



*Amarik K. Singh, Inspector General*

*Shaun Spillane, Chief Deputy Inspector General*

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# OIG | OFFICE *of the* INSPECTOR GENERAL

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Independent Prison Oversight

April 2026

**The Office of the Inspector General's  
2025 Review of the California  
Department of Corrections and  
Rehabilitation Routine Reviews of  
Allegations of Staff Misconduct**



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April 23, 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 section 6126(h), the Office of the Inspector General (the OIG) is required to “provide contemporaneous oversight of grievances that fall within the department’s process for reviewing and investigating inmate allegations of staff misconduct and other specialty grievances, examining compliance with regulations, departmental policy, and best practices.” Before January 1, 2025, the California Department of Corrections and Rehabilitation (the department) referred allegations that were less complex in nature and not listed on the department’s Allegation Decision Index to the appropriate hiring authority for assignment to a locally designated investigator to conduct a local inquiry into the issue. We discussed our monitoring of the department’s local inquiry process most recently in our annual report titled *The Office of the Inspector General’s Monitoring in 2024 of the Local Inquiry Process of the Department of Corrections and Rehabilitation*, which we published on May 6, 2025.

On January 1, 2025, the department modified its process for reviewing these types of allegations. Instead of assigning locally designated investigators to complete local inquiries into those allegations, the department now routes them to the prison where the alleged misconduct occurred for a supervisor to perform a routine review. This 2025 annual report is the first report in which we discuss our monitoring of the department’s new routine review process.

Beginning on April 1, 2025, the OIG reviewed a select number of routine review cases the department had already processed and closed. Attorney supervisors selected those cases from a report the department produced monthly that identified routine reviews with allegations of staff misconduct that had been closed during the previous calendar month and assigned each to an attorney. The attorney reviewed and assessed the department supervisor’s performance in fact-gathering and documentation and the reviewing authority’s performance in making a finding on the grievance. The OIG evaluated the performance of the supervisor and the reviewing authority using a list of assessment questions, which we include as Appendix A in this report. The OIG then issued an overall rating of *adequate*, *improvement needed*, or *inadequate*.



From April 1, 2025, through December 31, 2025, the OIG reviewed and evaluated 114 closed routine reviews. Of the cases we reviewed, we found that overall, the department's performance was *adequate* in 39 of the 114 cases, or 34 percent. The OIG found deficiencies in the department's performance and issued a rating of *improvement needed* in 24 of the 114 cases, or 21 percent. The OIG found the department's performance was *inadequate* in 51 of the 114 cases we reviewed, or 45 percent.

We found that supervisors frequently conducted insufficient fact-gathering because they did not complete all necessary and relevant interviews in 47 cases or 41 percent; did not request or preserve relevant video evidence or adequately document their review of video evidence in 45 cases or 39 percent; did not properly document all relevant facts, evidence, and supporting exhibits in the department's confidential records system in 65 cases or 57 percent; and did not identify or include policies and procedures relevant to the alleged misconduct in 38 cases or 33 percent.

In 49 cases or 43 percent of cases, we disagreed with reviewing authorities' decisions. In 40 of those cases, the supervisor's fact-finding was inadequate and the reviewing authority should have returned the case to the supervisor for additional fact-gathering. In the remaining nine cases, either the grievance contained allegations listed on the Allegation Decision Index, or the supervisor uncovered evidence of more serious misconduct. For more serious misconduct cases, the reviewing authority should have referred the allegation back to the Centralized Screening Team to be routed to the Office of Internal Affairs for investigation.

