In the third quarter of 2026, the OIG's Centralized Screening Monitoring Team monitored and closed 4,491 grievances. Of those grievances, the Centralized Screening Team and the OIG agreed that 3,581 of those grievances did not contain any allegations of staff misconduct. The OIG determined the remaining 910 grievances contained allegations of staff misconduct. We assessed the processing of those grievances containing allegations of staff misconduct as follows:

Table 1. The OIG's Assessment of 910 Grievances for July Through September 2026

Rating	*Staff Misconduct Grievances Only*	
	Number of Grievances	Percentage
Adequate	656	72
Improvement Needed	56	6
Inadequate	198	22
Totals	910	100

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

Table 2. Cumulative Monthly Statistics for July Through September 2026

Rating	*Number and Percentage of Grievances*									
	January	February	March	April	May	June	July	August	September	Totals
Adequate	116	143	165	141	199	209	227	216	213	1,629
	70%	73.5%	71%	73%	83%	78%	72.5%	76%	68.25%	74%
Improvement Needed	7	17	17	11	5	18	24	15	17	131
	4%	9%	7%	6%	2%	7%	7.5%	5%	5.5%	6%
Inadequate	43	34	51	40	35	41	62	54	82	442
	26%	17.5%	22%	21%	15%	15%	20%	19%	26.25%	20%
Staff Misconduct Grievances	166	194	233	192	239	268	313	285	312	2,202
Total Grievances Reviewed	1,320	1,260	1,432	1,188	1,137	1,046	1,440	1,501	1,550	11,874

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

This document presents eight notable cases monitored and closed by the OIG during the third quarter of 2026.

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OIG Case Number 26-0152691-CSMT

Rating Assessment
Inadequate

Incident Summary

Between April 23, 2026, and April 29, 2026, three officers allegedly compromised the safety and security of a prison by conspiring with an incarcerated person. The officers allegedly facilitated the incarcerated person's unauthorized use of a second incarcerated person's tablet for illicit communication with gang affiliates both inside and outside the prison.

Disposition

The Centralized Screening Team determined that the complaint contained no allegations of staff misconduct without reviewing the complaint documentation, which prison staff had failed to attach to the grievance record. The OIG did not concur. Following the OIG's dispute, the Centralized Screening Team obtained appropriate documentation and referred the allegations against the officers to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

Case Rating

The department's performance was *inadequate*. The Centralized Screening Team should have recognized the need to request the complaint documentation from the prison prior to rendering a screening decision about the complaint. The Centralized Screening Team's initial review was limited to the minimal grievance record amounting to two sentences submitted by prison staff about "the unauthorized transfer of a state issued tablet" for illicit communication between gang associates. After the OIG's dispute and request for the complaint documentation, the Centralized Screening Team obtained the necessary documentation and appropriately referred the allegations that three officers had endangered the safety and security of the prison and conspired with an incarcerated person to facilitate unauthorized tablet usage and illicit communication with gang associates to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

OIG Case Number 26-0152695-CSMT

Rating Assessment
Inadequate

Incident Summary

On May 19, 2026, an incarcerated person alleged custody staff and other incarcerated people treated him unfairly and custody staff denied him incontinence showers and garbage bags to clean up his incontinence supplies. The incarcerated person alleged that when he reported feeling suicidal, custody staff used profane language towards him and "put [him] on the ground." During a clarification interview, the incarcerated person stated that on May 6, 2026, officers did not release him for pill call. When the incarcerated person questioned an officer, the officer allegedly used profane language, pushed him to the ground, and threw a pair of gloves in his face.

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Disposition

The Centralized Screening Team referred the allegations that staff had used profane language towards the incarcerated person and treated him unfairly to the prison as a single, routine allegation of staff misconduct. The OIG concurred with these decisions. The OIG elevated the decision not to clarify the vague allegation related to being put on the ground, and not to treat potential Americans with Disabilities Act violations related to denial of incontinence showers as allegations of staff misconduct. Following the OIG's dispute, the Centralized Screening Team referred the incontinence allegations to the prison as a routine allegation of staff misconduct, and conducted a clarification interview for the vague unreasonable force allegation, which was subsequently referred to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

