Quarterly 2025 Intake Processing Unit Impact Case Blocks

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The Office of the Inspector General (the OIG), as part of our 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 that 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 13 complaints that the Intake Processing Unit reviewed and closed from September 2025 through November 2025. These cases highlight the OIG's impact and efforts to resolve the complainant's concerns.

Incident Date
July 27, 2025

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

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

OIG Case Number
25-0101606-PI

Complaint Summary
On July 27, 2025, the OIG received a complaint from an anonymous source (complainant) alleging two officers used unnecessary force on a transgender incarcerated person. The complainant alleged the incarcerated person was walking to the yard to retrieve an item when custody staff ordered the yard to be shut down. In response to the order, the incarcerated person sat down. Two officers then told the incarcerated person to get up, grabbed her by the neck, slammed her on the ground, and repeatedly hit her. The complainant alleged the unnecessary use of force and provided the date and time of the incident and the last names of the incarcerated person and the two officers.

OIG Actions
The OIG reviewed departmental records and verified a use-of-force incident involving the incarcerated person occurred on July 27, 2025. The OIG did not locate documentation indicating the department was aware of an allegation of staff misconduct for excessive or unnecessary use of force.

Therefore, on July 30, 2025, based on the details provided by the complainant, the OIG notified the warden of the allegation of excessive or unnecessary use of force and requested the allegation be considered for review and processing by the department's Centralized Screening Team (CST).

Disposition
On July 30, 2025, the investigative services unit notified the OIG that it had forwarded the allegation of staff misconduct to CST. On August 6, 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.

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Incident Date
September 15, 2025

Case Type
Safety Concern

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

OIG Case Number
25-0103000-PI

Complaint Summary
On September 15, 2025, the OIG received a complaint from a citizen (complainant) alleging an incarcerated person was suicidal and was threatening to hang himself. The complainant stated she had been reporting her concerns to prison staff for the past two weeks, but staff refused to place the incarcerated person on suicide watch.

OIG Actions
The OIG reviewed departmental records including medical and mental health records and did not locate documentation indicating the department was aware the incarcerated person had been experiencing suicidal thoughts.

On September 15, 2025, the OIG contacted the complainant to obtain more information. The complainant reported the incarcerated person was having a nervous breakdown and had made multiple suicidal statements to staff as recently as that morning. The complainant stated she notified prison staff the previous week that the incarcerated person was suicidal.

On September 15, 2025, the OIG notified the warden and chief of mental health that the incarcerated person had been experiencing suicidal thoughts and had been threatening to hang himself.

Disposition
On September 15, 2025, within two hours of the OIG's notification, the crisis intervention team evaluated the incarcerated person, and on the same day, the incarcerated person was admitted to a mental health crisis bed for patients needing emergency mental health care.

Incident Date
September 13, 2024

Case Type
Grievance and Appeal Process

Mission
Division of Adult Institutions: Region IV (Rancho Cucamonga Area)

OIG Case Number
25-0101509-PI

Complaint Summary
On July 25, 2025, the OIG received a complaint from an incarcerated person (complainant) alleging that nearly a year ago, the Office of Appeals (OOA) granted his appeal ordering custody staff to release him in a timely manner for his job assignment at the prison. However,

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prison management had not implemented the remedy, and the complainant was still consistently late to his job assignment.

OIG Actions

The OIG reviewed departmental records and located the relevant grievance and appeal decision. On May 6, 2024, the complainant filed a grievance claiming prison policy prevented him from reporting to his work assignment at the scheduled start time of 6:00 a.m., thereby causing a loss of pay and the course length of his job assignment to be extended.

On July 2, 2024, the Office of Grievances (OOG) denied the grievance. The complainant disagreed with the OOG's decision; therefore, the complainant submitted an appeal, which the OOA received on August 1, 2024. On September 13, 2024, the OOA granted the appeal and ordered the prison to ensure the complainant is released by 6:00 a.m. to report to his job assignment.