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Respectfully submitted,



Amarik K. Singh  
Inspector General

# Contents

<b>Illustrations</b>	<b>iv</b>
<b>Introduction</b>	<b>1</b>
The Department’s Routine Review Process and Responsibilities	2
<b>The OIG’s Methodology in Reviewing Closed Routine Review Cases</b>	<b>3</b>
<b>The OIG’s Findings After Reviewing Closed Routine Reviews of Allegations of Staff Misconduct</b>	<b>5</b>
The OIG Rated the Department’s Performance as <i>Inadequate</i> in 45 Percent of the Cases We Reviewed	5
The Hiring Authority Denied the Incarcerated Person’s Grievance in 95 Percent of the Routine Reviews We Evaluated, and the OIG Disagreed with 43 Percent of the Reviewing Authority’s Findings	6
The OIG Found That Supervisors Frequently Conducted Insufficient Fact-Gathering During Routine Reviews	7
In 41 Percent of the Routine Reviews the OIG Evaluated, Supervisors Did Not Complete All Necessary and Relevant Interviews	8
In 39 Percent of the Routine Reviews the OIG Evaluated, Supervisors Did Not Timely Request Video Evidence, Preserve Relevant Body-Worn Camera or Video Footage, or Adequately Document Their Observations	9
In 57 Percent of the Routine Reviews the OIG Evaluated, Supervisors Did Not Adequately Document Their Fact-Gathering	11
In 33 Percent of Routine Reviews the OIG Evaluated, Supervisors and Reviewing Authorities Did Not Identify the Departmental Policy or Procedures Applicable to the Alleged Staff Misconduct	12
<b>Conclusion</b>	<b>15</b>
<b>Appendix A: OIG Assessment Questions for Routine Reviews</b>	<b>17</b>
<b>The Department’s Response to Our Report</b>	<b>19</b>

## Illustrations

### **Figures**

- |    |  |   |
|----|--|---|
| 1. | The OIG’s Rating Criteria for Routine Reviews  | 3 |
| 2. | The OIG’s Findings Regarding Supervisors’ Fact-Gathering Efforts in the Routine Reviews We Evaluated | 8 |

### **Tables**

- |    |   |   |
|----|---|---|
| 1. | Overall Ratings of Closed Routine Reviews From April 1, 2025, Through December 31, 2025 | 5 |
|----|---|---|

## Introduction

The California Department of Corrections and Rehabilitation (the department) has a process in place in which an incarcerated person, a parolee, or any third-party individual or a group can make an allegation of staff misconduct and submit it to the department for further review and handling. An allegation of staff misconduct is a complaint in which an individual or group alleges that a departmental employee violated a law, a regulation, departmental policy, or an ethical or professional standard. A complaint may contain one or more allegations of staff misconduct. The Office of the Inspector General (the OIG) is statutorily required to “provide contemporaneous oversight of grievances that fall within the department’s process for reviewing and investigating inmate allegations of staff misconduct and other specialty grievances, examining compliance with regulations, departmental policy, and best practices.”<sup>1</sup>

The department maintains a list of the most serious allegations of staff misconduct called the Allegation Decision Index (ADI).<sup>2</sup> Allegations on the ADI, such as use of force, dishonesty, retaliation, or discrimination are referred for investigation by trained investigators within the department’s Office of Internal Affairs. Before January 1, 2025, if the department received an allegation that was less complex in nature and not listed on the ADI, the department referred the allegation to the proper hiring authority for a “local inquiry.” The hiring authority at the prison assigned the case to a locally designated investigator who was trained to conduct local inquiries. The locally designated investigator was then responsible for analyzing the complaint, thoroughly gathering facts, gathering and reviewing all relevant evidence, conducting all necessary interviews, and preparing a confidential draft report that summarized facts and evidence. The preliminary report and supporting exhibits, along with any subsequent revisions to the report were then reviewed by an Office of Internal Affairs manager to determine whether the inquiry was sufficient, complete, and unbiased. Once approved, the report was provided to the hiring authority for final consideration.<sup>3</sup>

On January 1, 2025, the department modified its process related to the review and handling of allegations of staff misconduct that are not listed on the department’s ADI. The department discontinued the previously described local inquiry process and began processing these allegations of staff misconduct as routine reviews. Instead of locally designated investigators completing local inquiries into allegations of staff misconduct that are not on the ADI, the allegations are routed to the prison where the alleged misconduct occurred for a supervisor to perform a routine review.

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1. California Penal Code section 6126(h).

