

VIA EMAIL ONLY

Prison Law Office

General Delivery, San Quentin, CA 94964 Telephone (510) 280-2621 • Fax (510) 280-2704 www.prisonlaw.com

October 17, 2025

Nicholas Mitchell Use-of-Force Consultant

RE: Armstrong v. Newsom

Plaintiffs' Counsel's Letter to Use-of-Force Consultant re:

Dkt. No. 3720

Dear Mr. Mitchell:

Executive Director: Margot Mendelson

Attorneys: Rana Anabtawi Patrick Booth

Tess Borden Rosalind Dillon Steven Fama Daniel Greenfield Mackenzie Halter Alison Hardy Sophie Hart

Sophie Hart Lily Harvey Ashe Huang Jacob Hutt Heather MacKay

Megha Ram Donald Specter Jerrod Thompson

We are counsel for the plaintiff class in *Armstrong v. Newsom*, a class action on behalf of people with certain disabilities who are incarcerated in the California Department of Corrections and Rehabilitation ("CDCR"). We are providing this letter to you because you have been retained by CDCR as a use-of-force consultant, pursuant to a September 26, 2025 stipulation between the parties in *Armstrong. See* Dkt. 3720. Per the stipulation, you will "review and offer recommendations about CDCR's use-of-force policies and practices, use-of-force training, and the Institutional Executive Review Committee (IERC) process." *Id.* at 4. You will also "provide recommendations on whether the IERC, or some entity other than [Office of Internal Affairs ("OIA")], can conduct comprehensive and unbiased investigations ... into allegations of staff misconduct based on use-of-force policy violations." *Id.* And you will describe "what, if any, modifications to Defendants' policies and procedures are necessary for the IERC, or some entity other than OIA, to conduct comprehensive and unbiased investigations into allegations of staff misconduct based on use-of-force policy violations." *Id.*

The stipulation arose out of ongoing negotiations between Plaintiffs and CDCR in the *Armstrong* lawsuit regarding CDCR's accountability system, including how the system holds officers accountable for improper uses of force. As discussed more fully below, the *Armstrong* court issued orders in 2020 and 2021 finding that staff at six CDCR prisons were repeatedly violating the rights of people with disabilities without facing any consequences. The orders required CDCR to revamp its investigation and discipline process. In 2022, the parties reached agreement on CDCR's plan for its new accountability system. Essential features of that system include that all use-of-force allegations be investigated by OIA (rather than by staff at the prison who may be more biased), that CDCR implement body-worn and fixed cameras at the six prisons covered by the orders, and that CDCR produce to Plaintiffs' counsel all investigation and discipline case files involving people with disabilities at those same six prisons.

Since 2022, we have reviewed thousands of staff misconduct investigations that CDCR has produced to us, including many hundreds of investigations involving allegations of unnecessary and excessive uses of force. Through our extensive review, we have found that (1) staff frequently use unnecessary and excessive force and (2) CDCR frequently fails to hold staff accountable for those use-of-force policy violations.

Plaintiffs entered into the stipulation to have you review the use-of-force system with the goal that you could identify why, notwithstanding the changes to the accountability system and other court-initiated efforts (discussed below), there has been little improvement to CDCR's use-of-force practices. We expect that you will consider whether changes are needed to CDCR's use-of-force policies, trainings, and review/accountability systems. Relatedly, we expect that you will evaluate the need for the availability of video footage—especially body-worn camera footage which includes audio—in order for CDCR to reduce improper uses of force.

Plaintiffs understand that CDCR entered into the stipulation to have you explore whether the IERCs, rather than OIA, could perform use-of-force investigations. CDCR has claimed that the staff misconduct complaint system is overwhelmed by the number of cases routed to OIA. CDCR has proposed that, to resolve caseload issues, the parties agree to allow CDCR to use the IERCs, which are located at each of CDCR's prisons, to investigate use-of-force allegations.

Unless CDCR makes significant changes, Plaintiffs have serious concerns about this proposal. First, tasking the local IERCs to investigate use-of-force allegations, rather than having those allegations investigated by headquarters-based OIA, would undermine one of the *Armstrong* court-ordered changes to CDCR's accountability system—that, to reduce bias in investigations, staff from outside the prisons must conduct investigations into serious allegations of staff misconduct. It is our position that, to reduce bias, all allegations of unnecessary or excessive force must either be investigated by or resolved by staff from outside the prisons. Second, as discussed below, the IERC has a terrible track record of identifying use-of-force violations. It is unclear to us how the IERC can become the primary entity for identifying excessive and unnecessary uses of force when it currently fails at that task. Third, only 10 of CDCR's 31 institutions have body-worn cameras, which, as we discuss below, are essential for being able to determine whether staff have violated use-of-force policies (especially policies requiring de-escalation) and for collecting evidence to hold such staff accountable.

This letter is intended to assist you in conducting your review of CDCR's use-of-force system. In Part I, we describe below the history of CDCR's troubled use-of-force system, including decades of sweeping court orders in *Armstrong* and other cases aimed at reducing the level and frequency of force used on people with disabilities. In Part II, we provide examples from specific staff misconduct cases illustrating current and ongoing violations of existing use-of-force policies and court orders. All of the examples include audio-video evidence of the uses of force. Viewing the audio-video evidence, linked below, is essential to understanding that the system is in dire need of reform. These cases are not isolated incidents but instead represent examples of problems seen across hundreds of cases spanning multiple

years at multiple prisons. In particular, our case review shows that officers use force much too quickly and often when a situation could likely be resolved without force. Officers commonly resort to force when a person presents no immediate threat, fail to employ de-escalation techniques that could avoid force altogether, and use excessive force, including the use of near-lethal force when such force is clearly unnecessary. Crucially, in every case we discuss, CDCR determined that the force was neither excessive nor unnecessary. As a result, CDCR did not hold a single officer accountable for any of these uses of force. In Part III, we explain how these cases demonstrate the failure of CDCR to recognize patterns of problems, to implement the *Armstrong* court orders, and to take appropriate action to prevent similar incidents in the future. Finally, in Part IV, we provide a series of questions that we would like you to consider as you review CDCR's use-of-force system and consider which recommendations to offer.

We are optimistic that your recommendations will help CDCR identify and address use-of-force violations in order to ensure compliance with existing court orders, to prevent future additional litigation, and, most importantly, to protect people with disabilities from being subjected to unnecessary and/or excessive force.

	Sincerely,
	PRISON LAW OFFICE
	ROSEN BIEN GALVAN & GRUNFELD LLP
cc:	

Table of Contents

I.	THREE DECADES OF COURT INTERVENTION AIMED AT REDUCING FORCE IN CDCR	. 1
	A. In 2020 and 2021, the Armstrong Court Overhauled CDCR's Use-of-Force Review Process .	. 1
	B. In 1995, the <i>Madrid</i> Court Ordered Broad Changes to CDCR's Use-of-Force Review Process to Address Unconstitutional Force and Ineffective Oversight	
	C. In 2014, the <i>Coleman</i> Court Ordered Significant Changes to CDCR's Use-of-Force Policies to Reduce Force.	
II.	CURRENT PROBLEMS WITH CDCR'S USE OF FORCE	.5
	A. CDCR Officers Use Unnecessary Immediate Force	.5
	i. CDCR Officers Use Immediate Force When No "Imminent Threat" Exists	.6
	ii. CDCR Officers Fail to Use De-Escalation Techniques to Avoid Force1	0
	iii. Potential Problems with CDCR's Policies and Interpretation of Its Policies	13
	B. CDCR Officers Use Excessive Force	15
	i. CDCR Policy Should Make Clear that Head Strikes are Excessive1	8
Ш	CDCR DOES NOT HOLD STAFF ACCOUNTABLE FOR MISUSING FORCE	9
	A. Investigations into Allegations of Excessive or Unnecessary Force Are Not Adequate1	9
	B. CDCR Does Not Use BWCs at All Prisons	20
	C. Hiring Authorities, Both as the Decision-Makers on OIA Investigations and the Head of the IERCs, Do Not Sustain Use-of-Force Violations	21
	D. CDCR Has Not Properly Used its Early Warning System	22
	E. Findings by the Office of the Inspector General Confirm that CDCR Has a Serious Problem With Uses of Force	23
IV	. INFORMATION AND QUESTIONS TO CONSIDER DURING A REVIEW OF CDCR'S USE-O FORCE POLICIES AND PRACTICES2	
	A. Relevant Information to Consider During the Review	24
	B. Important Questions to Consider During the Review	24

I. THREE DECADES OF COURT INTERVENTION AIMED AT REDUCING FORCE IN CDCR

Over the last 30 years, multiple federal courts have found that CDCR's use-of-force policies and practices violate the Constitution and other federal laws. In turn, those courts have imposed remedies to attempt to address use-of-force incidents in CDCR.