On July 25, 2025, and August 7, 2025, the OIG contacted the OOA to determine whether the complainant submitted a CDCR Form 602-3 (Request to Implement Overdue Remedy) for the related grievance. On August 11, 2025, the OOA indicated the remedy had been fully implemented and incarcerated people who begin work at 6:00 a.m. were being released prior to their work start time. However, when the OIG reviewed departmental records, we found the complainant and numerous incarcerated people assigned to the same job assignment were consistently about an hour late.

On August 20, 2025, the OIG requested a signed waiver from the complainant, which was completed and returned to the OIG on September 2, 2025. The completed waiver allowed the OIG to disclose the lack of implementation of the granted OOA decision.

On September 23, 2025, the OIG contacted the warden and shared the concerns that the prison had not implemented the OOA remedy, and many incarcerated people were still not being released on time to begin their job assignments.

Disposition

On September 25, 2025, a prison manager provided the OIG with the local operating procedure and daily activity schedule, which had been updated on September 24, 2025, the day after the OIG's contact. Specifically, the daily activity schedule was updated to reflect that incarcerated people who begin work at 6:00 a.m. were to be released at 5:45 a.m.

Incident Date

August 8, 2025

Case Type

Safety Concerns: Contraband

Mission

Division of Adult Institutions: Region II (Fresno Area)

OIG Case Number

25-0101992-PI

Complaint Summary

On August 8, 2025, the OIG received a complaint from an anonymous incarcerated person (complainant) alleging another incarcerated person was in possession of contraband, including a mobile phone, weapons, and drugs. The complainant indicated the incarcerated person kept the mobile phone hidden inside a medical device in their cell and reported that officers allowed the incarcerated person to have the mobile phone.

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OIG Actions
The OIG reviewed departmental records related to the incarcerated person's housing, disciplinary history, confidential reviews, and durable medical equipment.

On August 11, 2025, the OIG notified the warden of the alleged contraband mobile phone, weapons, and drugs.

Disposition
On August 11, 2025, within two hours of the OIG's notification, custody staff searched the incarcerated person's cell and discovered a mobile phone. The incarcerated person received a rules violation report for possession of the mobile phone. On August 31, 2025, the incarcerated person pleaded guilty, and the department imposed a 90-day loss of credits.

Incident Date
August 12, 2025

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

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

OIG Case Number
25-0102104-PI

Complaint Summary
On August 12, 2025, the OIG received a complaint from an anonymous incarcerated person (complainant) who alleged that on August 12, 2025, he saw two officers attack an incarcerated person because the incarcerated person had walked away from the officers. The complainant stated the officers grabbed the incarcerated person and immediately began punching him. The complainant also alleged he observed a second incident four minutes later in which the same officers attacked a different incarcerated person.

OIG Actions
The OIG reviewed departmental records and located incident reports associated with both use-of-force incidents that occurred earlier that day. The OIG determined that following the first incident, the involved incarcerated person made an allegation of excessive or unnecessary use of force, as documented by medical staff on a medical report of injury, which stated, "The police jump[ed] me. I can't open my eye." However, departmental staff did not identify the incarcerated person's statement as an allegation of staff misconduct; therefore, staff did not conduct a video-recorded interview with the incarcerated person, as required by policy.

Subsequently, the involved incarcerated person had not submitted a grievance alleging excessive or unnecessary use of force, and no documentation identified that an interview had been conducted regarding this allegation. Therefore, on August 29, 2025, the OIG notified the warden about the allegation of excessive or unnecessary use of force documented on the medical report of injury and shared the complainant's information regarding the first incident. The OIG requested this allegation be considered for review and processing by the department's Centralized Screening Team (CST) as an allegation of staff misconduct.

Furthermore, during the review of the second incident, the OIG found that on August 19, 2025, the Office of Grievances (OOG) had received a grievance from the involved incarcerated person alleging excessive or unnecessary use of force by officers on August 12, 2025, which OOG referred to CST. On August 26, 2025, CST referred the allegation of staff misconduct to the Office of Internal Affairs for investigation.

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Because of the nature of the allegations, including the unidentified allegation on the medical injury report, the OIG's Intake staff referred the allegations to the OIG's Staff Misconduct Monitoring Unit (SMMU) to monitor both Office of Internal Affairs' investigations.

