reporting of the PREA allegation to our office.

Disposition
On May 27, 2025, in the interest of justice, the prison's associate warden voided the RVR and the associated 90-day credit loss imposed on the complainant.

Incident Date
March 23, 2024

Case Type
Allegation of Staff Misconduct: Integrity, Other Misconduct

Mission
Division of Adult Institutions: Region II (Fresno Area); California Correctional Health Care Services (CCHCS)

OIG Case Number
24-0085433-PI

Complaint Summary
On July 12, 2024, the OIG received a complaint from a third party (complainant) about the death of her son, who was a supervised person. On July 17, 2024, OIG staff spoke to the complainant, who stated her son had recently died of a drug overdose and a departmental employee (subject) was involved in her son's death. She alleged multiple people, including the subject, supplied her son with drugs, which led to his death. The complainant further alleged the subject had a prior romantic relationship with her son, and once he was released from prison, they got back together. The complainant alleged the subject helped her son acquire and inject drugs. She also alleged that the subject had contact with other incarcerated people at multiple prisons and sent them drugs.

OIG Actions
The OIG reviewed departmental records and confirmed that the subject was employed as a medical staff member at a CDCR prison. We also found that the subject was an approved visitor

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for the supervised person while he was incarcerated. Two years after the subject's hire date, the subject, a woman, notified the department that the supervised person was her former fiancé. The OIG utilized departmental and public records, corroborated the complainant's allegations, and discovered additional confidential information.

The OIG requested a signed waiver from the complainant. This was done so we could share the complaint information with the department to conduct either an inquiry or an investigation pertaining to the allegation of staff misconduct. On August 22, 2024, the OIG received the signed waiver from the complainant.

On August 28, 2024, the OIG elevated the allegation of staff misconduct to both the involved chief executive officer (CEO) and the warden for consideration as an allegation of staff misconduct against the subject.

Disposition
On August 29, 2024, the Investigative Services Unit (ISU) informed the OIG that its staff would conduct an inquiry into the allegations. Based on ISU's findings, on October 7, 2024, the CEO submitted a confidential request for an Office of Internal Affairs' (OIA) investigation and on October 23, 2024, OIA approved a criminal investigation. On January 30, 2025, OIA completed its criminal investigation and referred the criminal case to the district attorney for possible prosecution. Furthermore, the hiring authority sustained 14 allegations of staff misconduct in a separate OIA administrative investigation. As of March 16, 2025, the subject was no longer employed by the department.

Incident Date
March 8, 2025

Case Type
Threat Against Officers; Contraband

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0097841-PI

Complaint Summary
On March 8, 2025, the OIG received a complaint from an anonymous source (complainant) who alleged an incarcerated person had a weapon under his mattress and was going to target two officers. The complainant provided the name and California Department of Corrections and Rehabilitation (CDCR) number of the incarcerated person who allegedly possessed the weapon and the names of the targeted officers.

OIG Actions
On March 8, 2025, the OIG reviewed departmental records, identified the housing unit of the incarcerated person who allegedly possessed the makeshift weapon, and identified that the targeted officers were assigned to the same housing unit. The OIG immediately notified the warden regarding the makeshift weapon and the potential threat to the officers. The notification included the name and CDCR number of the incarcerated person who allegedly possessed the makeshift weapon and the names of the targeted officers.

Disposition
Within two hours of the OIG's notification, officers interviewed multiple incarcerated people in the housing unit, searched the identified cell, and discovered a makeshift weapon affixed to the incarcerated person's mattress. The makeshift weapon appeared to be made from a

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toothbrush handle, measured approximately 5.5 inches in length and one-half inch wide, and was sharpened to a point at one end. The incarcerated person was subsequently rehoused in the restricted housing unit for potential safety and security concerns.

The incarcerated person was issued a rules violation report, and on April 12, 2025, was found guilty of possession of a deadly weapon. The incarcerated person received 360 days of credit loss.

Incident Date
March 26, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0098389-PI

Complaint Summary
On March 26, 2025, the OIG received two complaints from an incarcerated person (complainant) who alleged other incarcerated people wanted to kill him and that he was in immediate danger. The complainant stated he was recently assaulted by four incarcerated people, and when he told staff that the four other incarcerated people wanted to kill him, staff refused to take the safety concern seriously.