A. In 2020 and 2021, the *Armstrong* Court Overhauled CDCR's Use-of-Force Review Process

Armstrong v. Newsom is a long-standing class action under the Americans with Disabilities Act and the Rehabilitation Act involving the rights of people with certain disabilities incarcerated throughout CDCR. See generally Armstrong v. Wilson, 942 F. Supp. 1252 (N.D. Cal. 1996), aff'd, 124 F.3d 1019 (9th Cir. 1997) (describing the factual and legal background of the case). Plaintiffs' counsel monitors Defendants' compliance with the overarching remedial plan in the case (called the Armstrong Remedial Plan ("ARP")) and the ADA on an ongoing basis and have brought multiple enforcement motions to bring Defendants into compliance.

Beginning in 2007, the *Armstrong* court issued a series of orders aimed at reducing disability-related staff misconduct. A 2007 order required CDCR to log and investigate allegations of non-compliance with federal disability rights laws, CDCR policies, and court orders. *See Armstrong v. Schwarzenegger*, No. C 94-2307 CW (N.D. Cal. Jan. 18, 2007), Dkt. No. 1045. In 2012, the Court found that Defendants were not complying with the 2007 order and ordered that Defendants timely investigate allegations of non-compliance and provide Plaintiffs with the documents underlying the investigation. *See Armstrong v. Brown*, No. C 94-2307 CW, 2012 WL 3638675, at *11 (N.D. Cal. Aug. 22, 2012), *aff'd in part, vacated in part, remanded*, 768 F.3d 975 (9th Cir. 2014). In 2020, in response to reports from class members that staff misconduct, including improper uses of force, impacted their ability to request and receive disability accommodations, Plaintiff filed two enforcement motions, which the Court granted almost in full. *See Armstrong v. Newsom*, 484 F. Supp. 3d 808, 816, 845 (N.D. Cal. 2020), *Armstrong v. Newsom*, No. 94-CV-02307 CW, 2021 WL 933106, at *26 (N.D. Cal. Mar. 11, 2021).²

The class includes incarcerated people and parolees with upper and lower extremity mobility disabilities, vision disabilities, hearing disabilities, learning disabilities, speech disabilities, and kidney disabilities (*i.e.*, individuals receiving dialysis treatment), and parolees with cognitive/intellectual disabilities.

These orders were consolidated on appeal, and the Ninth Circuit largely affirmed the district court's order, vacating only remedial measures about modifying pepper-spray policies and increasing supervisory staff in the Five Prison order. *See Armstrong v. Newsom*, 58 F.4th 1283, 1301 (9th Cir. 2023).

The court described numerous examples of people with disabilities being punched in the face, slammed to the ground, or improperly pepper-sprayed after staff failed to take their disabilities into consideration during use-of-force incidents. *See Armstrong*, 2021 WL 933106, 4–6, *Armstrong*, 484 F. Supp. 3d 808, 824–27. The court further found that, "[a]s a result of the intimidation, threats, and coercion, these disabled inmates suffered injury in the form of giving up their rights to make requests for reasonable accommodations or to file ADA grievances, or in the form of severe emotional distress." *Armstrong*, 484 F. Supp. 3d 808, 845; *see also Armstrong*, 2021 WL 933106, at *26.

The court determined that the root cause of these violations of class members' rights was CDCR's inadequate staff investigation and discipline system, which failed to hold staff accountable for engaging in misconduct. The court concluded that CDCR's "system for investigating staff misconduct is deficient and ineffective" and that "the results of any investigations conducted pursuant to that system cannot be relied upon to hold wardens and staff accountable for violations of the ARP and ADA." Armstrong, 2021 WL 933106, *13. CDCR's accountability system at that time relied on local staff to initially investigate allegations of misconduct, including use-of-force allegations. OIA only investigated an allegation if local prison staff elevated the case to OIA, which occurred very infrequently. Concurrent with that process, the IERC, which is also made up of local prison staff, reviewed all uses of force to determine whether staff violated policy.

In rebuking that system, the court cited several reports from the Office of Inspector General (OIG) that concluded CDCR's local investigation system had a "lack of independence" and that CDCR should "reassign the responsibility of conducting staff complaint inquiries to employees who work outside of the prison's command structure[.]" *Id.* at *12 (quoting a January 2019 OIG Report). The court recounted how, according to an OIG report, wardens at local prisons undermined the staff accountability process. *Id.* at *12-13; *see also id.* at 13 ("The OIG expressed a 'deep concern[] about the low rate at which wardens determined their staff violated policy") (quoting a February 2021 OIG Report). Both the local investigation process and the IERC were unable to produce unbiased, meaningful investigation results.

For these reasons, the *Armstrong* court ordered the Department to implement specific remedial measures, including installing fixed surveillance cameras and body-worn cameras; reforming the staff complaint, investigation, and discipline processes to perform "comprehensive and unbiased investigations" and to "impose consistent and appropriate discipline"; monitoring by the court-appointed expert of staff investigation and discipline processes; and sharing information with Plaintiffs' counsel and the Court Expert. *See Armstrong*, 58 F.4th 1283, 1291–92 (summarizing the district court's orders). While these orders explicitly covered six prisons—RJD, CIW, COR, KVSP, LAC, SATF (the "Six Prisons")—much of the relief ordered impacts CDCR's statewide processes, including the staff misconduct investigation process, as CDCR generally operates only one staff misconduct system.³

³ CDCR currently operates 31 prisons. California Department of Corrections & Rehabilitation, List

Thereafter, the parties negotiated and agreed to remedial plans regarding CDCR's plans to comply with the court's orders ("Remedial Plans"). As required, CDCR implemented body-worn and fixed cameras at the Six Prisons. In addition, CDCR agreed to revamp its staff misconduct investigation process. Under the new system, all allegations of "serious" staff misconduct, including all use-of-force allegations, are investigated by OIA, rather than local prison staff. The intention behind this change was to eliminate the consistent bias introduced into investigations by local staff and to ensure better trained and more experienced investigators conducted the investigations. The categories of "serious" staff misconduct are listed on the Allegation Decision Index (ADI). When an incarcerated person makes an allegation of staff misconduct that falls into one of the ADI categories (*e.g.*, improper use of force), the allegation is automatically routed to OIA for investigation.

B. In 1995, the *Madrid* Court Ordered Broad Changes to CDCR's Use-of-Force Review Process to Address Unconstitutional Force and Ineffective Oversight

Three decades before the *Armstrong* staff misconduct orders, a federal court ordered CDCR to make sweeping changes to its use-of-force system because staff were misusing force and local prison administrators were not holding staff accountable. *See Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

The *Madrid* court held that CDCR staff at a particular prison "repeatedly violated" "the Eighth Amendment's restraint on using excessive force," "leading to a conspicuous pattern of excessive force." *Id.* at 1161. The court found that, "[i]n many instances, there was either no justification for the use-of-force," or "the use-of-force was appropriate, but the amount of force applied was so strikingly disproportionate to the circumstances that it was imposed, more likely than not for the very purpose of causing harm, rather than in a good faith effort to restore or maintain order." *Id.* According to the court, CDCR officials knew that officers were employing "unnecessary and grossly excessive force ... on a frequent basis," yet they "consciously disregarded the risk of harm, choosing instead to tolerate and even encourage abuses of force by deliberately ignoring them when they occurred, tacitly accepting a code of silence, and, most importantly, failing to implement adequate systems to control and regulate the use-of-force." *Id.* at 1251.

The *Madrid* court also found that CDCR's structure for reviewing non-lethal force was "strikingly deficient." *Id.* at 1146, 1187. In response, the court ordered CDCR to change its prison-level use-of-force review system, leading to creation of the IERC. The IERC, which consists of multiple levels of reviewers

of Adult Institutions, https://www.cdcr.ca.gov/adult-operations/list-of-adult-institutions/ (last visited Oct. 11, 2025). Those 31 prisons generally have uniform staff misconduct investigation processes and use-of-force policies.

⁴ Plaintiffs can provide the Allegation Decision Index upon request.

from the lieutenant-level up to the warden, reviews each use of force, regardless of whether there has been an allegation of unnecessary or excessive use of force, to assess "whether the staff's actions prior to, during, and subsequent to the force used" were compliant with relevant laws, regulations, and CDCR policies. 15 C.C.R. § 3268.1(e)(1); DOM § 51020.19(b). If the IERC identifies policy violations, it can recommend training, corrective action, or adverse action, though any adverse action requires an OIA investigation. DOM § 51020.19.5(l). More broadly, it can also recommend system-wide changes to training or procedure. *Id*.

