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

***Shaun Spillane**, Chief Deputy Inspector General*

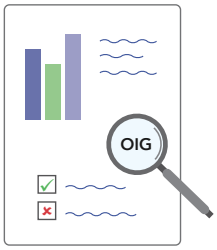
OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2026

2025 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
Shaun Spillane, Chief Deputy Inspector General

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

March 17, 2026

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 2025. In 2025, we issued 28 public reports detailing our oversight of the California Department of Corrections and Rehabilitation: 17 reports on medical inspection results; one report on our monitoring of the department's staff misconduct complaints process; one report on the department's internal investigations and employee disciplinary process, one report on both the department's staff complaints investigations and employee disciplinary process, one annual report on our monitoring of the department's local inquiry process; one report on our monitoring of the department's centralized screening team process, two audit reports, one special review, two semiannual reports on our monitoring of incarcerated-person advisory council meetings, and our 2024 annual report. We also released 22 sets of case blocks.

Respectfully submitted,

Amarik K. Singh
Inspector General

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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 a model oversight agency that ensures transparency and accountability within California's correctional system by providing clear, objective, and reliable assessments, accompanied by well-supported recommendations that promote systemic improvement. We are committed to strengthening public trust and delivering exemplary service to our stakeholders through diligent monitoring and impartial evaluation.

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, sexual misconduct monitoring, and a variety of special assignments.

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

— Amarik K. Singh
Inspector General

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

— *State of California*
Penal Code section 6125

Organizational Overview and Functions

The Office of the Inspector General (the OIG) is an independent agency of the State of California. The OIG was 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, colocated 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.

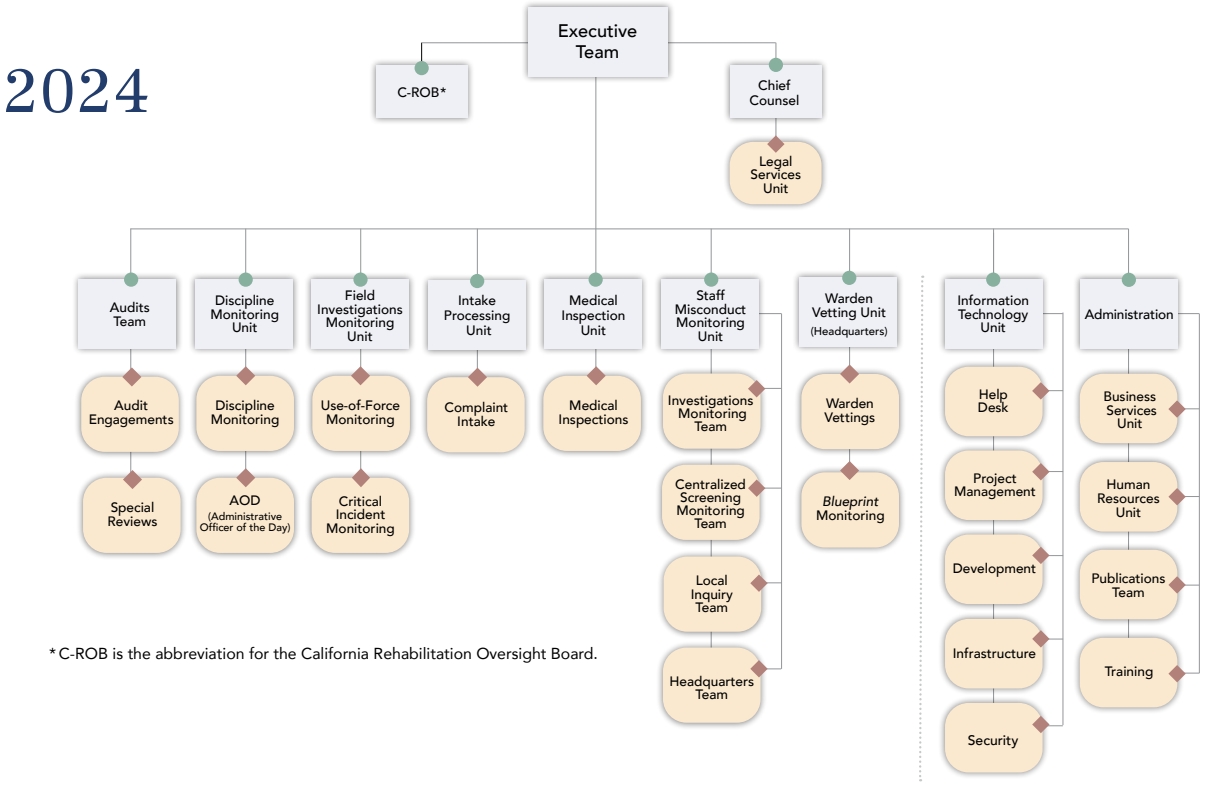
The OIG also employs a team of medical professionals, including physicians and nurses, in the Medical Inspection Unit. These practitioners evaluate policy adherence and quality of care within the prison system. Analysts, editors, and administrative staff within the OIG contribute in various capacities,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

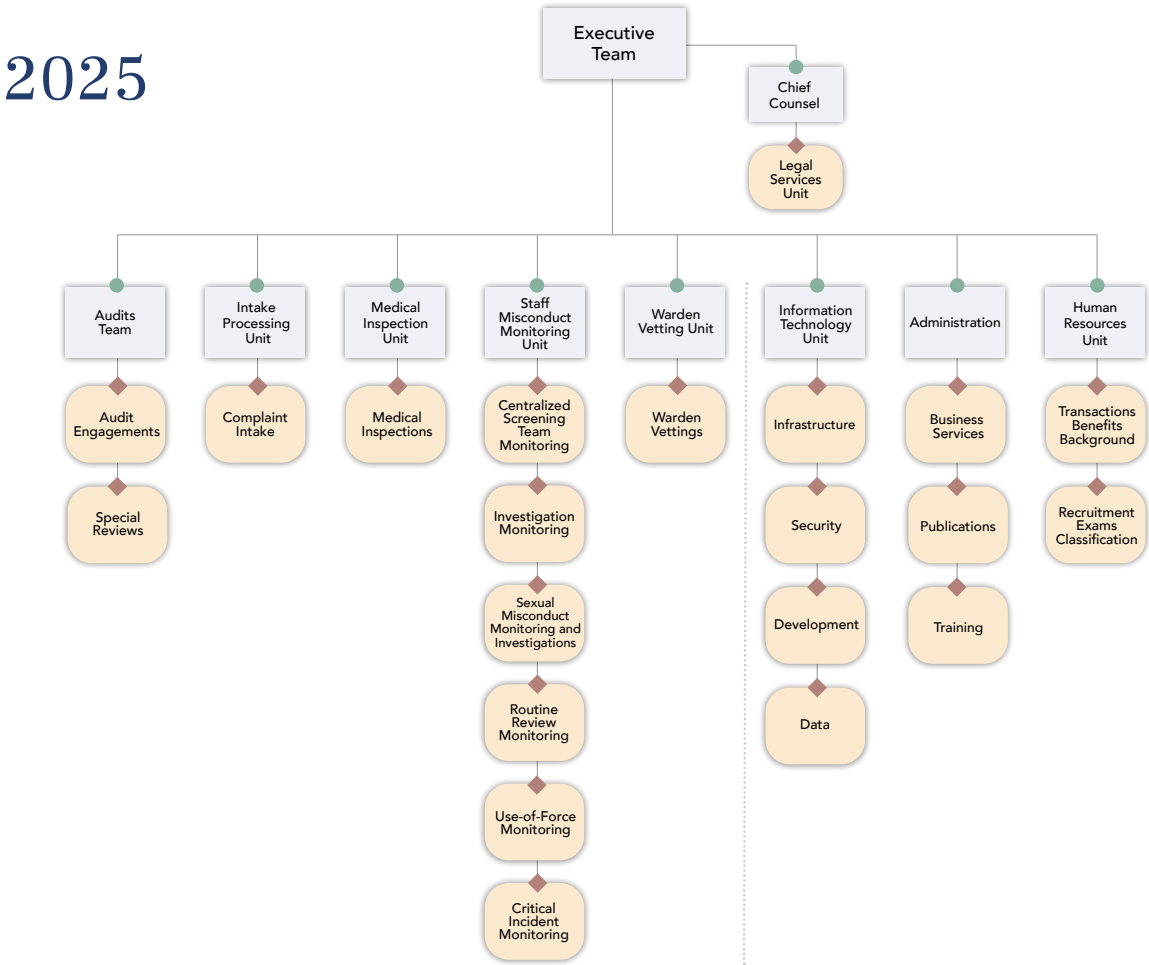
Staff in our office perform a variety of oversight functions relative to the department, including those listed below:

- Conduct medical inspections
- Carry out audits and special reviews authorized by the Governor's Office or Legislature, or at the Inspector General's own accord
- Staff the complaint hotline and intake unit
- Review, and when appropriate, investigate whistleblower retaliation complaints
- Handle complaints filed directly with the OIG by incarcerated people, employees, and other stakeholders regarding the department

- As ombudsperson, monitor Sexual Abuse in Detention Elimination Act (SADEA) and Prison Rape Elimination Act (PREA) cases
- Conduct warden and superintendent vettings
- Monitor the following:
    - Internal investigations and litigation of employee disciplinary actions
    - Critical incidents, including deaths of incarcerated people, large-scale riots, hunger strikes, and so forth
    - Staff complaint grievances filed by incarcerated people
    - Uses of force

Figure 1. The Office of the Inspector General Organizational Chart, 2024 and 2025





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Reports Published in 2025

Internal Investigations and Employee Discipline Monitoring

Staff Misconduct Monitoring Unit (SMMU) attorneys are responsible for the contemporaneous oversight of the department's internal investigations and employee disciplinary process. California Penal Code requires that the OIG publish its findings at least semiannually. We released three misconduct monitoring reports in 2025. The first report, released in March 2025, covered investigations conducted by the traditional section[1] of the Office of Internal Affairs during the July 2024 through December 2024 reporting period. The second report, also released in March 2025, covered investigations conducted by the Office of Internal Affairs' Allegation Investigation Unit from January 2024 through December 2024. The third report, released in December 2025, covered both types of investigations conducted from January 2025 through June 2025.

In 2025, we merged our team that monitors cases hiring authorities refer to the traditional section of the Office of Internal Affairs, with our team that monitors cases involving allegations of staff misconduct incarcerated people report, which the Centralized Screening Team routes to the Allegation Investigation Unit. 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 the two reporting periods (July 2024 through December 2024 and January 2025 through June 2025), we monitored and closed 411 administrative disciplinary cases and criminal cases. In 2024, we monitored 162 staff misconduct complaint cases, and we monitored 89 staff misconduct complaint cases in the first half of 2025.

We also introduced a new ratings system in 2025. Instead of rating each entity's performance as *sufficient*, *sufficient with recommendations*, or *insufficient* we now rate each entity's performance as *adequate, improvement needed,* or *inadequate.*

Each assessment is made across three separate indicators, and we use each of the three indicators to assess the performance of three CDCR entities as follows:

1. The Office of Internal Affairs' Field Operations and Special Investigation Unit, known as the Office of Internal Affairs' traditional section, generally investigates allegations of staff misconduct that are not directed toward an incarcerated or supervised person, allegations of criminal misconduct, and four of the most serious types of allegations that are directed toward an incarcerated person: sexual violence; involvement in a coordinated effort to prohibit the reporting of misconduct; intimidating, dissuading, or threatening witnesses; and misconduct resulting in significant injury or death.

1. The performance of hiring authorities in discovering alleged employee misconduct, referring the allegations to the Office of Internal Affairs, and making findings concerning investigations, allegations, and disciplinary determinations.

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

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

These indicators are organized to reflect the performance of the three groups within CDCR across all stages of the investigative and disciplinary process from a case's inception to its ultimate conclusion. One indicator is used to assess the hiring authority's performance, usually a warden. A second indicator is used to assess the Office of Internal Affairs' performance during the investigation. A third indicator is used to assess the Employment Advocacy and Prosecution Team (EAPT) attorney's performance during the investigative and disciplinary phases.

The OIG has developed compliance- and performance-related questions concerning each indicator. Our attorneys assigned to monitor each case answered these questions and rated each of the three indicators for each case.

We found that during the July 2024 through December 2024 reporting period, the department's performance was *sufficient* in 21 percent, *sufficient with recommendations* in 43 percent, and *insufficient* in 36 percent of the administrative disciplinary and criminal cases we monitored.

We found that during the January 2025 through June 2025 reporting period, the department's performance was *adequate* in 14 percent, *improvement needed* in 43 percent, and *inadequate* in 43 percent of the administrative disciplinary and criminal cases we monitored. We also found that the department's performance was *adequate* in 11 percent, *improvement needed* in 35 percent, and *inadequate* in 54 percent of the staff complaint misconduct cases we monitored.

Before we merged our teams, staff misconduct complaint cases were rated as *superior, satisfactory,* and *poor*. We found that in 2024, the department's overall performance was *poor* in 73 percent and *satisfactory* in 27 percent of staff misconduct complaint cases. No cases were rated as *superior.*

The OIG also identified and made recommendations regarding the disciplinary process. In our discipline monitoring report released in

March 2025, which covered the July 2024 through December 2024 reporting period, we made the following recommendation:

- We recommended that the department establish a policy or guideline requiring special agents to advise employees as to whether they are required to cooperate with criminal investigations, including whether they are compelled to provide a statement.

In our Staff Misconduct Complaint Report for the year 2024, also released in March 2025, we made the following recommendations:

- We recommended that investigators conduct initial interviews and request all video recordings within one month of case assignment, that the department implement a process to identify allegations that have already been investigated to avoid duplicative investigations, and that the department provide more robust training to employee relations officers about the disciplinary process and how to represent the department at hearings.
- We also recommended the department update its Department Operations Manual to prohibit officers from using neck restraints, hold in-depth training for officers regarding neck restraints, and update the manual to clarify specific information that hiring authorities need to provide to complainants.

In addition to publishing reports, we also publish our findings regarding individual cases monthly on our public-facing website. To read our findings, visit **www.oig.ca.gov** and click on our *Data Explorer* tab. Select the section labeled *Employee Discipline* for cases investigated by the traditional section of the Office of Internal Affairs and *Staff Misconduct* for cases investigated by the Allegation Investigation Unit.

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.

Styling for the bifurcated rating seals used in MIU reports as introduced for Cycle 7.

Medical Inspection Reports: Cycle 7

In 2025, the OIG completed its seventh cycle of medical inspections. We published Cycle 7 medical inspection reports for institutions 11 through 27, for a total of 17 published reports. Early in 2024, the OIG had retroactively amended the format of our reporting to bifurcate the overall institution ratings into individual ratings for the case review and compliance components of each report to promote greater clarity regarding our findings. The OIG then used this new format to publish medical inspection reports for the first 10 institutions in Cycle 7 in 2024.

In 2025, using our updated format, the OIG published 17 more medical inspection reports for Cycle 7 for the following institutions: Salinas Valley State Prison; California Correctional Institution; Avenal State Prison; Central California Women's Facility; Kern Valley State Prison; Correctional Training Facility; Centinela State Prison; Folsom State Prison; California Institution for Women; High Desert State Prison; California Men's Colony; Pelican Bay State Prison; Calipatria State Prison; Pleasant Valley State Prison; California State Prison, Sacramento; Mule Creek State Prison; and Sierra Conservation Center. Through these reports, the OIG made several recommendations to the department to further improve the delivery of medical care to its patients; these recommendations can be viewed on the OIG's dashboard at www.oig.ca.gov.