OIG Actions
The OIG reviewed departmental records and confirmed that on March 24, 2025, the complainant was assaulted by incarcerated people. Following the assault, the incarcerated people involved each signed a compatibility chrono—a document used to evaluate the seriousness of a dispute between incarcerated people housed on the same facility. During our office's review on March 26, 2025, we found no documents indicating the prison was aware of the complainant's new safety concerns.

On March 27, 2025, the OIG notified the warden of the complainant's new safety concerns.

Disposition
On March 28, 2025, the OIG found departmental staff had conducted a safety interview and moved the incarcerated person to a different facility.

Incident Date
February 25, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0097594-PI

Complaint Summary
On February 28, 2025, and March 6, 2025, the OIG received two complaints from a third party (complainant) who was concerned about the safety of an incarcerated person. The complainant

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alleged that an officer engaged in harassment of the incarcerated person based on their sexual orientation by using inappropriate sexual language, directing derogatory names toward them, and engaging in bullying behavior. The complainant alleged that the officer spoke to a group of incarcerated people, then left his assigned post, thereby enabling the group to assault and injure the incarcerated person and a second incarcerated person.

OIG Actions
The OIG reviewed departmental records and identified that on February 28, 2025; the first incarcerated person filed a grievance alleging staff misconduct that occurred on February 25, 2025. On March 5, 2025, the department's Centralized Screening Team (CST) referred these allegations to the Office of Internal Affairs (OIA) for an investigation. However, CST did not include the name of an involved officer who was identified as a subject in the grievance. On March 10, 2025, the OIG notified CST of the discrepancy.

Due to the allegations the incarcerated person raised, including the officer's involvement in the assault of incarcerated people, the complaint was referred by the OIG's Intake staff to the OIG's Staff Misconduct Monitoring Unit (SMMU) to monitor the investigation.

On March 27, 2025, the OIG reviewed departmental records; however, the named officer still had not been added as a subject in the investigation. Thus, on March 27, 2025, the OIG followed up with CST to determine what actions, if any, had been taken based on the OIG's recommendation.

Disposition
On March 11, 2025, the OIG's SMMU elected to monitor this OIA investigation. On March 27, 2025, following the OIG's subsequent contact, CST notified the OIG that the named officer had been added as a subject in the investigation.

Incident Date
April 15, 2025

Case Type
Safety Concern; Allegation of Staff Misconduct: Other Misconduct

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0098922-PI

Complaint Summary
On April 15, 2025, the OIG received a complaint from an anonymous source (complainant) alleging that a first incarcerated person was experiencing safety concerns with a second incarcerated person. The complainant alleged the first incarcerated person tried to report an overly familiar relationship between an officer and the second incarcerated person. The reporting party stated the first incarcerated person had additional evidence to support the allegations of overfamiliarity. The reporting party also indicated the officer was providing contraband, such as mobile phones and drugs, to the second incarcerated person and the officer had shared their computer password with other incarcerated people allowing them access to confidential information.

OIG Actions
The OIG reviewed departmental records and identified the second incarcerated person and the officer who were allegedly involved in the overly familiar relationship. The OIG also found that

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the first incarcerated person was housed in the restricted housing unit (RHU) for other safety concerns the prison was in the process of investigating.

On April 18, 2025, the OIG notified the warden of the first incarcerated person's safety concerns and allegations of staff misconduct.

On May 8, 2025, the OIG reviewed departmental records and found no documentation indicating the prison had addressed either the safety concerns or the allegations of staff misconduct. Therefore, the OIG followed up with the warden to determine what actions they had taken based on our prior notification.

Disposition
On May 8, 2025, the warden notified the OIG that on April 18, 2025, a cell search was completed for the first incarcerated person who was housed in the RHU, and an interview was scheduled for his previously reported safety concerns. The warden also stated the allegations of staff misconduct were forwarded to the Centralized Screening Team (CST). However, according to departmental records, the allegations of staff misconduct were not forwarded to CST until May 9, 2025, the day after we followed up with the warden. On May 13, 2025, CST referred the allegation of staff misconduct to the Office of Internal Affairs, which opened an investigation the same day.