Case Rating

The department's performance was *inadequate*. The allegation that staff had denied the incarcerated person incontinence showers and garbage bags to clean up his incontinence supplies qualified as an Americans with Disabilities Act violation and staff misconduct not on the allegation decision index, which required referral to a local supervisor for confidential fact-gathering. The Centralized Screening Team failed to recognize the need to conduct a clarification interview with the incarcerated person regarding the vague allegation of being "put on the ground" as a possible unreasonable force allegation. The Centralized Screening Team's initial review of the grievance failed to identify these allegations as staff misconduct. Following the OIG's dispute, the Centralized Screening Team referred the incontinence allegations to the prison as a routine allegation of staff misconduct and conducted a clarification interview, which did not include the OIG, regarding the possible unreasonable force allegation. Based on the additional clarifying information the incarcerated person provided during the interview, the Centralized Screening Team referred the unreasonable force allegation to the Office of Internal Affairs' Allegation Investigation Unit.

OIG Case Number 26-0153764-CSMT

Rating Assessment
Inadequate

Incident Summary

On June 12, 2026, officers allegedly disclosed an incarcerated person's status as a sexual offender to other incarcerated people, which led to other incarcerated people threatening to physically harm the incarcerated person and steal his property. When the incarcerated person reported his safety concerns, a sergeant and officers allegedly disregarded his concerns and his claims of being suicidal. On June 16, 2026, after the incarcerated person fought with another incarcerated person, staff allegedly failed to ensure his safety by removing him from the facility. Instead, staff only moved him to another building on the same yard.

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Disposition

The Centralized Screening Team routed the allegation that officers had endangered an incarcerated person's safety by disclosing confidential information back to the prison as a routine allegation against another incarcerated person. The OIG did not concur. Following the OIG's dispute, the Centralized Screening Team referred the allegations to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

Case Rating

The department's performance was *inadequate*. The allegations that officers had disclosed the incarcerated person's status as a sex offender to other incarcerated people, that a sergeant and officers had ignored the incarcerated person's reported safety concerns and suicidal ideation, and that staff had failed to sufficiently rehouse the incarcerated person following a physical altercation with another incarcerated person qualify as improper disclosure of confidential information, endangering the safety of an incarcerated person by violating policy, and creating a motive or opportunity for one incarcerated person to harm another, which are all on the department's allegation decision index as requiring referral to the Office of Internal Affairs' Allegation Investigation Unit. The Centralized Screening Team's initial review of the grievance failed to identify the allegations as staff misconduct, and the complaint only to be an allegation against another incarcerated person. Following the OIG's dispute, the Centralized Screening Team referred the three allegations to the Office of Internal Affairs' Allegation Investigation Unit as endangering the safety of an incarcerated person by violating policy and creating a motive or opportunity for one incarcerated person to harm another.

OIG Case Number 26-0153907-CSMT

Rating Assessment
Inadequate

Incident Summary

On February 28, 2026, a sergeant and six officers allegedly pepper sprayed an incarcerated person and broke his nose. Between February 28, 2026, and March 7, 2026, medical staff allegedly failed to provide the incarcerated person with medical treatment following the unreasonable force. Between February 28, 2026, and June 3, 2026, staff allegedly failed to provide the incarcerated person with video footage he had requested of the incident. On April 30, 2026, a seventh officer allegedly failed to address the incarcerated person's safety concerns and issued him a rules violation report for refusing housing. On May 1, 2026, a second sergeant allegedly made threatening and intimidating statements to the incarcerated person. The second sergeant and officers allegedly questioned the incarcerated person's reasons for not wanting to participate in yard activities and encouraged incarcerated people to resolve issues through violence. On May 12, 2026, staff allegedly spread false information about the incarcerated person's conviction offense to the incarcerated population, which resulted in him being assaulted, and medical staff allegedly failed to provide him with medical attention until the following day.

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Disposition

The Centralized Screening Team identified an unreasonable force allegation as staff misconduct, rejected the allegation as substantially duplicative of a prior grievance already referred to the Office of Internal Affairs' Allegation Investigation Unit, and determined the complaint contained no other allegations of staff misconduct. The OIG did not concur with the decision not to identify the alleged threats and intimidation, spreading of false information, and encouragement of violence between incarcerated people as allegations of staff misconduct. Following the OIG's dispute, the Centralized Screening Team referred the unreasonable force allegation to the Office of Internal Affairs' Allegation Investigation Unit as a subsequent source to an existing investigation, but failed to treat the alleged threats and intimidation, spreading of false information, and encouragement of violence between incarcerated people as allegations of staff misconduct.