In addition to our individual institution medical inspection reports, the OIG's Medical Inspection Unit has undertaken an analysis of cross-institution and cross-cycle trends over all institutions in Cycle 7. Following the publication of our report for the final institution of Cycle 7 in early 2026, the OIG plans to publish its first Medical Inspection Unit Cycle Analysis, summarizing these trends for Cycle 7, comparing them with Cycles 5 and 6, and providing graphs to illustrate our findings.

In 2025, as anticipated, the OIG further completed all inspections of the last four remaining institutions for Cycle 7: California Institution for Men; San Quentin Rehabilitation Center; Ironwood State Prison; and California Health Care Facility. We also met with stakeholders in July 2025 and August 2025 to discuss updates and changes to our medical inspection process for Cycle 8. After these meetings, we transitioned to our enhanced medical inspection process, and we initiated the inspection of Salinas Valley State Prison, the first institution for Cycle 8. We also submitted our preinspection document request for Substance Abuse Treatment Facility and State Prison, the second institution for Cycle 8.

In 2026, we anticipate publishing our last four Cycle 7 inspection reports, our Cycle 7 Summary Report, and our first cross-institution trend analysis of the 31 institutions we inspected in Cycle 7. Based on our updated inspection process, we also anticipate completing all on-site inspection processes for the first 11 institutions of Cycle 8 and publishing Cycle 8 medical inspection reports for the first seven of those institutions.

Table 1 below lists the institutions for which we completed our Cycle 7 inspections and issued final reports in 2025, the month each report was published, and our case review and compliance ratings for each institution.

Table 1. The OIG's Medical Inspections for Cycle 7: Final Reports Published in 2025

Adequate *Inadequate*

Institution Inspected	Publication Month	Overall Rating	
		Case Review	Compliance
Salinas Valley State Prison	February		
California Correctional Institution	February		
Avenal State Prison	February		
Central California Womens Facility	April		
Kern Valley State Prison	May		
Correctional Training Facility	May		
Centinela State Prison	May		
Folsom State Prison	May		
California Institution for Women	June		
High Desert State Prison	June		
California Men's Colony Prison	July		
Pelican Bay State Prison	July		
Calipatria State Prison	September		
Pleasant Valley State Prison	September		
California State Prison, Sacramento	September		
Mule Creek State Prison	October		
Sierra Conservation Center	December		

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

Audit Reports and Special Reviews

California Penal Code section 6126, subdivisions (b) and (c), authorize the OIG to initiate audits of departmental policies, practices, and procedures. In 2025, the OIG's Audits Unit issued two audit reports regarding the department's operational practices in preparing for natural disasters and in managing temperature conditions within California's prisons. In addition, the OIG conducted a special review of the department's response to incarcerated-person-on-incarcerated-person allegations under the Prison Rape Elimination Act.

Audit of the California Department of Corrections and Rehabilitation's Natural Disaster Emergency Preparedness and Mitigation Efforts

On May 1, 2025, the OIG issued an audit report of the department's emergency preparedness for natural disasters. During our audit, we reviewed the department's policies, procedures, and mandated staff trainings that it implemented to prepare for and respond to wildfires, floods, and earthquakes. We examined its coordination with federal, State, and local entities for emergency preparedness. We assessed the department's ability to evacuate prisons threatened by wildfires, floods, and earthquakes. Finally, we evaluated the 2024 emergency operations plans from 30 prisons to determine their compliance with laws, policies, and industry standards. We also evaluated the prisons' methods of assessing their risk of natural disasters, as well as the adequacy and management of on-site supplies and emergency essentials.

The results of our audit showed that California's overcrowded prisons are vulnerable to wildfires, floods, and earthquakes. The department lacked specific plans for externally evacuating prisons in response to natural disasters. Although all prisons had individual plans in place, those plans were general in nature and inadequate if large-scale external evacuations were necessary. The plans we reviewed included general language about coordinating evacuation routes with departmental headquarters staff who would be responsible for determining where evacuees would be transferred based on the availability of temporary housing with appropriate security. We also found that any effort to evacuate any of the 31 prisons would likely exceed 72 hours, a critical time frame to respond in an emergency. The department's inability to evacuate prisons within 72 hours significantly increases the threat to the safety of incarcerated people and overall stability of the prison in the event of a natural disaster. Moreover, the location and high mileage of transportation buses and other vehicles likely limit the department's ability to evacuate most prisons within 72 hours, and the overcrowding and proximity of neighboring prisons roughly doubles the incarcerated population to be evacuated during an emergency.

We also found that although almost all prisons assess their risk of natural disasters, they do so inconsistently. Generally, prisons used multiple

methods to assess their risk of wildfires, floods, and earthquakes. Because prisons used multiple methodologies to develop their risk assessment plans, the department could not easily review prisons' risk assessments to ensure compliance with departmental policy. The use of multiple risk assessment plans also likely caused inconsistent risk ratings between prisons. We even found inconsistency in ratings for prisons that were in close proximity to each other. For example, Folsom State Prison rated its risk of wildfire damage as moderate, while California State Prison, Sacramento, which is less than one mile away, rated its risk of wildfire as high.

The department's Emergency Planning Unit does not substantively review each prisons' site-specific emergency operations plans as required by California regulations and departmental policy, and we found the overall approval process to be flawed. Furthermore, the Emergency Planning Unit does not ensure prisons submit site-specific supplements or review them for adequacy. Lastly, at least two prisons have not entered into mutual aid agreements, and not all site-specific emergency plans include key details of mutual aid agreements.

In summary, the OIG offered several recommendations to improve the department's emergency response process. We recommended the department update its All Hazards Emergency Operations Plan and require prisons to develop site-specific plans that include procedures to evacuate prisons within 72 hours. The department should consider realigning transportation hubs to enable a more timely response to natural disasters and identify relocation sites if an evacuation is necessary. The department should implement training to better respond to emergency evacuations, ensure prisons have defensible space around facilities, and ensure fire retardant is available at prisons that are at high risk for wildfire. The department should standardize the risk assessment methodologies with a standard practice to address site-specific mitigation and evacuation strategies and ensure consistency between prisons that are colocated. The emergency planning unit should establish a formal process including prison site visits, for approving prison emergency plans and ensuring risk assessments are accurate. Finally, the department should formalize mutual aid agreements to standardize the process and ensure mutual aid agreements are included with emergency plans.

Audit of the Department of Corrections and Rehabilitation's Management of Temperature Conditions within California's Prisons

On September 11, 2025, the OIG issued an audit report of the department's management of temperature conditions within California's prisons. We focused on how departmental policies and procedures ensure the health and safety of the incarcerated population during extreme temperature conditions. We requested and reviewed documents from three prisons we tested that substantiated the department's actions

in managing and maintaining temperatures in prisons. We interviewed key personnel, conducted on-site observations, reviewed selected documentation, and tested key controls relevant to the audit objectives.

Our results found that the temperature in prison housing units frequently fell outside acceptable temperature ranges, and staff's failure to consistently complete heat logs hindered our ability to effectively analyze the full extent of these temperature variations. Specifically, we found prison housing units regularly reached temperatures outside of the department's design guidelines for prison housing units, which is between 68 and 89 degrees Fahrenheit. Custody staff also did not consistently maintain heat logs as required by ongoing *Coleman v. Newsom* litigation. Custody staff are required to record temperatures within prison housing units from May to October each year. Because custody staff in the three prisons we reviewed did not consistently maintain heat logs, it is likely the department had more days that were out of compliance than what it reported to our auditors. The department is considering solutions for tracking temperatures in prison housing units and is beginning a pilot project at select prisons to record temperatures with wireless devices.

We also found that budget challenges and inconsistent completion of preventive maintenance inhibits the department's ability to maintain outdated heating and cooling equipment. For example, at California State Prison, Corcoran, preventive maintenance was only completed on 81 percent of prison buildings from July 2023 through October 2024. Budget constraints posed a significant challenge, which hindered plant operations staff from purchasing replacement parts. When staff could purchase replacement parts, the replacement parts sometimes did not arrive for weeks or even months. However, the department has taken steps to request additional fiscal resources to replace any equipment that is well past its useful life and identify alternative options for heating and cooling prison buildings.