Incident Date
April 15, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region I (Sacramento Area); California Correctional Health Care Services (CCHCS)

OIG Case Number
25-0098821-PI

Complaint Summary
On April 15, 2025, the OIG received a complaint from an incarcerated person (complainant) who stated, "I'm in here cutting on myself," and "I don't know what else to do but cut on myself and I'm feeling suicidal."

OIG Actions
The OIG reviewed departmental records including medical and mental health records and found the complainant had not been seen by mental health staff since contacting our office. Prior to the complainant contacting the OIG, we found that on April 13, 2025, mental health staff conducted a suicide risk assessment for the complainant.

However, the OIG did not locate documentation indicating mental health staff were aware of the complainant's current self-harm. On April 16, 2025, the OIG notified the warden and the chief of mental health that the complainant was experiencing suicidal thoughts and committing self-harm. The department did not confirm receipt of or respond to the OIG's notification.

On April 21, 2025, the OIG reviewed departmental records to determine whether the complainant received a suicide risk assessment in response to the OIG's notification. On April 17 and 18, 2025, the complainant was seen for a separate mental health concern. However, there was no documentation located that the required mental health services

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procedures for someone showing signs and symptoms of suicide potential were initiated after the OIG had notified the department that the complainant complained of suicidal ideations and had harmed himself.

Thus, on April 21, 2025, the OIG sent another notification to the warden and to the chief of mental health to determine what actions they had taken based on the OIG's initial notification.

Disposition
On April 21, 2025, after the OIG's follow up, the complainant received a suicide risk assessment by a mental health clinician regarding these mental health concerns. During the encounter, the incarcerated person denied any suicidal ideations and any recent self-harming behaviors.

Incident Date
February 21, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0097428-PI

Complaint Summary
On February 21, 2025, after business hours, the OIG received a complaint from an anonymous incarcerated person (complainant) alleging a second incarcerated person was planning to stab a correctional counselor.

OIG Actions
On February 24, 2025, the next business day, the OIG reviewed departmental records and did not locate documentation indicating the department was aware of the threat to harm the correctional counselor. Therefore, the OIG notified the warden of the potential threat.

Disposition
The OIG reviewed departmental records and found that within three hours of our notification, the second incarcerated person was placed in the restricted housing unit for an investigation into threats against the correctional counselor. Furthermore, the correctional counselor was notified of the alleged threat and requested to return to their job assignment. The department could not locate any evidence to substantiate the threat, and on February 25, 2025, the second incarcerated person was released back into the facility.

Incident Date
April 23, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region II (Fresno Area)

OIG Case Number
25-0098624-PI

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Complaint Summary
Between April 5, 2025, and May 22, 2025, the OIG received twelve complaints from an incarcerated person (complainant) alleging a second incarcerated person was threatening and assaulting other incarcerated people, selling drugs, and engaging in sexual activity.

OIG Actions
The OIG reviewed departmental records and found the complainant filed a grievance on April 23, 2025, reporting the misconduct by the second incarcerated person. Records showed the grievance was redirected on April 25, 2025, to the facility staff for review; however, we did not find documentation indicating a review was completed.

On May 20, 2025, the OIG contacted the Office of Grievances (OOG) to determine to whom the grievance was redirected and what actions facility staff took to address the complainant's allegations.

Disposition
On May 22, 2025, OOG provided the OIG with documents that indicated facility staff were not made aware of the grievance until May 21, 2025, the day after we contacted OOG. The complainant was interviewed on May 21, 2025, and was unwilling to provide additional information.

Incident Date
February 20, 2025

Case Type
Allegation of Staff Misconduct: Integrity; Centralized Screening Team (CST): Screening Decision

Mission
Division of Adult Institutions: Region II (Fresno Area) and Office of Internal Affairs, Centralized Screening Team (CST)

OIG Case Number
25-0098812-PI

Complaint Summary
On April 9, 2025, the OIG received a complaint from an incarcerated person (complainant) alleging prison officials were facilitating "gladiator fights" on a general population yard. Specifically, the complainant alleged more than 50 incarcerated people with certain case factors made them susceptible to victimization, such as a prior sex offense or prior placement on a nondesignated programming facility (NDPF). The complainant referred to a February 20, 2025, incident and identified other involved incarcerated people.