2. Department Operations Manual Article 26 Section 33070.9.7

3. The OIG issued a 2024 Local Inquiry Report summarizing its monitoring of the former local inquiry process, which can be found at <https://www.oig.ca.gov/wp-content/uploads/2025/05/2024-Local-Inquiry-Monitoring-Report.pdf>.

## The Department's Routine Review Process and Responsibilities

Upon receiving a routine review, the prison's Office of Grievances (OOG) assigns the routine review to the appropriate associate warden who serves as the reviewing authority for the grievance. The reviewing authority reviews and assigns the routine review to the appropriate supervisor for fact-gathering. If the allegation concerns noncompliance with the Americans with Disabilities Act (ADA), the allegation shall be assigned to the institutional ADA coordinator to serve as the reviewing authority.

Although the department does not classify routine reviews as investigations, they involve many of the same steps. The supervisor assigned to complete the routine review shall:

- Conduct a complete review of each claim.
- Ensure all relevant evidence, including documents, interviews, video recordings, or audio recordings, are identified, summarized, and preserved.
- Interview the claimant or witness if the supervisor determines that doing so would assist in resolving the claim.
- Suspend the routine review and refer it back to the Centralized Screening Team (CST) if the supervisor discovers information that the claim involves complex issues requiring specialized investigative skills; the alleged misconduct is likely to result in adverse action if proven true; or the claim is similar to previous staff misconduct that was sustained against the involved departmental staff.
- Upon completion of the routine review, document fact-gathering, preserve all supporting documents in the confidential records system, and draft a recommended decision letter for consideration by the reviewing authority.<sup>4</sup>

The reviewing authority, who reviews the evidence and the recommended decision letter and determines whether to grant or deny the grievance, must be at least one rank higher than the highest-ranking employee accused of staff misconduct. A finding to grant or deny a grievance must be supported by a preponderance of evidence. The grievance must be reviewed and approved and a written decision letter must be issued to the claimant no later than 60 calendar days after it is received by the Office of Grievances.

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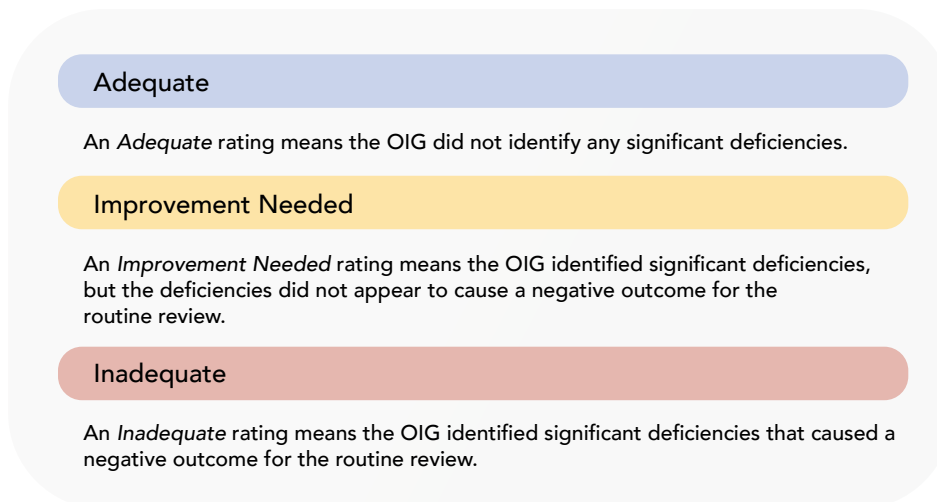
4. Crime Prevention and Corrections, 15 Cal. Code Regs. § 3483.

# The OIG's Methodology in Reviewing Closed Routine Review Cases

Beginning on April 1, 2025, the OIG reviewed a select number of routine review cases the department had already processed and closed. Attorney supervisors used a report produced monthly by the department's Office of Research, which identified routine reviews with allegations of staff misconduct the department had closed during the previous calendar month. The attorney supervisor selected cases from this report and assigned each routine review to an attorney for review.