Lastly, we found that the department does not protect a significant number of incarcerated people from the heat or cold. Until this audit, the department's efforts were directed to members of the incarcerated population who are vulnerable to heat due to the medications they take.[2] However, we found a significant number of incarcerated people who are also vulnerable to extreme temperatures due to age or other chronic conditions would also benefit from additional protections. The department does not have sufficient measures in place to protect vulnerable incarcerated people from cold weather conditions. For example, it does not always offer clothing options such as thicker coats.

The OIG put forth a number of recommendations pertaining to temperature management control within its prisons. We recommended the department establish consistent guidelines to monitor and track temperatures in living areas and for staff to record temperature readings

2. On March 17, 2025, the department updated its heat plan by expanding its protections to the entire incarcerated population in advance of our audit report.

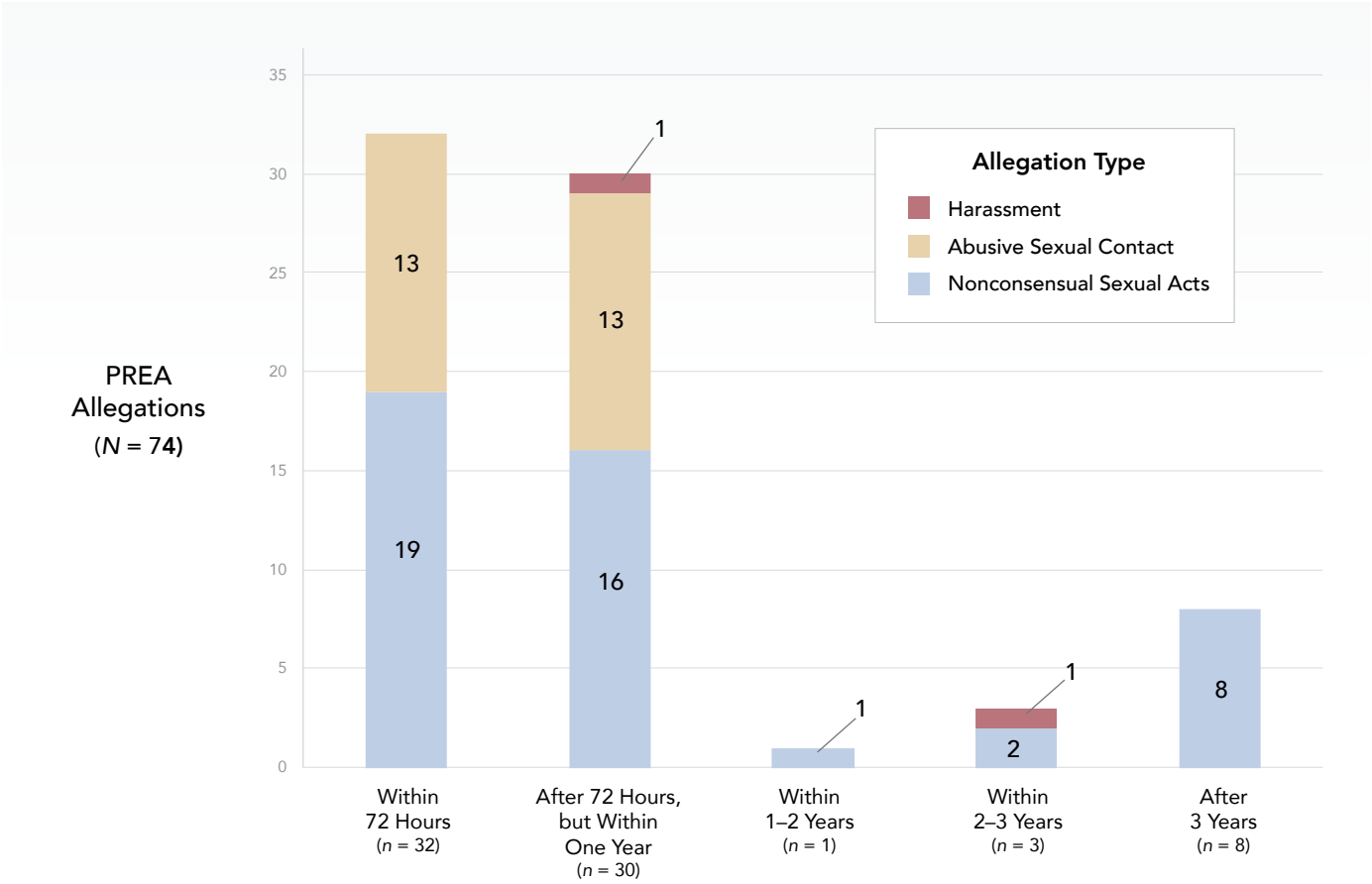
at consistent locations in prison housing units. We also recommended the department consider recording temperature readings in cells to determine whether the temperature differs from other locations in a housing unit. The department should ensure that all staff are aware of the process used to record temperatures in heat logs and establish a quality-control process. In addition, the department should prioritize replacing heating and cooling equipment that has outlived its useful life and ensure preventive maintenance is completed per manufacturers' guidelines. The department should establish statewide policies and procedures for plant operations staff to effectively track and complete preventive maintenance on heating and cooling equipment to maximize the useful life of these systems. Finally, we recommended the department consider expanding its heat plan for all incarcerated people due to an aging vulnerable population, and it should consider providing incarcerated people with an option for a thicker jacket to protect them from cold weather.

Special Review: The California Department of Corrections and Rehabilitation's Response to Incarcerated-Person-on-Incarcerated-Person Allegations Under the Prison Rape Elimination Act

On August 21, 2025, we issued a special review of the department's response to 74 alleged violations of the Prison Rape Elimination Act (PREA) that were reviewed by prison Institutional PREA Review Committees (review committee) from March 1, 2024, through August 31, 2024.

To combat rape in prisons nationwide, Congress enacted PREA in 2003, creating a zero-tolerance standard for rape in federal, state, and local correctional facilities. Sexual misconduct can include different forms of abuse that are specifically defined by law and departmental policy. Nonconsensual sexual acts are generally defined as unwilling or forced sexual contact or penetration such as rape. Abusive sexual contact is generally defined as unwanted touching directly or through the clothing of the genitalia or other intimate parts of a person in a sexual manner. Of the 74 incidents we reviewed, investigators substantiated seven PREA allegations, which means they determined the allegations likely occurred based on a preponderance of evidence. Investigators determined there was insufficient evidence to support most PREA allegations made, finding 65 allegations to be unsubstantiated, and two allegations to be unfounded.

Figure 2. PREA Allegation Reporting Times Post Incident



Source: The OIG's analysis of PREA allegations made against incarcerated people reviewed by the PREA Review Committee from March 1, 2024, through August 31, 2024.

We found that prison staff did not always perform required procedures when notified of a PREA allegation. The department developed procedures for staff and custody supervisors to follow upon receipt of PREA allegations to preserve and gather physical evidence, provide a timeline of events, provide medical and mental health evaluations to affected incarcerated people, and offer a victim support person and advocate, among other purposes. We found documentation showing that staff had taken steps to request that a PREA victim not shower, use the restroom, consume liquids, or remove clothing without custody supervision to preserve potential evidence for forensic medical examinations in only 21 percent of incidents alleging nonconsensual sex acts that had been reported within 72 hours. Custody staff also did not secure crime scenes in 42 percent of applicable allegations that had been reported within 72 hours. When a PREA incident required the victim to undergo a forensic medical examination, staff failed to do so 21 percent of the time, and when staff were required to consult a specialized nurse to determine whether a forensic examination was needed, they failed to

do so 50 percent of the time. Victims are also entitled to a support person or advocate to support them through the PREA process, but custody staff only offered a support person or advocate in 58 percent of the investigations we reviewed.