However, as recognized by the *Armstrong* court and as illustrated by the case discussions below, the IERC almost always serves as a rubber-stamp on inappropriate uses of force. Since the *Armstrong* court's 2020 and 2021 orders rejecting the IERC and the local investigation system, CDCR has not made any changes to improve the IERC. In light of the *Armstrong* court orders, it is unclear how CDCR believes that the same IERC process can now function as an effective use-of-force review committee.

C. In 2014, the *Coleman* Court Ordered Significant Changes to CDCR's Use-of-Force Policies to Reduce Force

In a case involving the class of people with mental illness in CDCR, a federal court in 2014 found that CDCR's use of force against people with mental illness violated the Eighth Amendment and demonstrated a "failure to properly consider the mental state of class members" *Coleman v. Brown*, 28 F. Supp. 3d 1068, 1078 (E.D. Cal. 2014). The court found that the constitutional violation arose from policies and practices of use of force against seriously mentally ill class members "without regard to (1) whether their behavior was caused by mental illness and (2) the substantial and known psychiatric harm and risks thereof caused by such applications of force." *Id.* As in *Madrid*, the court found that violations of the use of force policy "demonstrate[] the constitutional inadequacy of either the regulations or the review process." *Id.* at 1081.

In response to the court's order, CDCR made "substantial changes" to its use-of-force policies and practices, with explicit guidelines and limitations on uses of force, codified the requirement that staff consider the totality of the circumstances (including the mental health state of the individual) before resorting to force, and required staff to consider alternatives to force. *Coleman*, No. 2:90-cv-00520-LKK-DAD (E.D. Cal. Aug. 11, 2014), ECF No. 5196. CDCR also changed its controlled use of force policies, described in more detail below (*see below*, § II.A), to add protections for people with serious mental illness and to ensure that officers resort to force less frequently. Notwithstanding efforts by the *Coleman* court, current CDCR data shows that 86% of use-of-force incidents statewide involve people with mental health issues. (*See* Compstat report for August 2025, the most recent month publicly available, showing that out of a total of 1,095 documented uses of force, 946 incidents involved those with mental health issues.)

II. CURRENT PROBLEMS WITH CDCR'S USE OF FORCE

These court interventions to reduce excessive and unnecessary uses of force in CDCR have not been successful. As discussed above, as part of the *Armstrong* court's orders in 2020 and 2021, CDCR produces to us all completed staff misconduct investigation case files where the claimant is a person with a disability. These cases include many incidents in which the incarcerated person alleges that staff used unnecessary or excessive force. Most of the use-of-force cases include video—body-worn camera and/or fixed camera footage—of the incidents. Our review of these videos show that over-and-over again, CDCR officers routinely resort to using force too quickly, without appropriate justification, and without employing the *Coleman* court-ordered de-escalation techniques that are now required by policy. Additionally, CDCR officers escalate situations into dangerous use-of-force incidents and commonly use significantly more force than is necessary to accomplish their penological goals.

Below, we provide summaries of the relevant use-of-force policies. We then provide short summaries of incidents, along with links to relevant video and documentary evidence from the investigation case files, in which CDCR officers violated policy and endangered incarcerated people with unnecessary and excessive uses of force. The purpose of these examples is to highlight weaknesses in CDCR's use-of-force review process and to show how, in practice, uses of force frequently do not comply with policy. Importantly, in none of the cases discussed below did CDCR—either through the staff misconduct investigation process or the IERC—find that the force was unnecessary or excessive. In other words, CDCR did not hold any of the officers accountable for using improper force.

A. CDCR Officers Use Unnecessary Immediate Force

Current policy permits officers to use either "immediate force" or "controlled force." *See* 15 C.C.R. § 3268(4) and (6). Immediate force is permissible only "to respond to a situation or circumstance that constitutes an **imminent threat** to institution/facility security or the safety of persons." 15 C.C.R. § 3268(4) (emphasis added); DOM § 51020.4(a)(4)(A) (same). An "imminent threat" is "any situation or circumstance that jeopardizes the safety of persons or compromises the security of the institution, requiring immediate action to stop the threat." 15 C.C.R. § 3268(5); DOM § 51020.4(a)(5)(A). Examples of imminent threats "include, but are not limited to: an attempt to escape, on-going physical harm or active physical resistance." 15 C.C.R. § 3268(5); DOM § 51020.4. Typically, immediate uses of force "may be necessary to subdue an attacker, overcome resistance, effect arrest and custody, or prevent escape." 15 C.C.R. § 3268(4); DOM § 51020.4(a)(4)(B). But an incarcerated person's failure to comply with a lawful order, on its own, is not an imminent threat. 15 C.C.R. § 3268(4); DOM § 51020.4(a)(4)(C).

By contrast, officers can use controlled force "when there is not an imminent threat but an incarcerated person's presence or conduct poses a threat to safety or security and the incarcerated person is located in an area that can be controlled or isolated." 15 C.C.R. § 3268(6); DOM § 51020.4(a)(6)(A). Controlled uses of force include a number of safeguards and are designed to avoid the need for force

altogether. During a controlled use-of-force, staff must allow the incarcerated person to have a cool down period, during which time the incarcerated person has an opportunity to comply with custody staff orders. DOM § 51020.12(d). Force can be used only once a high-ranking custody supervisor and the mental health clinician determine that reasonable efforts to avoid force have been exhausted during the cooldown period. DOM § 51020.12(i). Before using either immediate or controlled force, officers must attempt whenever possible to use verbal persuasion to prevent the need for force. 15 C.C.R § 3268(b)(1); DOM § 51020.5(a).

The cases below reveal that CDCR officers violate these policies in numerous ways. Most significantly, officers use immediate force when no imminent threat exists, officers fail to use descalation techniques prior to employing immediate force, and officers escalate situations that do not require force, at times creating an imminent threat that justifies their force. These cases are illustrative of these problems. For each issue area below, Plaintiffs have identified dozens of other cases that reveal the same problems, demonstrating that these are not isolated incidents but rather are part of an ongoing pattern of misconduct that across multiple prisons.

i. CDCR Officers Use Immediate Force When No "Imminent Threat" Exists

CDCR officers routinely use immediate force when incarcerated people do not pose an "imminent threat." This problem has existed in CDCR for many years. In 2014, the *Coleman* court found that "for an extended period of time CDCR staff have been working with a broad definition of 'imminent threat,'" and that "immediate use-of-force has been used with far greater frequency than authorized by the written policy." *Coleman*, 28 F.Supp.3d 1068, 1082, 1083; *see also id.* at 1082 (CDCR's own expert opining that he identified "fairly quickly a number of incidents categorized as 'immediate' uses of force that evidence showed could have been managed through 'controlled force.").

The same problems continue today. The cases below include a variety of situations in which officers resorted to using force too quickly and in the absence of any imminent threat. In many of the cases below, the incarcerated person is handcuffed and being escorted, and after their slight resistance (or sometimes no resistance at all), the escort officers throws the incarcerated person to the ground, usually face-first. Not only is the amount of force in these situations objectively unreasonable, the decision to use force at all is often not justified under policy. In these incidents, the officer, at best, has not evaluated the threat level that exists and the action that is warranted in response; at worst, the incarcerated person does not present an imminent threat and no force is justified.

In reviewing these cases and videos, please consider the following questions:

1. What, if any, changes need to be made to CDCR policies to make clear that sworn staff can only use immediate force if there is an imminent threat?

- 2. What, if any, changes need to be made to CDCR training to ensure sworn staff understand what constitutes, and can recognize in practice, an imminent threat?
- 3. What, if any, changes need to be made to CDCR training to ensure sworn staff understand the imminent threat standard during escorts?
- 4. What, if any, changes need to be made to CDCR training to ensure sworn staff understand that an incarcerated person's failure to comply with a lawful order does not constitute an imminent threat?
- 5. What, if any, changes need to be made to CDCR policies to make clear that sworn staff must take into account an incarcerated person's disability, including mental health disabilities, before, during, and after using force?
- 6. What, if any, changes need to be made to CDCR training to ensure that sworn staff take into account an incarcerated person's disability, including mental health disabilities, before, during, and after a use-of-force incident?
- being escorted from administrative segregation to an emergent medical evaluation, an incarcerated person momentarily pauses. As shown on the AVSS, the escort officer immediately sweeps the incarcerated person's feet from under him and throws him face-first to the ground. Because his hands were cuffed behind his back, the incarcerated person was unable to brace himself at all. The incarcerated person tells the officer that he "tripped a little," that he did not mean to stop the escort, and apologizes. The officer responds, "No, you didn't. Do not stop my escort ever again, you understand me?" In his incident report, the officer claimed that the incarcerated person tried to break away from the escort, stopped the escort, and made contact with the officer's chest. *See* at 48. But the video shows none of those actions occurring.
- An elderly incarcerated person who is cuffed and in a wheelchair had just been transferred to a prison and was refusing to accept what he believed was a protective custody housing assignment to which he had not consented. The incarcerated person and the escorting sergeant and lieutenant are on an empty yard at night. The supervisors repeatedly insist that they are going to take the incarcerated person to a specific housing unit and will use force to do so if necessary. The incarcerated person repeatedly verbally refuses, requesting that they take

