Amarik K. Singh, *Inspector General*

Shaun Spillane, *Chief Deputy Inspector General*

OIG | OFFICE *of the* INSPECTOR GENERAL

Independent Prison Oversight

March 2026

The Office of the Inspector General's Review in 2025 of Use-of-Force Investigations Previously Completed by the California Department of Corrections and Rehabilitation

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OIG | OFFICE of the INSPECTOR GENERAL

Amarik K. Singh, Inspector General
Shaun Spillane, Chief Deputy Inspector General

Independent Prison Oversight

Regional Offices
Sacramento
Bakersfield
Rancho Cucamonga

March 2, 2026

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

Dear Governor and Legislative Leaders:

Pursuant to California Penal Code sections 6126(i) and 6133, the Office of the Inspector General is responsible for the oversight of the staff misconduct and the employee disciplinary processes of the California Department of Corrections and Rehabilitation (the department), and its process for reviewing uses of force. This report concerns the OIG's asynchronous—as opposed to contemporaneous—review in 2025 of staff misconduct investigations involving use-of-force allegations. The OIG reviewed these use-of-force investigation cases *after* the department had already investigated the allegations, made findings on the allegations, and closed the cases.

The OIG reviewed the performance of the department's Office of Internal Affairs' investigators in conducting investigations of unnecessary or excessive use of force by departmental employees, and the performance of wardens in reviewing and making decisions regarding the evidence in the use-of-force investigations. From January 1, 2025, through December 31, 2025, the OIG completed the reviews of 57 closed staff misconduct investigations involving use-of-force allegations. The OIG assigned one of three ratings to each case: *adequate*, *improvement needed*, or *inadequate*. We rated the department's overall performance as *adequate* in seven of the 57 cases, or 12 percent; *improvement needed* in nine of the 57 cases, or 16 percent; and *inadequate* in 41 of the 57 cases, or 72 percent.

Two principal departmental entities were involved in the cases we monitored: investigators from the Office of Internal Affairs and wardens. In addition to providing an overall rating for each case, the OIG evaluated the performance of investigators and wardens. The OIG rated the performance of Office of Internal Affairs' investigators as *adequate* in 14 of the 57 cases, or 25 percent; *improvement needed* in 10 of the 57 cases, or 17 percent; and *inadequate* in 33 of the 57 cases, or 58 percent.

The OIG rated wardens' performances as *adequate* in nine of the 57 cases, or 16 percent; *improvement needed* in 12 of the 57 cases, or 21 percent; and *inadequate* in 36 of the 57 cases, or 63 percent.

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Respectfully submitted,

Amarik K. Singh
Inspector General

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The OIG's Monitoring of the California Department of Corrections and Rehabilitation's Use-of-Force Cases

The California Department of Corrections and Rehabilitation (the department or CDCR) issues and maintains a Department Operations Manual. This manual contains the department's policies. Department Operations Manual section 51020.1 outlines its use-of-force policy. The section states, in part, ". . . Employees may use reasonable force as required in the performance of their duties, but shall not use unnecessary or excessive force." This is the general policy the department employs to analyze and review uses of force by its employees against incarcerated people in prisons.

From 2005 to the present, the OIG has overseen the department's process for reviewing uses of force in several ways, including the following:

- The OIG assesses the work of committees at each prison that are responsible for reviewing each use of force that occurs at a prison; upon the committee's review of an incident, the warden—or a designee—makes findings regarding whether an employee's use of force complied with departmental policy.
- The OIG contemporaneously monitors internal investigations performed by the department's Office of Internal Affairs regarding allegations of unnecessary or excessive use of force.
- The OIG monitors the work of the department's Deadly Force Review Board, which comprises internal departmental executives, as well as use-of-force experts from outside law enforcement agencies. The Deadly Force Review Board meets on a regular basis throughout the year to review uses of deadly force by departmental employees and to make recommendations regarding the department's use-of-force policies.[1]

1. The OIG publishes other reports on its website—www.oig.ca.gov—regarding its monitoring of the work of the committees at each prison that are responsible for reviewing uses of force; its contemporaneous monitoring of other use-of-force investigations; and its monitoring of the department's Deadly Force Review Board.