The attorney reviewed and assessed the department supervisor's performance in fact-gathering and documentation and the reviewing authority's performance in making a finding on the grievance. The OIG evaluated the performance of the supervisor and the reviewing authority using a list of assessment questions.<sup>5</sup> The OIG then issued an overall rating of *adequate*, *improvement needed*, or *inadequate*. In Figure 1 below, we identify the definitions of the ratings.

**Figure 1. The OIG's Rating Criteria for Routine Reviews**



Source: The Office of the Inspector General.

<sup>5</sup> Appendix A Assessment Questions.

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# The OIG's Findings After Reviewing Closed Routine Reviews of Allegations of Staff Misconduct

## The OIG Rated the Department's Performance *Inadequate* in 45 Percent of the Cases We Reviewed

From April 1, 2025, through December 31, 2025, the OIG reviewed and evaluated 114 closed routine reviews. As shown in Table 1 below, of the cases we reviewed, we found that overall, the department's performance was *adequate* in 39 of the 114 cases, or 34 percent. The OIG found deficiencies in the department's performance and issued a rating of *improvement needed* in 24 of the 114 cases, or 21 percent. The OIG found the department's performance was *inadequate* in 51 of the 114 cases we reviewed, or 45 percent.

**Table 1. Overall Ratings of Closed Routine Reviews From April 1, 2025, Through December 31, 2025**

Performance Rating	Number of Cases	Percentage
<i>Adequate</i>	39	34%
<i>Improvement Needed</i>	24	21%
<i>Inadequate</i>	51	45%
Total	114	100%

Source: The Office of the Inspector General.

## The Hiring Authority Denied the Incarcerated Person's Grievance in 95 Percent of the Routine Reviews We Evaluated, and the OIG Disagreed With 43 Percent of the Reviewing Authority's Findings

Of the 114 cases reviewed by the OIG, the reviewing authority denied the incarcerated person's grievance in 108 cases, or 95 percent. The OIG determined that the reviewing authority made appropriate findings for each allegation in 65 of the 114 cases, or 57 percent. The OIG disagreed with the reviewing authority's decision for each allegation in 49 of the 114 cases, or 43 percent. The OIG disagreed with the reviewing authority's findings in most of those 49 cases because the supervisor's fact-finding was inadequate. We believed that rather than making a determination regarding the allegation, the reviewing authority should have returned the case to the supervisor for additional fact-gathering.

In nine of the 114 routine reviews we evaluated, the OIG believed the reviewing authority should have invoked the Suspend and Elevate Process<sup>6</sup> and referred the allegation back to the Office of Internal Affairs' Centralized Screening Team for investigation. In these nine cases, the grievance either contained an allegation that appeared on the ADI or the supervisor performing the routine review uncovered evidence of more serious misconduct that should have been investigated by the Office of Internal Affairs. Departmental regulations require that the supervisor immediately suspend the routine review and refer the matter to the Centralized Screening Team in these circumstances.

Below are some examples of cases the OIG identified that should have been suspended and referred back to the Office of Internal Affairs:

25-03-12

A sergeant allegedly made verbal threats to an incarcerated person in retaliation for submitting a grievance against an officer. Allegations involving retaliation against incarcerated people for reporting staff misconduct are listed on the ADI. The reviewing authority should have suspended the routine review and referred the matter back to the Centralized Screening Team identifying that allegations of retaliation must be investigated by the Office of Internal Affairs.

25-03-16

Three officers allegedly asked an incarcerated person to show them his soiled diaper when the incarcerated person requested an incontinence

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6. Crime Prevention and Corrections, 15 Cal. Code Regs. § 3483.