Each case throughout this letter has a case number, which includes the abbreviation from CDCR prison where the allegation originated and an eight-digit file number (e.g., exception). For each case, we provide a hyperlink to the case file, which includes documentary evidence, and separate links to the video footage (fixed-camera footage labeled "AVSS" and body-worn camera footage labeled "BWC").

him to administrative segregation instead. At one point, the incarcerated person asks if the officers are going to throw him to the ground and "give him a case." The incarcerated person then begins slowly using his feet to move his wheelchair forward. Both supervisors then start dragging the incarcerated person backward in his wheelchair, against his will, while pulling firmly backward on the waist-chain. The incarcerated person leans forward, complaining that he cannot breathe because of the pressure from the waist-chain. He then slowly slides forward out of the front of his chair, all while still being pulled backward by the supervisors. The supervisors then force him to the ground. The incarcerated person states that his back, neck, and legs are injured. Despite the incarcerated person's requests that the supervisors not move him, they then lift him from the ground and place him back in his wheelchair.

- An incarcerated person expressed suicidality and needed to be escorted to a clinic. Prior to the use of force, while the incarcerated person was still in his cell, he and an escort officer had and then resolved a disagreement about the incarcerated person's jumpsuit. (The investigator did not retain the video footage of this initial interaction.) Once the incarcerated person is outside of his cell, he informs a sergeant and five other officers who are in the otherwise unoccupied dayroom that he does not want to be escorted by the escort officer. The sergeant and officers inform the incarcerated person that he does not get to choose who escorts him and order him to proceed with the escort. The incarcerated person repeatedly told the officers to "make me" proceed with the escort. Throughout the time period, he remains still and does not move his body. The escort officer tells the incarcerated person that he is giving him a direct order to proceed. After about twenty more seconds of the incarcerated person standing still and telling the escort officer to "make me go," the officer throws him to the ground.
- Prior to the force, officers responded to an in-cell fire. The incarcerated person, who has a mobility disability and a medical order to be cuffed using waist restraints and not with cuffs behind his back, exits the cell and walks to his walker, which is positioned right outside the cell door. An officer places a cuff on one of the incarcerated person's wrists and reaches to cuff the other wrist behind the person's back. The incarcerated person throws his hands up and says, "I don't get cuffed like that!" The incarcerated person sits on his walker. The officer immediately grabs the incarcerated person by the back of the neck, throws him and his walker to the ground, and lays on top of him for approximately 15 seconds before staff begin twisting the incarcerated person's arms to handcuff him behind his back. While on the ground, the incarcerated person yells in pain and says that he has special cuffing, that his shoulder is torn, and that his wrist cannot be cuffed.
- An incarcerated person passively refuses a sergeant's order to submit to restraints. In response, the sergeant suddenly grabs the incarcerated person by the arm and throws him to the ground with his entire body weight.

- Officers use OC spray on a mentally ill incarcerated person through the food port of his cell door after he refuses to move his arm from the food port.
- Officers used force twice in a several-minute timespan on an incarcerated person with mobility and vision disabilities who was handcuffed. The first use of force occurs 10:10:32 and is best viewed on BWC 1 and AVSS 1, the other at 10:12:25 and best viewed on BWC 2, BWC 3, and AVSS 2. In the first use of force, an officer gives him a "direct order" to go back to his cell even though the incarcerated person had expressed safety concerns. The incarcerated person is seated in an office and in waist restraints while two escort officers stand on either side of him. As the incarcerated person stands up to exit the room and begins walking, he slightly moves his left arm forward to shrug off one of the escort officers. The other escort officers reacts by immediately pulling the incarcerated person to the ground. While on the ground, officers apply leg restraints to the incarcerated person, and they continue escorting him out of the program office. During the escort, a different officer, who is holding the incarcerated person's left bicep, tells him twice, "Do not be tensing up like that." He then immediately grabs the incarcerated person by the back of the head and brings him to the ground.
- During an escort, the officer declines a request by the incarcerated person to speak with another incarcerated person in a nearby cell. After the incarcerated person takes a few steps in the direction of the cell, the officer pulls on the incarcerated person's arm and says, "Don't do this." About one second later, the escort officer grabs the incarcerated person's throat with his right hand and forcefully pushes backward, while using his left leg take the incarcerated person's legs out from under him, causing him to temporarily be airborne. The incarcerated person lands extremely hard on his back and head, unable to brace his fall. The escort officer then says, "I told you. You're fucking resisting me, bro. You don't fucking guide this. You don't fucking guide this. I'm letting you know."
- An officer is escorting a mentally ill incarcerated person through an empty day room. The incarcerated person takes a few steps, then tries to talk with another incarcerated person in a cell. The escort officer tells the incarcerated person not to stop the escort and "we aren't doing that right now," then begins to walk forward while pulling on the incarcerated person's arm. The incarcerated person turns back to the officer and twice says, "Don't fucking pull on me." After the second comment, the escort officer tackles the incarcerated person to the ground.
- Cuffed and using a walker—is walking towards a transport van while making inappropriate comments to a patio officer standing around 50 feet away. Eventually, the patio officer yells to the

escort officer, "Hey! Take control of the fucking escort and take the inmate back to the building!" The incarcerated person slightly turns his body and again yells profanities back at the officer on the patio and says he will kill the officer; the threat is not credible because he is handcuffed and walking away from the officer. Shortly thereafter, the escort officer places his hand on the back of the incarcerated person's head and slams him head-first into the concrete, sending the incarcerated person toppling over his walker.

- An officer orders the incarcerated person and several others in the dayroom to "take it in," but the incarcerated person declines to move until he fills up his water bottle. The officer escalates the situation and grabs the incarcerated person's left arm and pushes him against the wall. This leads to an extended struggle between the incarcerated person, that officer, and another officer. The incarcerated person sustained multiple lacerations to the tendons in his hand and had to receive sutures and then surgery following the incident.
- An incarcerated person is refusing to return to his cell because of a cellmate compatibility issue; he peacefully protests by sitting at a table in the dayroom. In response, the officer in the building conducts a retaliatory cell search, then escalates the situation to a use-of-force incident. The incarcerated person did not present an imminent threat; therefore, an immediate use of force was not justified.
- An officer slams a mentally ill, handcuffed incarcerated person to the ground during an escort from a mental health group. Although the incarcerated person was not consistently facing forward during the escort as the officer ordered, and was making strange and inappropriate comments, the incarcerated person did not pose an imminent threat at or before the force was initiated.

ii. CDCR Officers Fail to Use De-Escalation Techniques to Avoid Force

Pursuant to California statutes, regulation, and policy, CDCR officers must use de-escalation techniques to avoid using force when possible. The Government Code requires CDCR to maintain a policy that includes "[a] requirement that officers utilize deescalation techniques, crisis intervention tactics, and other alternatives to force when feasible." Cal. Gov't Code § 7286(b)(1). The Penal Code requires that CDCR provide "regular and periodic" training to officers on "[d]eescalation and interpersonal communication training, including tactical methods that use time, distance, cover, and concealment, to avoid escalating situations that lead to violence." Cal. Penal Code § 13519.10(a), (b)(2). Regulations and policies instruct CDCR officers to "accomplish custodial and correctional functions with minimal reliance on the use-of-force." 15 C.C.R § 3268(b); DOM § 51020.1(a). Before using force, officers must attempt whenever possible to use verbal persuasion to prevent the need for force. 15 C.C.R § 3268(b)(1); DOM § 51020.5(a). The verbal persuasion should take into account the incarcerated

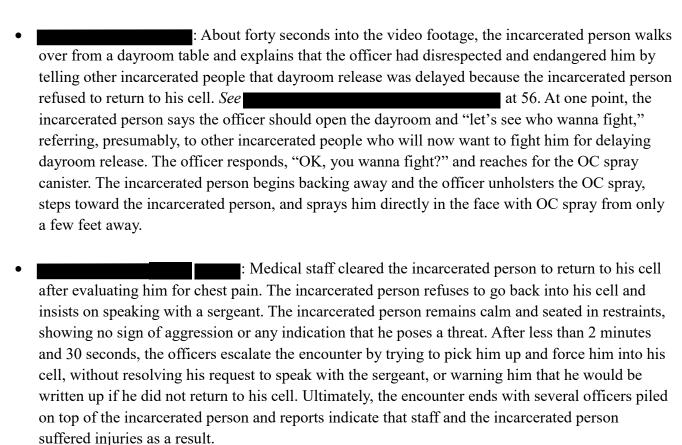
person's ability to understand what is going on. DOM § 51020.5(a) (requiring staff to "evaluate the totality of circumstances involved . . . includ[ing] consideration of an inmate's demeanor, bizarre behavior, mental health status if known ... as well as ability to understand and/or comply with orders ... to determine the best course of action and tactics to resolve the situation"). Officers should only use force if "verbal commands and de-escalation techniques do not work, or are not feasible in light of the situation." 15 C.C.R. § 3268(b)(2).