A New OIG Program to Review CDCR's Uses of Force

In 2025, the OIG implemented a new program to provide additional oversight of the department's reviews of its uses of force: the *asynchronous*—as opposed to contemporaneous—review of the department's Office of Internal Affairs' internal investigations into allegations of unnecessary or excessive use of force. The OIG reviewed the investigation cases *after* the department had already investigated the misconduct allegations, made findings on the allegations, and closed the cases.

For these cases, the OIG assigned deputy inspectors general (inspectors) to review closed use-of-force investigations completed by the Office of Internal Affairs in which a warden reviewed the case and made findings as to whether an employee's use of force complied with departmental policy. These seasoned inspectors have varying and decades-long experience in correctional policy, conducting and reviewing investigations, and management.

OIG inspectors reviewed and assessed investigations to determine whether Office of Internal Affairs' investigators completed thorough and timely employee misconduct investigations into allegations of unnecessary or excessive use-of-force and whether wardens made appropriate and timely decisions regarding the misconduct allegations.

The OIG's Methodology in Reviewing Closed Use-of-Force Investigation Cases

In 2025, the OIG reviewed and assessed a select number of the department's use-of-force investigations that the department had already processed and closed. The OIG selected for review and focused its work on use-of-force investigation cases that primarily met the following criteria:

1. Use-of-force investigation cases with egregious allegations, meaning cases in which the employee's conduct was particularly outside the norm of what is expected of a public safety officer, or cases in which the incarcerated person subjected to the use of force suffered or could have suffered serious bodily injury.
2. Use-of-force investigation cases in which one of the subjects of the investigation was in the classification of sergeant or higher. A sergeant is a first-level supervisor within the department.

The OIG reviewed cases that independently met either criterion or both criteria.

After selecting an Office of Internal Affairs investigation case to review, we reviewed the entirety of the case file, including the Office of Internal Affairs' investigative report and findings forms. In reviewing the Office of Internal Affairs' investigative report, the inspector reviewed the report itself and the exhibits the investigator attached to the investigative report, including video- and audio-recorded evidence and departmental use-of-force policies relevant to the investigation. We directly reviewed the source evidence the Office of Internal Affairs gathered during its investigation. Source evidence included evidence such as interview recordings, memoranda, surveillance videos, body-worn camera videos, logs, and photographs. We reviewed these materials to assess the thoroughness and timeliness of the investigation.

Once the Office of Internal Affairs completed an investigation, it submitted the case to a warden for review to make findings on the misconduct allegations investigated. For this part of our review, the OIG reviewed documentation regarding the warden's findings. We assessed and arrived at a conclusion about whether the warden had sufficient evidence from the Office of Internal Affairs to make a finding. We also assessed the warden's timeliness in conducting the review of the investigative report and in making findings.

To evaluate the performance of the Office of Internal Affairs' investigators in conducting investigations and the performance of wardens in making findings regarding investigations, the OIG inspector answered two sets of assessment questions.[2] The inspector used one set of questions to assess the performance of investigators and another set of questions to assess the performance of wardens. We then issued an individual rating of *adequate*, *improvement needed*, or *inadequate* for the performances of the Office of Internal Affairs and the warden, respectively. In Figure 1 below, we provide the definitions of the ratings.

For each case we reviewed, we issued an overall case rating of *adequate*, *improvement needed*, or *inadequate* as an evaluation of the sum of the department's performance for each case.

Throughout 2025, we published summaries of the completed use-of-force investigations we reviewed. A reader may find the case summaries on the OIG's website at **www.oig.ca.gov/publications**.

Figure 1. The OIG's Ratings

Adequate
An *adequate* rating means the OIG did not identify any significant deficiencies.
Improvement Needed
An *improvement needed* rating means the OIG found significant deficiencies, but the deficiencies did not appear to cause a negative outcome for the department or for the case.
Inadequate
An *inadequate* rating means the OIG found significant deficiencies that caused a negative outcome for either the department or the case.

Source: The Office of the Inspector General.