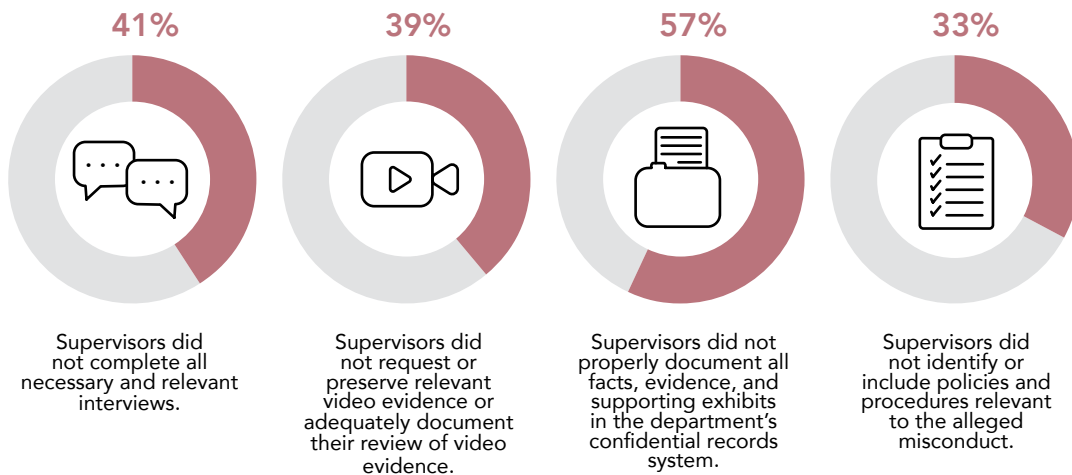
shower and then denied the incarcerated person access to the shower. The reviewing authority found sufficient evidence to grant the incarcerated person's grievance. The reviewing authority determined that corrective action was appropriate and issued the officers an employee counseling record. The OIG agreed but found that two of the officers allegedly lied about the incident when they denied asking the incarcerated person to show his soiled diaper, despite the video evidence confirming they had made that request. Upon discovering the information that suggested officers had been dishonest, the supervisor should have suspended the review and referred the matter to the Centralized Screening Team identifying that allegations of dishonesty must be investigated by the Office of Internal Affairs.

## The OIG Found That Supervisors Frequently Conducted Insufficient Fact-Gathering During Routine Reviews

A supervisor is assigned to conduct the fact-gathering in each routine review and provide a recommended decision to the reviewing authority as to whether to grant or deny the grievance. The OIG assessed the adequacy of supervisors' fact-gathering efforts in several areas, making the following findings as reflected in Figure 2 on the next page:

- In 41 percent of the routine reviews the OIG evaluated, supervisors did not complete all necessary and relevant interviews.
- In 39 percent of the routine reviews the OIG evaluated, supervisors did not request or preserve relevant video evidence or adequately document their review of video evidence.
- In 57 percent of the routine reviews the OIG evaluated, supervisors did not properly document all relevant facts, evidence, and supporting exhibits in the department's confidential records system.
- In 33 percent of the routine reviews the OIG evaluated, supervisors did not identify or include policies and procedures relevant to the alleged misconduct.

**Figure 2. The OIG’s Findings Regarding Supervisors’ Fact-Gathering Efforts in the Routine Reviews We Evaluated**



Source: The Office of the Inspector General.

## In 41 Percent of the Routine Reviews the OIG Evaluated, Supervisors Did Not Complete All Necessary and Relevant Interviews

In 47 of the 114 routine reviews we evaluated (41 percent), supervisors did not complete all necessary and relevant interviews to ensure a thorough review of the allegations. The OIG deems this a significant deficiency because completing all necessary and relevant interviews is a critical component of a routine review. Interviews help establish first-hand accounts of what occurred, identify inconsistencies, and assess the credibility of the individuals involved. Thorough interviews may also identify additional evidence, clarify timelines, and resolve conflicting statements, all of which are essential to the reviewing authority's ability to make accurate and complete findings. When necessary and relevant interviews are not completed, important facts may be overlooked, the reliability of the review may be undermined, and the reviewing authority may be unable to make a fully informed determination regarding the allegations.

In the case examples below, we rated the routine review *inadequate* because a supervisor did not complete all necessary and relevant interviews:

25-04-10

An officer allegedly withheld an incarcerated person's medical ducats on three occasions because the incarcerated person refused to sign the ducat acknowledging receipt. The supervisor did not interview the officer

but should have done so to inquire about the officer's alleged practice of requiring signatures on medical ducats, the officer's knowledge of policies and procedures governing the distribution of medical ducats, and the incarcerated person's allegations regarding the three specific incidents. Despite the failure to interview this critical witness, the reviewing authority found the draft decision adequate and denied the incarcerated person's grievance.