Notwithstanding these clear mandates, CDCR officers routinely fail to attempt to de-escalate situations. The de-escalation failures are closely related to the problem of officers rushing too quickly to use immediate force, as illustrated in the section above. As described in the cases below, officers consistently use force without first de-escalating or, even worse, after escalating a situation. This is especially true when the incarcerated person is simply attempting to have their concern addressed by a supervisor and staff appear determined to resolve the matter with force instead. Of heightened concern are instances when an alarm is sounded. The alarm appears to be the green-light signal for force. In numerous cases, back-up staff members rush to the scene apparently for the purpose of using force rather than, per policy, evaluating the totality circumstances to determine whether and how much force is necessary.

In reviewing these cases and videos, please consider the following questions:

- 1. What, if any, changes need to be made to CDCR policies to make clear that, when possible, sworn staff must attempt to de-escalate situations prior to using force?
- 2. What, if any, changes need to be made to CDCR training to ensure sworn staff understand the obligation to de-escalate?
- 3. What, if any, changes need to be made to CDCR training to ensure sworn staff are proficient in de-escalation techniques?
- An incarcerated person has a verbal dispute with the librarian. After about a minute, the librarian hits her alarm. The incarcerated person immediately and calmly sits down, waiting for officers to arrive. Two officers enter the library and begin yelling at the incarcerated person to turn around and cuff up. The incarcerated person remains seated, and attempts to explain: "Hold up, hold up, let me get my legal work ... please this is about making copies, sir. Please find out what the incident is before you cuff me up. No violence has happened." The officers continue to yell at the incarcerated person. Shortly after a sergeant enters the library, the incarcerated person continues trying to reason with staff: "There's no violence, look at what they're doing, look at the video cam from before they jumped, there's no violence, sir." The incarcerated person has his hands up in front of him and says, "I just wanted some copies made of some legal work, that's it Sarge. There's no need to get violent, please Sarge." Instead of embracing the incarcerated person's attempts at de-escalation, the sergeant continues ordering him

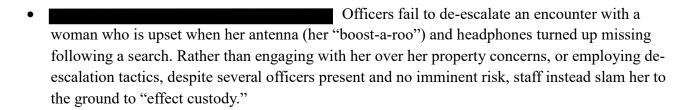
to cuff up. Officers then force the incarcerated person to his feet, before taking him down to the ground, knocking his glasses off.

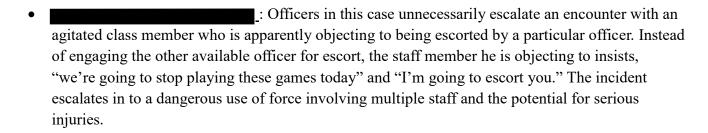


- Care to be a second of the first officer unnecessarily escalates a situation that another officer was actively engaged in dees calating, and then rushes across the dayroom to pepper spray two incarcerated people who did not pose any immediate threat. The officer also antagonized dozens of other incarcerated people who were suffering from exposure to pepper spray, including by challenging people to fight him.
- Officers placed an incarcerated person in a chokehold and flipped him over backward in his wheelchair, all because he had a pair of sunglasses in his pocket in an area of the prison where they were purportedly not allowed. The incident unnecessarily escalated when, rather than giving him an opportunity to vacate the area and return the glasses, or threatening to issue discipline, the officer reached into the incarcerated person's

The Hiring Authority sustained an allegation of "discourtesy" in this case, but did not sustain any use-of-force violations.

pocket and grabbed the glasses, resulting in a strong reaction and protests from the class member, apparently because they belonged to a deceased friend.





In other cases, officers seem to misunderstand the meaning of de-escalation. For example, in an officer who improperly used immediate force claimed in an interview with a staff misconduct investigator that he "chose to de-escalate the situation by using Physical Force to subdue" the incarcerated person. That is an obvious misunderstanding of the de-escalation requirement, which is meant as a tactic that is an alternative to force.

iii. Potential Problems with CDCR's Policies and Interpretation of Its Policies

We have identified two issues with CDCR policies that we would like you to examine. First, there exists a gap in CDCR's definitions of immediate and controlled usees of force. Staff can only use immediate force in response to an imminent threat. Conversely, when an incarcerated person poses a *non-imminent threat* to safety and security and "is located in an area that can be controlled or isolated," staff, if they are going to use force, must use controlled force. 15 C.C.R. § 3268(6); DOM § 51020.4(a)(6)(A). But the policies do not make clear how staff should approach a situation where an incarcerated person poses a non-imminent threat but is not located in an area that can be controlled and isolated. For example, policy does not make clear how staff should respond when an incarcerated person is passively refusing to return to his cell or peacefully sitting on the ground of the yard after yard time has ended. Video footage from the cases above reveals that CDCR fills that gap by using immediate force, even when no imminent threat exists.

The regulations state that "controlled use-of-force may be used when time and circumstances permit advance planning, staffing and organization." 15 C.C.R. § 3268(i). That regulatory language further confuses when controlled force should be used.

Second, CDCR policy is less than clear whether officers can use force when an incarcerated person refuses a direct order. As discussed above, officers can only use immediate force to address an imminent threat. 15 C.C.R. § 3268(4); DOM § 51020.4(a)(4)(A). CDCR further states that "[i]mmediate force may be necessary to ... overcome resistance." DOM § 51020(a)(4)(B). But officers cannot use immediate force "solely to gain compliance with a lawful order"; under such circumstances they must use controlled force. 15 C.C.R. § 3268(4); DOM § 51020.4(a)(4)(C). As reflected in many of the cases above (especially the escort cases), officers appear to be improperly interpreting these provisions as authorizing force when no imminent threat exists. Specifically, when an incarcerated person passively refuses an order or when there is a form of resistance that does not immediately give rise to an imminent threat, CDCR staff, including those that conduct use of force reviews, appear to interpret currently policy to authorize an immediate use of force, regardless of whether there is an imminent threat. Officers commonly write in their incident reports that they were "overcoming resistance" or "effecting custody." This phrasing justifies their need to use immediate force.

In both of the circumstances staff should (but do not) use non-force approaches available to them, including using de-escalation techniques, issuing clear direct orders, threatening to issue rule violations, or contacting a supervisor.

With the cases and videos above in mind, please consider the following questions:

- 1. What, if any, changes need to be made to CDCR policies to clarify how sworn staff should address circumstances in which an incarcerated person is not complying with an order or is otherwise delaying a peace officer but does not pose an imminent threat and is not located in an area that can be controlled and isolated?
- 2. What, if any, changes need to be made to CDCR training to clarify how sworn staff should address circumstances in which an incarcerated person is not complying with an order or is otherwise delaying a peace officer but does not pose an imminent threat and is not located in an area that can be controlled and isolated?

. .

Officers' use of vague and conclusory statements justifying their force is reminiscent of the incident reports that were at issue in the *Madrid* case. *See* 889 F. Supp. 1146, 1187 ("It is not unusual for a report to gloss over events and immate injuries by reporting little more than the team 'gained control' and 'applied mechanical restraints.""). Fortunately, the body-worn camera footage available now provides a clearer picture of these uses of force. However, at prisons that do not have require officers to wear body-worn cameras, officers' written reports are still the primary evidence that hiring authorities and the IERC must rely on to assess whether the force was unnecessary and/or excessive.

B. CDCR Officers Use Excessive Force

CDCR policies defining "reasonable" and "excessive" uses of force are straightforward. Officers may only use "reasonable force," which is "[t]he force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable" to respond to threats. 15 C.C.R § 3268(a)(1); DOM § 51020.4(a)(1)(A). Officers cannot use "excessive force," or "[t]he use of more force than is objectively reasonable to accomplish a lawful purpose." 15 C.C.R § 3268(a)(3); DOM § 51020.4(a)(3)(A). Additionally, officers must take into account a person's disability before, during, and after a use-of-force incident. In its 2020 and 2021 orders, the *Armstrong* Court described many examples of officers using excessive force against people with disabilities and failing to take their disabilities into consideration when using force. *See Armstrong*, 484 F. Supp. 3d 808 at 824 ("A failure to provide a reasonable accommodation can occur where a correctional officer could have used less force or no force during the performance of his penological duties with respect to a disabled person"); *Armstrong*, 2021 WL 933106, at *3 (same).