2. For a list of the assessment questions, see Appendix A.

The OIG's Findings After Reviewing Closed Use-of-Force Investigations

The OIG Rated the Department's Performance as *Inadequate* in 72 Percent of the Cases We Reviewed

From January 1, 2025, through December 31, 2025, the OIG reviewed and evaluated 57 closed use-of-force investigations. As shown in Table 1 below, of the cases we reviewed and evaluated, we found that overall, the department's performance was *adequate* in seven of the 57 cases, or 12 percent. The OIG found deficiencies in the department's performance and issued a rating of *improvement needed* in nine of the 57 cases, or 16 percent. The OIG found the department's performance was *inadequate* in 41 of the 57 cases we reviewed, or 72 percent.

Table 1. Overall Department Ratings

Rating	Number of Investigation Cases
Adequate	7
Improvement Needed	9
Inadequate	41
Total Cases Reviewed	57

Source: Analysis prepared by staff of the Office of the Inspector General.

The OIG assessed the Office of Internal Affairs' investigator's performance in each of the 57 cases we reviewed. As shown in Table 2 on the next page, we found the Office of Internal Affairs' investigator's performance was *adequate* in 14 of the 57 cases, or 25 percent. The OIG found deficiencies in the Office of Internal Affairs' investigator's performance and issued a rating of *improvement needed* in 10 of the 57 cases, or 17 percent. The OIG found the Office of Internal Affairs' investigator's performance was *inadequate* in 33 of the 57 cases, or 58 percent of the cases we reviewed.

Table 2. Office of Internal Affairs Ratings

Rating	Number of Investigation Cases
Adequate	14
Improvement Needed	10
Inadequate	33
Total Cases Reviewed	57

Source: Analysis prepared by staff of the Office of the Inspector General.

As shown in Table 3 below, the OIG assessed the warden's performance in each of the cases we reviewed and determined that in nine of the 57 cases, or 16 percent, the warden's performance was *adequate*. In 12 of the 57 cases, or 21 percent, the OIG identified deficiencies in the warden's performance and issued an *improvement needed* rating. In 36 of the 57 cases, or 63 percent, the OIG found the warden's performance *inadequate*.

Table 3. Warden Ratings

Rating	Number of Investigation Cases
Adequate	9
Improvement Needed	12
Inadequate	36
Total Cases Reviewed	57

Source: Analysis prepared by staff of the Office of the Inspector General.

In addition to issuing overall ratings for each case and rating the performances of Office of Internal Affairs' investigators and of wardens individually, the OIG also made additional specific findings regarding the department's investigative and employee disciplinary processes. In particular, the OIG found the following:

- In more than half of the use-of-force investigation cases, Office of Internal Affairs' investigators did not complete all necessary and relevant interviews.
- In some use-of-force investigation cases, wardens did not make reasonable decisions regarding the sufficiency of the investigations.

- In most use-of-force investigation cases, wardens delayed in reviewing investigative reports and in making findings on the employee misconduct allegations.

In the next sections, we provide information regarding these findings.

In More Than Half of the Use-of-Force Investigation Cases, Office of Internal Affairs' Investigators Did Not Complete All Necessary and Relevant Interviews

To ensure accountability, impartiality, and compliance with legal and professional standards, it is imperative that investigators conduct thorough investigations into allegations that departmental staff used unnecessary or excessive force. California Penal Code section 6065(c) sets forth that "investigators shall conduct investigations and inquiries in a manner that provides a complete and thorough presentation of the facts regarding the allegation or complaint. All extenuating and mitigating facts shall be explored and reported . . . All reports prepared by the investigator shall provide the appointing authority with a complete recitation of the facts and shall refrain from conjecture or opinion."[3]

Complete and thorough investigations are necessary for wardens to make accurate and adequate findings. Investigators who conduct comprehensive investigations demonstrate due diligence, help promote prison safety, and strengthen trust between departmental employees and the incarcerated population. Without a thorough and adequate investigation, a warden cannot make an informed decision regarding the allegations of misconduct.