We also found that almost all PREA allegations we reviewed were inadequate for one or more reasons. Specifically, we found that 67 of the 74 PREA investigations we reviewed had one or more deficiencies, including investigators' failure to conduct interviews or to conduct adequate interviews; investigators' failure to secure, collect, or consider evidence; and investigators' poorly written investigative reports. Investigators also did not video or audio record any interviews in 70 percent of PREA investigations we reviewed. If PREA investigators recorded interviews, custody supervisors and managers could better assess the quality of PREA investigations by identifying and addressing clear deficiencies in the investigators' conclusions or reporting. Lastly, investigators did not always collect and secure potential physical or documentary evidence to support the investigation.

Finally, we found the prisons' Institutional PREA Review Committees did not provide proper oversight to ensure that applicable laws, regulations, and policies were followed when they reviewed PREA allegations. PREA review committees are responsible for thoroughly reviewing allegations to ensure staff followed federal and state laws, as well as departmental policy and guidelines when responding to PREA allegations. In nearly all the PREA allegations we analyzed, review committees did not provide proper oversight to determine whether investigators used standard investigative techniques to gather evidence and corroborate allegations. We also found no evidence that review committees meaningfully discussed the investigations they reviewed. Lastly, review committees did not review several PREA incidents within the time frame required by departmental policy.

In summary, the OIG provided the department with recommendations to improve the PREA review process. Specifically, we recommended the department require all PREA allegation interviews to be audio or video recorded. The department should also ensure all investigators who conduct PREA investigations receive specialized PREA-investigator training. Hiring authorities should require corrective action if staff fail to comply with law or departmental policy for PREA allegations, implement monitoring processes to ensure staff follow departmental policy and procedures, and apply standard investigative techniques with complete and accurate reports. Finally, the department should identify and document areas for corrective action when PREA review committee members do not fulfill their responsibility under departmental policy.

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Other OIG Operational Units: Status Updates

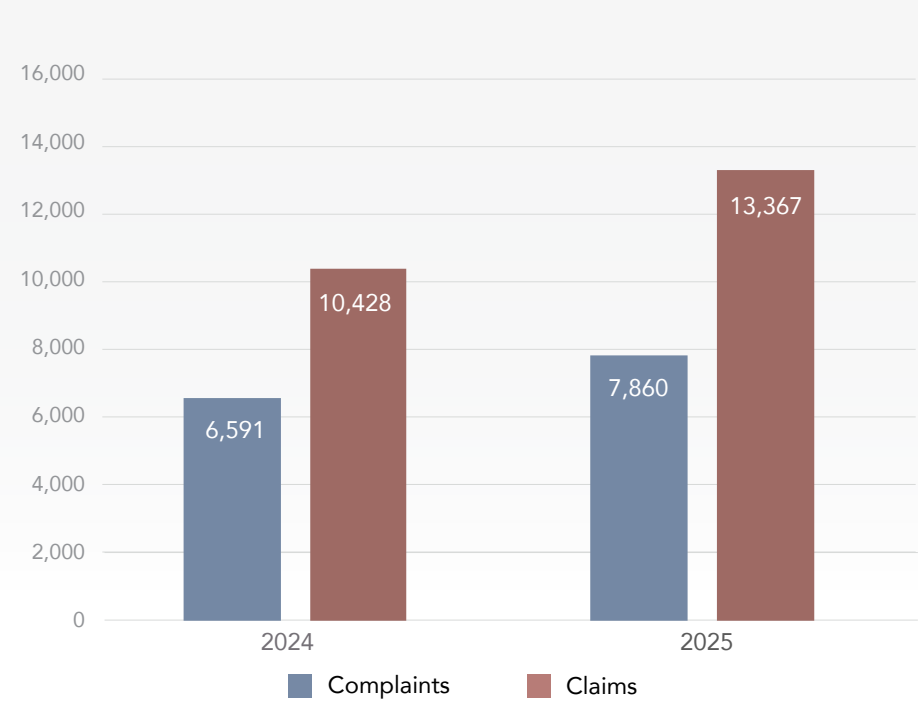
Complaint Intake

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 Intake Processing Unit (Intake) receives complaints from incarcerated people, supervised people,[3] their families, departmental employees, advocacy groups, and other complainants.

Complaints are submitted via letter, toll-free phone call, State-issued tablet, or our website. We strive to screen all complaints within one business day of receipt to identify potential safety concerns, serious medical or mental health concerns, or reports of sexual abuse.

In 2025, we received 7,860 complaints, a 19 percent increase from 2024. A complaint may contain one or more claims submitted for our review. From the 7,860 complaints we received, we processed 13,367 claims (see Figure 3, below), which was an average of 1,114 monthly claims. This is a 28 percent increase from the 10,428 claims we processed in 2024.

Figure 3. Total Number of Complaints and Claims the OIG Received in 2024 and 2025

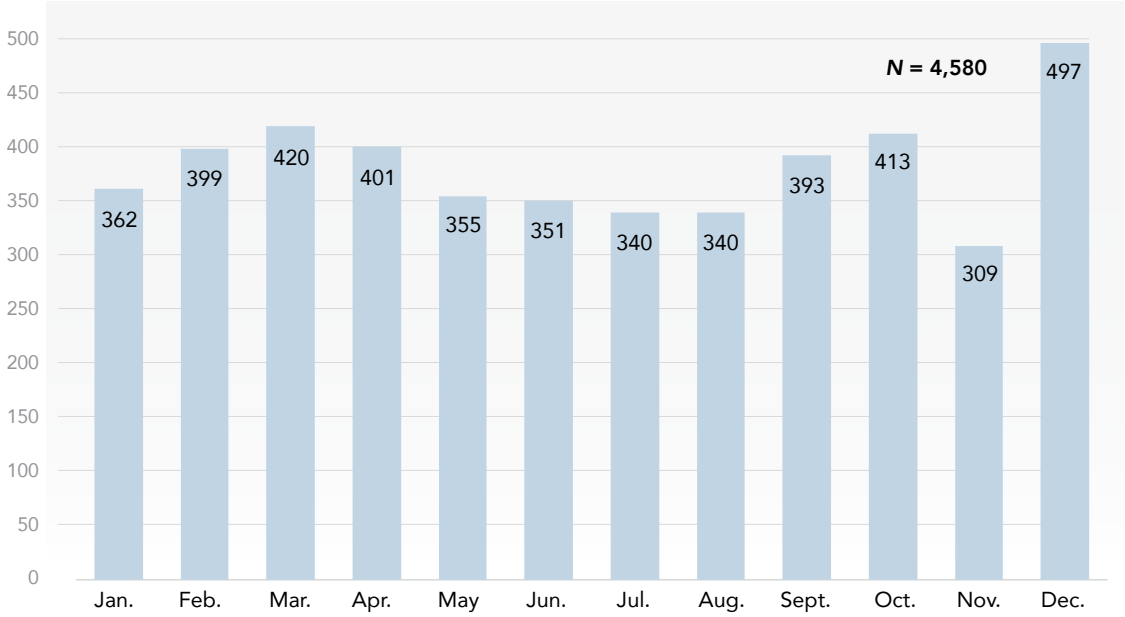


Source: The Office of the Inspector General Tracking and Reporting System.

3. *Supervised person* is a term the department uses to refer to individuals who have been paroled from the State's prison system but remain under the supervision of the department.

Of the 7,860 complaints we received in 2025, 58 percent were received via our OIG hotline and voicemail line (via phone and tablet); 26 percent were received by mail; and 15 percent were received through email, our website, and in person. Our office's hotline received an average of 382 complaints monthly in 2025, for a total of 4,580 complaints (see Figure 4, below).