Disposition
On September 2, 2025, following the OIG's notification about the first incident, the hiring authority forwarded the allegation of staff misconduct to CST. On September 8, 2025, CST referred the allegation of excessive or unnecessary use of force to the Office of Internal Affairs for an investigation. On September 2 and 10, 2025, the OIG's SMMU elected to monitor both Office of Internal Affairs' investigations.

Incident Date
July 25, 2025

Case Type
Allegation of Staff Misconduct: Off-Duty Misconduct/Incident

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

OIG Case Number
25-0101615-PI

Complaint Summary
On July 26, 2025, the OIG received a complaint from an anonymous citizen (complainant) alleging an off-duty officer was "drunk and aggressive" and threatened to fight others. The complainant also alleged the officer used her title as a correctional officer to scare and intimidate people. The complainant did not provide a date, location, or witnesses to the alleged misconduct.

OIG Actions
The OIG reviewed departmental records, identified the officer and the prison employment location, and reviewed the officer's disciplinary history for any related complaints.

On August 1, 2025, the OIG notified the warden of the alleged off-duty misconduct.

Disposition
On August 1, 2025, the warden forwarded the allegation to the investigative services unit (ISU) for review. On August 8, 2025, the involved officer authored a memorandum identifying that no physical altercation occurred and that the officer did not invoke her professional title at the party she attended. On August 11 and 13, 2025, two custody staff who attended the party authored memorandums that identified no misconduct by the officer. Based on the evidence, the ISU concluded there was no reasonable belief that the alleged staff misconduct occurred.

The OIG is highlighting this complaint in a positive manner to commend the prison for its thorough and prompt response to the OIG's notification.

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Incident Date
September 4, 2025

Case Type
Safety Concern

Mission
Division of Adult Institutions: Region III

OIG Case Number
25-0102716-PI

Complaint Summary
On September 4, 2025, the OIG received a complaint in Spanish from an incarcerated person (complainant) who expressed suicidal thoughts and alleged staff had been ignoring him. The translation of the complaint stated, "I want to take my life . . . I want to hurt myself and no one helps me . . . they treat me like a fool because I don't speak much English."

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. The OIG did not locate documentation indicating mental health staff were aware the complainant had been experiencing suicidal thoughts.

On September 5, 2025, the OIG notified the warden and chief of mental health that the complainant had been experiencing suicidal thoughts.

Disposition
On September 5, 2025, within three hours of the OIG's notification, a sergeant conducted a welfare check, and later that day, mental health staff completed an urgent mental health consultation. On September 5, 2025, the incarcerated person contacted the OIG to express his gratitude for our immediate action to notify the warden of his mental health concerns. The complainant also commended the sergeant who spoke with the complainant almost immediately and took time to help reduce his negative thoughts of depression and anxiety.

The OIG is highlighting this complaint in a positive manner to commend the prison for its prompt response to the OIG's notification.

Incident Date
September 25, 2025

Case Type
Allegation of Staff Misconduct: Integrity, Other Misconduct

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

OIG Case Number
25-0103375-PI

Complaint Summary
On September 26, 2025, the OIG received complaints from an incarcerated person (complainant) alleging that on the evening of September 25, 2025, staff did not provide assistance to a second incarcerated person who was suicidal with a noose around his neck.

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Furthermore, the complainant alleged that an officer "was playing on a cellphone" and had repeatedly accused the second incarcerated person of "manipulating the system." The second incarcerated person was found unconscious the next morning with a noose around his neck.

OIG Actions

The OIG reviewed departmental records and confirmed the second incarcerated person was found on the morning of September 26, 2025, with a noose around his neck. We did not locate documentation indicating the department was aware of the alleged staff misconduct.

On September 29, 2025, the OIG notified the warden of the allegation that an officer did not respond to a suicidal incarcerated person. We requested the allegation be considered for review and processing as an allegation of staff misconduct by the department's Centralized Screening Team (CST).

The OIG requested and received a signed waiver from the complainant so we could share the complaints and the identity of the complainant with the department. On October 10, 2025, the OIG shared this information with the warden.