The OIG assessed an investigator's performance in many areas to determine the thoroughness of an investigation, including but not limited to, how well the investigator conducted interviews throughout an investigation; whether the investigator completed all pertinent and relevant interviews; whether the investigator obtained and reviewed all relevant evidence; and whether the investigator completed a thorough and accurate investigative report.

In one aspect of Office of Internal Affairs investigations, the OIG found a marked need for improvement. In 30 of the 57 cases, or 53 percent, the OIG determined that the investigator neither independently identified nor completed all necessary and relevant interviews for a thorough investigation.

In one case, on September 26, 2023, an officer allegedly pointed a gun at an incarcerated person each time the incarcerated person asked to use the telephone or take a shower. The incarcerated person filed a complaint and reported that the incident occurred inside a housing unit. At the time the alleged incident occurred, the prison did not have a video surveillance system, nor did its staff don body-worn cameras.

3. An *appointing authority* is equivalent to a departmental hiring authority, the individual responsible for reviewing internal investigations regarding alleged staff misconduct and making findings on the misconduct allegations. In this report, the hiring authorities for all closed use-of-force investigation cases the OIG reviewed were wardens.

Therefore, for a thorough investigation, it was critical for the investigator to search for and interview individuals who, based on the evidence, may have reasonably witnessed the incident. Nevertheless, the investigator made no attempts to identify any employees or incarcerated people who may have witnessed the incident. The investigator only interviewed the officer who was the subject of the investigation. The warden found that there was enough evidence to make a finding regarding the allegation and did not sustain the allegation. The warden should have found the investigation to be insufficient and returned the case to the Office of Internal Affairs to conduct a complete investigation.

In another case, on October 31, 2023, three officers allegedly pulled an incarcerated person from his bed and threw him into a wheelchair. The three officers allegedly escorted the incarcerated person in the wheelchair to a stairwell and dragged him from the wheelchair to the top of the stairs. The officers allegedly grabbed the incarcerated person by his legs, carried him to his cell, threw him on the floor, and stepped on him upon removing his waist restraints. The incarcerated person filed a complaint. The incarcerated person suffered bruising and scratches to his right and left biceps and a cut to his right and left shins, which prison employees documented. The incarcerated person noted that another incarcerated person witnessed the incident. The investigator interviewed the three officers who were the subjects of the investigation, as well as two other officers who may have witnessed the incident. The investigator, however, did not interview the incarcerated person who allegedly witnessed the incident. In addition, despite the allegation that officers dragged an incarcerated person up a flight of stairs and carried him to a cell, the investigator did not identify and interview incarcerated people who were living in the cells near where the incident allegedly occurred. Despite not having taken these critical steps, the investigator closed the investigation. The warden reviewed the investigative report, found the investigation to be sufficient, and did not sustain the allegations. The warden should have found the investigation to be insufficient and returned the case to the Office of Internal Affairs to conduct a thorough investigation.

In Some Use-of-Force Investigation Cases, Wardens Did Not Make Reasonable Decisions Regarding the Sufficiency of the Investigation

Part of our review focused on whether wardens made reasonable decisions regarding the sufficiency of Office of Internal Affairs' investigations. Wardens must determine whether the Office of Internal Affairs' investigative report is sufficient to make decisions regarding misconduct allegation(s) or whether additional investigation is necessary. We found that wardens did not make a reasonable decision regarding the sufficiency of the investigation in 31 of the 57 cases we reviewed, or 54 percent. In each of these 31 cases, the warden found the investigation to be sufficient and made decisions regarding the misconduct allegations investigated by the Office of Internal Affairs, but the OIG reviewed the investigative reports and case materials and concluded the investigations were insufficient and that the warden should have returned the cases to the Office of Internal Affairs for further investigation.

For example, in one case, on September 19, 2020, officers allegedly struck an incarcerated person, planted a knife on him, and falsified reports that indicated they discovered the knife on the incarcerated person during a clothed body search. On January 29, 2024, the incarcerated person mailed a letter to the Office of Internal Affairs in which he alleged, in part, "Since 2018 on forward transferred from prison to prison harassed and beaten they planted a weapon on me on 9-19-2020 at [prison]."[4] The incarcerated person who submitted the complaint provided a specific date, prison location, and information regarding the alleged interactions between him and the officers. The Office of Internal Affairs investigated the allegations.