25-04-11

An officer allegedly searched an incarcerated person's bunk area and locker, wrongfully confiscated his religious medicine bag and dream catcher, and destroyed the dream catcher. The officer also allegedly used profanity toward the incarcerated person when he asked to speak with the officer on a later date. The supervisor did not interview either the incarcerated person or the officer. Because the supervisor did not interview either of these critical witnesses, there was insufficient evidence to determine whether the search occurred, whether religious property was confiscated or destroyed, whether other witnesses existed, whether staff complied with documentation and policy requirements, and the nature of the officer's interactions with the incarcerated person. Despite these omissions, the reviewing authority found the draft decision adequate and denied the incarcerated person's grievance.

### **In 39 Percent of the Routine Reviews the OIG Evaluated, Supervisors Did Not Timely Request Video Evidence, Preserve Relevant Body-Worn Camera or Video Footage, or Adequately Document Their Observations**

In 45 of the 114 routine reviews we evaluated (39 percent), supervisors did not properly utilize available video evidence in their fact-gathering process. The OIG deems this a significant deficiency because video evidence often plays an important role in determining whether misconduct occurred because it provides an objective record of the incident, can support or contradict statements made during interviews, and allows reviewers to assess the credibility and reliability of witness accounts. During our review period, we found repeated issues in supervisors' handling of video evidence, including the following:

- Reviewing video evidence but not preserving it
- Reviewing video evidence but not documenting or describing what it showed
- Requesting or saving video evidence that is unrelated to the incident and, therefore, failing to document its relevance to the allegation

- Not requesting video evidence within the required time frame

The department maintains a 90-day retention period for video evidence. If a supervisor does not request and preserve the video evidence within that time frame, the video evidence may no longer be accessible for future review. Without preserved video evidence, the ability to independently confirm what occurred during the incident may be limited. This also inhibits the reviewing authority's and the OIG's ability to verify findings and fully assess the basis for the supervisor's conclusions.

In the case examples below, the reviewing authority denied the incarcerated person's grievance despite deficiencies in the preservation and documentation of video evidence.

25-03-41

An incarcerated person alleged that an officer falsified records by documenting that showers were offered and provided when they had not actually been provided. The supervisor reviewed video footage and documented that showers appeared open and available on two separate dates. However, the supervisor did not preserve the video footage or document with sufficient detail what the video showed. As a result, we could not independently assess or verify the supervisor's conclusions.

25-03-30

An incarcerated person alleged that an officer acted unprofessionally by denying extra milk and fruit with a kosher meal. The supervisor reviewed video footage and concluded that misconduct did not occur. However, the video footage the supervisor preserved in the case file did not correspond to the time period of the alleged incident and instead captured events that occurred after the time the alleged events occurred. Because the preserved video footage did not reflect the incident reviewed by the supervisor, we could not independently assess or verify the basis for the supervisor's observations and conclusions.

25-04-12

An incarcerated person alleged that a sergeant harassed her by speaking loudly and disrespectfully toward her at her cell door regarding confidential information. The supervisor wrote that he had reviewed video footage but did not document a summary of what it showed. The decision letter referenced video footage from a different, unrelated date that showed the sergeant acting calmly and respectfully and the incarcerated person as verbally abusive and irate. However, the supervisor did not identify the date of the video, explain its relevance to the allegation, or preserve it. As a result, there is no documentation in the confidential records system that reflects how the video footage supported the supervisor's conclusion.

25-04-20

Lastly, an incarcerated person alleged that officers laughed at her after she reported concerns about her safety. The supervisor documented that video footage contradicted the allegation. However, the supervisor did not preserve the video or document a detailed summary of what it showed. Therefore, the basis for the supervisor's conclusion could not be independently assessed.