OIG Actions
The OIG reviewed departmental records and found that on April 14, 2025, the complainant filed a grievance alleging prison officials were facilitating "gladiator fights" on a general population yard. On April 16, 2025, the department's Centralized Screening Team (CST) referred the allegation of staff misconduct to the Office of Internal Affairs (OIA) for an investigation.

The OIG also identified two other grievances filed by a second and a third incarcerated person who were involved in the February 20, 2025, incident. The grievances filed by the second and third incarcerated people were nearly identical to the grievance filed by the complainant; however, none of the allegations filed by the second and third incarcerated people were identified as staff misconduct. On May 6, 2025, the OIG disputed CST's screening decisions for allegations made by the second and third incarcerated people.

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Disposition
On May 7, 2025, the CST conducted a second review of the grievances for the second and third incarcerated people and referred the allegations of staff misconduct to OIA, which opened an investigation on May 8, 2025. On May 9, 2025, the OIG's Staff Misconduct Monitoring Unit began monitoring the investigation.

Incident Date
May 21, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region I (Sacramento Area)

OIG Case Number
25-0099884-PI

Complaint Summary
On May 21, 2025, the OIG received a complaint from a private citizen (complainant) who alleged an incarcerated person had been repeatedly calling her for more than a month. The complainant alleged she had asked the incarcerated person, who was previously housed with her fiancé, to stop calling multiple times; however, the unwanted calls continued. The calls made the complainant feel uncomfortable and unsafe, and she requested the OIG's assistance to stop the calls.

OIG Actions
The OIG reviewed departmental records and confirmed the incarcerated person was previously housed with the complainant's fiancé. On May 22, 2025, we received a signed waiver from the complainant, authorizing us to share the complaint with the department so it could address the complainant's concerns.

On May 27, 2025, the OIG notified the warden of the complainant's safety concerns.

Disposition
On May 27, 2025, within one hour of our notification to the warden, the department issued the incarcerated person a cease-and-desist order, ordering the incarcerated person to no longer contact the complainant. The OIG commends prison staff for their quick response and actions taken following our notification.

Incident Date
March 7, 2025

Case Type
Allegation of Staff Misconduct: Dishonesty, Integrity

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0098304-PI

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Complaint Summary
On March 24, 2025, the OIG received a complaint from an incarcerated person (complainant) who alleged on March 7, 2025, he witnessed an officer plant drug evidence in a second incarcerated person's cell.

OIG Actions
The OIG reviewed departmental records and found that on March 7, 2025, two officers (one of whom allegedly planted the drug evidence) searched the second incarcerated person's cell, and found drugs. The second incarcerated person was issued a rules violation report for possession of a controlled substance.

On March 12, 2025, the complainant filed a grievance stating that he observed an officer plant drug evidence on March 7, 2025, in the second incarcerated person's cell. The OIG found that on March 14, 2025, the Centralized Screening Team (CST) referred the complainant's allegation of dishonesty by the officer for routine processing at the prison rather than sending it to the Office of Internal Affairs (OIA) for an investigation. The department uses an allegation decision index to determine to which unit within the department a complaint should be referred for processing.

On April 4, 2025, the OIG disputed CST's routine screening decision and elevated the decision to the CST's administrators for consideration of referral to Office of Internal Affairs for an investigation.

Disposition
On April 29, 2025, CST staff conducted a second review of the grievance and revised its initial routine screening decision and referred the allegation of dishonesty to OIA, which opened an investigation the same day.

Incident Date
April 2, 2025

Case Type
Appeal Process

Mission
Division of Correctional Policy Research and Internal Oversight (Headquarters)

OIG Case Number
25-0098431-PI

Complaint Summary
Between March 27, 2025, and April 11, 2025, the OIG received five complaints from an incarcerated person (complainant) alleging the Office of Appeals (OOA) failed to timely respond to three appeals. The appeals involved issues concerning a rules violation report, visiting privileges, legal issues, and classification issues. The complainant alleged OOA staff had violated the complainant's due process rights and caused the grievance and appeal process to become ineffective.