The investigator documented his investigative efforts in a report. The investigative report reflected that the investigator accessed departmental databases and found an incident report for an incident that occurred on September 19, 2020, in which two officers discovered a makeshift weapon and drug paraphernalia on the incarcerated person who filed the complaint. There were no other incident reports in the departmental databases regarding incidents involving the incarcerated person in the days before or after the September 19, 2020, incident. The investigator reviewed the incident reports of the two officers involved in the September 19, 2020, incident he found in the departmental databases.

Furthermore, the investigator documented that on October 8, 2024, he attempted to interview the incarcerated person who filed the complaint, but the incarcerated person refused to participate in an interview. The same day, however, the incarcerated person wrote to his housing

4. In his complaint, the incarcerated person specifically identified the prison at which this incident allegedly occurred. Per California Penal Code section 6133(b)(2), we have removed this identifying information from this report.

unit sergeant and stated that prison employees did not ask him to participate in an interview regarding the complaint he had filed. The investigator did not make another attempt to interview the incarcerated person. Ultimately, the investigator did not conduct any interviews for the investigation.

The Office of Internal Affairs closed its investigation and submitted its report to the warden. The investigator listed the subjects of his investigation as "unknown" even though the officers involved in the September 19, 2020, incident submitted incident reports with their names on the reports and the department's databases reflected the names of two officers who had interacted with the incarcerated person regarding an alleged weapon on September 19, 2020. The investigator ultimately concluded that "based on all the evidence reviewed, there was not enough factual data to support a continued investigation."

The warden determined the investigation was sufficient even though the investigator conducted no interviews at all and did not identify by name the two officers who allegedly committed misconduct. The warden should have found the investigation to be insufficient and returned the case to the Office of Internal Affairs to conduct a complete investigation.

In another example, on January 26, 2024, a sergeant and six officers allegedly grabbed an incarcerated person by his arms and threw him to the ground. The investigator reviewed a video-recorded statement of the incarcerated person's allegations completed by a sergeant at the prison along with written reports submitted by prison staff regarding the incident. The incarcerated person's statements about what occurred were inconsistent with the events as described in reports submitted by prison staff. There was no video evidence capturing the incident. However, the incarcerated person who filed the complaint identified other incarcerated people who, based on the evidence, may have reasonably witnessed the incident, but the investigator did not interview any of those potential witnesses. The warden determined the investigation was sufficient even though the investigator did not conduct any interviews. The warden should have found the investigation to be insufficient and returned the case to the Office of Internal Affairs to conduct a complete investigation.

In Most of the Use-of-Force Investigation Cases, Wardens Delayed in Reviewing Investigative Reports and Making Findings

Once the Office of Internal Affairs completes an investigation regarding alleged employee misconduct, it submits the investigative report to a warden to review and make findings. Generally, a warden has one year from the date of discovery of the alleged misconduct to issue a notice of disciplinary action to a public safety officer who was under investigation.[5] For departmental employees not in a public safety officer classification, the warden has three years from the date of an incident to issue a notice of disciplinary action against that employee.

The meeting at which a warden makes findings is called the investigative and disciplinary findings conference. Department Operations Manual section 33030.13 states, in part: "As soon as operationally possible, but no more than fourteen (14) calendar days following receipt of the final investigative report, the Hiring Authority shall review the investigative report and supporting documentation. The Hiring Authority shall consult with the Vertical Advocate, for all designated cases, and the SAIG, for all cases monitored by the [OIG] when reviewing the investigation and making investigative findings."[6]

The OIG and the department have a difference in opinion regarding the interpretation of this policy. The OIG's position is that the warden is to hold the investigative and disciplinary findings conference and to make findings within 14 days of receipt of the Office of Internal Affairs' investigative report. The department posited that the policy requires only that the warden review the investigative report and does not require a warden to hold a conference and make findings within 14 days of receipt of the Office of Internal Affairs' investigative report.