## In 57 Percent of the Routine Reviews the OIG Evaluated, Supervisors Did Not Adequately Document Their Fact-Gathering

In 65 of the 114 routine reviews we evaluated (57 percent), supervisors did not adequately document their fact-gathering efforts. The OIG deems this a significant deficiency because the documentation supervisors provided did not adequately reflect the evidence gathered, interviews conducted and summarized, or other actions taken to support the supervisors' recommended decision as to whether to grant or deny the grievance. This lack of documentation limits the reviewing authority's ability to fully evaluate the allegations. Furthermore, supervisors are required to document their fact-gathering efforts in the department's confidential records system. However, many routine reviews lack important information, including the following:

- Interview summaries
- Names of staff contacted
- Descriptions of evidence reviewed
- Explanations of how conclusions were reached

Despite the lack of documentation, reviewing authorities frequently accepted supervisors' recommendations to deny the grievance. In the case examples below, supervisors failed to adequately document their fact-gathering:

25-03-34

An incarcerated person alleged that an officer harassed her and used derogatory language. The reviewing authority granted the grievance and provided training to the officer. However, nowhere in the routine review was it documented how the supervisor identified the officer, whether interviews occurred, or whether video evidence was reviewed. In fact, the department's confidential record system does not contain substantive evidence to support the reviewing authority's determination that the officer violated policy and the decision to grant the grievance.

**25-03-02**

An incarcerated person alleged that an officer used discourteous language related to medical issues. The supervisor stated in the decision letter that the named officer did not exist and that staff assigned to the housing unit denied any negative or hostile interaction with the incarcerated person. However, the supervisor did not document which staff members were contacted, whether interviews were conducted, or whether video evidence was requested or reviewed. The confidential records system does not reflect the supervisor's fact-gathering efforts or evidence to support his conclusion. The reviewing authority denied the grievance without any additional fact-gathering to address the deficiencies documented in the routine review.

**25-04-01**

An incarcerated person alleged that an officer failed to accommodate his special handcuffing needs. The supervisor concluded that the officer had no prior knowledge of the accommodation requirement. However, the confidential records system does not contain documentation identifying evidence the supervisor reviewed or explaining how the supervisor determined that the officer lacked prior knowledge of the accommodation requirement. As a result, the basis for the supervisor's conclusion is not clearly supported by any verifiable documentation.

To improve documentation and evidence preservation, the department is working to implement a new Fact-Gathering Confidential Tracking System (FCTS). The department expressed concerns about confidentiality with the current system because it is accessible by all custody staff. Therefore, the new FCTS system is designed to provide a more secure platform for documenting fact-gathering activities and preserving evidence while limiting access to confidential information to authorized personnel only. As of the date of this publication, the department is in the process of training staff on using the new system.

### **In 33 Percent of Routine Reviews the OIG Evaluated, Supervisors and Reviewing Authorities Did Not Identify the Departmental Policy or Procedures Applicable to the Alleged Staff Misconduct**

In 38 of the 114 routine reviews we evaluated (33 percent), the recommended decisions supervisors forwarded to the reviewing authority did not reference or include as an exhibit relevant departmental policies or procedures applicable to the alleged staff misconduct.

Staff misconduct includes behavior that violates a law, regulation, policy, or procedure. Establishing accountability requires identifying the rule or rules in effect at the time of the alleged incident that govern the conduct at issue. Early identification of applicable rules is a critical step in a routine review because it helps define the scope of the review, identify relevant witnesses, develop appropriate interview questions, and guide the collection of evidence. Supervisors should question accused staff about their knowledge and application of governing rules and ensure that relevant evidence is identified and obtained.

Reviewing authorities must likewise identify policies and procedures applicable to the alleged misconduct and apply those to the evidence gathered during the routine review to determine whether a grievance should be granted or denied. When applicable policies or procedures are not identified, the routine review lacks a clear analytical framework. As a result, the reviewing authority may be unable to fully assess the evidence, evaluate findings, or understand the basis for the conclusions reached.

The case examples below illustrate how reviewing authority decisions can become ambiguous when the department fails to include relevant policies and procedures governing allegations of staff misconduct.

#### 25-04-14

An officer allegedly failed to take action after an incarcerated person reported finding a rock in their food. The supervisor cited a general regulation in the decision governing an incarcerated person's right to appeal but did not include policies or procedures governing food handling and staff responsibilities for responding to reported food contamination or safety concerns. Despite these omissions, the reviewing authority found the draft decision adequate, and the reviewing authority denied the incarcerated person's grievance.