Figure 4. Complaints Received by the OIG Hotline in 2025

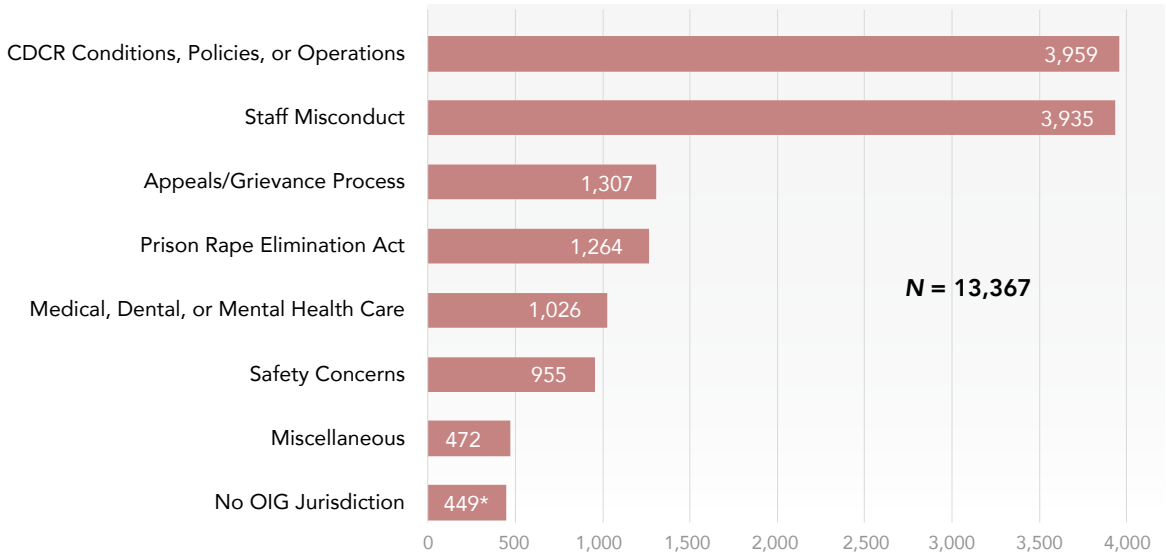


Source: The Office of the Inspector General Tracking and Reporting System.

Approximately 78 percent of complaints we received in 2025 were submitted by incarcerated people or supervised people, and 22 percent were submitted by others, such as private citizens, departmental employees, and advocacy groups. The most common types of claims we received in 2025 pertained to prison conditions, policies, or operations; allegations of staff misconduct; the grievance and appeals process; and the Prison Rape Elimination Act (PREA). Complaints frequently included multiple claims of improper activity occurring within the department. On the next page, Figure 5 shows the distribution of claim categories we received.

To document our case activity, our Intake staff create a unique identification number for each complaint we receive. In 2025, we reviewed and closed 7,617 of the 7,860 complaints received, a completion rate of 97 percent. Some incarcerated people submitted numerous

Figure 5. Number of Allegations the OIG Received in 2025 by Category



*Subsequent to publication of the *2025 Annual Report*, an error was identified in Figure 5 above. On April 7, 2026, the category for "No OIG Jurisdiction" was revised from 499 to 449 due to a typographical error. The correct amounts are now reflected herein.

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

complaints with duplicative claims, which our Intake staff had previously reviewed and closed. In 2025, we completed our review of 1,553 duplicative complaints received from 48 complainants. In 2026, our staff will continue working to resolve the remaining 243 complaints (3 percent) pending from 2025.

In response to these complaints, our staff often conducted inquiries by accessing information from various departmental databases, reviewing the department's policies and procedures, and requesting relevant documentation from the department. However, many complaints lacked the details needed to clearly identify and properly research the claims. After our review or inquiry into such complaints, we usually advised complainants about how they could address their concerns with the department or recommended that they provide us with more information. Typically, the OIG provides a written response to complainants outlining this information or technical assistance to resolve the complaint issue.

OIG Intake staff prepare impact case blocks throughout the year, which are published on a regular basis. Case blocks highlight select complaints that our Intake staff received; these complaints may have resulted in a positive change or impact or identified an area of concern. The initial work Intake staff undertake can lead to the OIG requesting the Office of Internal Affairs to open an investigation into an allegation of staff misconduct or result in the OIG's Staff Misconduct Monitoring Unit monitoring a routine review or investigation.

In one example, the OIG received a complaint from an anonymous complainant who alleged an incarcerated person had been selling contraband, such as drugs and mobile phones, which were being received via unmanned aerial vehicles (drones). The complainant alleged the incarcerated person kept the contraband in his cell. Furthermore, the incarcerated person allegedly maintained a social media account. After reviewing records, we did not identify any records that indicated the department was aware of the contraband or the incarcerated person's social media account. We immediately notified the warden of the safety concern, and as a result, the investigative services unit conducted a cell search.

The investigative services unit discovered a mobile phone and charger, SIM cards, and mobile payment information. The incarcerated person received a rules violation report and was found guilty. Pictured here is a photograph of the mobile phone and charger found in the cell. In 2025, our office published 57 Intake impact case blocks; they can be viewed on our website at **www.oig.ca.gov/ publications/.**

Photo 1. Mobile phone and charger found in cell (photographed by departmental staff on June 23, 2025).

Prison Rape Elimination Act

In accordance with federal Prison Rape Elimination Act (PREA) standards, the OIG forwards allegations of sexual abuse or sexual harassment, commonly referred to as PREA allegations, to the hiring authority and to the PREA compliance manager. Allegations may be received from incarcerated people, supervised people, family members, and other third parties.

Following a notification, the department typically reviews the allegations and interviews the involved parties. The expectation is that the department will evaluate the information and initiate an investigation if necessary. If alleged victims are dissatisfied with how the PREA investigation was handled, they can file a complaint with our office after they have exhausted all administrative remedies.

In 2025, the OIG received 1,264 complaints designated as involving a PREA allegation. The OIG sent 674 PREA notifications alleging sexual abuse or sexual harassment to the appropriate parties for processing. When multiple PREA allegations were received within a short period of time, they were sent as a single notification. In addition, some complaints did not meet PREA reporting criteria. Those complaints included allegations that did not involve an incarcerated person under departmental custody, a dispute of how an investigation was handled, or a disagreement with the results of a completed investigation.

Incarcerated-Person Advisory Council Meetings

As part of our complaint intake duties, we actively work to gain knowledge of local and department-wide issues by participating in periodic meetings with incarcerated-person advisory councils (IPACs) at prisons throughout the State. We have also begun to meet with California Correctional Peace Officer Association (CCPOA) and California Correctional Supervisors Organization (CCSO) representatives to understand issues and concerns raised by staff within their prisons.

During 2025, the OIG's Intake staff met with IPAC representatives at 25 prisons to educate them about the OIG's mission as well as to solicit input. Although most council representatives were aware of our office, we learned that representatives lacked an understanding of our functions and how our staff elevate and notify the department of concerns brought to our attention. Accordingly, during all our meetings, OIG staff provided an overview of the OIG, addressed confidentiality concerns, and explained how to contact this office. Council representatives discussed concerns and issues they felt were not being adequately addressed at the institutional level and shared some positive feedback. Our staff provided information about how we may be able to assist them with specific issues.

We also met with CCPOA and CCSO representatives at 11 prisons to provide information about the OIG and our oversight of the department. Most representatives appreciated that we met with them to understand staff's concerns at the prisons. We informed representatives that meeting with the OIG is voluntary. Of the representatives we met with, most emphasized staff safety and changes to the restricted housing unit process as their most pressing concerns. We informed the representatives that the OIG is available as a resource for departmental staff when they have concerns or witness potential misconduct.

In 2025, we published two semiannual reports that summarized our meetings with IPACs. In the first report, published in February 2025, we discussed meetings we attended from July 2024 through December 2024, and in the second report, published in September 2025, we discussed meetings we attended from January 2025 through June 2025. You can find these reports, along with all prior and future reports, at **www.oig.ca.gov/publications/**.

Disapproved Publications

Beginning on January 1, 2025, Penal Code section 6130 requires the OIG to publish the department's Centralized List of Disapproved Publications on the OIG's website. The list, which the department updates monthly, is also available on the department's website. The existing law grants incarcerated people the right to purchase, receive, and read publications (e.g., newspapers, periodicals, and books), subject to restrictions reasonably related to legitimate penological interests. The department's disapproved publications list includes publications that the department

has prohibited because the publication violates departmental regulations. Penal Code section 6130 permits the OIG to review publications on the list to determine whether we concur with the department's determination that the publication is in violation of departmental regulations.