Case Rating

The department's performance was *inadequate*. The allegations that staff had threatened and intimidated the incarcerated person, spread false information to other incarcerated people, and encouraged violence between incarcerated people qualify as staff misconduct on the allegation decision index, which requires referral to the Office of Internal Affairs' Allegation Investigation Unit. The Centralized Screening Team's initial review of the grievance failed to identify these three allegations as staff misconduct. Following the OIG's dispute, the Centralized Screening Team upheld its original decision. However, it referred the unreasonable force allegation to the Office of Internal Affairs' Allegation Investigation Unit as a subsequent source to an existing investigation. Although the OIG did not agree with the final decision, we did not dispute the decision further because the allegations were duplicative of other allegations the Centralized Screening Team had previously referred to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

OIG Case Number 26-0154868-CSMT

Rating Assessment
Inadequate

Incident Summary

On June 20, 2026, registered nurses allegedly ignored an incarcerated person's medical call button for hours as the incarcerated person tried to request medical attention and report a jaw injury he had allegedly received from a certified nursing assistant. The incarcerated person alleged a second certified nursing assistant had engaged in abusive and threatening behavior and verbal bullying, and waived his hands in the incarcerated person's face while mocking him. During a clarification interview specifically asking about the alleged jaw injury, the incarcerated person stated the first certified nursing assistant had "backhanded" him. During a second clarification interview, the incarcerated person stated the first certified nursing assistant had "slapped [him] really hard with the back of her left hand to the right side of [his] face."

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Disposition

The Centralized Screening Team referred the allegations that registered nurses had ignored the incarcerated person's requests for medical assistance and the second certified nursing assistant's unprofessional behavior to the prison as routine allegations of staff misconduct. The OIG concurred. The Centralized Screening Team did not refer the allegation that a certified nursing assistant had caused an injury to the incarcerated person's jaw as an allegation of staff misconduct. Following the OIG's dispute, the Centralized Screening Team conducted a clarification interview and referred the unreasonable force allegation back to the prison as a routine policy claim. Following the OIG's second dispute, the Centralized Screening Team conducted a second clarification interview with the incarcerated person. Subsequently, the Centralized Screening Team referred the unreasonable force allegation to the Office of Internal Affairs' Allegation Investigation Unit and to the department's Nursing Professional Practice Council.

Case Rating

The department's performance was *inadequate*. The Centralized Screening Team should have recognized the need to conduct a clarification interview with the incarcerated person regarding the vague allegation that he had sustained a jaw injury from a certified nursing assistant but instead failed to identify the allegation as staff misconduct. Following the OIG's dispute, the Centralized Screening Team conducted a clarification interview. When the incarcerated person clarified that his jaw injury was a result of the certified nursing assistant backhanding him, the Centralized Screening Team determined the allegation to be a routine policy claim rather than an allegation of excessive or unnecessary force that is listed on the department's allegation decision index as requiring referral to the Office of Internal Affairs' Allegation Investigation Unit. When the OIG questioned the decision, the Centralized Screening Team's subject matter expert acknowledged that the incarcerated person alleged that the certified nursing assistant had backhanded him but believed that meant that the certified nursing assistant had insulted the incarcerated person as opposed to striking him. The Centralized Screening Team's subject matter expert then elected to conduct a second clarification interview, during which the incarcerated person clarified that the certified nursing assistant allegedly struck him. The Centralized Screening Team then referred the unreasonable force allegation to the Office of Internal Affairs' Allegation Investigation Unit as well as to the department's Nursing Professional Practice Council for an expedited review of elder abuse.

OIG Case Number 26-0158573-CSMT

Rating Assessment
Inadequate

Incident Summary

On July 22, 2026, an interdisciplinary treatment team denied an incarcerated person access to a higher level of mental health care, despite an increase in violent behavior. On July 27, 2026, a licensed clinical social worker allegedly falsified an incarcerated person's refusal of mental health services. On July 29, 2026, the incarcerated person

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alleged staff had failed to provide workbooks, program credits, and packages. On August 17, 2026, an officer allegedly failed to conduct thorough and timely security cell checks, which created a larger window of opportunity for the incarcerated person's suicide and delayed the response of medical services.