Disposition

On October 10, 2025, the warden notified the OIG that the allegation of staff misconduct had been forwarded to CST. On October 13, 2025, CST referred the allegation of staff misconduct to the Office of Internal Affairs, which opened an investigation the same day.

Incident Date

September 17, 2025

Case Type

Allegation of Staff Misconduct: Other Misconduct

Mission

Division of Adult Institutions: Region I (Sacramento Area)

OIG Case Number

25-0103121-PI

Complaint Summary

On September 17, 2025, the OIG received a complaint from an anonymous source (complainant) alleging that on the same day, custody staff did not request medical assistance for an unidentified incarcerated person who requested emergency medical assistance for at least 45 minutes. The officers allegedly "laughed and taunted" the incarcerated person and, despite a team of medical technicians being in the area, the officer did not call for medical assistance.

OIG Actions

The OIG reviewed departmental records and identified the incarcerated person. According to medical records, the incarcerated person was examined by medical staff about 30 minutes after the complainant contacted the OIG. We did not locate documentation indicating the department was aware of the alleged staff misconduct.

On September 18, 2025, the OIG notified the warden of the allegation of staff misconduct, stating an officer allegedly did not properly respond to an incarcerated person who was seeking emergency medical assistance. We requested the department consider the allegation as an allegation of staff misconduct by the department's Centralized Screening Team (CST).

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Disposition
On September 22, 2025, prison management notified the OIG that the allegation of staff misconduct had been forwarded to CST. On October 3, 2025, CST referred the allegation to the Office of Internal Affairs, which opened an investigation the same day.

Incident Date
August 2, 2025

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

Mission
Division of Adult Institutions: Region IV (Rancho Cucamonga Area)

OIG Case Number
25-0104313-PI

Complaint Summary
On October 28, 2025, the OIG received a complaint from an incarcerated person (complainant) who alleged that on August 2, 2025, two officers used excessive or unnecessary force. The complainant stated the first officer placed him in a "choke hold," thereby preventing him from breathing, and the second officer held the complainant's hands so the complainant could not defend himself. Furthermore, the complainant alleged that on August 2, 2025, he attempted to report the excessive or unnecessary use of force. However, a lieutenant denied the complainant the right to a video-recorded interview, which is required when an incarcerated person makes an allegation of excessive or unnecessary use of force.

OIG Actions
The OIG reviewed departmental records and verified that on August 2, 2025, the complainant was involved in a use-of-force incident. Per departmental policy, a custody supervisor shall conduct a video-recorded interview with the incarcerated person when an allegation of unnecessary or excessive use of force is made. The OIG did not locate documentation that staff had conducted a video-recorded interview with the complainant. As of November 4, 2025, the complainant had not filed a grievance with the department's Office of Grievances alleging excessive or unnecessary force or that the lieutenant had denied the complainant a video-recorded interview to report his allegation.

On November 4, 2025, the OIG notified the warden of the allegations that two officers used excessive or unnecessary force and that a lieutenant denied the complainant a video-recorded interview when the complainant attempted to report the excessive or unnecessary use of force.

Disposition
On November 4, 2025, within four hours of the OIG's notification to the warden, a custody supervisor conducted a video-recorded interview with the complainant. On the same day, the prison's investigative services unit notified the OIG that it had forwarded the allegations of staff misconduct to CST. On November 13, 2025, the Office of Internal Affairs opened investigations into the allegations of excessive or unnecessary use of force by the two officers and an allegation of code of silence (an independent act that prevents or interferes with the reporting of misconduct) by the lieutenant.

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Incident Date
October 9, 2025

Case Type
Safety Concerns

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

OIG Case Number
25-0103815-PI

Complaint Summary
On October 9, 2025, the OIG received a complaint from an anonymous source (complainant) alleging an incarcerated person would have safety concerns if he were housed on a general population facility because he had informed staff that he no longer wanted to participate in gang activities.

OIG Actions
The OIG reviewed departmental records and confirmed that during an interview on October 4, 2025, the incarcerated person told staff he refused to participate in further gang activities, which made him a target for assault. He requested to be placed on a sensitive needs yard (SNY) due to his safety concerns.[1] During the interview, the incarcerated person shared confidential information about gang activities within the housing unit. Based on this information, custody staff conducted cell searches and interviewed gang members.