California Code of Regulations, Title 15, Section 3134.1 outlines the process for placing a publication on CDCR's Centralized List of Disapproved Publications. In summary, if a publication violates policy but is not already on the Centralized List of Disapproved Publications, the prison may temporarily disapprove it, notify both the incarcerated person and the publisher, and refer the matter to the Division of Adult Institutions (DAI). DAI then decides whether the disapproval becomes permanent within 30 calendar days of receiving the prison's notification for temporary disapproval. Publications cannot be disapproved solely for containing advertisements unless the advertisement or content violates specific regulations. DAI also determines whether a requested publication should be added to the Centralized List of Disapproved Publications. If a publication is already on the Centralized List of Disapproved Publications, it will not be delivered, and the incarcerated person will be notified.

In 2025, the OIG received 10 disapproved publication complaints in which a complainant disagreed with the department that the publication should be disallowed. We completed our analysis for each of the complaints, and for seven of those complaints, we were able to complete our analysis with the information provided by the complainant. We determined that the department made the correct decision to disallow all seven of these publications based on departmental regulations. For the remaining three complaints, we reached out to the department for additional information to support its determination to disallow the publications. Upon review of the information the department provided the OIG, we agreed with the department's decision to prohibit the three publications based on departmental regulations.

In one example, an incarcerated person alleged that he was wrongfully denied printed material related to a role-playing book. The OIG contacted DAI and requested the supporting documentation used to disallow the publication. The department provided supporting documentation that showed the publication promoted hostile behavior, violence, escape planning, or gang-like organization, which are all activities that fall under safety and security violations under departmental regulations. Based on the documentation the department provided to support disallowing the publication, we agreed with the department's decision.

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 reported improper governmental activity or refused to obey an illegal order (blew the whistle)—and that the complainant was thereafter subjected to an adverse employment action due to having blown 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 2025, the OIG received 47 retaliation complaints. We completed analyses of 32 complaints and determined that none stated the legally required elements of a whistleblower retaliation claim. We also completed an analysis of a complaint pending from 2024, which did not state the legally required elements of a whistleblower retaliation claim. We are still in the process of either reviewing the materials or awaiting the conclusion of Office of Internal Affairs investigations relating to 15 complaints we received in 2025.

Institutional Executive Review Committee Monitoring

As part of the OIG's monitoring of use-of-force incidents, we attend the department's Institutional Executive Review Committee (IERC) meetings. The IERC reviews all reported use-of-force incidents and serves as the final level of institutional review. The IERC is chaired by the warden or the warden's designee and includes associate wardens, captains, in-service training specialists, and health care professionals. Each incident is prepared for the IERC's review by a use-of-force coordinator who compiles incident reports, supporting documentation, and available video footage.[4] The IERC evaluates the force used—including chemical agents, expandable batons, physical strength and holds, and whether less-lethal or lethal weapons were used—with particular emphasis on necessity, proportionality, and the adequacy of documentation. During the IERC's final review, the warden determines whether the use of force complied with departmental policy, procedures, and training. If the IERC determines that the force was not in compliance, the warden may order corrective action or additional training. In cases involving more serious potential violations, the chairperson may refer the matter to the Office of Internal Affairs for investigation.

The department conducts IERC meetings on a weekly basis at each prison. In previous years, OIG staff attended multiple IERC meetings at each prison every month. However, due to recent changes to the staff misconduct grievance process, most incidents involving allegations of excessive or unnecessary force are currently being referred directly for investigation without an initial review by prisons' IERCs. As a result, we have reduced our monitoring of IERC meetings and shifted our resources to review an increased number of investigations the department has conducted into allegations of excessive and unnecessary force, as these investigations are now the primary manner in which the department reviews these use-of-force incidents. We began this transition in January 2025 and issued our first set of quarterly case summaries assessing the quality of these investigations in July 2025. In 2026, we will produce a standalone annual report summarizing our observations of additional use-of-force investigations we assessed during the 2025 calendar year.

In 2025, the OIG monitored IERC meetings at each prison on a quarterly basis, and on a bimonthly basis at the six prisons subject to the *Armstrong v. Newsom*[5] class action litigation involving incarcerated people with disabilities. These prisons are Richard J. Donovan Correctional Facility; California State Prison, Los Angeles County; California State Prison, Corcoran; Kern Valley State Prison; Substance Abuse Treatment Facility and State Prison; and California Institution for Women.

4. As of September 2025, the following prisons did not have audio-video surveillance system capabilities: CIM, CMC, CRC, CTF, and PBSP. As of September 2025, the following prisons did not have body-worn camera capabilities: ASP, CAL, CEN, CHCF, CIM, CMF, CMC, CRC, CTF, FSP, HDSP, ISP, NKSP, PBSP, PVSP, SCC, SOL, SQRC, VSP, and WSP.

5. 484 F. Supp. 3d 808 (N.D. Cal. 2020)

Our monitoring evaluates departmental performance across three phases of each use-of-force incident: actions taken prior to the incident, the use of force itself, and post-incident response and documentation. This comprehensive approach allows the OIG to identify deficiencies at each stage as well as to assess the department's effectiveness in recognizing and addressing those deficiencies.

The OIG found that in 2025, the department performed adequately during IERC meetings. We did note that on three occasions, the IERC delayed holding the meeting beyond the 30 days required by policy. However, our overall impressions were that IERC members were prepared and made appropriate findings and recommendations.

In 2025, the department retained an expert consultant to review the department's policies and practices concerning staff uses of force. The consultant will make recommendations on possible reforms and improvements to use-of-force policies and practices, including the incidents reviewed by the IERC. The OIG will continue to monitor the department's ongoing efforts to evaluate whether and under what circumstances the IERC, or some other entity, could conduct comprehensive and unbiased reviews of cases involving the use of force. As the department changes its processes for reviewing uses of force, the OIG must also examine its own monitoring processes. Accordingly, if the department implements additional changes to its processes for reviewing uses of force in the future, we intend to adapt our monitoring in a manner that provides the most efficient and valuable oversight of these processes.

New Teams Established in 2025

Force Investigation Review Team

In 2025, the OIG established a Force Investigation Review Team (FIRT). This statewide team consists of deputy inspectors general (inspectors) who asynchronously review closed use-of-force investigation cases. The inspectors review selected cases after the department's Office of Internal Affairs has investigated use-of-force staff misconduct allegations; a warden has made findings on the allegations in the investigation; and the department has closed the case. In reviewing investigations, inspectors evaluate Office of Internal Affairs' investigative reports as well as any exhibits the investigator attaches to the report, including video- and audio-recorded evidence. The inspector directly reviews all source evidence—not only the summary of the evidence in the investigative report—which includes the review of body-worn camera video footage, interview recordings, and written reports from departmental employees involved in the incident. Inspectors review the materials to assess the thoroughness and the timeliness of investigations conducted. Inspectors also review the findings made by wardens on these cases to determine whether each warden had sufficient evidence from the Office of Internal Affairs to make findings on the allegations. Inspectors also assess wardens' timeliness in reviewing investigations. In 2025, the OIG published quarterly summaries on its website of the 57 total closed investigations FIRT inspectors reviewed that year.

Sexual Misconduct Monitoring and Investigations Team

In 2025, the California Legislature amended California Penal Code 6133 to provide both monitoring and investigative authority regarding cases with allegations that departmental employees committed sexual misconduct involving incarcerated people. In response, the OIG created a Sexual Misconduct Monitoring and Investigations Team (SMMIT). This attorney team is different from other teams within the OIG in that, not only does it monitor departmental investigations concerning alleged staff misconduct, but it also is responsible for investigating cases involving allegations that departmental employees committed sexual misconduct. Pursuant to Penal Code section 6133, subdivision (a)(7)(A), the OIG may conduct a full investigation into a complaint that involves sexual misconduct that the department declines to investigate. Further, if the OIG determines the department is conducting an inadequate investigation, such as failing to interview complainants or witnesses or failing to gather relevant evidence, the OIG may supplement an ongoing investigation. The OIG may conduct either full investigations or supplemental investigations after we conclude that the department's investigation is inadequate. The OIG began to hire attorneys for this team in mid-2025. The team set up its processes; finalized a desk manual and an investigations handbook; and trained attorneys on monitoring and conducting investigations. In September 2025, SMMIT attorneys began to monitor departmental sexual misconduct investigations. As of the date of this annual report's publication, the OIG expects to continue to hire additional attorneys for this team. We will also continue to monitor departmental sexual misconduct investigations and, when authorized, conduct investigations. SMMIT expects to publish its first annual report in 2027.