OIG Actions
On April 8, 2025, the OIG reviewed departmental records and confirmed all three appeal responses were prepared, but OOA had not mailed them. On April 16, 2025, the OIG notified OOA staff that the three responses were overdue and had not been sent to the complainant.

Disposition
On April 16, 2025, OOA staff notified the OIG that each of the overdue appeal responses would be sent to the complainant, which we confirmed were mailed on April 16 and 17, 2025.

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Incident Date
April 10, 2025

Case Type
Allegation of Staff Misconduct: Excessive or Unnecessary Use of Force

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0099124-PI

Complaint Summary
On April 24, 2025, the OIG received a complaint from an incarcerated person (complainant) who alleged two officers engaged in misconduct during a use-of-force incident. The complainant stated that on April 10, 2025, while walking to his cell, two officers told him to "stop resisting" and then took him to the floor; both officers were on top of him, and one officer put his foot on the complainant's back. The complainant provided specific details, including the location and time of the incident.

OIG Actions
The OIG reviewed departmental records and verified a use-of-force incident involving the complainant occurred on April 10, 2025. The OIG determined the complainant made an allegation of excessive or unnecessary use of force, as documented by medical staff on a medical report of injury, which stated, "I'm ADA I got rushed by the Cos." However, departmental staff did not conduct a video-recorded interview with the complainant regarding this allegation. Further documentation showed the complainant reported the allegation of excessive or unnecessary use of force again on April 24, 2025. On April 24, 2025, the department conducted a video-recorded interview with the complainant regarding his allegation.

When an incarcerated person alleges excessive or unnecessary use of force, departmental policy requires prison staff to forward the allegation of staff misconduct to the Centralized Screening Team (CST). However, as of May 15, 2025, the OIG could not locate any record that this allegation had been submitted to CST for review.

On May 16, 2025, the OIG notified the hiring authority that the allegation of staff misconduct regarding excessive or unnecessary use of force had not been submitted to CST for review.

Disposition
On May 19, 2025, following the OIG's notification, the hiring authority suspended the use-of-force review process and forwarded the allegation of staff misconduct to CST. On May 21, 2025, CST referred the allegation of excessive or unnecessary use of force to the Office of Internal Affairs, which opened an investigation on May 22, 2025.

Incident Date
December 22, 2024

Case Type
Allegation of Staff Misconduct: Excessive or Unnecessary Use of Force

Mission
Division of Adult Institutions: Region II (Fresno Area)

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OIG Case Number
25-0096896-PI

Complaint Summary
On February 3, 2025, the OIG received a complaint from a third party (complainant) who alleged an officer hit an incarcerated person on the back of the head with a baton during a riot that occurred on December 22, 2024. The complainant alleged the incident was caught on video, and the incarcerated person had sustained a laceration to the head.

OIG Actions
The OIG's review of departmental records verified a riot occurred on December 22, 2024, that involved the use of force and had resulted in a head injury to the incarcerated person. We identified the officer who allegedly used his baton against the incarcerated person. However, in the incident report, the officer stated he used his baton against the incarcerated person's thigh area, not the head. According to the incident report, staff later noticed the incarcerated person was bleeding from the back of the head, and he was subsequently transported to an outside hospital for medical evaluation and treatment.

The OIG reviewed the incarcerated person's hospital records, which showed the incarcerated person received medical care for a laceration to his head and that officers had informed hospital staff the incarcerated person had been struck in the head with a baton. The incarcerated person also told hospital staff that he was struck in the head with a baton.

As of February 24, 2025, the incarcerated person had not submitted a grievance or an allegation of excessive or unnecessary use of force at the prison. On February 24, 2025, the OIG notified the warden of the alleged baton strike to the incarcerated person's head.

Disposition
On February 25, 2025, the warden referred the allegation of staff misconduct to the Centralized Screening Team (CST), and CST processed the allegation the same day. On March 3, 2025, the Office of Internal Affairs opened an investigation into the allegation of excessive or unnecessary use of force. The OIG is monitoring the investigation.