Despite these clear requirements, CDCR officers routinely use force that goes beyond what is reasonable for the circumstances. Officers strike people in the head or slam people to the ground, even when they are handcuffed. Officers also do not appear to consistently take into account important situational factors, like a person's disability needs, before using force. When officers use excessive force, CDCR's reviewing authorities rarely find that the conduct violated policy. The lack of accountability in excessive force cases blurs the line of "reasonableness" for staff engaging in the force and pushes the limits regarding the amount of force that is appropriate further and further away.

The following cases show officers using excessive force against incarcerated people, including incarcerated people with disabilities. In every single one of these cases, the Hiring Authority and the IERC concluded that the force was not excessive.

In reviewing these cases and videos, please consider the following questions:

- 1. What, if any, changes need to be made to CDCR policies to clarify when force is excessive?
- 2. What, if any, changes need to be made to CDCR training to ensure sworn staff understand when force is excessive and refrain from using excessive force?
- Officers struck a handcuffed incarcerated person in the head at least 13 times over a 17-second period. When the incarcerated person refuses to be escorted by a particular officer and pulls away from the officer, the officer uses immediate force and multiple officers respond to the incident. While three officers wrestle with the incarcerated person, who was handcuffed behind his back, a fourth officer sprints to the scene and immediately winds up and throws a punch to the incarcerated person's face. Another officer arrives and immediately

punches the incarcerated person in the face four times. Another officer throws seven additional punches to the incarcerated person's face. Then the officers shove the incarcerated person face-first into the wall, as he stumbles and loses his balance. As his face slides down the wall, with the weight of seven officers behind him, his head lands in a small white bucket. Officers push the incarcerated person's head into the bucket, and as his head slightly comes up for a moment, one of the officers forces his head back into the bucket. Another officer moves the bucket out of the way, but it appears that the incarcerated person's chest is on another bucket. At that point, with the incarcerated person's head hovering in the air, an officer sits up straight to wind up, drops his weight, and throws an elbow to the back of the incarcerated person's head.

- About ten custody and medical staff members in protective gear are placing an incarcerated person on a gurney for transport. The incarcerated person protests that a sergeant, against whom he had previously filed a PREA claim, is touching him. The sergeant continues to strap the incarcerated person into the gurney. The incarcerated person then spits on the sergeant's face shield. In reaction, the sergeant slaps the incarcerated person in the face, knocking his glasses off. The sergeant then pushes the incarcerated person off the gurney where he uses force to press him against the floor, while other officers try to pull the sergeant off and take over restraining the incarcerated person.
- Officers dressed in riot gear are performing a controlled use of force to extract the incarcerated person from his cell. The incarcerated person, who is sitting calmly on his bed, jumps up on the bed. The officers pin him against the wall with their shields and body weight. An officer then repeatedly punches the incarcerated person in the head 23 times. The officers then force the incarcerated person to lie on the ground. After the officers move the incarcerated person to the ground, a second officer strikes the incarcerated person in the head area at least three times with his fist. Meanwhile, a third officer hits the incarcerated person's leg repeatedly with his baton. The strikes cause the incarcerated person to bleed, resulting in a pool of blood on the floor.
- The incarcerated person, who is lying on the top bunk in his cell, has reportedly been completely unresponsive and motionless to verbal requests from medical and custody staff. Medical staff authorized an emergency cell rescue so he could be taken to the hospital. In the video, the incarcerated person can be seen lying unresponsive on the top bunk, with his arms hanging limply off the side. Staff, who are wearing protective gear and have shields, enter the cell, but the incarcerated person still does not respond. The first officer into the cell grabs the incarcerated person and pulls him off of the top bunk; the officer does very little, if anything, to brace the incarcerated person's fall (he claims in his incident report that he held on to the incarcerated person's clothing as he fell, though the video is unclear). The incarcerated person falls approximately 5 feet from the top bunk onto the concrete floor, landing on his side with almost the full force of his body weight.

An officer placed his knee on an incarcerated person's neck for almost thirty seconds on the dayroom floor. *See* AVSS at 3:16:26. The officer then placed his knee on the incarcerated person's neck several more times over the next ten seconds.
An incarcerated person was acting erratically in the dayroom, but was surrounded by eleven officers and beginning to comply with orders to prone out. Nevertheless, the

tower officer fired a block gun, hitting another officer.

An officer restrains an incarcerated person after the incarcerated person, who was frustrated at the officer for dismissing his safety concerns, threw a notebook near the officer. See BWC 1. The officer escorts the incarcerated person to a holding cell. See BWC 2. Once the holding cage door is opened, the officer forcefully throws the incarcerated person into the holding cage face-first and it appears that the incarcerated person hits the side of his face against the back of the holding cage. See BWC 2; AVSS. The incarcerated person then spits at the officer. The officer, who is clearly enraged, proceeds to slam the incarcerated person into the back of the holding cage multiple times and pushes his hands into the incarcerated person's face and neck area. See BWC 2; AVSS.

In other cases, officers use more force than is objectively reasonable on people with disabilities or who are otherwise vulnerable. In many of these examples, the incarcerated person with a disability is handcuffed when officers use excessive force, compounding the dangerousness of the situation.

- (Described above in Section CDCR Officers Use Immediate Force When No "Imminent Threat" Exists.) An officer used unnecessary and excessive force against an incarcerated person with a mobility disability. The incarcerated person, who was seated on his walker, told an officer that the officer was not applying handcuffs consistent with the incarcerated person's disability. In response, the officer immediately grabs the incarcerated person by the back of the neck, throws him and his walker to the ground, and lays on top of him for approximately 15 seconds before staff begin twisting the incarcerated person's arms to handcuff him behind his back. While on the ground, the incarcerated person yells in pain and says that he has a special cuffing restriction, that his shoulder is torn, and that his wrist cannot be cuffed.
- (Described above in Section CDCR Officers Use Immediate Force When No "Imminent Threat" Exists.) An officer grabs an incarcerated person behind his neck and throws him to the ground. At the time, the incarcerated person was secured in waist chains, using a walker to ambulate, and surrounded by numerous officers in an otherwise empty dayroom.

- (Described above in Section CDCR Officers Use Immediate Force When No "Imminent Threat" Exists.) An officer places his hand on the back of the incarcerated person's head and slams him head-first into the concrete, sending the incarcerated person toppling over his walker. At the time, the incarcerated person is secured in waist chains, in an area of the prison where movement is restricted, surrounded by custody officers, and only yelling at an officer who is around 50 feet away.
- An officer is escorting an incarcerated person, who is 58-yearsold, is in waist chains, and uses a walker. He complains multiple times that the waist chains are
 too tight, such that he cannot use his walker. When he stops again to adjust the waist chains, the
 officer activates her alarm. The officer then squeezes the incarcerated person's arm more tightly,
 which further aggravates him. As she is squeezing the incarcerated person's arm, the officer says,
 "Listen, you're going to let go, you're not gonna ... you're gonna hold your thing," referring to his
 walker. The incarcerated person interrupts her and says, "I'm not gonna hold a goddamn thing!
 Take me back to my goddamn cell." As the incarcerated person begins to turn his walker around in
 the direction of his cell, the officer grabs him with a second hand and forces the incarcerated
 person against the wall. A group of officers then come running in response to the alarm, and they
 dangerously tackle the incarcerated person over his walker and into an open cell.

The fact that neither the IERC nor the hiring authorities found issues with any of these cases underscores the problem. CDCR's interpretation of "reasonable force" is so broad as to allow almost any less-lethal force to be used. As a result of the lack of a meaningful check on the excessiveness of the force, CDCR officers are encouraged to continue misusing force. *See Madrid*, 889 F. Supp. 1146, 1160 (finding when "prison administrators fail to adequately supervise and monitor the use-of-force, the potential that force will be misused increases significantly").

i. CDCR Policy Should Make Clear that Head Strikes are Excessive

Striking a person in the head is very dangerous and can cause serious, lasting injury or death. These strikes should only be permitted in very rare circumstances, including when officers are authorized to use deadly force. *See* DOM § 51020.19 (listing "lethal target areas" as "head, eyes, throat, or spine"). However, CDCR officers frequently strike people in the head during routine uses of force. Considering that none of the officers in the above cases involving head strikes were issued discipline, much less any corrective training, it is clear that CDCR views that form of force—numerous strikes to a person's head—as reasonable even in non-lethal situations. Policy should be changed to reflect the danger and the risk of potential harm that results from open-hand or closed-fist strikes to the head.⁹

That position—that head strikes are very dangerous and should be used very sparingly and only in extreme circumstances—is consistent with the position of other experts in the field. *See e.g.*, *Rosas v. Luna*, No. 2:12-cv-00428-DDP-MRW, Plaintiffs' Memorandum of Points and Authorities in Support of

Please consider the following question:

1. Should CDCR policy prohibit the use of head-strikes except only in circumstances where officers are permitted to use lethal force?