Disposition

The Centralized Screening Team determined the complaint contained no allegations of staff misconduct. The OIG did not concur with the decision to not classify the allegation of falsifying official records as staff misconduct. The OIG discovered during its review that the incarcerated person had committed suicide three days before the OIG reviewed the complaint. Following the OIG's dispute, the Centralized Screening Team referred the dishonesty allegation to the Office of Internal Affairs' Allegation Investigation Unit. The Centralized Screening Team also opened a direct-entry case concerning a new allegation of staff's failure to complete timely security checks and referred it to the prison as a routine allegation of staff misconduct. The OIG did not concur, but following a dispute, the Centralized Screening Team subsequently referred the negligence allegation to the Office of Internal Affairs' field operations unit.

Case Rating

The department's performance was *inadequate*. The allegation that a licensed clinical social worker engaged in falsification of an incarcerated person's official records qualifies as dishonesty, which is listed on the department's allegation decision index as an allegation requiring referral to the Office of Internal Affairs' Allegation Investigation Unit. In the initial dispute, the OIG made the Centralized Screening Team aware that the incarcerated person had committed suicide the day before its decision date. The Centralized Screening Team's subject matter expert recognized the screening team's failure to consult before reaching a decision and referred the dishonesty claim to the Office of Internal Affairs' Allegation Investigation Unit and opened a second allegation of staff's failure to conduct timely security checks based on the advanced state of rigor mortis. However, the subject matter expert referred the staff's negligence allegation to the prison as a routine claim of staff misconduct. The OIG disagreed because officers performing their security checks of cells should have discovered the body before rigor mortis would have set in and recommended the Centralized Screening Team elevate the matter to the Office of Internal Affairs' field operations unit for investigation. The Centralized Screening Team then referred the officers' alleged failure to conduct timely security checks at the time of an incarcerated person's death and referred it to the Office of Internal Affairs' field operations unit as an allegation of gross negligence that led to the death of an incarcerated person.

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OIG Case Number
26-0160555-CSMT

Rating Assessment
Inadequate

Incident Summary

Between August 7, 2026, and August 14, 2026, a psychiatric technician allegedly instructed an incarcerated person to apply prescription ointment to open lesions on a second incarcerated person's rectum, showed her how to apply the ointment, and provided her with latex gloves. The incarcerated person alleged being uncomfortable but did not believe she could refuse the direct order, and she applied ointment between the second incarcerated person's buttocks for three days.

Disposition

The Centralized Screening Team referred the allegation against the psychiatric technician to the prison as a routine allegation of staff misconduct. The OIG did not concur. Following the OIG's dispute, the Centralized Screening Team referred the allegation against the psychiatric technician to the Office of Internal Affairs' Allegation Investigation Unit for investigation as well as to the Nursing Professional Practice Council.

Case Rating

The department's performance was *inadequate*. The allegation that a psychiatric technician directed an incarcerated person to apply prescription ointment to open lesions between her roommate's buttocks qualifies as endangering the safety of both incarcerated people, creating a motive or opportunity for one incarcerated person to harm another, and improper disclosure of one incarcerated person's confidential medical information, all of which are listed on the department's allegation decision index as requiring referral to the Office of Internal Affairs' Allegation Investigation Unit. Moreover, the possibility of medical negligence or malpractice plausibly meets the criteria for a complex issue requiring specialized investigative skills or resources that warrant assignment to the Allegation Investigation Unit for investigation. The Centralized Screening Team's initial review of the complaint failed to identify the allegation as staff misconduct on the allegation decision index or as complex and requiring specialized skills. Following the OIG's elevation, the Centralized Screening Team referred the allegations against the psychiatric technician to the Office of Internal Affairs' Allegation Investigation Unit for investigation and to the Nursing Professional Practice Council per health care policy violations.

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OIG Case Number
26-0160998-CSMT

Rating Assessment
Inadequate

Incident Summary

On April 30, 2026, officers allegedly strangled an incarcerated person with a chain.

Disposition

The Centralized Screening Team referred the allegation that officers used unreasonable force on an incarcerated person to the prison as a routine allegation of staff misconduct. The OIG did not concur. Following the OIG's dispute, the Centralized Screening Team referred the allegations of unreasonable force to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

Case Rating

The department's performance was *inadequate*. The allegation that officers had strangled an incarcerated person with a chain qualifies as unreasonable force, which is listed on the department's allegation decision index as requiring a referral to the Office of Internal Affairs' Allegation Investigation Unit. The Centralized Screening Team's initial review of the grievance determined the allegation to be unprofessionalism and misconduct not on the allegation decision index. Following the OIG's dispute, the Centralized Screening Team referred the allegation to the Office of Internal Affairs' Allegation Investigation Unit for investigation.

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