In April 2024, the OIG published a report titled: ***The Office of the Inspector General Monitoring in 2023 of the California Department of Corrections and Rehabilitation's Staff Misconduct Complaint Screening, Inquiry, Investigation, and Employee Disciplinary Processes***. In that report,

5. Generally, Government Code section 3304(d) and (g) require public safety officers to be served with notice of disciplinary action within one year of the discovery of the alleged misconduct by a person authorized to investigate. Government Code section 19635 provides, in part, that no adverse action shall be valid against any State employee for any cause for discipline based on any civil service law unless a notice of the adverse action is served within three years of the cause for discipline upon which the notice is based.

6. A *hiring authority* is an individual within the department responsible for making employee disciplinary decisions. In this report, wardens were the designated hiring authority for all the closed use-of-force investigation cases the OIG reviewed. In addition, the *BIR* is the former OIG Bureau of Independent Review. This was a unit of OIG attorneys who monitored Office of Internal Affairs' investigations and the employee disciplinary process. A *SAIG* is a Special Assistant Inspector General, which is an OIG attorney classification. OIG attorneys in the Sexual Misconduct Monitoring and Investigations Team and the Staff Misconduct Monitoring Unit are currently assigned to these responsibilities. A *vertical advocate* is a department attorney assigned to litigate employee discipline cases.

the OIG highlighted the OIG's and the department's difference in interpreting Department Operations Manual section 33030.13. The OIG recommended the department clarify its policy to reflect its position that the warden only had to review the completed investigative report and not necessarily determine a finding on the misconduct allegation(s). As of January 2026, the department has not updated the Department Operations Manual to clarify its interpretation of the policy.

The OIG has maintained its position that a warden is to conduct an investigative and disciplinary findings conference to determine a finding for each completed investigation it receives from the Office of Internal Affairs within 14 days. However, taking into account the ambiguity of the department's policy, to assess whether a warden timely made investigative findings, the OIG assessed whether the warden held an investigative and disciplinary findings conference and made findings within 30 days of receiving a completed Office of Internal Affairs investigation, provided the one-year statutory deadline in which the warden could issue disciplinary penalties to those public safety employees under investigation did not expire. If the warden held a conference and made findings within 30 days of receipt of the investigative report, we assessed the warden to be timely in making findings; if the warden held the conference and made findings after 30 days, we found the warden to not have been timely in making findings on the misconduct allegations.

In the cases we reviewed, the warden conducted timely investigative and disciplinary findings conferences in only 27 of the 57 cases, or 47 percent. The warden failed to conduct timely investigative and disciplinary findings conferences in 30 of the 57 cases, or 53 percent.

In all 30 cases in which the warden failed to conduct a timely investigative and disciplinary findings conference, the warden held the conference more than 30 calendar days following receipt of the Office of Internal Affairs investigative report. In 27 of the 30 cases, or 90 percent, the warden determined a finding before the one-year statutory deadline to take disciplinary action against the employee. In one case, the Office of Internal Affairs submitted the completed investigation to the warden after the deadline to take disciplinary action had already expired.

In two additional cases, the OIG found that wardens received the completed investigations from the Office of Internal Affairs with sufficient time to determine findings and impose disciplinary actions against employees for allegations of staff misconduct if warranted. However, wardens delayed months in holding investigative and disciplinary findings conferences and making findings such that the deadlines to take disciplinary action expired. In both cases, had the wardens sustained allegations of misconduct, they would have been unable to serve disciplinary actions against the employees under investigation.

In one case, on April 21, 2023, an officer allegedly failed to provide an incarcerated person with sufficient time to comply with orders to get down on the ground, slammed the incarcerated person to the floor, and then ignored his need for medical attention. The Office of Internal Affairs investigated the allegations. On December 29, 2023, the Office of Internal Affairs investigator completed the investigative report and provided it to the warden. The deadline for the warden to impose disciplinary action against the officer, had it been warranted, was June 29, 2024. The warden did not conduct the investigative and disciplinary findings conference until July 11, 2024, six months and 12 days after receiving the Office of Internal Affairs' report. The OIG determined the warden delayed conducting the investigative and disciplinary findings conference and making findings on the misconduct allegations for 12 days beyond the deadline to impose disciplinary action against the officer.