III. CDCR DOES NOT HOLD STAFF ACCOUNTABLE FOR MISUSING FORCE

The cases we have highlighted not only reflect breakdowns in use-of-force practices within CDCR, but also represent failures of CDCR's accountability system. As we noted above, CDCR did not sustain a single violation for unnecessary or excessive force against any of the officers involved in the above-discussed incidents. Below, we discuss potential reasons for these accountability failures, including inadequate reviews of uses-of-force by the IERC and OIA, the lack of BWCs at many prisons within CDCR, poor decision-making by hiring authorities, and underutilization of CDCR's early warning system.

A. Investigations into Allegations of Excessive or Unnecessary Force Are Not Adequate

CDCR currently has two separate systems for reviewing uses of force: (1) the IERC and (2) OIA investigations. The IERC reviews every use of force, regardless of whether there is an allegation that the use of force violated policy. If the IERC identifies a policy violation that might result in discipline, the IERC refers the case to OIA for an investigation, as CDCR cannot impose discipline against an officer without an investigation.

Meanwhile, OIA conducts investigations into all allegations that an officer used excessive or unnecessary force. If an incarcerated person makes a use-of-force allegation after the IERC has completed its review, then the OIA investigator to whom the case is assigned generally collects the IERC review as evidence in the OIA investigation. If, however, an incarcerated person submits a use-of-force allegation before the IERC has completed its review, the IERC process is paused while OIA conducts its investigation. See DOM § 51020.19.5(h). The OIA investigator gathers evidence and drafts an investigation report. 15 C.C.R. § 3486.2(b). OIA sends the report and evidence to the hiring authority, who then determines whether to sustain the allegation of misconduct. See 15 C.C.R. § 3392.1 (listing the possible outcomes of a staff misconduct allegation). The IERC then completes its review, but must, according to CDCR policy, "apply the findings of the Hiring Authority" from the OIA investigation. DOM § 51020.19(d). The IERC's review in these cases is therefore pointless.

Motion to Modify Implementation Plan, Dkt. 253 at 10 (C.D. Cal. May 31, 2023) ("Medical science informs us that head blows are the 'hidden injuries' that create or exacerbate mental illness. Agencies nationwide have long moved away from acceptance of head strikes.") (quoting the court-appointed monitors' report about the Los Angeles Sheriff's Department's compliance with its remedial plan provisions regarding use-of-force).

Both of these processes for reviewing uses of force are seriously flawed. In the cases discussed above (and many others not included in this letter), the IERC failed to identify any use-of-force policy violations. Investigations into allegations of misconduct are frequently deficient and biased. Moreover, CDCR has understaffed and undertrained its OIA investigators, and as a result, those investigators have not been adequately resourced to comprehensively investigate allegations of staff misconduct.

Please consider the following questions:

- 1. Can the IERC or some entity other than OIA conduct comprehensive and unbiased investigations into allegations of staff misconduct based on use-of-force policy violations?
- 2. What, if any, modifications to CDCR's policies and procedures are necessary for the IERC or some entity other than OIA to conduct comprehensive and unbiased investigations into allegations of staff misconduct based on use-of-force policy violations?

B. CDCR Does Not Use BWCs at All Prisons

As shown by the cases above, audio-visual evidence and, in particular, audio evidence from BWCs, are essential for ensuring that officers comply with use-of-force policies. Audio of dialogue just prior to the force is necessary for determining whether force was required, whether officers properly employed de-escalation techniques, whether a person's disability needs were considered (e.g., whether the person's disability prevented them from understanding the situation or the officer's orders, or otherwise impacted their ability to comply), and whether the degree of force was reasonable under the circumstances. Audio can also be useful for determining why officers used force, including whether they had a retaliatory motive.

CDCR does not, however, have body-worn cameras and fixed cameras at all of its prisons. In 2020 and 2021, to improve the quality of investigations into allegations of misconduct, including use-of-force allegations, the *Armstrong* court ordered CDCR to implement body-worn cameras and fixed cameras at six prisons. Relying on testimony from Plaintiffs' expert, Eldon Vail (the former Secretary of the Washington Department of Corrections), the court held that the use of body-worn cameras in correctional facilities results in "increased officer and inmate safety, fewer uses of force," and improved investigations of internal misconduct by officers, particularly when used in conjunction with surveillance cameras. *Armstrong*, 2021 WL 933106, at *20. CDCR has now installed fixed surveillance cameras (with video only) at many prisons, including the six prisons covered by the *Armstrong* orders. CDCR also now requires officers at 10 of the 31 prisons to wear body-worn cameras, which have video and audio features. *See* 15 C.C.R. § 3270.3(a) (listing the 10 prisons where body-worn cameras are required). However, officers at more than two-thirds of CDCR prisons (21 of 31 prisons) do not wear body-worn cameras. Accordingly, the majority of OIA investigations and IERC reviews of uses of force do not have access to

and cannot consider BWC footage, which significantly impacts their ability to hold staff accountable and make recommendations to reduce force.

Please consider the following questions:

- 1. In order to conduct comprehensive and unbiased investigations and reviews of use-of-force incidents, is audio and video footage necessary?
- 2. In order for a decision-maker to appropriately decide whether staff violated use-of-force policies, including de-escalation requirements, is audio and video footage necessary?
- 3. In order for a decision-maker to impose appropriate discipline for use-of-force policies, including de-escalation requirements, is audio and video footage necessary?
- 4. How does it effect CDCR's use-of-force review system that some prisons have BWC footage and others do not?

C. Hiring Authorities, Both as the Decision-Makers on OIA Investigations and the Head of the IERCs, Do Not Sustain Use-of-Force Violations

Hiring authorities also continue to be a barrier to CDCR holding staff accountable for use-of-force violations. As discussed above, wardens at the prisons may review uses of force in two ways. First, the wardens chair the IERCs, which review every use of force (regardless of whether there is an allegation of misconduct) to determine if officers complied with policy before, during, and after the use of force. Second, with an important caveat discussed below, wardens are the decision-makers on staff misconduct investigations into allegations that officers used unnecessary or excessive force.

Plaintiffs have extensive experience monitoring wardens in both of these processes. With respect to IERCs, as shown by the cases we discussed above and many others not included in this letter, IERCs frequently fail to identify and address use-of-force violations. Regarding OIA investigations, we have found that wardens frequently delay substantially in resolving cases, fail to identify and sustain allegations when evidence clearly demonstrates that force was unnecessary or excessive, and, even when they do sustain allegations, fail to issue discipline consistent with CDCR's disciplinary matrix. See 15 C.C.R. § 3392.5 (CDCR's disciplinary matrix).

In response to ongoing negotiations, CDCR created a headquarters-level centralized hiring authority unit, called the "Centralized Allegation Resolution Unit" ("CARU"), which began operations in January 2025. *See* Dkt. 3720 (stipulation between the parties describing the role of the CARU). Now, at 10 of the 31 CDCR prisons, the warden no longer serves as the hiring authority for allegations of excessive or unnecessary uses of force. Instead, those allegations are routed to the CARU, which decides whether staff violated policy.

Plaintiffs' counsel are supportive of the CARU. In theory, the unit can issue discipline in a timelier, less biased, and more consistent manner than local hiring authorities. It is unclear whether the CARU will be expanded to cover any of the remaining 21 CDCR prisons, where the wardens continue to act as hiring authorities. The CARU is also so new that Plaintiffs have not yet been able to determine through our monitoring whether it is resulting in better decision-making in cases involving use-of-force allegations.

Please consider the following question:

1. Do you recommend that, in order for the review of use-of-force incidents to result in consistent and appropriate disicpline, the decision-maker be outside of the institution at which the incident occurred?

D. CDCR Has Not Properly Used its Early Warning System

The *Armstrong* Court ordered CDCR to develop an Early Warning System ("EWS") "for tracking all incidents by date, time, location, staff involved, and incarcerated people involved, that includes information about whether inmates are disabled, any injuries they suffered, and related medical records." *Armstrong*, 2021 WL 933106, at *22.