#### 25-04-12

A sergeant allegedly harassed an incarcerated person by speaking loudly beside the incarcerated person's cell door about unspecified confidential information. In the decision, the supervisor cited regulations governing the rights and respect of others but failed to identify or include specific policies and procedures relevant to the allegations, including those governing the disclosure of confidential information. The reviewing authority agreed with the supervisor's draft decision and denied the incarcerated person's grievance.

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## Conclusion

The department's transition to routine reviews is evolving with the implementation of the new Fact-Gathering Confidential Tracking System. We anticipate the system will improve the department's processing of routine reviews.

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# Appendix A: OIG Assessment Questions for Routine Reviews

## Supervisor

1. Did the OIG identify any bias by the supervisor during the routine review?
2. Did the supervisor properly gather and review all relevant documentary and other evidence?
3. Did the supervisor complete all necessary and relevant interviews?
4. Did the supervisor obtain all relevant and necessary information through the interviews conducted?
5. Did the supervisor thoroughly and appropriately conduct the routine review?
6. Did the supervisor properly document all relevant facts, evidence, and supporting exhibits in the department's confidential records system?
7. Was the fact-gathering adequate to enable the reviewing authority to make an appropriate finding regarding each allegation?
8. Based upon the evidence, did the supervisor provide an appropriate and supported recommended determination to the reviewing authority?
9. If the supervisor identified information to suggest that the claim involves complex issues requiring specialized investigative skills or resources; the claim, if proven true, is likely to result in adverse action; or the claim is similar to previous staff misconduct that was sustained against the departmental staff involved, did the fact-gatherer immediately suspend their activities and refer the matter to the Centralized Screening Team?
10. Did the supervisor unreasonably delay in completing the routine review?
11. Did a departmental manager review the draft decision and appropriately approve the decision or return it to the supervisor for additional fact-gathering?

## Reviewing Authority

1. Did the reviewing authority ensure that any individual whose personal interaction with a claimant forms part of the claim was excluded from participating in the process as to that claim, including any interview of a claimant conducted as part of the process?
2. Was the reviewing authority who made the determination on the allegations at least one rank higher than the highest-ranking subject?
3. Did the reviewing authority review the draft decision and supporting evidence and appropriately determine whether the fact-gathering was adequate to make a determination on each allegation?
4. Did the reviewing authority make an appropriate finding for each allegation?
5. Did the department issue a written decision no later than 60 calendar days after the grievance was received?
6. Did the OOG send the written decision letter no later than 10 business after its issuance?
7. If corrective action was ordered, did the reviewing authority timely take the corrective action?

# 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



4/15/2026

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) thanks the Office of the Inspector General (OIG) for the opportunity to review the draft report titled *The Office of the Inspector General's 2025 Review of the California Department of Corrections and Rehabilitation Routine Reviews of Allegations of Staff Misconduct*.

The Department values OIG's ongoing partnership in strengthening the routine review process and welcomes the observations included in the draft report. In alignment with the Department's updated regulations, CDCR continues to emphasize the importance of conducting timely, relevant interviews to ensure each review is supported by complete and accurate information. The new regulatory framework strengthens expectations for thorough and well documented assessments, supporting consistent application of policy and systemwide accountability. CDCR has also clarified and reinforced requirements for the preservation and review of all available video evidence to safeguard the integrity of the review process. In support of these updates, the Department has implemented targeted training to ensure staff understand and consistently apply the updated standards across CDCR.

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

Sincerely,

DocuSigned by:

**Jeffrey Macomber**

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JEFF MACOMBER  
Secretary

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Review of the California Department of  
Corrections and Rehabilitation Routine Reviews  
of Allegations of Staff Misconduct**

**OFFICE of the  
INSPECTOR GENERAL**

*Amarik K. Singh*  
Inspector General

*Shaun Spillane*  
Chief Deputy Inspector General

STATE of CALIFORNIA  
April 2026

**OIG**