In another case, on February 4, 2024, one of two officers allegedly threw a chemical-agent-emitting grenade into an incarcerated person's cell "for no reason." The Office of Internal Affairs investigated the allegation and sent its investigative report to the warden on May 31, 2024. The deadline to take disciplinary action was February 4, 2025. The warden did not hold the investigative and disciplinary findings conference or make findings on the allegation until July 15, 2025, 13 months and 15 days after receiving the investigative report from the Office of Internal Affairs and five months and 11 days past the deadline to impose disciplinary action on the officer, had it been warranted.

Appendix A: OIG Force Investigation Review Team Assessment Questions 1 and 2[7]

Assessment Question 1

How well did the Office of Internal Affairs conduct the investigation?

1. Did the Office of Internal Affairs manager appropriately assign the investigation to an investigator of the appropriate level—sergeant, lieutenant, or special agent — in accordance with the Investigation Assignment Index?
2. Did the investigator provide appropriate interview notices and advisements to the subjects and witnesses before conducting interviews?
3. Did the investigator ask all necessary questions during interviews?
4. Did the investigator use effective interviewing techniques when conducting interviews?
5. Did the investigator complete all necessary and relevant interviews?
6. Did the investigator appropriately admonish the subjects and witnesses concerning confidentiality at the conclusion of interviews?
7. Did the investigator properly preserve, gather, and review all relevant evidence?
8. Did the investigator prepare a thorough, accurate, and unbiased report including all relevant information, evidence, policies, and exhibits?
9. Did the Office of Internal Affairs complete the investigation and provide the report to the warden or prosecuting agency before the deadline to take disciplinary action or file criminal charges?
10. Aside from statutory, regulatory, or policy time frames, did the Office of Internal Affairs unreasonably delay completion of the investigation?

7. For purposes of this report, we replaced hiring authority with warden in the assessment questions.

11. Did the investigator thoroughly and appropriately conduct the investigation?

12. Aside from any issue identified in another question, did the Office of Internal Affairs follow policy and procedure, and comply with best practices during the investigative process?

Assessment Question 2

How well did the warden determine findings concerning alleged employee misconduct and process the employee disciplinary case?

1. Did the warden make timely investigative and disciplinary findings?
2. Did the warden make a reasonable decision regarding the sufficiency of the investigation?
3. Did the warden identify the appropriate subjects and factual allegations for each subject?
4. Did the warden appropriately determine the findings for each allegation?
5. Did the deadline for taking disciplinary action expire before the department completed its findings and served the appropriate disciplinary action?
6. Aside from statutory, regulatory, or policy time frames, did the warden unreasonably delay in handling the case?

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The Department's Response to Our Report

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STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION GAVIN NEWSOM, GOVERNOR

OFFICE OF THE SECRETARY
PO Box 942883
Sacramento, CA 94283-0001

February 26, 2026

Ms. Amarik Singh
Office of the Inspector General
10111 Old Placerville Road, Suite 110
Sacramento, CA 95827

Dear Ms. Singh:

The California Department of Corrections and Rehabilitation (CDCR) appreciates the opportunity to review the Office of the Inspector General's draft report titled *The Office of the Inspector General's Review in 2025 of Use-of-Force Investigations Previously Completed by the California Department of Corrections and Rehabilitations.* CDCR regards these matters seriously and remains committed to conducting thorough and timely investigations into all allegations of unnecessary or excessive use of force.

If you have any questions, contact me at (916) 323-6001.

Sincerely,

DocuSigned by:
Jeffrey Macomber
5967F5D0C55F473...

JEFF MACOMBER
Secretary

The Office of the Inspector General's Review in 2025 of Use-of-Force Investigations Previously Completed by the California Department of Corrections and Rehabilitation

OFFICE *of the*
INSPECTOR GENERAL

Amarik K. Singh
Inspector General

Shaun Spillane
Chief Deputy Inspector General

STATE *of* CALIFORNIA
March 2026

OIG