CDCR developed an EWS that is broad and generally tracks staff misconduct allegations, but it does have the capability to filter data for use-of-force incidents. Responsibility for reviewing information in the EWS lies with the hiring authority at each prison. CDCR sends emails to hiring authorities every time allegations against a particular officer or allegations in general reach certain thresholds. During negotiations with Defendants about those thresholds, Plaintiffs' counsel raised concerns that the EWS did not go far enough. Thresholds were set based on statewide averages, meaning when prisons dipped above the average for complaints, an email was sent to the hiring authority. Instead, Plaintiffs' counsel pushed for thresholds to be lower than averages and to represent aspirational goals, rather than the status quo. Further, because individual prison yards and individual housing units throughout a prison might have very different populations, the thresholds should be specific and consider the unique factors of the custody environment and population in that housing unit. Lastly, Plaintiffs' counsel have raised concerns that hiring authorities will ignore autogenerated emails showing high-level EWS data for their prison and those that are not tech savvy may not dig deeper into the data in order to fully understand what is happening at their prison. Hiring authorities are also not required in policy to review and act on the EWS data.

. .

٠.

. .

Please consider the following questions:

- 1. Should CDCR use its Early Warning System to track the number of use-of-force incidents by prison yard, by prison housing unit, and by officer involved?
- 2. How can CDCR use its Early Warning System to reduce use-of-force rates?

E. Findings by the Office of the Inspector General Confirm that CDCR Has a Serious Problem With Uses of Force

The Office of Inspector General ("OIG"), an independent entity in California that monitors use-offorce and staff misconduct investigations in CDCR, has reported issues with CDCR's use-of-force review process. Specifically, the OIG has repeatedly identified numerous cases where officers use unnecessary force when an incarcerated person is not presenting an imminent threat, where officers use more force than is necessary, and where officers fail to employ de-escalation techniques before using force. The OIG has also repeatedly highlighted the failure of CDCR's oversight systems—hiring authorities and the IERC—to hold staff accountable for these violations.

In October 2025, for example, the OIG reviewed 13 of CDCR's use-of-force investigations closed between January and June 2025 and found that CDCR performed "inadequately" in 12 of those cases. *See* Cal. Office of the Inspector Gen., *Force Investigation Review Team Case Summaries* (July 31, 2025), available at https://www.oig.ca.gov/wp-content/uploads/2025/07/Force-Investigation-Review-Team-Case-Summaries.pdf (last accessed Oct. 17, 2025) at 2. In some of those cases, the OIG determined that OIA's investigations were very poorly conducted, including because investigators failed to conduct relevant interviews and request all relevant video footage. *Id.* at 3-7. The allegations in these cases were serious: an officer deployed pepper spray when an incarcerated person's back was turned and she was not posing an imminent threat (*id.* at 2-3); an officer unnecessarily slammed an incarcerated person to the floor and ignored his need for medical attention (*id.* at 2); four officers punched and kicked a handcuffed incarcerated person in the face, head, and ribs (*id.* at 3-4); an officer pulled an incarcerated person off of the toilet while he was defecating (*id.* at 6). However, none of the officers were held accountable.

The OIG identified the same issues in its December 2024 report. See Cal. Office of the Inspector Gen., September–December 2024 Use-of-Force Case Blocks (Dec. 30, 2024), available at https://www.oig.ca.gov/wp-content/uploads/2024/12/September%E2%80%93December-2024-Use-of-Force-Case-Blocks.pdf (last accessed Oct. 13, 2025). For that report, the OIG reviewed six of CDCR's use-of-force investigations and determined that either the hiring authority or the IERC failed to identify misconduct in each case.

CDCR's frequent use of unnecessary and excessive force and its broken accountabilty system for violating its use-of-force policies are longstanding problems. Courts, Plaintiffs' counsel, the OIG, incarcerated people, and CDCR's own data confirm the problem, yet CDCR has not properly resolved it.

IV. INFORMATION AND QUESTIONS TO CONSIDER DURING A REVIEW OF CDCR'S USE-OF-FORCE POLICIES AND PRACTICES

A. Relevant Information to Consider During the Review

We recommend that an evaluation of CDCR's use-of-force practices and policies include:

1	A review of CDCR's use-of-force policies, including statutes, regulations, the DOM, and local operating procedures	
2	A review of CDCR's use-of-force training materials, including materials related to: • recognizing an imminent threat; • avoiding force and de-escalating situations; • considering a person's disability needs before, during, and after force; • initiating a controlled use-of-force; • responding to resistance from an incarcerated person during hands-on escorts; • responding to an incarcerated person's refusal to comply with an order	
3	A review of video footage of uses of force, including immediate and controlled uses of force, and force used on people who have mobility disabilities	
4	A review of incident report packages, including incident narratives, from use-of-force incidents	
5	A review of complete IERC documents, including the video interview with the incarcerated person who had force used on them	
6	Observation of a real-time IERC being conducted	
7	A review of OIA investigation files into allegations of excessive and/or unnecessary uses of force	
8	Observation of case-conferences, where the decision-maker determines whether staff violated policy, regarding an allegation of excessive/unnecessary use-of-force	
9	A review of data related to uses of force in CDCR	

B. Important Questions to Consider During the Review

In addition to the questions included above (which we have reproduced below for your convenience), please consider the following questions:

1	What changes should CDCR make to its use-of-force policies to bring the policies in line with constitutional standards, the ADA, and best practices?
2	What changes should CDCR make to its use-of-force training to bring the training in line with constitutional standards, the ADA, and best practices?
3	Are the local operating procedures at individual prisons consistent with CDCR's statewide policies?

4	What steps should CDCR take to reduce the number of uses of force?	
5	What steps should CDCR take to improve accountability for officers who violate use-of-force policies?	

For your convenience, below, we reiterate the questions posed throughout the report:

	What, if any, changes need to be made to CDCR policies to make clear that sworn staff can only
1	use immediate force if there is an imminent threat?
2	What, if any, changes need to be made to CDCR training to ensure sworn staff understand what constitutes and can recognize in practice an imminent threat?
3	What, if any, changes need to be made to CDCR training to ensure sworn staff understand the imminent threat standard during escorts?
4	What, if any, changes need to be made to CDCR training to ensure sworn staff understand that an incarcerated person's failure to comply with a lawful order does not constitute an imminent threat?
5	What, if any, changes need to be made to CDCR policies to make clear that sworn staff must take into account an incarcerated person's disability, including mental health disabilities, before, during, and after using force?
6	What, if any, changes need to be made to CDCR training to ensure that sworn staff take into account an incarcerated person's disability, including mental health disabilities, before, during, and after using force?
7	What, if any, changes need to be made to CDCR policies to make clear that, when possible, sworn staff must attempt to de-escalate situations prior to using force?
8	What, if any, changes need to be made to CDCR training to ensure sworn staff understand the obligation to de-escalate?
9	What, if any, changes need to be made to CDCR training to ensure sworn staff are proficient in deescalation techniques?
10	What, if any, changes need to be made to CDCR policies to clarify how sworn staff should address circumstances where an incarcerated person is not complying with an order or is otherwise delaying a peace officer but does not pose an imminent threat and is not located in an area that can be controlled and isolated?
11	What, if any, changes need to be made to CDCR training to clarify how sworn staff should address circumstances where an incarcerated person is not complying with an order or is otherwise delaying a peace officer but does not pose an imminent threat and is not located in an area that can be controlled and isolated?
12	What, if any, changes need to be made to CDCR policies to clarify when force is excessive?
13	What, if any, changes need to be made to CDCR training to ensure sworn staff understand when force is excessive and refrain from using excessive force?

14	Should CDCR policy prohibit the use of head-strikes except only in circumstances where officers are permitted to use lethal force?	
15	Can the IERC or some entity other than OIA conduct comprehensive and unbiased investigations into allegations of staff misconduct based on use-of-force policy violations?	
What, if any, modifications to CDCR's policies and procedures are necessary for the entity other than OIA to conduct comprehensive and unbiased investigations into allest staff misconduct based on use-of-force policy violations?		
17	In order to conduct comprehensive and unbiased investigations and reviews of use-of-force incidents, is audio and video footage necessary?	
18	In order for a decision-maker to appropriately decide whether staff violated use-of-force policies, including de-escalation requirements, is audio and video footage necessary?	
19	In order for a decision-maker to impose appropriate discipline for use-of-force policies, including de-escalation requirements, is audio and video footage necessary?	
20	How does it effect CDCR's use-of-force review system that some prisons have BWC footage and others do not?	
21	Do you recommend that, in order for the review of use-of-force incidents to result in consistent and appropriate disicpline, the decision-maker be outside of the institution at which the incident occurred?	
22	Should CDCR use its Early Warning System to track the number of use-of-force incidents by prison yard, by prison housing unit, and by officer involved?	
23	How can CDCR use its Early Warning System to reduce use-of-force rates?	