Although the department identified localized safety concerns at the specific facility where the incarcerated person was housed, it did not identify systemic safety concerns with the statewide gang population. Staff subsequently recommended transferring the incarcerated person to a general population facility instead of SNY housing.

On October 13, 2025, the OIG notified the warden that the incarcerated person may have unaddressed systemic safety concerns on other general population facilities because he provided confidential information about gang activities.

Disposition
On October 13, 2025, the warden notified the OIG that staff would conduct another investigation to evaluate whether the incarcerated person had systemic safety concerns on other general population facilities. The second investigation concluded that the incarcerated person had systemic safety concerns. Therefore, the institutional classification committee recommended the incarcerated person be transferred to an SNY facility. On November 3, 2025, the incarcerated person was transferred to an SNY facility.

1. A Sensitive Needs Yard (SNY) houses designated incarcerated people whose safety would be endangered by a portion of the incarcerated general population. SNY-designated incarcerated people shall have documented and verified systemic safety concerns indicating no other viable housing options are available within the incarcerated general population.

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Incident Date
October 24, 2025

Case Type
Safety Concern

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

OIG Case Number
25-0104344-PI and 25-0104356-PI

Complaint Summary
On October 28 and 29, 2025, the OIG received complaints from an incarcerated person (complainant) alleging the department did not properly review his safety concerns. Specifically, the complainant had been housed in the restricted housing unit (RHU) and feared he was going to be released back to the facility where he had safety concerns. The complainant believed his life was in danger and that he would be killed if he returned to his prior housing assignment.

On October 29, 2025, the OIG also received a complaint from a third party. On October 30, 2025, OIG staff spoke with the third party who reiterated the safety concerns and stated she had received three anonymous calls stating her son was going to be killed.

OIG Actions
The OIG reviewed departmental records and determined the complainant was currently housed in the RHU for safety concerns.

We located a confidential memorandum completed on October 24, 2025 that documented the investigation into the complainant's safety concerns. During the investigation, the complainant provided information to staff identifying multiple incarcerated people who were allegedly involved in illegal activities. The alleged activities were a threat to institutional safety and security and resulted in a mass search of the housing area. Staff identified one incarcerated person as the complainant's enemy and issued a confidential offender-separation alert; however, they did not identify any safety concerns with other incarcerated people.[2]

We also found documentation indicating the complainant was going to be released from RHU and returned to his previous facility. Although the identified enemy was no longer housed in the same facility, the complainant had potential safety concerns with the remaining incarcerated people against whom he had made allegations.

On October 31, 2025, the OIG notified the warden of the complainant's safety concerns and recommended that staff not return the complainant to his previous facility.

Disposition
On November 6, 2025, the complainant's housing and safety concerns were reviewed during an institutional classification committee meeting, and on November 7, 2025, he was transferred to a different prison.

2. A separation alert is a record placed in an incarcerated person's central file that identifies an enemy concern. These alerts typically restrict an incarcerated person from being housed at the same prison (or facility) as any of the individuals identified in the record.

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Incident Date
October 1, 2025

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

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

OIG Case Number
25-0104030-PI

Complaint Summary
On October 16, 2025, the OIG received a complaint in Spanish from an incarcerated person (complainant) who alleged he had been attacked by four officers within the last few weeks.

OIG Actions
The OIG reviewed departmental records and verified that on October 1, 2025, the incarcerated person had been involved in a use-of-force incident and determined the incarcerated person sustained injuries. We did not locate documentation indicating the department was aware of the allegation of staff misconduct for excessive or unnecessary use of force.

Therefore, on October 24, 2025, the OIG notified the warden of the allegation of excessive or unnecessary use of force. The OIG requested this allegation be considered for review and processing as an allegation of staff misconduct by the department's Centralized Screening Team (CST).

Disposition
On October 24, 2025, the hiring authority notified the OIG that the allegation of staff misconduct had been forwarded to CST. On October 28, 2025, CST referred the allegation of excessive or unnecessary use of force to the Office of Internal Affairs, which opened an investigation.

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