Incident Date
April 25, 2025

Case Type
Allegation of Staff Misconduct: Excessive or Unnecessary Use of Force

Mission
Division of Adult Institutions: Region III (Bakersfield Area)

OIG Case Number
25-0099317-PI

Complaint Summary
On May 1, 2025, the OIG received a complaint from a third party (complainant) on behalf of an incarcerated person. The complainant alleged that on April 25, 2025, officers tackled the incarcerated person, beat him up, cuffed him, and hung him upside down in a phone booth.

OIG Actions
The OIG's review of departmental records verified a use-of-force incident involving the incarcerated person occurred on April 25, 2025. On the same day, departmental staff reviewed body-worn camera footage of the incident and discovered the complainant made a verbal

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allegation of staff misconduct. Staff timely conducted a video-recorded interview with the incarcerated person regarding the allegation.

When an incarcerated person alleges excessive or unnecessary use of force, departmental policy requires prison staff to forward the allegation of staff misconduct to the Centralized Screening Team (CST). However, as of May 15, 2025, the OIG could not locate any record that this allegation had been submitted to CST for review.

On May 15, 2025, the OIG notified the hiring authority that the allegation of staff misconduct regarding excessive or unnecessary use of force had not been submitted to CST for review.

Disposition
On May 16, 2025, following the OIG's notification, the hiring authority forwarded the allegation of staff misconduct to CST. On May 20, 2025, CST referred the allegation of excessive or unnecessary use of force to the Office of Internal Affairs, which opened an investigation the same day.

Incident Date
March 20, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region II (Fresno area)

OIG Case Number
25-0098222-PI

Complaint Summary
On March 20, 2025, the OIG received a complaint from an incarcerated person (complainant) alleging a second incarcerated person had been exhibiting self-harm. Specifically, the complainant stated the second incarcerated person was "purposely cutting himself to try to get a cell move."

OIG Actions
The OIG reviewed departmental records, including medical and mental health records, and determined mental health staff regularly evaluated the second incarcerated person. Medical records indicated the second incarcerated person had not exhibited behavior or made statements indicative of suicidal ideation.

On March 21, 2025, the OIG notified the warden and the chief of mental health that the second incarcerated person was demonstrating self-harming behaviors.

Disposition
On March 21, 2025, as a result of OIG's notification, mental health staff evaluated the second incarcerated person who acknowledged he had been cutting his wrist and planned to continue to harm himself. The department subsequently admitted him to a mental health crisis bed.

Incident Date
September 29, 2022

Case Type
Rules Violation Report (RVR)

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Mission
Division of Adult Institutions: Region I (Sacramento Area)

OIG Case Number
25-0098074-PI

Complaint Summary
On March 14, 2025, and April 1, 2025, the OIG received two complaints from an incarcerated person (complainant) who alleged his inappropriate rules violation report (RVR) was never dismissed. The complainant stated departmental staff reissued and reheard his RVR in 2023 for a due process violation. However, the complainant alleged that when the RVR was reissued, it was given a new log number. The complainant believed that he now has received two RVRs for the same incident that could negatively impact his upcoming parole hearing.

OIG Actions

The OIG reviewed departmental records and confirmed the complainant had filed a grievance regarding this concern on November 22, 2022, for the incident that occurred on September 29, 2022. The Office of Grievances (OOG) determined a staff assistant was assigned to the complainant; however, there was no record that the complainant and staff assistant had interacted before the RVR hearing. As a result, the OOG determined there may have been a due process violation and ordered departmental staff to reissue and rehear the RVR.

On January 12, 2023, the prison reissued and reheard the RVR using a new RVR log number rather than using the same log number assigned to the original RVR. The complainant was found guilty, and the administrative RVR was reduced to a counseling chrono—a document used to record disciplinary actions following minor misconduct.

On April 10, 2025, the OIG notified the hiring authority of the due process concerns and the issuance of two RVRs for the same violation. The OIG requested the hiring authority conduct a review to determine whether both RVRs should be dismissed in the interest of justice.

Disposition
On April 18, 2025, the warden voided both the initial RVR issued on September 29, 2022, and the RVR that had been reissued on January 12, 2023.