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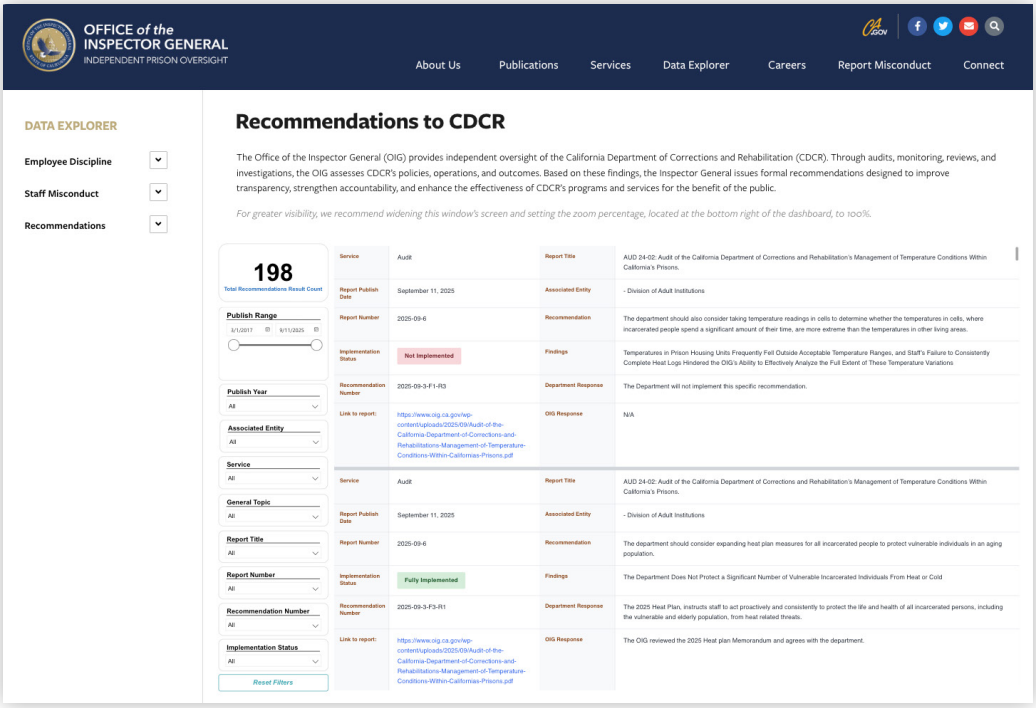
Recommendations Made to the Department

In 2025, the OIG published 28 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 on our website.

Clicking on the image below will take the reader to the interactive recommendations dashboard. Choose from among several filter options to select a specific group of recommendations; these filter options include publication date range, publication year, associated entity, service (i.e., audit, authorized/special review, discipline monitoring, staff complaint monitoring, and use-of-force monitoring), general topic, report title, report number, recommendation number, and implementation status. Also available is a separate dashboard that lists medical inspection report recommendations we have made to both California Correctional Health Care Services and the department. It can be found by selecting *Medical Recommendations* from the recommendations drop-down menu on the left side of the dashboard.

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



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Appendix: Publications Released in 2025

Annual and Semiannual Reports

- *Intake Processing Unit: Semiannual Report, July–December 2024* (February 25, 2025)
- *2024 Annual Report: A Summary of Publications* (March 3, 2025)
- *The Office of the Inspector General's Monitoring in 2024 of the Centralized Screening Team Process of the California Department of Corrections and Rehabilitation*: 2024 Annual Report (March 4, 2025)
- *The Office of the Inspector General's Monitoring in 2024 of the Staff Misconduct Complaint Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation*: 2024 Annual Report (March 10, 2025)
- *Monitoring Internal Investigations and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation: Semiannual Report, July–December 2024* (March 26, 2025)
- *The Office of the Inspector General's Monitoring in 2024 of the Local Inquiry Process of the Department of Corrections and Rehabilitation*: 2024 Annual Report (May 6, 2025)
- *Intake Processing Unit: Semiannual Report, January–June 2025* (September 8, 2025)
- *Monitoring Internal Investigations, Staff Misconduct Complaint Investigations, and the Employee Disciplinary Process of the California Department of Corrections and Rehabilitation: Semiannual Report, January–June 2025* (December 3, 2025)

Medical Inspection Reports: Cycle 7 Results

- Salinas Valley State Prison (February 6, 2025)
- California Correctional Institution (February 10, 2025)
- Avenal State Prison (February 13, 2025)
- Central California Women's Facility (April 7, 2025)
- Kern Valley State Prison (May 12, 2025)
- Correctional Training Facility (May 14, 2025)

- Centinela State Prison (May 16, 2025)
- Folsom State Prison (May 21, 2025)
- California Institution for Women (June 3, 2025)
- High Desert State Prison (June 24, 2025)
- California Men's Colony Prison (July 9, 2025)
- Pelican Bay State Prison (July 15, 2025)
- Calipatria State Prison (September 2, 2025)
- Pleasant Valley State Prison (September 4, 2025)
- California State Prison, Sacramento (September 30, 2025)
- Mule Creek State Prison (October 2, 2025)
- Sierra Conservation Center (December 8, 2025)

Audit Reports and Special Reviews

- *Audit of the California Department of Corrections and Rehabilitation's Natural Disaster Emergency Preparedness and Mitigation Efforts, Audit Report № 24-01* (Report and Fact Sheet) (May 1, 2025)
- *Special Review of the California Department of Corrections and Rehabilitation's Response to Incarcerated-Person-on-Person Allegations Under the Prison Rape Elimination Act* (Report and Fact Sheet) (August 21, 2025)
- *Audit of the California Department of Corrections and Rehabilitation's Management of Temperature Conditions Within California's Prisons, Audit Report № 24-02* (Report and Fact Sheet) (September 11, 2025)

Field Team Case Blocks

Centralized Screening Monitoring Team

- November 2024 Case Blocks (January 6, 2025)
- December 2024 Case Blocks (February 11, 2025)
- January 2025 Case Blocks (March 20, 2025)
- February 2025 Case Blocks (April 16, 2025)
- April 2025 Case Blocks (June 5, 2025)
- May 2025 Case Blocks (June 30, 2025)

- June 2025 Case Blocks (August 22, 2025)
- July 2025 Case Blocks (September 24, 2025)
- August 2025 Case Blocks (September 29, 2025)
- September 2025 Case Blocks (October 29, 2025)
- October 2025 Case Blocks (December 11, 2025)
- November 2025 Case Blocks (December 31, 2025)

Force Investigation Review Team

- January–June 2025 Case Summaries (July 31, 2025)
- July–September 2025 Case Summaries (November 14, 2025)

Intake Processing Unit

- November 2024 Impact Case Blocks (January 13, 2025)
- February 2025 Impact Case Blocks (March 28, 2025)
- March–May 2025 Quarterly Impact Case Blocks (July 8, 2025)
- June–August 2025 Quarterly Impact Case Blocks (October 13, 2025)

Local Inquiry Team

- October 2024 Case Blocks (January 6, 2025)
- November 2024 Case Blocks (January 6, 2025)
- December 2024 Case Blocks (January 6, 2025)

Staff Misconduct Monitoring Team

- April–June 2025 Routine Review Case Blocks (October 31, 2025)

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2025
Annual Report

A Summary of Publications

OFFICE *of the* INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
March 2026

OIG